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Agency of Human Services

M E M O R A N D U M

TO: Joint Fiscal Committee; Health Care Oversight Committee

CC: Mark Larson, Commissioner, Department of Vermont Health Access
Douglas A. Racine, Secretary, Agency of Human Services

FROM: Nancy Hogue, Pharm.D., Director of Pharmacy Services

DATE: July 26, 2013

RE: Follow-up on Memo Dated July 12, 2013; Legislative report: 33 V.S.A. §1998(c)(6) for Quarters 1, 2, 3 and 4 of State Fiscal Year 2013 (July 1, 2012, through June 30, 2013)

On July 12, 2013, the Department of Vermont Health Access (DVHA) submitted a memo to the Joint Fiscal Committee and the Health Care Oversight Committee regarding reporting required in 33 V.S.A. §1998(c)(6). Several committee members raised questions about the DVHA's efforts to explore a joint pharmaceuticals purchasing consortium. This memo provides a response to those questions.

1) **Why can't the OBRA program be used by other state programs within AHS? What is the barrier? Should that be reexamined or questioned?**

   Authority for DVHA's pharmacy programs falls under Title 19 of the Social Security Act and applies only to beneficiaries who are eligible for Title 19 programs (http://www.ssa.gov/OP_Home/ssact/title19/1900.htm). This Act dictates that manufacturers who participate in Title 19 (Medicaid) must sign a rebate agreement with CMS and provide rebates back to the states using a pre-defined formula set by the federal government (Chapter 1927). For Vermont, this means that anyone not covered under the Global Commitment Waiver is not eligible to receive drugs under this special pricing methodology

2) **How does a population specific arrangement negate the value of a establishing a consortium for the purpose of leveraging price? Who defines the "population"?**

   The drug needs of each of the state's drug programs (DOC, DMH/VSH, VDH, and DVHA) is quite unique and complex. It is difficult to imagine a state-established consortium that would work to secure more competitive pricing for the state than the current open and competitive bidding process that occurs today. DVHA's unique drug pricing arrangements are not applicable to other areas within the state due to federal prohibitions.

   DVHA believes there are possible opportunities for cost savings through better coordination of care between Departments, for example, between DOC and DVHA to better manage substance abuse in Medicaid eligible populations. Currently, DVHA works collaboratively with VDH and DMH to manage certain conditions and programs (such as drug treatment for mental health

disorders, and the coordination of vaccine programs).

3) **What is the actual data? I expected there would be an analysis and comparison of costs completed on the most frequent drugs used/ prescribed. Was there?**

Since there was no real opportunity to consolidate purchasing, a financial analysis was not performed.

4) **Each agency or department has its own drug purchasing program, each presumably paying different (at least for many drugs) prices for the same drugs, but is this overall in the best financial interest of the agencies and departments? And the feds prohibit other agencies and depts from utilizing the DVHA deal with the feds?**

Yes, this is correct. The areas within the state that were examined in 2009 included Corrections, Department of Health, Department of Mental Health (including VSH), and State Employees. Each contracts with specialty pharmacy vendors or purchasing groups specific to the site of service. The Corrections and State Employees contracts with pharmacy vendors were obtained through an open and competitive bidding process with other vendors who specialize in those unique services. VSH participated in hospital-based group purchasing consortiums, or hospital group purchasing organizations (GPO's). VDH obtains vaccines through special pricing obtained through the Centers for Disease Control. There are many niche players in the pharmacy world. For example, there are pharmacy vendors who specialize in managing the Corrections population since they have unique and specific needs. These same vendors are not likely to offer pharmacy services to the commercial or Medicaid populations. The most likely area for consolidation of vendors (and therefore joint purchasing) is between the DVHA Global Commitment populations and the State Employees. Under the single payer plan, it is envisioned that single payer would encompass those insured through DVHA as well as State Employees. This would however need to be negotiated through the bargaining unit.

5) **Is there a way to allow all departments of state government to get in on DVHA's program, if it actually gets the lowest prices? What prohibits this from happening?**

As mentioned previously, the authority for DVHA's pharmacy programs falls under Title 19 of the Social Security Act and applies only to beneficiaries who are eligible for Title 19 programs http://www.ssa.gov/OP_Home/ssact/title19/1900.htm. This Act dictates that manufacturers who participate in Title 19 (Medicaid) must sign a rebate agreement with CMS and provide rebates back to the states using a pre-defined formula set by the federal government (Chapter 1927). For Vermont, this means that anyone not covered under the Global Commitment Waiver is not eligible to receive drugs under this special pricing methodology.

6) **Is the intent of this requirement that the legislature be sure that DHVA pursues all possible avenues for cost savings?**

Yes. However, this is a complex system, and not easily consolidated.