



MISSOURI SENIOR RX PROGRAM

**From The Office Of State Auditor
Claire McCaskill**

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PERFORMANCE AUDIT



Statutory changes and improvements in management and oversight would benefit the Senior Rx program

The cost of prescription drugs, especially for senior citizens on fixed incomes, has been an ongoing concern for the last several years. The Missouri Senior Rx program was established in a September 2001 special legislative session to help seniors with these costs. Program administrative costs were \$2.8 million in fiscal year 2003 and budgeted at \$2.4 million in fiscal year 2004. The audit focused on whether the program was effectively and efficiently implemented.

Results-based strategic planning process not implemented

Program officials have not implemented a results-based strategic planning process outlining specific goals to be achieved. As a result, they cannot ensure a key element of strategic planning - accountability. (See page 11)

Fiscal year 2003 enrollment less than half what was anticipated

Enrollment was less than half what was anticipated for fiscal year 2003 and declined in fiscal year 2004. Lower enrollment for fiscal years 2003 and 2004 may have resulted from benefit details not being announced until after the initial fiscal year 2003 enrollment period and limited marketing opportunities between the fiscal years 2003 and 2004 open enrollment periods. Program officials increased program marketing for the fiscal year 2005 enrollment period. (See page 5)

Medicaid rates for multi-source drugs were lower than Senior Rx rates for those drugs

The Senior Rx program and seniors could have saved over 12 percent of total prescription expenditures (\$2.9 million of \$23.6 million) in fiscal year 2003 by using pharmacy reimbursement options similar to the state's Medicaid program. The specific amount of savings possible for seniors and the program cannot be determined due to co-payment and other issues; however, each would benefit about equally from any potential savings. Legislative action is needed to implement this change. (See page 11)

No review of rejection reasons performed

Our analysis of fiscal year 2003 claims data identified 27 percent of pharmacy submitted claims were rejected, costing the program about \$300,000. Program officials did not evaluate trends by pharmacies or reasons for rejected claims to identify correctable issues that unnecessarily increased program costs. (See page 15)

(over)

YELLOW SHEET

New federal Medicare drug benefit will force changes to state's program

Coordination of benefits will be necessary for any state programs in place once the Medicare prescription drug benefit is fully implemented. The Medicare legislation caps the first benefit tier at \$2,250 in prescription drug expenditures with no additional federal participation until a senior has \$3,600 in out-of-pocket costs. During fiscal year 2003, approximately 3,600 Senior Rx program enrollees had program related prescription costs exceeding \$2,250. These seniors would be the only ones to potentially realize any significant benefit from Missouri's program once the full Medicare benefit is established. (See page 6)

Private programs may offer better benefits

Most brand-name pharmaceutical manufacturers and other organizations operate discount programs to help low income individuals. Auditors determined some seniors and the state could have saved approximately \$60,000 and \$28,000, respectively, if they had enrolled in private pharmaceutical companies discount programs instead. State law allows the Senior Rx Commission to establish a clearinghouse to assist Missouri residents in accessing prescription drug programs to help evaluate the most cost-effective option. A clearinghouse was not funded by the legislature for fiscal years 2003 or 2004. (See page 8)

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ABBREVIATIONS

RSMo	Revised Statutes of Missouri
AWP	Average Wholesale Price
DAW	Dispense as Written
DOR	Department of Revenue
PTC	Property Tax Credit
CLAIM	Community Leaders Assisting the Insured of Missouri



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Missouri State Auditor

Honorable Bob Holden, Governor
and
Members of the General Assembly
and
Members of the Missouri Senior Rx Commission
and
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The cost of prescription drugs, especially for seniors on fixed incomes, has been an ongoing concern for the last several years, and has received more attention lately due to planned federal Medicare benefit changes. The Missouri Senior Rx program was established to help seniors with these costs. Our objectives were to determine if the program has been effectively and efficiently implemented, including whether other alternatives may exist to augment the program.

The recent federal Medicare prescription drug benefit will impact the future of the Senior Rx program. Other alternatives for providing prescription drug savings for Missouri citizens are available and need to be evaluated. Regarding program management, officials did not establish a strategic plan and mission statement to guide the program, failed to ensure state statutes were complied with, and did not sufficiently evaluate the results of contractor pharmacy audits and the reasons for rejected claims. The lack of management oversight resulted in seniors and the program incurring actual or potentially unnecessary costs and pharmacies being underpaid for some transactions. Pharmacy reimbursement changes could save seniors and the program several million dollars annually.

We have included recommendations to improve the management and oversight of the Senior Rx program.

We conducted our work in accordance with applicable standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and included such tests of the procedures and records as were considered appropriate under the circumstances.

A handwritten signature in black ink that reads "Claire McCaskill". The signature is written in a cursive style with a large initial "C".

Claire C. McCaskill
State Auditor

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INTRODUCTION

The Missouri Senior Rx program was established in a September 2001 special legislative session¹ to help defray the costs of prescription drugs for residents at least age 65 (referred to as seniors). The program began accepting applications in April 2002 and benefits were first offered to seniors in July 2002. The program is governed by a 15-member appointed commission and is considered part of the Department of Health and Senior Services, Division of Senior Services and Regulation. An executive director and five staff run the program on a day-to-day basis.

The Department of Health and Senior Services is to provide technical assistance for program administration. The Senior Rx Commission contracts with a company to do most of the day-to-day program processing such as processing applications and claims, determining eligibility, collecting enrollment fees, enrolling pharmacies, and distributing payments to pharmacies.

The Senior Rx program consists of two benefit tiers. Single seniors with incomes less than \$12,000 and married seniors with combined incomes of less than \$17,000 are eligible for tier one, which has an administrative fee of \$25 per person and an annual deductible of \$250. Single seniors with incomes less than \$17,000 and married seniors with combined incomes of less than \$23,000 are eligible for tier two, which has an administrative fee of \$35 per person and an annual deductible of \$500. After the \$250 or \$500 deductible has been met, seniors pay 40 percent of prescription costs while the Senior Rx program pays 60 percent. The Senior Rx program pays a maximum of \$5,000 per senior annually.

Pharmaceutical manufacturers must apply for participation in the program and agree to rebate a percentage of the actual manufacturer's price² to the state. The program received a 15 percent rebate for both brand-name and generic drugs in fiscal year 2003. For fiscal year 2004, the program is receiving rebates of 15 percent for brand-name drugs and 11 percent for generic drugs. Only drugs of participating manufacturers are reimbursable under the program. Generic drugs must be used for the program when available. Pharmacies receive a \$4.09 dispensing fee per completed transaction.

Table 1 shows program revenues and expenditures for fiscal year 2003:

Table 1: Fiscal Year 2003 Senior Rx Program Revenues and Expenditures

Area	Amount
Program Revenues ¹	\$2,382,219
Administrative Expenditures	\$2,770,484
Prescription Expenditures	\$10,535,949

¹ Enrollment fees and rebates from pharmaceutical companies.
Source: Senior Rx program data

Seniors paid deductibles and co-payments totaling about \$13 million in fiscal year 2003.

¹ The program is governed by sections 208.550 to 208.571, RSMo Cumulative Supp. 2003, and must be reauthorized by the General Assembly every 4 years.

² Actual selling price between a manufacturer and a wholesaler.

Methodology

We obtained claim information from the claims processor for fiscal year 2003. We tested the reliability of this data through analysis of edit checks and materially agreed the total of claims paid from this data to state payment records. We analyzed the data to determine if controls were working effectively, state laws were complied with, and charges to seniors and the Senior Rx program were correct. We also obtained and tested the reliability of drug pricing information for the Medicaid program at August 2003. The prices for a sample of these records were agreed to pricing information reported by the state to pharmacy providers. No material differences were noted. This data was used to analyze potential changes in pharmacy reimbursements for the Senior Rx program.

We obtained program enrollment records for fiscal years 2003 and 2004 to analyze enrollment trends. We obtained and reviewed the agreement with the program's processing contractor, pharmacy audit reports, and monthly program statistical reports prepared by the contractor. We reviewed internal controls over contract compliance, eligibility and transaction processing.

We reviewed state statutes and regulations for the Senior Rx program and the statutes and regulations for other states' prescription assistance programs. We also contacted officials of Illinois, Indiana, Iowa, Kansas, Maine, Michigan, North Carolina, Pennsylvania, South Carolina, and Wisconsin to obtain information on their programs.

We performed our work between July and November 2003. We obtained comments on a draft of this report during a meeting with the program's executive director on December 17, 2003 and in a letter from the Senior Rx Commission dated January 15, 2004, and incorporated those comments into the report as appropriate.

RESULTS AND RECOMMENDATIONS

1. National Events and Other Alternatives Impact Program's Future

Based on enrollment, seniors have not responded to the Senior Rx program (program) as state officials anticipated. Enrollment was less than half what was anticipated for fiscal year 2003 and declined in fiscal year 2004. The recent federal Medicare drug benefit legislation affects the future of this program. Other state program alternatives and/or private programs may be less costly for seniors and other potential enrollees. State officials must evaluate the Medicare drug benefit's impact on the Senior Rx program and the cost-effectiveness of other alternative drug assistance programs. In addition, the Senior Rx program can do more to assist seniors in evaluating the costs and benefits of prescription drug assistance options relative to their needs.

Enrollment less than expected

Eligible seniors have thus far not enrolled as expected in the program. Of the estimated 150,000 seniors eligible for the program, state officials³ anticipated enrollment of 50,000 and 75,000 in fiscal years 2003 and 2004, respectively. However, less than 22,000 and 19,000 enrolled during fiscal years 2003 and 2004, respectively. Over one-third of the enrollees in fiscal year 2003 received little or no benefit from the program—4,310 did not use their Senior Rx cards and 3,750 used their card at least once but did not meet their deductibles. Further, 83 percent of the enrollees that did not use their card did not re-enroll in fiscal year 2004. Lower fiscal year 2003 enrollment may have resulted from the commission not finalizing the benefit limits, deductibles and enrollment fees until after the enrollment period had ended due to budgetary concerns. Enrollment for fiscal year 2004 began halfway through the fiscal year 2003 program year and only 7 months after the initial enrollment leaving less opportunity to market the program and identify senior's program concerns.

Program officials⁴ increased program marketing for the fiscal year 2005 enrollment period, which ended February 28, 2004. The initiatives included (1) hiring a public relations firm to manage key aspects of the marketing effort, (2) identifying the zip codes in the state where the majority of program eligible seniors live and targeting marketing in those areas, (3) doubling the number of presentations and training events for seniors from the prior year, and (4) providing family practice and geriatric physicians more information about the program.

The enrollment period may also impact program participation. State law⁵ sets the program's open enrollment period, after the first year enrollment period, as the January and February prior to each new fiscal year beginning July 1. As a result, if seniors miss an enrollment period they have to wait up to 16 months to join the program.

Feedback provided to program staff by seniors indicated the limited enrollment period forces some seniors to estimate their household income on applications since they are receiving tax

³ Governor's Senior Prescription Drug Task Force report dated August 30, 2001.

⁴ The Senior Rx Commission and the executive director.

⁵ Section 208.559, RSMo Cumulative Supp. 2003.

documents throughout this period and inclement weather sometimes keeps them from seeking assistance completing the application.

According to program officials, the limited enrollment period was established because of budget concerns. That is, the legislature established the short timeframe to have final enrollment figures before approving program funding. However, extending the enrollment period could benefit seniors without causing budget concerns. For example, the legislature could set program funding at a maximum amount for each fiscal year with program staff estimating the maximum number of seniors that could be enrolled based on that funding. The enrollment period could then be extended, with enrollment ending when the estimated cap was reached or the new fiscal year started.

New federal Medicare program will affect the state program

The recent federal Medicare legislation designed to assist seniors with prescription drug costs also impacts how Missouri's program should be structured. In November 2003, the federal government passed legislation that will add an optional prescription drug benefit to the federal Medicare program, which will be fully implemented in 2006. Coordination of benefits will be necessary for any state programs in place once the Medicare program is implemented. The Medicare legislation caps the first benefit tier at \$2,250 in prescription drug expenditures with no additional federal participation until a senior has \$3,600 in out-of-pocket costs. Appendix I, page 19, shows a comparison of the benefit limits and a senior's maximum out-of-pocket costs for the 2006 Medicare prescription drug benefit and the current Senior Rx program.

During fiscal year 2003, approximately 3,600 Senior Rx program enrollees had program related prescription costs exceeding \$2,250. These seniors would be the only ones to potentially realize any significant benefit from Missouri's program once the Medicare benefit is fully established. Prescription expenditures for these enrollees outside of federal participation limits totaled approximately \$3.7 million in fiscal year 2003.

Other program alternatives are available

As of November 1, 2003, 29 states had pharmaceutical assistance programs in operation. We contacted 10 states to review the details of their programs and compare them to Missouri's program. Many programs were set up similar to Missouri's subsidy program with some level of benefit cap, co-insurance and enrollment fee. Some other alternative program design methods include (1) Medicaid Pharmacy Plus waivers, or (2) discount programs. Some states have set up both subsidy and discount programs covering different populations—not just seniors. Discount programs require less direct state funds, but also provide less savings for seniors or other eligible enrollees.

The federal government recently approved Medicaid Pharmacy Plus waiver projects in six states (Florida, Illinois, Indiana, Maryland, South Carolina and Wisconsin).⁶ Under this waiver, states can provide prescription and over-the-counter drug coverage to Medicare beneficiaries and/or

⁶ Five-year Medicaid Section 1115 Demonstration Waiver projects approved by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services.

people with disabilities who are not eligible for full Medicaid benefits⁷ and with incomes at or below 200 percent of the federal poverty level. Illinois was the first state to be granted such a waiver in January 2002.

Medicaid waiver projects provide a subsidized pharmacy benefit intended to assist individuals with limited income and assets in maintaining their health status to avoid becoming Medicaid eligible. These waivers require budget neutrality for the federal government. Therefore, the federal costs of services can be no more than the cost to provide all Medicaid services to the eligible groups without the waiver. A state operating under a Pharmacy Plus waiver would be responsible for any Medicaid costs above this level. In Missouri, federal matching funds would pay for about 61 percent of waiver program costs.⁸

Before applying, states would need to perform a cost-benefit analysis to evaluate the waiver's cost-effectiveness. Representatives from Illinois, Wisconsin and Florida each told us their cost-benefit analysis determined the waiver to be cost-effective. In November 2003, a Department of Social Services, Division of Medical Services⁹ official said Missouri has only very preliminarily researched the benefits to the state of setting up a waiver and has not applied for one because the first year implementation cost of a waiver would require new state resources and cost containment is the primary focus this fiscal year. This official said the division is monitoring the experience of other states that have implemented such waivers and the details of proposed federal Medicare drug legislation.

The Maine legislature has approved a new pharmaceutical assistance program to start January 2004. This program allows residents with an income at or below 350 percent of the federal poverty level with no prescription drug insurance benefit to receive discounts on drugs. The program requires participating pharmacies to sell covered drugs to qualified residents at Medicaid prices initially and possibly lower prices after October 1, 2004 if the state is able to negotiate secondary discounts with drug manufacturers. Pharmacies will be reimbursed by the state for the difference between the initial discounted price and the secondary discounted price. Program legislation indicates the state is using \$2.8 million in General Revenue monies for initial implementation and operation of the program and plans to use rebates received from pharmaceutical manufacturers to fund at least in part future administrative costs.

Maine's program and the Medicaid waiver programs expand prescription benefits to other low income individuals besides seniors. A Medicaid waiver program, while substantially paid for with federal funding, could ultimately cost a state more than an existing prescription assistance program for seniors due to more citizens being covered. A discount program like Maine's program requires no state subsidy putting less of a burden on a state's budget.

⁷ Under Title XIX of the Social Security Act.

⁸ Federal Register: November 15, 2002 (Volume 67, Number 221) for federal fiscal year ending September 30, 2004.

⁹ State agency responsible for the Medicaid program.

Some seniors could receive better benefits in private programs

We determined some seniors and the state could have saved approximately \$60,000 and \$28,000, respectively, if they had enrolled in private pharmaceutical company's discount programs rather than the Senior Rx program. To evaluate if Senior Rx enrollees could save money in a manufacturers' program, we determined, by manufacturer, the number of enrollees that were only prescribed drugs from either one or two manufacturers during fiscal year 2003. We evaluated claims data for 284 enrollees that were only prescribed drugs from the two brand-name manufacturers with the most recipients from the compiled list.

Most brand-name pharmaceutical manufacturers and other organizations operate discount programs to help low income individuals. In Missouri, citizens can obtain help determining which pharmaceutical program would be best for them from the Community Leaders Assisting the Insured of Missouri (CLAIM) program.¹⁰ A CLAIM official said the organization currently provides assistance to about 50 seniors weekly, and funding limitations could impact the ability to continue the service in the future.

State law¹¹ allows the Senior Rx Commission, subject to appropriation, to establish a clearinghouse to (1) assist all Missouri residents in assessing prescription drug programs, (2) educate the public on quality drug programs and cost-containment strategies, and (3) serve as a resource for pharmaceutical benefit issues.¹² Providing seniors with help identifying other prescription assistance options will allow them to make better informed decisions, save the seniors money and leave more state funding available for seniors for whom the Senior Rx program is more cost-beneficial. The Senior Rx executive director estimated it would take four additional staff to establish a clearinghouse. Since most of the pharmaceutical manufacturers' programs do not allow enrollees to have other insurance, a senior would have to evaluate the benefits of all programs before enrolling in one.

Clearinghouse
has not been
established

Conclusions

The state has a difficult task of achieving a delicate balance in offering seniors some relief from the soaring prescription drug costs while appropriately spending public funds. While Missouri's Senior Rx program is in its infancy, its future is uncertain because of less than anticipated enrollment and national events. State officials must evaluate the cost-effectiveness of alternative programs to determine the appropriate balance of providing seniors cost savings within available state revenues.

By the spring 2004, state officials should have a clearer idea whether or not Missouri's seniors are responding to the current program. If enrollment figures remain less than expected, then an alternative program needs to be considered. By not enrolling, many seniors may be saying they either do not see how the current program benefits them or are not interested in a state program.

¹⁰ Established through the Missouri Patient Care Review Foundation.

¹¹ Section 208.571, RSMo Cumulative Supp. 2003.

¹² The clearinghouse was not funded by the legislature for fiscal years 2003 or 2004.

National events and other practices suggest that other alternatives are being established on a regular basis providing options to replace or augment the Senior Rx program. The implementation of a federal Medicare prescription drug benefit over the next few years will impact the future of the Senior Rx program. Given these choices and alternatives, state officials must evaluate how the existing program could change without duplicating programs and incurring costs that could become the responsibility of the federal government.

Program officials also need to be cognizant of providing seniors with help identifying other prescription assistance options, either public or private, that will allow them to make better informed decisions, save both seniors and the state money, and leave more state funding available for seniors for whom the Senior Rx program is more cost-effective.

Recommendations

We recommend the General Assembly:

- 1.1 Monitor the establishment of a Medicare prescription drug benefit and its impact on Missouri's Senior Rx program. Modify the program as necessary based on the enacted federal program to limit the state's costs, but still benefit seniors in need of assistance.
- 1.2 Consider having the Senior Rx Commission evaluate programs currently operating in other states that could better benefit Missouri citizens.
- 1.3 Evaluate ways to expand the program enrollment period.

We recommend the Senior Rx Commission:

- 1.4 Establish a clearinghouse, as statutorily allowed, to assist seniors on prescription program alternatives.

Agency Comments

The Senior Rx Commission provided the following comments in a letter dated January 15, 2004:

- 1.1 *The Commission will continue to follow the statutory provisions and legislative intent of sections 208.550 through 208.571 RSMo. This recommendation would require consideration by the General Assembly through the legislative process.*
- 1.2 *The Commission will continue to follow the statutory provisions and legislative intent of sections 208.550 through 208.571 RSMo. This recommendation would require consideration by the General Assembly through the legislative process.*
- 1.3 *The Commission will continue to follow the statutory provisions and legislative intent of section 208.559.1 RSMo. This recommendation would require consideration by the General Assembly through the legislative process.*

1.4 *Section 208.571, RSMo Cum. Supp. 2003 does establish a clearinghouse within the Senior Rx Program, for the purpose of educating and assisting seniors and the public with accessing prescription drug programs. The clearinghouse function is by state law, subject to appropriations. No funds have been appropriated for the clearinghouse. If funding is made available, the Commission will proceed with its development.*

Providing the kind of advice and assistance to citizens, as envisioned by the audit report, would require staff who are trained to assess someone's drug usage and needs, and have a good understanding of all the available programs and their individual requirements.

The program staff does supply seniors who do not qualify for this program, or who miss the enrollment period, with information about other programs including programs sponsored by the pharmaceutical manufacturers.

2. Improvements in Management and Oversight and Statutory Changes Would Benefit the Program

We found various factors adversely affected the program's overall effectiveness. Use of alternative reimbursement rates used in the state's Medicaid program could save the program millions annually. Program officials did not ensure state statutes were complied with, evaluate the results of pharmacy audits, review reasons for rejected claims, and establish an effective and efficient applicant income eligibility means test. These problems, at least partially, resulted from management turnover, inadequate consideration of some issues, and program implementation challenges. In addition, program officials cannot ensure the program accomplished intended goals or accountability without a clearly defined strategic plan.

Results-based strategic planning process not implemented

Program officials have less assurance state funds expended for the program are accomplishing intended goals because they have not implemented a results-based strategic planning process and created a program mission statement. As a result, program officials cannot ensure a key element of strategic planning—accountability. Without accountability, taxpayers cannot be assured the program has spent available funding the most effectively. To address strategic planning adequately, program officials must (1) establish specific goals to be achieved, (2) use data to measure and/or report on progress achieved, (3) restrict the number of performance measures used, and (4) assess the impact of other programs and resources when implementing strategies. The program's strategic planning could be included in the Department of Health and Senior Services strategic planning process.

The lack of strategic planning may have been impacted by turnover in the executive director position. Since inception in the fall 2001, the program has had two executive directors and one interim director with the current director taking her position in January 2003.

Medicaid rates for multi-source drugs were lower than Senior Rx rates for those drugs

The Senior Rx program and seniors could have saved over 12 percent of total prescription expenditures (\$2.9 million of \$23.6 million) in fiscal year 2003 by using pharmacy reimbursement options similar to the state's Medicaid program. The Senior Rx program reimburses pharmacies for brand-name drugs at average wholesale price (AWP) minus 10.43 percent and generic drugs at AWP minus 20 percent. The Missouri Medicaid program reimburses pharmacies for prescription drugs at the lesser of:

- AWP minus 10.43 percent
- Missouri Maximum Allowable Cost
- Federal Maximum Allowable Cost
- Price Submitted by the Pharmacy
- Wholesale Acquisition Cost plus 10 percent¹³

¹³ Although the wholesale acquisition cost is a pricing option used by Medicaid, we did not observe any prescription drugs which Medicaid paid for using this option. We did not include it in our analysis of savings to the Senior Rx program.

The Missouri and federal maximum allowed cost rates are set for certain multi-source drugs.¹⁴ Upper payment limit rates are set based on the prices for a brand-name drug and its associated generic versions and normally set near the lowest price for any of the products. The Missouri maximum allowable cost is determined and maintained by the state's Medicaid program. The program's claims processing contractor currently has the federal maximum allowable costs in its claims processing system.

We obtained the August 2003 drug price information for the Medicaid program and compared it to the Senior Rx fiscal year 2003 paid claims. For those drugs with a Missouri or federal maximum allowable cost, the Senior Rx program and seniors could have saved approximately \$2.9 million if these maximum allowed rates had been used as reimbursement options. The specific amount of savings possible for seniors and the program cannot be determined due to co-payment and other issues; however, each would benefit about equally from any potential savings. Table 2.1 shows the savings for a month's supply of six drugs:

Table 2.1: Senior Rx Statutory Pharmacy Reimbursement Rates Compared to Medicaid Pharmacy Reimbursement Rates

Drug Name	Senior Rx Cost	Medicaid Cost	Difference	Percent of Senior Rx Cost
Darvocet®100 mg	\$21.08	\$3.03	\$18.05	85
Furosemide 20 mg	3.36	1.60	1.76	52
Lisinopril 20 mg	25.63	19.17	6.46	25
Lovastatin 20 mg	56.95	37.46	19.49	34
Prozac ® 20 mg	74.71	2.33	72.38	97
Zestril ®10 mg	27.56	17.91	9.65	35

Source: Senior Rx program data and Medicaid drug price data

Part of the state's saving could be offset by less rebate revenue and higher contractor costs charged to manage and implement any change.

Seniors incorrectly charged and pharmacies incorrectly compensated for some brand-name drug transactions

Program officials did not ensure state law was appropriately implemented when seniors received brand-name drugs with a generic equivalent. As a result, 4,540 seniors paid the wrong amount for over 27,000¹⁵ prescription transactions in fiscal year 2003. State law¹⁶ requires, "Generic prescription drugs shall be used for the program when available. An enrollee may receive a name-brand drug when a generic drug is available only if both the physician and enrollee request that the name-brand drug be dispensed and the enrollee pays the coinsurance on the generic drug plus the difference in cost between the name-brand drug and the generic drug." These prescriptions are commonly referred to as "dispense as written" (DAW) prescriptions.

¹⁴ See Appendix II, page 20, for detail on how these rates are set.

¹⁵ Approximately 3 percent of over 800,000 submitted transactions.

¹⁶ Section 208.562 (1), RSMo Cumulative Supp. 2003.

Our review of fiscal year 2003 paid claims for DAW prescription transactions disclosed seniors' coinsurance (40 percent of the cost of the drug) computations were not being done correctly in the reimbursement calculation process. After we discussed this issue with program officials, they reported it to the claims processing contractor for further review. Contractor staff also determined that the difference in cost seniors were required to pay was not based upon a generic drug price as required by statute, but the difference between the pharmacy billed amount and the allowed cost for the brand-name drug. A contractor representative said the claims processing system did not use a generic drug price because there can be multiple generic equivalents for a brand-name drug and no information had been provided by program officials as to which generic cost to use. Claims processor staff presented this issue at the September 30, 2003 commission meeting. As of December 2003, the contractor was implementing system changes based on a proposal provided to the commission.

We further reviewed the paid claims transactions after obtaining this information and identified that pharmacies were underpaid about \$74,000 for the DAW transactions. State law¹⁷ requires pharmacies to be paid the AWP minus 10.43 percent for brand-name drugs and AWP minus 20 percent for generic drugs. For DAW transactions, the program paid pharmacies AWP minus 20 percent for brand-name drugs.

Table 2.2 illustrates all 3 DAW transaction errors for a 30-day prescription for the brand-name drug Mevacor® (20 mg version). The highlighted areas represent the different calculation results for the pharmacy reimbursement amount and the cost responsibilities of the state and senior.

¹⁷ Section 208.562(2), RSMo Cumulative Supp. 2003.

Table 2.2: DAW Transaction Error Example

State's Current Calculation		State Law Calculation	
Brand AWP	\$79.09	Brand AWP	\$79.09
Senior Rx AWP reduction (20% of AWP)	<u>(15.82)</u>	Senior Rx AWP reduction (10.43% of AWP)	<u>(8.25)</u>
Brand Allowed Cost ¹	63.27	Brand Allowed Cost ¹	70.84
Pharmacy Billed Amount	\$79.10	Brand Allowed Cost	70.84
Brand Allowed Cost	<u>(63.27)</u>	Generic Allowed Cost (Generic AWP – 20%) ²	<u>(56.95)</u>
DAW Difference	15.83	DAW Difference	13.89
Co-pay Allocation Total	67.36 ³	Co-pay Allocation Total	61.04 ⁴
State's Percentage	<u>* .6</u>	State's Percentage	<u>* .6</u>
Subtotal	40.42	State's Payment	36.62
DAW Difference	<u>(15.83)</u>		
State's Payment	24.59		
Co-pay Allocation Total	67.36 ³	Co-pay Allocation Total	61.04 ⁴
Senior's Percentage	<u>* .4</u>	Senior's Percentage	<u>* .4</u>
Senior's Co-Payment	26.94	Senior's Co-Payment	24.42
DAW Difference	+ <u>15.83</u>	DAW Difference	+ <u>13.89</u>
Total Paid by Senior	42.77	Total Paid by Senior	38.31

¹The pharmacy would be paid this amount plus a \$4.09 dispensing fee.

²Generic drug Lovastatin was selected as the generic equivalent in this example.

³Brand Allowed Cost \$63.27 + \$4.09 dispensing fee.

⁴Generic Allowed Cost \$56.95 + \$4.09 dispensing fee.

Source: Senior Rx and Medicaid program data

We could not estimate the total over- or under-paid by seniors and/or the state because the generic rates necessary for the calculation have not been determined. Once the commission finalizes the generic drug cost to use in these transactions, program officials will still need to work with the contractor to resolve the pharmacy reimbursement and senior co-insurance calculation problems.

No action taken on pharmacy audits

Program officials failed to review contracted pharmacy audit reports or initiate any follow-up action until we asked about the audit results. While aware of the reports, officials could not provide an explanation why they had not been reviewed. On-site pharmacy audits were required in the Senior Rx claims processor contract. As of September 2003, the processing contractor's subcontracted auditor had completed audits of claim transactions for the fourth quarter of 2002 and the first quarter of 2003. The auditor identified questionable billing records or procedures at 14 of 20 pharmacies audited with recoupments totaling \$4,280 recommended from 11 of these pharmacies. The auditor recommended both further review and recoupments for 8 pharmacies, further review only for 3 pharmacies and recoupments only for 3 pharmacies.

The claims processor contract specified the scope of the audit services as well as optional audit services available. The commission has not elected to receive any optional services. The audits included a general overview of the pharmacy, examination of the pharmacy's practices and procedures and a test of transactions. The majority of the recoupments recommended were due to a lack of the recipient's signature on the claim log or a copy of the prescription was not available. The audit reports recommended two types of further review (1) letters to doctors prescribing or the patient receiving prescriptions to verify the prescription and/or receipt; or (2) an intensive pharmacy audit focusing on the on-site audit concerns.

The first pharmacy audit results were received in early 2003 during the transition period from the interim executive director to the current executive director. As a result of our inquiry, the commission formed a committee in September 2003 to develop policies and procedures for evaluating the pharmacy audits and make a decision on the recoupments. As of December 2003, these policies and procedures had not been finalized.

No review of rejection reasons performed

Program officials did not evaluate trends by pharmacies or reasons for rejected claims to identify correctable issues that unnecessarily increased program costs. The officials could not provide an explanation why such a review did not occur. Our analysis of fiscal year 2003 claims data identified 27 percent of pharmacy submitted claims were rejected, costing the program about \$300,000. For each rejected claim, the program paid \$1.3347 per transaction in fiscal year 2003 and \$0.5746 per transaction during fiscal year 2004.

We also identified 76 pharmacies that submitted at least 1,000 claims during the fiscal year had a rejection rate of 30 percent or higher. Program staff did not review these claims to identify rejection reasons, which would allow program staff to implement pharmacy training or education programs to limit future rejected claims, and, thus, reduce processing costs.

Claims processor edit records indicate claims could be denied for many reasons. For example, if (1) the drug was not covered in the program, (2) the claim is a duplicate to a previously submitted claim, or (3) the claim did not include a valid date of service. For each claim submitted for processing, whether it is paid or not, the claims processor receives a fee under the contract agreement with the program.

More efficient income testing could identify more ineligible applicants

Program staffs' income testing of applicants was not as effective and efficient as possible because results were not obtained and analyzed in an electronic format. As a result, program staff estimated 3 employees worked on the income test up to 60 percent of the time for over 3 months, but only 20 percent of applicants were included in the test. The test results indicate up to 16 percent of the untested population may be ineligible for the program or in the wrong benefit tier, but this population was not further evaluated. The time staff spent on this testing may also have contributed to some of the management weaknesses previously discussed.

To satisfy state law¹⁸ requirements of a eligibility means test, staff decided to test the income submitted for nearly 20 percent (4,200 of about 21,000 applicants) of fiscal year 2004 applicants against DOR property tax credit (PTC) form records. Only 85 percent of the applicants provided a social security number on their application and were included in the potential sample population.¹⁹ About 61 percent of tested enrollees (2,576) matched DOR records. Program staff received hardcopy results from the DOR and manually reviewed the information to determine if any differences occurred that would impact a senior's eligibility. For example, if a single senior's income was reported to the program as \$15,000 and on the PTC form as \$18,000, the senior's eligibility could potentially change to the tier 2 benefit level. Program staff sent letters to seniors whose income listed on their PTC form made them ineligible for the program or placed them in a different benefit tier. The staff said much of the test time was spent handling inquiries from the seniors and follow-up correspondences. The test resulted in 11 percent (298 of 2,576) of matched enrollees changing benefit tiers and 5 percent (116 of 2,576) being removed from the program.

Obtaining and analyzing the test results in an electronic format would allow quicker identification of applicants needing further review and would provide an opportunity to evaluate more applicants to ensure they are in the appropriate benefit tier and eligible for the program.

Pharmacy reimbursement statute needs clarification

Although the pharmacy reimbursement option approved by the Senior Rx Commission saves the program and seniors money, it is not specifically authorized by state law. State law²⁰ says pharmacies shall be reimbursed for brand-name drugs at the AWP minus 10.43 percent and generic drugs at the AWP minus 20 percent. The Senior Rx Commission has approved that pharmacies will be reimbursed the lower of the statute defined rates or the pharmacy's usual and customary price if this option is agreed to by the pharmacy.

As of January 2003, 977 of 1,056 pharmacies had agreed to be reimbursed under the alternative option. Senior Rx staff said approval of the alternative reimbursement option occurred because the commission felt it was the legislature's intent the statutory rates would be the maximum reimbursement allowed. While this interpretation may be what the legislature intended, the law is not worded that way.

Conclusions

Management and implementation challenges have hindered the program's ability to adequately and efficiently serve seniors. Improvements in program management would likely provide additional opportunities for seniors and the state to save on prescription drug costs. Program officials need to develop a strategic plan that clearly establishes program goals to be achieved and ensures accountability of public funds.

¹⁸ Section 208.556.9, RSMo Cumulative Supp. 2003.

¹⁹ Social security numbers are used for the match, but seniors are not required to provide it on the Senior Rx application.

²⁰ Section 208.562, RSMo Cumulative Supp. 2003.

Statutory changes to the pharmacy compensation calculations could reduce costs for seniors and the state and are needed to clarify the meaning. Increased management attention to compliance with state law, and analysis of the contracted pharmacy audits and claims activity is needed to control program costs and ensure seniors and the state pay the appropriate amounts. More efficient eligibility testing could also help limit program costs.

Recommendations

We recommend the General Assembly:

- 2.1 Clarify in Section 208.562, RSMo Cumulative Supp. 2003, if pharmacy reimbursement for covered drugs can be the lower of the providers usual and customary charge or the applicable statutory rate. Add the Missouri and federal maximum allowable costs to possible reimbursement options.

We recommend the Senior Rx Commission:

- 2.2 Develop a strategic plan and mission statement.
- 2.3 Work with the claims processing contractor to ensure pharmacy reimbursement calculations reflect state law and monitor those calculations on a regular basis.
- 2.4 Establish procedures for evaluating pharmacy audit results that ensure all applicable monies are recouped and additional audit procedures are performed when necessary.
- 2.5 Review and evaluate rejected claims data on a regular basis to identify trends or unusual patterns that could be corrected or eliminated resulting in lower contractor processing charges.
- 2.6 Establish eligibility testing that yields the maximum results with minimum expense and staff time. Future results should be obtained in an electronic format and consideration should be made of including all applicants that provided social security numbers in the test.

Agency Comments

The Senior Rx Commission provided the following comments in a letter dated January 15, 2004:

- 2.1 *The Commission will continue to follow the statutory provisions and legislative intent of section 208.562.2 RSMo. This recommendation would require consideration by the General Assembly through the legislative process.*
- 2.2 *The Commission will consider developing a strategic plan and mission statement.*
- 2.3 *The Commission is aware that the claims processing contractor's system was not calculating dispense as written (DAW) claims correctly. The Commission is considering*

what action to take with regard to this failure by the contractor. The Commission will monitor the contractor's pharmacy reimbursement calculations on a regular basis.

- 2.4 The Commission has new pharmacy audit procedures in place that will ensure all applicable monies are recouped and additional audit procedures are performed when the Commission determines they are necessary.*
- 2.5 The Commission will continue to review and evaluate the claims data provided by the claims processing contractor. The Commission is considering possible recoupments from the contractor for any claims incorrectly processed and paid for by the state that are due to contractor system errors.*
- 2.6 The Commission will request that the Department of Revenue provide the program with an electronic format for any data needed to perform the statutorily required income testing.*

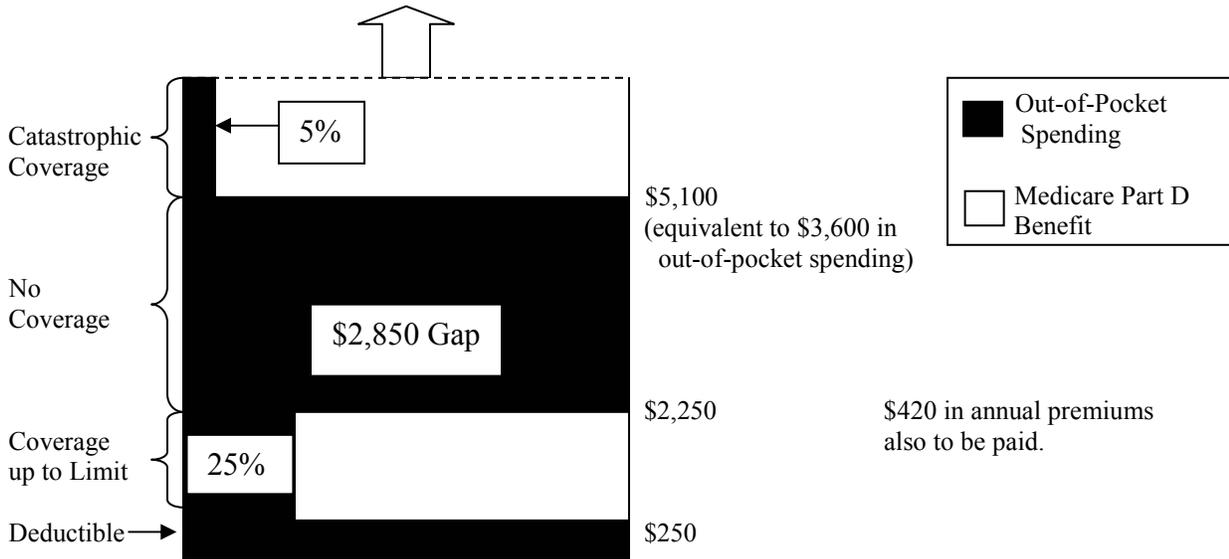
The substantial amount of staff time and associated expense spent on this income testing was not due to the lack of an electronic file from Department of Revenue. The income testing process required that the program send letters to any member whose eligibility was impacted by the testing. Some seniors were determined to be ineligible, which meant they had to be notified in writing, a refund of their enrollment fee had to be processed, and they had to be removed from the system. In some instances, seniors had to be moved from one benefit tier to another, which meant a written explanation about a change to their deductible and either collecting or refunding some of the enrollment fees. These letters and actions caused a great deal of confusion among seniors, which resulted in significant staff time dealing with their concerns and questions. The average age of our membership is 78 years old. The program staff is very cognizant of the needs of this population. So, they make considerable effort to ensure that seniors understand the results of the income testing, and the impact on them.

The Commission is aware that the program staff hope to make this process more efficient, but not at the cost of added confusion and anxiety for seniors.

The Commission will consider expanding the testing to all seniors who supply a social security number on their application, only if the staff confirms that they can administer the additional calls and provide the needed assurances to the seniors affected.

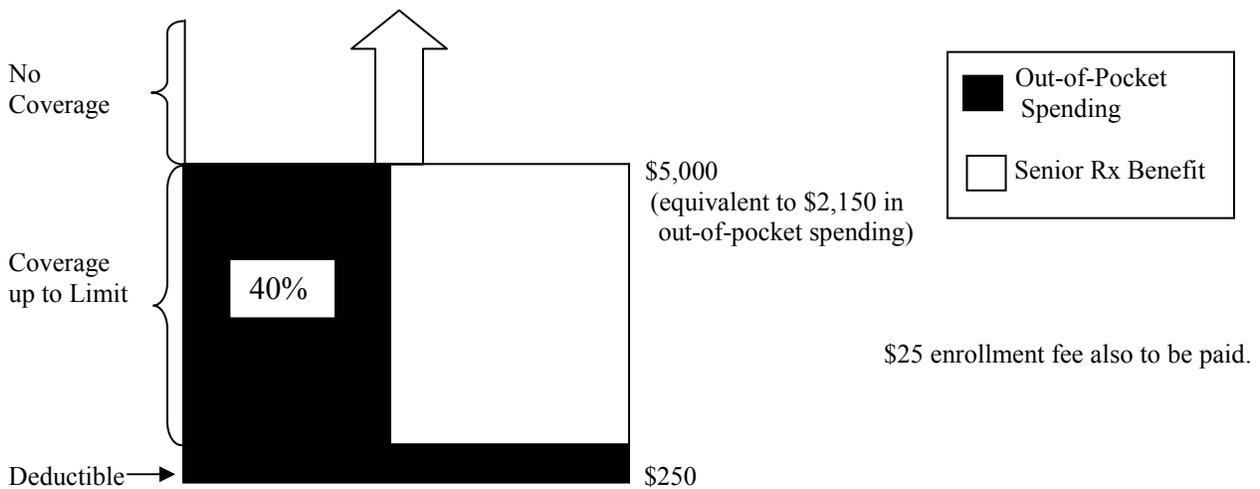
COMPARISON 2006 MEDICARE DRUG BENEFIT AND CURRENT SENIOR RX BENEFIT

2006 Medicare Benefit



Benefit levels are indexed to growth in per capita expenditures for covered Part D drugs. As a result, the Part D deductible is projected to increase from \$250 in 2006 to \$445 in 2013; and the catastrophic threshold is projected to increase from \$5,100 in 2006 to \$9,066 in 2013.

Current Tier I Senior Rx Benefit



The Tier II benefit requires a \$35 enrollment fee, \$500 deductible and maximum out-of-pocket spending of \$2,300.

Source: The Henry Kaiser Family Foundation and SAO analysis

MEDICAID PHARMACY REIMBURSEMENT OPTIONS

Medicaid regulations provide for the pharmacy reimbursement of outpatient drugs using two methods (multiple source and single source).

If a drug is a multiple source drug (brand-name drug and 3 or more generic versions of the drug), then reimbursement is based on the lower of the pharmacist's usual and customary charge to the general public or a federal upper limit amount plus a dispensing fee. The federal upper limit amounts are established by the Department of Health and Human Services, Centers for Medicare and Medicaid Services. The reimbursed amount for the brand-name and associated generic drugs will be the federal upper payment limit amount no matter what the billed cost of the drug. The rate is set based on the prices for each product and normally set near the lowest price for any of the products. Missouri also has established another option (state upper payment limit) which is similar to the federal upper payment limit, but may be set once a brand-name drug has at least 1 but generally 2 or more generic versions versus the federal criteria of 3 or more versions. Pharmacy reimbursement is based on the lower of the pharmacist's usual and customary charge to the general public, the state upper payment limit plus a dispensing fee or the federal upper limit amount plus a dispensing fee (if applicable).

If a drug is a single source drug (brand-name drug), or a generic drug for which a state or federal upper limit amount has not been established, then the reimbursement is the lower of the pharmacist's usual and customary charge to the general public or the estimated acquisition cost plus a dispensing fee. Missouri uses two potential estimated acquisition prices (1) AWP minus 10.43 percent and (2) Wholesale acquisition cost plus 10 percent.