California State Auditor

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State of California:

Its Containment of Drug Costs and Management of Medications for Adult Inmates Continue to Require Significant Improvements

January 2002
2001-012

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CALIFORNIA STATE AUDITOR

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January 9, 2002 2001-012

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As required by Chapter 127, Statutes of 2000, the Bureau of State Audits presents its audit report concerning the State's procurement of drugs and medical supplies.

This report concludes that the State's procurement process for drugs and medical supplies still requires significant improvement. Expenditures for drugs by the five state agencies most frequently purchasing drugs increased by an average of 34 percent annually, from $41.6 million in fiscal year 1996–97 to $135.1 million in fiscal year 2000–01. The Department of General Services has explored a variety of options, but has not gone far enough in improving this process. For example, it needs to more fully explore contracting directly with group purchasing organizations to ensure that the State is purchasing drugs at the lowest available price. Moreover, the State lacks a statewide process for purchasing medical supplies.

The report also concludes that the Department of Corrections' (Corrections) Health Care Services Division continues to have significant weaknesses that prevent it from effectively monitoring its pharmacies' purchase of drugs. Specifically, as of November 2001 it had not updated its formulary nor did it monitor compliance with the existing one. The purpose of the formulary is to promote the appropriate and cost-effective use of medications. It also lacks a utilization management program for drugs that could assist it in reducing costs. Also, pharmacy staff do not review monthly reports to ensure that drug purchases are cost-effective. Further, its pharmacy prescription tracking system cannot support monitoring, cost-containment, or day-to-day management of pharmacy services. However, Corrections does not intend to replace this system until 2006, and the development of the new system is already behind schedule. Finally, we found that Corrections is not eligible for some options, such as the State's AIDS Drug Assistance Program and the federal General Services Administration's supply schedule.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

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SUMMARY

Audit Highlights . . .

Our review of the State's drug and medical supply procurement practices reveals:

- ☑ *Annual expenditures for the five agencies most frequently purchasing drugs increased by an average of 34 percent per year between fiscal year 1996–97 and fiscal year 2000–01.*
- ☑ *The Department of General Services has explored a variety of options, but it has not gone far enough in improving the State's drug procurement process. Moreover, the State needs a statewide process for contracting for medical supplies.*
- ☑ *The Department of Corrections' (Corrections) Health Care Services Division continues to have significant weaknesses that prevent it from effectively monitoring its pharmacies' purchases of drugs, such as:*
  - *As of November 2001 it had not updated its formulary nor monitored compliance with the existing one.*
  - *It lacks a utilization management program that can assist in reducing costs.*

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RESULTS IN BRIEF

The Department of General Services (General Services) and state agencies such as the Department of Corrections (Corrections) could do more to control the State's drug expenditures, which exceeded $135 million in fiscal year 2000–01. From fiscal year 1996–97 to fiscal year 2000–01, annual expenditures for the five state agencies most frequently purchasing drugs increased by more than 200 percent. The average annual increase in purchases during this period was 34.3 percent, a rate that is almost three times higher than the national average annual rate of increase for drug purchases, 12.7 percent. Given these significant numbers, the State should be concerned about controlling additional increases.

General Services, the primary purchaser for the State, negotiates agreements with drug manufacturers and a wholesaler (prime vendor) who distributes the drugs to state agencies. Because of several reasons, such as the State's purchase volume being too low to generate enough interest and its belief that some bidders are unwilling to do business with the State, General Services has obtained contracts with only 45 manufacturers for 850 of the 1,838 items it requested. To increase the number of drugs available to state agencies at lower prices, General Services recently contracted with another state to gain access to a group-purchasing organization; however, this contract may not offer the best deal to the State. To improve its procurement process further, General Services has led efforts to develop a statewide *drug formulary,* a listing of drugs that is to promote appropriate and cost-effective use of medications, but has not ensured that state agencies will be able to enforce it. Currently, Corrections, which was responsible for roughly 68 percent of the State's drug purchases in fiscal year 2000–01, has an outdated formulary and lacks sufficient data to perform drug-utilization reviews that can identify questionable prescribing practices. The State also needs a statewide process for contracting for medical supplies. State agencies' inability to identify specific details on the types and amounts of medical supplies they purchase—in fiscal year 2000–01 this amount was roughly $14 million—hinders General Services' plan to contract with a vendor that already has a medical supply catalog in order to reduce these costs by soliciting bids for better prices.

- *Its pharmacy staff do not regularly review monthly reports to understand if purchases are cost-effective.*
- *Its pharmacy prescription tracking system cannot support monitoring, cost-containment efforts, or day-to-day management of pharmacy services.*
- *Corrections does not plan to replace this system until November 2006, and development of the new system is already behind schedule.*

☑ *Finally, we found that Corrections is not eligible for some options, such as the AIDS Drug Assistance Program and the federal supply schedule.*

Corrections spent $91 million in fiscal year 2000–01, or two-thirds of the State's expenditures from the prime vendor contract, to provide health care to more than 159,000 inmates. Its Health Care Services Division (Health Care Services), due to inadequate monitoring of management and delivery of health care, missed the opportunity to use its formulary process to identify those medical practitioners with prescribing practices that are not cost-effective. Health Care Services also does not control its pharmacies' drug ordering to ensure cost-effective purchases.

A major hindrance to improving Corrections' current drug procurement process is Health Care Services' inadequate prescription tracking system, which is unable to provide information that would allow the cost-effective and safe use of medications. Corrections does not plan to replace the current system with the health care component of the Strategic Offender Management System until November 2006, and development of that system is already behind schedule. Further, it has no plans to implement an interim solution. To limit further escalation in drug costs to the State and to improve its delivery of health care services to inmates, Corrections should plan improvements in its pharmacy services process based on results from a study currently in progress as soon as the consultant delivers the report.

RECOMMENDATIONS

To improve the prices that agencies pay for drug purchases, General Services should take the following actions:

- Increase its efforts to obtain more drugs on contract.
- Seek other ways to purchase drugs by fully analyzing measures to improve its procurement process, such as joining the Minnesota Multistate Contracting Alliance for Pharmacy or contracting directly with a group-purchasing organization.
- Address obstacles that could prevent the success of a statewide formulary such as agencies not enforcing the formulary at their institutions.
- Continue with its plans to contract for a medical supply catalog.

To improve its health care services, Corrections should await the results of its consultant's report, identify those recommendations that will most improve its pharmacy services, and implement them as quickly as possible.

To address its inadequate prescription tracking system and improve its pharmacy operations, Corrections should accelerate its timetable for the acquisition and implementation of the Strategic Offender Management System and its health care component.

AGENCY COMMENTS

General Services reports that it will take the appropriate actions to address our recommendations. However, it disagrees with our conclusion that its contract with another state to gain access to a group-purchasing organization may not offer the best deal to the State.

Corrections reports that it agrees with most of our recommendations and will work to adopt and incorporate them as appropriate. ■

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INTRODUCTION

BACKGROUND

The Department of Corrections (Corrections) operates all 33 state prisons, oversees a variety of community correctional facilities, and supervises parolees' reentry into society. As of October 2001 Corrections' total population was roughly 159,000 inmates. Its budget for fiscal year 2001–02 is more than $4.8 billion.

Corrections Provides Health Care Through Six Types of Facilities

Acute care hospitals

Provide 24-hour inpatient care, including basic services such as medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary.

Correctional treatment centers

Provide inpatient health services to that portion of the inmate population that does not require a general acute care level of basic service.

Outpatient housing units

Typically house inmates who do not require admission to a licensed health care facility but require monitoring or isolation from the general prison population.

Intermediate care facilities

Provide inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need supportive but not continuous care.

Skilled nursing facilities

Provide skilled nursing and supportive care to patients on an extended basis.

Hospices

Provide care to patients who are terminally ill.

Corrections must provide medically necessary health care to inmates and uses six types of facilities—four acute care hospitals, 16 correctional treatment centers, 12 outpatient housing units, two skilled nursing facilities, an intermediate care facility, and a hospice—to do so. It also contracts with the Department of Mental Health to provide all acute mental health inpatient services to inmates at the California Medical Facility in Vacaville. For care not available in its own facilities, Corrections contracts with health care providers in the community.

Corrections' Health Care Services Division (Health Care Services) is responsible for overseeing the management and delivery of health care to the inmate population at the individual prisons throughout the State. In fiscal year 2000–01 Health Care Services had an annual budget of $724 million, employing nearly 180 staff at its headquarters and roughly 4,900 staff at the prisons to carry out its program. In the same fiscal year, Corrections reported drug purchases that made up 12.6 percent of the budget for its health care services program.

Corrections is one of several agencies that provide health care directly to patients housed within their facilities. Other agencies providing direct patient care include the Departments of Developmental Services, Mental Health, Youth Authority, and Veterans Affairs, as well as the state university system. These agencies also are the main purchasers of drugs for their patients.

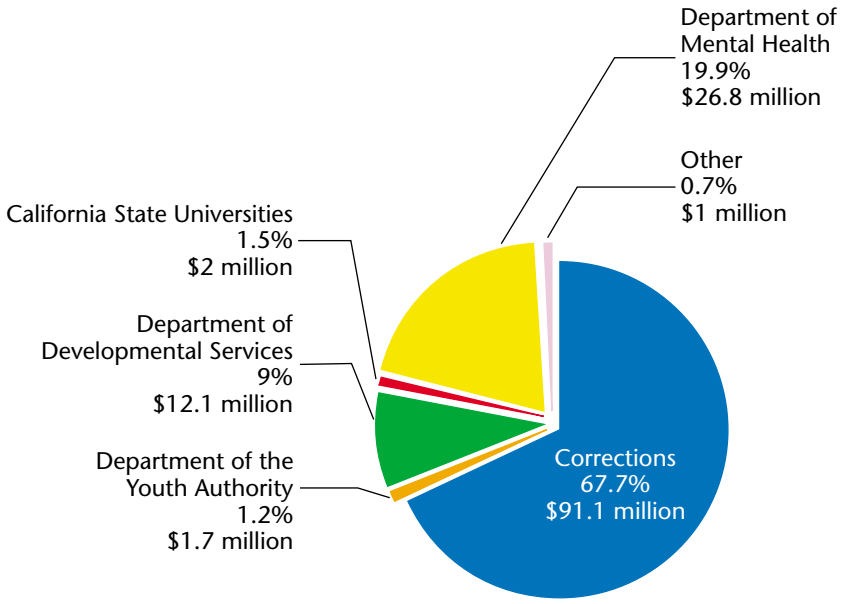
State law establishes the Department of General Services (General Services) as the State's purchaser for drugs. General Services negotiates contracts with drug manufacturers so that state agencies can purchase drugs at less-than-wholesale acquisition cost (contract drugs), the standard price a wholesaler pays a manufacturer for drug products not including special deals, such as rebates or discounts. These contracts become part of an agreement that General Services enters into with a wholesaler (prime vendor) to distribute the drugs. The prime vendor provides warehouse and distribution services and maintains a computer network that contains the contract drug prices, allowing state agencies to purchase these drugs electronically.

State agencies must purchase contract drugs in accordance with this agreement unless they receive an exemption from General Services. State agencies also have an option to purchase noncontract drugs and medical supplies using the prime vendor or another vendor. In fiscal year 2000–01 the State's five major purchasers of drugs spent roughly $135 million on drugs and medical supplies through this prime vendor contract system. As shown in Figure 1, Corrections spent more than two-thirds of this total, with all other purchasers combined making up the remaining one-third.

Corrections reported in December 2000 that its drug and medical supply expenditures were one of the fastest growing components of its health care costs, increasing from an annual total of $26.6 million to $77.5 million in the previous five fiscal years. These expenditures have continued to grow, reaching about $99 million in fiscal year 2000–01. The health care environment at Corrections is affected not only by an aging population and the specific diseases inmates bring with them into the correctional system but also by major litigation. During the 1980s and 1990s, inmates filed various class action lawsuits alleging deficiencies with health care, leading the courts to order Corrections to remedy the deficiencies. In certain cases, the litigation has led to improvements statewide. In response to one lawsuit contending that inmates with psychiatric conditions were unable to receive necessary and adequate mental health treatment, Corrections implemented a comprehensive mental health treatment system. Other lawsuits have affected the delivery of care at specific prisons. According to Corrections, it has spent a significant amount of resources to comply with the various court actions.

FIGURE 1

Corrections Made Two-Thirds of the State's Purchases From the Prime Vendor in Fiscal Year 2000–01



Source: Prime Vendor's Hospital Purchases Analysis reports.

Note: Other entities using the State's prime vendor during fiscal year 2000–01 include the California Department of Veterans Affairs, the California School for the Deaf, and the California Highway Patrol.

SCOPE AND METHODOLOGY

Chapter 127, Statutes of 2000, requires that the Bureau of State Audits (bureau) report to the Legislature on the trends in state costs for the procurement of drugs and medical supplies for offenders in state custody and that it assess the major factors affecting those trends. The statutes also require the bureau to summarize the steps that Corrections, General Services, and other appropriate state agencies have taken to do the following:

- Improve the existing statewide master agreement procedures for purchasing contract and noncontract drugs.
- Participate in the AIDS Drug Assistance Program.
- Seek membership in the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) or other cooperative purchasing arrangements with governmental entities.

- Increase centralization or standardization of procurement of drugs and medical supplies among individual prisons.

Further, the statutes require the bureau to report on the extent to which these state agencies have complied with the recommendations relating to necessary reforms to improve the procurement of drugs in our January 2000 report titled *California Department of Corrections: Utilizing Managed Care Practices Could Ensure More Cost-Effective and Standardized Health Care*. Finally, the statutes direct Corrections to consider establishing a program to obtain rebates from drug manufacturers. They also give Corrections the authority to adopt regulations requiring drug manufacturers to pay rebates and to enter into interagency agreements to minimize administrative costs and maximize benefits. However, based upon its research of the experiences that other states and the federal government have had in attempting to require rebates, Corrections believes that as written this legal authority is insufficient to lower drug costs.

To assess the trends in state costs for drugs and medical supplies, we requested information from the five agencies that provide direct patient care on the amount they spent for drugs and medical supplies between fiscal year 1996–97 and fiscal year 2000–01. We asked these agencies to explain the reason for any significant changes in expenditures for this period and evaluated the reasonableness of their explanations. We also obtained data from the State's prime vendor for the two-year period from August 1999 to August 2001 to identify the drugs that the State purchased in the greatest dollar amounts. Appendix A shows the top 50 drugs that the State purchased.

To summarize the steps that Corrections, General Services, and other state agencies took to implement the statutes, we did the following:

- To ascertain the improvements made to the existing statewide procedures for procuring drugs, we interviewed key staff at General Services and Corrections and reviewed relevant laws and procedures. We focused our efforts on changes that General Services has made to its contracts with drug manufacturers and the prime vendor. Further, we reviewed Corrections' procedures for reviewing contract and noncontract drug purchases.

- To determine whether Corrections could participate in the AIDS Drug Assistance Program, we interviewed relevant staff at the Department of Health Services' Office of AIDS. We also reviewed federal and state laws, program requirements, and other data to better understand the program. Further, we used similar procedures to determine whether Corrections was eligible to use the federal General Services Administration's supply schedule to obtain discounts on its drug purchases.

- To assess the progress made by General Services to seek membership in MMCAP, we interviewed key staff at General Services and MMCAP, as well as a representative from the Office of General Services in New York State, which is an MMCAP member. We also reviewed General Services' analyses of potential cost savings it could achieve from membership in MMCAP. General Services told us that it had joined the Massachusetts Alliance for State Pharmaceutical Buying (Massachusetts Alliance). Therefore, we reviewed analyses of potential cost savings that led to its decision to join the Massachusetts Alliance. Further, we spoke with staff at the alliance and the group-purchasing organization that it uses. Finally, we reviewed information about group-purchasing organizations on the Internet.

- To evaluate the actions that Corrections has taken to standardize and centralize its procurement of drugs and medical supplies among individual prisons, we interviewed key staff at Health Care Services. We also visited four prisons, two mental health facilities, a youth correctional reception center, and a developmental center to gain an understanding of the processes for purchasing drugs and medical supplies at Corrections and other state agencies. In addition, we reviewed the literature regarding pharmacy benefits managers. We interviewed relevant staff at the California Public Employees' Retirement System and AIDS Drug Assistance Program to understand how these two agencies use pharmacy benefits managers. We also reviewed Corrections' plans to hire a pharmacy benefits manager.

Finally, to determine the extent to which Corrections and other state agencies have complied with certain recommendations in our January 2000 report, we interviewed key staff and managers at these agencies and reviewed relevant data. Appendix B is a summary of Corrections' progress and its plans to address our prior recommendations relating to its pharmacy operations. ■

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CHAPTER 1

General Services Should Further Improve Its Procurement of the State's Drugs and Medical Supplies

CHAPTER SUMMARY

The Department of General Services (General Services) has explored a variety of options, but it has not gone far enough in improving the State's drug procurement process. General Services negotiates statewide contracts with drug manufacturers and with a wholesaler (prime vendor) to distribute the drugs. State agencies are also allowed to purchase drugs at the prime vendor's wholesale acquisition cost (noncontract drugs).

Annual expenditures for the five state agencies most frequently purchasing drugs have increased from $41.6 million in fiscal year 1996–97 to $135.1 million in fiscal year 2000–01, resulting in an average annual increase of 34.3 percent compared to the national average increase of 12.7 percent. State agencies claim that the dramatic increase in their drug expenditures was due to rising drug costs, the use of new drugs, and increasing use of drugs to serve client populations that are older and more ill. A pharmaceutical manufacturers' trade organization attributes the much lower national increase to similar factors.

To improve the drug procurement process, General Services recently contracted with the Massachusetts Alliance for State Pharmaceutical Buying (Massachusetts Alliance) but failed to fully analyze all options before doing so. This action may have prevented the State from achieving greater future savings. Further, General Services is spearheading efforts to establish a statewide drug formulary, but state agencies must develop and adhere to guidelines for enforcement of its use to reap the benefits of this price-reducing tool.

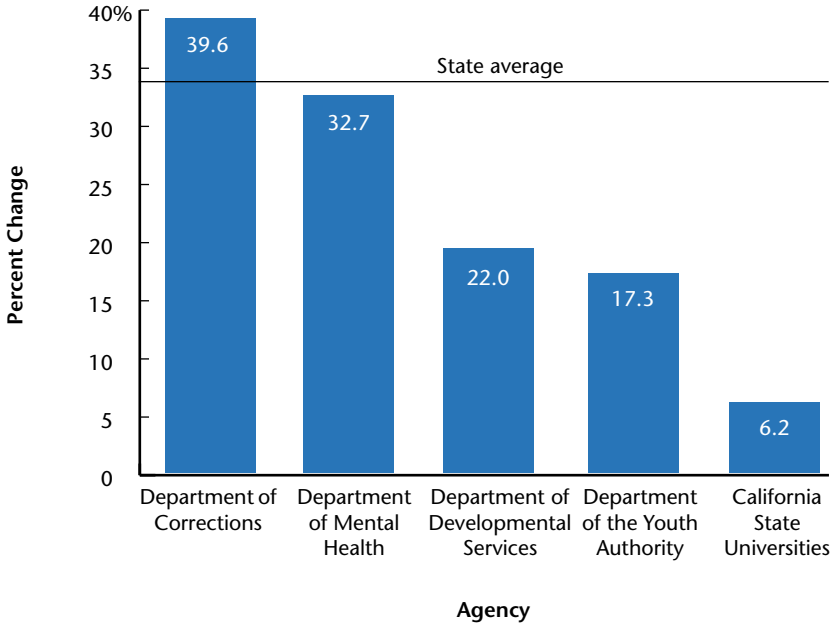
To further reduce health care costs, General Services needs to develop a central process for purchasing medical supplies. Currently, state agencies and individual facilities must solicit bids for medical supplies individually rather than using statewide purchasing power to negotiate better prices on common items.

STATE DRUG PURCHASES CONTINUE TO ESCALATE

General Services negotiates contracts with drug manufacturers so that state agencies can purchase drugs at less-than-wholesale acquisition cost (contract drugs), which is the standard price (not including special deals such as rebates and discounts) that a wholesaler pays a manufacturer. Also, General Services enters into an agreement with a wholesaler to distribute these drugs to the state agencies. In fiscal year 1996–97 state agencies purchased $41.6 million in drugs, but in fiscal year 2000–01 their purchases rose to $135.1 million, which represents an average annual increase of 34.3 percent for this five-year period. As Figure 2 indicates, the Department of Corrections (Corrections) exceeded even the State's average with an annual increase of 39.6 percent. National drug expenditures increased from $101.8 billion in 1997 to projected expenditures at the time of this report's writing of $169.2 billion in 2001, an average annual increase of 12.7 percent.

FIGURE 2

Corrections' Annual Average Increase in Drug Purchases Exceeded the State's Between Fiscal Year 1996–97 and Fiscal Year 2000–01



Source: Expenditure amounts reported by state agencies.

These state agencies reported a variety of reasons for drug expenditure increases, including rising costs for mental health and human immunodeficiency virus (HIV) drugs and an increase in the use of vaccines for hepatitis, meningitis, and influenza. For example, the Department of Mental Health (Mental Health) told us its use of new atypical antipsychotic drugs such as olanzapine and quetiapine, which have fewer side effects but are more expensive than traditional drugs, contributes to its increased drug costs. Corrections' purchases of antidepressants and antipsychotic drugs increased 34 percent over a 24-month period between August 1999 and July 2001, partly due to a class-action lawsuit requiring it to implement a comprehensive mental health treatment system for inmates. Both Corrections and Mental Health cite the increased cost of new drug therapies for HIV as a significant factor. A recent study by the Harvard School of Public Health reports that one three-drug HIV therapy can cost, on average, $12,000 per patient per year. Most state agencies also reported an increase in the number of vaccines they gave for hepatitis, meningitis, and influenza to inmates, youthful offenders, patients, and students. The cost for a single vial of vaccine is $60 for meningitis or $50 for influenza.

Corrections cites the increased cost of new drug therapies for HIV as a significant factor contributing to escalating expenditures for drugs.

Agencies also report an increase in the number of prescriptions their clients use, which appears reasonable. Nationally, the number of prescriptions has risen from 2 billion in 1990 to about 3.2 billion in 2000. Finally, Corrections was the only agency to cite aging client population as a factor. For example, the number of inmates age 50 and above entering into the prison system due to felonious crimes increased by almost 46 percent between calendar years 1995 and 2000.

GENERAL SERVICES HAS BEEN UNSUCCESSFUL IN SECURING DRUG CONTRACTS

General Services has secured individual contracts with 45 drug manufacturers to sell contract drugs to state agencies. For example, the State contracts for its top-purchased drug item, olanzapine, at $423.56 for a bottle of sixty 10-milligram tablets, whose wholesale acquisition cost in October 2001 was $449.06. General Services also has an agreement with a wholesaler (prime vendor) to distribute contract drugs to state agencies and if necessary, provide them with drugs at the prime vendor's wholesale acquisition cost (noncontract drugs) plus a service fee.

All California state agencies must purchase contract drugs through the prime vendor unless they receive an exemption from General Services. An agency wishing to purchase a drug like ibuprofen would check the prime vendor's ordering system to see whether General Services has a contract with the manufacturer for this product. If so, the agency orders the product from the prime vendor and pays the contract price. If General Services does not have a contract with the manufacturer (or it does but the item is out of stock), the agency can purchase a noncontract drug substitute from the prime vendor at the wholesale acquisition cost on that day. The prime vendor delivers the contract or noncontract drug to the agency's pharmacy the next day. The process for purchasing contract or noncontract drugs is illustrated in Figure 3.

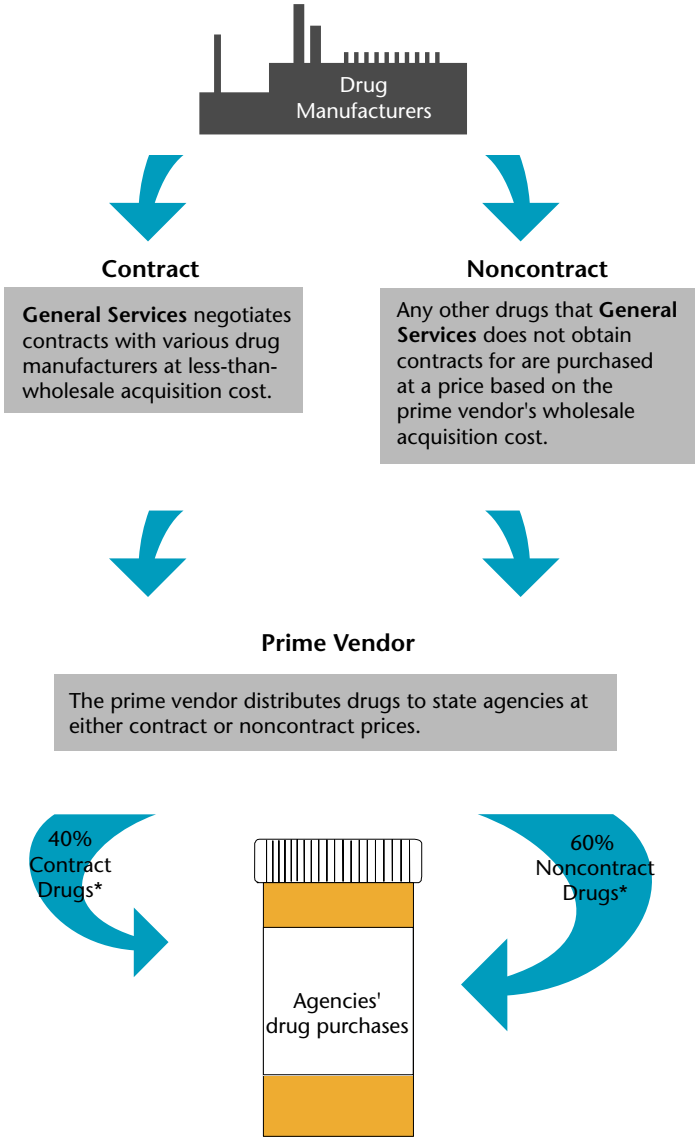
By November 2001 General Services had secured contracts for about 850 of the 1,838 drugs for which it sought bids—just 90 more drugs than it had under contract in January 2000.

This process is designed to provide agencies with competitive prices. In our January 2000 report titled *California Department of Corrections: Utilizing Managed Care Practices Could Ensure More Cost-Effective and Standardized Health Care*, we wrote that General Services had about 760 drugs on contract, or 54 percent of its requested bids for 1,400 drugs. Between January 2000 and November 2001 General Services has been able to secure only 90 more contract drugs. Specifically, during the solicitation process that began in July 2000, it secured bids with 42 manufacturers for about 780 of the 1,838 drugs it requested. Subsequent to the solicitation process, it was able to renegotiate terms and conditions with 3 manufacturers and add 70 more drugs.

For the past five fiscal years, state agencies purchased 60 percent of their drugs at the prime vendor's wholesale acquisition cost instead of at the contract price. General Services stated that it was unable to secure contracts for more drugs at less-than-wholesale acquisition cost for several reasons: (1) the State's purchase volume is too low to interest some manufacturers; (2) some drug companies have merged and consolidated their product lines; or (3) some are unwilling to do business with state government. Further, it did not contract for some drugs because the prices that the bidders offered were higher than those already available through the prime vendor or because the bidder would not give the State discounts on drugs such as antiretrovirals. However, General Services' inability to successfully secure more contract drugs continues to limit the State's ability to obtain drugs at lower cost.

FIGURE 3

Agencies Purchase Both Contract and Noncontract Drugs Through the Prime Vendor



* Average over the past five fiscal years.

GENERAL SERVICES NEEDS TO DO MORE TO IDENTIFY THE BEST OPTION FOR REDUCING DRUG COSTS

General Services does not know if it chose the most effective option for reducing the State's drug costs because it performed insufficient analyses when making its recent decision to contract with the Massachusetts Alliance. Based on its limited analyses, General Services rejected other options such as contracting with the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) and contracting directly with a group-purchasing organization. These organizations negotiate volume discounts with manufacturers and suppliers on behalf of their members, providing members with favorable prices, terms, and conditions.

General Services Failed to Perform a Thorough Analysis of Its Options

State law enacted in July 2000 suggested that Corrections, in cooperation with General Services, should consider membership in MMCAP or other cooperative purchasing agreements. However, it was not until January 2001 that state law reaffirmed General Services' legal authority to consolidate the needs of multiple state agencies for goods such as drugs and gave it new authority to establish contracts, master agreements, cooperative agreements, including agreements with entities outside the State, and other types of agreements that maximize its buying power.

By joining the Massachusetts Alliance the State may be ignoring other group-purchasing organizations through which it could achieve greater savings.

The limited analysis that General Services performed before joining the Massachusetts Alliance does not ensure that the State receives the best value. By joining this alliance, the State may be ignoring other group-purchasing organizations through which it could achieve greater savings. Also, General Services did not verify whether the Massachusetts Alliance contracts included the State's most purchased noncontract drugs. Finally, General Services' analysis did not identify drug manufacturers' policies that may result in the State jeopardizing some of its current drug contracts.

On October 19, 2001, General Services entered into a contract with the Massachusetts Alliance that expires on June 30, 2003. The Massachusetts Alliance has been in existence only since the summer of 2001. Currently, only the states of Massachusetts and California are members of this alliance, which contracts with a group-purchasing organization to take advantage of most of the wholesale acquisition prices through its contracts with drug

manufacturers. General Services told us that the benefit of joining this alliance was that it could achieve immediate savings for the State and it would not have to solicit bids on its own to contract with a group-purchasing organization. Prior to joining the alliance, General Services was considering contracting directly with such an organization to supplement its existing drug procurement process and be able to purchase a wider range of drugs below the prime vendor's wholesale acquisition cost.

An analysis of noncontract drugs showed that a group-purchasing organization other than that used by the Massachusetts Alliance generated the greatest cost savings.

Using the bids that the Massachusetts Alliance solicited from three group-purchasing organizations, General Services performed a limited analysis comparing potential costs for 256 of its current contract and noncontract drugs to the State's average cost for these same drugs in May 2001. The group-purchasing organization that the Massachusetts Alliance currently uses could generate a greater overall cost savings (slightly more than $217,000) than the other two group-purchasing organizations. Unfortunately, this analysis did not focus on the primary purpose for General Services wanting to use a group-purchasing organization, which is to obtain better prices for its noncontract drugs. General Services prepared another analysis comparing only the costs of noncontract drugs the State had to purchase from its prime vendor, which indicates that one of the other two group-purchasing organizations could generate savings of nearly $192,000, whereas the Massachusetts Alliance's group-purchasing organization's contracts could generate savings of only about $160,000. General Services did not use these results to support its decision to join the Massachusetts Alliance, stating that it felt the savings on the noncontract drugs were insignificant, and the opportunity to achieve additional savings was essentially the same. Moreover, General Services told us that the analysis did not distinguish clear pricing differences among the three group-purchasing organizations but did confirm that using a group-purchasing organization could achieve significant savings for the State.

However, General Services' statements concern us because it also told us that it had been moving toward establishing a contract with a group-purchasing organization for noncontract drugs for the last two years. Therefore, prior to doing the May 2001 analysis, General Services was aware that group-purchasing organizations could probably generate savings because it is common knowledge in the pharmaceutical industry that these organizations can obtain favorable prices, terms, and conditions from manufacturers due to their large purchasing volumes.

General Services was unable to quantify prior to joining the Massachusetts Alliance how many additional drugs would be available to the State at lower prices.

In 2001 General Services compiled another list of 217 drugs that it planned to use to solicit bids directly from group-purchasing organizations. However, it did not use this list to evaluate whether the group-purchasing organization that the Massachusetts Alliance uses could provide these drugs. Our analysis shows that, of the drugs General Services considered in its May 2001 analysis of the Massachusetts Alliance, only 90 of the 217 drugs it had previously identified as specific drugs the State needs were included in its analysis. Moreover, General Services was unable to quantify prior to joining the Massachusetts Alliance how many additional drugs would be available to the State at lower prices. In fact, General Services told us it would not know how much immediate savings it generated for the State until early December 2001. Thus, in its eagerness to join the Massachusetts Alliance, General Services may have prevented the State from achieving greater future savings because a more thorough analysis of group-purchasing organizations could show the potential to save more on the specific drugs the State purchases. If General Services had continued its efforts to solicit bids using its list of 217 drugs from group-purchasing organizations, it would be able to quantify the potential savings to the State. Without such analysis, General Services cannot be certain that it is obtaining the best value for the State.

One possible explanation for General Services' failure to continue its own efforts to secure a group-purchasing contract is that it did not have sufficient expertise in working with these organizations. For example, General Services learned after it joined the Massachusetts Alliance that 10 of the 45 individual drug contracts it has with drug manufacturers may be in jeopardy because these manufacturers have a one-contract-per-customer policy. This means that the State must negotiate with these manufacturers to see whether they will allow it to use both the contract it negotiated directly and the contract through the Massachusetts Alliance's group-purchasing organization. If the manufacturers will not negotiate on this policy, the State must decide if it is going to cancel its existing contracts with the manufacturer or use the Massachusetts Alliance's contract.

General Services recognizes that it lacks sufficient expertise in this area, stating that its plan has always been to use its contract with the Massachusetts Alliance as a low-risk approach to learning more about group-purchasing organizations. General Services plans to use its contract with the Massachusetts Alliance to collect data for about nine months and determine the benefits of this contract to the State's drug purchasing. It also plans

to gather data from other group-purchasing organizations, evaluate the market, and determine what changes it needs to make. General Services told us that it views this contract as a pilot program because it can cancel its involvement with the Massachusetts Alliance by exercising the 30-day cancellation clause in its contract.

General Services could have spent its time more effectively by soliciting bids on its own to contract directly with a group-purchasing organization.

General Services decided to go with the Massachusetts Alliance because it could enter into this agreement right away, allowing the State immediate savings. However, we believe that General Services could have spent its time more effectively by soliciting bids on its own to contract directly with a group-purchasing organization. For example, the Massachusetts Alliance's procurement manager told us that it was not difficult to work with group-purchasing organizations because they negotiate the prices more quickly with the manufacturers and send the final prices directly to the prime vendor. He also told us that only a few prime vendors exist and that most group-purchasing organizations are familiar with their data requirements. Therefore, General Services' learning curve should have been minimal. Specifically, once its solicitation process was complete and it had chosen a group-purchasing organization, General Services would have completed a substantial amount of its responsibility, leaving the rest of the work to the prime vendor.

General Services Should Not Dismiss Joining MMCAP

State law specifically identifies the MMCAP as one of the entities that the State should consider. General Services considered joining MMCAP, a group of state agencies and nonfederal governmental entities that purchase drug products using MMCAP's contracts with drug manufacturers and other vendors. In existence since 1985, the alliance, with members in 38 states and contracts with more than 130 manufacturers, gives its members access to more than 6,000 drugs.

In evaluating whether to join MMCAP, General Services compared prices for a sample of drugs the State purchased between May 2000 and May 2001 with MMCAP's prices as of May 1, 2001. General Services found that the State could have saved about 1 percent, or nearly $1.3 million, on purchases of these products. However, its primary reason for not pursuing MMCAP was that it did not see these savings as significant because prices can vary depending on where either entity is in their respective contract terms. It also expressed concern that joining MMCAP could limit its ability to implement other

State law specifically identifies MMCAP as one of the entities that the State should consider, but General Services did not thoroughly consider this option.

measures, such as joining another alliance, contracting with a group-purchasing organization, or developing its own contracts. General Services' concern was based on a statement found on MMCAP's Web site that "members are expected to buy pharmaceuticals from its contract, not from any other nongovernmental contract with which they may be associated." Although General Services told us that it reviewed the terms and conditions of MMCAP's agreement, it could not provide any documentation of its review. We spoke with the assistant director of MMCAP who told us that its agreement with participating states does not restrict them from buying drugs from other entities. Moreover, in our review of MMCAP's agreement, we did not find any terms and conditions that specifically preclude its members from buying drugs from other entities.

We believe that MMCAP is an option that General Services should thoroughly explore. The state of New York has been a member of MMCAP since 1995, and according to a representative from the New York Office of General Services, its MMCAP membership allows the state to make a wide variety of drugs available to its facilities, saving both time and the administrative expenses of soliciting multiple bids. Prior to joining MMCAP, the state of New York, like California, solicited bids to purchase drugs but failed to contract for many that it used.

We also believe that General Services should consider more than the benefits of MMCAP pricing. However, General Services has not performed a thorough analysis that includes other factors, such as the time it might save trying to secure contracts with drug manufacturers or the impact that MMCAP would have on distributing drugs. Without such an analysis, General Services may be prematurely dismissing the benefits the State could derive from membership in MMCAP.

General Services Faces a Significant Obstacle in Establishing a Statewide Formulary

General Services is spearheading efforts to develop a statewide drug formulary to obtain better pricing for drugs. A *drug formulary* is a listing of drugs and other information representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis and treatment of specific conditions. One of the main purposes of a formulary is to create competition among manufacturers of similar drugs when the clinical uses are roughly equal. However, concerns with how state agencies

currently manage their individual formularies, including failing to enforce them, may hinder the immediate success of a statewide formulary.

General Services' Role in Developing a Statewide Formulary

General Services will work with the Common Drug Formulary Committee to do the following:

- Develop guidelines, procedures, and policies for the administration of the drug formulary system.
- Consolidate formularies from each department into a common drug formulary.
- Apprise, evaluate, and select drugs for the formulary in terms of their impact on total health care costs.
- Establish cost-effective drug contracts.

General Services is in the early stages of developing a statewide formulary. On October 16, 2001, the Common Drug Formulary Committee (Formulary Committee), composed of medical and pharmacy representatives from the Departments of Corrections, Developmental Services, Mental Health, and Youth Authority, as well as the state university system, held its first meeting to discuss the development of a statewide formulary. The Formulary Committee agreed to work with the existing Pharmacy and Therapeutic Committees, which are responsible for developing, managing, updating, and administering their drug formulary systems at the individual agencies. The existing committees will review drug use data provided by the State's prime vendor to determine which drugs they should include on the statewide formulary. After the committee members have reached consensus, General Services expects to enter into contractual agreements to purchase these drugs.

However, the success of a statewide formulary and the State's ability to create enough competition to negotiate lower drug prices for certain products depend on how well state agencies adhere to the statewide formulary when they prescribe drugs. Currently, Corrections, which was responsible for roughly 68 percent of the State's drug purchases in fiscal year 2000–01, has an outdated formulary and lacks sufficient data to perform drug-utilization reviews that can identify medical practitioners' patterns for prescribing drugs. Introducing a statewide formulary into an environment in which regular monitoring does not exist reduces its potential for success. Consequently, although a statewide formulary could lower the State's cost of drugs by creating more competition among drug manufacturers, agencies that help develop but do not adhere to strict guidelines for enforcing the formulary would negate the State's effort.

A CENTRALIZED PROCESS FOR PURCHASING MEDICAL SUPPLIES COULD HELP CONTROL COSTS

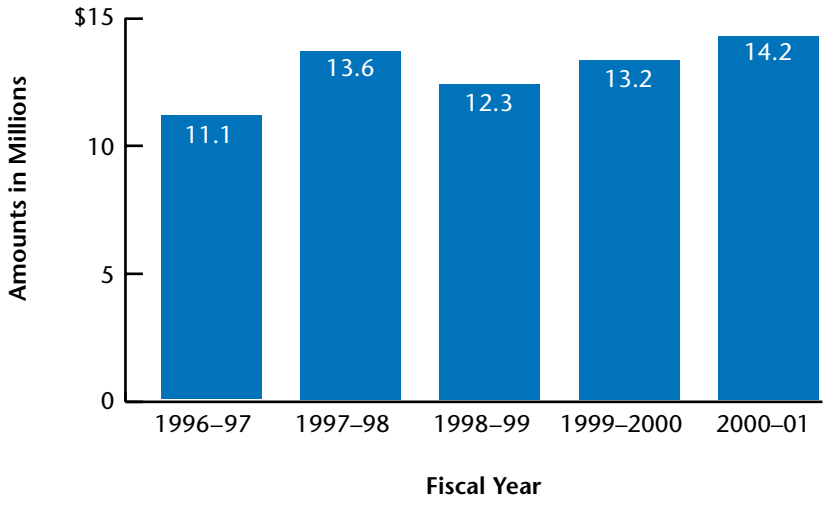
Although state agencies spent $14.2 million in fiscal year 2000–01 for medical supplies, often they are not aware of what their institutions are purchasing and how much they are paying for these items.

The State currently lacks statewide agreements for purchasing medical supplies. *Medical supplies* generally consist of products such as bandages, disposable gloves, plastic bags, oxygen, injection devices, and dental hygiene trays. General Services has medical supply contracts for only surgical gloves and disposable incontinent adult briefs. Each state agency or individual institution generally procures its own medical supplies. Often a state agency is not aware of what its institutions are purchasing and how much they are paying for these items.

Between fiscal year 1996–97 and fiscal year 2000–01, the combined medical supply purchases of the five state agencies that provide the majority of health care have increased by about 27 percent, compared to a 23 percent increase nationally between calendar years 1997 and 2001. Although the amount of money these state agencies spent on medical supplies is relatively small in comparison to their drug purchases, it is not insignificant. As shown in Figure 4, the state agencies we reviewed spent $14.2 million in fiscal year 2000–01, almost 11 percent of their drug purchases for the same year.

FIGURE 4

Combined Costs to Purchase Medical Supplies for the Five Primary Agencies Increased 28 Percent Over Five Fiscal Years



Source: Expenditure amounts reported by the Departments of Corrections, Developmental Services, Mental Health, Youth Authority, and the California state university system.

We requested data on the amount and type of medical supply purchases and found that the five agencies were able to give us the total amount they spent for medical supplies only by type. State agencies could not provide us with details such as how many items of each type they purchased or the cost per item because their individual institutions generally were responsible for procuring and accounting for these items. Corrections and Mental Health both cited costs and patient populations for the fluctuation in their medical supply purchases. However, neither the Departments of Developmental Services nor Youth Authority gave us any explanation for their increased spending for medical supplies. The California state university campuses gave varying reasons for the fluctuation in their medical supply purchases, including the opening of new health facilities, the replacement of outdated items, and price increases. For example, one campus told us that a syringe used for immunization that previously cost 5 cents now costs 55 cents due to state and federal mandates for safety.

Due to state and federal safety mandates, a syringe that previously cost 5 cents now costs 55 cents according to one campus.

According to its contract administrator, General Services had up to five statewide medical supply contracts in the past, but now few vendors are interested in contracting with the State for medical supplies. General Services believes that having a medical supply catalog would aid state agencies in obtaining these supplies. Currently, several such catalogs exist that include items such as bandages, surgical gloves, and syringes. General Services would solicit bids from vendors of medical supply catalogs and enter into a contract that would allow agencies the option to fill their needs at the contract price.

Contracting for a medical supply catalog could reduce the time that state agencies spend ordering common items such as bandages, plastic bags, and syringes and eliminate the need for each purchaser to identify vendors and solicit bids. Institutions and agencies would still have to procure their own specialty items; for example, a medical supply catalog would not offer the plastic rather than metal knee braces that Corrections uses for security reasons. As of November 16, 2001, General Services began meeting with medical supply vendors to enable the Emergency Medical Services Authority to purchase supplies in the event of a disaster. However, it has not taken any significant action to contract for a medical supply catalog. At this point, it is unaware of what medical supplies the agencies use and what they pay for them. In order to ensure that it selects a vendor

that would be useful to the agencies, General Services plans to analyze thoroughly what state departments currently purchase and what service needs they have.

RECOMMENDATIONS

To improve the prices that state agencies pay for drug purchases, General Services should take the following actions:

- Increase efforts to solicit bids from drug manufacturers so that it can obtain more drug prices on contract.

- Fully analyze measures to improve its procurement process, such as joining MMCAP or contracting directly with a group-purchasing organization. The analysis should include the availability of current noncontract drugs from each organization being considered and the savings that could result from spending less administrative time trying to secure additional contracts directly with drug manufacturers.

- Fully consider all obstacles that could prevent the successful development of a statewide formulary, such as agencies not strictly enforcing the formulary at their institutions. Furthermore, General Services should attempt to mitigate the obstacles it identifies. For instance, it should require agencies to adopt a policy requiring strict adherence to the statewide formulary.

Ask state agencies to determine their needs and then consider contracting for a medical supply catalog to maximize the State's buying power. ■

CHAPTER 2

Corrections Needs to Rein in Its Increasing Expenditures for Drugs

CHAPTER SUMMARY

The Health Care Services Division (Health Care Services) of the Department of Corrections (Corrections) does not effectively monitor its pharmacies' purchases of drugs. For example, by not updating or monitoring compliance with its *formulary,* a listing of drugs for use in treating patients, including dosing information and cost indicators, Health Care Services has missed the opportunity to identify medical practitioners whose prescribing practices are not cost-effective and prisons that fail to enforce the Corrections formulary. Further, Corrections should not hire a pharmacy services manager until it receives the results of a study it commissioned to examine and assess the process it uses to deliver pharmacy services. Finally, Health Care Services may have misused its mail-order pharmacy services contract, meant to alleviate its perceived pharmacist staffing shortage, because it failed to properly document its use of temporary pharmacists. Without monitoring its compliance with its formulary, mail-order contract, and use of the State's drug contract, Corrections cannot adequately control its drug expenditures. Monitoring is an even more important element in controlling drug costs as state and federal law deems Corrections ineligible to participate in programs such as the State's AIDS Drug Assistance Program (ADAP) and the federal General Services Administration's supply schedule (federal supply schedule).

HEALTH CARE SERVICES LACKS AN EFFECTIVE SYSTEM FOR CONTROLLING DRUG PURCHASES

Despite the recommendation in our January 2000 report to update the formulary and use it to control drug use, Health Care Services still has not done so. It also fails to monitor trends in how prisons purchase drugs at the wholesaler's (or prime vendor's) acquisition cost (noncontract drugs), missing its opportunity to guide them in purchasing drugs that are less expensive.

Health Care Services Neither Updated Its Formulary nor Monitored Compliance With It

Because it has not updated its formulary in several years and because it does not monitor compliance with its formulary, Health Care Services is unable to identify and enforce preferred treatments for specific conditions and to identify which medical practitioners have prescribing practices that are inappropriate or not cost-effective.

In our earlier audit, we found that Corrections had not updated its drug formulary in a few years. We recommended that it do this regularly and use the formulary to control which drugs medical professionals can prescribe routinely. Corrections' formulary provides physicians, dentists, and other prescribers with a listing of drugs for use in treating patients, as well as dosing information, indicated precautions, restrictions, and cost indicators. The purpose of the formulary is to promote appropriate and cost-effective use of medications. For example, Corrections' policy on the use of its formulary requires pharmacies to dispense equivalent, although generally less expensive, generic drugs instead of brand-name drugs unless the prescriber specifically orders for no substitution.

Health Care Services has not revised its formulary since 1997, therefore it does not list some important drugs and classes of drugs.

As of November 2001 Health Care Services still had not updated the formulary. Its deputy director stated that the formulary had not yet been updated because updating is a complicated task that Health Care Services has neither the staff nor the expertise to perform. An internal pharmacy task force made up of pharmacists, a nurse, an external consultant, and others first met in May 2001 to develop a new formulary. Although Corrections sent a draft of the revised formulary to prisons' health care managers for comment, it had not yet been approved for use. Because the formulary has not been revised since 1997, it does not list important drugs and classes of drugs, such as atypical antipsychotic drugs. For example, a pharmacist in charge at one prison told us that newer drug therapies given to inmates returning from facilities such as the University of California, Davis Medical Center would not be on the formulary.

Currently, the process for adding a drug to or deleting a drug from the formulary calls for a departmental Drug Formulary Committee, made up of physicians and pharmacists, to determine whether the drug belongs on the formulary. The Drug Formulary Committee is to consider comparable drugs already on the formulary and analyze costs before coming to a decision.

The prisons' Pharmacy and Therapeutics Committees, which are made up of physicians and pharmacists as well as nurses and other selected staff, are also to review the formulary and recommend changes to the Drug Formulary Committee at least annually. The pharmacist in charge, whom we mentioned previously, also told us that the chief medical officer at his prison approved the use of some of the new drugs as though they were on the Corrections formulary, even though they are not. If officials diverge from Health Care Services' policy, which is aimed at promoting appropriate and cost-effective use of medications, the policy loses its effectiveness.

Health Care Services lacks a utilization management program that can assist in reducing costs associated with inappropriate prescribing and use of drugs.

Another factor that hampers Health Care Services' ability to monitor compliance with its formulary is that it lacks sufficient data to perform drug-utilization reviews, a process of evaluating drug use to identify and then intervene to correct drug use problems. One goal of this review can be to reduce costs associated with inappropriate prescribing and use of drugs. However, Health Care Services does not perform a system-wide analysis of drug use after the drugs have been dispensed. The deputy director of Health Care Services said she is aware that there is a need to monitor formulary enforcement through a utilization management program that includes getting regular feedback; educating prescribers; holding all staff accountable for enforcement of the formulary, including the prisons' health care managers; analyzing current and retrospective data; and reviewing medical practitioners' prescribing practices. However, she acknowledges that Health Care Services lacks such a program.

Although Health Care Services requires physicians, dentists, and other health care practitioners who may prescribe nonformulary drugs to submit a nonformulary drug request, which the chief medical officer or a designee must approve, its lack of a drug-utilization management program hinders its ability to ensure that practitioners' reasons for prescribing a nonformulary drug are valid. Such reasons include treatment failures with the formulary drugs; therapeutic advantages of a nonformulary drug over a formulary drug; documented allergies, adverse reactions to, or side effects from formulary drugs; or lack of medications of the same therapeutic class on the formulary.

The deputy director of Health Care Services believes that monitoring the outdated formulary that is currently in use would not provide useful information. She also believes that the lack of electronic data collection ability that we discuss in Chapter 3 makes reviews of formulary use very labor-intensive and at

present, without a revised formulary, probably not cost-effective. Nevertheless, monitoring compliance with the existing formulary would at least allow Health Care Services to begin identifying prisons that do not enforce the formulary and medical practitioners who do not have cost-effective prescribing patterns.

Health Care Services Does Not Monitor Its Noncontract Purchases From the State's Prime Vendor

Although Health Care Services' policies and procedures manual requires the pharmacist to review items being ordered for cost and to make sure that prisons purchase drugs that are generic equivalents of more expensive brand-name drugs before placing an order, it does not explicitly require that the pharmacist select the least expensive unit cost (that is, per bottle or per bulk quantity of pills) or express a preference for contract drugs. We found that pharmacists reviewed the drug orders before transmitting them to the prime vendor at only one of the four prisons we visited. Pharmacists at the remaining three prisons told us that they reviewed the invoices or a monthly report of purchases. However, these types of reviews can occur only after the order has been placed and do not allow the pharmacists to fulfill their other requirement to review for cost and generic equivalents before placing the order.

Some prisons may not be evaluating the purchase of noncontract drugs for cost-effectiveness.

Prisons can use the prime vendor's monthly reports to document the reasons that the purchaser ordered a noncontract instead of a contract drug.[1] General Services' contract requires the prime vendor to send monthly contract compliance reports to each institution making purchases during the month. Pharmacists at two prisons we spoke with said they receive and review the reports; however, some prisons may not be evaluating the purchase of noncontract items for cost-effectiveness. For example, the other two prisons stated that they do not receive these reports. Corrections reported that it spent about $91 million on drugs in fiscal year 2000–01. Using data from the State's prime vendor that shows a breakdown of contract and noncontract purchases, we estimate that Corrections spent $33.3 million, or 36.5 percent, of the total for contract drugs and $57.9 million, or 63.5 percent, for noncontract drugs. Without monitoring its noncontract drug purchases, Health Care Services cannot substantiate the reasons its pharmacies are choosing to purchase potentially more expensive noncontract drugs.

[1] See Chapter 1 for a description of General Services' process of contracting for drugs.

In July 2001 a consultant for Health Care Services performed a limited review of prisons' compliance with purchasing contract drugs. Specifically, the consultant reviewed purchases of ibuprofen for a one-year period and found that prisons were purchasing 100-pill bottles of 800-milligram ibuprofen for up to $10.43 a bottle (or just over 10 cents per pill) when they could have more cost-effectively purchased 500-pill bottles at the same strength for as low as $14.53 (or just under 3 cents per pill). The consultant also found that one prison routinely did not purchase 800-milligram or 600-milligram strengths of ibuprofen but chose to use three 200-milligram pills or two 400-milligram pills, increasing the cost. Because Health Care Services does not monitor noncontract purchases, it cannot identify why prisons chose to purchase noncontract drugs and if they are spending more to buy drugs that they could purchase at a lower cost through contracts.

Health Care Services Plans to Hire a Pharmacy Services Manager to Improve Control Over Drug Purchasing

Neither an external pharmacy benefits manager nor an internal pharmacy services manager can accomplish the task of improving contracting and procurement for drugs until Health Care Services addresses significant deficiencies.

Neither an external pharmacy benefits manager (external manager) nor an internal pharmacy services manager (internal manager) can accomplish the task of improving contracting and procurement for drugs until Health Care Services addresses significant deficiencies. Health Care Services recognizes that its current system of procuring, dispensing, and monitoring drug use is antiquated. In June 2001 Corrections hired a consultant to examine and assess the process it uses to deliver pharmacy services to the inmate population and recommend changes. However, the results of the consultant's analysis are not due until January 2002, which is after the time of this report's writing. This is critical information that either an internal or external manager will need in order to make improvements. Health Care Services should not hire a manager until it receives the consultant's report, understands the magnitude of the problem, and decides on the necessary corrective action.

State law allows Corrections to contract with an external manager to provide any services necessary to improve the contracting and procurement of drugs and medical supplies for inmate health care. However, Health Care Services believes that it can accomplish this goal by hiring an internal manager to control and direct the efficient, appropriate, and cost-effective use of pharmaceutical resources. Health Care Services plans for the internal manager to monitor the use of drugs, develop

statewide pharmacy reports, provide training to the prisons, and meet with General Services to review drug contracts as well as manage pharmacy services.

In its April 2000 request for funding to retain consultants to study the provision of pharmacy services, Corrections justified its need for a consultant by stating that workload increases, poor work environments, and static staffing allocations have hampered its recruitment and retention of pharmacists, causing it to use costly staffing alternatives. Corrections also recognizes that its current pharmacy prescription tracking system cannot support its pharmacy services operations and that it lacks sufficient information concerning its pharmacy space and storage needs.

Corrections received approval for the funding in June 2000 but did not hire a consultant until a year later in June 2001. Corrections claims that it needed a year to find and negotiate a contract with its consultant. The consultant is to identify alternatives for improving current strategies for managing pharmacy services, including the possibility of contracting with an external management company that can offer mail-order drug service to ensure, among other things, just-in-time drug delivery and consistent application of the formulary. The consultant is also to explore the opportunity to obtain manufacturer rebates and volume discounts, consider the usefulness of prospective and retrospective drug-utilization systems, consider the benefits of unit-dose dispensing, analyze prescriber patterns, and suggest better ways to use existing pharmacy staff.

Corrections' consultant's report will be critical for identifying the magnitude of problems within its pharmacy operations and suggesting ways to improve delivery of services to inmates.

The consultant's report will be critical for identifying the magnitude of problems within Health Care Services' pharmacy operations and will assist in deciding how to improve delivery of pharmacy services to inmates. Without this information, Corrections cannot determine how either an external or an internal manager should function within the system because it has not determined how the system will work.

OTHER OPTIONS FOR REDUCING DRUG COSTS ARE NOT AVAILABLE

Corrections is not eligible for some options for reducing its drug expenditures, such as the State's ADAP and the federal supply schedule.

Corrections Cannot Use ADAP Funds to Supplant Its Spending

The Office of AIDS, within the California Department of Health Services (Health Services), manages ADAP, which provides drugs to individuals infected with human immunodeficiency virus (HIV), assisting people who could not otherwise afford them. The State's ADAP has three sources of funding to purchase drugs: federal funds from the Comprehensive AIDS Resources Emergency grant program, rebates from drug manufacturers, and state funds. Its funding has increased every year since fiscal year 1992–93, starting with almost $14 million and growing to $145.7 million in fiscal year 2000–01.

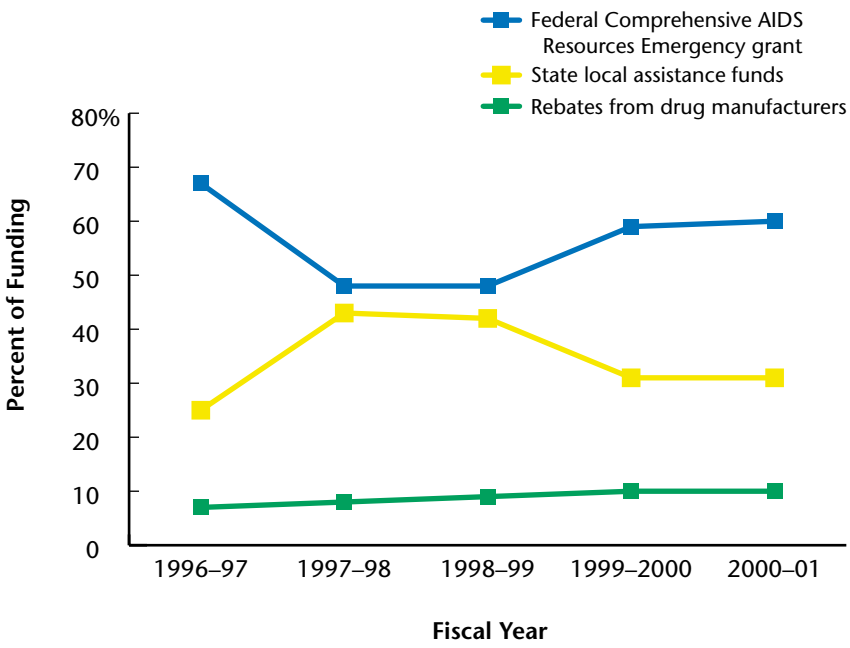
Although persons incarcerated in city or county jails may benefit from the federal funds given to a state's ADAP, HIV-positive inmates in Corrections' prisons are unable to do so.

Although persons incarcerated in city or county jails may benefit from the federal funds given to a state's ADAP, HIV-positive inmates in federal and state prisons such as Corrections' are unable to do so. Federal law excludes coverage of services that can be reasonably expected to be paid for by a state compensation program, insurance policy, or any federal or state health benefits program. California's ADAP was established in 1987 and began receiving federal funding to provide drugs to treat or prevent the deterioration of health resulting from the HIV disease in fiscal year 1991–92. Between fiscal year 1996–97 and fiscal year 2000–01, these federal funds have made up between 48.3 percent and 67.4 percent of the total funds used to support California's ADAP, as Figure 5 on the following page indicates. Because the State has an obligation to provide medically necessary health care to inmates, it may not use these federal funds to pay for the regular ongoing cost of services to inmates, including drugs.

The second major source of funds used to purchase drugs for the State's ADAP is state local assistance money. Between fiscal year 1996–97 and fiscal year 2000–01, state local assistance funding has made up 25.4 percent to 43.3 percent of ADAP funds. Like federal funds given to the ADAP, these local assistance funds cannot currently be used to pay for the regular costs of drugs to inmates because state law prohibits reimbursement for drugs that are available to the recipient under any other private, state, or federal program. However, the director of Health Services may grant an exemption to this law if the use of this program would constitute a cost savings to the State. Corrections has prepared a preliminary analysis showing that its proposed use of ADAP's state funds may not be cost-effective; therefore, it may not qualify for the exemption.

FIGURE 5

The State's ADAP Purchases Drugs Using Three Funding Sources



Source: Department of Health Services, Office of AIDS.

The third source of funds for the State's ADAP are rebates it receives from drug manufacturers, but these also are not available for use due to the federal and state funding restrictions mentioned previously. Federal law requires manufacturers to provide a rebate to decrease the price of drugs that certain programs purchase, including state-operated AIDS drug-purchasing assistance programs such as the State's ADAP. Generally ADAP does not receive the rebate at the time it purchases the drugs but sends estimated invoices to the manufacturers on a quarterly basis. Between fiscal year 1996–97 and fiscal year 2000–01, its rebates averaged 8.8 percent. Because ADAP receives these rebates based on federal and state funds it spends for drugs, the rebates are also subject to federal and state use restrictions.

Corrections Cannot Use the Federal Supply Schedule to Reduce Drug Costs

Other federal measures are also unavailable to Corrections for controlling its drug costs. For example, although it could provide significant savings, Corrections may not use the federal supply schedule, which by federal law places limits on the prices of drugs that the federal Department of Veterans Affairs, the

Department of Defense, the Public Health Service, and the Coast Guard purchase. The federal supply schedule helps these federal agencies purchase drugs at a reduced price. The federal law does not authorize state agencies that do not receive federal funds from these federal agencies to use the federal supply schedule to obtain discounts on drugs. Thus, Corrections is not eligible to use the federal supply schedule to obtain discounts on drugs it purchases to meet the medical needs of the inmate population because it is not affiliated with one of the federal agencies that federal law specifically names as eligible to use this service.

HEALTH CARE SERVICES DID NOT ALWAYS MEET CRITERIA FOR USING MAIL-ORDER PHARMACY SERVICES

Because Health Care Services did not demonstrate that it met criteria for using mail-order pharmacy services, it may have inappropriately spent up to $3.6 million for drugs and services provided through this contract.

Although Health Care Services obtained approval from General Services to use mail-order pharmacy services in prisons when pharmacist vacancy rates rise to more than 50 percent, it did not demonstrate that the use of mail-order pharmacy services was necessary. Further, it still lacks the ability to document its need for these services. Consequently, it may have inappropriately spent up to $3.6 million for drugs and services provided through this contract. Corrections should have to substantiate its need for these services before General Services prepares the next mail-order services contract, which could be ready after June 2002.

In January 2000 General Services contracted with a pharmacy to provide backup mail-order services to Corrections' pharmacies at an estimated cost of $12.8 million. This contract originally covered the period between January 24, 2000, and September 30, 2000, but was amended three times, most recently extending to September 30, 2001. This 8-month contract for $12.8 million grew to 20 months of service for a total cost of $21.1 million.

Health Care Services requested mail-order pharmacy services from General Services because it claimed that some prisons were having severe difficulty recruiting and retaining pharmacy services staff, which was affecting their ability to provide medically necessary pharmacy services to inmates. Health Care Services believed that a nationwide pharmacist shortage, noncompetitive salaries, the rural location of its facilities, and the difficult nature of providing care in a custody setting are the reasons that prisons cannot retain pharmacy services staff. It asserted to General Services that it would use the

mail-order pharmacy services only when all three of the following conditions applied: (1) the civil service pharmacist vacancy rate for a given prison was at or above 50 percent, (2) a prison had only one pharmacist, and (3) a pharmacist from the registry was not available. (A *registry service* provides pharmacists who can fill in for long- or short-term staffing needs resulting from vacancies, illnesses, or exceptional workload conditions.)

In our January 2000 report, Corrections also asserted that it experienced difficulties in managing its operations due to many pharmacist vacancies, which it believed were due to unattractive compensation. Since July 2000 pharmacists working for Corrections have been receiving recruitment and retention bonuses ranging between $800 and $1,000 per month, depending on the location of the prison. Additionally, pharmacists at three prisons in rural or remote locations receive an annual bonus of $2,400, and newly employed pharmacists at all prisons receive a lump-sum bonus of $2,400 after the first year. However, Corrections' efforts to reduce vacancy rates by increasing compensation do not appear to have had the desired effect because some of its facilities continue to have high vacancy rates.

Corrections' efforts to reduce vacancy rates by increasing compensation do not appear to have had the desired effect.

Nonetheless, our analysis of data for the month of June 2001 indicates that Corrections' vacancy rate appears to be in line with the national situation. According to a special workforce study conducted by the American Hospital Association in spring 2001, 715 hospitals in rural and urban locations nationwide reported vacancy rates for pharmacists that averaged 21 percent, with rural hospitals alone averaging 29 percent. As of June 2001 Corrections' vacancy rate averaged 22 percent.

Corrections provides health care using six types of facilities: acute care hospitals, correctional treatment centers, outpatient housing units, intermediate care facilities, skilled nursing facilities, and hospices. The average vacancy rate in June 2001 for pharmacists is highest at Corrections' acute care hospitals and skilled nursing facilities, about 32 percent and 36 percent, respectively. The California Medical Facility in Vacaville was hardest hit, with a vacancy rate of 67 percent. Also, facilities in the Corcoran region, which includes the Valley State Prison for Women, two facilities in Corcoran, and the Central California Women's Facility, had an average vacancy rate of almost 48 percent. However, the average vacancy rate for pharmacists at Corrections' treatment centers and outpatient housing units was substantially lower, about 9 percent and 24 percent, respectively.

Nine prisons used mail-order pharmacy services under the extended contract. However, only four of the nine had vacancy rates that were consistently at or above 50 percent during the contract period. Health Care Services directed the remaining five prisons to continue to use these services so that the mail-order pharmacy could gather data to update its formulary, obtain patient information, and complete monthly reports on use of certain drugs.

We cannot substantiate Corrections' shortage of pharmacists and thus its need for mail-order pharmacy services because Health Care Services lacks sufficient information about its use of registry employees. For example, although Health Care Services can provide data on the total dollars spent and the number of hours that registry employees worked by program, it cannot differentiate between pharmacists and pharmacy technicians. Therefore, although we do know that the four prisons with vacancy rates consistently at or above 50 percent used the registry services, we cannot determine how many pharmacists they used. In fiscal year 2000–01 Health Care Services spent almost $2.9 million for pharmacy registry services. Another obstacle that prevents us from substantiating Corrections' claim is it has not addressed our previous recommendation that it consider whether it has appropriately divided responsibilities between its pharmacists and pharmacy technicians. As of November 2001 Corrections had not performed such an analysis; however, the analysis may be a part of its consultant's report, expected in January 2002.

Some of the Duties of a Pharmacist

State laws and regulations allow a pharmacist to perform many tasks, such as the following:

- Receive a new prescription order from the prescriber.
- Consult with the patient.
- Identify, evaluate, and interpret a prescription.
- Interpret the clinical data in patient medication records.
- Consult with any prescriber, nurse, or health professional.
- Supervise the packaging of drugs and check the packaging procedure and product upon completion.
- Oversee pharmacy technicians to ensure that they perform their duties completely, safely, and without risk of harm to patients.

Generally, pharmacy technicians perform packaging, repetitive, and other nondiscretionary tasks while under the direct supervision and control of a pharmacist. State law limits most pharmacies to a one-to-one staffing ratio for pharmacist and pharmacy technicians, but a few state agencies such as Corrections are exempt from this staffing ratio. Corrections has yet to exercise its authority under this exemption. In fact, it still maintains a higher ratio of about two pharmacists for each pharmacy technician. The results of the analysis discussed above could indicate that Corrections may be able to allow pharmacy technicians to assume more responsibilities so that it can lower the number of pharmacists necessary to run its

pharmacies. Although the deputy director of Health Care Services told us that her requests for funding to increase the number of pharmacy technicians have been unsuccessful, she did not provide us with any documentation of her efforts.

Until Health Care Services is able to provide better data on its use of registry pharmacists and exercises its authority to modify the staffing ratio of pharmacists to pharmacy technicians, it cannot substantiate that a shortage of pharmacists exists or that it needs to use mail-order pharmacy services. Health Care Services must improve its ability to substantiate its pharmacist shortage because it is already working with General Services to enter into a new mail-order pharmacy services contract, expected to go into effect sometime after June 2002.

RECOMMENDATIONS

To improve the functioning of Health Care Services, Corrections should do the following:

- Update its formulary and monitor compliance so that it can identify prescribing practices that are not cost-effective. Monitoring of the formulary should take place at Health Care Services headquarters as well as at prisons.

- Ensure that prisons receive monthly contract compliance reports from the prime vendor and use them to monitor noncontract purchases.

- Await the results of its consultant's report and identify those recommendations that will be beneficial to the program. Only then should it decide whether to hire either an internal or external pharmacy manager to assist in resolving its pharmacy operations deficiencies. Further, if Health Care Services decides to hire a manager, it needs to clearly state the roles and responsibilities of this position.

- Take the necessary steps, such as tracking the number of hours that registry pharmacists work, to substantiate its position that a shortage of pharmacists exists. Additionally, it should prepare an analysis to determine whether it has the appropriate division of responsibilities between its pharmacists and pharmacy technicians. This analysis should include

an evaluation of whether the current staffing ratio of pharmacists to pharmacy technicians limits Corrections' ability to fill its vacant positions.

If it is able to substantiate its claims that a pharmacist shortage exists and General Services approves another contract for mail-order pharmacy services, Health Care Services should ensure that prisons meet the contract conditions before beginning to use these services and monthly thereafter. ■

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CHAPTER 3

Corrections Has Not Been Successful in Automating Its Pharmacy Operations

CHAPTER SUMMARY

The pharmacy prescription tracking system that the Department of Corrections (Corrections) uses cannot support today's complex medication monitoring and cost-containment requirements or the day-to-day management of its pharmaceutical services. The system contains data on drug interactions that are out of date; it cannot transfer data electronically between prisons; and it is unable to track data critical to managing pharmacy operations. Corrections has been trying to replace this tracking system and other health care information technology systems since 1991 without significant progress. Currently, it is behind schedule on its plans to implement a new health care management system by November 2006 and is not considering an automated pharmacy system in the interim.

Corrections did make an effort to streamline its drug dispensing process, but it did not adhere to the State's public contracting laws, intended to safeguard taxpayer dollars, when acquiring its new drug delivery system. Corrections also failed to consider thoroughly the legal ramifications of using an automated drug delivery system. To control misuse of such machines, state law allows them to be used only for dispensing new drug orders, drugs that inmates have been prescribed to use as-needed, and emergency drugs. Using its automated drug delivery system for routine dispensing and packaging has not had a negative effect on the State, Corrections, or the inmates, but Corrections should ensure that it uses the system in a manner that complies with current state law.

CORRECTIONS HAS MADE NO IMPROVEMENTS IN ITS PRESCRIPTION TRACKING SYSTEM

Inadequacies that exist in Corrections' current pharmacy prescription tracking system compel pharmacists to perform routine processing tasks instead of using their professional expertise to provide clinical and pharmacological information,

advice, or consultation to other health care professionals. Since 1991 Corrections has been aware of weaknesses in its prescription tracking system and their effects on the ability of its Health Care Services Division (Health Care Services) to manage its pharmacy operations. An example of such a weakness is the out-of-date drug interactions data. However, as of November 2001 Corrections had not made any significant progress in addressing those weaknesses.

The Current Prescription Tracking System Limits Corrections' Ability to Manage Pharmacy Operations

We brought weaknesses in Corrections' prescription tracking system to its attention in our January 2000 report. We pointed out key components that the current data collection system does not have, such as updated drug interactions, automated price updates, inventory control, and security controls against alteration of databases. In fiscal year 2000–01, while justifying its need for additional funds to improve its pharmacy operations, Corrections acknowledged these weaknesses, stating that the system cannot support today's complex medication monitoring and cost-containment requirements or the day-to-day management of pharmaceutical services to the inmate population.

Although there are at least 30,000 possible adverse drug interactions, Corrections' pharmacies must use out-of-date drug interaction data because it does not have a central process for updating this data in its system.

A major weakness is the incomplete data on drug interactions. Corrections' policy requires the pharmacist to screen all prescription orders for potential problems, including drug interactions. Corrections' current prescription tracking system can automatically compare an inmate's new prescription order with his or her existing orders to identify adverse interactions and alert the pharmacist. The pharmacist must then contact the prescriber directly for clarification. However, according to the manager of the tactical systems unit within the Information Systems Division, Corrections does not have a central process for updating drug interaction data in this system, which means that drugs released in recent years are not included. For example, during our visit to one prison, the pharmacist in charge gave us a demonstration by entering into the system a new drug that he knew would have an adverse interaction with another drug an inmate was already taking, and the system failed to signal the pharmacist.

Two of the prison pharmacies that we visited have taken the initiative to purchase up-to-date commercial drug interaction databases. However, the commercial databases do not link to Corrections' prescription tracking system and cannot access

patient profiles, which list each inmate's prescriptions over a specified period of time. Therefore, the pharmacists have to rely on their system's outdated interaction data and their own professional expertise to recognize a potentially adverse drug interaction, then refer to the commercial database to determine the severity of the interaction. At least 30,000 possible adverse drug interactions exist. The worst adverse drug interaction is deadly. Even drug interactions that are not life-threatening can decrease one or both drugs' effectiveness, which results in insufficient therapy and sometimes creates unnecessary costs. Up-to-date data on drug interactions are crucial to the efficient operation of Corrections' health care system.

Corrections cannot transfer inmate pharmacy data electronically between its prisons.

Another major weakness is that Corrections' cannot transfer inmate pharmacy data electronically between its 33 prisons. In calendar year 2000 it transferred almost 284,000 inmates between its prisons and received about 43,200 new inmates. As part of the intake process, all inmates pass through one of Corrections' 13 reception centers for an average of 58 days, where they are referred to psychiatric and medical staff as necessary for diagnosis, treatment, or recommendations. According to the chief of Corrections' transportation unit, when an inmate transfers between prisons, staff collect his or her central file and a sealed medical file. Staff compare a list of all transferring inmates to all the medical files in their possession. If a medical file is not available, staff ascertain the reason the file is missing; for example, because some transfers are temporary, such as when an inmate appears in court, the medical files do not need to accompany the inmate. When the inmate arrives at the receiving prison, a nurse delivers by hand or faxes the prescription drug profile to the pharmacy. If an inmate arrives without a drug profile, pharmacy staff at the receiving prison request that the sending prison fax the inmate's profile. If Corrections were able to electronically transfer the inmate's medical file to his or her destination or allow staff at the destination to download the inmate's up-to-date medical file from a central server, it could ensure that the inmate's destination has access to his or her complete and accurate medical file immediately.

Several factors hamper Corrections' ability to transfer pharmacy data electronically between its prisons. For example, its prescription tracking system does not have the ability to transfer data between prisons. In addition, only 7 of Corrections' 33 prisons are connected to its wide-area computer network and able to quickly share information. Even if the prescription tracking

system was capable of transferring data between prisons, it could transfer the data to only those few prisons that are part of the wide-area computer network.

Lastly, Health Care Services cannot use the current prescription tracking system to manage its pharmacy operations because most reporting tools are either not available or inaccurate. Access to timely, complete, and accurate pharmaceutical prescribing and administration data is critical to pharmacy management. To obtain comprehensive information about its medical practitioners' prescribing practices, Corrections must require each prison to gather most of the data manually, a cumbersome and time-consuming process. The current system does not allow pharmacy staff to identify the drugs that physicians are prescribing, for example. In addition, its cost data is unreliable. Our review of a medication cost report found no cost-per-unit data for commonly used drugs such as acetaminophen or Actifed. Further, Corrections told us that it relies on the companies it buys drugs from to provide data on departmentwide drug purchases and costs. Currently, the only remaining data source is the State's wholesaler or prime vendor, which provides data on overall drug purchases but not on prescribers or patients. Finally, the current system does not contain edits or red flags to identify incorrect doses, history of patient allergies, and premature refills on prescriptions.

Most reporting tools in the current prescription tracking system are either unavailable or inaccurate.

Managed care organizations have processes that allow for the efficient monitoring of prescription practices and even provide immediate information to physicians on the prices of the drugs they are prescribing. Unlike these organizations, Corrections does not have easy access to important information that would allow it to plan for effective purchasing and ensure that its medical practitioners follow appropriate practices for prescribing medications.

Corrections also cannot track the drug inventories in its prisons because of the limitations of its prescription tracking system. One of its consultants reported that Corrections' current system lacks many inventory functions used in the private sector, such as the ability to track the return of drugs to the wholesaler, to note that a dispensed medication has been returned to the pharmacy's stock, and to track drug-recall notifications or drug expirations. Weaknesses in the prescription tracking system such as these prevent Corrections from effectively managing and monitoring pharmacy services and operations.

Despite Two Unsuccessful Attempts, Corrections Has No Plans to Implement an Improved Health Care System Until 2006

Corrections' latest attempt at improving its information system has a health care component that includes automation of pharmacy operations, but it is already behind schedule in acquiring and implementing this component.

Corrections has made at least two unsuccessful attempts within the last decade to implement information technology systems that could improve its pharmacy operations. Now, it is in the early stages of designing a Strategic Offender Management System to capture and share offender information internally and with other criminal justice and law enforcement entities. The new system would also replace obsolete systems, such as the prescription tracking system. The new system will contain a health care management component that Corrections will use to, among other things, manage its pharmacy operations. However, it does not expect the health care component to be fully operational until November 2006, and development of the new system is already behind schedule. Moreover, Corrections does not plan to implement an interim information technology system for its pharmacies, although its failure to do so will continue to hamper its ability to perform the day-to-day management of pharmaceutical services for inmates.

The Correctional Management Information System Had Significant Cost Fluctuations and Schedule Delays

Corrections had hoped to consolidate the needs of all users of the offender information system into its Correctional Management Information System. However, development of the system began to experience severe cost fluctuations and schedule delays, and despite subsequent attempts to resurrect it, Corrections had to terminate the project in February 1997.

In December 1991 Corrections notified the Department of Finance's Technology Investment Review Unit (Finance) of its proposal for the comprehensive project. In January 1992 its feasibility study report was approved by Finance. At that time, Corrections estimated that project costs between fiscal year 1992–93 and fiscal year 1997–98 would be about $54.5 million. By August 1995 it estimated that project costs would reach almost $96 million by fiscal year 2000–01 due to reasons such as the installation of additional workstations and a visitor tracking application, the connection of the new system to the Criminal Law Enforcement Telecommunication System, and procurement delays.

Because Corrections had to terminate a project to consolidate the needs of all users of the offender information system, improvements to its health care operation, including inmates' drug prescription records, were also discontinued.

In February 1997 Corrections ceased the development of the new system on the advice of its project oversight consultant because of unacceptable design deliverables by the vendor. Although Corrections attempted to resurrect the project by submitting a new feasibility study report to Finance in March 1997, Finance and the Department of Information Technology denied its request. They asked Corrections to prepare and submit an alternative procurement business justification for further review but suspended the project in light of the governor's executive order requiring departments to defer computer projects not mandated by law and not directly related to the Y2K or Year 2000 problem. As a result of the project's ending, improvements to Corrections' health care operation, which were part of the third phase that was to include the automation and incorporation of inmates' health and drug prescription records, were also discontinued.

Corrections Has Been Unsuccessful in Establishing a Model Health Care Services System

In an attempt to correct inadequacies in the medical and mental health services at Pelican Bay State Prison in 1995, Corrections implemented MedSched, a computer application that was supposed to provide all patient appointment tasks and other health care-related functions. If it had been able to successfully implement MedSched at Pelican Bay in the mid-1990s, Corrections might have been able to use it as a model to improve the health care delivery systems at other prisons throughout the State. MedSched ultimately failed, and as of January 2001 Corrections is under court mandate to replace it as quickly as possible.

On January 10, 1995, in *Madrid v. Gomez,* a class-action lawsuit against Corrections, the court determined that the entire medical and mental health care delivery system at Pelican Bay State Prison was inadequate in meeting the health services needs of the inmate population. The court found that the Pelican Bay medical records system was so disorganized that it was impossible to understand the medical condition of the inmates. Without accurate and thorough records, providers were continually running the risk of prescribing contraindicated medications, failing to notice ongoing illnesses, or ordering inappropriate or even dangerous courses of treatment.

If it had been able to successfully implement MedSched at Pelican Bay in the mid-1990s, Corrections might have been able to use it as a model to improve the health care delivery systems at other prisons throughout the State.

Included in the remedy that Corrections proposed was an automated patient appointment scheduling system called MedSched, which was intended to accomplish all tasks related to patient appointments and to provide other information, such as patient pharmacy profiles. However, MedSched did not meet the court's or Corrections' expectations. The system crashed frequently, lost inmate appointments, and was slow to respond. Consequently, staff resorted to developing and using manual methods that led to significant problems with access to and continuity of health care services. Despite Corrections' attempts to improve MedSched, on January 24, 2001, the court ordered Corrections to replace it as quickly as possible with a more robust system that would support the health care services program for inmates at Pelican Bay. Corrections' chief information officer agreed that MedSched became increasingly difficult to use and maintain. Corrections expects MedSched's replacement to address the significant weaknesses that exist in its current prescription tracking system. Currently, it is soliciting bids for Pelican Bay to procure a patient information management system that includes 44 pharmacy automation requirements. However, it does not expect to implement this system until October 2002. Consequently, Corrections still does not have a model to improve the health care delivery systems at prisons throughout the State.

Corrections Does Not Plan to Implement an Interim Information Technology System for Pharmacies

Corrections is behind schedule in developing the health care management component of its Strategic Offender Management System, and as of November 2001 it had no plans to pursue an interim information technology system for its pharmacies. Therefore, it will continue to experience inefficiencies in monitoring prescription practices and controlling drug costs.

Overall, Corrections expects the new comprehensive management system to fulfill many purposes: integrate offender information, reengineer and automate job processes, replace obsolete systems, and capture and share offender information to serve integrated justice systems. The health care management component includes automation of pharmacy operations. Corrections is already behind schedule in acquiring and implementing the health care management component. It has not yet completed its funding request nor even prepared its written justification to Finance for wanting to use an alternative procurement process, which it was to complete by November 1, 2001.

According to its chief of Information Technology Planning, a primary reason for the delay is that Corrections did not receive funding to improve its communications infrastructure such as computer hardware and software to allow it to share data between all of its locations, which is a prerequisite for it to begin work on any information technology projects. The chief was unable to provide a new timeline for the development and implementation of the communications infrastructure.

Despite Corrections' past problems in implementing information technology systems, it does not have a good alternative to the current inadequate prescription tracking component, preferring to wait for the new comprehensive management system. Corrections told us that it is opposed to developing an interim system because it believes that this work would detract from and duplicate its efforts to develop its new comprehensive management system. Specifically, because the same staff would work on developing both systems, any attempt to implement an interim system would decrease this staff's ability to finish the comprehensive system. Also, Corrections told us that it plans to use the experience it gains from implementing the Pelican Bay patient information management system to facilitate the implementation of its new comprehensive system.

Corrections lacks a good alternative to its current inadequate prescription tracking system, preferring to wait for its new comprehensive management system.

However, the weaknesses in the current prescription tracking system are too significant for Corrections not to implement quickly its new comprehensive system that includes a health care management component. Corrections' failure to do so will continue to hamper its ability to perform the day-to-day management of providing pharmaceutical services to the inmate population.

CORRECTIONS MADE SIGNIFICANT ERRORS IN ATTEMPTING TO STREAMLINE ITS DRUG DISPENSING PROCESS

In an attempt to reduce staff time taken up by routine chores and free pharmacists to perform drug-utilization functions and to participate in interdisciplinary treatment teams, Corrections began using an automated drug delivery system that picks, packs, and labels oral solid medications from bulk inventories. Although Corrections' justification for using the drug delivery system appears reasonable, it did not seek the necessary approvals to contract with the vendor nor ensure that it uses the system in accordance with state law.

In October 2000 the California State Prison, Sacramento, entered into an agreement with a vendor for two automated drug delivery machines. The prison wanted to evaluate the benefits of using these machines in addressing its acute shortage of pharmacists. It hoped to reduce the time that staff spends on directly observed therapy, which it believes consumes 65 percent of pharmacy staff's workday. *Directly observed therapy* requires health care staff to administer, observe, and monitor patient compliance with taking each dose of certain types of drugs such as antipsychotics and antidepressants to prevent hoarding and control drug abuse. The automated drug delivery machines store drugs as bulk inventory in refill cartridges and containers, package inmates' drugs using their patient profile data from Corrections' prescription tracking system, label envelopes with inmate names and drug information, and organize the inmates' envelopes into tote carriers from which the health care staff administers the drugs. The machines automate the manual process for dispensing medication, which requires health care staff to check each inmate's medication administration record, open medication doses already packaged by the pharmacist, and place the doses in individual envelopes before administering drugs to the inmates.

Automated drug delivery machine

Although the use of an automated drug delivery system appears to reduce health care staff time, the prison did not adhere to the State's contracting procedures to acquire the system. Corrections ordered two automated drug delivery machines from a vendor and agreed to pay $4,999.99 to use the systems between November 1, 2000, and March 31, 2001.

State contracting law requires agencies to secure at least three competitive bids for each contract of $5,000 or more. The prison's entering a limited-time agreement that is one cent below the $5,000 threshold for competitive bidding appears to be a circumvention of the State's purchasing process. Moreover, as of November 2001 the prison continued to use the drug delivery machines without a state-approved contract. Since November 1, 2000, Corrections has paid almost $22,000 to its vendor for the two drug delivery machines and consumable supplies, which includes more than $7,700 it paid for supplies purchased after the contract expiration.

Corrections also has been using the drug delivery machines since the end of the contract period without paying for either the purchase of the machines or lease fees. According to the vendor's executive director, this could amount to lease costs of

at least $2,050 per unit per month (roughly $29,000 through October 31, 2001) or $184,000 to purchase these two units. Additionally, the vendor has not been paid for its development of an interface between the automated drug delivery machines and Corrections' prescription tracking system, equaling $8,000 and maintenance costs of $900 per unit per month. The vendor told us that it has allowed Corrections to continue using the automated drug delivery machines because it has been investing in Corrections for one year and expects to sell more machines.

It was not until November 2001 that Corrections completed a feasibility study report to support its position that automated drug delivery machines are necessary to reduce costs for preparing and dispensing doses using directly observed treatment procedures at the prison. According to an analysis prepared by the pharmacist in charge at the California State Prison, Sacramento, the results from using these two machines indicate that Corrections can save roughly $5,000 per month. Corrections is right to try to improve the operation of its pharmacies and relieve the burdens of its pharmacists, but its failure to adhere to the State's public contracting laws can make it appear that it is favoring one vendor over others that may be qualified to offer similar products and services.

State law allows the removal of drugs from an automated drug delivery machine in only one of three circumstances: (1) to provide drugs for a new prescription order, (2) to provide drugs in an emergency, or (3) to provide drugs that the medical practitioner has prescribed for an inmate to take when the need arises, such as a pain reliever for a headache.

Another issue that Corrections must resolve before it continues to use the automated drug delivery machines is whether it is complying with state law that governs how the machines may be used. State law allows the removal of drugs from an automated drug delivery machine in only one of three circumstances: (1) to provide drugs for a new prescription order, (2) to provide drugs in an emergency, or (3) to provide drugs that the medical practitioner has prescribed for an inmate to take when the need arises, such as a pain reliever for a headache.

Corrections' authority to use an automated drug delivery machine in health care facilities of its prisons is unclear. Specifically, Chapter 778, Statutes of 1998, amended Section 1261.5 of the Health and Safety Code to permit skilled nursing or intermediate care facilities to exceed the number of doses of drugs their pharmacies provide when an automated drug delivery machine is in use. However, it also added Section 1261.6 to the Health and Safety Code, which states the purposes for which such a system may be used and appears to apply to the use of automated drug delivery machines in all health care facilities, including those located in Corrections' prisons. Although the legislative history of this bill indicates that the Legislature had skilled nursing and

intermediate care facilities in mind in drafting it, the state law setting forth the circumstances in which automated drug delivery machines may be used refers to "facilities" in a generic sense and not merely skilled nursing and intermediate care facilities. Moreover, state law does not authorize the use of those delivery machines for the routine filling of prescriptions. The prison's use of these machines does not match any of the three state-approved circumstances. Corrections contends that it is using the system appropriately. However, our attorney's analysis of the law is that it pertains to all facilities and does not limit use of the automated drug delivery machines only to skilled nursing and intermediate care facilities.

RECOMMENDATIONS

To address weaknesses in its prescription tracking system and improve its pharmacy operations, Corrections should accelerate the acquisition and implementation of the Strategic Offender Management System and its new health care management component.

To ensure that its use of the automated drug delivery machines is appropriate, Corrections should do the following:

- Cease using its automated drug delivery system until it secures a contract in accordance with the State's public contracting laws.

- Seek an opinion from the attorney general to support its current use of the machines.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: January 9, 2002

Staff: Joanne Quarles, Audit Principal, CPA
Wendy Stanek, CIA
Matthew Liu
John J. Romero

APPENDIX A

The table on the following page represents the top 50 drugs that the State purchased from the prime vendor from August 1999 to August 2001.

TABLE

The State's Top 50 Drug Purchases From the Prime Vendor

Ranking	Generic Name	Therapeutic Description	Amount Spent ($)
1	OLANZAPINE	Antipsychotic agents	47,081,355.39
2	RISPERIDONE	Antipsychotic agents	14,099,814.38
3	DIVALPROEX SODIUM	Miscellaneous anticonvulsants	8,322,600.28
4	QUETIAPINE FUMARATE	Antipsychotic agents	7,203,853.73
5	FLUOXETINE HCL	Antidepressants	6,733,413.46
6	RIBAVIRIN/INTERFERON A-2B	Antivirals	5,864,109.33
7	OMEPRAZOLE	Miscellaneous gastrointestinal drugs	5,618,963.14
8	ZIDOVUDINE/LAMIVUDINE	Antiretroviral agents	5,571,841.72
9	GABAPENTIN	Miscellaneous anticonvulsants	4,910,577.16
10	SERTRALINE HCL	Antidepressants	4,698,612.36
11	PAROXETINE HCL	Antidepressants	4,225,588.12
12	STAVUDINE	Antiretroviral agents	3,418,023.99
13	LAMIVUDINE	Antiretroviral agents	2,830,119.90
14	BECLOMETHASONE DIPROPIONATE	Adrenals	2,263,350.14
15	ENALAPRIL MALEATE	Cardiac drugs	2,146,692.09
16	NIFEDIPINE	Cardiac drugs	2,050,737.28
17	LOVASTATIN	Antilipemic agents	1,640,715.88
18	CIPROFLOXACIN HCL	Miscellaneous anti-infectives	1,573,927.94
19	FLUCONAZOLE	Antifungal antibiotics	1,440,334.93
20	METFORMIN HCL	Miscellaneous antidiabetic agents	1,377,807.34
21	LANSOPRAZOLE	Miscellaneous gastrointestinal drugs	1,287,319.28
22	SAQUINAVIR	Antiretroviral agents	1,267,640.07
23	NELFINAVIR MESYLATE	Antiretroviral agents	1,252,476.13
24	MIRTAZAPINE	Antidepressants	1,248,293.48
25	CLOZAPINE	Antipsychotic agents	1,167,069.45
26	TRIAMCINOLONE ACETONIDE	Adrenals	1,157,572.02
27	INDINAVIR SULFATE	Antiretroviral agents	1,085,998.52
28	PHENYTOIN SODIUM EXTENDED	Hydantoins	1,080,871.67
29	ALBUTEROL	Sympathomimetic (adrenergic) agents	1,053,942.30
30	ATORVASTATIN CALCIUM	Antilipemic agents	1,037,137.54
31	CARBAMAZEPINE	Miscellaneous anticonvulsants	1,016,354.65
32	LAMOTRIGINE	Miscellaneous anticonvulsants	965,093.77
33	BUPROPION HCL	Antidepressants	962,235.22
34	ABACAVIR SULFATE	Antiretroviral agents	954,538.27
35	NEVIRAPINE	Antiretroviral agents	942,816.69
36	TOPIRAMATE	Miscellaneous anticonvulsants	939,904.23
37	HEP B VIR VACC RECOMB	Vaccines	926,294.69
38	VENLAFAXINE HCL	Antidepressants	840,577.11
39	IBUPROFEN	Nonsteroidal anti-inflammatory agents	835,999.56
40	INTERFERON ALFACON-1	Antineoplastic agents	816,852.21
41	LEUPROLIDE ACETATE	Antineoplastic agents	816,342.94
42	CELECOXIB	Nonsteroidal anti-inflammatory agents	783,844.60
43	RITONAVIR	Antiretroviral agents	767,848.75
44	AZITHROMYCIN	Macrolides	696,618.35
45	ITRACONAZOLE	Antifungal antibiotics	686,768.10
46	RANITIDINE HCL	Miscellaneous gastrointestinal drugs	630,927.96
47	CEFTRIAXONE SODIUM	Cephalosporins	583,101.83
48	IPRATROPIUM BROMIDE	Antimuscarinics/antispasmodics	547,284.20
49	AMOX TR/POTASSIUM CLAVULANATE	Penicillins	520,281.62
50	EPOETIN ALFA	Hematopoietic agents	506,464.65

Source: Prime vendor data for August 1999 to August 2001.

APPENDIX B

Summary of the Department of Corrections' Progress Toward Implementing the Recommendations Relating to Pharmacy Operations From the Bureau's January 2000 Audit Report

Recommendations	Progress	Plans
The Department of Corrections (Corrections) should ensure that its methods for procuring pharmaceuticals allow for the fullest amount of competition possible. To do this, it should identify obstacles that are limiting competition and take action to eliminate them. The department should work with the Department of General Services (General Services) to ensure that it places as many items on the contract as possible and that it makes changes to the process to allow manufacturers to bid competitively to supply therapeutic drug classes when drugs are clinically interchangeable.	Corrections staff has been working with General Services on contracting issues. For example, Corrections is aiding General Services in its efforts to develop a statewide formulary. Please refer to pages 20 through 21.	Corrections will work with General Services on the statewide formulary to facilitate negotiations and get more of the regularly used drugs on the contract and secure the best negotiating power.
Corrections should explore other procurement processes, including the federal General Services Administration's supply schedule (federal supply schedule), that could save it more money. It should work with legislative and administration leaders to fully explore its ability to participate in these processes. If such participation is not possible, the department still should revise its current contracting process to adopt techniques used in other more successful processes to allow for greater competition and higher savings.	Corrections staff has been working with General Services on contracting issues. For example, Corrections is aiding General Services in its efforts to develop a statewide formulary. Please refer to pages 20 through 21. Corrections cannot use the federal supply schedule or the AIDS Drug Assistance Program to reduce or supplant its spending for drugs. Please refer to pages 30 through 33. State law gives Corrections the authority (1) to adopt regulations requiring drug manufacturers to pay rebates and (2) to enter into interagency agreements to minimize administrative costs and maximize benefits. However, based upon its research of the experiences that other states and the federal government have had in attempting to require rebates, Corrections believes that as written this legal authority is insufficient to lower drug costs. Therefore, no progress has been made to establish a program to obtain rebates from drug manufacturers.	Corrections will work with General Services on the procurement process and provide any support possible considering the limited staff that Corrections has available.

Recommendations	Progress	Plans
Corrections should identify the conditions that are limiting its ability to collect and report data on its pharmaceutical operations and propose needed action so that information can be readily accessible and used to increase efficiency and effectiveness.	Corrections has made little progress on this recommendation. Although it is aware of the conditions that limit its ability to collect and report data on its pharmacy operations, it has made little progress in replacing the existing prescription tracking system it uses to collect and report data. Please refer to pages 39 through 42. Corrections is in the process of procuring an information technology system for the Pelican Bay State Prison that includes 44 elements for pharmacy data collection. Corrections expects to implement this system by October 2002. It is also in the process of designing a Strategic Offender Management System with a health care management component that includes automation of pharmacy operations. However, it does not expect the health care component to be fully operational until November 2006, and development of the system is already behind schedule. Please refer to pages 44 through 46.	Corrections' Health Care Services Division will continue to work with the Information Systems Division on information technology solutions for patient management and data collection.
Corrections should ensure that its pharmaceutical operations are staffed properly by addressing conditions that have led to vacancies among its pharmacists. If the problem is unattractive compensation, the department should pursue the means to improve it by working with the pharmacists' bargaining unit. Additionally, the department should consider whether it has the appropriate division of responsibilities between its pharmacists and pharmacy technicians and whether a realignment of staff is warranted. Finally, if the pharmacies lack sufficient workspace to operate properly, the department should identify such needs and take steps to obtain additional space.	Corrections was able to secure recruitment and retention bonuses for its pharmacists that became effective in July 2000. However, these bonuses do not appear to have had the desired effect because as of June 2001, some prisons had vacancy rates as high as 67 percent. As of November 2001 Corrections had not performed an analysis to determine whether it has the appropriately divided responsibilities between its pharmacists and pharmacy technicians. However, Corrections told us that it did attempt to increase the number of pharmacy technicians, but its funding request was denied. Please refer to pages 33 through 36. Corrections still has not identified the workspace needs of its pharmacies.	Corrections expects its consultant's report, due in January 2002, to address staffing and workspace needs in the pharmacies and offer recommendations. It also states that current statewide fiscal constraints do not permit the hiring of additional staff at present.
Corrections should monitor and document drug usage, including physician prescription practices, periodically so that information regarding the most appropriate and cost-effective drugs is available for developing and updating the department's drug formulary. Further, the department should update its formulary regularly and use it to control which drugs medical practitioners can prescribe routinely.	Corrections has not improved its prescription tracking system, which it must do to improve the quality and quantity of data available to enable it to monitor and document drug use. Further, as of November 2001 Corrections had not updated its formulary. Please refer to pages 26 through 28.	Corrections' Health Care Services Division will continue to work with the Information Systems Division on solutions to resolve the pharmacies' information technology needs.

Agency's comments provided as text only.

State and Consumer Services Agency
Office of the Secretary
915 Capitol Mall, Suite 200
Sacramento, CA 95814

December 11, 2001

Elaine Howle, State Auditor*
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, California 95814

Dear Ms. Howle:

Enclosed is our response prepared by the Department of General Services to the Bureau of State Audits' Report No. 2001-012 entitled, *State of California: Its Containment of Drug Costs and Management of Medications for Adult Inmates Continue to Require Significant Improvements."* A copy of the response is also included on the enclosed diskette.

If you have any questions or need additional information, please contact me at 653-2636.

Sincerely,

(Signed by: George Valverde)

George Valverde
Deputy Secretary

Enclosures

*California State Auditor's comments begin on page 61.

Date: December 10, 2001 File No.: 2001-012

To: Aileen Adams, Secretary
State and Consumer Services Agency
915 Capitol Mall, Room 200
Sacramento, CA 95814

From: **Department of General Services**
Executive Office

Subject: **RESPONSE TO BUREAU OF STATE AUDITS' REPORT NO. 2001-012– "STATE OF CALIFORNIA: ITS CONTAINMENT OF DRUG COSTS AND MANAGEMENT OF MEDICATIONS FOR ADULT INMATES CONTINUE TO REQUIRE SIGNIFICANT IMPROVEMENTS"**

Thank you for the opportunity to respond to the Bureau of State Audits' (BSA) Report No. 2001-012 which addresses recommendations to the Department of General Services (DGS). The following response addresses each of the recommendations contained in Chapter 1 of the report.

OVERVIEW OF THE REPORT

The DGS has reviewed the findings, conclusions and recommendations presented in Report No. 2001-012. As discussed in this response, the DGS will take appropriate actions to address the recommendations.

Overall, the DGS is pleased that the BSA is supportive of the department's plans for developing a statewide drug formulary and medical supply catalog. The planning for each of these procurement methods has just begun. The BSA indicates that for the formulary program to be successful it must include enforcement provisions. The DGS will ensure that formulary policies have governance provisions which ensure the use of drugs within approved formulary lists. For the medical supply catalog, the BSA recommends that the DGS continue its current plans for contracting for a catalog. In the near future, the DGS will perform a needs assessment which is the first step in developing a contract.

The primary concern expressed in the report involves the BSA's view that the DGS' recent contract with another state to access a group purchasing organization may not offer the best deal to the state. The DGS continues to believe that the use of a group purchasing organization approach to procure drugs is the most innovative technique currently available to reduce
(1) drug costs and that the recent contractual arrangement is a reasonable and low-risk approach to obtaining additional knowledge of and experience with this procurement method. DGS estimates that by entering into the pilot contractual arrangement will generate significant savings of at least $3 million per year. This far exceeds DGS' analysis of the estimated savings by entering into other cooperative purchasing arrangements such as the Minnesota Contracting Alliance for Pharmacy, which was estimated to save at most $1.3 million. This arrangement will also enable DGS to learn about potential enhancements to include in future

competitive bidding arrangements, and the potential pitfalls to avoid in entering into this contracting method. The DGS provides its assurance that this arrangement is only a pilot project whose success will be fully evaluated within nine months. If this project does not show success, the DGS is committed to exploring other opportunities.

Chapter 1 of the report discusses the BSA's view that further actions need to be taken to control the state's drug expenditures. Subsequent to the BSA's January 2000 report on the California Department of Corrections that expressed concerns with the state's systems for procuring drugs, the DGS took action to ensure that its procurement process includes best practices within the specialty of pharmaceutical contracting. Of primary importance, the DGS' Procurement Division (PD) created an Integrated Product Team specifically for pharmaceuticals. This team is made-up of a pharmacist who is an expert in the pharmaceutical field and two staff members with acquisitions expertise. The team has been tasked with the responsibility for implementing a pharmaceutical contracting program that is in the best interests of the state. As part of this process, the team has the responsibility for continually seeking new methods for procuring drugs at lower prices and evaluating the effectiveness of existing procurement methods.

As discussed in the BSA's report, to date, the PD has taken two significant actions to ensure that best practices for procuring drugs are in place within the state. First, in October 2001 the DGS entered into a contract with the Massachusetts Alliance for State Pharmaceutical Buying as a group purchasing organization pilot project. Although as previously stated the BSA has concerns with this contract, the PD has initially estimated that this arrangement will save the state approximately $3 million a year. (1)

Second, the DGS is also in the early stages of developing the previously discussed statewide drug formulary (the first meeting of a state agency formulary committee occurred in October 2001). An effective drug formulary will create competition among manufacturers of similar drugs resulting in reduced prices.

The following response only addresses the recommendations. In general, the actions recommended by the BSA have merit and will be promptly addressed.

RECOMMENDATIONS

CHAPTER 1

RECOMMENDATION # 1: ***General Services should increase efforts to solicit bids from drug manufacturers so that it can obtain more drug prices on contract.***

DGS RESPONSE # 1:

The DGS is committed to continually pursuing procurement activities that result in more drugs being available under contract. As discussed in the Overview section of this response, during the last year the PD has created an Integrated Product Team specifically

for pharmaceuticals. A task of this team, which was formed after the hiring of a second buyer in November 2000 and a pharmacist in January 2001, involves identifying and negotiating the inclusion of additional drugs under contract. The providing of a pharmacist for the first time within the procurement process has allowed the DGS to more effectively work with the pharmaceutical community, i.e., state agency pharmacists and drug manufacturers, to increase drugs under contract.

It should be noted that, while only being successful in obtaining contract prices for 850 of 1838 drugs in which bids were requested during its last contracting effort, the DGS was successful in obtaining contracts for the top six drugs purchased by state agencies as shown within the table in Appendix A of the BSA's report. According to the BSA's data, these six drugs totaled approximately $89 million over a two year period. It is also expected that the involvement of the Integrated Product Team with the next drug contracting effort, which is to be conducted in the summer and fall of 2002, should result in a further increase in contracted drugs. This team was not in place during the prior drug contracting effort that was conducted in the fall of 2000.

RECOMMENDATION # 2: ***General Services should fully analyze measures to improve its procurement process, such as joining the Minnesota Contracting Alliance for Pharmacy or con tracting directly with a group purchasing organization. The analysis should include the availability of current noncontract drugs from each organization being con sidered and the savings that could result from less administrative time spent trying to secure additional contracts directly with drug manufacturers.***

DGS RESPONSE # 2:

The DGS' strategy for pharmaceutical contracting is to achieve the best cost through the use of a variety of procurement methods. In fact, the previously discussed Integrated Product Team was specifically created to ensure that best practices within the pharmaceutical procurement field were pursued and implemented.

(1) To date, the team has determined that the best approach to achieving additional cost savings is to enter into a pilot project with the Massachusetts Alliance to access a group purchasing organization procurement methodology. The options of joining the Minnesota Multistate Contracting Alliance for Pharmacy or contracting directly with a group purchasing organization have also been considered by the DGS but not pursued. However, these options have not been rejected from further consideration. The DGS will continue to explore all reasonable options to reduce drug costs.

In addition, the Massachusetts Alliance pilot project is scheduled for an effectiveness review within nine months. Prior to finalizing any decisions as to continuing that contract, the DGS commits to fully analyzing all relevant options. However, the PD believes that the use of a group purchasing organization methodology either through continuance of the
(1) Massachusetts Alliance or the DGS directly contracting with a group purchasing organization will be shown to be the best and most innovative approach to reducing drug costs.

RECOMMENDATION # 3: ***General Services should fully consider all obstacles that could prevent the successful development of a statewide formulary, such as agencies not strictly enforcing the formulary at their institutions. Further more, General Services should attempt to mitigate the obstacles it identifies. For instance, it should require agencies to adopt a policy requiring strict adherence to the statewide formulary.***

DGS RESPONSE #3

The DGS will ensure that the newly formed Common Drug Formulary Committee is fully aware that any formulary program must include adherence and enforcement provisions. Furthermore, any other significant obstacles to success that are identified in the formulary development process will be fully considered and addressed prior to implementation.

RECOMMENDATION # 4: ***General Services should ask state agencies to deter mine their needs and then consider contracting for a medical supply catalog to maximize the State's buying power.***

DGS RESPONSE # 4

As noted in the BSA's report, the DGS is in the process of contracting for a medical supply catalog. The contract development cycle has just begun and is estimated to take from 12 to 18 months. As a first step, the PD will perform a thorough analysis of what state agencies currently purchase and their service needs.

CONCLUSION

The DGS has a firm commitment to effectively and efficiently controlling the state's procurement of drugs and medical supplies. As part of its continuing efforts to improve this process, the DGS will take appropriate actions to address the issues presented in the report.

If you need further information or assistance on this issue, please call me at 376-5012.

(Signed by: Rosamond C. Bolden for)

BARRY D. KEENE, Director
Department of General Services

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COMMENTS

California State Auditor's Comments on the Response From the State and Consumer Services Agency

To provide clarity and perspective, we are commenting on the Department of General Services' (General Services) response to an excerpt of our audit report. The number below corresponds to the number we placed in the margins of General Services' response.

(1) General Services is attempting to minimize our concern. As we state on pages 16 through 18, the limited analysis that General Services performed before joining the Massachusetts Alliance for State Pharmaceutical Buying (Massachusetts Alliance) does not ensure the State receives the best value. Although its most recent analysis estimates that by using the Massachusetts Alliance's group-purchasing organization the State will save about $3 million a year for noncontract drugs, this analysis was not prepared until after General Services joined the Massachusetts Alliance. In addition, neither this analysis nor General Services' first limited analysis discussed on page 17 can ensure that the group-purchasing organization used by the Massachusetts Alliance will achieve the greatest savings for the State. As we state on page 18, a more thorough analysis of group-purchasing organizations could show the potential to save more on the specific drugs the State purchases. Specifically, group-purchasing organizations use the aggregated needs of their customers to obtain lower contract prices, but their portfolios do not necessarily contain all products that a given member may want to purchase. Further, General Services' statement that its estimated savings from the Massachusetts Alliance far exceeds that of the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) is incorrect because, as we state on pages 19 and 20, General Services' analysis of MMCAP only included a comparison of prices and did not consider other factors, such as the time it might save trying to secure contracts with drug manufacturers or the impact that MMCAP would have on distributing drugs.

Finally, we believe it to be unnecessary for General Services to use the Massachusetts Alliance contract as a low-risk approach to obtaining knowledge and experience about group-purchasing organizations and that this approach may delay the State's

ability to obtain optimal savings. As we state on page 19, the Massachusetts Alliance's procurement manager told us that it was not difficult to work with group-purchasing organizations because they negotiate the prices more quickly with the manufacturers and send the final prices directly to the prime vendor. He also told us that only a few prime vendors exist and that most group-purchasing organizations are familiar with their data requirements. Therefore, General Services' learning curve should have been minimal. Specifically, once its solicitation process was complete and it had chosen a group-purchasing organization, General Services would have completed a substantial amount of its responsibility, leaving the rest of the work to the prime vendor.

Agency's comments provided as text only.

Department of Corrections
1515 S Street
Sacramento, CA 95814

December 11, 2001

Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Subject: **RESPONSE TO BUREAU OF STATE AUDIT DRAFT REPORT**

The attached documents are in response to the Bureau of State Audits (BSA) Draft Report entitled: *State of California: Its Containment of Drug Costs and Management of Medications for Adult Inmates Continue to Require Significant Improvements,* dated January 2002 (2001-012).

The California Department of Corrections (CDC), in its continuing commitment to providing the most cost-effective quality health care, commissioned Fox Systems, Inc., to conduct a survey of its pharmacy services. The CDC anticipates receipt of the final Fox Report by late January 2002. Once the final report has been received, its recommendations will be reviewed and adopted, as appropriate.

Due to State budget restriction, court mandates, statewide hiring freeze, high vacancy rates due to noncompetitive salaries for clinicians and other professional staff, the CDC continues to face enormous obstacles and challenges. In spite of these challenges, the CDC remains diligent in its commitment to deliver quality health care in an efficient and cost effective manner.

We appreciate the opportunity to respond to the BSA's findings and recommendations. If additional information is required, please contact Michael Pickett, Deputy Director (A), Health Care Services Division, at 323-0229.

(Signed by: Kathy Kinser for)

EDWARD S. ALAMEIDA, JR.
Director
Department of Corrections

Attachments

*California State Auditor's comments begin on page 75.

DEPARTMENT OF CORRECTIONS
RESPONSE TO THE BUREAU OF STATE AUDITS' DRAFT REPORT

The California Department of Corrections (CDC) has reviewed the Bureau of State Audits' (BSA) Report: *State of California: Its Containment of Drug Costs and Management of Medications for Adult Inmates Continue to Require Significant Improvements* – January 2002 (2001-012).

The CDC appreciates the efforts and cooperation of BSA in bringing their recommendations to the forefront. The CDC agrees with these recommendations as set forth below. The CDC has commissioned the Fox Systems, Inc., to conduct a survey of the CDC pharmacy services. The CDC anticipates receiving the final Fox recommendations by the end of January 2002. The CDC will work to adopt and incorporate both the BSA and Fox recommendations, as appropriate.

The following information is in response to the BSA's Report and is organized around the BSA findings and recommendations in Chapters 2 and 3.

CHAPTER 2

Corrections Needs to Rein in Its Increasing Expenditures for Drugs

1. Bureau of State Audits Recommendation:

"Update its formulary and monitor compliance so it can identify prescribing practices that are not cost effective. Monitoring of the formulary should take place at the Health Care Services Division as well as at prisons."

California Department of Corrections response:

(1) A. The CDC in partnership with the Department of General Services (DGS) is preparing a request for bid proposal to award a statewide procurement contract for pharmaceuticals.
- This contract will service all State agencies, resulting in significant discounts and/or credits in drug costs.
- Together DGS, CDC and other purchasing State agencies will be identifying all pharmaceuticals listed on the statewide Formulary that are name brand items. The CDC, DGS and other State agencies will be working with the manufacturer(s) of those items to obtain appropriate discounts and/or rebates.

B. The CDC Pharmacy and Therapeutics Committee (PTC) has examined the issues related to escalating pharmacy costs. At the recommendation of the PTC, the Formulary[1] has been updated and is in the final draft review process.
   - It is anticipated that the Formulary will be finalized by the end of January 2002. The PTC will review, on at least an annual basis, the Formulary and the non formulary drugs for consideration of new medications.
   - After the Formulary has been adopted, separate statewide teleconference training will be conducted for 1) all physicians, 2) psychiatrists, 3) pharmacists, and all other pertinent parties. This training will introduce the revised Formulary, discuss the impact of cost savings, and the appropriate avenues available to obtain non formulary medications. This will include justification for items that are not on the Formulary that are needed for life threatening illness.
   - The statewide pharmaceutical procurement contract through DGS is anticipated to be in place by the first of July 2002.

C. After the revised Formulary has been adopted and the statewide contract awarded and in place, a policy directive will be issued. This directive will mandate that all drugs currently in the pharmacies that are not on the revised Formulary be inventoried and returned for credit.

D. Evaluation of the CDC's current Pharmacy Prescription Tracking System (PPTS), has determined that the system has limited capability and capacity. Due to these factors, the system is in danger of imminent failure. To solve the PPTS problems, CDC has taken the following action: (2)
   - Proposed a service memorandum to the institutions instructing them to perform maintenance activities on their system to ensure continued service.
   - Allocated a sufficient number of computers so that each pharmacy manager will have a (current industry standard) personal computer (PC). These PCs will have enough memory to allow network capability as the HCSD establishes its communication infrastructure.
   - Established a PPTS task force that is evaluating the purchase of an "off-the-shelf pharmacy system" that will track medication errors, incompatible drug interactions, prescribing practice of physicians, patient profiles and costing information. Anticipate a recommendation by March 2002. (2)
   - Is evaluating the current infrastructure capacities to determine what additional resources will be required to support an upgraded, multidiscipline pharmacy tracking system. This evaluation is being conducted in conjunction with Information Systems Division and a report is anticipated in the near future.
   - Once the infrastructure needs are known and a recommendation for pharmacy system has been made, CDC will revise its action plan and develop the requests for the appropriate resources.

[1] A Formulary lists all the drugs that are approved and authorized by CDC to be prescribed by a physician without prior Management review and approval.

A non formulary drug would be all drugs not listed on the Formulary that a physician may prescribe. Prescription/dispensing of non formulary drugs must be reviewed and approved by Management prior to their purchase/dispensing.

2. Bureau of State Audits Recommendation:

"Ensure that prisons receive monthly contract compliance reports from the prime vendor and use them to monitor noncontract purchases."

California Department of Corrections Response:

- The outdated Formulary is responsible for the amount of non contract purchases. The implementation of an updated Formulary (and continued review and updating of that Formulary by the PTC) will ensure that non contract purchases are monitored and limited to an appropriate level. (3)
- The CDC received allocation for a Utilization Management (UM) Pharmacy Services Manager (PSM) in fiscal year 2000/01. Although allocation has been received, the position has not yet been established. This position will be established upon receipt and adoption of the final Fox Report. Once the position is established the UM PSM will provide to the institutions' PSM/Health Care Manager (HCM), on a monthly basis, the Health Care Services Division at headquarters generated contract compliance reports together with recommendations on how to limit non contract purchases.The UM PSM will also monitor non contract purchases for compliance.

3. Bureau of State Audits Recommendation:

"Await the results of its consultant's report and identify those recommendations that will be beneficial to the program. Only then should it decide whether to hire either an internal or an external pharmacy manager to assist in resolving Health Care Services' pharmacy operations deficiencies. Further, if Health Care Services decides to hire a manager, it needs to clearly state the roles and responsibilities of this position."

California Department of Corrections Response:

A. Pending the final Fox Report and recommendation, the UM PSM will be responsible to either coordinate pharmacy activities within the HCSD, and/or interact with an external pharmacy consultant. The UM PSM shall provide direction in resolving Health Care Services pharmacy operational deficiencies and implement the adopted recommendations of the final Fox report.
   - The duty statement of this UM PSM position (when established) will clearly designate the authority, roles and responsibilities for the position. These duties will include, but not be limited to, responsibility for the timely completion and distribution of the reports to ensure appropriate pharmacy management practices.
   - This UM PSM position will be delegated the authority to direct changes, as appropriate.

4. Bureau of State Audits Recommendation:

"Take the necessary steps, such as tracking the number of hours worked by registry pharmacists, to substantiate its position that a pharmacist shortage exists. Additionally, it should prepare an analysis to determine whether it has the appropriate division of responsibilities between its pharmacists and pharmacy technicians. This analysis should include an evaluation of whether the current pharmacist to pharmacy technician ratio limits Corrections' ability to fill its vacant positions."

California Department of Corrections Response:

A. The CDC has informally conducted salary studies to evaluate salaries of pharmacists working within California State government (see attachment 1).
   - The CDC will continue to conduct informal salary studies to evaluate current competitive salary structure.
   - The CDC will continue to advise the Department of Personnel Administration (DPA) of our findings. CDC will request a DPA formal review and action to resolve salary inequities/inadequacies.

B. The CDC will evaluate its usage of the pharmacy registry to assist in identifying staffing shortages.
C. The CDC will evaluate appropriate pharmacy staffing on a per-institution basis.
D. The CDC will maintain job descriptions for pharmacy managers, pharmacists, pharmacy assistants, and technicians. Develop and evaluate standards for performance for each classification.
E. Conduct periodic evaluations on the ratio for the number of pharmacy managers, pharmacists, pharmacy technicians, and assistants.

5. Bureau of State Audits Recommendation:

"If it is able to substantiate its claims that a pharmacist shortage exists and XX approves another contract for mail-order pharmacy services, ensure that the contract conditions are met prior to allowing the prisons to begin using these services and monthly thereafter."

California Department of Corrections Response:

A. There is a statewide shortage of pharmacists. (Two new pharmacy schools have been recently established in California to increase the number of pharmacists.)
B. The CDC has found (see attachment 1) that there is a great disparity in the salaries of pharmacists working within California State government. These findings show that (4) pharmacists working within CDC are the lowest paid of all State departments. CDC continues its efforts to bring this disparity to the attention of the DPA for resolution.
C. The CDC acknowledges that mail-order pharmacy services significantly impacts the pharmaceutical budget for numerous reasons, including, but not limited to, costly dispensing fees. The use of the mail-order pharmacy services must continue as an option until the (5) CDC can resolve its salary disparity and become more competitive in its recruitment efforts. CDC continues its recruitment efforts and will work with DPA to resolve the salary disparity issues.
    - As the attached survey (Attachment 2) shows, CDC's statewide pharmacist vacancy rate is approximately 22 percent. However, many of the CDC institutions, due in part to their remote locations, are experiencing a high vacancy rate of 50 percent or more.

CHAPTER 3

Corrections Has Not Been Successful in Automating Its Pharmacy Operations

6. Bureau of State Audits Recommendation:

"To address weaknesses in its prescription tracking system and improve its pharmacy operations, Corrections should accelerate the acquisition and implementation of the Strategic Offender Management System and its new health care management component."

California Department of Corrections Response:

- The CDC is allocating computers to the CDC pharmacies. The PPTS task force is exploring (2) software alternatives that would be appropriate to improve pharmacy operations and tracking systems.
- The CDC Medication Errors workgroup is exploring alternatives to address medication errors for presentation to Department of Health Services.
- The implementation of the Strategic Offender Management System is dependent on infrastructure and resources. The CDC is proceeding through the correct approval processes to move forward on this project.

7. Bureau of State Audits Recommendation:

"To ensure that its use of the automated drug delivery machines is appropriate, Corrections should do the following:

Cease using its automated drug delivery system until it secures a contract in accordance with the State's public contracting laws."

California Department of Corrections Response:

The CDC believes that the proposed contract is lawful under health licensing law and will assist the department in providing quality patient care that is timely, safe and cost efficient. The CDC acknowledges that formal approval of the proposed contract has been significantly delayed past the proposed effective date; however, the CDC is taking all appropriate steps to rectify this situation and to ratify the contract for the services that have been provided. (6)

- California State Prison-Sacramento (SAC) obtained the drug delivery system through the Service and Expense Order process in order to conduct a pilot project. The SAC negotiated terms for the piloting of the automated drug dispensing device(s) to test automation, and to ensure a successful interface with current CDC systems. The SAC did not want to enter into a costly automation agreement/contract without knowing its success in a correctional environment. When it was determined that the pilot (November 1, 2000 – March 31, 2001) was successful, SAC submitted a contract request form to the Department's Contracts Management Branch to obtain a long-term contract without knowing that a Feasibility Study Report (FSR) was required for this type of equipment. An FSR was completed on November 21, 2001, however, this caused significant delays in the process. (6)
- As of December 11, 2001 SAC is close to completing the contract for the drug delivery system. The SAC is now aware of the proper process necessary for these types of projects.
- The BSA report suggests CDC favors one vendor over other vendors who may be qualified to offer similar products and services. Prior to obtaining the services of KVM Technologies, SAC looked at systems from 11 other vendors. KVM Technologies was the only vendor that could meet the needs of the Department. The automated drug dispensing system provided software compatibility with the current pharmacy software at the institution and has the ability to meet the functional requirement of providing STAT doses within one hour, meeting CDC needs. (7)
- The CDC will further evaluate the automatic drug dispensing system and complete a Post Implementation Evaluation Report prior to making any future decisions concerning its use. (6)

8. Bureau of State Audits Recommendation:

"To ensure that its use of the automated drug delivery machines is appropriate, Corrections should do the following:

Seek an Attorney General's opinion to support its current use of the machines."

California Department of Corrections Response:

The CDC's Legal Affairs Division has analyzed the statutes cited by the BSA in this section and disagrees with BSA's conclusion that these sections apply to CDC, and therefore will not seek an opinion from the Attorney General. The CDC's position is supported by the licensing entities involved. It is the view of CDC, the Department of Health Services, and the State Board of Pharmacy that Health and Safety Code Sections 1261.5 and 1261.6 are intended to apply only to those licensed facilities without an on-site licensed pharmacy (i.e., skilled nursing and intermediate care facilities). In contrast, SAC has a licensed pharmacy, and the automated drug dispensing machines are controlled by licensed pharmacists.

(8)

Attachment 1

State of California
Salary Report - Governmental Employers - December 2000

Benchmark Title: Pharmacist
State Comparison
Journey Level: Pharmacist I

Government Data	Journey	
	Salary Minimum	Salary Maximum
State of California	$4,818	$5,474
Alameda County	—	—
Contra Costa County	$5,584	$6,464
Fresno County	$5,319	$5,865
Los Angeles County	$6,183	$6,183
Orange County	$4,924	$6,631
Riverside County	$4,878	$6,042
Sacramento County	$4,616	$5,611
San Bernardino County	—	—
San Diego County	$5,649	$6,867
Santa Clara County	$5,572	$6,751
SF City/County	$5,416	$6,584
City of Fresno	—	—
City of Los Angeles	$5,284	$5,888
City of Oakland	—	—
City of Riverside	—	—
City of Sacramento	—	—
City of San Diego	—	—
City of San Jose	—	—
California State University	$4,837	$6,413
University of California	$5,155	$6,413
Federal Government	$4,450	$5,784

Average Private Salary	$6,572
Average State Salary	$5,404

Pharmacist - Incumbents are journey level, licensed professional pharmacists. They prepare and dispense drugs and pharmaceutical preparations, fill prescriptions, and as required, supervise and instruct nonprofessional assistants in routine phases of the work. Appointment requires a valid license issued by the California State Board of Pharmacy.

Attachment 1

California Department of Corrections
Health Care Services Division
Pharmacist Annual Base Salary Survey

Attachment 2

VACANCY RATES FOR PHARMACISTS
APRIL 2001 (State Controller's Report)

Institution	Pharmacist I			Pharmacist II			TOTALS		
	Established	Vacant	Rate	Established	Vacant	Rate	Established	Vacant	Rate
ASP	4.0	3.0	75%	1.0	-	0%	5.0	3.0	60%
CAL	1.0	-	0%	1.0	-	0%	2.0	-	0%
CCC	1.0	-	0%	1.0	-	0%	2.0	-	0%
CCI	2.0	-	0%	1.0	-	0%	3.0	-	0%
CCWF	2.1	1.1	52%	1.0	-	0%	3.1	1.1	35%
CEN	2.0	1.0	50%	1.0	-	0%	3.0	1.0	33%
CIM	8.0	-	0%	1.0	-	0%	9.0	-	0%
CIW	1.5	-	0%	1.0	-	0%	2.5	-	0%
CMC	5.0	1.0	20%	-	-	0%	5.0	1.0	20%
CMF	8.0	6.0	75%	1.0	-	0%	9.0	6.0	67%
COR	5.0	2.0	40%	-	-	0%	5.0	2.0	40%
CRC	2.0	-	0%	1.0	-	0%	3.0	-	0%
CTF	3.0	-	0%	1.0	-	0%	4.0	-	0%
CVSP	1.0	-	0%	1.0	-	0%	2.0	-	0%
DVI	1.7	-	0%	1.0	-	0%	2.7	-	0%
FSP	-	-	0%	1.0	-	0%	1.0	-	0%
HDSP	1.0	-	0%	1.0	-	0%	2.0	-	0%
ISP	1.0	-	0%	1.0	-	0%	2.0	-	0%
LAC	4.0	2.0	50%	1.0	-	0%	5.0	2.0	40%
MCSP	1.0	-	0%	1.0	1.0	100%	2.0	1.0	50%
NCWF	1.0	-	0%	-	-	0%	1.0	-	0%
NKSP	3.0	1.0	33%	2.0	1.0	50%	5.0	2.0	40%
PBSP	2.0	-	0%	1.0	-	0%	3.0	-	0%
PVSP	3.0	-	0%	1.0	1.0	100%	4.0	1.0	25%
RJD	2.0	-	0%	1.0	1.0	100%	3.0	1.0	33%
SAC	4.0	-	0%	1.0	-	0%	5.0	-	0%
SATF	3.0	3.0	100%	1.0	1.0	100%	4.0	4.0	100%
SCC	1.0	-	0%	1.0	-	0%	2.0	-	0%
SOL	3.0	-	0%	1.0	-	0%	4.0	-	0%
SQ	3.0	-	0%	1.0	-	0%	4.0	-	0%
SVSP	1.0	-	0%	1.0	-	0%	2.0	-	0%
VSPW	4.1	1.1	27%	1.0	-	0%	5.1	1.1	22%
WSP	4.0	1.0	25%	1.0	-	0%	5.0	1.0	20%
Total/Average	**88.4**	**22.2**	**25%**	**31.0**	**5.0**	**16%**	**119.4**	**27.2**	**23%**

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COMMENTS

California State Auditor's Comments on the Response From the Department of Corrections

To provide clarity and perspective, we are commenting on the Department of Corrections' (Corrections) response to our audit. The number corresponds to the number we have placed in the response.

(1) Corrections plays a minor role in the State's procurement process for drugs. As we state on page 6, the Department of General Services (General Services) negotiates contracts with drug manufacturers so that state agencies can purchase drugs at less-than-wholesale acquisition cost. However, in the past, a few staff from Corrections have assisted General Services in evaluating the bids.

(2) Corrections' proposed purchase of an off-the-shelf pharmacy system cannot solve the pharmacy prescription tracking system's problems. As stated on pages 39 through 42, Corrections lacks a communications infrastructure, such as computer software and hardware, to allow it to share data between all of its locations. Without this infrastructure, Corrections cannot transfer inmate pharmacy data electronically between its 33 prisons even if it does purchase an off-the-shelf pharmacy system. This is particularly important because in calendar year 2000 Corrections transferred almost 284,000 inmates between its prisons throughout the State and received about 43,200 new inmates. Moreover, it is highly unlikely that an off-the-shelf pharmacy system can handle the massive amount of data Corrections' prison system generates. Further, as page 46 indicates, Corrections previously told us that developing an interim system would detract from and duplicate its efforts to develop its new comprehensive management system that contains a health care component. However, the weaknesses in Corrections' current prescription tracking system are too significant for it not to take any action, which is why we recommended on page 49 that it should accelerate the acquisition and implementation of the Strategic Offender Management System.

3. Corrections is wrong. Its outdated formulary does not prevent pharmacists from reviewing items being ordered to determine cost and to make sure that they purchase drugs that are generic equivalents of more expensive brand name drugs. Moreover, as we state on page 28, although the prisons can use the State's prime vendor's monthly reports to document the reasons they purchase noncontract drugs, some prisons may not be doing so. Therefore, as we recommend on page 36, Corrections should ensure that prisons receive monthly contract compliance reports from the prime vendor and use them to monitor noncontract purchases.

4. Corrections is misrepresenting the facts. Its pharmacists are not the lowest paid of all state departments. All state pharmacists are subject to the same collective bargaining agreement that ensures they receive equitable treatment for issues such as salary. Moreover, as we state on page 34, since July 2000 pharmacists working for Corrections have been receiving recruitment and retention bonuses ranging between $800 and $1,000 per month, depending on the location of the prison. Additionally, pharmacists at three prisons in rural or remote locations receive a lump-sum bonus of $2,400 after the first year.

5. Our report does not state the use of mail-order pharmacy services is not an option for Corrections. Rather, on pages 35 and 36, we point out that because Corrections lacks sufficient information about its use of registry employees and has not considered whether it has appropriately divided responsibilities between its pharmacists and pharmacy technicians, we cannot substantiate that Corrections has a shortage of pharmacists and thus its need to use mail-order pharmacy services. Therefore, as we recommend on page 36, Corrections must address these issues before it can justify the use of these services.

6. Corrections is understating the seriousness of its actions. The situation that we describe on pages 47 and 48 addresses more than its failure to obtain the necessary approvals promptly. First, the prison's entering a limited-time agreement that is one cent below the $5,000 threshold for competitive bidding appears to be a circumvention of the State's purchasing process. Second, the prison has continued to use the drug delivery machines without a state-approved contract. Lastly, Corrections continues to expose the State to liability because it has not paid the vendor for either the purchase of the machines or lease fees, the cost of developing an interface between the machines and the pharmacy prescription tracking system, and monthly maintenance

costs. Therefore, as we recommend on page 49, Corrections should cease using its automated drug delivery system until it secures a contract in accordance with the State's public contracting laws.

7 Corrections is overstating its effort. Specifically, Corrections told us that it conducted informal inquiries with other vendors. Furthermore, due to the potential dollar amount of this contract if it chooses to install these machines in all of its prisons, Corrections failure to adhere to the State's public contracting laws for competitive bidding creates the appearance that it is favoring one vendor over others. It is particularly important that Corrections comply with competitive bidding requirements because it has already given the appearance that it circumvented the State's purchasing process when it entered into a time-limited agreement that is one cent below the $5,000 threshold for competitive bidding.

8 Corrections is misrepresenting the facts. Although the licensing entities may support its position, according to Corrections' acting deputy director of the Health Care Services Division neither the Department of Health Services nor the Board of Pharmacy provided Corrections with a legal opinion. Thus, we stand by our recommendation that Corrections seek an opinion from the attorney general to support its current use of the machine.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
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