With the global outbreak of Coronavirus Disease 2019 (COVID-19), ABPM continues to monitor information from the Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), the American Medical Association (AMA), and state and local agencies, as well as other prominent news resources and will share current news and relevant information with our Diplomates.

At this time, ABPM recommends its Diplomates refer to and monitor and adhere to all appropriate state and federal recommendations and guidance.

Continue to exercise evidence-based decision making in your practice to ensure your staff, your patients and you remain healthy. Diplomates are encouraged to visit the WHO's and CDC's websites for the most up-to-date global and national information regarding the virus.

Policy Updates and Resources for Diplomates

State Policies on Coverage and Access Amid COVID-19

Boards of Pharmacy and Other Actions Relating to COVID-19 Prescribing

AMA Cybersecurity Work-from-Home Guide

AMA Computer Security Checklist

**Policies to Improve Access to Pain Treatment**

To address the challenges posed by COVID, the U.S. Drug Enforcement Administration (DEA) issued several provisions to remove refill and prescribing barriers for patients with chronic pain.

 Telemedicine Guidance allows DEA registered practitioners to issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation.

 A guidance letter was sent to DEA-registered practitioners providing increased flexibility for refill and prescribing controlled substances for chronic pain patients. Specifically, these include authorizing a 90-day supply of Schedule II medications and providing increased flexibility for certain in-person evaluation and prescribing rules for existing patients. The guidance also permits physicians to prescribe buprenorphine for the treatment of opioid use disorder to issue these prescriptions to new and existing patients based on an evaluation via telephone.

 A flow chart "How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency," was issued which provides further guidance.

**Activity in the States**

Several states, including **Texas**, **Georgia**, **Indiana** and **Ohio** have increased prescribing flexibility for patients with pain. Specifically, the Texas Medicine Board issued an extended waiver that allows for telephone refills for pain treatment medications by a physician with an established chronic pain patient (the physician remains responsible for meeting the standard of care and all other laws and rules related to the practice of medicine).

The medical boards of Georgia , Indiana , and Ohio offer similar guidance, stating that a DEA-registered prescriber may issue prescriptions for all Schedule II-IV controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided: (1) the prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of their professional practice; (2) the telemedicine communication is conducted using an

audio-visual, real-time, two way interactive communication system; and (3) all other applicable federal and state laws are followed. (Georgia adds an additional requirement that "the practitioner conducted a medical evaluation on the patient using telemedicine communication"). [1]

**Minnesota** enacted H.F. 4531 to relax refill restrictions and limitations on controlled substances. It allows Schedule II-V controlled substances to be dispensed for more than 30 days and removes existing refill limitations. The law allows patients with chronic diseases to stay home during shelter-in-place and other social-distancing efforts aimed at limiting the spread of COVID-19.

[1] **AMA Issue Brief: Reducing Access to Pain Medications During COVID-19 (accessed July 27, 2020)**

**State Policies to Reduce Administrative Burdens**

Several states have taken action to protect patients and physicians from the harms and waste associated with prior authorization during the COVID-19 pandemic.

For example:

 Forty-one states temporarily suspended prior authorization requirements for fee-for-service Medicaid under a 1135 waiver (e.g. **Alaska**, **Idaho**, **Massachusetts** and **Oregon**) and 34 states also require that prior authorizations granted before the emergency orders remain valid until the end of the public health emergency (e.g. **Arizona**, **Colorado**, **Connecticut**, **Idaho**, **Illinois**, **Maryland**, **Missouri**, **Nebraska**, **New Jersey**, **Oklahoma**, **Vermont**).

 Some states have also suspended prior authorization requirements for Medicaid managed care plans (e.g. **Ohio**, **Virginia**).

Several states are requiring health insurers to ease prior authorization for prescription medications in certain situations. For example, in **California**, insurers must streamline or eliminate processes for requesting prior authorization, step therapy exceptions, and exceptions for obtaining off-formulary drugs when a drug is unavailable due to supply chain disruptions or similar issues.

**New York** recently suspended all prior authorization requirements for all services performed at hospitals, including lab work and radiology, until June 18, 2020.[2] (See AMA COVID Prior Authorization and Step Therapy State Policies for links to individual state policies.)

[2] **Prior Authorization and Step Therapy: State Action for COVID-19** **(accessed July 27, 2020)**

**Health Insurer Policies**

Some health insurers have taken steps to reduce the burden of prior authorization and other utilization management requirements on patients and providers during this time. For example, several national plans have removed prior authorization for COVID-19 testing, and some have relaxed prior authorizations for admissions to post-acute care settings. See **AMA Chart: Insurers' COVID-19 Prior Authorization Policy Changes**

**Other Notable Legislation**

On July 2, **Colorado** Governor Jared Polis (D) vetoed HB 20-1085, a comprehensive bill which aimed to reduce administrative barriers to non-opioid pain treatment and would have required the Insurance Commissioner to promulgate rules to establish diagnosis of covered conditions for which nonpharmacological alternatives to opioids are appropriate. Additionally, the bill would have required each health benefit plan to provide coverage for at least 6 physical therapy visits and 6 occupational therapy visits per year or 12 acupuncture visits per year, with a maximum of one copayment per year for 12 covered visits. HB 20-1085 also would have prohibited an insurance carrier from limiting or excluding coverage for an atypical opioid or a nonopioid medication that is approved by the FDA by mandating that a covered person undergo step therapy or obtain prior authorization if the atypical opioid or nonopioid medication is prescribed by the covered person's health care provider. Finally, the insurance carrier would have been required to make the atypical opioid or nonopioid medication available at the lowest cost-sharing tier applicable to a covered opioid with the same indication.

**Florida** passed S.B. 743, a bill that requires health care providers to discuss the advantages and disadvantages of nonopioid alternatives and provide a pamphlet before prescribing a Schedule II opioid drug. The bill provides an exemption for hospice, critical and emergency care.

Last week, the AMA's Opioid Task Force released its Annual Report which documents a dramatic increase in fatalities involving illicit opioids, stimulants (e.g. methamphetamine), heroin and cocaine and a similarly dramatic drop in the use of prescription opioids.

Key points from the 2020 report:

 **Opioid prescribing decreases for a sixth year in a row**. Between 2013 and 2019, the number of opioid prescriptions decreased by more than 90 million—a **37.1 percent decrease nationally**.

 **Prescription Drug Monitoring Program (PDMP) registrations and use continue to increase**. In 2019, health care professionals nationwide accessed state PDMPs more than 739 million times—a 64.4 percent increase from 2018 and more than an 1,100 percent increase from 2014. More than 1.8 million physicians and other healthcare professionals are registered to use state PDMPs.

 **More physicians are certified to treat opioid use disorder**. More than **85,000 physicians** (as well as a growing number of nurse practitioners and physician assistants) now are certified to treat patients in-office with buprenorphine—an increase of more than 50,000 from 2017.

 **Access to naloxone is increasing. More than 1 million naloxone prescriptions** were dispensed in 2019—nearly double the amount in 2018, and a 649 percent increase from 2017.4

The report points to ABPM's 2020 Barriers to Pain Treatment Survey which found 92 percent of pain medicine physicians said they have been required to submit a prior authorization for non-opioid pain care.

**Additional resources:**

 2020 AMA Opioid Task Force Report Note ABPM's Survey "Barriers to Pain Treatment" was highlighted in the report.

 FSMB Chart: States' Waiving Telehealth Requirements

 "Pain Management Best Practices from Multispecialty Organizations during COVID-19 Pandemic and Public Health Crisis" provides "a framework for pain management services, systems-wide and individual decisions must take into account clinical considerations, regional health conditions, government and hospital directives, resource availability, the welfare of health care providers."

 The American Academy of Physical Medical & Rehabilitation's COVID-19 specific recommendations and considerations

 AMA Chart: Insurers' COVID-19 Prior Authorization Policy Change

 SAMHSA issued FAQs about the provision of methadone and buprenorphine for the treatment of OUD during COVID-19 emergency.