



Objective

- The goal of the Medicaid Lock-in Program is to prevent and restrict inappropriate and fraudulent overutilization of certain medications.

Key Facts

- Medicaid Lock-in programs are active in 46 states.
- The design of state Medicaid Lock-in programs varies due to the broad parameters federal legislation provides to states.
- Federal law prohibits states from restricting access to emergency department services for a person with Medicaid.

Key References:

42 CFR 431.54(f)

TAC Rule 354.2401(9)

TAC Rule 354.2403

TAC Rule 354.2407

Texas Medicaid Provider Procedures Manual: Vol. 1 (June 2018), Section 4.42 - 4.42.8

MEDICAID LOCK-IN PROGRAM

Patient review and restriction programs are commonly called “Lock-in” programs and are used to restrict the overuse of medical services, such as prescription drugs. Lock-in programs operate by “locking in” an individual to one provider and/or pharmacy to prescribe/dispense certain prescription medication, like controlled substances (e.g. morphine, hydrocodone) to prevent their abuse or overuse. Individuals enrolled in a lock-in program must purchase all of their prescriptions from the pharmacy from which they are “locked in.” Generally, persons are eligible for Medicaid Lock-in Programs (MLIP) when a pre-defined threshold of prescriptions of controlled substances, provider visits, or both are reached. MLIP enrollment is intended to prevent persons with Medicaid from provider or pharmacy “shopping” or misuse of medications. Payment records (i.e. Medicaid claim data) are used to identify patterns of suspicious use.

Federal regulations authorize states to operate MLIPs. The Texas Administrative Code and the Texas Medicaid Provider Procedures Manual give additional guidance and clarity about their operation and eligibility requirements. Medicaid contracts require Managed Care Organizations (MCO) providing services to persons enrolled in STAR, STAR+PLUS, STAR Health, and STAR Kids to maintain written policies to operate MLIPs. MCOs are required to submit documentation annually to the Office of Inspector General (OIG).

OIG OPERATES TEXAS MEDICAID LOCK-IN PROGRAM

The OIG manages and operates the Texas MLIP. Referrals to place individuals in the program are submitted to the OIG by a provider, the public, law enforcement, and Medicaid MCOs. Qualified OIG medical personnel validate the submitted information to determine if a person is a candidate for the MLIP. Some MCOs that have demonstrated a high degree of accuracy in their referrals are allowed to submit referrals without supporting documentation for approval from OIG staff. In these cases, MCO lock-in decisions and supporting documentation are reviewed periodically for accuracy and compliance with rules and guidelines. Referrals received from sources other than MCOs may be submitted through the OIG telephone hotline or an electronic form on the OIG web site. Upon receipt of the referrals, OIG staff confirm the referral candidate is eligible to receive Medicaid services and a review and analysis of the submitted information is performed. Documentation related to diagnoses, acute care services, prescription drug history, are examples of the types of information that are reviewed to determine if the referral is appropriate for the MLIP.

Once a person’s eligibility is confirmed, s/he will receive written notification about the MLIP referral, a form to choose a provider for the length of the lock-in period, and information about the right to have a hearing to contest the lock-in status. If a provider is not selected, the Health and Human Services Commission (HHSC) will choose a provider for the person with Medicaid. If a request for a hearing is received by the lock-in start date, the lock-in period will not begin until after the hearing and a final decision is rendered. If a hearing is requested after the lock-in

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period has started, then the lock-in status will remain in effect until the hearing and a final decision is rendered. Lock-in periods are 36 and 60-months or may last a lifetime under certain circumstances. Persons with a lock-in status are issued a Medicaid card with “Lock-in” printed on the card, as well as the names of the designated provider and pharmacy.

Several studies from other states show that MLIPs can reduce expenditures and the use of controlled substances. For example, Oklahoma’s program demonstrated that after enrollment in the MLIP, patients in the program used fewer narcotics, decreased the number of multiple visits to pharmacies and physicians, and went to the emergency departments less. The Iowa MLIP reported saving \$2 million annually in 2008 as a result of its efforts to prevent abuse of certain medications. Similarly, the Texas MLIP is estimated to result in \$2 million of avoided costs in state fiscal year (SFY) 2018 due to its efforts.

MEDICAID LOCK-IN PROGRAM REFERRALS FROM MCOS

The number of annual referrals to the MLIP varies by MCO. Figure 1 shows MCOs referrals for the previous three state fiscal years. The majority of referrals to the MLIP come from MCOs as shown in Figure 2; however, because all data fields of the referral form are not required, the source of the referral may not always be able to be determined or tracked for statistical purposes.

Figure 1: MCO Referrals to the Texas Medicaid Lock-in Program, State Fiscal Years 2015 to 2017

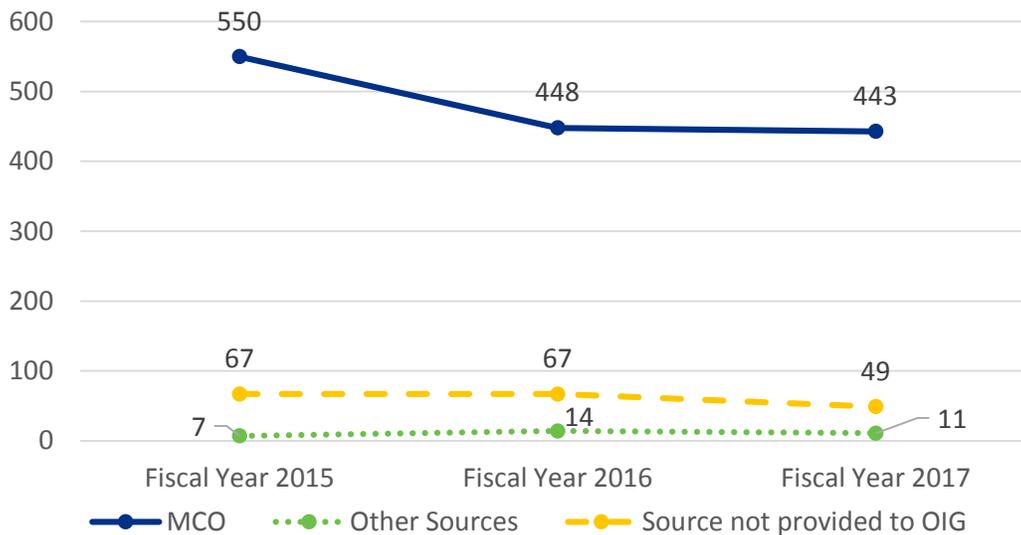
MCO	2015	2016	2017	MCO Total
Superior Health Plan	322	154	106	582
Driscoll Health Plan	12	76	169	257
Cigna-HealthSpring	102	37	61	200
Amerigroup	2	37	60	99
Molina Healthcare	30	41	4	75
United Healthcare	0	44	19	63
Texas Children's Health Plan	10	31	2	43
Community Health Choice, Inc.	43	0	0	43
Aetna	17	9	2	28
Seton Health Plan	1	8	7	16
Cook Children's Health Plan	1	2	9	12
Scott & White Health Plan	6	1	1	8
Blue Cross Blue Shield of Texas	1	3	2	6
FirstCare Health Plan	0	4	1	5
Community First Health Plans	0	1	0	1
Parkland Community Health Plan	1	0	0	1
Christus Health Plan	1	0	0	1
El Paso First Health Plans	1	0	0	1
Sendero*	0	0	0	0
Children's Medical Center Health Plan*	0	0	0	0
Fiscal Year Total	550	448	443	1441

Source: Office of Inspector General.

*Children’s Medical Center joined Texas Medicaid in November 2016; Sendero withdrew from Texas Medicaid May 1, 2018.

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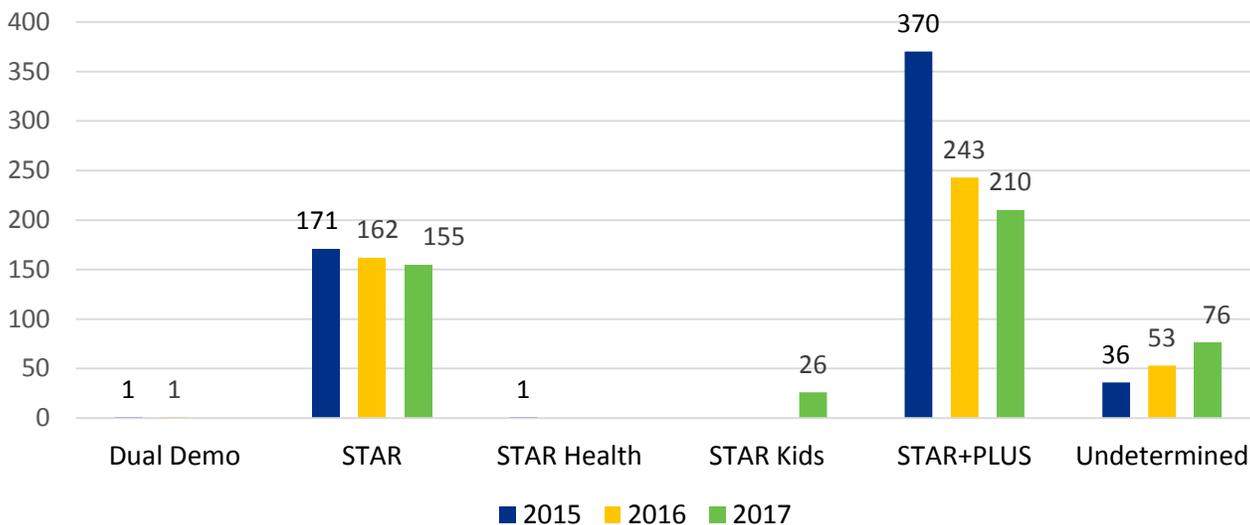
Figure 2: Number of Referrals by Source to the Medicaid Lock-in Program for State fiscal years 2015–2017



Note: Other Sources include: Providers, Public, Law Enforcement
 Source: Office of Inspector General.

Of the Medicaid managed care programs, STAR+PLUS has the most number of annual referrals to the MLIP. Figure 3 shows the number of persons referred to the MLIP by Medicaid managed care program for SFYs 2015 to 2017.

Figure 3: Number of Accepted Medicaid Lock-in Program Referrals by Medicaid Program by State Fiscal Year, 2015–2017



Source: Office of Inspector General.

Per legislative direction in 2017 to increase participation in the Lock-In program, the OIG collaborated with the MCOs to establish revised criteria that lowered thresholds for referral to the program. The new criteria takes advantage of some of the monitoring tools available to MCOs and their Pharmacy Benefit Managers. These tools include Morphine Equivalent Dosing (MED); this method determines a patient’s total intake of any opioid class drugs within 24 hours.

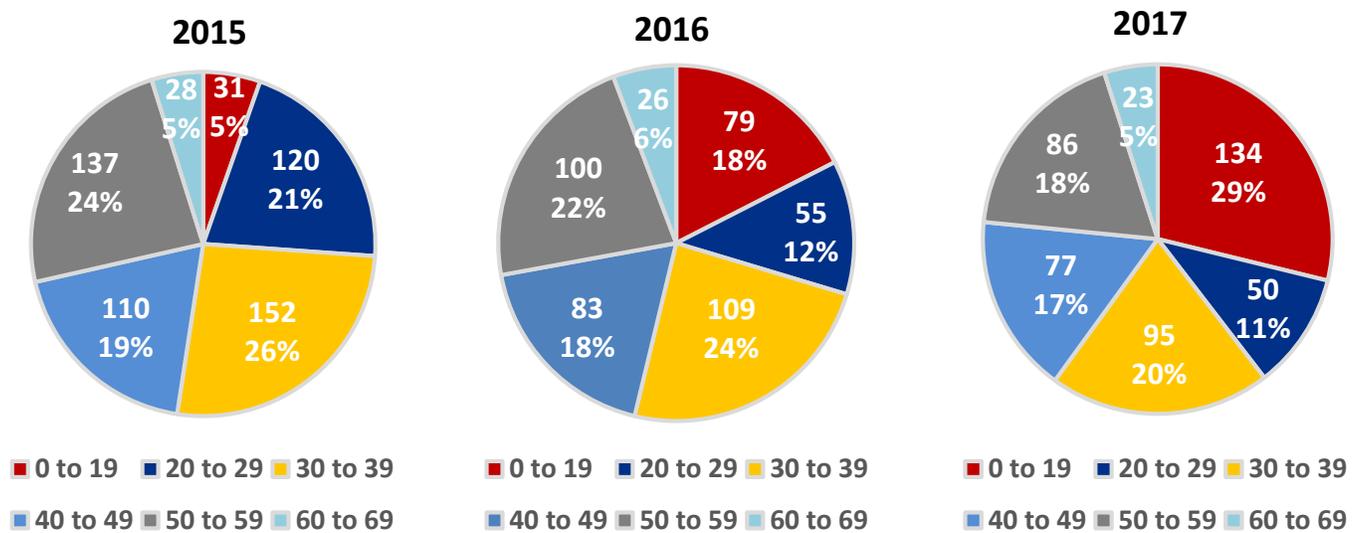
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Its purpose is to reduce overdoses or abuse of certain drugs, whether accidental or intentional. Other collaboration activities include OIG staff routinely providing support and training through bi-monthly meetings with MCOs that include discussions about updates to processes and other useful tips. MCOs may request OIG staff to provide training about specific topics and orientation about the MLIP.

REFERRALS FOR YOUTH INCREASING DRAMATICALLY

The demographics of persons MCOs have referred to the MLIP have shifted since SFY 2015. At that time, youth ages 0 to 19 accounted for 5 percent of referrals, while adults between the ages of 20 to 59 accounted for 90 percent of the referrals. However in SFY 2016, a shift occurred. Referrals for youth ages 0 to 19 increased to 18 percent. Next year in SFY 2017, referrals for youth ages 0-19 increased further to 29 percent and represented the largest percentage of referrals for any age group since 2015. Figure 4 shows the number of referrals by age group and by state fiscal year.

Figure 4: Medicaid Managed Care Lock-in Program Referrals by Age Group and State Fiscal Year, 2015 to 2017



Note: In state fiscal year 2015, data was insufficient to determine the age of 1 person.

Note: In state fiscal year 2016, data was insufficient to determine the age of 7 persons.

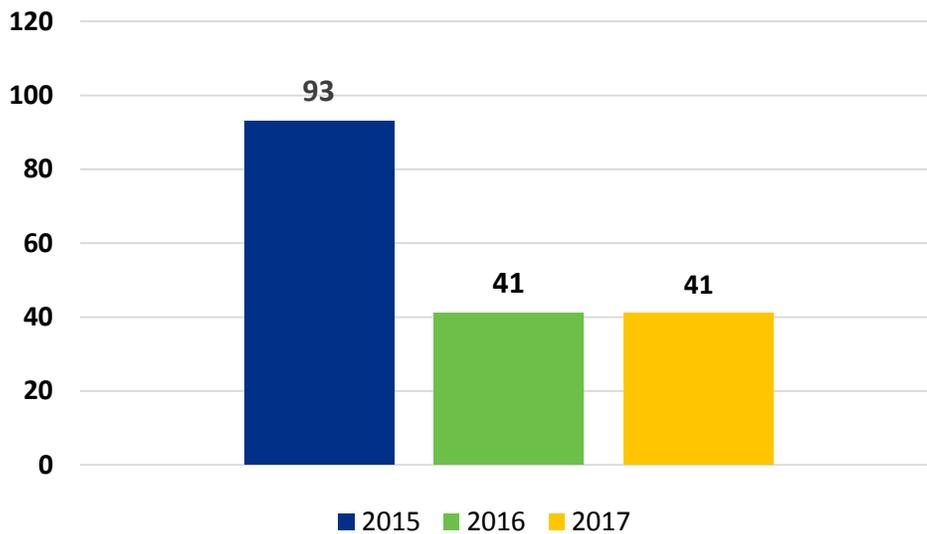
Note: In state fiscal year 2017, data was insufficient to determine the age of 2 persons.

Source: Office of Inspector General.

Nationally, young adults between ages 18 to 25 are the most frequent users of prescription drugs for non-medical use than other age groups, according to the National Institute on Drug Abuse. In Texas, MLIP referrals for young adults age 18 to 25 have decreased since state fiscal year 2015 as a result of decreased referrals from Superior, an MCO that serves a large share of the total Medicaid population. However, referrals for youth age 11 to 17 have dramatically increased. MLIP referrals for youth age 11 to 17 have increased by 1,000 percent from state fiscal year 2015 to 2016 and a further 115 percent increase in state fiscal year 2017. Driscoll, an MCO that serves youth age 20 and younger, is responsible for almost all the referrals in state fiscal year 2017 for youth age 11 to 17. Figures 5 and 6 show these changes in MLIP referrals for ages 18 to 25 and ages 11 to 17, respectively.

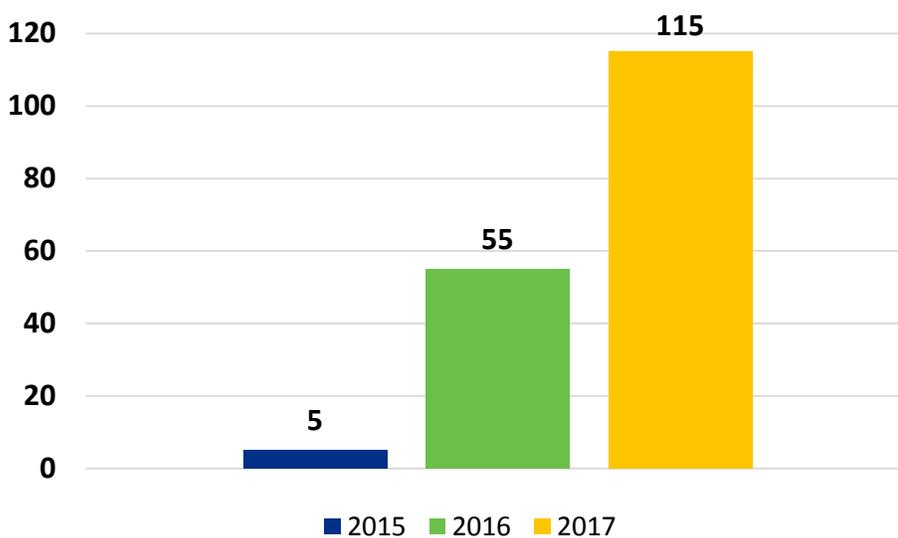
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Figure 5: Medicaid Managed Care Lock-in Program Referrals for Young Adults Ages 18 to 25 by State Fiscal Year, 2015–2017



Source: Office of Inspector General.

Figure 6: Medicaid Managed Care Lock-in Program for Youth Ages 11 to 17 by State Fiscal Year, 2015–2017



Source: Office of Inspector General.

FUTURE ISSUES

Lock-in restrictions for prescriptions can be avoided if persons with Medicaid pay out-of-pocket for the medication instead of allowing Medicaid to cover the cost. Paying out-of-pocket results in no claim being filed with Medicaid to document the transaction. Prescription monitoring programs (PMP) are one way to improve detection of persons exploiting this regulatory gap. PMPs are databases that collect and analyze controlled substance prescription information submitted by pharmacies. Prescribers and dispensers of medication can access the PMP to view patient history of controlled substances regardless of payment source. As part of the OIG responsibility to detect fraud, waste, and abuse in Texas Medicaid program, the OIG seeks access to the PMP database. With PMP access, OIG staff will be better positioned to identify patterns of patient and physician behavior that may be abusive or unnecessary use of

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controlled substances and relaying it to appropriate agencies and organizations.

Despite the widespread use of MLIPs, evaluation data about them is limited. States that have evaluated their MLIP focused on the financial or economic impacts MLIPs may have on their state Medicaid spending. However, even less is known about the clinical outcomes MLIPs have on clients. A study of Michigan's MLIP found that more than half of the MLIP participants ended their Medicaid coverage after one month of enrollment in the program. On the other hand, clients who remained in the program were found to be more likely to improve their opioid use by quitting or reducing the amount used.

Montana revamped its MLIP to achieve outcomes focused on clients, instead of focusing on the program's restrictive actions. Once clients are enrolled in the Montana MLIP, they receive highly coordinated and interdisciplinary care, as well as extensive health education for two years. The goal is to continue to engage MLIP clients in a positive manner and to make recommendations to pain management specialists or substance use treatment, when needed.

DISCLAIMER:

"This document is part of an ongoing discussion of an important health care issue. It is provided for general informational purposes only, and is not intended to present an official position of the State of Texas, HHSC, or the Office of Inspector General. This document does not constitute an official interpretation of the HHSC Managed Care Contract (Contract), or state or federal law. Specific questions concerning the appropriate interpretation of the Contract or state or federal law are dependent upon the precise facts and circumstances then existing. Any particular question should be evaluated independently."