



***Update on Oversight of Opioid Prescribing
and Monitoring of Opioid Use:***

**States Have Taken Action To Address
the Opioid Epidemic**

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Why We Did This Audit

- Opioid abuse and overdose deaths are at crisis levels in the United States.
 - Nearly 47,000 Americans died of drug overdoses involving opioids in 2018.
 - 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 audit. We gathered information from the States on their actions related to their oversight of opioid prescribing and their monitoring of opioid use and summarized the results of those audits in factsheets issued to each State and made publicly available on the Office of Inspector General (OIG) website.
- In July 2019, we issued a report summarizing and comparing information provided by the eight States and then selected three additional States to include in this series. This report summarizes and compares information provided by all 11 States as of various dates between October 2018 and May 2020.
 - See Appendix A for a list of the factsheets and the July 2019 summary report.

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). The use of 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 health care 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 through 2018, almost 450,000 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: (1) guidance to address policy issues and (2) 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 days’ supply limits for short- and long-acting opioids, application of statewide Prescription Drug Monitoring Programs (PDMPs), and use of morphine daily dose alerts to prevent drug overdoses.

* 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).



Background: CMS Guidance on Opioids (cont.)

- Since our July 2019 report was issued, CMS has issued an Informational Bulletin, “State Guidance for Implementation of Medicaid Drug Utilization Review (DUR) provisions included in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271)” (Aug. 5, 2019).
- CMS has issued a Notice of Proposed Rulemaking (NPRM) for “Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability (TPL) Requirements (CMS-2482-P)” (June 19, 2020).
 - This NPRM proposes minimum standards in State Medicaid DUR programs designed to reduce opioid-related fraud, misuse, and abuse.
 - These changes reflect CMS’s continued efforts to: (1) reduce prescription-related fraud, abuse, and misuse and (2) assure that opioid prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results.

CMS’s State Program Integrity Reviews of Medicaid-Funded Opioid Prescribing

- CMS program integrity desk reviews collect information on how State Medicaid Program Integrity policies and procedures identify and investigate fraud, waste, and abuse of Medicaid-funded opioid prescriptions, as well as how States coordinate across State government agencies. Those desk reviews examine efforts such as:
 - reviews and investigations of fraud, waste, and abuse;
 - Patient Review and Restriction/Lock-In programs;
 - prepayment controls;
 - provider contracting, education, and guidelines;
 - State collaboration; and
 - State initiatives in response to the opioid epidemic.
- In 2020, 12 States are scheduled for review. Once these reviews are completed, CMS will have completed these desk reviews for all 50 States and the District of Columbia.



How We Conducted This Audit

- To select the initial eight States included in our audit, we analyzed CDC data showing State trends in opioid overdose deaths. The eight States were Nebraska, Nevada, New Hampshire, Tennessee, Texas, Utah, Washington State, and West Virginia.
- For this update to our original audit, we selected an additional three States in the Appalachian region, an area with high rates of opioid overdose deaths: Alabama, Kentucky, and Ohio. (See the map on slide 11 for all 11 States included in our audit.)
- The selected States included ones that participated and did not participate in the Medicaid expansion under the Patient Protection and Affordable Care Act.

Selected States' Information Was Current as of the Following Dates:

State	Current As Of
Alabama	October 2019
Kentucky	January 2020
Nebraska	November 2018
Nevada	October 2018
New Hampshire	November 2018
Ohio	May 2020
Tennessee	October 2018
Texas	November 2018
Utah	October 2018
Washington	November 2018
West Virginia	October 2018



How We Conducted This Audit (cont.)

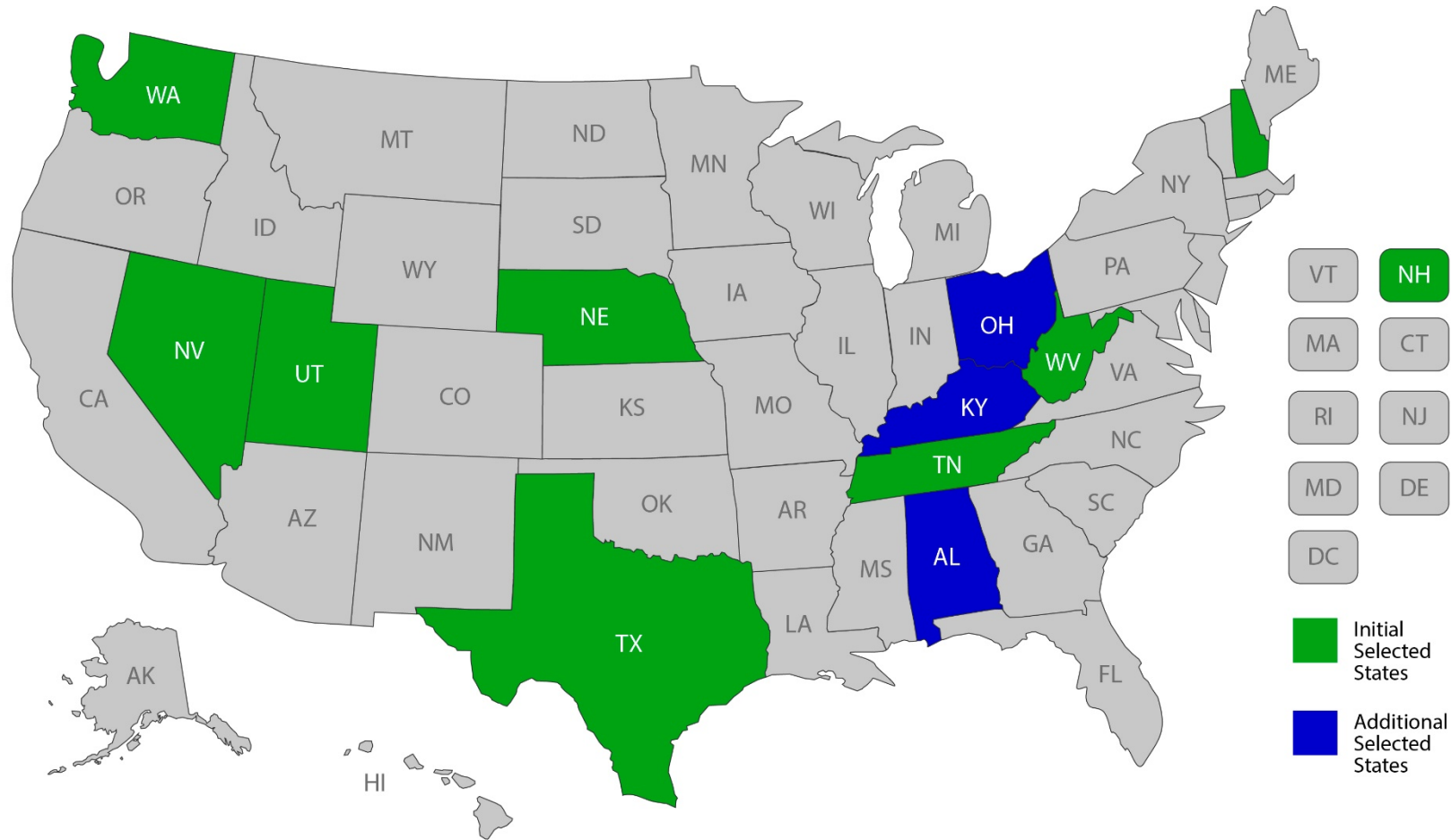
- We developed a questionnaire for the selected States to complete to identify their policies and procedures, data analytics, outreach, programs, and other actions related to opioid prescribing and monitoring of opioid use.
- We held discussions with State officials to discuss their responses to the questionnaire and to obtain additional information on their actions related to opioid prescribing and monitoring of opioid use.
- We discussed the results of our audit with CMS officials.
- We provided our draft report to CMS 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.
- We did not assess CMS's or the States' internal controls because they were not significant to our audit objective. The objective did not require us to assess CMS's or the States' internal controls related to opioid prescribing and monitoring of opioid use. Additionally, we did not evaluate whether CMS or the States complied with applicable Federal and State requirements.



Selected States for Audit



Results of Audit

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.

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1. Policies and Procedures: Opioid Prescribing

- All of the selected States 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).
 - Kentucky passed a law (Revised Statutes § 218A.172) that addresses prescribing and dispensing of Schedule II controlled substances and Schedule III controlled substances containing hydrocodone.

Opioid Prescribing Limits

- CDC issued a guideline 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 two slides for a comparison of the selected States' opioid prescribing limits with the CDC guideline.

* *CDC Guideline for Prescribing Opioids for Chronic Pain.*
https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf.
Accessed on August 4, 2020.



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

CDC Guideline	Alabama	Kentucky	Nebraska	Nevada	New Hampshire	Ohio
<p>Use extra precautions when increasing opioid prescriptions to ≥ 50 MME per day.</p> <p>Avoid or carefully justify increasing dosage to ≥ 90 MME per day.</p> <p>For acute pain, 3 days or less will often be sufficient; more than 7 days will rarely be needed.</p>	<p>Medicaid policy limits short-acting prescription opioids for beneficiaries with no opioid claims history in the past 180 days to a maximum supply of:</p> <ul style="list-style-type: none"> 7 days for adults, 5 days for children 18 years old and younger, and 50 MME per day on a claim. <p>Medicaid policy denies opioid claims that exceed a cumulative MME of 250 per day and will gradually decrease the MME limit until it reaches the CDC recommendation of 90 MME per day.</p>	<p>State law limits the prescription of Schedule II drugs to a 3-day supply if the drugs are intended to treat pain as an acute medical condition. The limitation is subject to certain exceptions, such as when the practitioner believes that more than a 3-day supply is medically necessary to treat the patient or the prescription is for pain associated with a cancer diagnosis, hospice, or end-of-life treatment. Claims of medical necessity must be adequately documented.</p>	<p>Medicaid policy limits the quantity of short-acting opioids to 150 tablets or capsules per rolling 30 days.</p> <p>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.</p>	<p>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.</p>	<p>Medicaid policy requires any beneficiary who reaches a daily MME of 100 or more to receive prior authorization to continue with that dose.</p>	<p>State law limits the initial opioid prescription for the treatment of acute pain to a 7-day supply for adults, and the MME is not to exceed an average of 30 MME per day.</p> <p>Medicaid policy limits patients with short-acting opioid therapy to 30 MME per prescription and a maximum of 7 days per prescription. Prior authorization from the prescriber is required to exceed the limits.</p>



State-by-State Comparison: Opioid Prescribing Limits Compared With CDC Guideline (cont.)

CDC Guideline	Tennessee	Texas	Utah	Washington	West Virginia
<p>Use extra precautions when increasing opioid prescriptions to ≥ 50 MME per day.</p> <p>Avoid or carefully justify increasing dosage to ≥ 90 MME per day.</p> <p>For acute pain, 3 days or less will often be sufficient; more than 7 days will rarely be needed.</p>	<p>State law limits initial opioid prescriptions to a 3-day supply of a 180-MME dose.</p> <p>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.</p>	<p>Medicaid policy limits opioid prescriptions to a maximum of 90 MME.</p>	<p>State law limits opioid prescriptions for acute, non-complex, non-chronic conditions to a 7-day supply.</p> <p>Medicaid policy limits the initial fill of short-acting opioids to no more than a 7-day supply (a 3-day supply for dentists).</p>	<p>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.</p>	<p>State law limits opioid supply to no more than:</p> <ul style="list-style-type: none"> • 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 selected States have laws, regulations, or policies related to 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.
 - Kentucky Revised Statutes (§ 218A.172) required prescribers to check the PDMP data before the initial prescribing or dispensing of any Schedule II or Schedule III controlled substance containing hydrocodone and every 3 months thereafter for continued use.
- See the next two slides for a comparison of the selected States' requirements for reviewing PDMP data.

Sharing of PDMP Data With Law Enforcement

- All of the States we audited 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

Alabama	Kentucky	Nebraska	Nevada	New Hampshire	Ohio
Prescribers should review patient prescribing history through the PDMP data at least two times per year when prescribing controlled substances of more than 30 MME per day and query the PDMP data to review patient prescribing history every time a prescription for more than 90 MME per day is written.	Prescribers are required to check the PDMP data before the initial prescribing or dispensing of any Schedule II or Schedule III controlled substance containing hydrocodone and every 3 months thereafter for continued use.	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 obtain patient information from the PDMP data that covers at least the previous 12 months before initially prescribing or personally furnishing opioids or benzodiazepines. In addition, prescribers are required to make periodic requests for patient information from the PDMP data if the treatment continues for more than 90 days.



State-by-State Comparison: State Requirements for Reviewing PDMP Data (cont.)

Tennessee	Texas	Utah	Washington	West Virginia
<p>Prescribers are required to check the PDMP data:</p> <p>(1) before prescribing certain controlled substances, including opioids and benzodiazepines, to a patient at the beginning of a new episode of treatment and</p> <p>(2) if the prescriber is aware or reasonably certain that a person is attempting to obtain a controlled substance, including opioids, for illicit purposes.</p>	<p>Beginning in September 2019, prescribers will be required to check the PDMP data before prescribing opioids and other controlled substances.</p>	<p>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.</p>	<p>New opioid-prescribing rules (effective late 2018 and early 2019) require prescribers to check the PDMP data. These prescribing requirements vary by health care profession. Detailed information can be found at:</p> <p>https://www.doh.wa.gov/ForPublicHealthandHealthcareProfessionalsandFacilities/OpioidPrescribing/HealthcareProviders/Toolkits.</p>	<p>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).</p>



2. Data Analytics

- All of the selected States 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.
 - In Ohio, the State Medical Board analyzes data at a provider level using individual prescriptions and wholesale reporting of prescription data by medical condition, makes operational decisions based on the data, and communicates to licensees failing to follow requirements.
- See the next two slides for examples of data analysis performed by the selected States.

Data Analysis by Managed-Care Organizations

- Many of the selected States' Medicaid services are provided through managed-care organizations (MCOs).
- Some 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

Alabama	Kentucky	Nebraska	Nevada	New Hampshire	Ohio
<p>Routinely performs data analytics on opioid prescribing and pharmacy trends. Examples of analyses performed include:</p> <ul style="list-style-type: none"> • opioid prescribing trends by age, provider specialty, and location; • opioid drug spending trends; and • neonatal abstinence syndrome trends. 	<p>Analyzes data by pharmacy, provider, and beneficiary.</p> <p>Analyzes data based on the number of prescriptions, dollar amount of drugs dispensed, percentage of total prescriptions, peer comparison, dosage levels, MME data, days' supply, MCO, and geographic location.</p>	<p>Uses an operational dashboard, which contains aggregate prescription data, to identify opportunities to drive policy changes and recommendations.</p> <p>Medicaid MCOs, covering 98 percent of Nebraska's Medicaid beneficiaries, perform data analytics to monitor opioid prescribing.</p>	<p>Used data analytics to identify the top 10 opioid-prescribing providers, to monitor these providers.</p> <p>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.</p>	<p>Periodically analyzed opioid prescribing in the Medicaid populations, focusing on member use rates by drug; strength, supply, and frequency of prescriptions; and demographics.</p> <p>Performed provider-based reporting on a pilot basis.</p>	<p>Multiple State agencies analyze data. Examples include analysis on:</p> <ul style="list-style-type: none"> • licensees or prescribers that may be in violation of criminal and administrative laws; • Medicaid recipients who exceed opioid dosage thresholds; • drug overdoses, including those related to opioids; and • annual comparisons of injured workers receiving opioid prescriptions.



State-by-State Comparison: Examples of Data Analysis (cont.)

Tennessee	Texas	Utah	Washington	West Virginia
<p>Analyzes the top prescribers of controlled substances and releases to prescribers a report card identifying those prescribing controlled substances at a high rate.</p> <p>Uses data analytics to identify specific providers for engagement and outreach.</p>	<p>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.</p>	<p>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.</p>	<p>Uses Medicaid claim data, along with PDMP data, to analyze by pharmacy, provider, and beneficiary.</p> <p>Creates internal reports for quality control, internal policy development, and decisionmaking and creates external reports for intervention purposes and to ensure patient safety and quality health care.</p>	<p>Analyzes Medicaid claim data and creates utilization reports to allow for identification of at-risk Medicaid beneficiaries and high-prescribing physicians.</p> <p>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.</p>



3. Outreach

- All of the selected States participate in opioid-related outreach to both providers and patients.
- Optional or required opioid-related training for providers was furnished in all of the selected States. (See the next two slides.)
- Examples of outreach to patients include the following:
 - 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.
 - In Alabama, the “Courage for All” media campaign focuses on awareness and treatment of opioid addiction, including the courage to make a change and seek help.

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 who 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

Alabama	Kentucky	Nebraska	Nevada	New Hampshire	Ohio
<p>Provides face-to-face training on Medicaid policy changes.</p> <p>Provides training for physicians and other medical providers on medication-assisted treatment (MAT) and how to incorporate MAT into a practice. In addition to MAT training, qualified individuals participate in buprenorphine waiver training.</p>	<p>Provided an online webinar on opioid use in Kentucky, opioid stewardship, and strategies for educating families on prevention, safe storage and disposal solutions, and treatment resources, through the Kentucky Chapter of the American Academy of Pediatrics.</p> <p>The Responsive Education to Support Treatment in Opioid Recovery Efforts Initiative provided summits in the Supreme Court and Court of Appeals Districts.</p>	<p>Offers Medicaid provider training opportunities, including training on the PDMP, pain guidance, and naloxone, as well as the MAT Summit.</p>	<p>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/.</p>	<p>Provides optional training through the Bureau of Drug and Alcohol Services.</p> <p>Provides free introductory-level workshops designed for people working in any helping profession whose daily work engages people with substance use disorders.</p> <p>Provides advanced training via the New Hampshire Training Institute on Addictive Disorders.</p>	<p>Provides a training module on appropriate and safe treatment of pain.</p> <p>Provides continuing education for physicians who treat patients with substance use disorders through an Extension for Community Healthcare Outcomes project.</p> <p>Provides a free training program for prescribers to obtain a unique license to prescribe buprenorphine for MAT.</p> <p>Provides free continuing education to any health care provider through an annual medical and health symposium.</p>



State-by-State Comparison: Opioid-Related Training for Providers (cont.)

Tennessee	Texas	Utah	Washington	West Virginia
<p>Created online training for opioid prescribing in partnership with East Tennessee State University's Quillen College of Medicine.</p> <p>Created an online opioid antagonist training for pharmacists.</p>	<p>Provides optional opioid-related training for health care providers through the Texas Health and Human Services Commission's Texas Health Steps Online Provider Education.</p>	<p>Conducts outreach to controlled substance prescribers through promotion of guidelines, academic detailing, and mandated prescriber education.</p>	<p>Provides optional free trainings and educational videos for Medicaid providers via Washington's Agency Medical Directors' Group website: http://www.agencymeddirectors.wa.gov.</p>	<p>Has facilitated the Substance Abuse and Mental Health Services Administration's (SAMHSA's) "Partnering for Opioid Addiction Prevention" training for prescribers.</p> <p>Hosted a 1-day, in-person training titled "Addressing Opioid Overdose: Understanding the Role of Prevention."</p>



4. Programs

- All of the selected States 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 audited currently share, or are working on sharing, PDMP data with other States. (See the next two slides.)
 - **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
Alabama	21
Kentucky	24
Nebraska	3
Nevada	16
New Hampshire	9
Ohio	59
Tennessee	13
Texas	92
Utah	16
Washington	25
West Virginia	9

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 selected States are using funding provided by SAMHSA’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

Alabama	Kentucky	Nebraska	Nevada	New Hampshire	Ohio
Shares PDMP data with other States via PMP InterConnect and RxCheck.	Shares PDMP data with other States via PMP InterConnect and RxCheck.	Shares PDMP data with other States via RxCheck.	Shares PDMP data with other States via PMP InterConnect and RxCheck.	Shares PDMP data with other States via PMP InterConnect and RxCheck.	Shares PDMP data with other States via PMP InterConnect and RxCheck.

- **PMP InterConnect** facilitates the transfer of PDMP data across State lines. It allows participating State PDMPs across the United States to be linked through a single memorandum of understanding instead of through contractual agreements with each participating State.
- **RxCheck** 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 on this slide with more current information obtained from the PMP InterConnect website, <https://nabp.pharmacy/initiatives/pmp-interconnect/>, accessed on July 27, 2020, and the RxCheck website, https://www.pdmpassist.org/pdf/RxCheck_states_map.pdf, accessed on July 27, 2020.



State-by-State Comparison: Sharing of PDMP Data With Other States (cont.)

Tennessee	Texas	Utah	Washington	West Virginia
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 RxCheck.	Shares PDMP data with other States via PMP InterConnect and RxCheck and is working on an agreement with Oregon.	Shares PDMP data with other States via PMP InterConnect and RxCheck.

Note: Information originally provided by the States in the factsheets was updated on this slide with more current information obtained from the PMP InterConnect website, <https://nabp.pharmacy/initiatives/pmp-interconnect/>, accessed on July 27, 2020, and the RxCheck website, https://www.pdmpassist.org/pdf/RxCheck_states_map.pdf, accessed on July 27, 2020.



5. Other Actions

- In addition to policies, data analytics, outreach, and programs, all of the selected States 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.
 - Ohio developed the InnovateOhio technology initiative, which will develop a statewide strategy to improve information and data-sharing techniques across agencies, boards, and commissions.

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.

Because this report contains no recommendations, CMS did not provide written comments on our draft report but did provide technical comments, which we addressed as appropriate.



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

Report Title	Report Number	Date Issued
<i>Factsheet: Ohio's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-05-19-00036	7/24/2020
<i>Factsheet: Kentucky's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-04-19-02022	3/3/2020
<i>Factsheet: Alabama's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-04-19-00125	11/27/2019
<i>Oversight of Opioid Prescribing and Monitoring of Opioid Use: States Have Taken Action To Address the Opioid Epidemic*</i>	A-09-18-01005	7/24/2019
<i>Factsheet: Texas' Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-06-18-04000	3/27/2019
<i>Factsheet: West Virginia's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-03-18-03302	3/5/2019

* Summary report covering the initial eight selected States.



Appendix A: Related OIG Work on States' Oversight of Opioids (cont.)

Report Title	Report Number	Date Issued
<i>Factsheet: New Hampshire's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-01-18-01501	2/25/2019
<i>Factsheet: Nevada's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-09-18-01004	2/14/2019
<i>Factsheet: Utah's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-07-18-05115	2/8/2019
<i>Factsheet: Tennessee's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-04-18-00124	2/6/2019
<i>Factsheet: Nebraska's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-07-18-06080	1/31/2019
<i>Factsheet: Washington State's Oversight of Opioid Prescribing and Monitoring of Opioid Use</i>	A-09-18-02001	12/11/2018



Appendix B: Glossary of Terms

- **benzodiazepines:** Sedatives often used to treat anxiety, insomnia, and other conditions. Combining benzodiazepines with opioids increases a person's risk of overdose and death.
- **medication-assisted treatment (MAT):** Treatment for opioid use disorder combining the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.
- **morphine milligram equivalents (MME):** 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 (PDMP):** A State or territorial-run electronic database that tracks controlled substance prescriptions. A PDMP helps providers identify patients at risk of opioid misuse, opioid use disorder, 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 July 30, 2020.

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 July 30, 2020.

Ending America’s Opioid Crisis. <https://www.whitehouse.gov/opioids>. Accessed on August 5, 2020.

Opioid Basics. <https://www.cdc.gov/drugoverdose/opioids/index.html>. Accessed on July 30, 2020.

Opioid Overdose Crisis. <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis>. Accessed on July 30, 2020.

Understanding the Epidemic. <https://www.cdc.gov/drugoverdose/epidemic/index.html>. Accessed on July 30, 2020.

