

**Development of a Preferred Drug List Program  
by the Virginia Department of Medical Assistance Services**

**Status Report**



**Virginia Department of Medical Assistance Services**

**April 1, 2003**

April 1, 2003

**MEMORANDUM**

**TO:** The Honorable Vincent F. Callahan, Jr.  
Chairman  
House Appropriations Committee

The Honorable John H. Chichester  
Chairman  
Senate Finance Committee

**FROM:** Patrick W. Finnerty  
Director

**SUBJECT:** Medicaid Preferred Drug List Program

Pursuant to Item 325 #4c of the 2003 Budget Conference Committee Report, the Department of Medical Assistance Services (DMAS) is required to provide a report on the final design components of the Medicaid Preferred Drug List (PDL) program. The enclosed report conveys the status of this program as of April 1, 2003.

At this time, DMAS is not able to submit a report on the final design because DMAS is continuing to meet with stakeholders for input; the Pharmacy and Therapeutics Committee must meet and make recommendations; and a Contractor must be hired to administer the Preferred Drug List program. DMAS intends to submit subsequent memoranda to you, which will provide updates at key decision points. For example, once the membership of the Pharmacy and Therapeutics Committee is finalized in mid-April, this information will be shared with the Committees. At a minimum, updates will be provided at the key milestones throughout the development and implementation process. These updates include when the Request for Proposals is published for the PDL Contractor, when a PDL Contractor is selected, when the program design for both the PDL program and the prior authorization processes are finalized, and following the implementation of the PDL program on January 1, 2004. In addition, DMAS will publish all progress on the PDL program on its agency website.

Should you have any questions regarding this report, please do not hesitate to contact me.

PWF/bws

cc: The Honorable Jane H. Woods

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## INTRODUCTION

Item 325 #4c of the 2003 Budget Conference Committee report directs the Department of Medical Assistance Services (DMAS) to establish a preferred drug list (PDL) program no later than January 1, 2004. The required savings to the Medicaid pharmacy program is approximately \$18 million in general funds annually (\$9 million in state fiscal year 2004). A copy of the budget language is in Attachment A. The budget language provides criteria for the design of a Medicaid PDL program. It directs DMAS to:

- Form a Pharmacy and Therapeutics Committee, between eight and 12 members, with a ratio of physicians to pharmacists of 2:1. This committee will recommend: (1) therapeutic classes to be included in the preferred drug list; (2) appropriate exclusions for certain medications; and (3) appropriate grandfather clauses when prior authorization would interfere with established complex drug regimens.
- Develop the PDL program with input from physicians, pharmacists, pharmaceutical manufacturers, patient advocates, and other stakeholders.
- Ensure that the PDL program's cost effectiveness is based on the safety and clinical effectiveness of a drug first. The program should also include provisions for emergency supply of prescribed drugs, timely prior-authorization procedures, expedited review of denials, and comprehensive consumer and provider education.
- Work with the Department of Mental Health, Mental Retardation, and Substance Abuse Services to consider utilizing a preferred drug list for its non-Medicaid clients.

The Governor has submitted an amendment related to the budget language for the Medicaid PDL program, which is technical in nature. The language included in the enrolled budget includes two sentences which are somewhat redundant, one of which mandates that DMAS complete the final design of the program by April 2<sup>nd</sup> while the next sentence requires DMAS to report on the final design by April 1<sup>st</sup>. Since the Reconvened Session is scheduled for April 2<sup>nd</sup>, the budget bill will not be enacted until after the April 1 and April 2 deadlines included in the General Assembly proposed language. Thus, the amended language requires DMAS to report to the General Assembly on the design of the Preferred Drug List within 10 days upon the enactment of the budget bill.

This report is in response to the budget language, which required DMAS to submit a report on the final design components of the program to the Chairmen of the House Appropriations and Senate Finance Committees. At this time, DMAS is not able to provide all aspects of the final design of the PDL program because DMAS is continuing to meet with stakeholders for input; the Pharmacy and Therapeutics

Committee must meet and make recommendations; and a Contractor must be hired to administer the PDL program. DMAS intends to submit subsequent memoranda to the Chairmen of the House Appropriations and Senate Finance Committees, which will provide updates at key decision points. For example, once the membership of the Pharmacy and Therapeutics Committee is finalized in mid-April, this information will be shared with the Committees. At a minimum, updates will be provided at the key milestones throughout the development and implementation process. These updates include when the Request for Proposals is published for the PDL Contractor, when a PDL Contractor is selected, when the program design for both the PDL program and the prior authorization processes are finalized, and following the implementation of the PDL program on January 1, 2004. In addition, DMAS will publish all progress on the PDL program on its agency website.

As of April 1, 2003, the following tasks have been completed:

- DMAS met with 28 stakeholder groups, including physicians, pharmacists, pharmaceutical manufacturers, consumer advocates, service providers, and other interested parties to receive input to the design of the PDL program. Attachment B is a sample of the letter sent to the stakeholders requesting their input.
- DMAS sent a letter to the academic health centers, several medical societies, the Virginia Pharmacy Congress, and other provider associations to request nominees for the Pharmacy and Therapeutics Committee. Attachment C is a sample of the letter requesting nominees for the Committee. Each group was requested to send their nominations to DMAS by March 19, 2003. In addition, several individuals with specific expertise required by the budget language also were contacted regarding the P&T Committee. The Secretary of Health and Human Resources will make the final selection of Committee members.
- DMAS began the development of a Request for Proposals (RFP) for a qualified contractor to administer the PDL program, as well as other pharmacy cost savings initiatives. The RFP will be published in April 2003. The RFP will provide a basic framework for how the PDL program will work.

This report consists of four sections. The first section provides a background on trends in Medicaid expenditures for pharmaceuticals and other DMAS pharmacy savings. The second section provides an overview of the key provisions of other state Medicaid PDL programs. The third section describes Virginia's proposed PDL program, and provides information on some key decisions that have been made thus far. Other key decisions cannot be made until after the P&T Committee makes its clinical recommendations regarding the PDL, and a Contractor is hired to administer the

program. The final section describes the work plan for implementing a Virginia Medicaid PDL program.

## **BACKGROUND**

Authorized under Title XIX of the Social Security Act, Medicaid is an entitlement program for low-income people financed by federal and state funds and administered by the states according to federal guidelines. The Virginia Medicaid program is administered by the Department of Medical Assistance Services (DMAS).

Virginia Medicaid plays a fundamental role in the provision of pharmacy services to the low-income population and is particularly important for the low-income elderly and disabled enrollees who depend upon prescription drugs to maintain or improve their health care functioning. Pharmaceuticals are an increasingly important part of medical care and health care costs, and the fastest growing component of health care spending, not just in Medicaid, but generally. All state Medicaid programs face the challenge of managing pharmacy expenditures in a difficult economic environment while maintaining beneficiary access to appropriate care. Pharmacy costs in Virginia is one of the top Medicaid cost drivers.

### **Medicaid Coverage of Prescription Drugs**

Prescription drug coverage is an optional benefit that all state Medicaid programs currently provide. This benefit provides access to a broad range of prescription drugs to a population that otherwise might be unable to get necessary but expensive drug therapy, including those with severe mental illness or HIV/AIDS.

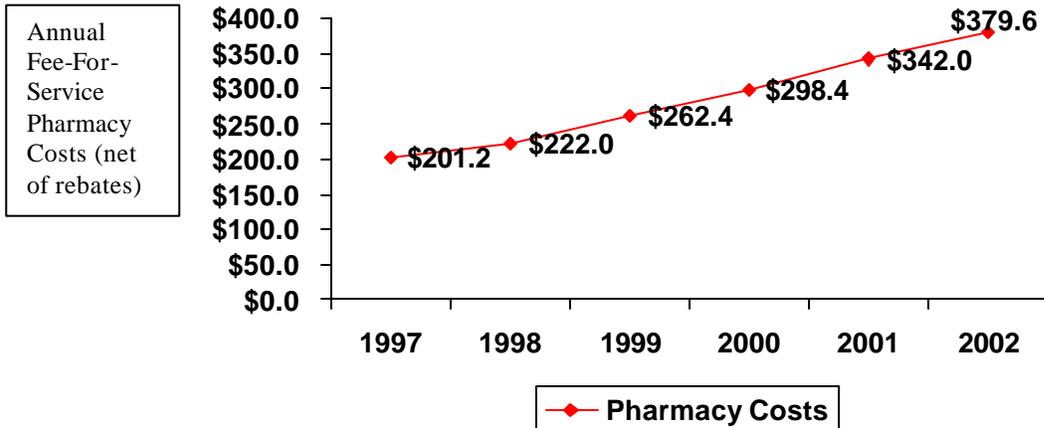
In Virginia, the prescription drug benefit is provided through a fee-for-service program and a managed care program. The 220,000 clients that remain in the fee-for-service program are those who live in areas of the State that currently do not have a managed care organization available or who are excluded from managed care (such as persons in nursing facilities, community based care waiver programs, and foster care). Approximately 60 percent (more than 300,000 recipients) of the Medicaid recipients receive pharmacy benefits through managed care organizations. The focus of this report is implementing a PDL in the fee-for-service program. The 300,000 Medicaid recipients in one of Virginia's five managed care organizations are already subject to a preferred drug list or similar program.

### **Trends in Medicaid Spending for Prescription Drugs**

National studies indicate that the main factors for the increase in the growth of pharmacy expenditures are the discovery of new drug treatments, the increased use of drugs in treatment of various health conditions, the increased advertising by drug manufacturers, and the growth in the elderly and disabled population. In addition, drug cost inflation accounts for about a third of the increase. Many of these factors are beyond the control of state Medicaid programs.

Virginia Medicaid payments for fee-for service pharmacy costs have increased by 89 percent since 1997, from \$201 million to \$380 million after drug rebates (see Table 1 below). This has been in spite of the major shift of recipients to Medicaid managed care plans in December 2001.

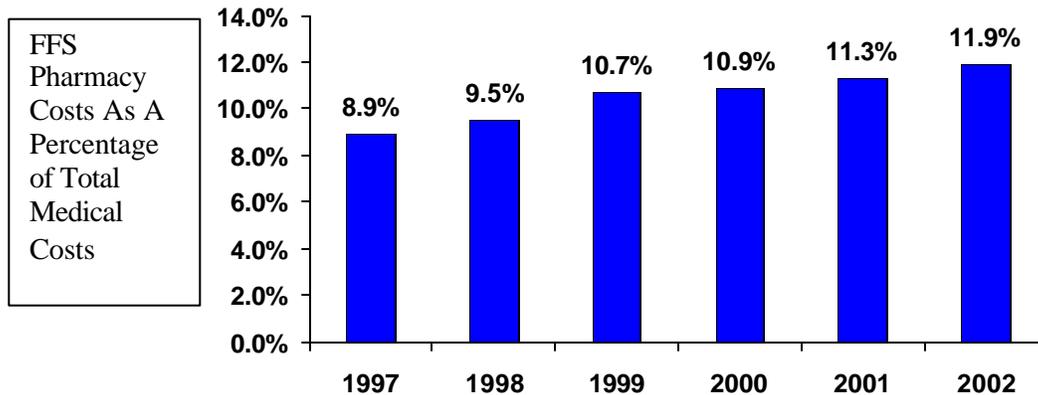
**Table 1**  
**Increase in Virginia Medicaid Fee-For Service Pharmacy Costs**



**Source:** Statistical Record of the Virginia Medicaid Program

Pharmacy costs as a percentage of total medical costs are also increasing, from nine percent of the Medicaid budget in 1997 to 12 percent in 2002. See Table 2.

**Table 2**  
**Increases in Fee-for-Service Pharmacy Costs as Percentage of Virginia Total Medicaid Budget**



**Source:** Statistical Record of the Virginia Medicaid Program

## **Managing Medicaid Drug Use and Costs**

Within federal guidelines, Virginia has several tools at its disposal to control prescription drug utilization and spending. Prior to 2002 and ongoing, Virginia has the following cost containment methods in its fee-for-service program:

- Generic substitution for brand name drugs
- Drug utilization review, both through online messages to pharmacies and retrospective reviews
- Disease state management for complex patients with high drug costs, such as asthma, diabetes, and congestive heart failure.
- Drug rebates from manufacturers
- Pharmacy lock-in for abusers

Cost control strategies implemented in the fee-for-service program in 2002 will save \$24.6 million in general funds in state fiscal years 2002-2004:

- Reduced Medicaid reimbursement for pharmacies from average wholesale price (AWP) minus 9 percent to AWP minus 10.25 percent
- Expedited access to generics
- Revised pricing for anti-hemophilia drugs
- Established 34-day supply limit
- Increased co-pay for brand drugs to \$2
- Improved third party recovery program

Additional cost savings strategies in the 2003 Budget Conference Committee report will generate an additional \$22 million in FY 2004 general fund savings:

- Establish a Preferred Drug List (\$9 million)
- Prior authorization for clients with more than nine unique prescriptions within 180 days (\$8.9 million)
- Prior authorization for institutionalized clients with more than nine unique prescriptions within 30 days and reduce “Beer’s List” drugs (\$2.0 million)
- Increase co-pay for brand drugs from \$2.00 to \$3.00 (\$0.9 million)
- Reduce pharmacy dispensing fee from \$4.25 to \$3.75 (\$2.0 million)

Because of the rising costs of Medicaid drugs under the fee-for-service program, the Virginia Medicaid program will implement a PDL program. A PDL program is a type of prior authorization plan that divides Medicaid covered prescription drugs into two categories: those that require prior authorization before they can be dispensed, and those that do not. While there are many classifications of drugs that are not subject to the PDL or prior authorization, a PDL contains a wide range of generic and brand name products

that have been approved by the Food and Drug Administration (FDA). In general, a medication becomes a preferred drug based on safety and efficacy first, then on cost-effectiveness. A Pharmacy and Therapeutics (P&T) Committee develops the list of preferred drugs. Unlike many commercial plans, Medicaid plans are required to give access to all FDA approved drugs. Drugs on the PDL are covered without prior authorization. Non-preferred drugs are approved for coverage if the prescribing physician provides medical justification that meets the clinical criteria recommended by the P&T Committee and established by the state.

## **KEY PROVISIONS OF MEDICAID PREFERRED DRUG LIST PROGRAMS**

This section provides a brief overview of the Centers for Medicare and Medicaid Services' (CMS) position on preferred drug lists, how other states have implemented a PDL program, and a description of how a reference pricing and supplemental rebate process works.

### **Centers for Medicare and Medicaid Services' Position on Preferred Drug Lists and Supplemental Rebates**

In a September 18, 2002 letter from the Centers for Medicare and Medicaid Services (CMS) to all 50 state Medicaid directors, CMS clarified its position on preferred drug lists. The letter clarified two issues related to supplemental drug rebate agreements and prior authorization of Medicaid covered outpatient drugs. First, it clarified that "states may enter separate or supplemental rebate agreements as long as such agreements achieve drug rebates equal or greater than the drug rebate set forth in the Secretary's national rebate agreement with drug manufacturers." Second, "states may subject covered outpatient prescription drugs to prior authorization as a means of encouraging drug manufacturers to enter into separate or supplemental rebate agreements for covered drugs purchased by Medicaid recipients." In essence, CMS states that the Social Security Act affords states broad authority and flexibility to implement a prior authorization program in order to secure cost savings for the Medicaid program. CMS' view is that the savings generated from a preferred drug program will benefit both the federal government and the states.

CMS does require, however, that the states submit a State plan amendment of proposed prior authorization programs and/or proposed supplemental rebate agreements. CMS is aware that Virginia will be implementing a PDL program.

### **States with Preferred Drug List Programs**

Because prescription drug costs is one of the key drivers of Medicaid spending growth, more states are looking for additional cost savings measures in this area. CMS staff have indicated that 30 states either have implemented or are planning to implement a PDL in their Medicaid program; Michigan and Florida are two examples that have

implemented programs since 2001. Other states include California, Illinois, Indiana, South Carolina, North Carolina, Ohio, Vermont, Maine, Louisiana, Minnesota, New Mexico, Kentucky, West Virginia, and Oregon.

PDL programs in the private sector have been around for years, especially in managed care programs. In many states, including Tennessee, Arizona, Maryland, and Pennsylvania, a majority of Medicaid recipients already access their drug coverage through preferred drug lists with prior authorization requirements through managed care plans. In Virginia, 60 percent of all Medicaid recipients fall into this category (more than 39,000 of these recipients are aged, blind, or disabled).

Because PDLs for the Medicaid population are relatively new, there is no single, uniform definition of a preferred drug list. According to a National Governor's Association Issue Brief, the three states listed below provide examples of approaches to PDLs.

- **Florida** was one of the first states to establish a PDL. Through a Pharmacy and Therapeutics Committee, drugs were determined to be efficacious, safe, and cost effective. This program included supplemental rebates from manufacturers, which guaranteed their drugs on the PDL list. Pfizer and Bristol-Meyers Squibb negotiated arrangements with the state to fund disease management and health literacy programs in lieu of supplemental cash rebates. All antipsychotics, antidepressants, anticonvulsants, and HIV related antiretroviral agents are exempt from prior authorization restrictions.
- **Michigan** created a PDL program to cover all pharmacy programs funded through the department of Community Health, in addition to its Medicaid clients. Its Pharmacy and Therapeutics Committee members are appointed by the Governor and staffed by the department. Based on the Committee's recommendations, the department created a list of the most effective drugs for treating specific conditions. The state negotiated supplemental rebates with manufacturers of non-preferred drugs that were equal to or close to the difference in price between the more expensive drug and the drug on the preferred drug list; these drugs then were added to the PDL. Several drug manufacturers declined to participate in Michigan's program. Michigan exempts HIV/AIDS and cancer drugs and existing SSRI prescriptions are grandfathered.
- **Oregon's** PDL program is voluntary for physicians. A commission studies the clinical effectiveness of drugs within the class designated by the state. A separate subcommittee is appointed for each class of drugs. The state focuses on educating providers about the list and changing prescribing behavior to be consistent with the evidence reviewed by a commission. Oregon began with four major drug

classes: proton pump inhibitors, long-acting opioids, statins or cholesterol lowering drugs, and NSAIDS. This program does not use supplemental rebates.

Because Florida and Michigan are the first two states to adopt a comprehensive preferred drug list for Medicaid recipients, these programs are being watched closely by other states considering similar approaches. A recent Kaiser Commission report on the Michigan PDL program found that this program was implemented too rapidly, excluded views of key stakeholders, failed to educate the physicians, pharmacists, and beneficiaries adequately, and appears to be restrictive in certain categories of drugs, such as mental health, cardiac, and diabetes treatments. Michigan's prior authorization and appeals processes also have been criticized as being too cumbersome and difficult for providers and patients.

### **Reference Pricing and Supplemental Rebates**

Under a PDL and prior authorization model with reference pricing and supplemental rebates, a state will reduce pharmacy costs regardless of whether some, all, or none of the pharmaceutical manufacturers agree to pay supplemental rebates. However, the net savings to the state will be greater when more manufacturers agree to pay supplemental rebates since the cost of the drugs will be less and fewer prior authorization reviews will be needed.

Reference pricing and supplemental rebates produce price equity within therapeutic classes. In such a process, the following steps are taken:

- For each therapeutic class, drugs would be recommended based on clinical efficacy
- Of the recommended drugs, a "reference price" is established based on the price of the most cost effective drug
- Manufacturers of other recommended drugs can offer supplemental rebates to lower the price of their drug(s) to the reference price and get their drugs on the PDL
- Final PDL includes all clinically effective drugs that are at or below the reference price.
- Drugs not on the PDL are available through prior authorization.

### **VIRGINIA'S PROPOSED PREFERRED DRUG LIST PROGRAM**

This section provides an overview of the design of Virginia's proposed PDL program at the present time. The final design of the program is not possible until the P&T Committee makes its recommendations and a Contractor to manage the PDL program is hired. In addition, DMAS is continuing to receive comments and input from a variety of stakeholders. The following describes the initial assumptions and program design decisions made thus far.

## **Assumptions Used in Developing Virginia's Savings Estimate for a Preferred Drug List Program**

In order to determine potential savings from a Medicaid PDL program in Virginia, Medicaid claims data were analyzed and several policy assumptions were made. While selected components of the Michigan and Vermont Medicaid PDL program served as a model for potential cost savings, Virginia's program will be developed with considerable public comment into the development of both the P&T committee process and the PDL program. This public input period has already started and is discussed in a section below.

The savings estimates (\$9 million GF in FY 2004; \$18 million GF in each fiscal year thereafter) were developed by annualizing Virginia Medicaid fee-for-service claims from January 1, 2002 through June 30, 2002. The savings estimate:

- Reflects actual utilization of drugs by the fee-for-service population and the prescribing patterns of Medicaid physicians.
- Re-prices Virginia's claims according to a model base PDL program.
- Reflects savings, which are net of administrative costs associated with the PDL and prior authorization process.

The policy assumptions of the Virginia base PDL in the cost savings analysis assumed:

- Eighty-five percent of the physicians will prescribe from the PDL. This will require considerable physician education in advance of the implementation of the PDL and on an ongoing basis.
- The PDL program will utilize reference pricing and supplemental rebates.
- Drugs on the PDL will be covered without prior authorization. Non-preferred drugs can be approved for coverage through prior-authorization.
- The PDL will not apply to all therapeutic classes.
- Therapeutic classes should be excluded from the base PDL for any of the following reasons:
  - Uniqueness of prescribing requirements or the treatment regimen for a particular illness or disease (i.e., not clinically appropriate)
  - There is only one drug in a specific therapeutic class
  - There is very low utilization in a specific therapeutic class
  - Economics of including on PDL and administering prior authorization do not generate savings (i.e., not cost-effective)
- A contractor would take prior authorization requests 24 hours a day, seven days a week; a 72-hour emergency supply of a drug would be provided when requested by a physician.

**Key Therapeutic Categories Excluded from the Virginia Medicaid Preferred Drug List Program**

One of the most sensitive issues surrounding the implementation of Virginia’s PDL program is which classes of drugs to exclude from the PDL and prior authorization process. The selection of which classes to include or exclude from the PDL program is a dynamic process and will be routinely revisited. The initial savings estimate discussed above assumes many classes of drugs would be excluded. Among those assumed to be excluded from the program are many classes of drugs (e.g., cold and cough agents, antibacterials and antiseptics, dermatologicals, etc.) that rarely, if ever, were identified by stakeholders as being critical to their constituencies. However, a number of drug classes that have been mentioned frequently by various interested parties also were assumed to be excluded from the program.

Based on a review of other Medicaid PDL programs, the assumptions used in determining the estimated cost savings, direction provided by the Budget Conference Report, and comments received from a variety of key stakeholders, several key classes of drugs will be excluded from Virginia’s PDL program. Table 3 identifies these key classes of drugs. Table 3 is not the complete list of excluded drugs. As noted above, there are many rarely-mentioned classes of drugs that were assumed in the savings estimate to be excluded. These are not listed in Table 3. Table 3 also should not be considered the final list of key exclusions; however, the most appropriate avenue to determine any additional exclusions or “grandfathering” of certain classes of drugs is through the Pharmacy and Therapeutics Committee.

It is important to note that antipsychotics (typicals and atypicals) used to treat serious mental illness were not among those classes of drugs assumed to be excluded when the savings estimate was calculated. However, given the critical nature of these drugs and the vulnerable populations who are treated with these medications, it has been determined that this class of drugs will be excluded from the PDL program.

**Table 3  
Initial List of Key Therapeutic Classes of Drugs to Be Excluded From  
Virginia’s PDL Program.**

<b>Therapeutic Class Description</b>	<b>Commonly Used in the Treatment of</b>
Insulins	Diabetes
Cholinesterase Inhibitors	Alzheimers
Platelet Aggregation Inhibitors	Clotting Disorders
Antivirals for HIV	HIV/AIDS
Cancer Chemotherapeutic Agents	Cancer
Anti-convulsants	Seizure Disorders, Mental Health
Immunosuppressants	Transplant Rejection; Arthritis
Antiemetics	Nausea in Cancer Patients, Aging, Vertigo
Antipsychotics, Atypical and Typical	Serious Mental Illness

### **Fiscal Impact of Excluding Additional Categories of Drugs**

Additional exclusions from the PDL should focus on specific therapeutic classes and not on general diagnoses. The budget language directs the P&T Committee to determine which drugs should be subject to the PDL program and prior authorization requirements, as well as appropriate exclusions. The drug classes already excluded address several of the directives provided in the budget language.

It is important to note that additional exclusions not already included in the base PDL savings assumptions will reduce the amount of savings. The medical and pharmacy experts on the P& T Committee will make recommendations to DMAS regarding how other drugs, including mental health drugs, will be treated under this program. Mental health drugs are one of the most expensive categories of drugs in the Virginia Medicaid fee-for-service program. To ensure continued availability of selected mental health agents to stabilized patients, selected therapeutic classes may be “grandfathered.” If it is determined that antidepressants, for example, will be excluded or “grandfathered,” the fiscal impact to the program savings would be approximately \$11 million total funds for exclusion and \$5.5 million (or half the savings) if grandfathered. If not excluded or grandfathered, Medicaid clients will have access to the necessary mental health drugs through the PDL for preferred drugs and through prior authorization for non-preferred drugs.

### **Other Key Design Components Required by the General Assembly**

The 2003 Budget Conference Committee report also directed DMAS to monitor all new prior authorization processes and to ensure that there are no financial incentives connected with the approval or denial of a particular drug. These two budget amendments are in Attachment D.

Item 322 #1c directs DMAS to monitor the impact of all new prior authorization requirements implemented in the fee-for-service program and for Family Access to Medical Insurance Security (FAMIS) and Medicaid services that take effect on or after July 1, 2003. Specifically, the Department should maintain data that captures the number of service denials, the number of appeals for prior authorization denials and the outcomes, and the associated administrative costs. DMAS also intends to conduct a cost benefit analysis of all new prior authorization processes to ensure that access to necessary health care services has not been impacted and that the expected cost savings has been achieved.

Item 325 #8c directs DMAS to base any contractor’s fee for pharmaceutical benefit management services on the reasonable cost of services provided, not on any financial incentive that is tied to a denial or delay of medically appropriate prescription drug therapy. DMAS never intended to design an incentive-based PDL program, and will abide by the direction of the General Assembly.

## Use of Reference Pricing and Supplemental Rebates

The design of the PDL program must ensure access to prescription drugs for Medicaid clients. The program design also must ensure that the required savings are achieved; otherwise, cuts in other areas of the Medicaid program would be necessary that could result in fewer services being covered or fewer clients being served. Many other provider groups (e.g., hospitals, nursing homes, and pharmacists) already have experienced reductions in their Medicaid reimbursement.

A critical and controversial aspect of the PDL program is how to generate the necessary savings. As previously noted, the savings estimate assumed that the PDL program would include reference pricing and supplemental rebates. The pharmaceutical manufacturers clearly are opposed to this approach. The chart below identifies other potential PDL program options identified by manufacturers. However, Option I, which includes reference pricing and supplemental rebates, is the one most likely to achieve the savings on an annual basis.

<b>PDL Program Options</b>		<b>Comments</b>
I.	PDL program with reference pricing and supplemental rebates	Manufacturers oppose this option. Other state programs with this approach have achieved substantial savings; Virginia's cost estimate is based on this approach.
II.	PDL Program with preferred drugs, supplemental rebates are an additional percentage discount rather than discounting to a reference price; their drugs become preferred	DMAS will realize savings through this option but somewhat less than Option I.
III.	PDL program in which drug companies provide other cost saving strategies (e.g., disease state management program) in lieu of supplemental rebates to get their drugs on preferred list	Most of the other cost saving strategies suggested by the drug companies involve disease state management, which is long-term savings and not likely to produce the needed savings in fiscal year 2004. In addition, DMAS already must generate another cost savings of \$20 million total funds for fiscal year 2004 for the expansion of disease state management.
IV.	PDL program in which drug companies pay the State a lump sum payment which reflects a percentage of the total savings needed (this percentage is tied to its proportion of their overall drug costs in the previous year)	This Option would work only if all manufacturers agreed to fully participate. In addition, it is unknown how this system will impact cost savings in future years.
V.	PDL Program with preferred drugs and prior authorization; no supplemental rebates	DMAS will realize savings through prior authorization requirements but not the amount required by the budget.

Given the savings that other states have achieved in using reference pricing and supplemental rebates, the experience that PDL contractors have with such an approach,

and the uncertainty of savings produced through other options identified above, DMAS will design the PDL program to include reference pricing and supplemental rebates.

## **WORKPLAN FOR IMPLEMENTING A VIRGINIA MEDICAID PREFERRED DRUG LIST PROGRAM**

### **Workplan Considerations**

DMAS has an ambitious workplan for implementing a preferred drug list program by January 1, 2004. This expedited timeline presents several key challenges for implementing an effective PDL program in Virginia. DMAS will have to move quickly and decisively to implement the program in order to achieve the required savings. In doing so, DMAS will make every effort to seek public input in the process. As will be discussed later in this report, a considerable amount of input already has taken place. However, it is necessary to keep an appropriate balance between having an open process in the implementation of a PDL program and meeting the established deadline so the program achieves the required savings.

In addition, DMAS recently has been told by CMS that it must develop a Request for Proposals to select a Contractor to manage the PDL program. Even with an expedited RFP process, this delay will push the selection of the Contractor to develop the PDL program to September 2003.

### **Creation of a Pharmacy and Therapeutics Committee**

One of the most important aspects of the PDL program will be the P&T Committee that will make clinical recommendations to the Department regarding the administration of the PDL. As noted in the budget language, the P&T Committee has several critical responsibilities. This committee will recommend: (1) therapeutic classes to be included in the preferred drug list; (2) appropriate exclusions for certain medications; and (3) appropriate grandfather clauses when prior authorization would interfere with established complex drug regimens. In addition to the specific tasks outlined in the budget language, the P&T Committee will also provide input to both DMAS and the Contractor on ways to improve the quality management of drug regimens for Medicaid recipients.

The Committee will examine medical literature and expert medical opinions to make decisions. The Committee will analyze the following for each drug during its deliberations:

- Safety (not just FDA approval)
- Effectiveness
- Comparison studies
- Medical outcome and pharmacoeconomic studies
- Contribution of drug cost to the total cost of disease management.

The Committee will make recommendations on the most clinically appropriate and cost effective drugs for the preferred drug list. They will recommend removing and adding drugs to the list as new, more effective drugs are developed.

According to the budget language, the P&T Committee must include eight to 12 members, with a ratio of physicians to pharmacists of 2:1. The physicians must be licensed in Virginia; one must be a psychiatrist, and one must specialize in care for the aging. The Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services will be one of the P&T Committee members. The pharmacists on the Committee also must be licensed in Virginia; one must have clinical expertise in mental health drugs, and one must have clinical expertise in community-based mental health treatment. To ensure the Committee has appropriate representation and expertise, it has been decided to have 12 members on the Committee (eight physicians and four pharmacists). A physician will chair the Committee.

The creation of the P&T Committee is a public process. The Secretary of Health and Human Resources sent a letter to the academic health centers, American Academy of Pediatrics, Old Dominion Medical Society, Medical Society of Virginia, Virginia Pharmacists Association, Psychiatric Society of Virginia, Virginia Hospital and Healthcare Association, Virginia Academy of Family Physicians, CHAPO, and Virginia Association of Health Plans for nominees for the P&T Committee. Other individuals with specific expertise required by the budget language were contacted regarding their interest in serving on the Committee. Each group was requested to send their nominations to DMAS by March 19, 2003. Once the various organizations submit their nominees, the Secretary of Health and Human Resources will select individuals for the Committee that assures a cross-section of the physician and pharmacy community. All nominees as well as the nominating organizations will be notified of the committee appointments.

The Committee will meet frequently during the initial development of the PDL program and will provide input to the prior-authorization program. There will be opportunity for public input to the development of the preferred drug list. Pharmaceutical companies will have the opportunity to provide written comment, at a minimum, on the clinical aspects of the drugs that are under consideration for the PDL program. Other interested parties also will have the opportunity to provide written comment, at a minimum, to the P&T Committee. However, there will need to be a balance between public comment and allowing the P&T Committee to effectively perform its duties. The P&T Committee members will need to spend the majority of the meeting time discussing materials that they reviewed prior to the meetings, and making critical decisions regarding the PDL program.

The ongoing frequency of the P&T Committee meetings will be determined by the workload and how frequently the PDL will be reviewed and updated. As directed by the budget language, DMAS or its contractor will document all recommendations made

by the P&T Committee, as well as any decisions that deviate from the recommendations of the Committee.

### **Stakeholder Input into the Design of the Preferred Drug List Program**

The design of the PDL program will also be completed with input from the public. As directed by the budget language, DMAS has met or has scheduled meetings with 28 different groups, including physicians, pharmacists, pharmaceutical manufacturers, patient advocates, service providers, and other stakeholders to receive input into the design of the PDL program. Attachment E is a copy of the meeting schedule. Persons who would like to provide comment and are not on the current list should contact the Department. Comments can also be provided in writing.

The Director and/or Chief Deputy Director from DMAS attended each of the one hour meetings with the stakeholders. With rare exception, a representative of the Office of the Secretary and/or the Governor's office also was present at each meeting. Each group was asked to provide ideas on how to design an effective PDL program. Written comments were requested of all groups; some groups have yet to submit their comments in writing. A summary of the general comments is listed below.

***Pharmaceutical Companies.*** In general, the pharmaceutical companies are not in favor of a PDL program, especially the concept of reference pricing and supplemental rebates. Instead, some of the companies offered various short or long-term cost cutting strategies in lieu of a PDL program. In some states, the pharmaceutical companies offer these strategies to get all of their products on the PDL, without having to negotiate supplemental rebates. The most common strategy offered is a disease state management program. However, DMAS has another cost savings measure tied to this strategy, which requires a total savings of \$20 million for Fiscal Year 2004. DMAS is very interested in pursuing some of the suggested cost saving strategies, but these measures would need to be in addition to the PDL program.

In addition to opposing reference pricing and supplemental rebates, the issues mentioned most frequently by companies included: (i) developing a streamlined prior authorization and appeals process; (ii) including physicians on the P&T Committee who treat Medicaid recipients; (iii) excluding various classes of drugs from the PDL program; (iv) allowing the P&T Committee to receive clinical data and input from manufacturers; (v) providing safeguards to ensure patients have access to prescription drugs; (vi) "grandfathering" patients who are stabilized on certain medications; and (vii) ensuring the ultimate authority of the prescriber, the patient's physician.

***Consumer Advocates.*** DMAS met with several groups that represent the Medicaid recipients who will be subject to the PDL program. As summarized by the Virginia Poverty Law Center, the key points for consideration of a PDL program is one that maintains access to medically necessary drugs, a simplified process to obtain medically necessary drugs, and one that saves the Commonwealth money. Many of these groups worked closely with the legislators in drafting the budget language to ensure that

careful consideration is given to the therapeutic classes that are excluded from the PDL program; and for those that are included, that the prior authorization process is timely and appropriate. They also want to ensure that consumers, physicians, and pharmacists are adequately educated about the PDL process. Mental health providers and advocates for Medicaid recipients with mental illness or mental retardation urged the Department to exclude various classes of drugs used to treat serious mental illness and to make certain the program has protections for these vulnerable populations.

***Medicaid Service Providers.*** DMAS met with a variety of service providers, including pharmacists, nursing facilities, managed care organizations, hospitals, and physicians. The key point that these providers made was that they wanted the same Contractor to administer the prior authorization of more than nine drugs and the PDL program. DMAS intends to combine these processes and work with these groups to ensure that the prior authorization process is straightforward and manageable. These provider groups were generally supportive of a PDL program as a way to provide some needed oversight to the management of the drug regimens of the Medicaid recipients and to save the Commonwealth money.

### **Development of a Request for Proposals**

Due to the savings required and the short implementation time, DMAS contacted CMS about the potential for modifying a current contract to administer the PDL program for the first year. However, CMS has initiated a new policy that requires the states to develop a Request for Proposals (RFP) rather than utilize a sole source contract for its PDL programs. Therefore, DMAS will expedite the development of an RFP, and solicit proposals from qualified firms for the administration of a PDL program for Medicaid fee-for-service clients. The RFP will be published in April 2003 in order to meet the implementation date of January 1, 2004. This date is necessary to realize the \$9 million in general fund savings for fiscal year 2004. The Contractor will:

- Provide support to the Pharmacy and Therapeutics Committee;
- Develop and maintain a Preferred Drug List;
- With the assistance of the Pharmacy and Therapeutics Committee, negotiate and administer supplemental drug rebates;
- Administer the prior authorization component of the PDL program;
- Provide educational outreach services;
- Provide management reports which track the prior authorization activities and call center activities; and
- Other services specified in the RFP.

In addition, this same Contractor will administer the two other prior authorization cost saving initiatives: the prior authorization of more than nine drugs in a 180 day period for non-institutionalized patients and the prior authorization of more than nine drugs in a 30 day period for institutionalized patients. These programs are not intended to place limits on the number of prescriptions. Instead, the focus will be on the careful review of all the prescriptions to ensure the most appropriate mix of medicines for

the patient's health needs. Several of the advocates and the service providers support that one contractor manage both cost savings initiatives to reduce the administrative burden on physicians, pharmacists, and consumers.

**Other Key Tasks and Timeline for Development of the Preferred Drug List Program**

In addition to forming the P&T Committee and securing a Contractor to managed the PDL program, DMAS must also complete several other tasks. These tasks include:

- Determine the computer systems needs to support the PDL program and other pharmacy savings initiatives.
- Develop emergency regulations for the PDL program.
- Submit a State plan amendment to the Centers for Medicare and Medicaid Services for the PDL program and supplemental rebates.
- Coordinate the educational and notification requirements for physicians, pharmacists, and consumers with the Contractor, provider associations, and other stakeholders.

The timeline for the implementation of a Preferred Drug List program is provided on below.

<b>Key Tasks</b>	<b>Time Frame</b>
<b>Create a Pharmacy and Therapeutics Committee</b>	March-April 2003
<b>Meet with Stakeholders to Provide Input</b>	March 2003 and throughout the PDL process
<b>Develop RFP for PDL Contractor</b>	March –April 2003
<b>Develop April 1 Report for the General Assembly</b>	March 2003
<b>PDL Contractor Selected</b>	September 2003
<b>PDL Contractor Begins Operational Development</b>	September 2003-December 2003
<b>PDL Program Implemented</b>	January 2004

# **ATTACHMENT A**

**2003 Budget Conference Committee Report  
Item 325 #4c: Medicaid Preferred Drug List Program**

**Item 325 #4c**

**Health And Human Resources**

Department Of Medical Assistance  
Services

Language

**Language:**

Page 322, strike lines 56 through 58 and insert:

"ZZ.1. Notwithstanding § 32.1-331.12 et seq., Code of Virginia, the Department of Medical Assistance Services, in consultation with the Department of Mental Health, Mental Retardation and Substance Abuse Services, shall amend the State Plan for Medical Assistance Services to modify the delivery system of pharmaceutical products to include a Preferred Drug List program no later than January 1, 2004. In developing the modifications, the Department shall consider input from physicians, pharmacists, pharmaceutical manufacturers, patient advocates, and others, as appropriate.

2. The Department shall utilize a Pharmacy and Therapeutics Committee to assist in the development and ongoing administration of the Preferred Drug List program. The Pharmacy and Therapeutics Committee shall be composed of 8 to 12 members, including the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, or his designee. Other members shall be selected or approved by the Department. The membership shall include a ratio of physicians to pharmacists of 2:1. Physicians on the Committee shall be licensed in Virginia, one of whom shall be a psychiatrist, and one of whom specializes in care for the aging. Pharmacists on the Committee shall be licensed in Virginia, one of whom shall have clinical expertise in mental health drugs, and one of whom has clinical expertise in community-based mental health treatment. The Pharmacy and Therapeutics Committee shall recommend to the Department (i) which therapeutic classes of drugs should be subject to the Preferred Drug List program and prior authorization requirements; (ii) specific drugs within each therapeutic class to be included on the preferred drug list; (iii) appropriate exclusions for medications, including atypical anti-psychotics, used for the treatment of serious mental illnesses such as bi-polar disorders, schizophrenia, and depression; (iv) appropriate exclusions for medications used for the treatment of brain disorders, cancer and HIV-related conditions; (v) appropriate exclusions for therapeutic classes in which there is only one drug in the therapeutic class or there is very low utilization, or for which it is not cost-effective to include in the Preferred Drug List program; and (vi) appropriate grandfather clauses when prior authorization would interfere with established complex drug regimens that have proven to be clinically effective. In developing and maintaining the preferred drug list, the cost effectiveness of any given drug shall be considered only after it is determined to be safe and clinically effective.

3. The Department shall establish a process for acting on the recommendations made by the Pharmacy and Therapeutics Committee, including documentation of any decisions which deviate from the recommendations of the Committee.

4. The Preferred Drug List program shall include provisions for (i) the dispensing of a 72-hour emergency supply of the prescribed drug when requested by a physician and a dispensing fee to be paid to the pharmacy for such supply; (ii) prior authorization decisions to be made within 24 hours and timely notification of the recipient and/or the prescribing physician of any delays or negative decisions; (iii) an expedited review process of denials by the department; and (iv) consumer and provider education, training and information regarding the Preferred Drug List prior to implementation, and ongoing communications to include computer access to information and multilingual material.

5. The Preferred Drug List program shall generate savings as determined by the Department that are net of any administrative expenses to implement and administer the program of not less than \$9,000,000 in general funds in fiscal year 2004 and not

less than \$18,000,000 in general funds in each fiscal year thereafter. The final design of the program, including all operational components, shall be completed no later than April 2, 2003. The Department shall submit a report on the final main design components of the program to the Chairmen of the House Appropriations and Senate Finance Committees no later than April 1, 2003.

6. Notwithstanding § 32.1-331.12 et seq., Code of Virginia, to implement these changes, the Department of Medical Assistance Services shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act. With respect to such state plan amendments and regulations, the provisions of § 32.1-331.12 et seq., Code of Virginia, shall not apply. In addition, the Department shall work with the Department of Mental Health, Mental Retardation, and Substance Abuse Services to consider utilizing a Preferred Drug List program for its non-Medicaid clients."

Page 323, strike lines 1 through 23.

**Explanation:**

(This amendment adds language setting forth criteria for the design of the Medicaid Preferred Drug List program. The preferred drug list will be implemented no later than January 1, 2004. It directs the Department of Medical Assistance Services to use a Pharmacy and Therapeutics Committee composed of physicians and pharmacists to recommend (a) the therapeutic categories to be included on the Preferred Drug List, (b) appropriate exclusions for certain medications used to treat serious mental illnesses, brain disorders, cancer, and HIV-related conditions, and (c) appropriate grandfather clauses when prior authorization would interfere with established complex drug regimens that have proven to be clinically effective. In developing and maintaining the preferred drug list, the cost effectiveness of any given drug shall be considered only after it is determined to be safe and clinically effective. It requires the department to document any decisions regarding the development of the Preferred Drug List that deviate from the recommendations of the Pharmacy and Therapeutics Committee. It also adds language allowing for a limited supply of an individual's prescription to be covered in an emergency and requires immediate prior authorization decisions and notification of negative decisions to patients and their physicians. It requires patient and physician education and training, and ongoing communications on the program. The design of the program requires savings to the Medicaid pharmacy program of approximately \$18 million in general funds annually, net of administrative expenses; however, only \$9 million in general fund savings are assumed in fiscal year 2004, since the program would not be implemented until January 1, 2004. Nothing in this language prohibits the Department of Medical Assistance Services from using reference pricing or negotiating supplemental rebates. Language is added to allow for the issuance of emergency regulations to implement the program. Finally, language is added directing the Department of Medical Assistance Services to work with the Department of Mental Health, Mental Retardation, and Substance Abuse Services to consider utilizing a preferred drug list for its non-Medicaid clients.)

## **ATTACHMENT B**

### **Sample of Letter Sent to Stakeholder Groups Requesting Input Into PDL Program Design**

March 4, 2003

Name of Company/Organization

Address

Address

Dear <Name>:

As you know, Item 325 #4c of the 2003 Budget Conference Committee report directs the Department of Medical Assistance Services to establish a preferred drug list (PDL) program no later than January 1, 2004. A copy of the budget language is attached for your review.

In developing the program, the Department will be considering input from physicians, pharmacists, pharmaceutical manufacturers, patient advocates, and others. Accordingly, I am writing to seek your input into the development of this important program. We will be holding separate meetings with the various stakeholders over the next few weeks, and would appreciate the opportunity to meet with you or another representative of your organization. My assistant, Bonnie Scott, will be contacting you within the next few days to schedule a convenient time. In addition to meeting with you to discuss the PDL program, I would also like to receive your input in writing. It would be most helpful to receive your written input either before or as soon after the meeting as possible. If you feel that a meeting is not necessary and prefer to simply submit your input in writing, please let me know.

I appreciate very much your interest in this matter and look forward to receiving your input.

Sincerely,

Patrick W. Finnerty

Director

PWF/bws

Enclosure

cc: The Honorable Jane H. Woods  
David H. Hallock, Jr.

## **ATTACHMENT C**

**Sample of Letter Sent to Stakeholder Groups Requesting Nominees  
for Pharmacy and Therapeutics Committee**

March 4, 2003

Ms. Becky Snead  
Virginia Pharmacists Association  
c/o Virginia Pharmacy Congress  
5501 Patterson Avenue, Suite 200  
Richmond, Virginia 23226

Dear Ms. Snead:

As you know, Item 325 #4c of the 2003 Budget Conference Committee report directs the Department of Medical Assistance Services (DMAS) to establish a preferred drug list (PDL) program no later than January 1, 2004. A copy of the budget language is attached for your review.

One of the most critical aspects of the PDL program will be a Pharmacy and Therapeutics (P&T) Committee that will make clinical recommendations to the Department regarding the administration of the PDL. As noted in the attached budget language, the P&T Committee has several critical responsibilities. The Committee will be composed of eight physicians and four pharmacists. I am writing to the Virginia Pharmacy Congress to request nominations for the pharmacists who will be appointed to the Committee. The budget language requires that one of the pharmacists have expertise in mental health drugs and one have expertise in community mental health treatment. It would be helpful to have these requirements reflected in your pharmacist nominations.

While four pharmacists ultimately will be appointed, I would appreciate your providing to DMAS the names and contact information of eight pharmacists who would be willing to serve on the P&T Committee. The additional nominations will provide us some flexibility and assure that the overall Committee has appropriate diversity. In considering persons to nominate for this Committee, it should be noted that these individuals would need to attend several meetings during the initial development of the PDL, most likely during the May – July timeframe. After that time period, the meetings will be less frequent, perhaps bi-monthly. There likely will be some work that can be accomplished through e-mail and document review. DMAS will pay Committee members' travel expenses to attend meetings.

Please have your list of nominees include persons who reflect an appropriate diversity in terms of minority and geographic representation. We will select pharmacists from your list of nominations that assures a cross-section of the pharmacist community. We will notify all nominees as well as the nominating organizations of the committee appointments.

Please send your list of nominees to Patrick Finnerty at DMAS by March 19<sup>th</sup>. You may mail the list to: DMAS, 600 E. Broad Street, 13<sup>th</sup> Floor, Richmond, Va. 23219; fax the list to 804-371-4981; or e-mail it to [pfinnerty@dmass.state.va.us](mailto:pfinnerty@dmass.state.va.us). Should you have any questions about the P&T Committee, please feel free to contact Pat (804-786-8099) or me (804-786-7765).

I truly appreciate your cooperation in this matter, and look forward to receiving your nominations.

Sincerely,

Jane H. Woods

/pwf  
Enclosure

Cc: David H. Hallock, Jr.  
Patrick W. Finnerty

## **ATTACHMENT D**

**Budget Language (Prior authorization and contractor fees)**

Item 322 #1c

**Language:**

Page 307, after line 28, insert:

"J. The Department of Medical Assistance Services shall monitor the impact of all new prior authorization requirements implemented in the fee-for-service program for Family Access to Medical Insurance Security (FAMIS) and Medicaid services that take effect on or after July 1, 2003. The Department shall maintain data including the number of service denials, the number of prior authorization requests submitted, the number of requests approved and denied, the number of appeals from prior authorization denials, the outcome of those appeals, and all associated administrative costs. Such information shall be reported to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees on an annual basis. The first annual report for fiscal year 2004 shall be submitted no later than 45 days after the end of the fiscal year."

**Explanation:**

(This amendment requires Department of Medical Assistance Services to maintain and report data necessary to evaluate implementation of the new FAMIS and Medicaid prior authorization requirements.)

Item 325 #8c

**Language:**

Page 327, after line 3, insert:

"UUU. In the event that the Department of Medical Assistance Services decides to contract for pharmaceutical benefit management services to administer, develop, manage, or implement Medicaid pharmacy benefits, the Department shall establish the fee paid to any such contractor based on the reasonable cost of services provided. The Department may not offer or pay directly or indirectly any material inducement, bonus, or other financial incentive to a program contractor based on the denial or administrative delay of medically appropriate prescription drug therapy, or on the decreased use of a particular drug or class of drugs, or a reduction in the proportion of beneficiaries who receive prescription drug therapy under the Medicaid program. Bonuses cannot be based on the percentage of cost savings generated under the benefit management of services."

**Explanation:**

(This amendment adds language that would prohibit the Department of Medical Assistance Services from offering or paying incentives to any potential contractor for pharmacy benefit management services based on denying or delaying medically appropriate prescription drug therapy, should the Department decide to contract for these services.)

# **ATTACHMENT E**

## **List of Stakeholder Group Meetings**

Date	Time	Agency/Company	Contact	Interest
March 6	5:00 p.m.	Pfizer	Gary Bolick Charles Duvall	Drug Company
March 13	9:00 a.m.	Virginia Health Care Association	Mary Lynn Bailey	Provider Association
March 14	10:00 a.m.	Virginia Association of Non-Profit Homes for the Aging	Marcia Tetterton	Provider Association
March 17	4:00 p.m.	GlaxoSmithKline	Jan Burrus Richard Grossman	Drug Company
March 18	9:00 a.m.	Virginia Pharmacists Association	Becky Snead	Provider Association
March 18	10:00 a.m.	Eli Lilly and Company	Wayne Covert Guy Rohling	Drug Company
March 18	11:00 a.m.	Johnson and Johnson	George Irving	Drug Company
March 18	1:00 p.m.	Virginia Department of Aging	Jay DeBoer	State Agency
		Alzheimer's Association	Carter Harrison	Consumer Advocate
March 19	10:00 a.m.	Virginia Poverty Law Center	Judy Hanken	Consumer Advocate
		Virginia Quality Healthcare Network	Judy Castleman	Consumer Advocate
March 20	11:00 a.m.	Novartis	Steve Mitchell	Drug Company
March 20	1:00 p.m.	Troutman Sanders	Ann Leigh Kerr	Drug Company
March 20	2:00 p.m.	Virginia Association of Health Plans	Mark Pratt/Joy Bechtold	Provider Association
		Virginia Hospital & Healthcare Association	Chris Bailey	Provider Association
March 20	4:00 p.m.	Wyeth Pharmaceuticals	John Palya Richard Grossman	Drug Company
March 21	10:00 a.m.	Virginia Association of CSBs	Mary Ann Bergeron	Provider Association
		Virginia Network of Private Providers	Jennifer Fidura	Provider Association
March 21	11:00 a.m.	Barr Laboratories	Madeline Abbitt	Drug Company
March 21	1:00 p.m.	Purdue Pharma	Ann Leigh Kerr Mike Heizmann	Drug Company
March 21	2:00 p.m.	Virginia Primary Care Association	Rick Shinn	Provider Association
March 26	10:00 a.m.	Bristol Myers Squibb	Mike Woods	Drug Company
March 26	11:00 a.m.	Merck	Elizabeth Benedetti Robert Hunter	Drug Company
March 26	1:00 p.m.	National Association for the Mentally Ill	Val Marsh Alexander Macaulay	Consumer Advocate
March 26	2:00 p.m.	Boehringer-Ingelheim	Mike Sheffield	Drug Company
March 26	3:30 p.m.	DMHMRSAS	Jim Reinhard	State Agency
March 26	4:30 p.m.	Old Dominion Medical Society	Randall Dalton, M.D.	Provider Association
March 28	10:00 a.m.	AstraZeneca	Mike Draine	Drug Company