Opioid Prescribing Work Group

Minutes — May 20, 2021
12:00 pm –2:00 pm
WebEx Video Event

Members present: Nathan Chomilo, Kurtis Couch, Julie Cunningham, Kurt DeVine, Sen. Chris Eaton, Tiffany Elton, Dana Farley, Rebekah Forrest, Bret Haake, Chad Hope, Chris Johnson, Murray McAllister, Richard Nadeau, Adam Nelson, Charlie Reznikoff, Saudade SammuelSon, Charles Strack, Lindsey Thomas

Members absent: Matthew Lewis, Charlie Reznikoff

DHS employees: Ellie Garrett, Jessica Hultgren, Sarah Rinn, David Kelly

Welcome and introductions

Julie Cunningham called the meeting to order and welcomed members. Opioid Prescribing Work Group (OPWG) members introduced themselves. Members reviewed the April OPWG draft meeting minutes. Haake moved to approve the April minutes. Eaton seconded the motion and the minutes were approved.

State agency updates

Ellie Garrett provided a brief update on the status of the Opioid Prescribing Improvement Program (OPIP) statute change. The proposal is part of the DHS omnibus bill and remains under review.

Opportunity for public comment

No public comments were provided.

Opioid prescribing reports and quality improvement program update

Jessica Hultgren informed the members that approximately 50% of the providers required to participate in the quality improvement (QI) program in 2021 have confirmed they received their report. She also provided a brief update on the provider notification process. DHS has notified approximately 40 provider groups, focusing on large health systems or clinics, and organizations with multiple QI providers. There are approximately 170 provider groups, 75 of which are high priority.

DHS has received feedback that from organizations that there are providers in their data file that are not affiliated with their health system. The OPIP team continues to analyze the issue, but it so far it appears that the attribution methodology is simply picking up some atypical business relationships, e.g., the provider provides services at a location but does not have a formal business relationship. The message provided to the organizations is that they should support their providers, and they do not need to contact the providers who are not part of their organization.

Hultgren announced that DHS has contracted with the Institute for Clinical Systems Improvement (ICSI) to provide guidance and technical assistance to DHS, participating providers and their affiliated organizations on the quality improvement program. ICSI staff will present an overview of the work plan at a future OPWG meeting.

Office of Inspector General: Surveillance and Integrity Review Section

Rinn introduced Melanie LaBrie, a manager in the Office of Inspector General (OIG) Surveillance and Integrity Review Section (SIRS) provider investigation unit. The SIRS unit is response for investigating fraudulent, abusive, wasteful or erroneous activities in DHS public programs reimbursed by Minnesota Medicaid. SIRS conducts post-payment reviews to ensure compliance with DHS policy, and issues appropriate sanctions based on investigations. LaBrie presented an overview of the SIRS unit, including the investigative process, the types of administrative actions and sanctions SIRS can issue, the appeals process, and referrals to other regulatory agencies. A copy of her slides are available upon request.

LaBrie answered a few follow-up questions from the members. With regard to the SIRS time line, the goal is to reach a decision about provider sanctions 90 days from when the investigation is opened. However, the appeal process can take much longer. She confirmed that all providers have the right to appeal a SIRS decision. With regard to the provider exclusion list, she confirmed that providers on the exclusion list cannot work for any organization—in any capacity—that bills for Medicaid payment. Discussion then turned to opioid-related SIRS investigations. LaBrie commented that there have been a fair number of opioid-related cases in the last 5 years. Often, the opioid-related cases do not get through the entire process. She commented that SIRS uses death report data when relevant, and it is often used to identify connections to providers. She offered to follow-up with the group and provide the number of recent cases with an opioid-related death. A member then asked who determines medical necessity in an investigation. LaBrie clarified that the SIRS staff uses independent reviewers to assist with those reviews. A member asked about the relationship of SIRS to the licensing boards and managed care organizations (MCOs). LaBrie stated that MCOs are required to notify SIRS when investigating a complaint, but the licensing boards do not typically contact SIRS. Usually SIRS contacts the boards when there is a finding.

A member asked if it is common for providers to have multiple issues that warrant investigation. LaBrie commented that they investigate providers who have past investigations or a pattern of problematic behaviors, but that they also receive referrals on providers who were previously not known to them. She commented they often identify other issues in addition to the issue that triggered the investigation. Garrett asked LaBrie to confirm whether individuals or members are able to file complaints with the SIRS unit. LaBrie confirmed that SIRS does receive complaints from individuals through the hotline. Members briefly discussed the possibility for the OPIP QI work to influence the types of opioid-related complaints SIRS receives, and whether there is any opportunity to evaluate the impact. DHS staff will flag this for further review.

A brief discussion ensued about how to identify patterns of concerning behavior. LaBrie confirmed that the SIRS investigators review providers for patterns of concerning behavior, and that decisions about unsafe patterns of behavior are very dependent on the type of behavior being investigated. A member asked about the relationship of the OPIP QI program and SIRS. If SIRS received a complaint about a provider in the QI program, would they wait for the QI program to be completed? LaBrie clarified that the SIRS review would still

take place. LaBrie then clarified that cases are closed (data is private) until a decision is made, and that the OIG referral is not public.

Disenrollment standards: Approach and domains

Rinn presented three different approaches to the disenrollment standard work. Providers could be investigated based on any one of the following options:

1. Clinical criteria or standards that are separate from the OPIP sentinel measures;
2. Progression from quality improvement program to additional sanctions; and/or
3. Direct referral from DHS OPIP program to OIG for investigation.

Discussion ensued about the second approach. Members asked about how successful completion of the QI program will be determined. That is part of the work that DHS will complete with ICSI in the QI program design. The intent is to routinize the process so that DHS can address it with existing systems, processes and resources. Discussion then turned to any existing overlap between OIG cases and OPIP QI providers. DHS staff will explore the option of sharing our OPIP QI provider list with OIG, and to explore whether there is any way to identify commonalities between the two lists. Members briefly discussed whether refusal to participate in the QI process could be a reason to refer the patient to the OIG. Hope commented that OIG referrals are a more common practice within DHS than most would realize. The referral to OIG is not the 'nuclear option'. The OIG is the entity within DHS with the expertise and resources to investigate fraud, waste and abuse, and referral to OIG ensures that complaints are properly reviewed.

Rinn presented the four domains previously discussed as grounds for disenrollment (or at least referral to OIG). Members discussed the challenges around patient abandonment, e.g. how this may have unintended consequences where providers are afraid to taper. Abrupt cessation of high-dose chronic opioid therapy may be a better way to frame the issue. A member suggested it may be easier to describe a good taper versus a bad taper, but that there are possible pitfalls of approaching it either way. A member expressed concern that providers are not communicating information about tapers to their patients, and the patient often learns of the dose reduction once they are at the pharmacy. A suggestion was made to approach the standards similarly to how a diagnosis is sometimes made: develop a list of criteria and then set a number (sum) that would constitute patient abandonment. A member expressed concern about the scope of this work, and the timeline we have. There is a difference between tapering when it is working and when it is not. A provider should not abandon people and leave them without opioids, but that provider may also not be the best person to care for that patient. Often the people who can best manage the taper—especially among those who can't wean—have expertise in treating Opioid Use Disorder.

Meeting adjourned.