



Delivery of Mental Health and Substance Use Disorder Treatment Via Telehealth to Aid Maryland's Recovery from COVID-19

Introduction

In response to the COVID-19 pandemic, Maryland has increased flexibilities for the delivery of telehealth services to ensure Marylanders with mental health (MH) and substance use disorders (SUD) and co-occurring disorders across the State can receive treatment while minimizing the risk of exposure to and transmission of the virus. As the country and State gradually reopen, the safety of Medicaid providers and participants must remain a priority, particularly as the Medicaid system begins to meet the growing need for MH and SUD care. Maryland's providers will be unable to operate at full capacity in community-based settings while the need for social distancing and the use of personal protective equipment (PPE) continues to prevent the spread and resurgence of COVID-19. Medicaid participants, who frequently lack access to private transportation and other resources, should not be placed at greater risk as they access health care. In addition, residents of rural and other communities that experience provider shortages and limited access to broadband service must continue to have access to life-saving health services. All Marylanders, including our most vulnerable residents, must be able to continue to receive MH and SUD services safely and efficiently.

Accordingly, the undersigned 36 members of the Maryland Parity at 10 Coalition and the Maryland Behavioral Health Coalition are calling for emergency action to meet the growing demand for continued flexibility in telehealth requirements for MH and SUD services after the federal and State public health emergency declarations are lifted. These standards should remain in place over the next year, at a minimum, until an effective vaccine is readily available for all residents.

The Coalition recommends the following telehealth standards and practices in the Medicaid program to ensure safe and comprehensive access to SUD and MH care as Maryland gradually reopens and prepares for subsequent COVID-19 surges.

1. **Originating sites:** authorize expansion of permissible sites where patients can access telehealth, including patients' homes and additional locations that meet patients' needs;
2. **Distant sites:** authorize reimbursement for telehealth services delivered by provider and paraprofessionals on the same basis as in-person services;
3. **Technology:** authorize reimbursement of additional telehealth technologies to meet the needs of all Medicaid members;
4. **Reimbursement:** continue payment parity standards for telehealth services and remove discriminatory authorization requirements for MH and SUD telehealth services; and
5. **Access to Medication for SUD and MH Treatment:** advocate with federal regulators to extend the exemption of in-person medical examination requirements for treatment initiation and prescription of controlled substances and take-home dose restrictions for methadone.

Our recommendations are based on the following principles:

1. **Continuation of Telehealth:** The COVID-19 pandemic requires the continuation of flexible telehealth practices so that high quality MH and SUD care can be delivered safely and without disruption pending the development of a

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AND MENTAL HEALTH DISORDERS. IT'S THE LAW.**

vaccine. Telehealth flexibilities for MH and SUD care must be equivalent to those for medical/surgical care, consistent with the Mental Health Parity and Addiction Equity Act (Parity Act).

2. **Patient Choice:** Patients have the right to work with their providers to determine the most appropriate service delivery model – in-person services, audio-visual telehealth, telephone calls, or a mix – based on therapeutic considerations and individual needs. Patients must retain the right to refuse the delivery of services via telehealth without risking the loss or withdrawal of program benefits. Service delivery options must be equivalent to those for medical/surgical care, consistent with the Parity Act.
3. **Privacy:** Consumers have the right – and a critical need – for privacy and security protections when accessing SUD and MH care, including adherence to protections for patients receiving SUD treatment under 42 C.F.R. Part 2.
4. **Quality:** Telehealth services must meet the same level of quality required of in-person care.

Originating Site

Background

The Maryland Medicaid Program requires telehealth services to be delivered to a patient who is located at one of 13 designated originating sites by a provider at a distant site.¹ The State enacted legislation in April 2020 to authorize MH telehealth services to originate in a patient's home and require the Maryland Department of Health (MDH) to apply for an 1115 waiver to implement a pilot program to provide chronic case management services through telehealth regardless of the program participant's location.² MDH is also required to study whether SUD services may be provided through telehealth to a patient in their home setting.

During COVID-19, MDH has expanded access to telehealth by relaxing the restrictions on originating sites and providing reimbursement under these circumstances. The State has allowed most telehealth services to originate in "a participant's home or any other secure location as approved by the participant and the provider."³ Medicaid participants have also been able to utilize telehealth while residing in psychiatric rehabilitation programs (PRP) and SUD residential facilities.⁴

Recommendations

Maryland Medicaid should expand its designated originating sites to ensure on-going and safe access to SUD and MH services that meet the needs of the State's most vulnerable residents and reimburse for telehealth services at these locations.

1. The designated originating sites should include a participant's home or any other location as approved by the participant and the provider. The definition of "home" should include shelters, any other location for persons who experience homelessness or lack a permanent residence, and recovery residences. Participants who feel unsafe or lack privacy in their homes should be able to identify an alternative setting with their providers for telehealth services.
2. Designated originating sites should include residential rehabilitation and treatment settings, including PRPs and SUD residential treatment facilities.
3. Maryland should utilize data from this emergency period to satisfy the HB 1208/SB 502 study requirement and conclude that the delivery of SUD telehealth services to patients in their home is appropriate and essential to service delivery on a permanent basis.

¹ COMAR §§ 10.09.49.02, 10.09.49.06(C).

² HB 1208/SB 502 (2020). This legislation conditions reimbursement of MH telehealth services originating in a patient's home on state budget limitations.

³ MDH Guidance COVID-19 #1 (Mar. 12, 2020).

⁴ MD Executive Order No. 20-03-20-01 (Mar. 20, 2020); MDH COVID-19 Guidance #4b, #4c (Mar. 21, 2020).

Justification

It is essential for patients to access telehealth for SUD and MH services from their homes, or wherever they may be located at the time of service delivery. This includes residential treatment settings, where patients and providers may need to physically isolate to reduce the risk of contracting COVID-19, while ensuring access to the full scope of treatment.

As Maryland Medicaid begins to assess whether it will continue to reimburse for the delivery of MH and SUD telehealth services from a patient's home, it should follow Medicare standards that explicitly authorize the home as an originating site for individuals with SUDs for the purpose of substance use disorder treatment.⁵ At least 20 states authorized the home to be the originating site for Medicaid telehealth services pre-COVID-19.

Early reports indicate that both patients and providers in Maryland have seen extraordinary benefits from expanding access to SUD and MH telehealth services from homes and other facilities. The [Maryland Addiction Directors Council's survey](#) of over 400 patients found that the majority of respondents were satisfied with the quality of their telehealth services and were able to access care that would not have otherwise been available to them during the pandemic. Likewise, [Community Behavioral Health's survey](#) of more than 4,000 patients found that the vast majority of respondents wished to retain the ability to access telehealth services after the State of Emergency ends and be able to utilize the telehealth option in combination with in-person visits. Seventy percent (70%) of respondents prefer to use telehealth services for at least half of their visits.

Patients have benefited from the economic security associated with not needing to finance transportation to appointments or miss work or arrange childcare to keep appointments. Reducing unnecessary financial barriers to treatment is essential as more families experience unemployment and furloughs and an associated need for MH and SUD services. Health Care for the Homeless has reported that missed appointment rates for behavioral health services have significantly declined since the expansion of telehealth and that practitioners are better able to manage a patient's medications and co-occurring conditions. Other providers have found that it is easier to fill open slots with telehealth, schedule appointments to accommodate patients' work schedules, continue and resume treatment for patients who have moved to a new location, and provide additional language translation services for patients whose primary language is not English. Providers have also been able to get a better sense of a patient's home environment during telehealth visits, including those that do not have a home, such that they can tailor treatment more effectively to meet the patient's needs.

Medicaid members who are experiencing homelessness and those who do not feel safe and secure in their homes have greatly benefited from the opportunity to use telehealth from an alternate location that is identified with their providers. Many individuals who seek behavioral health treatment have a unique and heightened need for privacy and may not feel comfortable using telehealth in their homes where family members can overhear conversations. For patients who are participating in group telehealth sessions, the need for that privacy and security extends to all members of the group as well as the provider and may require service delivery outside of a patient's home when a facility-based site is not accessible.

Finally, the State has sufficient data from this emergency period to determine that SUD services may be safely and effectively provided by telehealth to Medicaid patients in the home. It is unnecessary and redundant to conduct a separate study. Maryland should take the necessary and immediate steps to expand this practice under Medicaid via regulations or a State Plan Amendment to ensure reimbursement.

⁵ 42 C.F.R. § 410.78(b)(3)(xii).

Provider/Distant Site Recommendations

Background

The State requires providers to be enrolled in Maryland Medicaid and offer services within the scope of their practice to deliver MH and SUD care via telehealth.⁶ Within assertive community treatment (ACT) and mobile treatment services (MTS), only psychiatrists and psychiatric nurse practitioners are permitted to serve patients through telehealth.⁷ Certified peers or paraprofessionals who work within ACT and MTS programs are not permitted to serve clients via telehealth. This restriction applies in other SUD and MH programs and settings in which certified peers and paraprofessionals may not be reimbursed for telehealth services despite working under supervision in licensed programs and providing the same services in-person.

During COVID-19, the U.S. Department of Health and Human Services issued a broad waiver to allow providers with equivalent licenses in other states to serve Medicaid members across state lines.⁸ Maryland received a waiver to relax these requirements, and to streamline provider enrollment in Maryland Medicaid.⁹ MDH issued a directive allowing Alcohol and Drug Trainees (ADT) to deliver telehealth services within the scope of their practice and with adequate supervision and appropriate technologies.¹⁰ Maryland also expanded the ability of all licensed ACT and MTS programs to allow the use of telehealth by all team members (licensed and paraprofessional).¹¹

Recommendations

Maryland Medicaid should permit all providers and paraprofessionals who provide in-person services in a licensed Maryland program to continue serving patients via telehealth within the scope of their practice. Professional licensing boards should facilitate the licensure process of all MH and SUD provider applications, including those from out-of-state, to address the shortage of MH and SUD providers and unmet needs in the community.

1. All providers and paraprofessionals working within a licensed MH or SUD program in Maryland should be reimbursed for providing services via telehealth consistent with reimbursement of those services when delivered in person. In particular, ADTs should continue to be reimbursed for telehealth services.
2. Maryland's health occupation boards should evaluate the impact of licensure flexibility during the pandemic and identify measures that will facilitate the licensure of MH and SUD providers.

Justification

Maryland has a significant shortage of MH and SUD providers, and the Medicaid provider network is inadequate to meet the needs of Medicaid members, particularly those who need language accessible services. To ensure continuity of care, all providers and paraprofessionals working within a licensed MH or SUD program, including ADTs, must be authorized to use telehealth to meet the needs of their patients. Licensed programs have supervisory structures and quality assurance practices in place for in-person service delivery, and the telehealth platform does not alter that structure.

⁶ COMAR § 10.09.49.06.

⁷ MD Ins. Code § 15-105.2. This law will sunset on September 30, 2021.

⁸ Dep't of Health & Human Services, Waiver or Modification of Requirements Under Section 1135 of the Social Security Act (Mar. 13, 2020), <https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx>.

⁹ Dep't of Health & Human Services, Section 1135 Waiver Flexibilities – Maryland Coronavirus Disease 2019 (Mar. 26, 2020), <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/87756>.

¹⁰ MDH, Directive and Order Regarding the Board of Professional Counselors and Therapists (Apr. 6, 2020), <https://health.maryland.gov/bopc/Documents/mdhorderbopc1.pdf>.

¹¹ MDH, Telephone Services Authorized During State of Emergency for Mobile Treatment and ACT Services (Mar. 25, 2020), [https://bha.health.maryland.gov/Documents/Telephone%20Services%20Authorized%20for%20Mobile%20Treatment%20and%20ACT%2032520\(1\)%20\(1\).pdf](https://bha.health.maryland.gov/Documents/Telephone%20Services%20Authorized%20for%20Mobile%20Treatment%20and%20ACT%2032520(1)%20(1).pdf).

Out-of-state providers who have filled a specific need during the pandemic (e.g. services for college students who have received out-of-state care) should continue to be allowed to serve patients, with appropriate assurances of high-quality care and accountability, during the declared State of Emergency. The Professional Boards should facilitate access to MH and SUD care by adopting measures to ensure prompt licensure of providers.

Technology

Background

Maryland Medicaid regulations define telehealth as the delivery of medically necessary somatic or behavioral health services through the use of multimedia communication equipment permitting two-way real-time interactive audio-visual communication between a patient at an originating site and a provider at a distant site.¹² The regulations impose minimum technological requirements regarding the type of camera equipment, audio equipment, bandwidth speed, display monitor size, and transmission length.¹³ Providers are required to comply with Maryland privacy laws, HIPAA privacy rules, and 42 C.F.R. Part 2, and ensure that all interactive video technology-assisted communication complies with HIPAA patient privacy and security regulations at the originating site, distant site, and in the transmission process.¹⁴

These requirements have not been enforced during the pandemic, pursuant to federal and State declarations.¹⁵ The State has authorized the delivery of telehealth through an audio-only telephonic delivery model for MH, SUD, and other medical services, as well as the expansion of remote patient monitoring (RPM) for “all conditions capable of monitoring via RPM.”¹⁶

Recommendations

Maryland Medicaid should reimburse for telehealth services that are delivered via all communication technologies that comply with the HIPAA, including audio-only technologies, when patients request such mode of communication and providers implement reasonable safeguards, consistent with HIPAA's privacy rule.

1. Telehealth should include audio-only services, and Maryland Medicaid should authorize reimbursement when a patient is unable to access audio-visual communications and requests the use of audio-only services, pursuant to HIPAA and 42 C.F.R. Part 2, as applicable.
2. Existing technological requirements for audio-visual telehealth services in COMAR should be updated to allow for reimbursement of any interactive audio or interactive video that complies with the HIPAA security rule.
3. Remote patient monitoring (RPM) for MH and SUD treatment should be reimbursed.
4. Maryland should explore funding and reimbursement options to expand telehealth access across Maryland for secure technology devices, WiFi, broadband, phone minutes, and any other resources that Marylanders may need to access telehealth.

Justification

Income, race, age, disability and geographical disparities result in limited access to the technology standards that Maryland Medicaid currently requires for telehealth services. Technology, which changes rapidly, should not be a barrier to MH and SUD services. It is vital to continue audio-only telehealth services and to revise Maryland's definition of audio-

¹² COMAR §§ 10.09.49.02, 10.09.49.09(B).

¹³ COMAR § 10.09.49.07(B).

¹⁴ COMAR § 10.09.49.08.

¹⁵ Dep't of Health & Human Services, Waiver or Modification of Requirements Under Section 1135 of the Social Security Act (Mar. 13, 2020), <https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx>.

¹⁶ MDH Guidance COVID-19 #4a, #4b, #4c (Mar. 21, 2020); Maryland State Plan Amendment #20-0003 (May 4, 2020), https://mmcp.health.maryland.gov/Medicaid%20COVID19/Updated%20MD%20SPA%2020-0003%20APPROVAL%205_1_2020.pdf.

visual technology to eliminate standards that prevent all Medicaid members from participating because they lack the technology, resources, or experience to access telehealth.

Nothing in Medicaid law prohibits reimbursement of audio-only telehealth; only Medicare law. Outside of telehealth, in 2019, Medicare authorized reimbursement for patient-initiated “virtual check-ins” with providers and practitioners through a range of devices that include telephones.¹⁷ Additionally, nothing in the Social Security Act requires Medicaid to base its definition of telehealth or reimbursement standards on Medicare law. Individual patient considerations and circumstances necessitate the use of telephonic, audio-only telehealth, especially for the State’s most vulnerable populations.

HIPAA permits audio-only telehealth over the phone, as long as providers implement reasonable safeguards under the Privacy Rule, such as conducting telehealth in private settings and adopting safeguards to limit incidental disclosure and use of patient information.¹⁸ HIPAA permits a provider to use personal health information (PHI), including a patient’s phone number, for treatment purposes and does not include voice transmitted via telephone as an electronic transmission subject to the security rule.¹⁹ The State should authorize reimbursement for audio-only telehealth, provide patient education on how to secure personal devices and ensure that conversations are not overheard, and issue guidance for patients and providers on how to verify each other’s identities. Colorado recently passed legislation permitting the use of audio-only telephones for telehealth services in Medicaid when they are used in a HIPAA-compliant manner,²⁰ and Maryland could follow this example.

Behavioral health providers have found the use of RPM to be extremely beneficial to ensure patients are maintaining their medication regimens and staying on track with their treatment plans. The State’s temporary expansion of telehealth to include all conditions capable of monitoring via RPM, arguably including MH and SUD conditions, demonstrates the value of this service. To the extent Medicaid reimburses RPM for medical conditions but not MH and SUD, it likely violates the federal Parity Act. Maryland should therefore authorize the use of these technologies in MH and SUD settings and seek funding to expand equitable access to them.

Even with the COVID-19 relaxations, there is an ongoing need to minimize the gaps in access to technology that perpetuate health disparities including sufficient broadband, WiFi, and other infrastructure to access telehealth. Low-income residents and many with chronic psychiatric conditions are less likely to have phones with cameras, encryption technology, or minutes to access the audio-only services they might need. Maryland Medicaid should explore reimbursement models, grants, and funding to ensure that members can access these vital resources to bridge the digital divide.

¹⁷ CMS, Medicare Telemedicine Health Care Provider Fact Sheet (Mar. 17, 2020), <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>.

¹⁸ 45 CFR § 164.530; *see also* U.S. Dep’t of Health & Human Services, “Where can health care providers conduct telehealth?” (Mar. 27, 2020), <https://www.hhs.gov/hipaa/for-professionals/faq/3021/where-can-health-care-providers-conduct-telehealth/index.html>. Audio-only telehealth is not subject to the Security Rule, which only governs electronic PHI and does not include voice transmitted via telephone. 45 CFR §§ 160.103, 164.302.

¹⁹ 45 CFR § 164.506(c)(1).

²⁰ Colo. S.B. 20-212 (2020), <https://leg.colorado.gov/bills/sb20-212>.

Reimbursement

Background

Maryland Medicaid reimburses telehealth services in the same manner and at the same rate as in-person services – commonly referred to as “payment parity.”²¹ The State regulations do not reference the payment parity requirement, fail to make clear that SUD intensive outpatient and other services may be reimbursed when delivered via telehealth, and explicitly exclude reimbursement for distant site facility costs. Additionally, all MH and SUD telehealth services require prior authorization, while no such limitation exists for medical/surgical services.²²

The Maryland Health Care Commission has supported the expansion of telehealth technology,²³ but to date, few community-based MH and SUD providers have been awarded funds and may have had limited need to pursue funding previously based on the pre-COVID clinic model of care. In response to the pandemic, additional funding opportunities have become available, including the CARES Act Federal Communication Commission’s COVID-19 Telehealth Program.²⁴

Recommendations

Maryland Medicaid should ensure that providers are reimbursed for the full range of MH and SUD services at the same level as in-person services and eliminate any coverage barriers that limit access to MH and SUD care.

1. Reimbursement rules should explicitly require payment parity for all providers of telehealth services, consistent with in-person services, and clarify that all SUD and MH services may be reimbursed under telehealth, consistent with therapeutic practice and patient needs.
2. MH and SUD services delivered via telehealth should not be subject to more stringent prior authorization requirements than medical/surgical services, consistent with the Parity Act.
3. Maryland should explore opportunities to provide additional grants and sustained reimbursement to Medicaid providers seeking to invest in telehealth technologies that satisfy the HIPAA security rules and expand patient access to mobile devices, smartphones and RPM equipment.

Justification

Payment parity for telehealth services is essential to ensure that MH and SUD providers, including federally qualified health centers, can sustain services at a time when demand is expected to increase. MH and SUD services provided via telehealth are directly equivalent to the services being provided in-person, and the costs associated with providing those services – salaries for practitioners and administrative staff, program overhead, and facility costs – remain the same. At least 25 other states require payment parity for telehealth services, and three of which – Colorado, Kentucky, and Nebraska – require the reimbursement of telehealth services to be “at a minimum” the equivalent of in-person services.

Providers bear significant costs to purchase and maintain HIPAA-compliant telehealth technology and train providers and patients to use these platforms. Even with reimbursement parity, telehealth saves money across the health system, as it increases access to MH and SUD services, prevents acute episodes, and avoids reliance on higher cost treatment in emergency rooms and hospitals. Identification of covered telehealth services and reimbursement standards will lend certainty to the care delivery model and encourage providers to invest in telehealth.

²¹ COMAR § 10.09.49.09(A); MHCC, Reimbursement for Telehealth Services (Mar. 2019),

https://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_Telehealth_Reimbursement_Flyer_20200330.pdf.

²² COMAR § 10.09.49.09(E)(4).

²³ Maryland Health Care Commission, Health Information Technology, Telehealth (updated Apr. 30, 2020),

https://mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/hit_telemedicine.aspx.

²⁴ Federal Communications Commission, COVID-19 Telehealth Program (updated May 20, 2020), <https://www.fcc.gov/covid-19-telehealth-program>.

The Parity Act explicitly prohibits Maryland Medicaid from imposing non-quantitative treatment limitations (NQTL), including prior authorization, to MH and SUD benefits that are more restrictive than those for medical/surgical benefits.²⁵ The imposition of prior authorizations for all MH and SUD telehealth services, but not all medical/surgical telehealth services, violates the Parity Act and should be removed immediately.

Medications for Substance Use Disorders and Mental Health Conditions – Induction and Administration

Background

Federal laws and regulations govern how providers may initiate and administer medications for opioid use disorders (MOUD) and controlled substances for patients with mental health conditions. An in-person physical exam is required before a provider may initiate MOUD in an opioid treatment program (OTP)²⁶ or other office-based settings and to prescribe a controlled substance for mental illness.

During COVID-19, the Substance Abuse and Mental Health Services Administration (SAMHSA) has exempted OTPs from the requirement to perform an in-person physical evaluation before prescribing buprenorphine to a new patient, assuming an adequate evaluation of the patient can be accomplished via telehealth, but has continued to require an in-patient examination to initiate methadone treatment.²⁷ SAMHSA also issued guidance allowing greater flexibility around take-home doses of methadone for patients who are deemed stable by their treatment provider.²⁸ Finally, the Drug Enforcement Administration (DEA) has lifted the Controlled Substances Act requirement²⁹ for an in-person medical evaluation of patients prior to prescribing a controlled substance.³⁰

Recommendations

Maryland should request that the federal government continue to authorize the initiation of buprenorphine treatment and prescription of a controlled substance via telehealth and permit the initiation of MOUD treatment via telehealth within an OTP, along with continued flexibility for take-home medication and reimbursement for medication delivery programs.

1. Maryland should advocate for an extension of the exemption for the in-person examination requirement before initiating MOUD treatment and treatment with controlled substances for MH conditions.
2. Maryland should advocate for the continued flexibility of take-home doses of MOUD to reduce in-person encounters for patients who are deemed stable.
3. Maryland should reimburse SUD providers and programs to deliver MOUD directly to patients to minimize the risks of transmitting COVID-19.

²⁵ 42 C.F.R. §§ 438.910(d), 440.395(b)(4), 457.496(d)(4)-(5).

²⁶ 21 U.S.C. 829(e); 42 C.F.R. § 8.12(f)(2).

²⁷ SAMHSA, FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency (updated Apr. 21, 2020), <https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf>

²⁸ SAMHSA, Opioid Treatment Program (OTP) Guidance (updated Mar. 19, 2020), <https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf>

²⁹ 21 U.S.C. § 829(e).

³⁰ DEA, How to Prescribe Controlled Substances to Patients During the COVID-10 Public Health Emergency, (March 31, 2020), [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)

Justification

As overdose deaths increase in Maryland,³¹ effective and safe access to OTP services and other providers of MOUD is essential. OTPs and other programs will be unable to operate at full capacity while social distancing and the use of PPE is required to conduct in-person examinations to initiate methadone treatment and dispense medication. To ease the burden on providers and reduce risk to both patients and providers, the State should urge SAMHSA and the DEA to extend the exemption for the in-person physical examination requirement and continue to allow for greater flexibility in take-home medication standards. In addition, OTPs should be permitted to initiate methadone treatment through telehealth by allowing examinations to be conducted on-site with the patient and provider using telehealth communications, such as a tablet. Finally, for patients who are not eligible for extended take-home medication, the State should reimburse programs for expanded delivery programs to protect both patients and staff, such as the delivery program supported by Behavioral Health Systems Baltimore. Similarly, the State should urge the DEA to extend the exemption for the in-person examination requirement for the initiation of treatment and prescription of a controlled substance to patients with mental illnesses.

Advocates for Children and Youth
Arundel Lodge
Baltimore City Substance Use Disorder Directorate
Baltimore Crisis Response, Inc.
Brain Injury Association of Maryland
Catholic Charities of Baltimore
Community Behavioral Health Association of Maryland
Cornerstone Montgomery
Eastern Shore Behavioral Health Coalition
Greater Washington Society for Clinical Social Work
Health Care for the Homeless - Baltimore and Maryland
Healthy Harford
Horizon Foundation of Howard County
Institutes for Behavior Resources
Key Point Health Services
Legal Action Center
Licensed Clinical Professional Counselors of Maryland
Maryland Addiction Directors Council
Maryland Association for the Treatment of Opioid Dependence

Maryland Association of Behavioral Health Authorities
Maryland Clinical Social Work Coalition
Maryland Coalition of Families
Maryland Coalition on Mental Health and Aging
Maryland-DC Society of Addiction Medicine
Maryland Heroin Awareness Advocates
Maryland Psychiatric Society
Maryland Rural Health Association
MedChi, The Maryland State Medical Society
Mental Health Association of Frederick County
Mental Health Association of Maryland
Mid-Atlantic Association of Community Health Centers
Mid Shore Behavioral Health Coalition
National Alliance of Mental Illness - Maryland
National Council on Alcoholism and Drug Dependence of Maryland
Save Our Children
Springboard Community Services

Thank you for your consideration of our recommendations. We look forward to working with Maryland Medicaid to ensure high-quality MH and SUD services to Marylanders as the State reopens and continues delivery of care and works to avoid a deadly resurgence of COVID-19 among our most vulnerable residents and treatment providers. Please contact Ellen Weber (eweber@lac.org) and Deb Steinberg (dsteinberg@lac.org) at the Legal Action Center with any questions.

³¹ Before It's Too Late, "Opioid Operational Command Center, Department of Health Release First-Quarter Opioid Data for 2020" (June 10, 2020), <https://beforeitstoolate.maryland.gov/opioid-operational-command-center-department-of-health-release-first-quarter-opioid-data-for-2020/>.