DEPARTMENT OF HUMAN SERVICES

Opioid Prescribing Improvement Program: 2019 opioid prescribing reports

The Minnesota Legislature authorized the Opioid Prescribing Improvement Program (OPIP) in 2015 to reduce opioid dependency and misuse in Minnesota related to opioid prescriptions. The Opioid Prescribing Work Group (work group) is the expert advisory body convened to advance the program.[1] The work group is tasked with providing recommendations on the program components, which include:

- Statewide opioid prescribing guidelines for acute pain, post-acute pain and chronic pain *(April 2018)*;
- **Annual reports to prescribers who serve Minnesotans on public health care programs using a standard set of sentinel opioid prescribing measures *(March 2019)*;**
- A quality improvement program for prescribers who serve Minnesotans on public health care programs and whose prescribing behavior is outside of community standards *(2020)*; and
- Education resources for providers about prescribing opioids for pain management *(January 2019)*.

The Opioid Prescribing Improvement Program excludes patients diagnosed with cancer or who receive hospice or palliative care services. Conditions defined by recurrent acute pain are out of the scope of this program, such as sickle cell disease. Recurrent acute pain is characterized by severe, acute painful episodes caused by tissue damage, for which the underlying mechanism is a chronic disease.

Opioid prescribing reports

The DHS opioid prescribing reports compare an individual provider's prescribing rates in seven opioid prescribing measures *to the average rate of their specialty peer providers*. The reports do not identify any individual or group peers. The purpose of the reports is to support quality improvement among providers at the local and the state level by increasing awareness among providers about their own prescribing behavior, as well as how they compare to their peers. The reports also identify providers whose prescribing rates are currently outside of community standards. Providers who stay outside of community standards in future reporting cycles will be required to participate in the OPIP quality improvement program.

Who will receive a report?

DHS is required to send opioid prescribing reports to clinical providers who serve Minnesotans enrolled in public health programs (Medical Assistance and MinnesotaCare). Health care providers who prescribed at least one opioid to a public health program enrollee in the measurement year will receive a report.

[1] Minnesota Statute § 256B.0638 defines the membership categories for the OPWG. Work group members represent the medical, dental, behavioral health, health insurance, public health, law enforcement and other professions. Members represent health systems and communities across the state.

What is in the report?

The opioid prescribing reports provide an individual provider's prescribing rates across seven sentinel measures of opioid prescribing.

The data within the reports comes from DHS administrative claims data and encounter data, eligibility data and provider enrollment data. The data reported is not from the Prescription Monitoring Program. The reports identify the provider, his or her National Provider Identifier (NPI) number, and specialty group (based on provider enrollment as a Medicaid provider). The reports do not include any identifiable patient data, or information related to specific prescriptions.

Opioid Prescribing Sentinel Measures

DHS and the work group developed seven measures of opioid prescribing to be applied at the individual provider level.

1. Rate of prescribing an index opioid prescription (Index opioid prescription is the first opioid prescription after a period of 90 days of opioid naiveté)
2. Rate of prescribing an index opioid prescription over the recommended dose (100 MME for non-surgical provider specialties; 200 MME for surgical specialties)
3. Rate of prescribing more than 700 cumulative MME during the acute and post-acute pain period.
4. Rate of prescribing chronic opioid analgesic therapy.
5. Rate of prescribing high-dose (≥ 90 MME/day) chronic opioid analgesic therapy.
6. Rate of prescribing concomitant opioid and benzodiazepine therapy.
7. Percent of patients on chronic opioid analgesic therapy who receive opioids from 3 or more providers.

Learn more about the measures in this overview and in the complete measure technical specifications.

Thresholds for quality improvement (QI) for each measure are displayed on the report. These thresholds vary for surgical and non-medical specialties. Providers whose prescribing rates are above the QI threshold in the first year of the reports are not required to participate in quality improvement. The quality improvement program will begin after the release of the second set of reports.

Provider Specialty Groups

The reports compare an individual provider's prescribing rates to the average rate of their specialty group, with the exception of measures 4 and 7. Providers are assigned to a specialty using information from the Center for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System. The state used NPI primary taxonomy codes to identify a provider's specialty, and then consolidated the specialties into 30 provider specialty groups. The groups were created based on a variety of factors, including practice type and expected use of opioid analgesia. In addition, the state consulted with other state programs who have used the NPI taxonomy codes to develop provider specialty groups. The groups are:

> Addiction Medicine, Allergy and Immunology, Anesthesiology, Dental-General, Dermatology, Emergency Medicine, Family Medicine, Hospice, Hospitalist, Internal Medicine, Obstetrics and Gynecology, Oncology, Ophthalmology, Optometry, Oral and Dental Surgery, Orthopedic Surgery, Otolaryngology, Pain Medicine, Pathology, Pediatrics, Physical Medicine & Rehabilitation, Physician Assistant and

Advance Practice Nurse[2], Podiatry-General, Podiatry-Surgical, Preventive Medicine, Psychiatry and Neurology, Radiology, Rheumatology, Surgery, Urology.

DHS recognizes that the NPI data may not be current, or that providers may not have designated a primary taxonomy code in the CMS data. There are a significant number of physician assistants and advanced practice nurses who do not have a specialty code. Providers will be able to contact DHS about their specialty grouping, however with the exception of PAs and APRNs, DHS will continue to use the NPI primary taxonomy code as the identifier.

Providers who wish to update their primary taxonomy code may do so at https://nppes.cms.hhs.gov/#/

Opioid medications included in the reports

Only outpatient opioid prescriptions are included in the reports.

Measures about acute and post-acute pain

The first three measures in the report provide information about an index opioid prescription and the amount of opioid exposure from the date of the index opioid prescription plus 45 days. These measures correspond to the acute and post-acute pain phases.

Only oral tablet formulations are included in these measures. Excluded dosage forms include sublingual tablets, lozenges, solutions, films, syringe, cartridges, vials, suppositories, powders, liquids, oral concentrate, oral suppositories, PCA syringe, PCA vial, system PCA, ampul, and vial port. Medications prescribed in inpatient and medical office settings are not included.

Measures about chronic opioid analgesic therapy

Measures 4-7 provide information about chronic pain. The sentinel measures define chronic opioid analgesic therapy (COAT) as a ≥ 60 consecutive days' supply of opioids from any number of prescriptions. A ≤ 3 day gap separating the end of one active prescription and the beginning of the next prescription (the service date on the claim) is permissible.

Additional formulations are included in the COAT measures. Excluded drugs include:

1. Buprenorphine-naloxone buccal films
2. fentanyl transdermal device (Ionsys®)
3. Injectables
4. Opioid cold and cough products

DHS will separately assess the use of formulations developed for the treatment of opioid use disorder.

[2] DHS placed PAs and APRNs in a specialty category whenever possible. However, there are a significant number of PAs and APRNs without a specialty indicator either in the NPPES data or in the Minnesota Health Care Program provider enrollment data. PAs and APRNS without a specialty indicator are included in the general "Physician Assistants ad Advanced Practice Registered Nurse" category.

Report dissemination

DHS will deliver the opioid prescribing reports to providers using two different mechanisms in the first year: electronically and postal delivery.

- Electronic reports will be delivered straight to the providers' MN–ITS mailboxes, where they will be placed in a folder created for this program. Electronic delivery of the reports is preferred for data privacy reasons.
- Paper copies of reports will be mailed to a limited number of providers via the U.S. Postal Service. The reports will be sent to the address listed in DHS' provider enrollment record. Mailed reports will be sent after electronically delivery to the mailboxes. DHS will not mail reports via the U.S. Postal Service upon request when a provider has a MN–ITS mailbox.

MN-ITS Mailbox

To access your report, you must register for a MN–ITS account. MN–ITS is the free, web-based HIPAA-compliant system for electronic billing and communication with providers. Enrolled providers receive a customized MN–ITS Registration Letter with an initial user ID and password which the MN–ITS administrator must use during the MN–ITS registration process. DHS will send MN–ITS Registration Letters to all opioid-prescribing providers who do not currently have a MN–ITS account, via U.S. Postal Service. Please watch for this letter and notify your administrative staff or billing office to watch for it and route it to you so you can register your account.

Training on how to access your report in the MN–ITS mailbox will become available prior to the release of the reports. We will provide a link to the training on the Provider news and updates (mn.gov/dhs/mhcp/providers/news) and the Opioid Prescribing Work Group (mn.gov/dhs/opwg/) webpages.

Data privacy

DHS will not share a provider's report with an affiliated practice or the public at this time. In the future, DHS and the work group will set parameters for disclosures to affiliated practices in 2020 and 2021 in accordance with Minn. Stat. 256B.0638. Public disclosure will be limited to providers who demonstrate inappropriate opioid prescribing over time, and fail to participate successfully in the quality improvement program.

Quality improvement program

The DHS Opioid Prescribing Quality Improvement Program will begin after the second set of reports are released – likely in mid-2020.

The work group was charged with recommending quality improvement standard thresholds to identify providers whose prescribing practices may fall outside of community standards. The group developed thresholds for five of the seven sentinel measures. The goal is to reduce the prescribing variation found among and in provider specialties, while allowing for normal variances that are expected in any given provider's practice.

The purpose of the quality improvement program is to support providers and provider groups to reduce variation in opioid prescribing behavior, and to ensure that enrollees receiving opioid therapy are being managed according to evidence-based and best practices for opioid therapy. It is not the intent of the program

to penalize providers currently prescribing opioid therapy, or to see dramatic reductions in the number of public health care program enrollees who are appropriately receiving opioid therapy.

Process overview

The quality improvement program is currently being developed by DHS with the work group and partners in the medical community. More details will be shared as the plan is finalized. The information below provides a high-level overview.

The program will begin with the second release of the opioid prescribing reports. Providers whose rates exceed any of the quality improvement thresholds will be required to participate in the review. Providers who prescribed under a specific threshold of opioid prescriptions to Minnesota Medicaid recipients in the measurement year will not be included in the quality improvement program. The work group and DHS will determine that threshold prior to releasing the first reports. DHS is actively working with provider organizations and statewide quality improvement organizations to support efforts to improve prescribing ahead of subsequent reports.

DHS and the work group will develop a set of quality improvement activities to be included in a providers plan. Providers will then submit a quality improvement plan to DHS for review that incorporates those activities appropriate for the measures for which improvement is desired, provider's specialty, practice type, practice setting, capacity, existing quality improvement efforts, and patient mix. An external group of community providers will review the submitted quality improvement plans.

Special cause exemption

Providers may request special cause exemption from the quality improvement program based on specific criteria. DHS, the work group and partners in the medical community are currently developing the special cause exemption criteria and process. Requests will be reviewed by an external group of community providers. Providers will be able to request special cause exemption once they are identified to participate in the quality improvement program, i.e., after the provider receives the second opioid prescribing report and notification of their participation status. Those who request and are granted an exemption will be asked to track alternative measures or processes to assure the safety of their patients.

Enrollment termination

State law (Minn. Stat. § 256B.0638) permits DHS to terminate enrollment for providers who do not demonstrate improvement in opioid prescribing behavior over time and whose prescribing is considered to be unsafe. The disenrollment thresholds will differ from the quality improvement thresholds and may consider additional factors patient adherence to provider group, stability of dosing and appropriate, long-term weaning of high-dose medications.

Frequently asked questions

1. **Who will receive an opioid prescribing report?**

   Providers who prescribed at least one opioid analgesic in an outpatient setting to public health care program enrollees in the measurement year will receive a report. Specific opioid formulation exclusions apply.

2. **How will the report be delivered to me?**

   DHS intends to electronically send the reports to as many providers as possible. The reports will be sent to the provider's MN–ITS mailbox. Additional information about how to access your mailbox is forthcoming.

3. **Where does the data for the reports come from?**

   The reports rely on claims data for Minnesotans on pubic health care programs (fee-for-service and managed care organization members). The first set of reports will use 2018 prescribing data.

4. **Are any patients excluded?**

   Prescriptions for patients with a cancer diagnosis or treatment in the measurement year, and patients who received hospice or palliative care services are excluded.

5. **Are any providers excluded?**

   No. All providers who prescribed an opioid analgesic to a public health program enrollee in an outpatient setting will receive a report.

6. **How does DHS classify a provider's specialty?**

   Specialty information comes from the CMS National Plan and Provider Enumeration System. Each provider's specialty group is based on their National Provider Identifier (NPI) primary taxonomy code. DHS also reviewed provider enrollment data when a primary taxonomy code was missing.

7. **How do I change my specialty if I disagree with what is indicated in the first report?**

   Providers are encouraged to change the primary taxonomy code provided with their NPI number. Alternatively, providers can update their enrollment information with DHS to change or add a specialty code associated with their provider type. DHS is also exploring options for physician assistants and advanced practice registered nurses to correctly identify their specialty practice.

8. **Will DHS share the opioid prescribing practice report with a prescriber's practice or the public?**

   Not at this time. In the future, DHS and the work group will set parameters for disclosures to affiliated practices in 2020 or 2021 in accordance with Minn. Stat. 256B.0638.

9. **Is specific information about patients or prescriptions provided in the report?**

   No.

10. **How will I know if I have to participate in a quality improvement review in the future?**

    There are quality improvement thresholds for five of the seven opioid prescribing sentinel measures. Providers whose prescribing rate is above the threshold for any of the five measures will be required to participate, if they also prescribed above a certain volume of opioid analgesic prescriptions to public health

care program enrollees in the measurement year. DHS and the work group will set the volume threshold prior to release of the reports.

The reports present the comparative rates in bar graphs, and the quality improvement threshold is clearly marked in each graph. If your prescribing rate is above the threshold, then you may be subject to participation (based on your prescribing volume). Prescribers will also receive additional information about participating in the quality improvement review.

Participation in the quality improvement program is based on the second set of reports which will be released in about a year. The second set of reports will provide updated data and prescribing rates reflecting the time after receipt of this first report.

11. What kinds of changes are expected among providers who have to participate in quality improvement?

DHS, the work group, and partners in the medical community are currently developing the quality improvement program. It is our intent to identify a set of required activities—based on pain phase—that a provider would incorporate into their quality improvement plan. The activities will take into account different measures that are over set thresholds, provider practice types, system capacity, and existing quality improvement efforts within clinics or systems. Providers will submit their plan to DHS for review by an external body.

12. I work with chronic pain patients, and we are working on tapering their daily dosage. The taper may take months to years. Will this be taken into account when evaluating prescribing habits?

Yes, the state is aware that providers who care for patients receiving long-term opioid therapy face specific challenges related to managing their patients. The quality improvement efforts related to COAT measures will focus on harm reduction, provider education, peer consultation and risk assessment.

The state is also aware that providers may inherit significant numbers of chronic pain patients for example, when a pain specialist in their geographic area retires. This will be considered, and may be reason for a special cause exemption.

13. I am a provider who treats patients with very severe, acute pain (burn victims) or who cares for patients who experience severe post-operative pain for an extended duration (major orthopedic surgery). Will this be taken into account when evaluating prescribing habits?

Providers who treat patients with very severe, acute pain of extended duration will be considered for a special cause variation. Additional information about how to request exemption will be provided closer to beginning the quality improvement program.

As a reminder, surgical specialties are exempt from quality improvement based on their prescribing rate for measure 1 (frequency of prescribing an index opioid prescription).