Department of Community Health
Boilerplate Report – Section 1629(2), P.A. 60 of 2001
Fourth Quarter

Persons Enrolled	14,682
Year-To-Date Expenditures	$21,910,986.00
Projected Expenditures	$21,910,986.00

Also attached is the department's quarterly report as required by the EPIC Legislation, Section 8 of P.A. 499 (2000).

DEPARTMENT OF COMMUNITY HEALTH

EPIC PROGRAM

FOURTH QUARTER IMPLEMENTATION REPORT

Section 8 of PA 499 (2000) requires that quarterly reports be transmitted to the Senate and House Appropriations Committees and the senate and house fiscal agencies. These reports are required to include the following:

- quantified data as to the number of program applicants and enrollees
- the amount of expenditures
- the number of enrollees subsequently found eligible for Medicaid
- an estimate as to whether the current rate of expenditures will exceed the existing amount of money appropriated for EPIC in the current fiscal year

The following report addresses each of these requirements.

Applications and Enrollment

At this time, general enrollment has not been opened for new EPIC participants. However, the emergency program remains open and will enroll any eligible applicant. Thus far, emergency enrollees have been provided an expedited enrollment and coverage extended to 365 days. These extensions will occur when EPIC is open for general enrollment or when funds permit such extensions.

As of September 28, 2002 total enrollment was 14,682 which includes 392 approved emergency enrollees. Reported enrollment has declined from previous reports since this report reflects individuals no longer enrolled in EPIC, primarily due to the death of the participant. Other reasons include an increase in income, a change of residency such as to a nursing home, evidence of other prescription insurance coverage, a move out of state, etc. For reference, as of November 9, 2002, enrollment was 14,923.

Other Activities

The renewal process was initiated in August 2002 and through mid-November; about 14,400 renewal application packets have been mailed. Originally, a 60-day time period was planned for mailing, returning, and processing renewal applications for EPIC participants. However, about 50% of the re-enrollment packages being returned are incomplete and as a result, are “pended” until the additional information is received and reviewed. To address this problem, the 60-day time period has been increased to 90 days. Additionally, applications are being “triaged” so that applications for participants with the earlier end dates are being processed first. Call center staffing has also been increased to handle the call volume.

Several changes were made in the application as well. Proof of income is required annually, but the application form was changed so that all income sources could be listed. Also, a copy of the social security statement, which includes the amount withheld for Medicare premiums is now required. This change has improved the completeness and accuracy of income reporting. In the initial application process, about 10% of EPIC participants reported that they were not eligible/enrolled in Medicare. This compares to 1-2% of the national population. Since underreporting was suspected, a copy of the Medicare card is also required.

Also, anecdotally, it appeared that a number of EPIC participants have other insurance coverage which was not identified in the initial enrollment process. Correspondingly, the information requested in the application regarding other coverage was clarified. Also, a question as to whether the applicant is a US Veteran was added since most veterans are eligible for VA prescription benefits and thereby would be ineligible for EPIC.

Because most EPIC participants enrolled between September 1st and January 31st, the re-enrollment process is expected to be substantially complete by mid-January, 2003. Based on the results of this first renewal process, it is expected that renewal applications will be revised for the 2003-2004 cycle.

Medicaid-eligible Enrollees

Applicants who are at or below 100% of the federal poverty level, when approved for enrollment, are told in their enrollment letter that:

- they may be eligible for Medicaid
- Medicaid provides a broader range of coverage/benefits
- their local FIA office can provide additional information

Senior EPIC Centers may also refer individuals to the local Medicare Medicaid Assistance Program staff. In many instances, these are the same staff who assist seniors with EPIC matters. However, the EPIC legislation does not require Medicaid-eligible participants to enroll in Medicaid.

Of all participants as of September 28th, 18% appear to be Medicaid-eligible based on the information submitted with the application. Note, however, that EPIC does not consider assets in determining eligibility. Of the emergency applications, approximately 22% may be eligible for Medicaid benefits. To date, 55 confirmed matches for full Medicaid eligibility have been identified with disenrollment. However, the automated file match between Medicaid and EPIC eligibility files is still in development.

Expenditures

The EPIC program did not exceed the appropriation. FY 02 expenditures were $21.9 Million.

1. Claims

   Through the pharmacy claims billing period ending September 29,2002 there have been 606,183 paid claims, which total $22,650,728 (including participant co-pays). Excluding administrative costs, the cost to EPIC was $19,885,516. The average participant co-pay is 12.3% of the cost of the claim.

2. Administrative Costs

   Through September - June, administrative costs have been approximately $2.0 million and include significant one-time amounts associated with the start-up of the program.

FY02 EPIC PROGRAM REPORT

ENROLLMENT

- August, 2001 began sending application packets to MEPPS recipients. Of almost 13,000, 58% enrolled in EPIC.

- October, 2001 began sending application packets to Senior Prescription Drug Tax Credit recipients. 23% of almost 33,000 tax credit recipients enrolled in EPIC.

- As of September 28, 2002, enrollment is 14,672.

- No general open enrollment is currently scheduled.

EMERGENCY ENROLLMENT

- Emergency enrollment will remain “open” as required by the EPIC legislation.

- Emergency enrollments were deemed eligible for re-enrollment.

- There were 392 emergency applicants enrolled. Seniors who enroll under emergency criteria are typically younger than the “average” EPIC participant.

- All emergency enrollments were offered expedited enrollment for 365 days of coverage. Providing expedited enrollment is subject to budget availability.

- During the first year of implementation, 69 Senior EPIC Center’s processed emergency applications. Training was held in SE Michigan in June, and by phone conference in July for all Senior EPIC Centers to help ensure that all senior epic center staff had the information and knowledge to process emergency applications.

- From October through May, emergency enrollments averaged 24 per month. In September, the total was 69.

RE-ENROLLMENT

- Re-enrollment began August 2002. Because of the higher number of incomplete renewal applications received from current members, it was decided that renewal packets would be mailed 90 days before the date benefits end. Additionally, a post card is being included with the renewal applications for those members who do not intend to re-enroll to send to First Health.

- The renewal process requires a complete application and all proof documents except age and residency (if the participant has not moved in the past year). The most common reasons for non-renewal are that income exceeds EPIC eligibility limits and that the participant does have other prescription insurance.

- As of November 9, 14,392 re-enrollment packages had been mailed by First Health. Of these, 5,834 have been approved. Additionally, 87 have been denied, primarily due to income exceeding eligibility criteria. About 50% of applications are pended since the re-enrollment application was incomplete. The remaining received applications are under review.

- Application review is being “triaged” with the intent of maintaining coverage for participants whose eligibility dates have, or will soon end.

- So far, 250 re-enrollment packets have been returned to First Health by the postal service primarily because of expired forwarding orders or the participant’s death.

- A survey questionnaire is being sent with all renewal packets. The survey asks about satisfaction with the program and health status.

PHARMACY PARTICIPATION

- 2,093 Michigan pharmacies are enrolled as EPIC providers

- EPIC benefits are available nationally through chains such as CVS, Walgreen's, Rite Aid, Wal-Mart, etc.

SENIOR SERVICES INVOLVEMENT

- There are about 150 Senior EPIC Centers statewide. Since last year, one site (Wayne County) has closed however, there are other Senior EPIC Centers nearby.

- Education and Outreach agreements with all Area Agencies on Aging and the state MMAP program remain in place.

- Communication with Senior EPIC Centers takes place through a written "Advisory" process, telephone conference call meetings and phone-based consultation with the Michigan Department of Community Health and First Health Services EPIC staff.

- Senior EPIC Centers vary in terms of their level of involvement and outreach in the EPIC program.

EPIC PARTICIPANT CHARACTERISTICS

- Age:

  10% are 65- 70 years old
  19% are 71-75 years old
  25% are 76-80
  45% are over age 8l

- Gender

  82% are female

- Marital Status

  25% are married and living together with their spouse

- About 100 participants report children as dependents

- About 200 participants report having a legal guardian

- Income
  18% are at or below the FPL
  35% are between 100-125% of FPL
  32% are between 125-150% of FPL
  15% are between 150-200% of poverty

  FPL for individuals is currently $8,850 and $11,940 for couples.

- Minority populations are 4 times more likely to enter the EPIC program as emergency enrollees.

- There are only minor differences in income characteristics between emergency and “regular” enrollees at or below 150% FPL.

  21% of both groups are below 100% of the FPL

- 90% of participants report Medicare Part A coverage and 87% report Medicare Part B coverage. This is significantly below national levels.

PARTICIPANT DRUG UTILIZATION

- Between January 1 and July 31st (7 months) the distribution of participants, by number of claims was:

1-20 claim	15%
11-20 claims	23%
21-30 claims	23%
31-40 claims	17%
41-50 claims	10%
over 50 claims	10%

- One participant accounts for 154 prescriptions in this time period

- 50% of the prescriptions are related to cardiovascular disease and high cholesterol

- "Top ten" drugs dispensed are:

  10% Calcium Channel Blockers
  9.3% Lipitropics
  8.7% Beta Adrenergic Blockers
  7.3% Ace Inhibitors
  7.1% Vasodilators
  7%% Gastric Acid Secretion
  6.4% Potassium Supplements
  6.0% Narcotic Analgesics
  5.3% Anti-inflamatory Agents
  4.8% Bone Ossification

- About 1% of prescriptions are written as DAW by the prescribing physician

CLAIMS COSTS

- Through September 31, 2002 claims (total number of prescriptions filled and paid by EPIC) have totaled 606,183

- Through September 31, 2002, EPIC has paid out approximately $20M in pharmacy claims

- In October, 2001 the average EPIC cost per claim was $34.02 and in September, 2002 it was $36.88, representing an increase of 8.4%

- The total average cost per claim (including co-pays) has increased from $36.47 in October to $41.82 in September, 2002 representing an increase of 14.7%

- Currently, administrative costs are approximately $.93 per claim. This will decrease in FY03 due to a reduction in the administrative cost per claim and because first year implementation fixed costs decline in relation to the number of claims processed.

- In each 2-week period, on average, 3.1 claims are processed for each participant with pharmacy claims

- In any month, about 85% of EPIC participants file claims. And, these average 5.1 claims for participants billing prescriptions. This results in about 61 pharmacy claims a year if there are no seasonal variations in pharmacy utilization.

PARTICIPANT CO-PAYS

- EPIC Legislation establishes a copay obligation of between 1 & 5% of the participant's monthly income, depending on their income.

- A $15 co-pay is also required for brands when a generic is available unless the state MAC price is paid.

- About 1.3% of paid claims are for brands.

- In total, co-pays average 12.3% of the cost of the prescription. The required co-pay is 20% of the cost of the claim up to the out-of-pocket maximum.

- The total copay amount (including the brand co-pays), on average, is about $4.60 per claim. It is $4.41 excluding the $15.00 brand copay.

- Consistent with Medicaid requirements, multi-source brands require a prior authorization. Between October 1, 2001 and August 30, 2002, there have been about 2,000 brand-related prior authorizations not related to the preferred drug list

GENERIC UTILIZATION AND INGREDIENT COST-Before Rebates

- Ingredient cost and claim utilization is summarized by three types of drugs—multi-source brands, single source (patent) drugs and generics.

- Overall, the ingredient cost of drugs has increased from $35.00 in October to $38.05 in September—a net increase of 8.7%.

- Use of unbranded generics by EPIC participants began at 54% of total claims and in September represented 58% of total claims. Most of the increase began in March.

- The ingredient cost of non-branded generic drugs has increased from $13.55 in October to $15.71 in September-an increase of 15.9%.

- Multi-source brands began at about 7.4% of claims in October 2001 and were 3.5% of claims in September.

- The ingredient cost of multi-source drugs has declined from $39.03 to $30.97 between October and September— a reduction of 20.7%.

- Single source drugs are down slightly from 39% of utilization in October to 38% in September.

- The ingredient cost of single source drugs was $63.73 in October and increased to $72.55 in September - an increase of 13.9%.

MPPL/PDL IMPLEMENTATION

- Although the reason for the changes in utilization patterns is not definitive, it appears that the MPPL/PDL implementation contributed to:
    - A shift in utilization from branded to generic products
    - A shift within branded products to less expensive products
    - Prior authorizations associated with the implementation of the preferred drug list totaled 5,222 from February 1 until August 30.
    - Of these, 82% were approved and 18% were changed by the prescribing physician to a preferred drug.
- Through mid August, there have been 14 denials, and no appeals.
    - The prior authorizations associated with the preferred drug list represented 1.6% of total epic claims for this time period.

PRO AND RETRO-SPECTIVE UTILIZATION

- ProDur consists of a process at point of sale, which is intended to help pharmacists ensure that participants receive appropriate medications.
- When a prescription is presented to the pharmacy and the claim entered in the claims processing system, the medication is compared to the participant's drug history.
- As a result, an electronic "message" may be sent to the pharmacist. The message informs the pharmacist of possible drug interactions, ingredient duplication with other prescriptions or dosage problems.
- RetroDur involves a review of paid claim data to identify utilization patterns which might result in adverse effects.

- A history of utilization is required to carry out retro-DUR functions. The retro-DUR process was implemented in April. Topics reviewed to date have been poly-pharmacy, Ambien usage, Serevent inhalers, high dose narcotic use and duplication of therapy.

FUTURE PLANS

- The emergency program will remain open and provide expedited enrollment to 365 days if the budget permits.

- DCH continues to consider submission of a Pharmacy Plus Waiver. This waiver requires Medicaid cost neutrality for the 65+ population.