AMA
AMERICAN MEDICAL ASSOCIATION

OVERDOSE EPIDEMIC REPORT 2023

Physicians' actions to help end the nation's drug-related overdose and death epidemic—and what still needs to be done.

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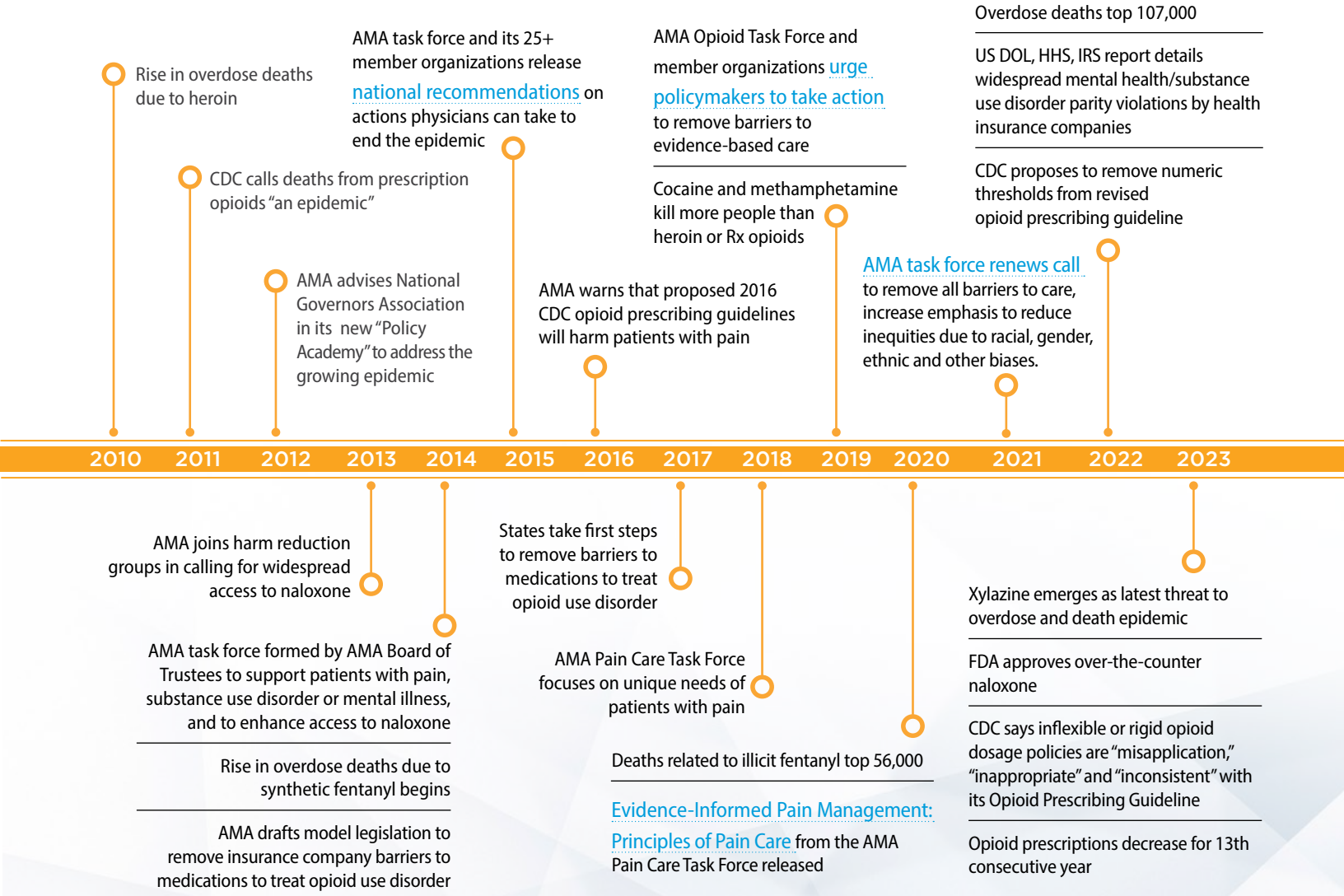
The drug-related overdose epidemic is deadlier than ever

Opioid prescriptions decrease for the 13th consecutive year while overdose and death related to illicitly manufactured fentanyl, methamphetamine and cocaine increase. Xylazine and other toxic synthetic adulterants present new challenges.



The American Medical Association Substance Use and Pain Care Task Force continues to advance evidence-based recommendations for policymakers and physicians to help end the nation's drug-related overdose and death epidemic. In recent years we have witnessed positive actions from physicians, growth in harm reduction services, and policy advancements. Tragically, these positive strides are hindered by a lack of meaningful implementation and enforcement of policies that support affordable, accessible and evidence-backed care for patients with substance use disorders, pain or those needing harm reduction services like naloxone, syringes and fentanyl test strips. Specifically, Black and Brown communities, pregnant individuals, and youth are disproportionately dying at increasing rates compared to other population groups.

We urge all stakeholders to come together to help reverse this national epidemic.

> "This report highlights that the physician community is working on multiple fronts to remove barriers to evidence-based care for patients with substance use disorders and pain. Progress in reducing deaths, however, has been incredibly difficult due to a combination of factors, including the increasingly dangerous illicit drug supply contaminated with fentanyl and other toxic substances; the continued stigma faced by individuals with a substance use disorder; and the fact that health insurers, year after year, continue dragging their feet and are not stepping up to help patients access evidence-based care. We must all work together to end the epidemic and relieve the suffering experienced by every community in the United States."
>
> **–Jesse M. Ehrenfeld, MD, MPH**
> President, AMA

Key indicators in the nation's drug overdose epidemic

In the past decade, physicians and other health care professionals have reduced opioid prescribing in every state—by nearly 50% nationally.[1] State prescription drug monitoring programs (PDMPs) are highly utilized in every state—more than 1.3 billion queries of PDMPs in 2022.[2] Buprenorphine dispensed by community pharmacies for the treatment of opioid use disorder (OUD) nearly doubled in the past 10 years, and naloxone dispensed has increased to 1.7 million prescriptions since 2018.[1]

Despite these positive efforts, drug-related overdose and death continue to increase, primarily due to illicitly manufactured fentanyl, fentanyl analogs, stimulants and other substances.

49.4%
decrease in opioid prescriptions from 260.5M in 2012 to 131.9M in 2022[1]

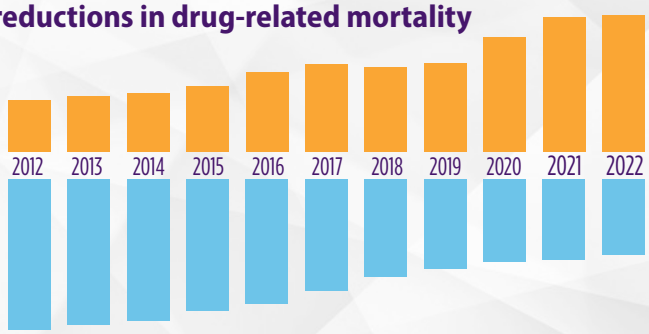
197.3%
Increase in PDMP use from 450M queries in 2018 to 1.3B in 2022[2]

202.9%
Increase in naloxone dispensed 2018–2022[1]

Reductions in opioid prescribing have not led to reductions in drug-related mortality

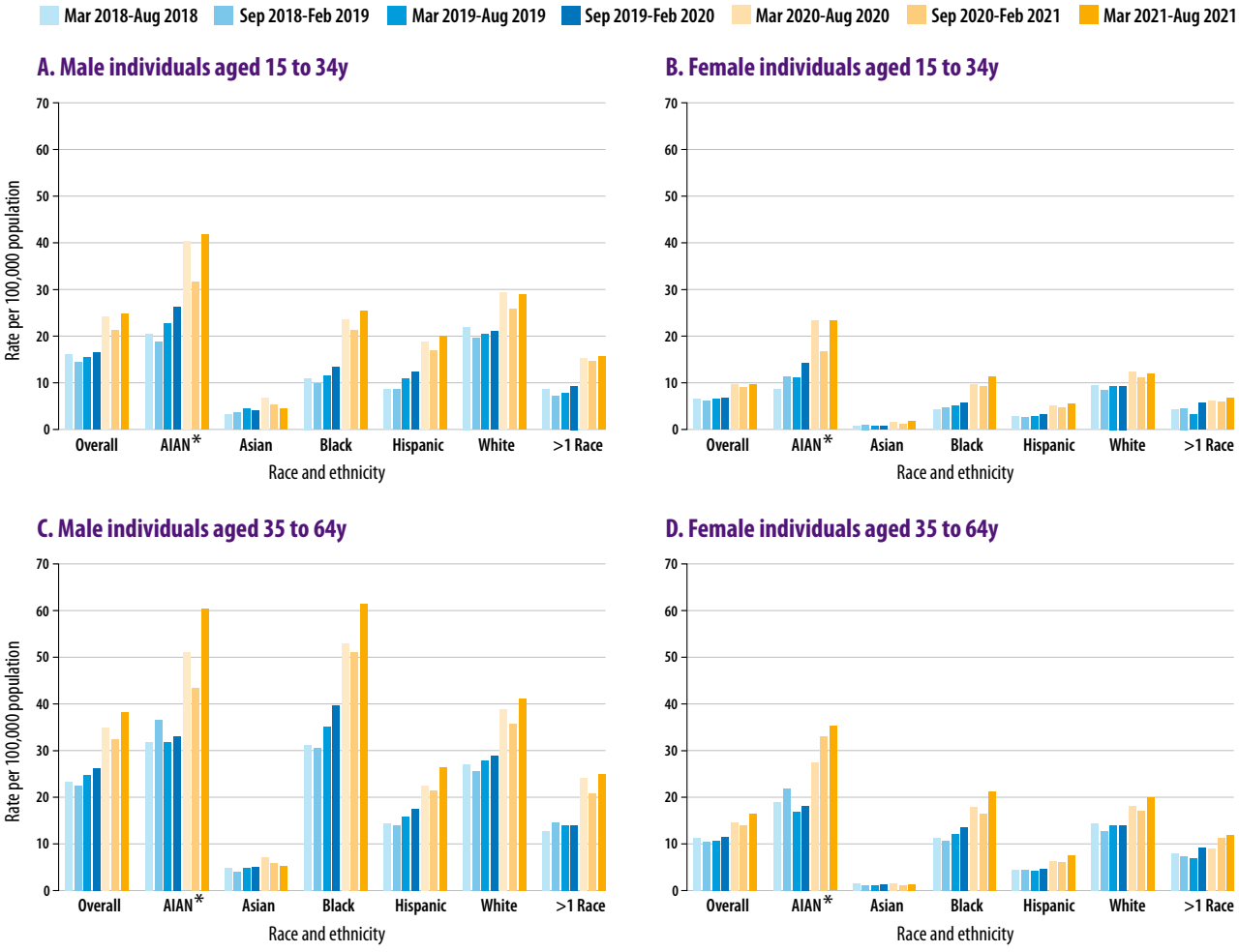
2022 overdose deaths:
109,360*

2022 opioid prescriptions:
131,897,053[1]
(49.4% decrease since 2012)



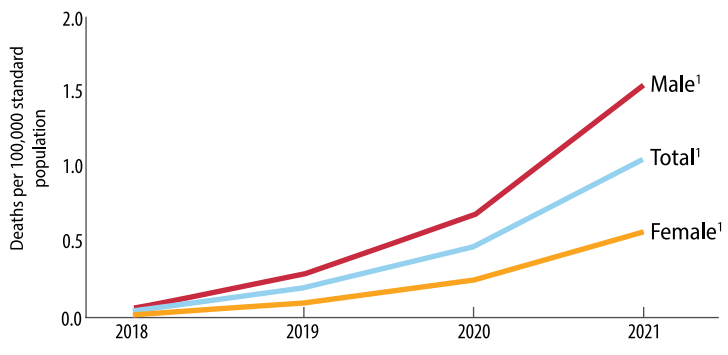
*Provisional data from 12-month period Jan. 2022–Dec. 2022
https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Drug overdose rates among U.S. individuals by age, sex, and race and ethnicity before and during COVID-19 pandemic[3]



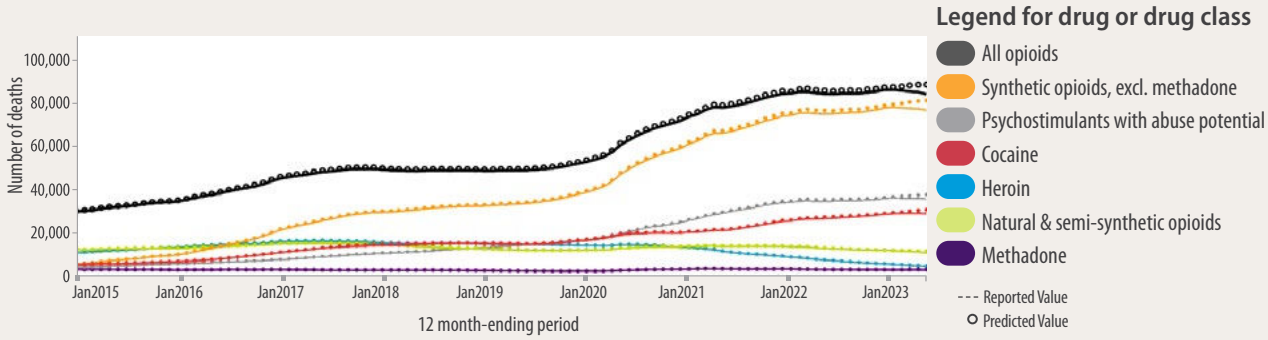
*American Indian and Alaska Native

Age-adjusted rate of drug overdose deaths involving xylazine[4]



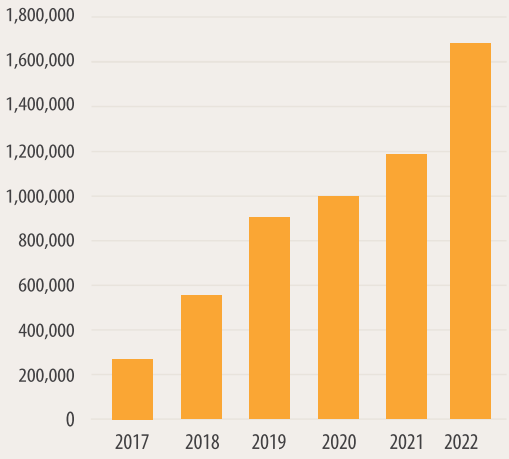
In 2021, the age-adjusted rate of drug overdose deaths involving xylazine was 35 times higher than the 2018 rate, increasing from 0.03 per 100,000 standard population to 1.06.

12 month-ending provisional number of drug overdose deaths by drug or drug class[5]



Naloxone prescriptions dispensed from community pharmacies[1]

United States 2017–2022



The AMA urges physicians to educate patients on naloxone and prescribe to patients at risk of overdose, and also successfully advocated for naloxone to be available over the counter to make it readily accessible to everyone as an essential step to save lives from opioid-related overdose.

Harm reduction and other community-based organizations **distributed more than 3.7 million doses of naloxone between 2017–2020.**[6]

From August 2021 to July 2023, national harm reduction organization, Remedy Alliance For The People, sent **1,639,542 doses of generic injectable naloxone to 196 harm reduction projects in 44 US states, DC, and Puerto Rico, of which 206,371 doses were provided at no-cost to 138 under-resourced harm reduction projects.**[7]

More than half of states have decriminalized fentanyl test strips. The AMA urges all states to take action to decriminalize drug checking supplies that test for illicit fentanyl and other adulterants. The AMA also urges all states to reform Good Samaritan statutes to protect those who overdose or those who seek assistance during an overdose event.

Increasing access to evidence-based treatment is essential to improve outcomes and reduce mortality. In 2021[8]:

3M of 43.7M
people with an illicit drug or alcohol use disorder received treatment in the past year.

93% received no treatment

2M of the 5M
adolescents aged 12 to 17 with a past-year major depressive episode received treatment for depression.

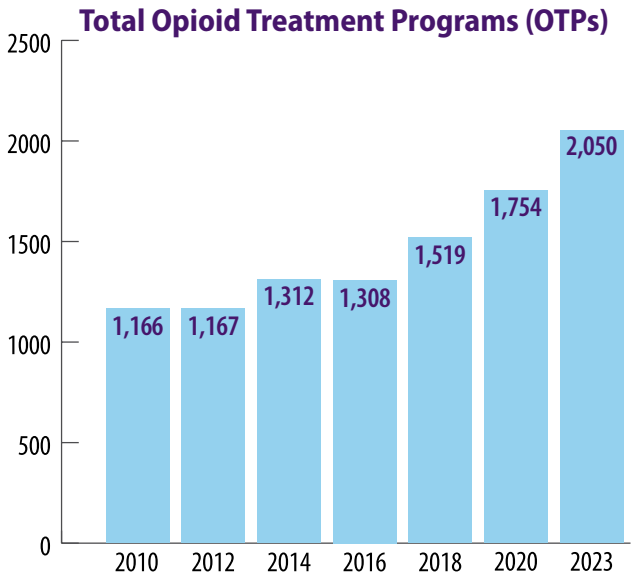
59% received no treatment

Less than half of the 57.8M
adults aged 18 or older with any mental illness received treatment.

53% received no treatment

Buprenorphine prescriptions dispensed from community pharmacies[1]	
2017	13,240,043
2018	14,538,167
2019	15,543,882
2020	16,043,746
2021	16,109,700
2022	16,047,891

Opioid treatment programs are an evidence-based option to help people with opioid use disorder[9]



National coverage on the drug overdose epidemic

'Same day delivery': Parents warn of fentanyl dealers targeting kids on Snapchat –King 5

Despite soaring overdose rates, Americans face barriers to treatment –OHSU News

Endocarditis in patients with cocaine or opioid use disorder saw marked increase between 2011 to 2022 –National Institutes of Health

New research finds racial disparity in use and access to medications for opioid use disorder –RTI International

In rural America, deadly costs of opioids outweigh the dollars tagged to address them –NPR, Northern Colorado

Lifesaving fentanyl test strips still illegal in some states under '70s-era war on drugs law –ABC News

Under new rules, methadone clinics can offer more take-home doses. Will they? –STAT

Teen overdose deaths have doubled in three years. Blame fentanyl. –The Hill

Experts slam plan to sell overdose antidote Narcan at about $50 a kit –Washington Post

U.S. opioid crackdown hampers some patients' access to psychiatric drugs –Reuters

CDC's new opioid guidelines are too little, too late for chronic pain patients, experts say –NBC News

The Persistent Criminalization of Pregnant People Who Use Drugs –Network for Public Health Law

Narcan vending machine in Flint used 500 times in just three weeks –Mid-Michigan Now

Protecting Good Samaritans bearing naloxone. –Colorado Politics

Opioid Overdose Deaths Nearly Triple Among Black Virginians –U.S. News

'Dead people cannot recover': Drug safety kits available in Oklahoma City. –Fox 25

Medication Treatment for Addiction Is Shorter for Black and Hispanic Patients, Study Finds –The New York Times

Fentanyl is dominating headlines, but there's a more comprehensive drug problem happening in Texas –Texas Tribune

Lifesaving Narcan available free to the Florida State University community –Association of American Medical Colleges

Read about reports in all 50 states: AMA issue brief[11]
National snapshot of overdose epidemic

2022–2023 federal updates

CDC issues new opioid prescribing guideline[12]

The new guideline updates and replaces the 2016 version that was significantly misapplied and harmed patients with pain. This update includes nearly all previous AMA recommendations, including the removal of arbitrary numeric thresholds on prescription opioid dose and quantity. **The AMA urges all states, health plans, pharmacy chains and others to remove policies based on the 2016 guideline.**

X-waiver requirement eliminated for buprenorphine prescribing[13]

The Consolidated Appropriations Act of 2023 eliminated the requirement for physicians to obtain a waiver from the DEA to prescribe buprenorphine for opioid use disorder (OUD) treatment. The AMA has long viewed the X-waiver requirement as a major barrier between the number of patients who need OUD treatment and the number who obtain it. **The AMA urges state and federal officials to ensure health plans have adequate networks of physicians who are accepting new patients and offer buprenorphine for OUD.**

FDA makes naloxone available over-the-counter[14]

The FDA has approved two naloxone products for over-the-counter sale and distribution without a prescription. **The AMA urges all manufacturers of overdose reversal agents to submit OTC applications and price their products responsibly. Payers must also cover naloxone at low- or no-cost.**

DEA extends prescribing of controlled substances via telehealth[15]

The ability to prescribe controlled substances based on telehealth patient visits was set to expire when the COVID-19 public health emergency ended on May 11. After receiving more than 38,000 comment letters, including AMA public testimony at a DEA listening session, the DEA extended the same policies that had been in place during the COVID-19 PHE until Dec. 31, 2024. **The AMA urges states to ensure that there are no conflicts between federal flexibility and state laws.**

MATE Act requires substance use disorder education[16]

On Dec. 29, 2022, the Consolidated Appropriations Act of 2023 enacted a new one-time requirement now in effect for any DEA-registered practitioner (except for veterinarians) to complete eight hours of training "on the treatment and management of patients with opioid or other substance use disorders." **While the AMA opposed the mandate, the AMA worked to ensure that the AMA EdHub™ provides multiple, free CME activities to fulfill the eight-hour requirement.**

Naloxone is a harm reduction success

Harm reduction aims to minimize the negative health, social and legal impacts associated with drug use.

If it wasn't for naloxone, tens of thousands—if not hundreds of thousands—of Americans would be dead today. The AMA strongly urges support for the following:

- **Naloxone in schools.** States, communities and educational settings are encouraged to remove barriers to students carrying safe and effective overdose reversal medications.
- **Naloxone in public settings.** More lives can be saved through widespread implementation of easily accessible naloxone rescue stations (public availability of naloxone through wall-mounted display/storage units that also include instructions) throughout public spaces similar to those for automated external defibrillators.
- **Updated naloxone access laws.** States and others should prepare for future overdose reversal agents to counteract non-opioid related overdoses, for substances such as stimulants and other psychoactive drugs. This includes updates to account for the possession, distribution and use of future overdose-reversal agents, including but not limited to naloxone.

Sterile needle and syringe services programs

Syringe services programs (SSPs) provide comprehensive services to decrease drug-related harms while increasing access to naloxone, harm reduction supplies and medications to treat opioid use disorder (MOUD).

- **SSPs reduce HIV and HCV.** SSPs are associated with an estimated 50% reduction in HIV and HCV incidence.[17] When combined with MOUD, HIV and HCV transmission is reduced by more than two-thirds.[18,19] SSPs can help serve as a bridge to other health services, including HIV and HCV testing, counseling and MOUD.
- **SSPs are more than just needle exchanges.** In addition to providing sterile needles and syringes to help reduce blood borne infections, SSPs distributed more than 700,000 doses of naloxone, including refills, during a 12-month study period that captured the responses of 263 SSPs nationwide.[20]
- **SSPs are a trusted resource.** People who use drugs trust SSPs to be non-judgmental and provide helpful resources. SSPs can help serve as a bridge to other health services, including HIV and HCV testing and treatment and MOUD.

The nation's drug-related overdose and death epidemic has led to a rise in infectious diseases such as HIV, hepatitis A, B, and C viruses, as well as bacterial, fungal and other infections (transmitted either via injection drug use or risky sexual behaviors).[21]

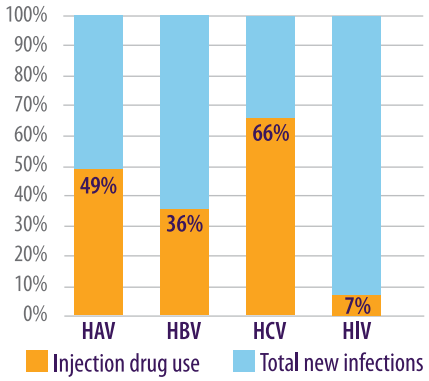
Hepatitis A: Among the 4,816 (48%) reported cases that included risk information for injection drug use, 2,339 (49%) reported injection drug use.

Hepatitis B: Among the 1,115 (52%) reported cases that included risk information for injection drug use, 402 (36%) reported injection drug use.

Hepatitis C: Among the 1,540 (32%) reported acute cases that included risk information for injection drug use, 1,017 (66%) reported injection drug use.

HIV: In 2021 injection drug use accounted for 7% (2,513) of all new HIV diagnoses in the United States.

New reported cases of HIV and viral hepatitis in injection drug users[22,23]



*Note: data shown for HAV, HBV, and HCV is from 2020 and from 2021 for HIV.

The AMA encourages physicians, hospitals, health plans, pharmacies and others to incorporate harm-reduction strategies wherever possible. Visit the Centers for Disease Control and Prevention National Harm Reduction Technical Assistance Center for comprehensive resources, education and strategies: https://harmreductionhelp.cdc.gov/s/

Fentanyl test strips and other drug checking supplies

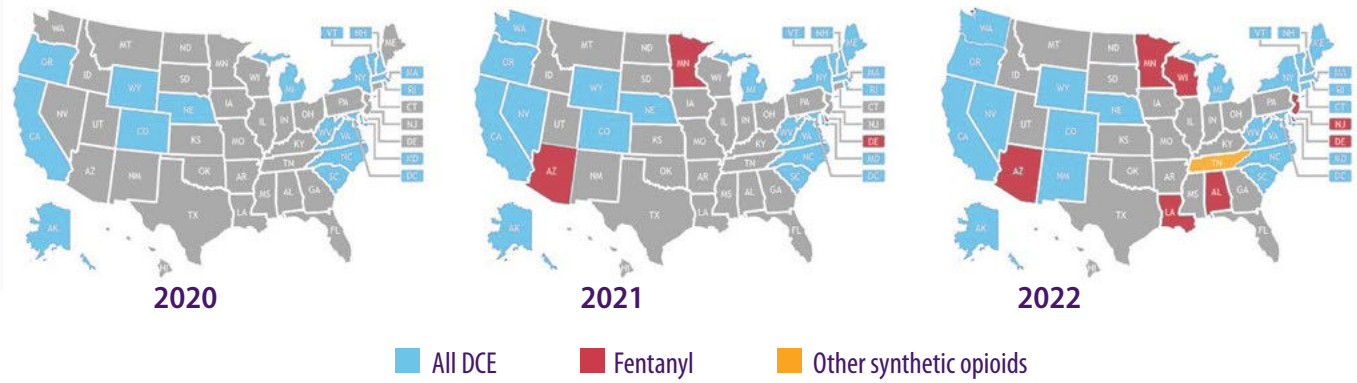
Access to drug checking technologies empowers individuals to make informed decisions about drug use and can be vital in providing timely public health responses to emerging drug trends.

Drug checking equipment (DCE) helps detect fetanyl and other adulterants. Preliminary research shows that drug checking services have a positive impact on individuals' intended drug use behaviors, including making changes to their overall drug use practices such as keeping naloxone nearby to prevent fatal overdose. Informing individuals who use drugs about the presence of adulterants and other substances in the drug supply can reduce harms associated with drug use.[24]

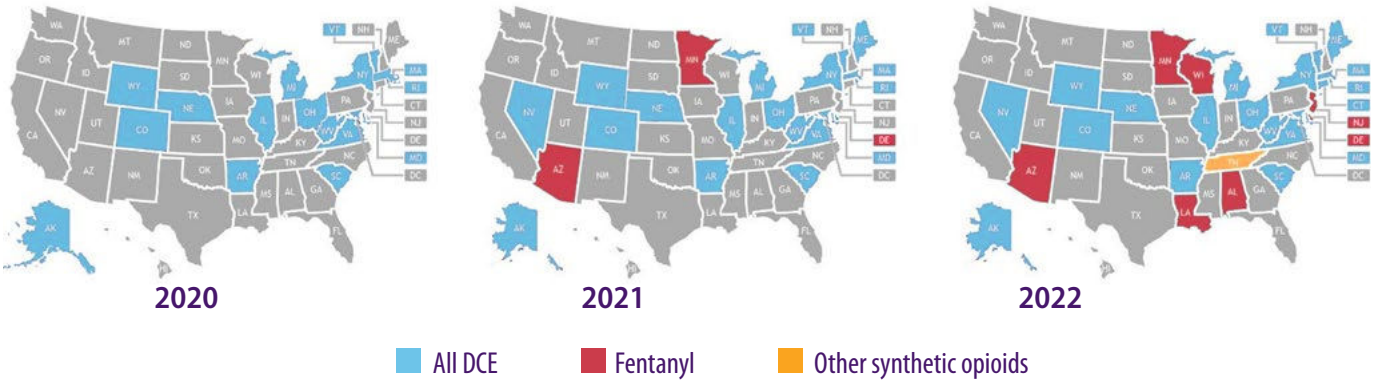
Understanding the drug supply. Public health experts and harm reduction organizations view drug checking technology as an integral surveillance tool. Drug checking technologies are used to analyze the chemical component of illicit drugs and are an evolving practice within the field of harm reduction and overdose prevention.

Additional state advocacy needed. Almost half the states have decriminalized the use of fentanyl test strips, but additional state advocacy is needed to decriminalize test strips and other drug checking supplies for emerging adulterants, including xylazine. State laws should provide criminal protections for all drug checking technologies (i.e., immunoassay testing strips, spectrometry devices, reagents), not just those used to detect synthetic opioids (i.e., fentanyl test strips).

States with laws permitting possession of drug checking equipment (DCE), by year[25]



States with laws permitting free distribution of DCE, by year[25]



Overdose prevention sites

At this point in the nation's epidemic, the AMA urges states and communities to consider all evidence-based approaches to prevent overdose death and help connect individuals to health care and treatment.

- **Overdose prevention sites (OPSs) are a public health strategy:** The data shows that OPSs help reduce risky drug use behaviors, overdose, and death while improving public safety and access to health care.[26-30] OPSs increase referrals and access to treatment and decrease syringe sharing associated with injection drug use, the spread of infectious diseases, and overdose deaths in the neighborhood of the facility.[31-35]
- **OPSs save lives:** Whether in Canada, Europe or the sites in New York City, thousands of overdose reversals have taken place while there have been no reported fatalities at the sites.
- **OPSs increase access to health services:** 52.5% of OPS participants received supportive services including naloxone distribution, counseling, hepatitis C testing, medical care and holistic services.[36]
- **OPSs reduce public drug use:** 75.9% of OPS participants used the OPS instead of a public or semipublic location.[36]

Data gaps limit ability to pursue evidence-based, public health outcomes

State, national and federal stakeholders are all working hard to improve surveillance efforts, but even the best efforts often lag several months behind current data trends. Current available data is often incomplete, non-standardized for comparison, years behind, and fails to provide a comprehensive picture. While metrics for drug-related overdoses are generally accessible, information on drug specificity, non-fatal overdoses, rates of infectious diseases, and other crucial indicators is not consistently collected or standardized across states and communities. Furthermore, due to restrictive laws, there is limited research and significant data gaps regarding the efficacy of OPSs, SSPs and drug checking supplies. Improving the comprehensiveness, standardization, quality, and timeliness of data collection and analyses will help advance local prevention, treatment and harm reduction efforts as well as broader public policy initiatives to improve outcomes and reduce overdose and death.[37]

Issue: Harm-reduction services are not universally supported at the federal, state and local levels, including funding and support for syringe service programs.

Actions needed

- Increase access to naloxone through changes to Good Samaritan laws, insurance and OTC access, and affordability and direct funding of naloxone distribution in the community.
- Remove barriers to SSPs such as 1:1 syringe exchange requirement.
- Revise restrictive drug paraphernalia laws to allow for the distribution and possession of drug use equipment, supplies and drug checking technologies.
- Support increased funding and research for SSPs, pilot OPSs and drug checking supplies.

> **You know, President Biden has been very clear—let's make sure we're saving lives and getting people with science-driven policy to help the need. And issues like naloxone, syringe service programs, fentanyl test strips for people to know that there's fentanyl in their own drug supply are some of the most lifesaving strategies, but they also help connect people, help us meet people where they are and connect them to care and other services.**
>
> **–Rahul Gupta, MD, MPH, MBA**
> Director, Office of National Drug Control Policy
> Oct. 26, 2022

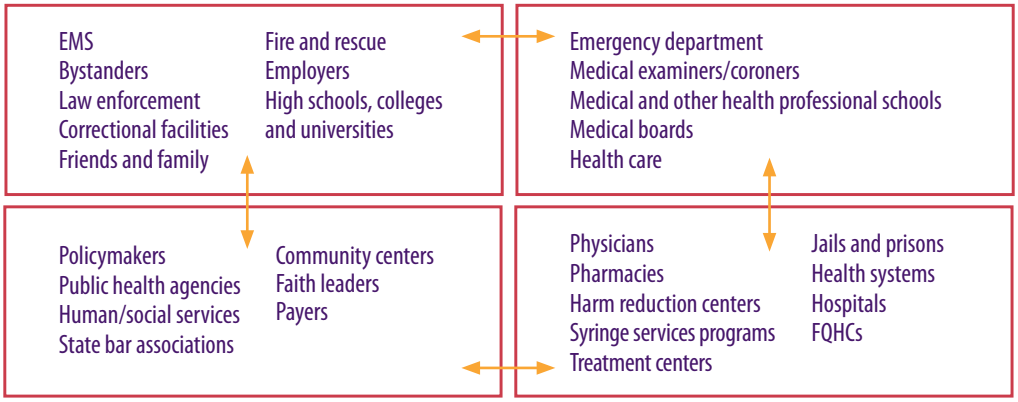
Stakeholder collaboration

Ending the nation's drug-related overdose and death epidemic—as well as improving care for patients with pain, mental illness or substance use disorder (SUD), and increasing access to harm reduction services—requires partnership, collaboration and commitment.

The AMA continues to urge:

- State insurance departments to meaningfully enforce mental health and SUD parity laws
- Opioid treatment programs to expand their reach to underserved communities by using their existing license to operate "mobile treatment programs"
- Policymakers to support legislative and other actions to remove administrative and other barriers—such as prior authorization, step therapy and dosage caps for medications to treat opioid use disorder (MOUD), including dosage caps on buprenorphine
- State officials to support pregnant people and families by removing punitive policies against pregnant, peripartum, postpartum and parenting individuals who have an SUD (This includes ensuring state policies have clear distinctions that a report of a substance-exposed newborn shall not automatically be construed as a report of abuse or neglect.)[38]
- State departments of corrections and private jails and prisons to ensure that all individuals with an OUD or mental illness are screened upon entry, receive MOUD while incarcerated, and linked to care upon release (These elements are among those protected by the U.S. Constitution and federal law.)[39-40]
- Faith and community leaders to help destigmatize SUDs and harm reduction by educating members about the benefits of MOUD, naloxone and fentanyl test strips, as well as holding overdose awareness and prevention events
- Medical and other health care professional licensing boards to help patients with pain by reviewing and rescinding arbitrary restrictions on opioid therapy—as now recommended by the CDC
- Employers to review their health insurance and benefits plans to ensure employees and their families have access to pain specialists and affordable access to comprehensive, multimodal pain care; physicians who provide MOUD; and psychiatrists who are in the employer's network
- Public health officials, colleges, universities, and other educational settings to adopt best practices to reduce harms and help control infectious disease spread through supporting comprehensive needle and syringe exchange services, and supporting widespread, community-level distribution of naloxone and fentanyl test strips

Stakeholders should also address racial disparities and health inequities as well as underlying social needs that amplify overdose deaths such as housing and transportation. All stakeholders have a role to play in removing barriers for individuals with a substance use disorder, patients with pain, and to increase access to comprehensive harm reduction efforts.



Mental health and substance use disorder parity

Payers continue failing to meet state and federal law requirements; patients continue to suffer.

What is parity?

- The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted in 2008 to protect individuals with a mental illness or substance use disorder. As the Legal Action Center says, "insurance is complicated, but parity is simple." It's about fairness.
- If an individual has insurance coverage for a medical or surgical condition (such as diabetes or hypertension), the individual should have a similar level of coverage for mental health and substance use disorder treatment. If the coverage is not as comprehensive—or if it's more restrictive—the health insurance company is likely discriminating against the individual and violating the law.

What is the problem?

- When federal or state regulators investigate health insurance companies to determine if they are complying with the law, the investigations reveal widespread failures and violations that result in harm to individuals with a mental illness or substance use disorder.
- Common violations include requiring prior authorization at greater intervals or using more strict requirements for mental health and SUD treatment, including medication, than for medical and surgical conditions. Violations also include inadequate networks that require individuals and families to face greater delays and higher costs for out-of-network care for mental health and SUD services.

What is the solution?

- Because health insurers systematically fail to comply with the law on their own, state and federal regulators must (1) increase meaningful enforcement of the law; (2) significantly increase financial and other penalties against health insurers who violate the law; and (3) require comprehensive corrective actions from health insurers to meaningfully protect patients.

Health insurers' failures at the federal level

The 2022 and 2023 MHPAEA Reports to Congress found:

- Failure to document comparative analysis before designing and applying the NQTL
- Conclusory assertions lacking specific supporting evidence or detailed explanation
- Lack of meaningful comparison or meaningful analysis
- Non-responsive comparative analysis
- Documents provided without adequate explanation
- Failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classification affected by a non-quantitative treatment limitation (NQTL)
- Limiting scope of analysis to only a portion of the NQTL at issue
- Failure to identify all factors
- Lack of sufficient detail about identified factors
- Failure to demonstrate the application of identified factors in the design of an NQTL
- Failure to demonstrate compliance of an NQTL as applied

> **"Anyone who has ever lived with a mental health condition or substance use disorder—or who has a friend or family member who has—knows how hard getting through the day can be at times and should not have to be worried about facing obstacles to getting treatment. Yet, throughout the U.S., people in need of help continue to encounter illegal restrictions on their mental health and substance use disorder benefits and struggle to find mental health and substance use treatment providers that participate in their plan's networks."**
>
> **–Lisa M. Gomez**
> Assistant Secretary for Employee Benefits Security

(Mental health and substance use disorder parity continued)

Health insurers' failures at the state level

- Prior authorization required more frequently for mental health and substance use disorder care than for medical and surgical benefits
- More restrictions on medications for treating opioid use disorder and behavioral health conditions (e.g., autism spectrum disorder) when compared to medications for other medical conditions
- More limited benefits for mental health care than for medical or surgical care
- Different and inadequate action to ensure adequate networks for mental health and substance use disorder care

Examples include:

- **California Providers Can't Keep Up With Mental Health Parity Law:** https://news.bloomberglaw.com/health-law-and-business/california-providers-cant-keep-up-with-mental-health-parity-law
- **Connecticut: State Executes Stipulation and Consent Order against 4 Health Plan Subsidiaries with over $1 Million in Fines and Education Payments**: https://www.paritytrack.org/resources/state-parity-enforcement-actions/
- **Delaware: Three health plans, United Health Care, Optimum Choice and Cigna Health Life and Insurance Company, entered into separate consent orders two years after the initial market conduct exams** were completed. https://www.paritytrack.org/resources/state-parity-enforcement-actions/
- **Insurers often shortchange mental health care coverage, despite a federal law** https://stateline.org/2023/10/11/insurers-often-shortchange-mental-health-care-coverage-despite-a-federal-law/
- **Pennsylvania: Insurance Department Exam Finds Geisinger Violations, Results In Restitution For Members** https://www.media.pa.gov/pages/insurance-details.aspx?newsid=494
- **Pennsylvania: State fines UPMC Health Plans $250,000 for Parity and Affordable Care Act Violations:** https://www.paritytrack.org/resources/state-parity-enforcement-actions/
- **New York: UnitedHealth to Pay $15.7M to Settle Mental Health Benefits Parity Case:** https://www.thinkadvisor.com/2021/08/12/unitedhealth-to-pay-15-7m-to-settle-mental-health-benefits-parity-case/
- **Minnesota fines HealthPartners $150K over alleged mental health parity violations:** https://www.startribune.com/healthpartners-insurer-fined-150k-over-alleged-mental-health-parity-violations-in-minnesota/600272382/
- **Illinois: Pritzker Administration Announces a $500,000 fine for Quartz Health Insurance Corporation for Violation of the Mental Health Parity and Addiction Equity Act:** https://www.illinois.gov/news/press-release.25897.html
- **Minnesota: Medica to pay $300,000 fine for violating mental health parity laws** https://kstp.com/kstp-news/local-news/medica-to-pay-300000-fine-for-violating-mental-health-parity-laws/
- **Washington: UnitedHealthcare failed to meet mental health requirements, WA says** https://www.seattletimes.com/seattle-news/mental-health/unitedhealthcare-fined-in-wa-for-failing-to-meet-mental-health-requirements/

Drug-related overdose and death disproportionately impact Black and Brown Americans

Young people and pregnant people are also dying at high rates.

While data lags in overdose surveillance continue to challenge public health officials from having a contemporaneous picture of the epidemic, the data that are available show disturbing trends.

American Indian and Alaskan Native men aged 15–34 dying at the highest rate for younger men. From March 2018 to August 2021, the age-adjusted death rate was 42.0 per 100,000 involving any drug.[41]

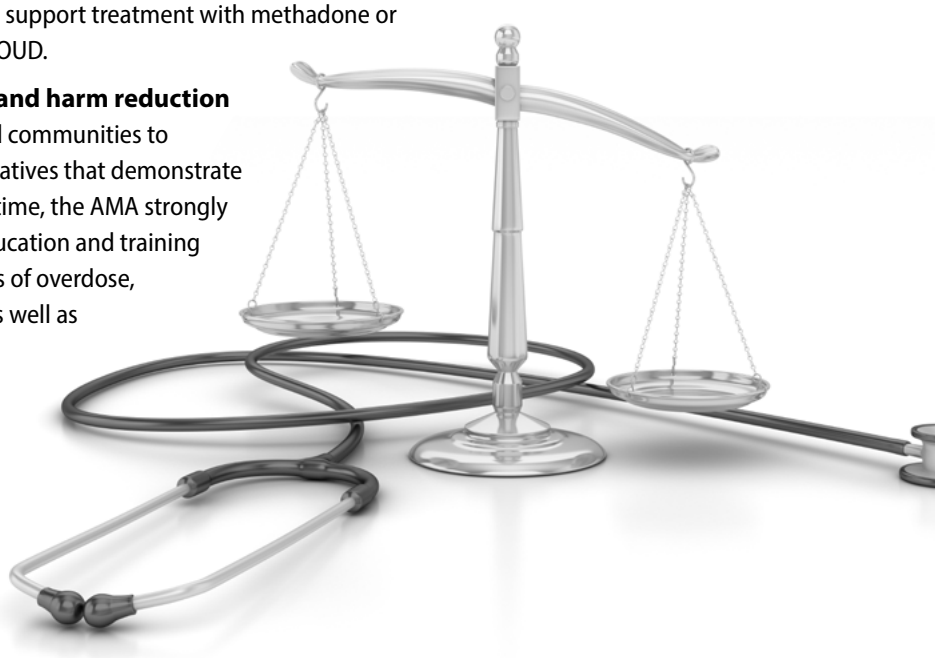
Older Black men dying at highest rates overall. From March 2018 to August 2021, non-Hispanic Black or African American men aged 35–64 had an age-adjusted death rate of 61.2 per 100,000.[41]

Pregnancy-related overdose on the rise. From 2017 to 2020, there was a relative increase of 81% in pregnancy-associated overdose mortality. Researchers found the increases in 2020 "were more pronounced than increases during any prior year."[42]

Youth dying at increasing rates. Comparing overdose rates in July-December 2019 to July-December 2021, researchers found that "median monthly overdose deaths among persons aged 10–19 years increased 109%; [and] deaths involving illicitly manufactured fentanyl increased 182%." Researchers also found that counterfeit pills were involved in one-quarter of deaths, and bystanders were present two-thirds of the time.[43]

To combat these disturbing trends, the AMA recommends:

- **Confront health care disparities.** Increased efforts should be focused on removing barriers to care disproportionately experienced by Black and Brown patients.[44] This includes urging physicians to prescribe MOUD to their Black and Brown patients with an opioid use disorder. Data is clear that "When Black adults with OUD are provided access to high-quality MOUD treatment, they demonstrate positive OUD outcomes."[45]
- **Remove barriers to MOUD for pregnant people.** The high incidence of stigma faced by pregnant people with a substance use disorder limits access to treatment and increases mortality risk. Policies to ensure access to MOUD demonstrate improved outcomes for the pregnant person, the fetus, newborn and family. "Methadone and buprenorphine are first-line therapy options for pregnant people with OUD," according to the U.S. Centers for Disease Control and Prevention. The AMA, the American College of Obstetricians and Gynecologists, the American Society of Addiction Medicine, and the U.S. Substance Abuse and Health Services Administration all support treatment with methadone or buprenorphine for pregnant people with an OUD.
- **Increase access to primary prevention and harm reduction services.** The AMA strongly urges states and communities to identify and support primary prevention initiatives that demonstrate success in preventing drug use. At the same time, the AMA strongly recommends increased efforts to provide education and training to students and young people about the risks of overdose, including making naloxone more available as well as access to fentanyl test strips and other drug checking supplies.



Recommendations

The AMA urges policymakers and other stakeholders to take meaningful action to remove barriers and increase patients' access to evidence-based care, to save lives and help end the epidemic.

1. Remove barriers to evidence-based care for patients with a substance use disorder (SUD). This includes removing prior authorization, step therapy and dosage caps for medications for opioid use disorder (MOUD), continuing federal flexibilities for take-home medication for opioid treatment programs and continuing audio-visual and audio-only telehealth options for patients to begin MOUD.
2. Remove barriers to MOUD and treatment for SUDs and co-occurring mental illness in the nation's jails and prisons or under judicial supervision. This includes ensuring pregnant people with an opioid use disorder (OUD) can receive MOUD and continue MOUD post-partum. There is no legal, medical, or policy reason to deny access to MOUD or mental health care for justice-involved persons.
3. Take immediate steps to protect families by focusing on increasing access to evidence-based care rather than using punishment and the threat of family separation for persons with an SUD who are pregnant, peripartum, postpartum and parenting.
4. Support patients with pain by following CDC's 2022 revised opioid prescribing recommendations and rescinding arbitrary opioid prescribing dose and quantity thresholds, laws and policies. Further support patients with pain be requiring health insurance companies and other payers to make non-opioid pain care alternatives more accessible and affordable, emphasizing social determinants of health, including transportation, housing, employment and other factors.
5. State insurance commissioners, attorneys general and the U.S. Department of Labor must increase efforts to review health insurers' policies on a regular basis to ensure they comply with the Mental Health Parity and Addiction Equity Act—and hold them accountable if not.
6. Increase access to opioid overdose reversal medications through multiple strategies, including requiring health insurance companies to cover the medications at low- or no-cost; supporting distribution programs through emergency departments and educational settings; urging manufacturers to price OTC naloxone responsibly; and advocating for pharmacies and other retail settings to prominently display OTC naloxone.
7. Support increased efforts to expand sterile needle and syringe exchange services programs, implement pilot overdose prevention sites, decriminalize drug checking technologies (e.g., fentanyl test strips), and further enhance Good Samaritan laws to protect individuals who seek care for those who overdose and those who overdose.
8. Develop and implement systems to collect timely, adequate and standardized data to identify at-risk populations, fully understand polysubstance drug use, and implement public health interventions that directly address removing structural and racial inequities.

> "America's physicians call on our colleagues, other health care professionals, community leaders, policymakers, faith leaders, employers and all others to work together to increase access to care for substance use disorders, pain, mental illness and harm reduction initiatives. Increasing access to care—and removing barriers to care—remains incredibly challenging, but we must continue our efforts. We urge action on the policy recommendations in this report because they are actions that will save lives. If we do not take these actions, no one should be surprised as the epidemic kills and harms more and more Americans."
>
> **–Bobby Mukkamala, MD**
> Chair, AMA Substance Use and Pain Care Task Force

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