



MICHAEL P. STARKOWSKI
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

TELEPHONE
(860) 424-5053

TDD/TTY
1-800-842-4524

FAX
(860) 424-5057

EMAIL
commis.dss@ct.gov

To: The Honorable Jonathan A. Harris, Co-Chair, Public Health Committee
The Honorable Elizabeth B. Ritter, Co-Chair, Public Health Committee
The Honorable Dan Debicella, Ranking Member, Public Health Committee
The Honorable Janice R. Geigler, Ranking Member, Public Health Committee
Members of the Public Health Committee

The Honorable Paul R. Doyle, Co-Chair, Human Services Committee
The Honorable Toni E. Walker, Co-Chair, Human Services Committee
The Honorable Robert J. Kane, Ranking Member, Human Services Committee
The Honorable Lile R. Gibbons, Ranking Member, Human Services Committee
Members of the Human Services Committee

From: Michael P. Starkowski, Commissioner, DSS
Dr. Martin Anderson, Commissioner, DAS

Date: October 6, 2010

Re: Prescription Drug Purchasing Program Report

Pursuant to PA 09-206, we are pleased to submit the Prescription Drug Purchasing Program Report to the Connecticut General Assembly. The legislation required that several state agencies, in addition to the Office of the State Comptroller, develop a plan for implementing a drug purchasing program in Connecticut, as well as for joining a multistate Medicaid pharmaceutical purchasing pool.

This has been a long and detail-oriented process that began in late summer 2009, when the Commissioners and/or designated staff of the Departments of Social Services, Administrative Services, Insurance, and Public Health, as well as the Office of State Comptroller and the Office of Policy and Management, met on a number of occasions. In the initial meetings, members shared information about pharmaceutical purchasing in their respective agencies, discussed strategies for cost containment and savings, and shared research on national pharmacy purchasing pools. As the committee delved deeper into the issue, the members grew to appreciate the complexities. Therefore, due to the significant amount of work required to ensure that all possible approaches were considered, the committee decided to continue to meet into the current year.

Prescription Drug Purchasing Program Report
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This report summarizes the committee's work and its findings, including options available to the state for implementing a Pharmacy Bulk Purchasing Pool, the savings that may be achieved, and the factors that must be considered in choosing a particular option. The report defines the challenges as well as the cost savings that may result. Because some of the options require legislative action, further review and analysis by the legislature will be the next step in the development of a plan.

Feel free to contact me at 860-424-5053 or Evelyn Dudley, DSS Pharmacy Manager at 860-424-5654 if you would like any additional information.

Thank you and regards.

cc: The Honorable M. Jodi Rell, Governor
The Honorable Brenda L. Sisco, Acting Secretary, OPM
The Honorable Nancy Wyman, Comptroller
The Honorable J. Robert Galvin, Commissioner, DPH
The Honorable Thomas J. Sullivan, Commissioner DOI
Dr. Mark Schaefer
Evelyn Dudley
Anne Foley

Public Act 09-206

Report on Multistate Purchasing Pools and Pharmacy Bulk Purchasing

Presented to the Public Health and Human Services Committees

October 6, 2010

Introduction

This plan is submitted to the Public Health and Human Services Committees of the Connecticut General Assembly pursuant to Public Act 09-206, An Act Concerning Health Care Cost Control Initiatives. The act charges several state agencies with the responsibility of creating a plan for pharmaceutical bulk purchasing in Connecticut.

Specifically, it requires the Commissioners of Social Services and Administrative Services and the Comptroller, in consultation with the Commissioners of Public Health and Insurance to carry out two specific directives: 1) to implement a prescription drug purchasing program and procedures to aggregate or negotiate the purchase of pharmaceuticals for pharmaceutical programs, including HUSKY B, Charter Oak, ConnPACE, as well as for Department of Corrections inmates and individuals eligible for group hospitalization and medical/surgical insurance plans under CGS Sec. 5-259 and 2) to join an existing multistate Medicaid pharmaceutical purchasing pool.

The act requires that the plan be submitted to the Public Health and Human Services Committees and include 1) a timetable for implementation, 2) anticipated costs or savings resulting from its implementation and maintenance, 3) a timetable for achievement of any such savings, and 4) proposed legislative recommendations necessary to implement the plan.

Background

Currently, the Department of Social Services reimburses retail pharmacies for pharmaceuticals written and filled for individuals enrolled in any one of the Connecticut Medical Assistance Programs (e.g., HUSKY, Medicaid, ConnPACE, etc.). The department does not purchase these pharmaceuticals directly, but rather, the pharmacies purchase pharmaceuticals for clients of these programs from wholesalers/manufacturers who are then reimbursed by the department at a rate defined in state statute for brand name drugs.

Approximately \$920 million are spent annually by the Department of Social Services (DSS), the Office of the Comptroller, and contracted for by the Department of Administrative Services (DAS) for pharmaceuticals for the unique populations they serve. Each agency has individualized methods of purchasing, reimbursement and rates

for the pharmaceuticals prescribed for the specific populations under their purviews. The intent of this legislation was to explore savings opportunities which may be available to the state by aggregating the purchase of pharmaceuticals across agencies and/or by joining an existing multistate pharmacy purchasing pool.

Purpose

This report summarizes the options available to the state for implementing a Pharmacy Bulk Purchasing Pool (PBPP), the savings that may be achieved, and the factors that must be considered in choosing a particular option. The report defines the challenges as well as the cost savings that may result. Because some of the options require legislative action, further review and analysis by the legislature will be the next step in the development and eventual implementation of a plan.

Process

Beginning in late summer 2009, the Commissioners and/or designated staff of the Departments of Social Services, Administrative Services, Insurance, and Public Health, as well as the Office of State Comptroller and the Office of Policy and Management, met on a number of occasions. In the initial meetings, members shared information about pharmaceutical purchasing in their particular agencies, discussed strategies for cost containment and savings, and shared research on national pharmacy purchasing pools. Attachment A provides a comparative analysis of state agency pharmaceutical purchasing.

As stated in the December 30, 2009, letter from Commissioner Starkowski and former DAS Commissioner Sisco to Governor Rell, the committee members decided that due to the significant amount of work required to ensure that all possible approaches were considered, the committee decided to continue to meet into the current year. Specifically, the committee decided that Connecticut could benefit greatly from the expertise of the national Pharmacy Benefits Administrators (PBA) who have experience with Pharmacy Bulk Purchasing Pools (PBPP).

There are currently five national pharmacy purchasing or supplemental drug rebate pools approved by the Centers for Medicare and Medicaid Services (CMS). These five pools harness the purchasing power of forty-four states, the District of Columbia, and the cities of Chicago and Los Angeles for Medicaid, hospitals, clinics, public employees, and various pharmacy programs.

The committee gathered information on all five CMS approved PBPPs and agreed to meet with three of the five PBAs that administer the respective purchasing pools. The two that were not chosen do not serve Medicaid or public employee programs and therefore were not deemed as meeting the intent of this legislation.

The PBPPs were offered an opportunity to present their system, their processes and the

potential financial benefits to Connecticut for joining their purchasing pool. Each entity was provided statistical and financial data for each participating state agency in order to provide more accurate financial savings for Connecticut. The meetings were held with the following entities on the dates indicated:

- Goold Health Services/Sovereign States Drug Consortium – February 25, 2010
- Provider Synergies/The Optimal PDL SolutionSM (TOP\$SM) Program – March 4, 2010
- Magellen Health Services/Benefit Management Solutions – March 4, 2010

After meeting with the three PBPPs, the committee engaged in several follow up internal discussions to determine what options were viable in Connecticut. In order to enhance the comprehensiveness of this report, on August 17, 2010 the committee met with representatives of other state agencies who purchase or pay for pharmaceuticals for individuals under their care. Representatives of the Department of Correction, Department of Developmental Services, Department of Mental Health & Addiction Services, Department of Children & Families-Riverview Hospital, UConn Health Center/John Dempsey Hospital, in addition to Department of Social Services, Department of Administrative Services, and Office of the Comptroller, Department of Public Health and the Office of Policy & Management were in attendance. The purpose of this meeting was to gain an understanding of pharmacy purchasing arrangements in place outside of the retail pharmacy setting. Each entity provided an overview of the populations they serve, their individual pharmaceutical programs, the needs of their agency and the clients they serve and the venue in which pharmaceuticals are provided and reimbursed.

Based on subsequent meetings and discussions, the committee feels that the process is complete and all of the necessary information has been gathered, reviewed, and discussed. The following sections present the options available to Connecticut, the pros and cons of each, and the potential savings to be achieved.

Multi-State Purchasing Pool

Public Act 09-206 directed the committee to develop a plan to have the state join a multistate Medicaid pharmaceutical purchasing pool. In a letter dated September 16, 2010, from Commissioner Starkowski to Provider Synergies the state of Connecticut approved the implementation of Connecticut's Medicaid Preferred Drug List and supplemental rebate programs into Provider Synergies Multi-State PDL Initiative, TOP\$SM - The Optimal PDL SolutionSM. DSS is preparing the appropriate State Plan Amendment for submission to the Center for Medicare and Medicaid Services to receive federal approval of this action. Savings for this state fiscal year will be contingent on the CMS approval date.

The Department of Social Services currently contracts with Provider Synergies for the design, implementation, and management of the State's Preferred Drug List (PDL). The TOP\$ program is a multistate Medicaid-only pharmaceutical purchasing pool with seven

states currently participating: Delaware, Idaho, Louisiana, Maryland, Nebraska, Pennsylvania, and Wisconsin. Joining this pool will produce additional savings, while also maintaining control of the existing PDL and existing DSS Pharmaceutical & Therapeutics Committee.

The anticipated savings associated with joining TOP\$ is approximately \$6 to \$7 million annually based on the preferred drug list that existed in SFY 2010. Since DSS currently contracts with Provider Synergies and has been offered the option to join TOP\$ without any modifications to the existing PDL, through the notification letter signed by DSS Commissioner Starkowski, the Department officially joined TOP\$ on September 16, 2010.

Pharmacy Purchasing Options

The committee identified two viable options for achieving substantial state savings in pharmacy purchasing.

Bulk Purchasing

State employee and retiree pharmacy programs administered through the State Comptroller's Office aggregate the purchase of pharmaceuticals through a Pharmaceutical Benefits Manager (PBM) contract with Caremark. If the participating state agencies execute a contract with a PBM, similar to that currently utilized by the state comptroller's office, they can aggregate and negotiate the purchase of pharmaceuticals across all agencies and several state programs, thereby achieving substantial savings to the state through a reduction in reimbursement to pharmacies.

In order to achieve this, DSS and the other retail purchasing state agencies could be required to join the state's existing prescription drug program administered by the Comptroller for the state employee and retiree prescription drug plan. Specifically, these programs would be included under the existing Caremark PBM, which would allow the State to receive greater pharmacy product discounts, reduce dispensing fees, allow for national network coverage, and enable DSS to continue to receive federal and supplemental rebates.

A financial analysis was conducted in order to determine the impact of moving DSS programs under the state employee/retiree prescription drug plan administered by Caremark on behalf of the Comptroller. The State Comptroller's Office requested basic claims information from the Department of Social Services in order to have its actuarial consultant, Milliman, conduct an analysis. DSS provided current reimbursement methodologies, current dispensing fee, total pharmacy expenditures, and total scripts filled, in order for Milliman to project potential savings from joining the Caremark PBM. Based on existing terms included in the Caremark contract with the Comptrollers Office, Milliman concluded that potential annual savings in the area of **\$70 million** could be achieved. These potential savings are based on deeper pharmacy reimbursement

discounts and a lower dispensing fee, as compared to the existing DSS reimbursement rates.

As stated previously, the committee met with three national PBAs that administer purchasing pools and carefully considered the option of joining one of those pools. However, in our meetings, the three national PBAs expressed their concerns and identified potential problems that might occur by joining one of their purchasing pools. These state purchasing coalitions are primarily Medicaid-based and thus provide a limited network and only include pharmacies located in the states represented in the coalition. This could pose a problem for Connecticut given the significant numbers of state retirees who relocate to other states, as this creates a need for the State employee and retiree pharmacy purchasing to have access to a seamless national network of retail pharmacies.

Another challenge posed by joining one of the three national PBAs stems from the fact that Medicaid plans are eligible for both federally negotiated rebates and coalition negotiated supplemental rebates from the drug manufacturers that the employee and retiree plans are not eligible to receive. While rebates are required for federal programs and some state administered programs such as ConnPACE, no mechanism presently exists for the employee and retiree plans to receive rebates.

Given the concerns raised by the national PBAs, the committee determined that it would not recommend joining a multi state PBA. In lieu of this alternative, if the legislature's intent is to obtain the maximum savings, it can consider having all state agencies join the existing prescription drug program administered by the Comptroller for the state employee and retiree prescription drug plan (Caremark) or statutorily change the reimbursement rates paid by state agencies to pharmacies.

Contracting with Caremark for this purpose poses its own set of challenges, some of which were raised by CMS, with whom the committee also consulted as part of this process. The following concerns with regard to contracting with Caremark were raised:

- This would in effect be a “sole source” contract which would require the approval of the Office of Policy and Management.
- “Sole sourcing” could add additional costs to the contract with Caremark.
- Caremark is affiliated with CVS which could create the perception that CVS would be the only network pharmacy, which in reality, would not be the case.
- CMS advised that if we did merge all programs under Caremark, they would be required to maintain the state employees/retirees separate and distinct from the programs administered by DSS for purposes of claims adjudication/drug rebate processing.
- Caremark would need real time access to client eligibility for point of sale processing of pharmacy claims. This would be burdensome and costly and require interfacing with DSS' fiscal intermediary Hewlett Packard (HP).
- For federal claiming purposes, it may be necessary for claims to be adjudicated through the Medicaid Management Information System (MMIS); meaning that

Caremark may have to establish a distinct interface with their system, participating pharmacies and the DSS HP MMIS.

- At a minimum, for rebate purposes, claims must be passed through the Medicaid Management Information System (MMIS); meaning that Caremark would adjudicate the claim and would need to set up an interface with HP to pass along the claims for rebate purposes. While DSS has not costed out the individual interfaces required and the systems changes necessary to meet the federal reporting/claiming requirements, it should be noted that determining the specifications for these automated system enhancements, developing these enhancements and implementing these enhancements would require funding, staff resources and time.

Adjust DSS' Reimbursement Rates

Given the challenges presented by aggregating all state pharmaceutical purchasing under Caremark, CMS advised the committee that making adjustments to our existing state statutes and state plan to mirror the rates of the state employee and retiree program would be a more efficient and less burdensome way to achieve savings.

Thus, another option that could be considered by the legislature to achieve significant savings in pharmacy purchasing, is to adjust DSS' reimbursement rates in statute to mirror the reimbursement rates paid on behalf of state employees. Should the legislature direct DSS to adjust its reimbursement rates to align with those of paid on behalf of participating state employees, DSS could achieve savings in the range of the Milliman projections.

As stated above, CMS informed the department that were we to aggregate all state pharmaceutical purchasing under Caremark, the implementation of rebate invoicing/collection would require that pharmacy claims be passed through the Medicaid Management Information System (MMIS). If pharmacy claims were no longer processed and adjudicated through our current claims processor, HP, an interface would need to be established between the PBM and the MMIS (HP). As stated above, this would require funding, staff resources and time for the significant programming that would be required to implement such an interface.

In addition, CMS pointed out that DSS obtains savings not only from rebates, but also from reduced reimbursements to pharmacies. In Connecticut, the discounts received from local pharmacies are set either by statute or by negotiation at the state or coalition level. For the State employee and retiree plan, the prescription drug discounts are established through competitive bidding among the largest Pharmacy Benefit Managers in the nation. In Connecticut, the State employee and retiree prescription drug purchasing discounts with Caremark are currently substantially greater than the discounts established by statute for programs administered by the Department of Social Services.

Accordingly, adjustment of DSS' rates without involvement of a PBM is in line with CMS' advice and addresses the concerns they raised with regard to bulk purchasing.

An amendment to our existing state statutes and Medicaid state plan would be required to implement reimbursement rate changes.

Either the bulk purchasing option through a pharmacy benefit administrator or the reimbursement rate adjustment through a statutory change option has the potential for significant savings, achieved, in both cases, through the adjustment of pharmacy reimbursement rates. A decision on the appropriate course of action to pursue to achieve the savings now lies with the legislature. Only with the proper statutory authority can the participating agencies amend existing contracts and achieve anticipated savings. Should the legislature choose to merge all pharmacy purchasing under Caremark, sole-sourcing authorization would also be required from the Office of Policy and Management before we could move forward with implementation.

With either option, the savings identified will significantly reduce reimbursement rates to participating chain and local pharmacies. With either option, we estimate that savings can begin to be achieved within the first quarter after implementation.

Additional Savings Opportunities

After holding meetings with representatives from various other state agencies that provide/ dispense/pay for pharmaceuticals for individuals they serve, the committee has identified other opportunities for savings that may be available and should be pursued. Unlike DSS and the State Comptrollers Office, the prescription drugs prescribed for the individuals served by these agencies are not dispensed in the retail pharmacy setting. Rather, there are two distinct arrangements under which these agencies purchase pharmaceuticals.

First, several agencies purchase and dispense medications to patients while they are in an inpatient setting. These agencies also purchase and dispense medications for patients receiving outpatient services in their clinics, such as chemotherapy treatments.

The second purchasing arrangement is through a contract with a wholesaler, Cardinal Health. For instance, John Dempsey Hospital purchases the majority of its medications through this wholesaler. The hospital receives a discounted price due to the large volume of their purchases. Most of the contracts for the pharmaceuticals that are purchased are negotiated through the Novations group purchasing organization. Novations group represents 40% of the staffed hospital beds in the country. With this arrangement, there are millions in savings to the hospital through the Cardinal contract.

The following state facilities with pharmacies are included in the Cardinal contract – Connecticut Valley Hospital, Blue Hills Hospital (orders separately but is now under Connecticut Valley Hospital); Southwest Mental Health Systems (which includes Bridgeport Mental Health Hospital and FS DuBois Center); Capitol Region Mental Health Center; CT Mental Health Center; Department of Public Health; UCONN

Infirmary; John Dempsey Hospital and Correctional Managed Health Care. The Department of Mental Health and Addiction Services (DMHAS) and Department of Public Health (DPH) also benefit from the savings that John Dempsey Hospital receives through their contract with Cardinal Health/Novations. Memorandums of Understanding (MOUs) have been in place between those agencies and UConn Health Center (UCHC) since 2004 enabling those agencies to reap the same discounts/savings.

Additionally, in April 2009, John Dempsey Hospital qualified for 340b status. Hospitals with 340b status are able to purchase medications for their outpatients at highly discounted prices. In order to receive these 340b discounts, the individual must be a patient of a physician on the John Dempsey staff. Since qualifying for 340b status, the state has realized savings of approximately \$3.4 million; \$2.4 million by John Dempsey Hospital and \$1 million by the Correction Managed Health Care (for prison inmates).

A financial benefit may be gained by agencies that purchase pharmaceuticals from non-retail sources to join forces by joining the Novation group purchasing organization or a similar entity. The committee and representatives from these agencies will continue to meet to discuss and pursue any further opportunities that may be available to them.

Conclusion

This report presents one provision that has been completed by the Department of Social Services and two options available for consideration that would achieve significant savings in the purchase of pharmaceuticals for state programs.

- Multi-State Purchasing Pool - In a letter dated September 16, 2010, from Commissioner Starkowski to Provider Synergies, the State of Connecticut approved the implementation of Connecticut's Medicaid Preferred Drug List and Supplemental Rebate Programs into Provider Synergies Multi-State PDL Initiative, TOP\$SM - The Optimal PDL SolutionSM. The anticipated savings associated with joining TOP\$ is approximately **\$6 to \$7 million** annually.

The following two options would result in estimated savings of approximately \$70 million each. While only one can be selected, we present them to the legislature for further review and consideration. It should be noted that in choosing either option, the legislature should take into consideration the impact that it will have on the participating pharmacies.

- Bulk Purchasing - State employee and retiree pharmacy programs administered through the State Comptroller's Office aggregate the purchase of pharmaceuticals through a Pharmaceutical Benefits Manager (PBM) contract with Caremark. If the Comptroller's Office executes a contract amendment with Caremark to include DSS through their existing contract or if DSS enters into a contract with another PBM, similar to the Caremark contract terms, they can achieve substantial savings to the state through a significant reduction in reimbursement to

pharmacies. Milliman concluded that potential annual savings in the area of **\$70 million** could be achieved in DSS. With potentially other state agencies participating, greater savings could be achieved.

- Adjust DSS' reimbursement Rates - Adjust DSS' reimbursement rates in statute to mirror the reimbursement rates paid on behalf of state employees (in line with the terms of the Caremark contract). Savings could be achieved in the range of **\$70 million in DSS.**

With the release of this report, the committee has fulfilled its obligations under PA 09-206 and awaits the legislature's action. Department representatives are available to discuss the report and answer any questions you may have.

Bulk Purchasing Report Attachment

State Agency	Total # of Scripts	Total Expenditures	Reimbursement Methodology	Brief Descriptive Overview of Program
DSS	8,984,216	\$599,480,082.85	For Brand Drugs: AWP-14% For Generic Drugs: AWP-50% Dispensing Fee: \$2.90	Provides outpatient prescription drug coverage managed internally by the Dept. for all CT Medical Assistance Programs (Medicaid fee-for-service, HUSKY A/B, ConnPACE, CADAP, and Charter Oak. Current reimbursement is AWP-14% for brand drugs and AWP-50% for generics with \$2.90 dispensing fee. We receive federal and supplemental rebate from manufacturers. The supplemental rebate is received from those manufacturer's whose drugs are on our Preferred Drug List. Last year we received \$188 million in federal plus supplemental rebate. Cost saving controls currently in place include prospective and retrospective drug utilization review, a preferred drug list, prior authorization for brand medically necessary, early refill, preferred drug list, optimal dose, and certain high cost drugs.
DCF	12,947	\$849,339.09	For Brand Drugs: AWP-20% For Generic Drugs: AWP-50% Dispensing Fee: \$2.75	DCF Riverview Hospital purchases prescription drugs as well as frequently used over the counter medications through an outside pharmacy via a DAS Purchasing contract (09PSX0052) as awarded through the state competitive bidding process. Riverview Hospital does not have an in-house Pharmacy. The contracted pharmacy adheres to all Hospital rules/regulations and the Medication Management standards of the Joint Commission. A registered consultant pharmacist provides oversight and supervision of the pharmacy services and the prescribing practices of the hospitals LIP's The pharmacy services are available to the hospital 24/7/365 year. All other DCF service recipients are on HUSKY A/B.
UCONN/John Dempsey	N/A	\$14,266,381	Reimbursement for hospital services varies widely by payor, for example, Medicare pays for inpatient hospitalization based on a DRG amount, HMO's may pay a per diem or case rate amount for similar services. For outpatient services, Medicare will pay a set	JDH purchases and dispenses medications for inpatient use and for patients receiving treatment at UCHC outpatient clinics (ie. chemotherapy treatments). The JDH Pharmacy does not purchase pharmaceuticals for patients to be administered in the home setting. JDH has a contract with Cardinal Health Wholesale to provide the vast majority of medications for the hospital and CMHC inmate population. In addition, the UCHC contract pricing is available to DMHAS, DPH and the UConn Infirmary. Contracting services are provided by "Novation" through the University Health Consortium. JDH qualifies for 340B pricing enabling the Hospital to purchase medications for outpatients at highly discounted prices.

Bulk Purchasing Report Attachment

<p>DMHAS</p>	<p>Annual Inpatient Pharmacy Orders - CRMHC: 14,534 CVH: 150,432 Annual Outpatient Scripts - CRMHC: 4,313 CMHC: 10,381</p>	<p>CY09 \$8,269,953.16</p>	<p>N/A</p>	<p>Drugs for DMHAS clients (inpatient and some outpatient) at the four large facilities : CVH (Blue Hills Hospital), CMHC, CRMHC and SWMHS are paid through the UCHC/DPH/DMHAS agreement with Cardinal/Novation. Some DMHAS outpatient clients at our three small facilities (RVS, SMHA, WCMHN) use a retail pharmacy. The retail pharmacy is told to bill either Medicaid or Part D Medicare where applicable. If the outpatient client does not have an entitlement, DMHAS pays the retail pharmacy through a DAS contract or a Purchase Order. DMHAS expenditures have decreased SFY10 over SFY09 due to increased use of generic drugs, increase in client entitlements and the closing of Cedarcrest Hospital.</p>
<p>DDS</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>	<p>During the period noted above, DDS did not incur any prescription drug costs since all DDS clients receive Title XIX benefits which covers the cost of their prescriptions. DDS clients receive their drugs via pharmacy delivery on a regular and STAT basis. As of June, 2010, we have been informed that certain food supplements that were previously covered by Title XIX will no longer be covered, which will result in DDS purchasing these types of pharmaceuticals utilizing DDS funds. At this time, we do not know the overall impact on the DDS budget.</p>
<p>DOC</p>	<p>CMHC pharmacy estimates 24,000 prescriptions for discharge and Half way house patients annually in addition to filling 100% of the orders for the inmate population</p>	<p>\$13,700,828</p>	<p>CMHC does not bill any 3rd party payors. The MOA between UCONN CMHC and DOC explains the invoice reimbursement</p>	<p>CMHC pharmacy participates in the Cardinal Health contract with JDH and uses the same pharmacy group purchasing organization for contract management(novation). CMHC pharmacy accesses 340b pricing for JDH outpatient inmates as a child account linked to the JDH DSH qualified 340B account with Cardinal Health. CMHC provides prescription services for the inmates in the custody of the Department of Correction housed in jails, prisons, halfway houses and a 2 week discharge program. CMHC pharmacy manages a state wide formulary and participates in both medical and mental health pharmacy and therapeutics committees overseeing the formulary. CMHC pharmacy packages all solid oral dosage forms in a tamper evident packaging to allow for maximum recovery of discontinued prescription orders and maximizing savings on the dispensing of these recovered medications. No employee or non inmate prescriptions are filled by the CMHC pharmacy.</p>

Bulk Purchasing Report Attachment

<p>State employee and retiree program</p>	<p>3,540,000</p>	<p>\$315,000,000</p>	<p>For Brand Drugs: AWP-18.5% For Generic Drugs: AWP-68% Dispensing Fee: \$1.50</p>	<p>OSC contracts with a PBM (Caremark) for prescription drugs through retail pharmacies nationwide, specialty pharmacy, and mail order. Hospital, physician and other institutionally dispensed drugs are paid by the medical plan. Caremark contracts directly with the retail and specialty pharmacy groups and pays claims directly to those groups. OSC is invoiced twice per month for claims. Manufacturer's rebates are processed through Caremark and are allocated to each script filled.</p>
<p>DPH</p>	<p>1,000,000</p>	<p>\$8,895,843</p>	<p>none...all 340b pricing</p>	<p>DPH provides pediatric vaccines to health care providers at no cost. Providers can not bill insurance or patients for the vaccine but can bill DSS up to \$21.00 for administration. DPH also provides medication to TB patients that are unable to pay and do not have health insurance. ALL medications that DPH provides are free to clinics/hospitals/providers.</p>