



Oversight of Opioid Prescribing and Monitoring of Opioid Use:
States Have Taken Action To Address the Opioid Epidemic

July 2019
A-09-18-01005

Contents

- Why We Did This Review (slide 3)
- Objective (slide 4)
- Background (slides 5–6)
- How We Conducted This Review (slide 7)
- Selected States for Review (slide 8)
- Results of Review (slides 9–20)
- Conclusion (slide 21)
- Appendix A: Related OIG Work on States' Oversight of Opioids (slide 22)
- Appendix B: Glossary of Terms (slide 23)
- Appendix C: Sources of Background Information (slide 24)



Why We Did This Review

- Opioid abuse and overdose deaths are at crisis levels in the United States.
 - More than 47,000 Americans died of drug overdoses involving opioids in 2017.
 - Ensuring the appropriate use and prescribing of opioids is essential to protecting the health and safety of Medicaid beneficiaries and the integrity of the Medicaid program.
- We analyzed Centers for Disease Control and Prevention (CDC) data showing State trends in opioid overdose deaths and selected eight States for review. We summarized the results of those reviews in factsheets issued to each State and made publicly available on the Office of Inspector General (OIG) website.
 - See Appendix A for a list of the factsheets.
- This report summarizes and compares information provided by the eight States as of October and November 2018.
- Three ongoing State reviews are not covered in this report. We plan to issue factsheets for these States later in 2019.

The Impact of Opioid Abuse on Medicaid Beneficiaries

- The opioid epidemic has had a disproportionate impact on Medicaid beneficiaries.
- Opioid abuse is of particular concern for Medicaid beneficiaries because they are more likely to have chronic conditions that require pain relief.
- Medicaid beneficiaries are prescribed painkillers at twice the rate of non-Medicaid patients and are at three to six times the risk of overdose.



Objective

Our objective was to identify selected States' actions related to their oversight of opioid prescribing and their monitoring of opioid use.



Background: Opioids

- Doctors prescribe opioids to treat moderate to severe pain, but opioids may have serious risks and side effects.
- Common prescription opioids are oxycodone (OxyContin), hydrocodone-acetaminophen (Vicodin), morphine, and methadone.
- Fentanyl is a synthetic opioid pain reliever, which is many times more powerful than other opioids and is approved for treating severe pain (typically advanced cancer pain). Illegally made and distributed fentanyl has been on the rise in several States.
- Heroin is an illegal opioid. Its use has increased across the United States among both men and women, most age groups, and all income levels.
- See Appendix B for a glossary of terms used in this report and Appendix C for sources used for background information on opioids.

The Opioid Epidemic

- In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to prescribe them at greater rates.
- Increased prescribing of opioid medications led to widespread misuse of both prescription and nonprescription opioids before it became clear that these medications could be highly addictive.
- From 1999 to 2017, almost 400,000 people died from overdoses involving opioids, including prescription and illicit opioids.
- In October 2017, President Trump declared the opioid crisis a national public health emergency, authorizing executive agencies to use appropriate emergency authority to address the opioid epidemic.



Background:

CMS Guidance on Opioids

- The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing laws related to Medicaid. CMS issues guidance to explain how laws will be implemented and what States and others need to do to comply. CMS also issues guidance to address policy issues as well as operational updates and technical clarifications of existing guidance.
- CMS has issued the following guidance to States related to opioids:
 - Informational Bulletin, “Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction” (Jan. 28, 2016);
 - Informational Bulletin, “State Flexibility to Facilitate Timely Access to Drug Therapy by Expanding the Scope of Pharmacy Practice . . .” (Jan. 17, 2017);
 - State Medicaid Directors Letter #17-003, “Strategies to Address the Opioid Epidemic” (Nov. 1, 2017);
 - State Medicaid Directors Letter #18-006, “Leveraging Medicaid Technology to Address the Opioid Crisis” (June 11, 2018);
 - Informational Bulletin, “Medicaid Strategies for Non-Opioid Pharmacologic and Non-Pharmacologic Chronic Pain Management” (Feb. 22, 2019); and
 - Frequently Asked Questions, “Medicaid Opportunities for Enhanced Match for Certain PDMP Expenditures” (May 14, 2019).

CMS’s Monitoring of Opioids in Medicaid

- CMS uses the Medicaid Drug Utilization Review (DUR) Program,* in which States report on prescribing, including control measures such as quantity limits and day supply limits for short- and long-acting opioids, application of State-wide prescription drug monitoring programs, and use of morphine daily dose alerts to prevent drug overdoses.
- CMS conducts program integrity desk reviews to look at State oversight and monitoring of opioid use in Medicaid programs, covering such areas as:
 - Patient Review and Restriction/Lock-In programs;
 - prepayment controls;
 - provider contracting, education, and guidelines;
 - State collaboration; and
 - best or promising practices.

* Section 1004 of the SUPPORT for Patients and Communities Act (P.L. No. 115-271) sets minimum standards for States to report their DUR activities (beginning Oct. 1, 2019).



How We Conducted This Review

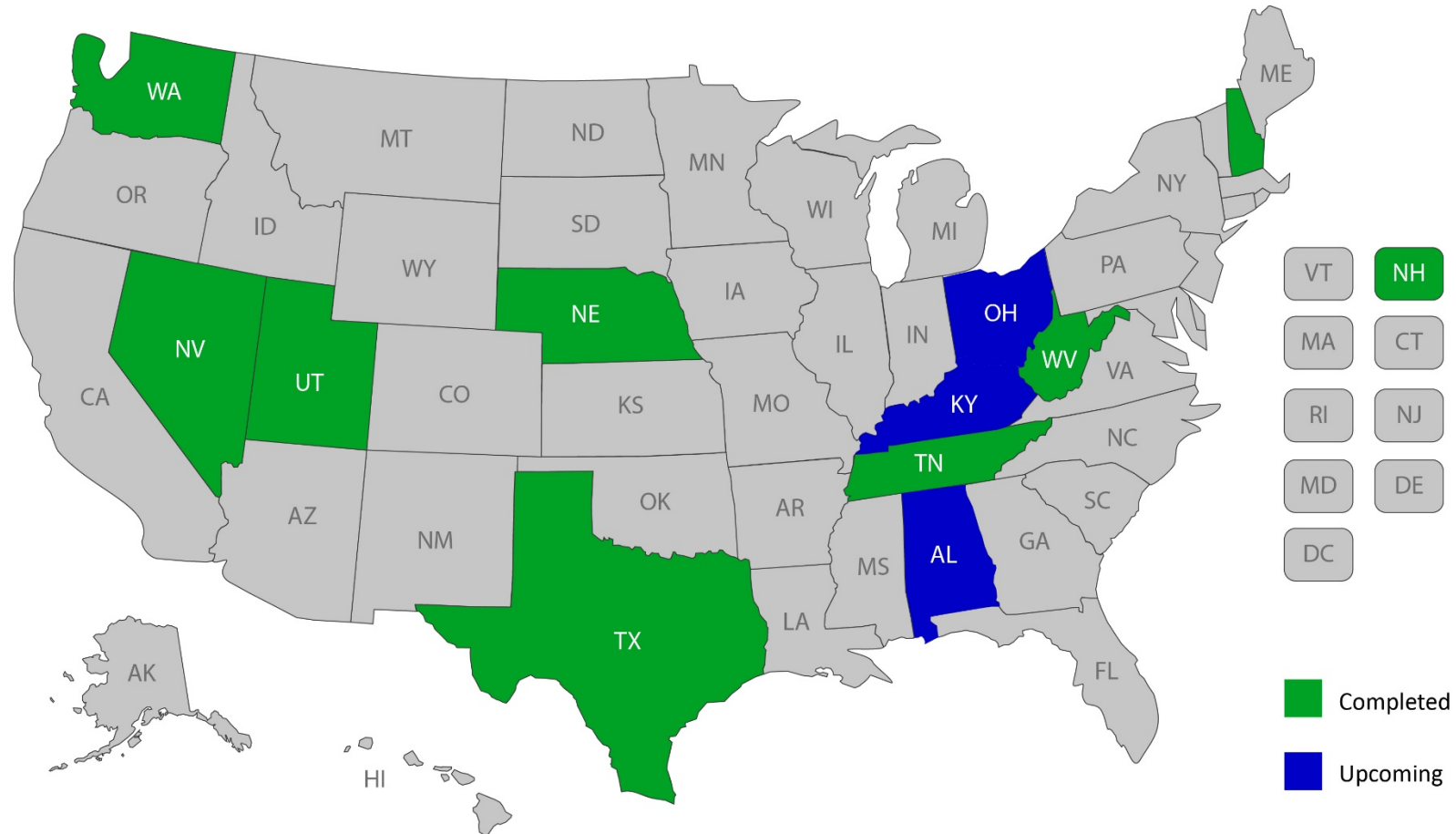
- To select eight States for review, we analyzed CDC data showing State trends in opioid overdose deaths. The selected States included ones that participated and ones that did not participate in the Medicaid expansion under the Patient Protection and Affordable Care Act.
 - The eight States were Nebraska, Nevada, New Hampshire, Tennessee, Texas, Utah, Washington State, and West Virginia. (See map on the next slide.)
- We developed a questionnaire for the selected States to complete to identify their policies and procedures, data analytics, outreach, programs, and other actions related to opioid prescribing and monitoring of opioid use.
- We held discussions with State officials to discuss their responses to the questionnaire and to obtain additional information on their actions related to opioid prescribing and monitoring of opioid use.
- We discussed the results of our review with CMS officials and incorporated CMS's technical comments as appropriate.

Generally Accepted Government Auditing Standards

- We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.



Selected States for Review



Results of Review

We identified actions that the selected States took related to their oversight of opioid prescribing and their monitoring of opioid use in the following categories:

1. **Policies and Procedures:** State laws, regulations, guidance, and policies related to oversight of opioid prescribing and monitoring of opioid use (e.g., policies for prescribing opioids).
2. **Data Analytics:** Data analysis that the States perform related to opioid prescribing and monitoring of opioid use (e.g., analyzing data to determine the number of opioid prescriptions written by providers to detect high-prescribing providers).
3. **Outreach:** Outreach that the States provide related to preventing potential opioid abuse and misuse (e.g., opioid-related training for providers).
4. **Programs:** State programs related to opioids (e.g., opioid-use-disorder treatment programs).
5. **Other Actions:** Other State activities related to opioids that are not covered by the previous categories.

9



1. Policies and Procedures: Opioid Prescribing

- All of the States we reviewed have State laws, regulations, or policies related to opioid prescribing.
- Examples follow:
 - Washington created an interagency guideline in 2007 for prescribing opioids for pain. Legislation was passed in 2010 and 2017 to strengthen opioid-prescribing rules.
 - West Virginia passed the Opioid Reduction Act in 2018, codifying several opioid-related efforts. Among other requirements, this act requires prescribers to discuss the risks of opioid use and alternatives to opioid therapy, such as physical therapy, acupuncture, and massage therapy.
 - Nebraska passed a law (Revised Statutes 28-473) that outlines information that prescribers must discuss with patients before prescribing Schedule II-controlled substances (including any opioid medications).

Opioid Prescribing Limits

- CDC issued guidelines on prescribing opioids, which, among many guidelines, include limiting the morphine milligram equivalents (MME) and duration of the prescriptions.*
- Opioid prescribing limits vary by State. For example, States set limits based on:
 - MME,
 - days supply, or
 - number of dosages.
- See the next slide for a comparison of the selected States' opioid prescribing limits with the CDC guidelines.

* CDC Guideline for Prescribing Opioids for Chronic Pain.
https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf.
Accessed on June 6, 2019.

10



State-by-State Comparison: Opioid Prescribing Limits Compared With CDC Guidelines

CDC Guidelines	Nebraska	Nevada	New Hampshire	Tennessee	Texas	Utah	Washington	West Virginia
Use extra precautions when increasing opioid prescriptions to ≥ 50 MME per day. Avoid or carefully justify increasing dosage to ≥ 90 MME per day. For acute pain, 3 days or less will often be sufficient; more than 7 days will rarely be needed.	Medicaid policy limits the quantity of short-acting opioids to 150 tablets or capsules per rolling 30 days. Medicaid implemented a claim system edit to identify opioid naive patients, which limits the patient to a 7-day supply and a maximum dosage of 50 MME per day.	Medicaid policy requires prior authorization to exceed a 7-day supply or 60 MME per day or 13 prescriptions in a rolling 12-month period.	Medicaid policy requires any beneficiary that reaches a daily MME of 100 or more to receive prior authorization to continue with that dose.	State law limits initial opioid prescriptions to a 3-day supply of a 180-MME dose. Medicaid policy states that for first-time or non-chronic opioid users, opioid prescriptions are covered for up to 15 days in a 180-day period at a maximum dosage of 60 MME per day.	Medicaid policy limits opioid prescriptions to a maximum of 90 MME.	State law limits opioid prescriptions for acute, non-complex, non-chronic conditions to a 7-day supply. Medicaid policy limits the initial fill of short-acting opioids to no more than a 7-day supply (a 3-day supply for dentists).	Medicaid policy limits opioids for acute usage to a maximum of 18 dosages per prescription for anyone less than 21 years old and a maximum of 42 dosages per prescription for anyone 21 years old or older. For acute use, there can be no more than 42 days of use in a 90-day period.	State law limits opioid supply to no more than: - a 4-day supply in an emergency or urgent-care setting, - a 3-day supply for minors, - a 3-day supply for dentists, and - a 7-day supply for prescribers in a nonemergency setting issuing an initial opioid prescription.



1. Policies and Procedures: Prescription Drug Monitoring Program Data

- All of the States we reviewed have laws, regulations, or policies related to Prescription Drug Monitoring Program (PDMP) data.
- Examples follow:
 - Nevada's Revised Statutes (§ 639.23507) required prescribers to review a patient's PDMP report before issuing an initial prescription for a controlled substance. Assembly Bill 474 established an additional requirement to obtain a new report at least every 90 days during extended courses of treatment.
 - West Virginia required prescribers to check the PDMP data when issuing an initial prescription for a controlled substance and at least annually. If the prescriber is a physician in a licensed pain-management clinic, the PDMP data must be checked at least every 90 days.
- See the next slide for a comparison of the selected States' requirements for reviewing PDMP data.

Sharing of PDMP Data With Law Enforcement

- All of the States we reviewed have requirements for sharing PDMP data with law enforcement; however, the level of sharing varies by State:
 - In some States, such as Nebraska and Washington, law enforcement must have a warrant or be engaged in an investigation of a specific person to have access to PDMP data.
 - In other States, such as Utah and Tennessee, law enforcement can be provided more open access to PDMP data.



State-by-State Comparison: State Requirements for Reviewing PDMP Data

Nebraska	Nevada	New Hampshire	Tennessee	Texas	Utah	Washington	West Virginia
Information was not provided by the State.	Prescribers are required to review the PDMP data before issuing an initial prescription for a controlled substance and at least every 90 days during extended courses of treatment.	Prescribers are required to check the PDMP data before prescribing an initial opioid prescription and at least twice a year thereafter.	Prescribers are required to check the PDMP data (1) before prescribing certain controlled substances, including opioids and benzodiazepines, to a patient at the beginning of a new episode of treatment and (2) if the prescriber is aware or reasonably certain that a person is attempting to obtain a controlled substance, including opioids, for illicit purposes.	Beginning in September 2019, prescribers will be required to check the PDMP data before prescribing opioids and other controlled substances.	Prescribers are required to check the PDMP data before issuing the first prescription of an opioid to a patient unless the prescription is for a 3-day supply or less or for a 30-day post-surgery supply. For ongoing prescriptions, prescribers are required to periodically check this database.	New opioid-prescribing rules (effective late 2018 and early 2019) require prescribers to check the PDMP data. These prescribing requirements vary by healthcare profession. Detailed information can be found at: https://www.doh.wa.gov/ForPublicHealthandHealthcareProfessionals/HealthcareProviders/HealthcareProfessionsandFacilities/OpioidPrescribing/HealthcareProviders/Toolkits .	Prescribers are required to check the PDMP data when issuing an initial prescription. If the prescriber continues to treat the patient with a controlled substance, the prescriber must continue to check the PDMP data at least annually (or at least every 90 days if the prescriber is a physician in a licensed pain-management clinic).

13



2. Data Analytics

- All of the States we reviewed perform data analytics related to opioid prescribing and monitoring of opioid use.
- Examples follow:
 - In West Virginia, the Drug Utilization Review committee sends prescriber reports to high-prescribing providers based on data analytics.
 - In Washington, the Medicaid program sends prescriber report cards to prescribers based on data analytics for the measures of chronic use, high dose, and concurrent opioid and sedative prescribing.
 - In Texas, analysts developed an algorithm that looks at outpatient pharmacy claims for opioid prescriptions that are disproportionately prescribed by non-pain providers participating in Medicaid.
- See the next slide for examples of data analysis performed by the selected States.

Data Analysis by Managed-Care Organizations

- Many of the States' Medicaid services are provided through managed-care organizations (MCOs).
- MCOs perform their own data analysis related to opioids. Examples follow:
 - In Tennessee, each MCO performs analytics for two key purposes: (1) tracking and monitoring the opioid epidemic and subsequent member engagement and (2) program integrity to prevent fraud, waste, and abuse.
 - In New Hampshire, Medicaid MCOs are required to perform data analytics related to opioids, specifically to calculate certain new opioid-related measures and to use the data for care management.



State-by-State Comparison: Examples of Data Analysis

Nebraska	Nevada	New Hampshire	Tennessee	Texas	Utah	Washington	West Virginia
Uses an operational dashboard, which contains aggregate prescription data, to identify opportunities to drive policy changes and recommendations. Medicaid MCOs, covering 98 percent of Nebraska's Medicaid beneficiaries, perform data analytics to monitor opioid prescribing.	Used data analytics to identify the top 10 opioid-prescribing providers, to monitor these providers. Uses the Web Infrastructure for Treatment Services data repository, which allows the State to (1) collect and share behavioral health data across the State and (2) collect and analyze opioid prevention, treatment, and recovery data.	Periodically analyzed opioid prescribing in the Medicaid populations, focusing on member use rates by drug; strength, supply, and frequency of prescriptions; and demographics. Performed provider-based reporting on a pilot basis.	Analyzes the top prescribers of controlled substances and releases to prescribers a report card identifying those prescribing controlled substances at a high rate. Uses data analytics to identify specific providers for engagement and outreach.	Conducts reviews of opioid use, including opioid use during pregnancy, naloxone for opioid-related overdoses, methadone overdose risk prevention, benzodiazepine anxiolytics, controlled sedative hypnotics, and opioid prescribing in adults.	Analyzes opioid morbidity and mortality data by provider specialty, number of prescriptions, percentage of total prescriptions, MME, doctor-shopping indicators, and overlapping opioid and benzodiazepine prescriptions.	Uses Medicaid claim data, along with PDMP data, to analyze by pharmacy, provider, and beneficiary. Creates internal reports for quality control, internal policy development, and decision making for intervention purposes and to ensure patient safety and quality healthcare.	Analyzes Medicaid claim data and creates utilization reports to allow for identification of at-risk Medicaid beneficiaries and high-prescribing physicians. Creates reports that detail the percentage change in the population's MME use beginning at intake and organizes this information according to patients' risk assessment levels.

15



3. Outreach

- All of the States we reviewed participate in opioid-related outreach to both providers and patients.
- These outreach efforts include the following:
 - Optional or required opioid-related training for providers was provided in all of the States we reviewed. (See the next slide.)
 - In West Virginia, comprehensive drug awareness and prevention programs are required in all public schools.
 - In Utah, the “Use Only as Directed” campaign is designed to prevent and reduce misuse and abuse of prescription pain medications by providing information and strategies regarding safe use, safe storage, and safe disposal. Efforts include a paid media campaign, online presence, local community outreach, and nontraditional public relations events.

Reports and Letters to Providers and Patients

- In Washington, the Medicaid program sends reports and letters to providers and patients based on opioid-related measures. These include:
 - prescriber feedback reports, which allow prescribers to compare themselves with similar prescribers;
 - letters sent to providers for any patient that had a nonfatal overdose with a concurrent opioid prescription;
 - feedback reports sent to directors of emergency departments on emergency room physicians’ opioid prescribing; and
 - warning letters sent to Medicaid patients with at-risk behaviors (e.g., patients who make cash payments for prescriptions or seek medically unnecessary procedures).



State-by-State Comparison: Opioid-Related Training for Providers

Nebraska	Nevada	New Hampshire	Tennessee	Texas	Utah	Washington	West Virginia
Offers Medicaid provider training opportunities, including training on the PDMP, pain guidance, and naloxone, as well as the Medication-Assisted Treatment (MAT) Summit.	Provides opioid-related training to Medicaid providers via the Department of Health and Human Services, Division of Public and Behavioral Health website, Prescribe365: http://dpbh.nv.gov/Resources/opioids/Prescription_Drug_Abuse_Prevention/ .	Provides optional training through the Bureau of Drug and Alcohol Services. Provides free introductory-level workshops designed for people working in any helping profession whose daily work engages people with substance use disorders. Provides advanced training via the New Hampshire Training Institute on Addictive Disorders.	Created online training for opioid prescribing in partnership with East Tennessee State University's Quillen College of Medicine. Created an online opioid antagonist training for pharmacists.	Provides optional opioid-related training for healthcare providers through the Texas Health and Human Services Commission's Texas Health Steps Online Provider Education.	Conducts outreach to controlled substance prescribers through promotion of guidelines, academic detailing, and mandated prescriber education.	Provides optional free trainings and educational videos for Medicaid providers via Washington's Agency Medical Directors' Group website: http://www.agency.meddirectors.wa.gov .	Has facilitated the Substance Abuse and Mental Health Services Administration's "Partner for Opioid Addiction Prevention" training for prescribers. Hosted a 1-day, in-person training titled "Addressing Opioid Overdose: Understanding the Role of Prevention."



4. Programs

- All of the States we reviewed have opioid-related prevention, detection, and treatment programs.
- Examples of prevention programs include prescription take-back programs, which allow for safe disposal of unused medications, and pain management hotlines and telehealth connections for providers.
- Examples of detection programs include the following:
 - **PDMPs.** These programs track controlled substance prescriptions. Many of the States we reviewed currently share, or are working on sharing, PDMP data with other States. (See the next slide.)
 - **Medicaid Lock-In Programs.** At-risk beneficiaries are “locked in” to a specific provider type (i.e., a pharmacy or physician). The criteria used to identify at-risk beneficiaries vary by State. For example:
 - In Utah, one factor is four or more pharmacies accessed for controlled medications in a 12-month period.
 - In Texas, one factor is four or more emergency room visits resulting in an opioid prescription.

Opioid Treatment Programs

- The number of opioid treatment programs (OTPs) varies by State:

State	No. of OTPs
Nebraska	3
New Hampshire	9
West Virginia	9
Tennessee	13
Nevada	16
Utah	16
Washington	25
Texas	92

Note: The number of patients served by each OTP can vary.

- Many OTPs provide MAT, and some States are working to expand access to MAT.
- Many of the States we reviewed are using funding provided by the Substance Abuse and Mental Health Services Administration’s State Targeted Response to the Opioid Crisis grants to expand opioid treatment services.



State-by-State Comparison: Sharing of PDMP Data With Other States

Nebraska	Nevada	New Hampshire	Tennessee	Texas	Utah	Washington	West Virginia
Does not share its PDMP data with other States.	Shares PDMP data with other States via PMP InterConnect.	Shares PDMP data with other States via PMP InterConnect.	Shares PDMP data with other States via PMP InterConnect.	Shares PDMP data with other States via PMP InterConnect.	Shares PDMP data with other States via PMP InterConnect and Rx Check.	Shares PDMP data with other States via PMP InterConnect and Rx Check and is working on an agreement with Oregon.	Shares PDMP data with other States via PMP InterConnect.

- **PMP InterConnect** facilitates the transfer of prescription-monitoring program data across State lines. It allows participating State prescription-monitoring programs across the United States to be linked.
- **Rx Check** is a fully operational hub that enables States to securely and efficiently share PDMP data.

Note: Information originally provided by the States in the factsheets was updated with more current information obtained from the PMP InterConnect website, <https://nabp.pharmacy/initiatives/pmp-interconnect/>, accessed on May 9, 2019, and the Rx Check website, https://www.pdmpassist.org/pdf/RxCheck_states_map_20190411.pdf, accessed on May 9, 2019.



5. Other Actions

- In addition to policies, data analytics, outreach, and programs, all of the States we reviewed have initiated many other efforts to address the opioid epidemic.
- Many of the selected States' efforts to address the opioid epidemic involve collaboration among various entities. Examples follow:
 - Utah's Coalition for Opioid Overdose Prevention was formed to prevent and reduce opioid abuse, misuse, and overdose deaths through a coordinated response.
 - Washington's Governor's Executive Order 16-09 brought together multiple agencies to address the opioid crisis.
 - Tennessee implemented the "Public Private Partnership," a group whose objective is to ensure there is "no wrong door" for a Tennessean seeking treatment.

Specialty Drug Courts

- Many of the selected States' judicial systems use specialty drug courts, providing court-supervised probation and mandated treatment:
 - Nevada started a Law Enforcement Assisted Diversion program and a Specialty Courts program, which aim to provide people with a chance to get treatment rather than end up incarcerated.
 - New Hampshire established specialty courts to address treatment and recovery needs of individuals with substance use disorders.
 - Tennessee's specialty drug courts incorporate intensive judicial supervision, treatment services, sanctions, and incentives to address the needs of addicted nonviolent offenders who meet the criteria of the drug court program and voluntarily want to participate in the program.



Conclusion

We identified actions that the selected States took related to their oversight of opioid prescribing and their monitoring of opioid use. The States have created policies and procedures and passed laws and regulations related to opioids. The States are using opioid-related data to perform data analytics, as well as performing outreach to providers and patients. The States have implemented a number of opioid-related prevention, detection, and treatment programs. Finally, the States have taken many other actions to address the opioid epidemic.

This report contains no recommendations.



Appendix A: Related OIG Work on States' Oversight of Opioids

<i>Factsheet: Texas' Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	<u>A-06-18-04000</u>	3/27/2019
<i>Factsheet: West Virginia's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	<u>A-03-18-03302</u>	3/5/2019
<i>Factsheet: New Hampshire's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	<u>A-01-18-01501</u>	2/25/2019
<i>Factsheet: Nevada's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	<u>A-09-18-01004</u>	2/14/2019
<i>Factsheet: Utah's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	<u>A-07-18-05115</u>	2/8/2019
<i>Factsheet: Tennessee's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	<u>A-04-18-00124</u>	2/6/2019
<i>Factsheet: Nebraska's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	<u>A-07-18-06080</u>	1/31/2019
<i>Factsheet: Washington State's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	<u>A-09-18-02001</u>	12/11/2018



Appendix B: Glossary of Terms

- **medication-assisted treatment:** Treatment for opioid use disorder combining the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.
- **morphine milligram equivalents:** The amount of milligrams of morphine an opioid dose is equal to when prescribed.
- **opioid use disorder:** A problematic pattern of opioid use that causes significant impairment or distress. A diagnosis is based on specific criteria, such as unsuccessful efforts to cut down or control use, or use resulting in social problems and a failure to fulfill obligations at work, school, or home, among other criteria.
- **opioids:** Natural or synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain and reduce the intensity of pain signals and feelings of pain. This class of drugs includes the illegal drug heroin; synthetic opioids, such as fentanyl; and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, and morphine.
- **Prescription Drug Monitoring Program:** A State-run electronic database that tracks controlled substance prescriptions. A PDMP helps providers identify patients at risk of opioid misuse, abuse, or overdose due to overlapping prescriptions, high dosages, or co-prescribing of opioids with benzodiazepines.



Appendix C: Sources of Background Information

About the Epidemic. <https://www.hhs.gov/opioids/about-the-epidemic/index.html>. Accessed on March 8, 2019.

CMCS [Center for Medicaid and CHIP Services] Informational Bulletin, “Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction.” <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf>. Accessed on June 15, 2018.

Opioid Basics. <https://www.cdc.gov/drugoverdose/opioids/index.html>. Accessed on March 8, 2019.

Opioid Overdose Crisis. <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis>. Accessed on March 7, 2019.

The Opioid Crisis. <https://www.whitehouse.gov/opioids>. Accessed on March 8, 2019.

Understanding the Epidemic. <https://www.cdc.gov/drugoverdose/epidemic/index.html>. Accessed on March 8, 2019.

