Opioid Prescribing Work Group

Minutes — April 22, 2021
12:00 pm –2:00 pm
WebEx Video Event

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

Members absent: Sen. Chris Eaton, Matthew Lewis

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 January and February OPWG draft meeting minutes. A member recommended modifying the discussion about clinical recommendation number two: "Providers should not taper a patient for their own convenience or solely to comply with pharmacy benefit manager, health insurance company or state policy." The recommended change was to remove the underlined portion of the following statement made during the meeting: There is political value in its inclusion, in part because it inoculates the state and work group against criticism and takes away 'provider short-cuts'.

Thomas moved to approve the January minutes, as amended. Haake seconded the motion and the minutes were approved. Elton moved to approve the February minutes, Thomas seconded. 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 is still in committee.

Rinn reviewed the meeting agenda and changes to the meeting participation format. Beginning with the April meeting, the chat function in WebEx is limited to OPWG members (voting and non-voting) and DHS staff. Members of the public may provide comment during the public comment opportunity, but otherwise their WebEx audio lines are muted.

Opportunity for public comment

Cammie LaValle provided public comment. Ms. LaValle has no financial conflicts of interest to disclose. Ms. LaValle asked the work group members and DHS staff whether there will be any information provided to patients that would allow them to seek recourse against decisions made by their physicians or pharmacy

benefit managers (PBMs). Specifically, instances when PBMs change aspects of a prescription that negatively affect the patients. She shared a recent example of how a change made by her PBM resulted in duplicate entries into the PMP, which has implications for flagging her and her physician for closer monitoring.

Sheila Grabosky provided public comment. Ms. Grabosky has no financial conflicts of interest to disclose. She expressed concern about a lot of conflicting statements in the revised taper and chronic pain guidance. Her pain clinic already has many of these elements in place, and she is concerned that this work will force physicians to give up their DEA license. Ms. Grabosky commented that it is concerning that none of the work group members actually experience chronic pain, and that this work is causing chronic pain patients to suffer.

Kurtis Couch provided a brief response and follow-up to Ms. LaValle's comments. He shared with the work group that her experience is not uncommon. When errors are made at the pharmacy—either due to an error in the prescription or user entry error—the staff have a narrow window in which to fix the error. If the error is not addressed in time, than it can result in needing to adjust the prescription at a later date which can flag the patient and/or physician in the PMP.

Reflection on February OPWG meeting

Members did not have any additional comments about the public comments provided during the February meeting. DHS staff requested that OPWG members reach out any time with questions or concerns about meeting content.

Opioid prescribing reports and quality improvement program update

Jessica Hultgren informed members that the 2020 opioid prescribing reports will mail today. DHS mailed 15,481 reports in total, and of those, 310 providers are required to participate in the quality improvement program. She encouraged members to let people know the April 28 Rural Health Series ECHO is about the reports. Charlie Reznikoff will present an updated version of 'How to interpret your report'.

Hultgren shared that the QI contract is nearly final. The contract has a pretty aggressive plan to start work, in order to start the QI work with providers in June.

Provider disenrollment standards: Options

Sarah Rinn reviewed the meeting objectives: 1) agreement on the purpose of the disenrollment standards; 2) seek consensus on a framework for reviewing; and 3) review potential domains for future discussion. The disenrollment standards are distinct from the quality improvement thresholds in statute, and may be described in terms of the length of time in which prescribing falls outside of community standards and the nature and amount of opioid prescribing that falls outside of community standards. The standards defined by the OPWG will not warrant automatic disenrollment from Minnesota Medicaid and MinnesotaCare. Rather, they will be used to trigger additional investigation into that provider.

Rinn presented two approaches to the disenrollment work for member consideration. First, the disenrollment standards could be defined as an extension or escalation of the quality improvement program. Failure to participate successfully in the QI program—with additional criteria to take into account length of time and scope—would trigger a referral for additional investigation. Second, the disenrollment standards could be

distinct from the domains captured by the OPIP sentinel measures and separate from the QI program. The two approaches are not mutually exclusive.

Discussion ensued about the need for a tiered approach to disenrollment. Given the gravity of disenrollment from the program, members expressed the importance of a stepped process from being flagged for consideration to disenrollment. Questions arose including whether the provider should first be assessed against the sentinel measures, and then the disenrollment standards? Will there be an opportunity for quality improvement outside the disenrollment standards prior to termination? Several members agreed that the disenrollment standards must be able to identify a pattern of behavior, and that a single instance cannot be grounds for disenrollment.

Members then discussed the data available to DHS to make these decisions. The prescribing data available via the Medicaid administrative claims data is probably not sufficient for this work, especially since egregious prescribing also involves the failure to provide care or document decision making. DHS staff requested that the work group members not limit the discussion to what is possible with DHS administrative claims data. DHS will have to codify the disenrollment standards—either in statute or administrative rules—so there is an opportunity to indicate that additional data sources are necessary for disenrollment. While the OPIP staff does not have access to the PMP or the bandwidth/expertise to conduct chart reviews, there are individuals in the DHS Office of Inspector General for whom this type of data review is their job. If the OPWG members believe additional data is needed, then DHS will request access to the data in order to complete the OPIP statutory required tasks.

Discussion turned back to the role of the QI program and the OPIP sentinel measures. Members discussed whether disenrollment should follow repeated prescribing in excess of the QI thresholds, e.g. year over year participation in the quality improvement program. The sentinel measures may serve as a foundation for the disenrollment standards, but there are other behaviors that warrant consideration, e.g. behaviors that put patients at high risk of harm. A member commented that we will likely learn a lot about how the sentinel measures capture prescribing practices over the course of the year. Making a decision now about how the sentinel measures fit into the disenrollment standards may be premature.

DHS confirmed that disenrollment is going to be an exceptionally rare event, and hopefully it will never occur. In light of this, a member commented that the work group should also think about the strength of the conversation as a messaging tool. What signals are we sending to 'good prescribers' and institutions? We need to keep disenrollment simple, understandable and focus on the most extreme outliers. Given that disenrollment is likely to be very rare, a member questioned whether it makes sense to recommend a highly elaborate chart review process. Can the quality improvement program evolve if providers are not adapting, or can there be an option to address QI providers whose practice does not change that is short of disenrollment? Disenrollment probably should not be the remedy for a defiant provider. A more appropriate remedy is escalated QI work.

Members representing the health plans shared that when a provider requires an intervention for behavior that violates the medical practice act, then there is referral to the Board of Medicine. A member commented that this is the right group of people to deal with the highest level of infraction. Adam Nelson shared that intervention usually occurs when a law is broken or when they are in direct violation of the health plan. Garrett shared that DHS staff have spoken with other health plan and state Medicaid representatives. These have been useful conversations, and we will share what we learn with OPIP. One thing learned from the MCOs is

that the consequence of DHS taking action against a clinician is more significant. She then confirmed that this is the purview of the licensing boards, but what is slightly different is that Medicaid is tasked with preventing fraud and abuse within the program. The work group has the option to recommend disenrollment only if there is a criminal violation, but there is support to do something just short of that, especially around abrupt tapering and cessation and patient abandonment.

Provider disenrollment standards: Framework for domain review

Discussion ensued about using a framework to guide evaluation and discussion of domains other than those addressed by the OPIP sentinel measures. A copy of the slides is available upon request. Members commented that rate of occurrence (of any behavior that is identified) is important, as well as appropriate referrals and documentation. Dose and duration remain important when considering abrupt tapering, given that an abrupt taper at 20 MME is different than an abrupt taper at 200 MME. Another possible domain is when a patient clearly has an opioid use disorder and receive chronic opioid therapy. This is not an uncommon issue. A member commented that when we talk about referrals, we should focus on successful transfers of care rather than just referrals. His clinic receives referrals for patients with an obvious OUD, but they do not treat OUD at their pain clinic.

A member shared his recent experience with an abrupt opioid cessation and patient abandonment. His physician tapered him completely off opioid therapy over the course of 4 weeks, and did not provide any support or follow-up. His care was not continued after the taper, and no treatment was provided to help him manage the taper. He commented on his concerns for other patients who have experienced a similar situation, and the important of addressing abandonment and rapid cessation in the disenrollment standards.

Discussion turned to how DHS can use its available data to develop the disenrollment standards. If patient abandonment and abrupt cessation of opioid therapy are potential disenrollment domains, how will DHS be able to capture this information in claims data? Currently there is only access to administrative claims data, which may not be sufficient. However, if additional data sources are required a disenrollment investigation, the OWPG can recommend that. Members briefly discussed how tapers are monitored in other settings, but in general, it is not common practice. If someone is identified for quality improvement in measures 5 or 6, the state will want to know how that person “graduated”. It may warrant a review of prescribing data to assess whether patient abandonment or a too aggressive taper occurred.

Disenrollment standards: Domains

Discussion moved on to review possible domains for disenrollment. A brief discussion ensued about polypharmacy. In general, there was emerging consensus that polypharmacy is an appropriate domain for disenrollment, but significant work must be done to define what is meant by polypharmacy. It could mean multiple controlled substances with negative reactions, or it could mean prescribing in highly unusual ways. Another member mentioned that prescribing cascades of controlled substances with negative interactions is likely more common than we realize. Other domains briefly discussed included unaddressed opioid use disorder and a blatant disregard for patient safety, which may include continued opioid prescribing despite clinical evidence that opioids are threatening the patient’s life (an important sub-set is substance use disorder, renal failure, etc.).

A member reminded the group that these discussions will send a powerful message, and it may be the quickest way to change behavior. The ideal situation is that interventions occur at the clinic and system level before they reach the state's attention. A member commented that as we move to analyzing behavior at the individual level, we will need to think about the combination of behaviors and the acceptance thresholds. For example, if a chart review finds that a provider has 10 patients on dangerous poly pharmacy, is that enough? There will need to be clearly defined standards.

Meeting adjourned.