DEPARTMENT OF HUMAN SERVICES

Legislative Report

Sunset Recommendations for the Opioid Prescribing Improvement Program (OPIP)

Health Care Administration

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I. Executive Summary

During the 2023 Legislative Session the state legislature directed the Department of Human Services (DHS) to convene a panel tasked with recommending criteria to sunset the Opioid Prescribing Improvement Program (OPIP). DHS convened this panel in the fall of 2023 and submits this report to the legislature with details on the panel's recommendations.

The panel held three robust discussions pertaining to the sunset of OPIP and the current state of the opioid crisis. Through these discussions they agreed that two of the goals of OPIP have been met and subsequently provided criteria for sunset. However, they found the final program goal, pertaining to supporting patients with chronic pain, has not been met. Given the progression of the opioid crisis, its intersections with chronic pain management, and the limitations of the OPIP program the panel agreed that OPIP will not likely accomplish its third program goal.

In acknowledgement of OPIP's unmet third goal, the panel prioritized seven key issues that warrant further attention from the legislature. The panel also recommended funding to support continued functionality and utilization of the Prescription Monitoring Program (PMP), a critical tool for providers in appropriately prescribing opioids.

Ultimately, the panel urges policy makers to direct their attention to the critical issues surrounding prescription opioids and the management of chronic pain within the context of the ever-evolving opioid crisis.

II. Introduction

Program statutory language

The Minnesota Legislature established the Opioid Prescribing Improvement Program (OPIP)[1] in 2015 to address opioid dependency and substance use by Minnesota Medicaid and MinnesotaCare enrollees due to the prescribing of opioid analgesics by health care providers.

In 2023, the Minnesota Legislature added new language to the OPIP statute stating, "[t]he commissioner of human services shall recommend criteria to provide for a sunset of the opioid prescribing improvement program."[2] The following report serves as the Commissioner's recommended criteria for sunset of the Opioid Prescribing Improvement Program.

[1] Minn. Stat. 256B.0638.
[2] Minn. Laws 2023, Chapter 61, Art. 6, Sec. 6.

Opioid Prescribing Improvement Program (OPIP) background

When OPIP was enacted in 2015, it represented one component of Minnesota's response to the rising number of overdose deaths attributed to prescription opioids.[3] The legislature called on the Department of Human Services (DHS) to work in conjunction with the Minnesota Department of Health to accomplish OPIP's three program goals:

1. Reduce inappropriate or excessive opioid prescribing for acute and post-acute pain.
2. Reduce inappropriate variation in opioid prescribing for acute and post-acute pain; and
3. Support patients who remain on chronic opioid analgesic therapy through patient-centered, multimodal treatment approaches, improved monitoring of safety and harm reduction strategies.

The statute also called for DHS to appoint an opioid prescribing work group (OPWG) – a panel of experts to guide DHS's work related to this program. The OPWG served DHS for six years between 2016 and 2022. Additionally, statute specified four strategies DHS and the OPWG should undertake to accomplish OPIP goals. They are:

1. Develop statewide opioid prescribing guidelines for three pain phases, Acute, Post-acute, and Chronic pain.
2. Issue annual opioid prescribing reports to clinicians who serve Minnesotans on public health care programs.
3. Implement a clinical quality improvement program for clinicians whose opioid prescribing behavior is outside of community standards.
4. Create and disseminate educational resources for providers about prescribing opioids for pain management.

Evolution of the opioid crisis

In an era where fentanyl involved deaths outnumber prescription involved deaths, five to one[4], it is necessary to address the complex relationship between the two opioids. The CDC explains that the rise in opioid-involved overdose deaths between 1999 and 2021 occurred in three distinct waves – the first wave began with increased prescribing of and overdose deaths involving opioids in the 1990s; the second wave began in 2010 with rapid increases of overdose deaths involving heroin; the third wave began in 2013, with significant increases in overdose deaths involving synthetic opioids, particularly those involving illicitly manufactured fentanyl.[5]

Figure 2 in the appendix depicts deaths involving prescription opioids, heroin, and illicit fentanyl as three interconnected components of the same, burgeoning epidemic. Prescription opioids continue to contribute to the evolving opioid crisis. As Figure 1 indicates, deaths involving prescription opioids reached an all-time high in 2020.

Interventions to stymie pharmaceutical opioid abuse, such as "abuse-deterrent" opioid formulations and provider education to reduce opioid prescribing, successfully decreased excess prescription opioids available for misuse. Limiting the supply of prescription opioids, combined with the rapid increase in available fentanyl, led to a situation where fentanyl became a cheap and readily available alternative to pharmaceutical opioids, facilitating its use in the

[3] Figure 1 in the appendix demonstrates the uptick in opioid involved deaths between 2011 and 2015 which was a contributing factor to OPIP's establishment.
[4] SOURCE: Minnesota death certificates, Injury and Violence Prevention Section, Minnesota Department of Health, 2013-2022
[5] https://www.cdc.gov/opioids/basics/epidemic.html

community. The increase in fentanyl supply, along with a shift to a greater number of people obtaining opioids from the illegal drug market, contributed to the skyrocketing number of overdoses in recent years. [6, 7]

While market forces do account for much of the proliferation of fentanyl in the last several years, risk factors for overdose do not generally vary between prescription opioids and illicit fentanyl; these risk factors include comorbid mental health conditions, substance use disorders, history of overdose, concurrent use of other substances, and returning to high dose after losing tolerance[8]. Additionally, there is a small but growing body of evidence which suggests that some people who use opioids prefer and actively seek out fentanyl.[9] Simply stated, propensity towards substance use disorders is generally dependent on the person and their risk factors and not the substance.

Notably, prior use/misuse of prescription opioids has been correlated to subsequent illicit drugs such as heroin and fentanyl. In 2015 study, the National Institute on Drug Abuse that found prescription opioid use was a statistically relevant risk factor for heroin use.[10] Similarly, a Social Autopsy Report published by the Vermont Department of Health found more than half of the people who died of an overdose in 2021 (54%) received a Schedule II-IV prescription within a year of their death, and 26% had an active controlled substance prescription at the time of death.[11]

It is imperative policy approaches address the medical evidence – the prevalence of untreated or undertreated mental health conditions, substance abuse, and chronic pain, significantly contribute to the ever-growing opioid crisis, regardless of opioid type.

III. OPIP Sunset

As indicated above, the legislature required DHS to convene a panel of stakeholders for the purpose of developing the sunset criteria. The statutory language also codified a definitive end date for the OPIP program on December 31, 2024, or when the recommended sunset criteria have been met, whichever comes first.[12] A summary of the panel and their recommendation for sunset criteria is provided here.

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[6] Alpert A, Powell D, Pacula RL. Supply-side drug policy in the presence of substitutes: Evidence from the introduction of abuse-deterrent opioids. *Am Econ J Econ Pol.* 2018;10(4):1–35. doi: 10.1257/pol.20170082.

[7] 24. Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA Psychiatry.* 2014;71(7):821–826. doi: 10.1001/jamapsychiatry.2014.366.

[8] https://www.cdc.gov/opioids/patients/reduce-risks.html

[9] Foglia R, Kline A, Cooperman NA. New and Emerging Opioid Overdose Risk Factors. Curr Addict Rep. 2021;8(2):319-329. doi: 10.1007/s40429-021-00368-6. Epub 2021 Apr 22. PMID: 33907663; PMCID: PMC8061156.

[10] NIDA. Prescription opioid use is a risk factor for heroin use. National Institute on Drug Abuse website. https://nida.nih.gov/publications/research-reports/prescription-opioids-heroin/prescription-opioid-use-risk-factor-heroin-use. October 1, 2015 Accessed December 5, 2023.

[11] https://www.healthvermont.gov/sites/default/files/document/dsu-2021-Vermont-social-autopsy-report.pdf

[12] Minn. Laws 2023, Chapter 61, Art. 6, Sec. 6.

Sunset panel membership

Statute identified specific perspectives that must be included in the sunset panel. These perspectives include the Minnesota Medical Association, the Minnesota Society of Interventional Pain Physicians, clinics that practice pain management, addiction medicine or mental health, and either current or former Minnesota health care program enrollees who use or have used opioid therapy to manage chronic pain. See the Appendix for a list of panel members.

Summary of panel meetings

The OPIP sunset panel met three times in 2023, a summary of those meetings is included below.

September 14, 2023 – DHS provided a brief background of the OPIP program and then presented data points that most closely align with the three OPIP goals. The panel agreed there has been general statewide improvements in opioid prescribing. They also emphasized the importance of maintaining a balance between appropriate and inappropriate use of opioid analgesics for the treatment of pain, particularly chronic pain. They cautioned against unintentional harms for both patients and the provider community. The group agreed quantitative measures are not entirely sufficient in evaluating whether all three goals of OPIP have been attained. Specifically, they indicated the third OPIP goal around patient-centered care required a more qualitative approach. DHS concluded that the qualitative aspects of goal 3 would be the focus of the next meeting.

October 17, 2023 – DHS proposed five data-driven criteria to indicate that the OPIP program satisfied its three statutorily defined goals. The panel offered some edits, but generally agreed on four of the five criteria. DHS took this feedback and proposed to revise and re-route the criteria for the final meeting. There was also robust discussion on the proposed criteria related to chronic pain and addressing concerns of chronic pain patients. The discussion included validating the patient perspective, emphasizing the value of buprenorphine as a pain management tool, agreement that full agonist opioids are necessary-but not a panacea, shared concerns about insufficient access to care, as well as medical stigma, bias, and racism. There was general agreement that while OPIP is not the right tool for addressing the complex challenges of treating chronic pain in today's environment, it is critical the health care community undertake efforts of improving the system.

November 16, 2023 – DHS confirmed consensus for the four, previously established sunset criteria. The panel also agreed there is a need for continued state funding of the Board of Pharmacy's Prescription Monitoring Program "1-Click Integration." Finally, the panel discussed persistent gaps and issues associated with OPIP's third goal - to support patients who remain on chronic opioid analgesic therapy through patient-centered, multimodal treatment approaches, improved monitoring of safety and harm reduction strategies. DHS asked the panel to prioritize critical issues from both the patient and provider perspectives. The group agreed that these problems were vast in scope and beyond this panel's ability to fully evaluate, but critical to consider in relation to future policy decisions. The group acknowledged pressing public health concerns around opioids continue to grow in complexity.

IV. Sunset data

All data for the OPIP program comes from the Medicaid and MinnesotaCare claims database. DHS staff analyzed Medicaid and MinnesotaCare pharmacy claims data to identify potential sunset indicators, focusing on data points that most directly align with OPIP's three primary goals: a) to reduce inappropriate or excessive opioid prescribing for acute and post-acute pain, b) to reduce inappropriate variation in opioid prescribing for acute and post-acute pain, and c) to support patients who remain on chronic opioid analgesic therapy through patient-centered, multimodal treatment approaches, improved monitoring of safety and harm reduction strategies. Figure 3 below illustrates four indicators the panel agreed most align with OPIP goals, and depicts progress made towards each goal between 2016 and 2022. For a better understanding of variation within the context of the OPIP program, refer to Figure 4 in the Appendix.

Figure 3: Progress towards OPIP goals and recommended sunset criteria.

Figure 3 represents stated OPIP goals, progress made towards these goals, and proposed sunset criteria. For definitions of "excessive acute and post-acute prescribing" and "acute and post-acute prescribing variation" see the Figure 6 in the Appendix.

OPIP goal	Progress to goal (2016 – 2022)	Proposed criteria
Goal 1: Reduce initiating opioid therapy for medical conditions not indicated for opioid analgesia	Excessive acute prescribing decreased by 51% in 7 years	Excessive acute prescribing is reduced by 40% between 2016 and 2023
	Excessive post-acute prescribing decreased by 40% in 7 years	Excessive post-acute prescribing is reduced by 40% between 2016 and 2023
Goal 2: Reduce inappropriate variation in opioid prescribing for acute and post-acute pain	Acute prescribing variation in emergency medicine decreased by 63% in 7 years	Variation in acute prescribing for emergency medicine providers is reduced by at least 50% between 2016 and 2023
	Post-acute prescribing variation in orthopedic surgery decreased by 60% in 7 years	Variation in post-acute prescribing for orthopedic surgeons is reduced by at least 50% between 2016 and 2023
Goal 3: Support patients who remain on chronic opioid analgesic therapy through patient-centered, multi-modal treatment approaches, improved monitoring of safety and harm reduction strategies.	Not quantifiable	No recommendation

Notably, the data did not provide suitable indicator for Goal 3. DHS presented options for indicators including prescription overdose trend data (Figure 1) and identifying members most at risk for opioid-related harms (Figure 3). The panel agreed there are no objective criteria to evaluate progress on Goal 3, which is clearly qualitative in nature. They emphasized that important aspects of person-centered care are not quantifiable through metrics, but generally supported through tools such as peer review and quality improvement.

V. Recommendations

OPIP sunset criteria

The sunset panel recommends the following sunset criteria for each OPIP goal:

Goal 1: to reduce inappropriate or excessive opioid prescribing for acute and post-acute pain.

- **Excessive acute prescribing decreases by 40% between 2016 and 2022. [CRITERIA MET]**
- **Excessive post-acute prescribing decreases by 40% between 2016 and 2022. [CRITERIA MET]**

Goal 2: to reduce inappropriate variation in opioid prescribing for acute and post-acute pain.

- **Variation in acute prescribing decreased by 50% between 2016 and 2022. [CRITERIA MET]**
- **Variation in post-acute prescribing decreased by 50% between 2016 and 2022. [CRITERIA MET]**

Goal 3: to support patients who remain on chronic opioid analgesic therapy through patient-centered, multimodal treatment approaches, improved monitoring of safety and harm reduction strategies.

- **No objective criteria available to evaluate progress on Goal 3 [NO RECOMMENDATION]**

State funding for PMP "1 Click Integration"

The Prescription Monitoring Program (PMP) is one of the earliest interventions to combat the nation's prescription opioid crisis. This tool gives opioid prescribers real-time access to a database where they can review a patient's prescription history. Not only does this tool prevent the practice of 'doctor hopping', but it also gives clinicians a comprehensive view of their patients'-controlled substance prescription profile. The PMP empowers clinicians to avoid prescribing concomitant medications with unsafe, sometimes lethal, interactions (opioids and benzodiazepines, for example).

While checking the PMP is required by law, clinicians have faced many barriers in accessing patient prescription history. One of the biggest barriers was the lack of integration into existing electronic medical records (EMR's), requiring clinicians to spend precious minutes clicking out of the EMR and logging into the PMP to access the data they needed. In turn, the Minnesota Board of Pharmacy worked with a vendor to integrate access to the MN PMP database into EMRs, which resulted in an immediate and continued uptick in PMP utilization. Since the statewide license to integrate access for prescribers, PMP searches have increased by 62%[13].

The statewide license for EMR integration has not had funding since September 2023. The Minnesota Board of Pharmacy attempted to secure sustainable, or even temporary, funding through multiple avenues but has yet to achieve

[13] https://mn.gov/boards/assets/2022%20Annual%20Report_tcm21-596636.pdf

success in this endeavor. Proponents worry the lack of continued funding by the board will cause a widespread discontinuation of the integrated service leading to a broad decrease in PMP utilization. Thus, the OPIP sunset panel strongly supports ongoing state funding of the integration licensing fees and offers the following recommendation to the legislature.

- **Continue funding for the licensing fees that allow 1-click access for clinicians to the Prescription Monitoring Program (estimated $750K/year).**

Critical issues in chronic pain management persist

The sunset panel spent a significant amount of time deliberating OPIP's third goal. As previously noted, the panel widely agreed Goal 3 cannot be quantitatively measured. Additionally, even with some evidence of progress towards Goal 3, critical gaps and significant issues around chronic pain management persist. There is general agreement that OPIP is not the right framework for addressing the ever-growing concerns around chronic pain care. As such, the panel asks the legislature to consider interventions that support chronic pain patients and their providers.

Priorities for persons with chronic pain

According to the CDC, 20.4% of Americans experienced chronic pain in 2019. 7.4% of adults had chronic pain that frequently limited life or work activities (referred to as high impact chronic pain) in the previous 3 months.[14] Chronic pain can have debilitating effects on a person's quality of life, and in far too many cases, leads to the unnecessary loss of life. The prescription opioid crisis and subsequent response of government and health care have contributed to unintended, negative consequences for millions of chronic pain patients. As such, the onus is on the health care system, including DHS, to continue building and strengthening supports for persons whose lives are impacted by chronic pain.

The sunset panel discussed a myriad of issues facing chronic pain patients and prioritized the most prevalent concerns to be elevated to the attention of the legislature. In order of priority:

- Barriers to multi-modal therapies persist for chronic pain patients. The access issue is confounded by geography, the number of licensed providers, therapies and treatments that are not covered by insurance, and providers available to take new patients, which is particularly true of mental health care.

- Patients who experience chronic pain, especially those who use opioids, experience high degrees of stigma. There are certainly health conditions that warrant use of chronic opioid analgesic therapy. Yet, persons diagnosed with chronically painful conditions consistently report their pain is not 'believed' and their plight for pain relief is erroneously labeled as drug-seeking behavior. This stigma significantly impedes patient access to person-centered care.

- Closely related, racism and bias permeate the treatment of pain, an adverse phenomenon repeatedly proven in medical literature. This exacerbates the fact that Minnesotans of color face some of the most significant health disparities in the country.

[14] https://www.cdc.gov/nchs/products/databriefs/db390.htm

- Chronic pain patients have minimal, if any, means to address the harms they experience seeking healthcare. Whether they are abandoned by providers, victimized by racism, or turned away from care, they have limited means for self-advocacy. An unfortunate and prevalent concern for chronic pain patients is seeking health care within a structure where they do not have a voice.

Priorities for clinicians who treat chronic pain

DHS also asked the panel to prioritize the challenges that providers and health systems encounter when providing multi-modal pain treatment. Panel members agreed that the 'pain infrastructure' in Minnesota is not sufficiently equipped to appropriately support the thousands of Minnesotan's who experience chronic pain. Panel members, elevated four problems that create barriers to more effectively treating patients:

- To date, Minnesota has not had a robust, collaborative framework to socialize and standardize clinical practice guidelines for multi-modal pain treatment - similar to what the Institute for Clinical Systems Improvement (ICSI) accomplished through its Minnesota Health Collaborative.

- The panel identified the need for a centralized clearinghouse for up-to-date clinical guidelines, tools, and literature supporting multi-modal pain treatment. This state-specific resource does not currently exist and would be an asset for providers and patients alike. Similarly, the panel expressed need for an expanded, comprehensive and centralized referral source for multi-modal pain providers.

- The nation's healthcare workforce is in peril. The Health Resources and Services Administration monitors and publicizes provider shortages at a county level[15]. Anecdotal feedback from panel members suggests that workforce shortages are perhaps even more dire in chronic pain management, a specialty that has become increasingly more complicated. Panel members pointed to rising labor costs, diminishing reimbursement rates, insurance requirements (such as prior authorizations) and other regulatory impediments as contributing factors. They are deeply concerned that Minnesota's infrastructure for chronic pain treatment is ill-equipped to serve this patient population.

VI. Conclusion

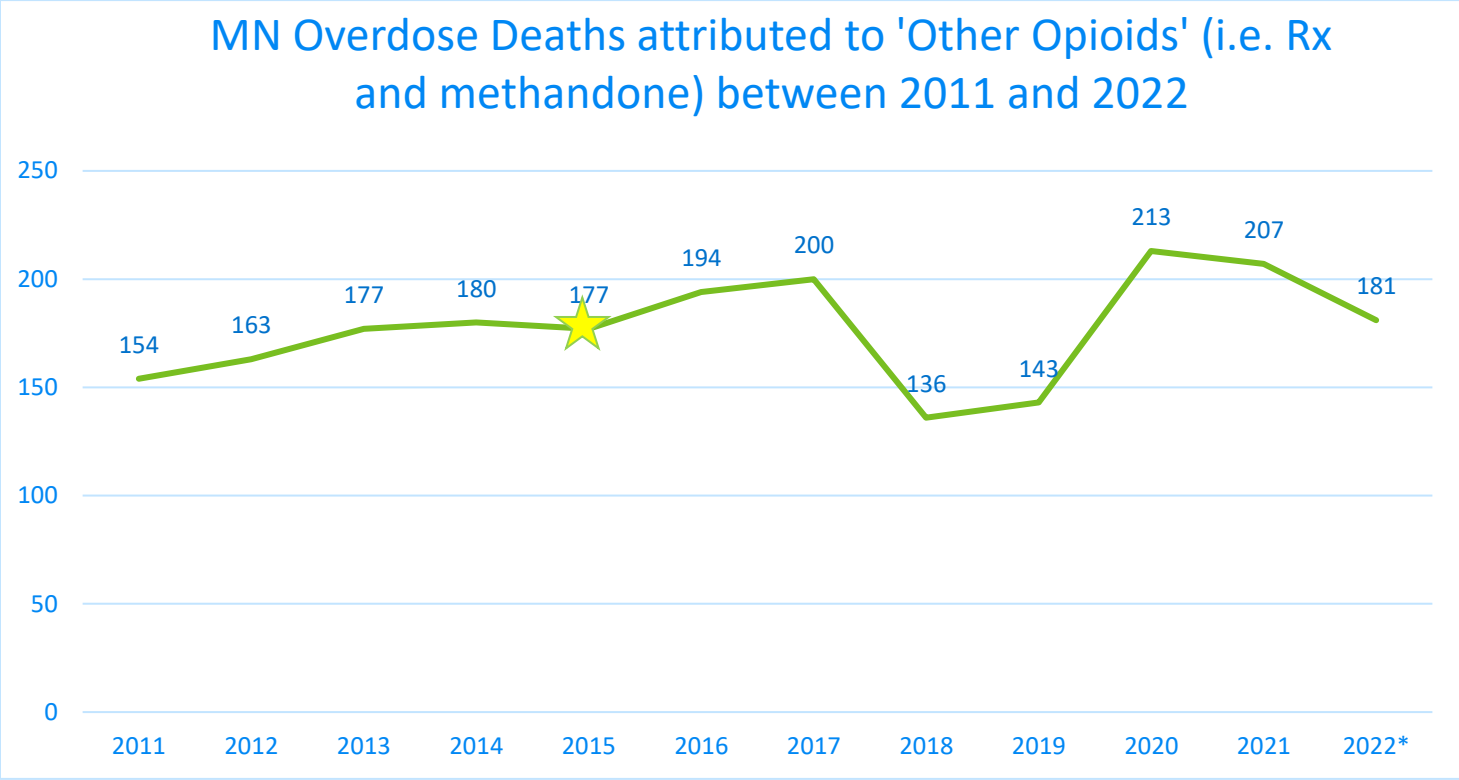
The OPIP sunset panel collaboratively completed its statutorily directive; They recommended sunset criteria for two out of three of OPIP program goals (according to these criteria, OPIP goals one and two have already been met). The panel also recommended renewed state funding for the integration of the PMP into electronic health records, a critical public health tool.

However, the panel declined to recommend a criterion for OPIP's third goal, which pertains to systemic support and care of chronic pain patients. Through the panel's discussions there is consensus that challenges remain in this space and additional interventions need to be established to address the continued progression of the Opioid crisis. Thus, the OPIP sunset panel recommends future policy analysis and continued focus on chronic pain management.

[15] https://data.hrsa.gov/tools/shortage-area/hpsa-find

VII. Appendix

Figure 1: Overdose trend data before and after the initiation of OPIP



**NOTE: 2022 data are preliminary and likely to change when finalized*

Indicates when OPIP was enacted into law.

Source: Minnesota death certificates, Injury and Violence Prevention Section, Minnesota Department of Health, 2022

Figure 2: Three waves of the national opioid crisis according to the Centers for Disease Control

Figure 2 depicts three distinct waves of the opioid crisis between 1999 and 2022. The three waves, respectively are prescription opioids, heroin and illicit fentanyl.

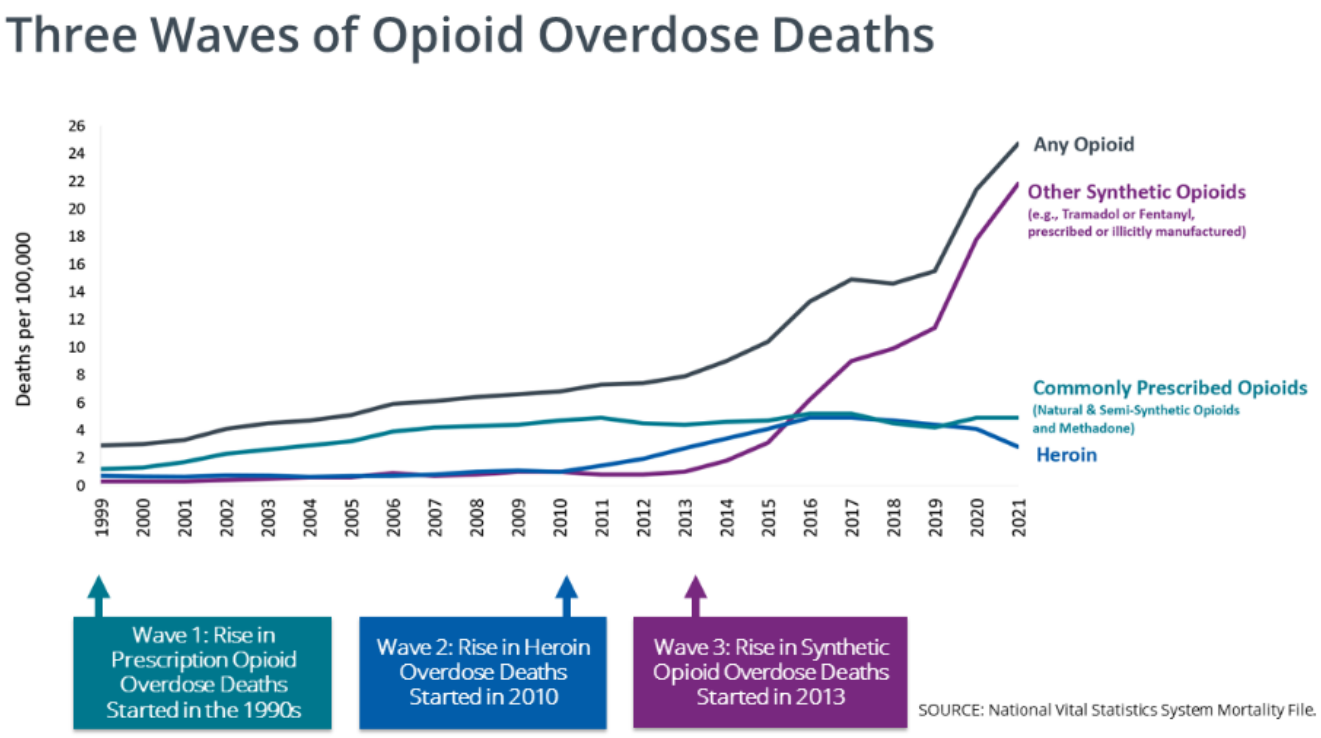


Figure 3: Prescriber variation in acute prescribing

Figure 3 depicts variation data in the acute pain phase. Roughly 1000 emergency medicine specialists are divided into quartiles based upon the number of acute prescriptions they write that exceed 100 total MME. In 2016, there was significant variation between the 1st and 4th quartile, (.3% to 67.5%). By 2022, the variation gap decreased by more than half (from 0% to 29%).

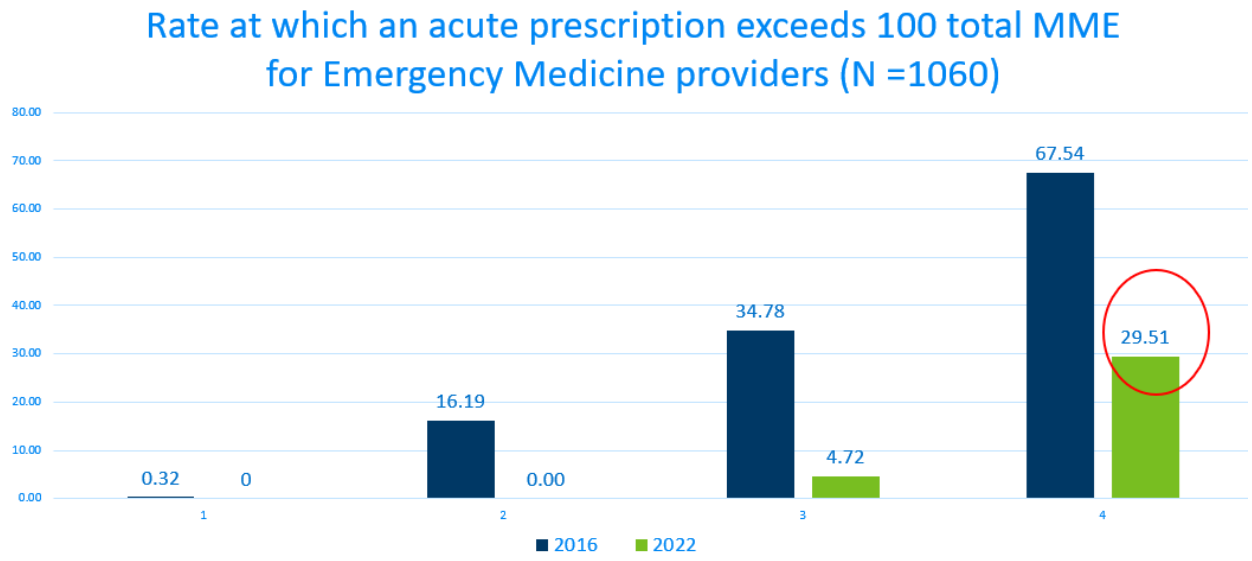


Figure 4: Sunset panel membership

Table 4 lists the experts appointed to the sunset panel and their respective membership category

Sunset panel members	
Andrew Will, MD, Minnesota Society for Interventional Pain Physicians	Kathy Nevins, DNP, Opioid Epidemic Response Advisory Council
Benjamin Lai, MD, Mayo Health System	Kimberly Tjaden, MD, Minnesota Medical Association representative
Christina Wiekamp, CNP, MHealth Fairview	Laurel Reis, MD, Minnesota Medical Association representative
Craig Uthe, MD, Sanford Health	Melanie Ripley, DO, Essentia Health
Erica Barnes, MA, Minnesota Rare Disease Advisory Council	Rory O'Brien, Lived experience expert
James Parmele, MD, Minnesota Society for Interventional Pain Physicians	Saudade SammuelSon, Lived experience expert

Figure 5: Data definitions

Table 5 list commonly utilized definitions specific to the OPIP program.

Term	OPIP definition
Excessive acute prescribing	When a prescriber exceeds 100 total MME for an index prescription more than 50% of the time in the measurement period (threshold is 200 MME for those in surgical specialties)
Excessive post-acute prescribing	When a prescriber writes a prescription that gives a patient 700 cumulative MME threshold in the 45 days following an index prescription more than 15% of the time in the measurement period
Variation in acute prescribing	The degree of difference in opioid prescribing patterns between clinical peers, in this case, those practicing emergency medicine
Variation in post-acute prescribing	The degree of difference in opioid prescribing patterns between clinical peers, in this case, those practicing orthopedic surgery
Index prescription	The first opioid prescription in the measurement period after at least 90 days of opioid naiveté.
Morphine Milligram Equivalents (MME)	The equianalgesic of a specific dose and formulation of opioids to parenteral morphine. Standard conversion ratios are used to calculate each opioid's equianalgesic dose.