

STATE OF COLORADO FY 2011-12 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Schedule 13 Change Request for FY 2011-12 Budget Request Cycle											
Decision Item FY 2011-12		Base Reduction Item FY 2011-12 <input checked="" type="checkbox"/>			Supplemental FY 2010-11			Budget Amendment FY 2011-12			
Request Title:		Client Overutilization Program Expansion				Dept. Approval by:		John Bartholomew <i>JB</i>		Date: November 1, 2010 <i>10/20</i>	
Department:		Health Care Policy and Financing				OSPb Approval:		<i>John Bartholomew</i>		Date: 10-21-10	
Priority Number:		BRI-1									
	Fund	1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual FY 2009-10	Appropriation FY 2010-11	Supplemental Request FY 2010-11	Total Revised Request FY 2010-11	Base Request FY 2011-12	Decision/ Base Reduction FY 2011-12	November 1 Request FY 2011-12	Budget Amendment FY 2011-12	Total Revised Request FY 2011-12	Change from Base (Column 5) FY 2012-13
Total of All Line Items	Total	2 900 589 951	3 141 411 896	0	3 141 411 896	3 133 105 031	71 300	3 133 176 331	0	3 133 176 331	(1 234 800)
	FTE	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
	GF	768 284 614	706 740 725	0	706 740 725	1 085 968 152	(16 325)	1 085 951 827	0	1 085 951 827	(617 400)
	GFE	0	161 444 485	0	161 444 485	161 444 485	0	161 444 485	0	161 444 485	0
	CF	344 338 297	342 066 649	0	342 066 649	309 512 573	0	309 512 573	0	309 512 573	0
	CFE/RF	4 017 583	7 695 571	0	7 695 571	3 434 581	0	3 434 581	0	3 434 581	0
	FF	1 783 949 457	1 923 464 466	0	1 923 464 466	1 572 745 240	87 625	1 572 832 865	0	1 572 832 865	(617 400)
(1) Executive Director's Office;	Total	22 767 387	34 553 769	0	34 553 769	31 825 489	207 900	32 033 389	0	32 033 389	0
(C) Information Technology	FTE	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
Contracts and Projects,	GF	5 348 546	6 134 303	0	6 134 303	6 147 926	51 975	6 199 901	0	6 199 901	0
Information Technology	GFE	0	0	0	0	0	0	0	0	0	0
Contracts	CF	642 364	2 433 429	0	2 433 429	1 766 770	0	1 766 770	0	1 766 770	0
	CFE/RF	100 328	100 328	0	100 328	100 328	0	100 328	0	100 328	0
	FF	16 676 149	25 885 709	0	25 885 709	23 810 465	155 925	23 966 390	0	23 966 390	0
(2) Medical Services	Total	2 877 822 564	3 106 858 127	0	3 106 858 127	3 101 279 542	(136 600)	3 101 142 942	0	3 101 142 942	(1 234 800)
Premiums	FTE	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
	GF	762 936 068	700 606 422	0	700 606 422	1 079 820 226	(68 300)	1 079 751 926	0	1 079 751 926	(617 400)
	GFE	0	161 444 485	0	161 444 485	161 444 485	0	161 444 485	0	161 444 485	0
	CF	343 695 933	339 633 220	0	339 633 220	307 745 803	0	307 745 803	0	307 745 803	0
	CFE/RF	3 917 255	7 595 243	0	7 595 243	3 334 253	0	3 334 253	0	3 334 253	0
	FF	1 767 273 308	1 897 578 757	0	1 897 578 757	1 548 934 775	(68 300)	1 548 866 475	0	1 548 866 475	(617 400)
Non-Line Item Request:		None									
Letternote Revised Text:		None									
Cash or Federal Fund Name and COFRS Fund Number:		FF Title XIX									
Reappropriated Funds Source, by Department and Line Item Name:		None									
Approval by OIT?		Yes: <input type="checkbox"/> No: <input type="checkbox"/> N/A: <input checked="" type="checkbox"/>									
Schedule 13s from Affected Departments:		N/A									

CHANGE REQUEST for FY 2011-12 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BRI-1
Change Request Title:	Client Overutilization Program Expansion

SELECT ONE (click on box):

- Decision Item FY 2011-12
- Base Reduction Item FY 2011-12
- Supplemental Request FY 2010-11
- Budget Request Amendment FY 2011-12

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:

- Not a Supplemental or Budget Request Amendment
- An emergency
- A technical error which has a substantial effect on the operation of the program
- New data resulting in substantial changes in funding needs
- Unforeseen contingency such as a significant workload change

Short Summary of Request:

The Department requests an increase of \$71,300 total funds and a reduction of \$16,325 General Fund in FY 2011-12 and a reduction of \$1,234,800 total funds, \$617,400 General Fund in FY 2012-13 in order to expand the Client Overutilization Program (COUP) by 200 additional clients. The Department would offer an incentive payment to physicians to participate in the program in order to ensure that there are an adequate number of providers to serve clients in the program.

General Description of Request:

The Client Overutilization Program is authorized by 42 CFR § 456.3 and § 431.54(e) to identify patterns of misuse and overuse of medical services by recipients and to implement safeguards against this behavior. Clients are locked in with one primary care physician (PCP), pharmacy, or managed care organization (MCO) when there is evidence that the client has improperly or excessively utilized Medicaid benefits that are not medically necessary. The Department identifies a client as one who overutilizes medical services when at least one of the following criteria is met in the span of a quarter:

1. Use of three or more drugs in the same therapeutic category;
2. Use of three or more pharmacies;

3. Use of sixteen or more prescriptions; or
4. Referral, review, or other analysis indicates possible overutilization, such as excessive physician and emergency department visits.

Although the Department has identified approximately 200 clients who meet these criteria, there are only twelve clients currently in the program. This is due in part to a lack of partnering physicians who are willing to serve as lock-in providers for potential COUP clients. Further, once clients are enrolled, it is difficult for the physicians and the Department to manage these clients as the Medicaid Management Information System (MMIS) is not set up to effectively notify providers of the clients enrolled in COUP or to allow for all necessary services to be provided to the clients to ensure they still receive quality care. This request aims to address both of these concerns in order to expand the program to those clients who are currently abusing Medicaid services and incurring avoidable costs. Historical data of the program in Colorado and a similar program in Oklahoma have shown that state expenditure on services for these clients is significantly reduced in response to the lock-in restrictions, creating a net savings from the implementation of the program expansion.

Provider Incentive Payment

The primary obstacle to placing 200 additional clients into the program is finding providers who are willing to serve lock-in clients. As a lock-in provider, the physician and any prescribing provider is wholly responsible for all of the client's care and prescribing needs, and the client is not able to be seen by any other physician or facility. Clients enrolled in COUP tend to be resource-intensive for the physician, creating a shortage of partnering providers.

Clients who meet the criteria for COUP demonstrate patterns of high-risk behavior such as excessive narcotic use enabled by having access to multiple Medicaid providers and the emergency room. The experience of the Department has shown that these clients are some of the most difficult to manage. Over the past several years, the Department has solicited multiple providers and clinics to participate in COUP as lock-in providers. While only two dozen providers have indicated a willingness to accept a lock-in client,

the Department has identified over 200 clients that immediately qualify for participation. A lock-in program survey conducted in Kansas revealed that while 83% of providers believed clients would benefit from one prescriber, only 20% were willing to serve in this capacity.

Due to the intensity of resources that will be required of participating providers, the Department proposes giving an incentive payment of \$30.00 per member per month to providers for any COUP-enrolled clients for whom they are the designated lock-in provider. This amount is within the range that the Department currently pays for care coordination, which varies between \$20.00 and \$32.40. The Department believes that a monthly fee at the upper range of its current programs will cover the resource costs for the extra time and attention required in managing these clients' medical services. The incentive payment will make it cost-effective for providers to treat lock-in clients, creating a larger pool of providers who are willing to participate. This will reduce the difference between potential COUP clients and providers willing to partner with them.

The Department assumes that it will enroll 50 clients per month starting in March of FY 2011-12 until 200 clients are enrolled in the program. The incentive payment will require \$15,000 total funds in FY 2011-12 for the first four months of implementation, and \$72,000 total funds in FY 2012-13 for a full year of implementation. The cost of the incentive payment is calculated in tables 1.2 and 2.2.

Automated Lock-In Process

Under the current process, the Department's claims system, the MMIS, uses its Managed Care Lock-In feature in order to restrict clients in the program to specified providers for health care services. The requirements for the Lock-In feature include:

- The client must be Medicaid-eligible with current eligibility and active enrollment status;

- An individual PCP must be assigned and be listed in the MMIS as a “Physician” or “Osteopath” provider type;¹
- The designated PCP provider must be active as well as accepting new clients;
- Only one PCP can be assigned;
- Only one pharmacy can be assigned;
- Multiple provider types can be locked in with a client at the same time as long as one of the providers is a PCP; and
- The client is required to be locked in for a period of at least 1 year. This first lock-in date span can be extended beyond 12 months if desired, and after the first lock-in year, subsequent lock-in spans can be of shorter duration.

These criteria are not adequate for ensuring that providers are notified as to which clients are enrolled in COUP and which providers are able to prescribe to them. In addition, it becomes necessary for the selected PCP, MCO, or the Department to designate other providers – such as specialists – to prescribe medication and for the client to move in and out of the program over the years. The MMIS will need to be edited in the following manner to resolve these issues:

- Allow any provider type to be locked in with a COUP client, e.g. PCP, MCO, Specialist, Nurse Practitioner (NP), Physician’s Assistant (PA), Federally Qualified Health Center (FQHC), Clinic, or Institution, and allow and prescribing provider under the assigned “parent” provider ID to treat the client;
- Recognize that a designated PCP is not required for the lock-in program;
- Enable certain drug therapeutic classes to be bypassed for lock-in clients in the event of an emergency treatment as prescribed by another provider;
- Allow date spans for clients enrolled in COUP to be flexible;
- Identify all providers with whom the client is locked in;

¹ Additional institutional provider types that can be designated as a PCP are Rural Health Clinic, Clinic, Federally Qualified Health Center (FQHC), and Indian Health Service. Although these provider types are designated as PCPs, this designation is not currently recognized with the lock-in process and their lock in entry for a client must be accompanied by an *individual* PCP (Physician or Osteopath). Physician or Osteopath providers may be specialists (family practice, internal medicine, etc.) but some restrictions apply; for example, Psychiatrists are not currently allowed to be locked in with a client.

- Provide notification to all providers that the client is enrolled in COUP, e.g. via eligibility verification in the State Portal;
- Provide the Prescription Drug Card System (PDCS) Pharmacy system with the ID of at least four (or more as necessary) prescribing providers through the current MMIS or PDCS interface; and
- Pay claims from these additional providers as long as the assigned provider is identified on the claim as the attending, rendering, referring, or supervising physician on a professional claim or as the billing or attending physician on an institutional claim.

By editing the MMIS in this way, there will be greater transparency in identifying which clients are enrolled in COUP and which providers are allowed to prescribe for them. It also enables clients to receive certain medications in case of emergency and to be locked in with the most appropriate provider, even if that provider is not a primary care physician or osteopath. Consequently, the program will be easier to manage and clients in the program will receive more appropriate care.

The Department's fiscal agent, Affiliated Computer Services, Inc., estimates that it will take 1,650 hours to complete the necessary changes to the MMIS at a rate of \$126.00 per hour. The one-time cost of this change will be \$207,900. Affiliated Computer Services, Inc. will begin working on the system changes on July 1, 2011. It will take eight months to complete the project, allowing the Department to begin enrolling new clients into the program on March 1, 2012. The cost of the system changes are calculated in table 1.3.

Savings Generated from Lock-In System

The Client Overutilization Program generates savings by decreasing excessive use of medical services and thereby reducing the expenditure for medically unnecessary claims. The program criteria primarily target the abuse of prescription medication, but also include inappropriate use of emergency room and/or physician services. Analyses of the Department's current program as well as of a similar lock-in program in Oklahoma provide evidence for the cost-saving efficacy of the program.

Analysis on the Department's current program is limited by the small sample size of clients who have been through the program. There are ten clients who are currently or have recently been through the program and have accumulated at least six months of data since the point in which they were enrolled. To estimate the savings that resulted from the program, the Department examined the amount of expenditure incurred on pharmaceutical claims during the six months before and after the point of lock-in for each of the ten clients. Expenditure decreased by 30.73% in the six months after lock in compared to the six months prior to lock in. The difference in means between the two periods was statistically different from zero at the 10% confidence level, despite the small sample size.

To check whether the decrease in expenditure experienced by the Department is valid, the Department researched the lock-in programs implemented by health care agencies in other states. Of the states researched, Oklahoma provided the most comprehensive study on the effect of its program on Medicaid expenditure for lock-in clients. The Oklahoma Health Care Authority released a report on the results of this analysis.² The study included 52 members who were enrolled in the SoonerCare Lock-In Program between January 1, 2006 and October 31, 2006. Regression analyses were performed to test whether the post lock-in average costs were statistically different from pre lock-in average costs. Their results reveal that pharmacy costs decreased by 22.21%, and pharmacy costs combined with emergency department costs decreased by 54.12%. Taken together, both the Colorado data and the Oklahoma study supports the conclusion that lock-in programs effectively curb state spending on those who are known to abuse the system.

To estimate the cost savings from expanding the program to 200 clients, the Department calculated the average expenditure on pharmaceuticals per month for the 200 clients identified by the Department as eligible for COUP and trended this value forward to account for inflation. This figure was multiplied by 30.73%, the percentage decrease in

² Keast, Shellie, Pharm.D., M.S. "Retrospective Analysis of Oklahoma SoonerCare Lock-In Program: Executive Summary Report." Prepared for the Oklahoma Health Care Authority, September, 2008.

pharmacy costs demonstrated by the current COUP clients, to arrive at average per client per month savings of \$505.33 in FY 2011-12 and \$544.50 in FY 2012-13. Total savings are estimated to be \$151,600 in FY 2011-12 and \$1,306,800 in FY 2012-13. Due to cash accounting, savings estimates are calculated under the assumption that there will be a one month lag between the time the expansion is implemented and the time savings are achieved. This gap incorporates the approximate time between a claim is incurred and the time that the claim is paid by the Department. The Department assumes it will enroll 50 clients per month until 200 clients are enrolled in the program. The savings are calculated in tables 1.1 and 2.1.

Consequences if Not Funded:

If this request is not funded, the Department will not realize a \$16,325 General Fund reduction in FY 2011-12 and a \$617,400 General Fund reduction in FY 2012-13. Without appropriate management, the Department will continue to pay for avoidable expenses for clients who are overutilizing services. Additionally, clients may be harming themselves by unrestrained use of prescription drugs.

Calculations for Request:

Summary of Request FY 2011-12	Total Funds	General Fund	Federal Funds	FTE
Total Request	\$71,300	(\$16,325)	\$87,625	0.0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$207,900	\$51,975	\$155,925	0.0
(2) Medical Services Premiums	(\$136,600)	(\$68,300)	(\$68,300)	0.0

Summary of Request FY 2012-13	Total Funds	General Fund	Federal Funds	FTE
Total Request	(\$1,234,800)	(\$617,400)	(\$617,400)	0.0
(2) Medical Services Premiums	(\$1,234,800)	(\$617,400)	(\$617,400)	0.0

Table 1.1: Calculations of Client Over Utilization Program Expansion Savings on Pharmaceuticals

Row	Item	FY 2011-12	FY 2012-13	Description
A	Average Cost per Client per Year in FY 2008-09	\$15,776.07	\$15,776.07	Total pharmaceutical costs incurred by potential clients over FY 2008-09 divided by 200 potential clients.
B	Inflation Factor	7.75%	7.75%	Percentage increase in expenditure for prescription drugs from FY 2007-08 to FY 2008-09.
C	Estimated Average Cost per Client per Year	\$19,735.61	\$21,265.13	Formula to inflate average cost in FY 2008-09 by three years to FY 2011-12: Row A * (1+Row B) ³ Formula to inflate average cost in FY 2008-09 by four years to FY 2012-13: Row A * (1 + Row B) ⁴
D	Average Cost per Client per Month	\$1,644.63	\$1,772.09	Row C / 12
E	Average Percentage Cost Avoidance per Client	-30.73%	-30.73%	Average percentage decrease of current COUP clients from six months prior point of lock in to six months after point of lock in.
F	Average Cost Avoidance per Client per Month	(\$505.33)	(\$544.50)	Row D * Row E
G	Total Number of New Clients Enrolled in Program	200	200	Proposed number of expansion clients.
H	Total Cost Avoidance per Year ⁽¹⁾	(\$151,600)	(\$1,306,800)	FY 2011-12: Table 2.1 FY 2012-13: Row F * Row G * 12

(1) Due to staggered program enrollment, FY 2011-12 cost avoidance is calculated in Table 2.1.

Table 1.2: Calculations of Client Over Utilization Program Incentive Payments				
Row	Item	FY 2011-12	FY 2012-13	Description
A	Incentive Payment per Client per Month	\$30.00	\$30.00	Proposed incentive payment amount.
B	Total Number of New Clients Enrolled in Program	200	200	Proposed number of expansion clients.
C	Total Costs of Incentive Payments per Year ⁽¹⁾	\$15,000	\$72,000	FY 2011-12: Table 2.2 FY 2012-13: Row A * Row B * 12
(1) Due to staggered program enrollment, FY 2011-12 incentive payment costs are calculated in Table 2.2.				

Table 1.3: Calculations of Client Over Utilization Program MMIS Changes				
Row	Item	FY 2011-12	FY 2012-13	Description
A	Cost per Hour for Changes to MMIS	\$126.00	\$126.00	Hourly rate paid to ACS to make MMIS changes.
B	Number of Hours Required for Changes to MMIS	1,650	0	Number of hours estimated by ACS to make all MMIS changes.
C	Total Cost for Changes to MMIS	\$207,900	\$0	Row A * Row B

Table 2.1: FY 2011-12 Estimated Savings by Month

Row	Month	Average Savings per Month ⁽¹⁾	Description
A	March 2012	\$0	Footnote 2
B	April 2012	(\$25,267)	Table 1.1.F * 50
C	May 2012	(\$50,533)	Table 1.1.F * 100
D	June 2012	(\$75,800)	Table 1.1.F * 150
E	FY 2011-12 Total	(\$151,600)	Row A + Row B + Row C + Row D

(1) Program start date is March 1, 2012. 50 clients per month will be enrolled until there are 200 additional clients in the program.

(2) Savings estimates are calculated under the assumption that there will be a constant one month lag between the time the expansion is implemented and the time savings are achieved.

Table 2.2: FY 2011-12 Estimated Total Costs of Incentive Payment by Month

Row	Month	Costs of Incentive Payment per Month ⁽¹⁾	Description
A	March 2012	\$1,500	Table 1.2.A * 50
B	April 2012	\$3,000	Table 1.2.A * 100
C	May 2012	\$4,500	Table 1.2.A * 150
D	June 2012	\$6,000	Table 1.2.A * 200
E	FY 2011-12 Total	\$15,000	Row A + Row B + Row C + Row D

(1) Program start date is March 1, 2012. 50 clients per month will be enrolled until there are 200 additional clients in the program.

Table 3: Calculation of COUP Expansion Fund Splits						
Row	Item	Total Funds	General Fund	Federal Funds	FMAP Rate	Description
	FY 2011-12					
A	Savings from Decreased Expenditure	(\$151,600)	(\$75,800)	(\$75,800)	50.00%	Table 1.1.H
B	Cost of Incentive Payment	\$15,000	\$7,500	\$7,500	50.00%	Table 1.2.E
C	MMIS System Change	\$207,900	\$51,975	\$155,925	75.00%	Table 1.3.E
D	Total	\$71,300	(\$16,325)	\$87,625		Row A + Row B + Row C
	FY 2012-13					
E	Savings from Decreased Expenditure	(\$1,306,800)	(\$653,400)	(\$653,400)	50.00%	Table 1.1.H
F	Cost of Incentive Payment	\$72,000	\$36,000	\$36,000	50.00%	Table 1.2.E
G	Total	(\$1,234,800)	(\$617,400)	(\$617,400)		Row E + Row F

Cash Funds Projections: Not applicable.

Assumptions for Calculations: Assumptions are noted in table descriptions and footnotes of the “Calculations for Request” section as well as in the narrative above.

Impact on Other Government Agencies: Not applicable.

Cost Benefit Analysis:

Cost Benefit Analysis	Costs	Benefits
FY 2011-12	The costs of this request include \$207,900 total funds and \$51,975 General Fund to make Medicaid Management Information System changes as well as \$15,000 total funds and \$7,500 General Fund to pay providers an incentive payment for each COUP-enrolled client with whom they agree to partner.	This request will allow the Department to place clients who are excessively using Medicaid benefits, such as prescription drugs, in a monitored program to ensure they are only receiving treatments that are medically necessary. The clients who are placed in this program will receive more appropriate care and attention based on their medical needs. The State will benefit by not paying for inappropriate or excessive claims incurred by these clients. The savings in FY 2011-12 is estimated to total \$16,325 General Fund.

Cost Benefit Analysis	Costs	Benefits
FY 2012-13	The cost of this request is \$72,000 total funds and \$36,000 General Fund to pay providers an incentive payment for each COUP-enrolled client with whom they agree to partner.	This request will allow the Department to place clients who are excessively using Medicaid benefits, such as prescription drugs, in a monitored program to ensure they are only receiving treatments that are medically necessary. The clients who are placed in this program will receive more appropriate care and attention based on their medical needs. The State will benefit by not paying for inappropriate or excessive claims incurred by these clients. The savings in FY 2012-13 is estimated to total \$1,234,800 total funds and \$617,400 General Fund.

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period	01/01/2011 to 6/30/2011
System Modifications Made	07/01/2011 to 02/29/2012
Start-Up Date	03/01/2012

Statutory and Federal Authority:

42 CFR § 456.3 *Statewide surveillance and utilization control program. The Medicaid agency must implement a statewide surveillance and utilization control program that -- (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; (b) Assesses the quality of those services; (c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and (d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.*

42 CFR § 431.54(e) *Lock-in of recipients who over-utilize Medicaid services. If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only. The agency may impose these restrictions only if the following conditions are met:(1) The agency gives the recipient notice and opportunity for a hearing (in accordance with procedures established by the agency) before imposing the restrictions.(2) The agency ensures that the recipient has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality.(3) The restrictions do not apply to emergency services furnished to the recipient.*

Performance Measures:

This request will assist the Department in meeting its performance measure to contain health care costs. The Client Overutilization Program is designed to eliminate costs on services that are medically unnecessary and are not being utilized for appropriate and quality care to Medicaid clients. By eliminating these costs, the State will save money that can be used more effectively in other areas.