

What medical societies can do to help end the nation's drug overdose and death epidemic

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The legislative, regulatory and other items below represent a short list of policies and advocacy initiatives to improve patients' outcomes and reduce mortality. For a comprehensive review of policy recommendations working in states today, please consult the AMA-Manatt Health 2022 publication, [State Toolkit to End the Nation's Overdose Epidemic: Leading-Edge Strategies to Remove Barriers to Evidence-based Patient Care](#).

Increase access to evidence-based treatments to help patients with a substance use disorder

- **Prohibit prior authorization for all medications to treat opioid use disorder**, including all formulations of buprenorphine, methadone and naltrexone. See [New York's Section 3216, Individual accident and health insurance policy provisions](#):

(31-a) (A) No policy that provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for all buprenorphine products, methadone or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder except where otherwise prohibited by law.

- **Require states to use ASAM criteria** as the basis for evaluating medical necessity; and also require Medicaid and all other payers to adopt **all levels** of ASAM criteria for coverage. [Illinois law requires](#), in part: "Medical necessity determinations for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity determinations for substance use disorders."

- **Require jails and prisons to assess, treat and ensure access to evidence-based care for mental illness and substance use disorder, including for individuals who are pregnant and postpartum.**
Key resources:

- Introduce AMA model legislation, "Ensuring Access to High Quality Care for the Treatment" and "An Act to Create and Implement Family Care Plans for Infants, Children and Families.
- Ensure every jail and prison understands that the denial of medications to treat opioid use disorder is arguably a violation of the Americans with Disabilities Act. This position was affirmed by the [U.S. Court of Appeals for the First Circuit](#) and is an increasing source of advocacy by the [U.S. Department of Justice](#), which has an online complaint form physicians and patients can use if there are suspected or actual denials of care.

Ensure access to evidence-based care and identify treatment gaps to addiction medicine, psychiatry, and other trained physicians

- **Require medical necessity determinations to be based on medical evidence and practice.** Introduce legislation based on [California Senate Bill 855](#), which requires all payers to base determinations of medical necessity on the generally accepted standard of care as determined and generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment.
- **Require payers to submit specific information about mental health and substance use disorder provider networks.** [This form required by the Colorado Division of Insurance](#) does not solve the problem of inadequate mental health and substance use disorder networks, but it will help provide a clear picture of where problems are greatest—and where interventions are most needed.

Enforce mental health and substance use disorder parity laws

- [Illinois](#)' parity law has led to multiple enforcement actions demonstrating parity violations and leading to corrective action plans, including for formulary-focused violations harming patients with mental illness and substance use disorders. Urge your state DOI to take similar actions.
- [Delaware](#) and [Oklahoma](#) provide good examples of the type of specific reporting requirements payers must submit to demonstrate whether they comply with parity laws.

Improve access to multidisciplinary, multimodal care for patients with pain—remove all reference to arbitrary numeric thresholds

- [Minnesota](#) provides an excellent example of supporting individualized patient care for patients with pain. The [CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022](#) removed all numeric thresholds for dose and quantity of prescription opioid analgesics and explicitly recommends:

“This clinical practice guideline provides voluntary clinical practice recommendations for clinicians that should not be used as inflexible standards of care. The recommendations are not intended to be implemented as absolute limits for policy or practice across populations by organizations, health care systems, or government entities.”

The Minnesota law builds on the 2022 CDC revision and provides:

(b) No physician, advanced practice registered nurse, or physician assistant, acting in good faith and based on the needs of the patient, shall be subject to disenrollment or termination by the commissioner of health solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations or thresholds specified in state or federal opioid prescribing guidelines or policies, including but not limited to the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention and Minnesota opioid prescribing guidelines.

(c) A physician, advanced practice registered nurse, or physician assistant treating intractable pain by prescribing, dispensing, or administering a controlled substance in Schedules II to V of section [152.02](#) that includes but is not limited to opioid analgesics must not taper a patient's medication dosage solely to meet a predetermined morphine milligram equivalent dosage recommendation or threshold if the patient is stable and compliant with the treatment plan, is experiencing no serious harm from the level of medication currently being prescribed or previously prescribed, and is in compliance with the patient-provider agreement as described in subdivision 5.

(d) A physician's, advanced practice registered nurse's, or physician assistant's decision to taper a patient's medication dosage must be based on factors other than a morphine milligram equivalent recommendation or threshold.

(e) No pharmacist, health plan company, or pharmacy benefit manager shall refuse to fill a prescription for an opiate issued by a licensed practitioner with the authority to prescribe opiates solely based on the prescription exceeding a predetermined morphine milligram equivalent dosage recommendation or threshold. Health plan companies that participate in Minnesota health care programs under chapters 256B and 256L, and pharmacy benefit managers under contract with these health plan companies, must comply with section 1004 of the federal SUPPORT Act, Public Law 115-271, when providing services to medical assistance and MinnesotaCare enrollees.

Remove fentanyl test strips and other testing equipment from drug paraphernalia laws.

The following are current, state-based legislative language that provides different approaches to remove fentanyl test strips from the definition of drug paraphernalia:

- [Arizona](#): “Testing equipment used, intended for use or designed for use in identifying or analyzing the strength, effectiveness or purity of drugs, other than narcotic drug testing products that are used to determine whether a controlled substance contains fentanyl or a fentanyl analog.”
- [Colorado](#): “Testing equipment used, intended for use, or designed for use in identifying or in analyzing the strength, effectiveness, or purity of controlled substances.”
- [Georgia](#) takes a broad approach: “... any testing equipment used to determine whether a controlled substance has been adulterated and contains a synthetic opioid shall not be considered a drug related object as defined by Article 2 of Chapter 13 of Title 16.”
- [Maryland](#) removed “test” and “analyze” from a list of prohibited activities relating to controlled substances.
- To help with development of tests for emerging drugs of abuse, consider:

“For the purposes of this chapter, drug paraphernalia does not include a test strip, device or other testing equipment or product used, intended for use, or designed for use in identifying or analyzing the strength, presence or purity of a controlled substance, toxic substance or hazardous compound including, but not limited to fentanyl or fentanyl analogues.”

Expand naloxone access laws

Colorado’s [naloxone access law](#) has multiple innovations:

- Direct authorization for a wide range of entities to directly [dispense](#) naloxone without a patient-specific prescription, without record-keeping requirements, and with comprehensive liability and other civil protections (pp. 18-21)
- Authority to distribute expired naloxone, including liability protections (p. 24)
- Provision of naloxone upon release from jail or prison (p. 25, 26)
- Authority for jails/prisons to purchase naloxone and fentanyl test strips (p. 28)
- Section 50, starting on p. 65, provides for a hospital and emergency department to be reimbursed for dispensing naloxone to someone who has survived an overdose or dispensed to an individual.

Support pilot projects to evaluate overdose prevention sites

- Rhode Island enacted “[An Act Relating to Health and Safety—Harm Reduction Center Advisory Committee and Pilot Program](#),” followed by [regulations](#) to implement the law.

Five key stakeholders to partner with and help advocate for evidence-based uses of opioid litigation settlement funds

- **Bring treatment to the community.** Opioid treatment programs (OTP) can use their existing license to operate a mobile “[narcotic treatment program](#)”—also known as “methadone vans” or a “buprenorphine bus”. These mobile units provide a wide range of harm reduction resources, including methadone (for an OTP-operated unit), naloxone, prevention and treatment education, sterile syringe services as well as methadone or buprenorphine, as appropriate.
- **Help SUD patients get to treatment.** State medical and specialty society chapters can detail why removing [transportation](#) barriers for Medicaid enrollees can help increase treatment for those with a substance use disorder.
- **Work with patient advocates.** To help enforce network adequacy, parity and other laws to ensure access to evidence-based care, support adding specific appropriations to the state Department of Insurance to hire experts—see [Section 10 of recent Arizona law](#) for an example.
- **Invest in pain medicine and addiction physicians.** Medical schools need long-term funding to effectively recruit and hire pain management and addiction medicine/psychiatry physicians to provide essential education and training for medical students, residents and [fellows](#).
- **Build on what works.** Support community-based harm reduction organizations to receive direct funding for community-based harm reduction efforts, including [low-barrier buprenorphine](#), naloxone, sterile syringe exchange services, fentanyl test strips and educational resources.

For more information

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