

**Meeting of the  
PDL Implementation Advisory Committee  
600 East Broad Street, Suite 1300  
Richmond, Virginia  
December 16, 2003**

**FINAL Minutes**  
As amended 03/16/04

**Present:**

Cheryl Roberts, DMAS, Chaired for Cindi Jones  
Madeline Abbitt, Generic Manufacturers Association  
James Evans, M.D., DMHMRSAS  
Andy Wilson for Sheryl Garland, Virginia Hospital & Healthcare Assn.  
Jill Hanken, Virginia Poverty Law Center  
J.E. (Hill) Hopper, R.Ph., Virginia Health Care Association  
Mike Jurgensen, Medical Society of Virginia  
Anne Leigh Kerr, PhRMA  
John Pezzoli, Virginia Association of Community Services Boards  
Matthew Sheffield, Boehringer-Ingelheim  
Becky Snead, Virginia Pharmacy Congress  
Valeria D. Thomas, Virginia Health Care Association  
Susan Umidi, Virginia League of Social Services Executives

**DMAS Staff:**

Patrick Finnerty  
Adrienne Fegans  
Debbie Giffin  
Nancy Malczewski  
Craig Markva  
Javier Menendez  
Bryan Tomlinson  
Wayne Turnage

Guests: 25 guests attended

**Absent:**

Sheryl Garland, Virginia Hospital & Healthcare Association  
David Markowitz, Psychiatric Society of Virginia

**Call to Order**

Cheryl Roberts, Deputy Director of Programs and Operations for the Department of Medical Assistance Services (DMAS), introduced herself as Chair since Ms. Jones was unavailable today, and called the meeting to order at 10:05 a.m. She asked the members to introduce themselves. She thanked the Committee members for their comments and noted that most material, including today's presentations, is put on the web usually within 48 hours.

Ms. Roberts asked for a motion to accept the minutes. A motion was made and seconded; a unanimous vote taken. (However, at the October 20 meeting, Ms. Jones noted that it was not necessary to vote to approve the minutes. It had also been noted that additional meeting comments, and DMAS' response(s) be added as appendices.)

**Evaluation of the Preferred Drug List (PDL) Program**

Mr. Wayne Turnage, Director of the Division of Policy and Research, provided information on the development of the workplan to evaluate how the PDL is working. He noted three issues: 1)

Assessment—How the Plan is Being Implemented, 2) Cost Savings, and 3) Evaluation of Health Affects.

- 1) Assessment—With information provided from First Health Services (FHS), the DMAS Policy and Research Division will track physician compliance rates, physicians requesting Prior Authorizations (PA), and denial/appeal rates. The FHS Call Center will provide information weekly with the number of calls received, hold times, and outcomes.
- 2) Cost Savings—Since no information is available, cost savings must be estimated, using: history of drug spending prior to the implementation of the PDL versus post PDL; by drug class or recipients; and what is driving the costs or savings.
- 3) Evaluation—Do these members have different health outcomes than people not in the PDL? People will be tracked for the long-term to make sure the data is correct and to determine the Medicaid spending is a reliable estimate.

In conclusion, Mr. Turnage noted that reports will be compiled and will be distributed to the DMAS Executive Management Team weekly, and monthly. It is up to the Director to decide if the reports will be made public quarterly, semi-annually, or annually. He then took questions from the Committee. Ms. Roberts noted that due to time limitations and the Committee being well represented, the questions must be limited to the Committee members only. She noted that other questions or suggested data that be captured should be addressed to Mr. Turnage at the email [pdlinput@dmass.state.va.us](mailto:pdlinput@dmass.state.va.us)

### **Pharmacy Threshold Program**

Ms. Cheryl Roberts noted that she wanted to give a brief update on implementation for the next three months. She wanted everyone to be aware that the Pharmacy Unit is being rebuilt and restaffed and that people should view the DMAS web site for changes <http://www.dmass.state.va.us/pharm-home.htm>. She introduced the program manager of the PDL program, Bryan Tomlinson, Director of Health Care Services, and the new Director of Pharmacy, Javier Menendez.

Ms. Roberts recapped what has occurred with the PDL since the last meeting in October. She noted important accomplishments that have occurred, such as: supplemental rebate contracts with pharmaceutical companies are in place; the FHS Call Center began operations; correspondence to providers, enrollees (in English and Spanish), and other State agencies; and the State Plan Amendment was submitted to the Centers for Medicare and Medicaid Services (CMS). She continued with the January agenda of events and noted the phase-in schedule in five stages, and that the “soft edits” on all classes start January 5<sup>th</sup>. Anyone can call FHS now, and be pro-active for PAs.

There was discussion regarding the long term community billing 30-days retrospectively. The Associations have notified their groups/provider community that they would have a 30-45 day window before the hard edits occur. Ms. Roberts noted, all classes were originally going to begin February 1<sup>st</sup>, but it was decided that would be very disruptive to phase-in the different classes over a one-month period. After the classes were decided by the P&T Committee, there were major market-share shifts, and it was determined that it would have created too many operational problems. Most states have rolled out programs in a three-month period, Virginia is doing it in two-months.

Ms. Roberts noted that this group meets every other month and the decision to make the change occurred in November. She stated that DMAS made a mistake because material should have been sent to the Committee members noting the changes to the implementation. It was stated by a member that this group does not drive the implementation decisions of the program and is only being made aware of how it is being implemented, offering feedback and guidance, but the decisions are being made by the Department and vendor(s) based upon information gathered from all sources. Mr. Finnerty disagreed and noted this Committee has had significant input in how this program is being put together and implemented. He noted this may be an issue of “timing” of soft edits and hard edits, however, this is a dynamic process.

A member (Ms. Snead) stated, due to the dynamics and intricacies of the program, there is much that occurred in a different direction since the Committee last met. Another example is the training program. She is not dissatisfied with what the Department is doing, but wants to make it clear, the Committee’s role is to come in, get updated, and provide input with what is being presented at the time. There is a lot that happens in-between meetings that the Department has to do. Even though the rationale is understandable, to say the Committee helped create this is inappropriate.

Another member (Mr. Sheffield) noted that the Minutes do not reflect the input given by the Committee members either in writing or at the meeting(s). The members don’t get feedback for all their input. It took a long time after the last meeting before the Committee saw the input given by several members. Ms. Roberts noted from the “operations side” that every comment made has been taken very seriously, and have changed major pieces of the program—maybe the members don’t see it—but with each suggestion and every situation, DMAS asks, What will happen to the enrollee? Portions of implementation of the program have been stopped to make sure something received in writing has been addressed. Some things cannot be done or incorporated. Ms. Roberts continued that of all the programs she has helped to implement at DMAS, that no other program has taken as much time to go through every single concern. FHS and DMAS staff went through each suggestion; then things were changed as a result. If it is necessary, Ms. Roberts can say what issue suggested has contributed to the program. Since this program is moving quickly, Mr. Tomlinson and Mr. Menendez talk to Ms. Snead regularly in order for her to be aware of an action and so DMAS may know what is her position on the issue(s). Mr. Finnerty noted that DMAS staff meet after each meeting with the different Committees. He agreed with Ms. Roberts and reiterated that the Department has taken each suggestion seriously and reviewed all comments. Perhaps DMAS should send information back to the Committee Members noting the suggestion and what action was taken.

A member (Ms. Snead) noted that we had to look forward from today and ask the question, Why is this different from the last time we met? Another member (Mr. Sheffield) asked if the PDL IA Committee could meet closer to the P&T Committee meetings perhaps within a week. Ms. Roberts agreed more meetings can be scheduled but noted that DMAS needs more than one week to post items and review the impact of the P&T Committee’s decisions.

Ms. Roberts continued with her presentation and referred the Committee to the Quick List which showed the drugs requiring prior authorization and age limit if associated. She noted the information could be obtained from the DMAS or FHS website including the PDL criteria or the Quick List.

Ms. Roberts stated the next P&T Committee meetings will be held January 6, 2004, and February 9th to review the July drugs. The drugs DMAS believes will be used in July, along with glaucoma, will be posted on the DMAS web site on Friday, December 19. Ms. Roberts noted all the information is on the web as soon as possible. The January 6, 2004, meeting at 1:00 p.m. will discuss glaucoma first, go into the Executive Session, and then discuss the supplemental financials on the phase-two drugs. She continued with the agenda from February through July. She noted that July would finish the first round of PDL, and would review what has been done for the year

Ms. Roberts noted the timeframe from the soft edits to when the hard edits begin will be determined at each P&T Committee meeting. The dates noted in the presentation are tentative and currently as a "hold." They can move depending on how the classes look. A member (Ms. Snead) reminded the group that for the soft edits to be of substantial value to the providers, they need to be on the system at least 30 days prior to implementation due to a 30-day supply of drugs, and then the refill.

Ms. Roberts continued with the prescriber ID number. DMAS saw that 30 percent of the claims filed were using a "dummy" prescriber number. It would be impossible to evaluate the PDL program if that practice was continued, therefore, the "dummy" number was turned off on December 15. High utilizers were targeted and contacted: chain drug stores, and nursing home providers regarding this issue. FHS agreed to take the calls from providers. Pharmacies were calling the old Medicaid number, but now have noted the new number. Mr. Finnerty thanked Ms. Snead for all the work she has done to get the word out to the pharmacies.

Ms. Roberts continued that when they were updating the threshold information that the ProDUR (drug utilization review) program had not been updated. At the November 6<sup>th</sup> meeting of the DUR Board, it was decided for a health and safety issue that the updated ProDUR edits went from message-only to a provider override (the provider must stop, review and then override). For those enrollees who get prescriptions filled at different pharmacies rather than within the chain, they can have drug-to-drug interactions, etc., and at least FHS will be the only ones to know this information. Then next meeting of the DUR Board will occur February 5<sup>th</sup>. A quick list was created, and a Medicaid Memo will probably be released in February. She continued with the Threshold program. A retrospective review will occur in February for people with more than nine prescriptions in over 60 days. This is different than what was asked to do within 180 days. These people are being focused on in order that a positive impact can be made. She then discussed what will be occurring in March with the Threshold program and the ProDUR edits for patients taking over nine prescriptions and a drug-to-drug interaction.

There was discussion (Mr. Sheffield) regarding whether or not the PA criteria can be made available at the time of the P&T meeting or at least 24-hours after. He noted that as a member of the audience at the P&T meeting, things that were discussed that impacted providers, patients, and manufacturers were confusing since the audience did not have the document to also review. He also asked about the process for input being given to the P&T members. Ms. Roberts noted the reasons it could not be done. She noted the procedures taking place, that DMAS staff were working nights to get the information out as quickly as possible, and the steps taken to ensure that the PDL criteria matched the quick list, and coding. DMAS is posting more things on the web than other states; and regulations state that minutes of public meetings be posted in 10 working days. The process and timelines were also noted for the distribution of information for the P&T Committee. DMAS staff

will discuss what documents are available under the Freedom of Information Act (FOIA), what goes to the PDL IA group and the P&T Committee members. Ms. Carol Perkins, First Health Services (FHS) Clinical Manager, noted the PDL criteria was a good template. There was discussion regarding occurrence of Executive “closed door session,” and what should have been discussed under the Virginia Administrative Code and Federal Code. Ms. Roberts noted that an agenda “cheat sheet” could be created for the audience, and then stop the P&T Committee from phase-to-phase during the meeting so there will be no confusion as to where they are on the agenda. There was difficulty understanding the drugs placed on the PDL because the audience cannot pronounce the names. DMAS staff will help the non-pharmacists by posting the drug class, then note for example, that this is for a heart condition.

### **PDL Provider Education**

Ms. Cheryl Roberts noted that DMAS has provided more education on the PDL program than any other program implemented by the agency. She noted that training will continue until approximately mid-January. The presentation is on the web site and is about 30 minutes long for those interested. She introduced Ms. Barbara Dowd, of FHS.

Ms. Dowd noted that she has lead the education effort since September. Today’s presentation is what is given to all pharmacy providers and prescribers. The teams of trainers will have at least two people; one from FHS, and one or more people from DMAS. DMAS’ goal for the PDL is to maintain quality of care: being safe, effective and appropriate drug therapy at a reasonable cost to the Virginia Medicaid program. This is being implemented for fee-for-service and MEDALLION enrollees.

Ms. Dowd asked that prescribers proactively look at the preferred drug list, and as appropriate, modify or change Medicaid enrollees’ drug therapy to drugs that are included on the PDL. For new drug therapies, prescribers should start with drugs on the PDL, then contact the FHS call center for prior authorization (PA) for drugs not on the PDL. Pharmacy providers, during the soft edit phase, should contact the prescriber to let them know the patient is on a non-preferred medication and either change the drug or pursue the PA with FHS. She noted the assistance from prescribers and pharmacists is key to the success of the program. There was discussion about if the pharmacists “should” vs. “must” contact the prescriber.

Ms. Dowd noted there were 99 classes of drugs. FHS prepared a utilization report containing: those drugs that are clinically effective, broad difference in prices, and top utilized drugs in the Virginia Medicaid program. The P&T Committee is to decide if they are suited for inclusion in the PDL.

Ms. Dowd continued with the phase-in process and noted it would minimize the impact of the program on enrollees and providers as new classes would be implemented quarterly. All affected Medicaid enrollees have been notified by mail with a letter and a Frequently Asked Questions (FAQ) sheet; and all providers have been notified by mail and/or e-mail. Several presentations have already been made to Medicaid providers to introduce the program and explain the operational procedures, and more are being scheduled.

Ms. Dowd noted the drug classes included in the PDL program beginning January 2004. She continued with the drugs that have been excluded, and then continued with the drug classes proposed for implementation in April 2004. She noted that classes of drugs will be excluded from the program either by legislative mandate or that have typically been excluded by the Virginia Medicaid program. She continued with the prescribers' and the pharmacists' responsibilities and noted that effective immediately the prior authorization request can be processed by phone, fax, or mail. She then provided several scenarios for actions taken prescribing and dispensing drugs for a preferred and non-preferred drug.

There was discussion regarding 72-hour supply (question by Jill Hanken). Ms. Roberts noted that a "guidance" document has just been prepared on this issue. Ms. Snead noted that this training is important because the 72-hour supply does not occur in the private sector. There was further conversation regarding the use of the word "emergency" supply in the provider Medicaid Memo compared to FAQ to enrollees which just said supply. Ms. Dowd noted the word "emergency" was being used such as the prescriber cannot be contacted. Ms. Kerr noted that Florida used the word "temporary" rather than "emergency." Ms. Dowd continued that an asthma medication may be an emergency for some patients. Ms. Snead noted the patient may still have medication at home, but there would be no way to give a 72-hour supply for an inhaler. Mr. Finnerty noted that Centers for Medicare and Medicaid Services (CMS) used the term emergency with the intent there is not a health emergency, but the prescriber cannot be contacted. Ms. Perkins (of FHS) noted that "if it is in the best interest of the patient" to get the 72-hour supply, then it should be requested.

Ms. Roberts noted the next Medicaid Memo will be released on Pro-DUR, and an update to PDL before the hard edits go live. In that Memo, a clarification of any issues, such as the 72-hour supply, and guidance issues on how to submit 72-hour claims to get paid, will be addressed.

Ms. Dowd continued with the Prior Authorization (PA) process: contacting the FHS Call Center, the PA form, the required information, the turn around time for processing the PA, and denials and appeals. She noted that the FHS pharmacy technicians are not authorized to deny the request; therefore, it would then be transferred to a clinical pharmacist if there is a question of denial. She continued with the process.

A member (Ms. Kerr) asked, What drug would the patient get if they were denied the prior authorization request and had to go through the appeals process? Someone noted, it may depend upon if it was a pre-existing therapy vs. a new therapy. Mr. Finnerty noted that DMAS would get an answer; as the appeals process is not a day, nor a week, but the statute and regulations must be followed. The number of times this occurs will be extremely minimal, but the issue will be addressed.

Ms. Dowd concluded with the quality initiatives, such as: drug-to-drug interactions; retrospective and prospective reviews; and polypharmacy. She noted prescribers will receive letters as appropriate and noted the new Pharmacy Call Center numbers.

### Adjournment

Ms. Roberts noted that DMAS does not usually have public meetings during the General Assembly Session, however, a member (Mr. Sheffield) has asked that the PDL IA group meet after the P&T Committee. The P&T Committee will meet on January 6, 2004, and February 9, 2004. Ms. Roberts asked, When would the group like to meet and address what issue(s)? since implementation will have begun. If the group planned to meet at the end of January, at least one class of hard edits will have run, but DMAS will not have enough data to distribute.

Ms. Snead noted that she is interested in the “new drugs” that have entered the market on a class already reviewed—How will they be handled? Ms. Roberts noted that the P&T Committee would address that issue. The information can be put to the Chair and the information sent to the PDL IA.

Ms. Snead also asked, If a patient was already stable on a medication, would they be able to continue on that medication through the “grandfather” clause? Ms. Roberts stated the P&T Committee addressed this issue, and will not “grandfather” drugs for the first 13 classes.

There was discussion on budget projections and a letter from the Joint Commission on Health Care. It was noted that DMAS will not meet budget projections and has not yet received the letter from the Joint Commission on Health Care. Mr. Finnerty noted that the PDL has not been driven by budget. DMAS has a budget to meet, and it will not be met. This program is driven primarily by the P&T Committee, and clinical issues which is best for the provider and the client. ~~This could have been done differently, since DMAS had to save \$X million.~~ This could have been done differently, since DMAS had to save \$27 million general fund in the biennium. (As amended March 16, 2004 at the PDL IAG meeting.)

There was discussion regarding presentations already scheduled for top prescribers (utilizers), such as the University of Virginia (UVA), Virginia Commonwealth University (VCU)/ Medical College of Virginia (MCV), and the health systems. DMAS is tracking responses of groups that have control of many doctors—who has been contacted and their decision whether they want training or not. Some groups decided they only want the list since they are already familiar with formularies for commercial plans.

Discussion continued regarding the next meeting. A member (Ms. Hanken) suggested that the next meeting be held after the GA Session, but asked that the group be sent the reports which Mr. Turnage mentioned. Ms. Roberts agreed that an interim report will be sent to the group, and if necessary, an emergency meeting will be called and asked if everyone was in agreement.

Another question (by Ms. Hanken) was addressed regarding consumers being surveyed. Ms. Roberts noted that a Consumer Assessment Household Survey (CAHPs) survey is done annually broken out by program: Fee-for-Service, MEDALLION, and Medallion II. Special questions can be added to address the PDL.

**Ms. Roberts asked if the group would agree to meet on Tuesday, March 16, 2004, 10:00 a.m. - 12:00 p.m. at DMAS.** No one opposed the date.

There was discussion regarding operational questions. Ms. Roberts stated that the PDL IA members contact Mr. Tomlinson and herself directly by phone or e-mail, all others must send comments or questions to the [www.pdlinput.com](http://www.pdlinput.com). Mr. Finnerty noted that the members' input was important, and if they had concerns to please contact DMAS staff.

Other specific questions and answers discussed will be attached in the appendix. If a Committee Member cannot attend, they may send an alternate, but to notify DMAS staff who will represent their association. The meeting was adjourned at 12:28 p.m.