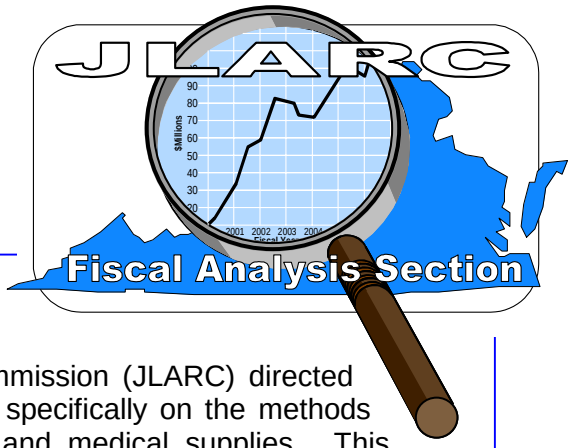
Special Report:

State Spending on Medical Supplies and Pharmaceuticals



Summary

The Joint Legislative Audit and Review Commission (JLARC) directed staff to undertake a follow-up review focused more specifically on the methods and procedures used to procure pharmaceuticals and medical supplies. This special report responds to JLARC's request by providing a brief background on the main agencies involved in purchasing medical supplies and pharmaceuticals. It also discusses opportunities for improving or enhancing some programs, which could result in total savings to institutions and the State ranging from $26.5 to $50.3 million.

The Commonwealth pays a broad range of prices for the prescription drugs that it purchases. For example, prices paid by seven agencies for Flovent®, used to treat respiratory problems, range from $33.26 to $67.11. Prices for drugs procured using the federal Public Health Service 340B drug-pricing program are the lowest, although not all entities are eligible to participate in this program. Those entities not participating in 340B purchase pharmaceuticals through a variety of means including State contracts, group-purchasing arrangements, and individual contracts with third-party providers.

Medicaid fee-for-service pharmacy costs rose 61 percent between FY 1998 and FY 2002. If growth continues at an average annual rate of 13 percent, by 2009 the program could be spending more than $1 billion (general and non-general funds) annually on prescription drugs. In order to curtail rising prescription drug costs, this report discusses several options for savings at the Department of Medical Assistance Services. These include the implementation of a Preferred Drug List, changing the discount on the average wholesale price paid to pharmacies, redefining the usual and customary charge to reflect the lowest price paid by any payer, and decreasing the pharmacy dispensing fee. Implementation of these programs could generate general fund savings ranging from $20.5 million to $40 million per year.

Expanding participation in the federal Public Health Service 340B drug-pricing program could generate savings up to $4.7 million, including up to approximately $3 million at the Department of Corrections. Using 340B participating entities to address high cost populations at the Department of Juvenile Justice and the Department of Mental Health Mental Retardation and Substance Abuse Services may result in additional savings to the Commonwealth.

In order to address double digit annual increases in pharmaceutical costs for the Commonwealth's self-insured health plans, a tiered co-payment structure could be implemented. Estimated annual program savings resulting from a tiered co-payment could exceed $4 million.

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The Heinz Family Philanthropy, in conjunction with the actuarial firm William M. Mercer, is currently conducting a study of aggregate purchasing across a number of agencies in the Commonwealth. The Heinz study team plans to conduct an actuarial analysis of bulk purchasing in Virginia and present options for savings to the Secretary of Health and Human Resources prior to the 2003 General Assembly Session.

The JLARC and Heinz options present potential savings to the Commonwealth. In order to fully implement these options and achieve savings, however, a number of statutory, regulatory, and policy changes will likely need to take place. Furthermore, the savings estimates provided in this JLARC report are preliminary. Additional study and analysis may be required to more completely assess the costs and benefits of the various options for short and long-term savings.

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Glossary of Selected Terms

340B: The Public Health Service Act (PHS) drug discount program was established in Section 340B of the Veteran' s Health Care Act of 1992, and was designed to offer eligible drug purchasers outpatient pharmaceuticals at discounted rates. Discounts average approximately 20 percent below Medicaid rates.

Group Purchasing Organization (GPO): Generally owned by their members, GPOs use volume purchasing as leverage in negotiating with vendors. In addition to lower prices for products, GPOs generally offer indirect savings in the form of reduced contracting costs.

Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP): MMCAP is a group purchasing organization consisting of state agencies and non-federal governmental units. Like other GPOs, MMCAP uses volume purchasing to obtain contracts for pharmaceuticals and allied supplies and services.

Novation: One of the nation's two largest group-purchasing organizations. Membership in Novation is limited to hospitals and is comprised of Voluntary Hospitals of America (VHA) and the University Hospital Consortium (UHC). Novation provides a variety of services to its members, including volume-purchasing discounts.

Psychotropic Drugs: Psychotropic drugs include antidepressants, neuroleptics, antipsychotics, and antianxiety agents.

BACKGROUND

The 2001 General Assembly passed House Joint Resolution 773 and House Bill 2865 directing the Joint Legislative Audit and Review Commission (JLARC) to analyze the causes of budget growth in Virginia. To respond to these mandates, in January 2002 JLARC staff completed an initial *Review of State Spending,* and in June 2002 staff completed an update to this report. Following the June 2002 spending report, JLARC directed staff to undertake a follow-up review focused more specifically on the methods and procedures used to procure pharmaceuticals and medical supplies. This special report addresses State expenditures for pharmaceuticals and medical supplies, the predominant methods of procurement now in use, and the types of medical goods and services that are procured.

This report provides brief background on the main agencies involved in purchasing medical supplies and pharmaceuticals. It also discusses opportunities for improving or enhancing some programs, which could result in some savings to specific institutions and to the State overall. The particular areas of opportunity addressed are: implementation of a preferred drug list (PDL) and changes to pharmaceutical reimbursement rates for dispensing and ingredient fees at the Department of Medical Assistance Services; expansion of the federal 340B drug-pricing program; cost sharing or tiered co-pays for the State's self-insured health insurance plans; exploration of group purchasing organizations and bulk purchasing arrangements; and use of eVA, Virginia's electronic procurement system, to achieve cost savings for medical supplies.

To carry out this review, JLARC staff interviewed staff of the Department of Medical Assistance Services (DMAS), the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the Department of Corrections (DOC), the Department of Juvenile Justice (DJJ), the Department of Health (VDH), the Department of Human Resource Management (DHRM), the University of Virginia Health System (UVA), the Virginia Commonwealth University Health System (VCU), and the Department of General Services (DGS). In addition, JLARC staff interviewed officials from other states and the federal government, as well as independent researchers who are currently working with states to implement various cost containment initiatives. The staff also collected and analyzed data from the agencies listed above related to pharmaceuticals and medical supplies.

This report focuses on the programs and agencies where the greatest percentage of State expenditures for medical supplies and pharmaceuticals is being procured. The report is organized into seven sections, including the background and introduction, which provides an overview of the agencies involved in the procurement of medical supplies and pharmaceuticals. The remaining sections provide overviews of each of the areas evaluated and found to offer potential savings, including a discussion of current programs and proposed changes designed to achieve enhanced savings. Specifically, the report addresses options for savings related to pharmaceuticals within DMAS, enhancing or expanding the use of the federal public health service's 340B pricing program, opportunities for savings at DHRM, the use of group purchasing organizations and bulk purchasing, and a discussion of medical supply procurement. Finally, a conclusion highlighting potential opportunities for savings is provided.

The analysis provided in this report is a preliminary assessment of potential cost savings. Further analysis may be required to estimate the full costs and benefits of each discussed program. In addition, changing market conditions may impact estimates. Estimates presented in this report are designed to illustrate the potential savings available if changes are made to existing programs.

THE COMMONWEALTH SPENT $811 MILLION IN FY 2002 ON PHARMACEUTICALS AND MEDICAL SUPPLIES

Virginia purchases pharmaceuticals and medical supplies in its role as a promoter of public health, a protector of public safety, and an employer. This review focuses on the seven agencies responsible for 94 percent of State expenditures for medical supplies and pharmaceuticals. Additionally, the review examines practices at the VCU Health System.

In Fiscal Year 2002, the Commonwealth spent $682 million for pharmaceuticals and $129 million for medical supplies (includes State general funds, federal funds and all other funds). These totals do not include expenditures made by VCU, because VCU is an independent authority.

While State agencies and programs serve populations with different needs and demographic characteristics, all of the programs expend significant resources for these goods. Table 1 provides total FY 2002 expenditures (general and non-general funds) for medical supplies and pharmaceuticals for the agencies selected for review.

Table 1

FY 2002 Total Pharmaceutical and Medical Supply Spending Across Selected Agencies (General and Non-General Funds) ($Millions)

Agency	Medical Supplies	Pharmaceuticals	Total
DMAS (fee-for-service only)	$0.1	$443.4	$443.5
DHRM	0	124.9	124.9
UVA	61.9	40.4	102.3
DMHMRSAS	3.4	35.5	38.9
VDH	8.8	23.1	31.9
DOC	3.6	13.1	16.7
DJJ	0.3	0.8	1.1
Selected Agency Total	**$78.1**	**$681.2**	**$759.3**
Total State Spending	**$129.3**	**$681.9**	**$811.2**
VCU	$26.3	$30.0	$56.3

Note: VCU was excluded from total State spending because of its status as an independent authority.

Source: JLARC staff analysis of data provided by the Department of Accounts and the individual agencies.

State agency expenditures for pharmaceuticals have continued to increase since FY 1998. Figure 1 shows the change in spending in these two areas. State agency spending on medical supplies has decreased. Some of the decrease may be attributable to VCU becoming a separate authority in July 2001. Spending for pharmaceutical procurement has risen at a pace greater than the rate of inflation for medical care. It is unclear whether the extent to which the increases in pharmaceutical expenditures are due to increasing prices or quantities purchased.

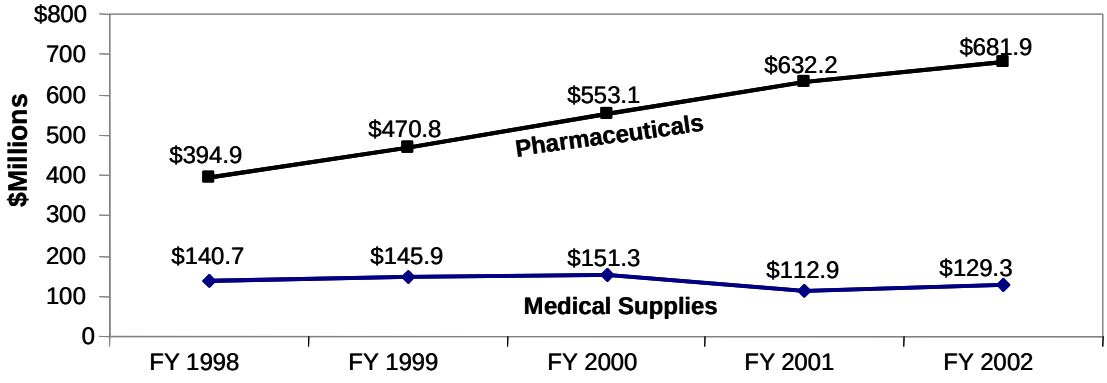
The Department of Medical Assistance Services is the largest State purchaser of prescription drugs, followed by the Department of Human Resource Management. Together, these two agencies account for about 75 percent of all State pharmaceutical expenditures. Despite serving different populations, the average drug cost per fee-for-service recipient at DMAS has increased 73 percent from FY 1998 through FY 2001 and 57 percent over the same period for DHRM.

In recent years, Virginia, like most other states, has experienced rapid growth in expenditures on pharmaceuticals. For example, Medicaid prescription-drug expenditures nationwide grew 20.5 percent between federal fiscal year (FFY) 1999 and FFY 2000. In addition, a recent study by federal researchers showed a 16.4 percent increase in prescription drug expenditures for FFY 2001. While expenses for prescription drugs continue to rise, decreased expenses in other areas of medical care may offset part of this increase. For example, some new drug therapies may stabilize patients such that the amount of in-patient facility care or the number of emergency admissions are reduced.

State agencies obtain pharmaceuticals through a variety of different methods, including group purchasing organizations, State contracts and agency-specific contracts with full-service mail-order pharmacies. The State also pays negotiated rates for drugs provided to State agency clients by third-party pharmacy administrators. For example, DOC and DJJ, which do not operate in-house pharmacies, contract for mail-order pharmacy services for care provided on-site and use a third-party administrator to obtain negotiated rates for care provided outside of State fa-

Figure 1

Total Pharmaceutical and Medical Supply Procurement
FY 1998 to FY 2002



Source: JLARC staff analysis of data provided by DOA, DHRM, and DMAS.

cilities. In contrast, the in-house pharmacies at DMHMRSAS and VDH order in bulk through a group purchasing organization. DMAS and DHRM do not procure pharmaceuticals directly; rather they reimburse pharmacies and other entities for claims on behalf of their members or clients.

Agencies pay a wide range of prices for pharmaceuticals. Table 2 provides a sample of drugs commonly provided by or reimbursed by the selected agencies in this study. As shown in Table 2, agencies eligible for 340B pricing receive the lowest prices for most drugs. 340B is a federal drug-pricing program designed to offer federal drug purchasers outpatient pharmaceuticals at discounted rates. The 340B prices are generally about 20 percent lower than Medicaid prices. However, all agencies and programs are not eligible for 340B pricing discounts. For example, while UVA and VCU are eligible for 340B discounts for their outpatient population, the program is not applicable to the inpatient population. Therefore, UVA and VCU reported both outpatient 340B prices and inpatient contracted (through Novation or other contracts) purchasing prices. As DOC and DJJ contract with similar private vendors for full-service pharmacy services and with Trigon for some specific drugs or drugs provided off-site, prices paid by these agencies are comparable to each other.

There is a wide range of drug prices paid between the agencies that participate in 340B and those that do not. As shown in Table 2, the prices paid by agencies not participating in 340B are, on average, approximately 50 to 150 percent higher than the applicable 340B prices. However, the range of prices paid across the agencies that do not participate in 340B is narrower. For example, when comparing

Table 2

Comparison of 2002 Drug Prices Paid by Selected Agencies

Drug	340B (outpatient)			DMAS	DJJ	DOC	Inpatient		DMHMRSAS
	UVA	VCU	VDH				UVA	VCU	
Flovent® 110mcg	33.26	33.90	34.11	55.95	53.72	67.11	56.76	57.84	58.23
Prilosec® 20mg	2.76	2.80	2.83	3.23	4.26	3.97	3.57	3.28	3.42
Prevacid® 30mg	0.23	0.24	0.24	3.15	4.09	3.84	0.23	0.24	3.30
Celebrex® 200mg	1.63	1.66	1.67	1.98	--	2.39	2.09	2.13	2.03
Claritin® 10mg	1.17	1.07	1.20	2.02	2.62	2.72	2.01	2.06	2.05
Lipitor® 10mg	1.27	1.28	1.30	1.64	--	--	1.88	1.82	1.68
Zyprexa® 10mg	5.85	6.01	7.54	6.69	8.19	8.00	7.51	7.65	7.60
Zoloft® 100mg	1.49	1.51	1.53	1.88	2.16	2.20	1.95	1.90	2.02
Depakote® 500mg	0.61	0.62	0.62	1.30	1.49	1.60	1.52	1.50	1.45

1. Per unit prices were not available from DHRM. DOC drugs included on Diamond formulary are not included. DJJ did not process any claims for Lipitor 10 mg or Celebrex 200 mg. UVA and VCU reported 340B prices for outpatient drugs and Novation prices for inpatient pharmaceuticals. VDH is also a 340B provider. DMAS prices are post-rebate (computed by applying a 20 percent reduction to pre-rebate prices).
2. Not all entities are eligible to participate in the 340B federal drug-pricing program.
3. The differences in 340B prices between VCU and UVA are the result of slightly different discount structures with wholesalers. The same is true for the inpatient price differentials.
4. DOC and DJJ do not operate in-house pharmacies.
5. DMAS does not procure pharmaceuticals. Rather, it reimburses pharmacies or other entities for pharmaceutical claims.

Source: All information included in the table was reported to JLARC staff by the respective agency.

prices across only the non-participating 340B agencies, the highest drug prices are approximately 14 to 34 percent higher than those at the bottom of the range.

Flovent®, used to treat respiratory problems, provides an example of how drug prices vary across programs. As noted in Table 2, Flovent (110mcg) prices exhibit a 100 percent price differential, ranging from the 340B rate of approximately $33.26 to DOC's rate of $67.11 (raised from $61.49 in July 2002). When compared only across the entities that do not participate in 340B, however, the price differential is approximately 25 percent. In all of the examples within Table 2, the 340B rate is the lowest, but not all entities are eligible to participate in the 340B drug-pricing program.

The Commonwealth spent $129 million in FY 2002 for medical supplies. The seven State agencies highlighted in this report constituted more than 60 percent of this statewide total. Expenditures for the UVA Health System and the UVA academic campus were almost 50 percent of the statewide total or the largest single percentage of medical supply purchases. The bulk of medical supply purchasing is done through State contracts and the group purchasing organization used by UVA. Since most medical supply purchasing is decentralized at the facility level, the State is currently unable to capture commodity-level data concerning the items being purchased and the volume of such items. As the use of eVA (the State's computerized purchasing system) increases, the State should be able to capture more detailed information and utilization data about medical supply purchases and position itself more favorably in contract negotiations.

OVERVIEW OF PHARMACEUTICAL AND MEDICAL SUPPLY PROCUREMENT IN SELECTED AGENCIES

Each of the eight selected entities utilizes a slightly different process for procuring medical supplies and pharmaceuticals. Several agencies use bulk purchasing coalitions. DMHMRSAS, for example, utilizes an inter-state bulk purchasing coalition called the Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP). UVA and VCU purchase through a large group purchasing coalition called Novation. The Virginia Department of Health (VDH) also participates in MMCAP, but procures the majority of its pharmaceuticals through the federal 340B drug-pricing program. Other agencies such as DMAS and DHRM do not procure pharmaceuticals directly, but reimburse participating entities for pharmaceuticals dispensed.

Department of Medical Assistance Services

The Department of Medical Assistance Services (DMAS) primarily administers Virginia's Medicaid program. The agency administers the State's Medicaid plan, certifies provider eligibility, and provides payment to Medicaid providers for services rendered to individuals eligible for Medicaid. The Virginia Medicaid program is both federally and State funded. The federal funding participation rate for medical expenditures is approximately 50 percent. In the Medicaid program, states are generally permitted to set their own eligibility standards, and to determine the type, duration, and scope of services they will cover. States also have considerable flexibility in setting payment rates for services. However, the federal Medicaid pro-

gram restricts federal financial participation (FFP) for services provided to inmates of correctional facilities and patients in institutions for mental diseases. While prescription drug coverage is an optional benefit, all state programs provide this coverage. Virginia has done so since 1969.

During the course of this review, JLARC staff focused on pharmacy services for Medicaid recipients under the fee-for-service (FFS) program. Table 3 provides some detailed information about expenditures in the fee-for-service program. The number of Medicaid FFS clients has been declining in recent years due to the proliferation of managed care. Managed care, implemented in 1996 and expanded to 103 of the 136 localities in the Commonwealth in 2001, requires the mandatory enrollment of most Medicaid clients into HMOs. The main exceptions from enrollment in managed care are long-term care recipients who are in institutions and those recipients who are enrolled in separate home and community-based care waiver programs targeted to the elderly and disabled. On average, persons exempted from managed care are more susceptible to severe illness, have higher pharmacy utilization, and use more costly medication. For example, in a recently released report, JLARC staff reported that the blind and disabled category accounts for only 19 percent of recipients, but 45 percent of total annual Medicaid spending.

Table 3

DMAS Fee-for-Service Total Pharmacy Program Costs (General and Non-General Funds)

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
Pharmacy Expenditures	$274,637,472	$321,383,848	$372,091,108	$410,391,473	$443,434,923
Rebates	54,358,385	60,522,588	75,477,394	70,691,112	88,686,985
Total Program Expenditures	2,342,477,366	2,461,612,625	2,732,427,319	2,330,828,425	2,353,267,540
Number of Recipients	384,764	378,168	341,141	332,515	316,890
Average Pharmacy Expenditure Per Recipient	714	850	1,091	1,234	1,399
Change in Pharmacy Expense Per Recipient	--	19%	28%	13%	13%

Source: JLARC staff analysis of data provided by DMAS.

As administrator of the Medicaid program, DMAS provides reimbursement for goods and services rendered. Accordingly, the agency does not generally procurepharmaceuticals and medical supplies directly. In FY 2002, DMAS expended approximately $443 million in general and non-general funds (before drug rebates) for pharmacy services for its fee-for-service population. (Medicaid receives drug rebates of approximately 20 percent. Approximately 50 percent of the Medicaid expense is covered by federal funds.)

Medicaid fee-for-service pharmacy costs have increased 61 percent from FY 1998 through FY 2001. If growth continues at an average annual rate of 13 percent, by 2009 the program could be spending over $1 billion (State and federal funds) annually on prescription drugs. In FY 2002, DMAS spent $76,928 on medical supplies. DMAS expenditures related to supplies are relatively small, because the agency does not purchase items directly, but, rather, reimburses for services.

Department of Human Resource Management (DHRM)

The Department of Human Resource Management administers the Commonwealth's health benefits program for 116,756 active employees and retirees. Health insurance benefits for State employees are paid for by contributions from the employer and the employee, but the amount paid by the employer and employee varies by the type of coverage selected. For example, premiums for the Cost Alliance plan are funded entirely by the Commonwealth. Retirees pay 100 percent of the cost of premiums, although the retiree premiums may be offset by the VRS health care credit. DHRM also offers several HMO options to employees, but only a small number (4.3 percent) of employees and retirees elect to enroll in the HMO plans. This report focuses on the Commonwealth's self-insured plans (Key Advantage and Cost Alliance).

Much like DMAS, DHRM reimburses providers for claims for the provision of goods and services and does not procure medical supplies and pharmaceuticals directly. In FY 2002, DHRM spent approximately $125 million on pharmaceuticals for the self-insured plans which cover active employees and retirees. All of these funds are special funds consisting of employee and employer premiums. In FY 2002, DHRM spent only $54 for medical supplies, because the agency is billed for these items by providers and does not generally directly purchase these goods.

Virginia Department of Health (VDH)

The Virginia Department of Health (VDH) provides public health, environmental health, and medical services through 119 local health departments. Medical services, including prescription drugs provided to VDH clients, are funded through a combination of State general funds, local match funds, agency-generated revenues (typically from patient co-payments determined on a sliding scale), and any additional local funding. Based on the *Code of Virginia*, pharmaceuticals and biologics are provided at no charge for certain sexually transmitted diseases and for immunizations required for school entry.

In FY 2002, VDH spent approximately $23 million on prescription drugs: $6.1 million in State general funds; $10.4 million in federal funds; and $6.6 million from other sources. About $18 million of the total is spent through the federal AIDS Drug Assistance Program (ADAP). In addition, VDH spent approximately $8.8 million for medical and laboratory supplies. VDH estimates that more than 95 percent of medical supply purchases are obtained through State contracts. VDH also reported that approximately $5.5 million of its total pharmaceutical and medical supply expenditures was collected from local health departments, thereby offsetting VDH expenditures but not necessarily reducing overall State spending.

VDH operates a central pharmacy that serves most of the public health departments, although ten health districts have established their own pharmacies. VDH procures drugs through a combination of the Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP) contracts and 340B pricing administered by the federal public health service (PHS). VDH also utilizes patient drug assistance programs, which provide approximately $4 to $5 million in free drugs per year. In addition to requiring generic substitution for all multi-source brand-name products unless "brand necessary" is specifically indicated, the use of 340B pricing by VDH generates significant savings for the Commonwealth.

Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)

DMHMRSAS operates ten mental health facilities and five mental retardation training centers that provide in-patient treatment for persons suffering from mental illness, mental retardation, and alcohol or other substance abuse problems. Each of these in-patient facilities operates a department of pharmacy. Clients access the State-operated facilities through community service boards (CSBs). CSBs are responsible for delivering mental health, mental retardation, and substance abuse services to citizens in their localities, and referring those individuals with severe conditions to State-run in-patient facilities.

While all of the in-patient facilities operate their own pharmacies, most CSBs provide prescription drugs to outpatient clients through the mail-order aftercare pharmacy located on the campus of Hiram W. Davis Medical Center. The aftercare pharmacy employs a number of effective cost containment methods including maintaining a strict formulary, encouraging the use of generics, package merging, and dose manipulation (for example, two 50 mg caplets in the place of one 100 mg caplet). In addition, the aftercare pharmacy implemented a unique program, called Medsaver, designed to conserve unclaimed medication by collecting undispensed prescription drugs from the CSBs and then by repackaging and redistributing the medication. In FY 2002, the Medsaver program saved $2.6 million. Savings in FY 2003 through September were approximately $1.4 million.

In FY 2002, DMHMRSAS spent approximately $35.5 million on prescription drugs: $24.5 million in State general funds; $331,500 in federal funds; and $10.6 million from other sources (including Medicare, Medicaid, and private insurance payers). Pharmaceutical supplies are purchased through the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP). In addition, DMHMRSAS spent approximately $3.4 million for medical supplies. DMHMRSAS estimates that approximately 52 percent of its medical supply purchases are obtained through State contracts. Much of the remaining supply purchases are considered small purchases and are made by individual facilities.

Department of Corrections (DOC)

In its 58 facilities, the Department of Corrections (DOC) houses more than 28,000 Virginia inmates and 3,000 inmates from other states. State general funds account for about 87 percent of expenditures and the remaining balance is paid for with special funds (mostly in the form of payments by other states for housing their inmates). DOC is responsible for providing health care for the inmates housed in its facilities. While secondary and tertiary care is provided off-site, all primary care is provided on-site. At six of its institutions, DOC uses an outside medical contractor which agrees to accept a fixed fee for medical services (including prescription drugs) provided to inmates. However, DOC pays a separate fee, which is not part of the fixed medical service contract, for dialysis and for any antiretroviral (HIV) and hepatitis C medications taken by inmates at these six institutions.

In FY 2002, DOC spent approximately $13 million in State general funds on pharmaceuticals. For those inmates not covered under medical services contracts, DOC contracts with a mail-order pharmacy and pays a per capita rate for a

closed formulary that includes most pharmaceuticals. However, under the terms of the medical services contract and the per capita pharmacy benefit, other drugs including antiretrovirals and hepatitis C drugs can be purchased separately through negotiated rates. DOC stated that mental health drugs and antiretroviral, HIV, and hepatitis drugs constituted the bulk of prescription expenditures. For example, DOC estimates that in FY 2002, $6 million (or 46 percent of the total expended for pharmaceuticals) was for antiretroviral, HIV, and hepatitis drugs. In addition, DOC estimates that approximately $2 million (or approximately 15 percent of the total pharmaceutical costs) were expended for mental health drugs. The remaining $5 million was spent for all other treatments. In FY 2002, DOC also spent approximately $3.6 million for medical and laboratory supplies. DOC procures medical supplies through State contracts and independent vendor contracts. As procurement at DOC is decentralized throughout its facilities, DOC could not estimate the percentage of medical supply purchases obtained through State contracts.

DOC encourages the use of formulary drugs and generics. Using substitutions established by a Pharmacy and Therapy Committee, DOC is developing a step-therapy plan whereby the lowest cost pharmaceutical in a drug class (for select drug classes) will be dispensed prior to the use of more costly alternatives. DOC also has a prior authorization program in place for a limited number of drugs.

Department of Juvenile Justice (DJJ)

The Department of Juvenile Justice operates the Commonwealth's juvenile correctional centers. DJJ, like DOC, is responsible for purchasing prescription drugs and medical supplies for the juvenile offenders in its custody. DJJ receives about 94 percent of its funding through State general funds.

In FY 2002, DJJ spent approximately $824,698 in State general funds on prescription drugs. In addition, DJJ spent approximately $349,390 for medical and laboratory supplies. DJJ contracts with a private full-service mail-order vendor for pharmacy services. For emergencies and for care provided off-site, the agency contracts with a vendor that provides claims processing services and affords DJJ access to more favorable negotiated rates for pharmaceutical and medical services than it would be able to obtain on its own. DJJ estimates that approximately 75 percent of the medical supplies it uses are available through State contracts.

Approximately 50 percent of the youth housed at DJJ receive medication and about 25 percent are receiving psychotropic (anti-anxiety, anti-depressant, and anti-psychotic) medication. Approximately 34.5 percent of offenders have a history of psychotropic usage prior to entering a facility or are on psychotropics upon admission. As a result of the relatively short length of stay for most offenders, DJJ maintains an open formulary. According to officials at DJJ, when possible, physicians try to use generic medications. For most medical situations, the use of generics does not pose a problem. However, the process of substituting medications becomes more challenging when dealing with psychotropic or atypical medications. Due to the short length of stay by juvenile offenders, DJJ reports that facilities generally prescribe the same drug for the juvenile that he or she used prior to detention and that will be provided post-detention in the community.

University of Virginia and Virginia Commonwealth University Health Centers (UVA and VCU)

UVA and VCU are integrated networks of primary and specialty care services. The services provided range from routine checkups to the most technologically advanced care. The UVA health system operates a hospital with 541 beds. In FY 2001, UVA had 27,653 admissions, more than 564,000 out-patient visits, and 56,688 emergency visits. Similarly, with 822 beds, VCU records approximately 31,000 admissions, 500,000 outpatient visits each year, and 82,000 visits to the emergency department. In addition, both systems serve as State-designated Level I trauma centers.

UVA's total medical center budget for FY 2003 is $586 million, about 30 percent is for medical supplies and pharmaceuticals. In FY 2001, 6.4 percent of UVA Health System's expenses were paid through State appropriations. The remaining revenue is derived from contracts for care or predetermined payment mechanisms. Effective July 1, 2000, the Virginia Commonwealth University Health System was established through a merger of the clinical activities of the Medical College of Virginia Hospitals, MCV Physicians, and the VCU School of Medicine. The VCU system now operates as an independent authority.

In FY 2002, UVA spent approximately $40.4 million and VCU expended $30 million on prescription drugs. In addition, the UVA and VCU health systems spent approximately $61.9 million and $26.3 million respectively for medical and laboratory supplies. A portion of the difference can be attributed to the fact that VCU does not use the same sub-object codes for medical supplies and pharmaceutical as the remaining State entities. For example, while blood products are included by UVA, they are not included by VCU.

UVA and VCU make limited use of State contracts. For example, UVA and VCU reported using State contracts for very few of its medical supply purchases. UVA and VCU conduct most of their prescription drug purchasing through Novation, a large group purchasing organization. Novation contracts are also used for the procurement of medical supplies.

OPTIONS FOR SAVINGS ACROSS STATE AGENCIES AND PROGRAMS

While many State agencies have implemented cost containment initiatives, a number of additional options for increasing savings across agencies and programs are available to the Commonwealth. As shown in Table 4, improving, enhancing, or expanding some programs could result in savings ranging from $26.5 to $50.3 million. At DMAS, for example, the implementation of a preferred drug list (PDL) and a reduction in the reimbursement rates and dispensing fees paid to pharmacies could achieve significant savings. Additionally, increasing the utilization of the public health service's 340B drug-pricing program and the implementation of a tiered co-payment structure at DHRM could achieve savings for the State.

Table 4

Potential Options for Savings (Annually, $Millions)

Initiative	Range of Savings
Preferred Drug List	$17.8 – $22.0
AWP Change	$1.6 – $10.4
Dispensing Fee Decrease	$1.1 – $7.5
DOC Expansion of 340B	$1.6 – $3.0
340B Hospital Expansion	$0.2 – $1.7
Total Potential General Fund Savings	**$22.3 – $44.6**
DHRM Tiered Co-pay	$4.2 – $5.7
Total Potential Other Fund Savings	**$4.2 – $5.7**
Grand Total	**$26.5 – $50.3**

Source: JLARC staff analysis.

OPTIONS FOR SAVINGS WITHIN THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

In FY 2002, the Department of Medical Assistance Services (DMAS) spent approximately $443.4 million on fee-for-service (FFS) pharmaceutical reimbursements. Approximately half of that amount came from State general funds. The remaining half was funded through a federal matching grant. Consistent with other states, DMAS' total annual FFS prescription drug spending has increased 61 percent since 1998 (Figure 2). DMAS has taken steps to contain these rising costs. However, several additional cost savings options (some requiring enabling legislation) are available to DMAS, including the use of a preferred drug list, lower ingredient payments, and lower dispensing fees.

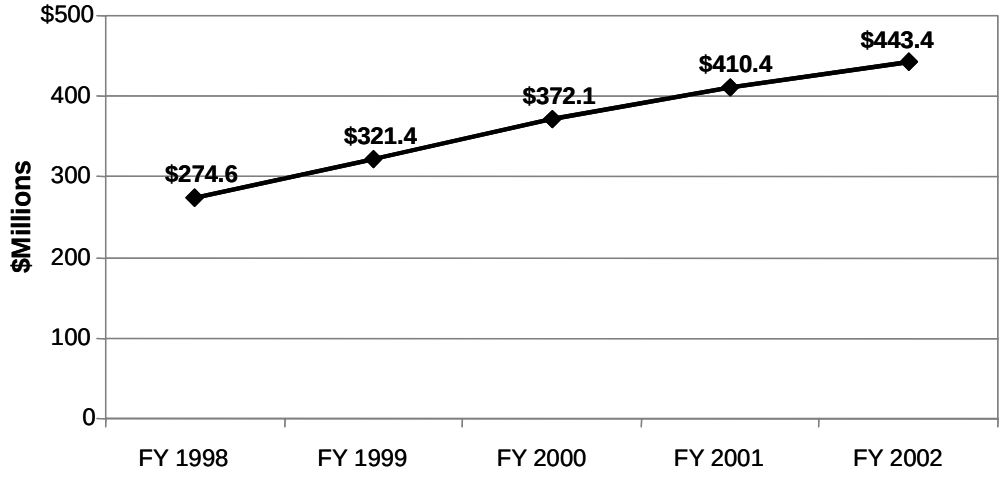
Medicaid Prescription Drug Coverage

Congress established the Medicaid program in 1965 as a jointly funded collaborative venture between state and federal governments. Its purpose is to provide appropriate medical care to needy and low-income populations. The provision of a prescription drug benefit within the Medicaid program is optional. Currently, however, all 50 states and the District of Columbia elect to provide this benefit. The pharmacy benefit, according to the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), includes all drugs for which a manufacturer agrees to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services.

For a number of years, pharmacy costs have continued to rise. In FY 2002, Virginia spent $443.4 million (State and federal funds) on prescription drugs for its unduplicated 290,980 FFS eligible clients, representing approximately 11.9 percent of total 2002 Medicaid expenditures. As illustrated in Figure 2, FFS pharmacy costs have increased from $274.6 million in 1998 to $443.4 million in 2002, an increase of 61 percent.

Figure 2

Medicaid Fee-for-Service Pharmaceutical Expenditures (General and Non-General Funds) FY 1998 to FY 2002



Source: JLARC staff analysis of data provided by the Department Of Medical Assistance Services.

In an effort to control the rising cost of prescription drugs, DMAS has incorporated several cost containment programs. For example, DMAS utilizes a pharmacy lock-in program to curb potential abuse. Additionally, DMAS has increased the use of generic drugs where available, increased pharmaceutical co-pays ($1.00 for generic and $2.00 for brand-name; the maximum allowable co-pay under federal law is $3), and implemented a third-party recovery program, designed to reduce payments on behalf of Medicaid clients with other sources of insurance coverage (in FY 2002, this program recovered approximately $3 million).

To further control rising costs, there are several additional options available to DMAS. These options include initiation of a preferred drug list and various methods to decrease pharmacy expenditures.

Options for Savings: Implement a Preferred Drug List

Preferred drug lists (PDLs), which have been used by other state employee health plans, private hospitals, health maintenance organizations and pharmacy benefit managers for several years, are an increasingly popular method of containing pharmaceutical costs within state Medicaid programs. PDLs are, essentially, prior authorization plans developed by Pharmaceutical and Therapeutics Committees that divide Medicaid allowable prescription drugs into two categories: those that require prior authorization before they can be dispensed, and those that do not. A preferred drug list contains a wide range of generic and brand name products that have been approved by the FDA. In general, a medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness.

Several states, including Michigan, Florida, Georgia and California, currently utilize PDLs. A number of others, including West Virginia, Indiana, Oregon and Louisiana, have passed the legislation necessary to implement a PDL.

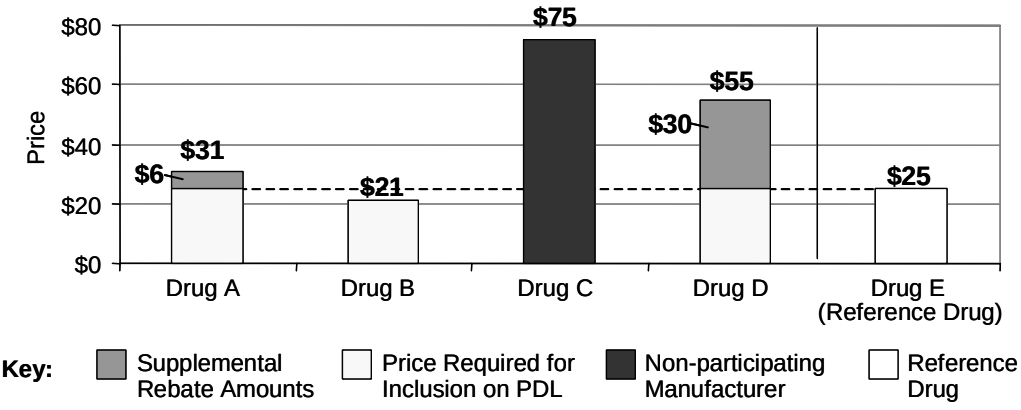
According to other states and industry experts interviewed by JLARC staff, PDLs are estimated to save approximately eight to ten percent of Medicaid prescription drug costs. This would represent a savings of approximately $35.5 to $44 million for Medicaid – $17.8 to $22 million in general funds. This savings is achieved in a variety of ways: (1) by encouraging the use of generic drugs; (2) promoting the use of low cost therapies prior to utilization of high cost alternatives; and (3) by providing the states with the leverage necessary to negotiate supplemental rebates.

Michigan Reports Achieving Substantial Savings through the Use of a PDL. Michigan implemented a PDL in February 2002, approximately seven months after the enabling legislation was passed. Michigan's PDL represents 40 of the 99 total therapeutic classes (a therapeutic class contains pharmaceutical products designed to treat specific indications; for example, antihistamines are a therapeutic class). The more controversial mental health therapeutic classes are included within the PDL. However, a grandfather clause allowing individuals currently taking these medicines to continue on their regimen was included. Approximately 75 percent of Michigan's cost was within these 40 classes.

In selecting the medicines to be included on the PDL, Michigan utilized a clinical selection process. For each drug class, a committee, comprised primarily of pharmacists and physicians, utilized clinical protocols to select a "reference drug." As illustrated in Figure 3, all drugs priced at or below the cost of the reference drug were then included on the PDL. Those manufacturers with pharmaceuticals in the class that were priced higher than the reference drug were then asked to provide a supplemental rebate to Medicaid that would make the end-cost equal to the cost of the reference drug. Any drug whose cost was greater than the cost of the reference drug and for which there was no supplemental rebate agreement was placed on the prior authorization list (this requires a physician to obtain approval from Medicaid before a written prescription can be filled).

Figure 3

Development of a Preferred Drug List Based on a Reference Drug



Source: JLARC staff illustration of PDL pricing based on Michigan data provided by First Health Services.

Compliance (use of a reference drug or a drug priced at or below the reference drug price) with the Michigan PDL on the part of prescribers is approximately 85 percent for the majority of therapeutic classes. Michigan reports that as health care providers and clients become more familiar with the program, compliance continues to increase.

Michigan's PDL development and prior-authorization processes are administered by First Health Services, a Pharmacy Benefit Administrator (PBA) that currently acts as Virginia Medicaid's fiscal agent. Michigan officials estimate savings of approximately $900,000 per week, or roughly eight percent of prescription drug costs.

If Virginia experienced a similar percentage savings, DMAS could save approximately $17.8 million (general funds) per year. An estimate prepared by First Health Services (using a different methodology) found that a PDL in Virginia would produce annual savings in the range of $37 to $49 million with administrative fees of approximately $1.5 to $4.0 million. Half of this savings, or $16.5 to $23.8 million, would be general fund savings.

While the potential savings are substantial, there are several obstacles to implementing a PDL in Virginia that must be considered. First, because prior authorization provides states with the leverage necessary to negotiate supplemental rebates, a successful PDL requires an effective and useable prior authorization system. As noted in JLARC's 2002 *Review of Selected Programs in the Department of Medical Assistance Services*, the current prior authorization committee is ineffective and should be redesigned.

An Effective Prior Authorization Program Is Needed. In 1993, the General Assembly directed DMAS to implement a prior authorization program for high cost drugs. The legislation established an advisory panel (called the Prior Authorization Committee) to determine and recommend certain drugs for prior authorization. However, DMAS has found the statutory language that describes the prior authorization process to be burdensome and unnecessary. For example, Section 32.1-331 of the *Code of Virginia* requires the committee to conduct public hearings and to notify any manufacturer of the drug whose product is being reviewed before it can begin the process to recommend a drug for prior authorization status to the Board of Medical Assistance Services (BMAS). If the recommendation is accepted by BMAS, then it must still go through the full Administrative Process Act (APA), which requires additional public comment.

The current requirements under the law would effectively mitigate any savings that could be obtained through a PDL. In order to allow the Prior Authorization Committee to select drugs for prior authorization, the sections in the *Code of Virginia* (and the associated Medicaid State Plan and regulations) that mandate the process for prior authorization should be streamlined. This should include, at a minimum, the removal of the dual public comment process. In addition, DMAS staff should be able to recommend drugs for inclusion on the prior authorization list. DMAS staff have the expertise and the direct access to pharmacy and medical care claims to conduct a cost-benefit analysis and to determine the impact of the overall health of the recipient for any drugs they would recommend.

While the restrictions placed on the implementation of a PDL by the prior authorization statute are significant, there may be alternative methods to consider. For example, South Carolina utilized a third party advisory committee to develop its PDL, rather than relying on a traditional Pharmaceutical and Therapeutics Committee.

States Utilizing PDLs have Encountered Litigation. Virginia may wish to proceed cautiously while the PDL-related lawsuits initiated by the Pharmaceutical Research Manufacturing Association (PhRMA) against Michigan, Maine, and Florida are considered. The litigation PhRMA filed against Florida, alleging that the PDL law illegally created a "formulary," which restricts care for the poor by "creating barriers to the most expensive drugs," was found in Florida's favor by the U.S. 11th Circuit Court of Appeals. The Michigan litigation alleges that Michigan's Pharmaceutical Best Practices Initiative program "restricts access to medicines for America's most vulnerable patients" based exclusively on price. The lawsuit seeks a preliminary injunction to block Michigan's initiative and several similar programs. The U.S. District Court in Washington D.C. has not yet ruled on the Michigan plan although a ruling is expected soon.

The litigation initiated in Maine challenges the "Maine Rx Program," whereby individuals without pharmaceutical coverage can "purchase prescription drugs from participating Maine pharmacies at a discounted price." The Maine program is different from a strict PDL, because of its focus on extending Medicaid prices to individuals who do not qualify for Medicaid.

The outcome of the Maine case and others may have an affect on the direction of state PDLs. The U.S. First Circuit Court of Appeals upheld the Maine law in February. The case has, however, been granted a writ of certiorari by the U.S. Supreme Court and is scheduled for argument on January 22, 2003.

PDLs Require Substantial Resources to Implement and Maintain. PDLs, particularly the prior authorization program, can be resource intensive to implement and administer. Given the current fiscal situation and the resources required to implement a PDL, DMAS may find it difficult to implement such a program with existing staff. There may be options available, however. For example, West Virginia Medicaid currently runs its prior authorization process through a cooperative partnership with the West Virginia University (WVU) School of Pharmacy. WVU School of Pharmacy runs a non-profit business through which it conducts prior authorization for the Medicaid program. Additionally, several states have privatized their prior authorization processes. Michigan's agreement with First Health Services, for example, includes management and administration of the prior authorization program.

Recommendation (1). **Pending the resolution of current litigation from other states, the General Assembly may wish to amend Section 32.1-331.13-14 of the *Code of Virginia* to facilitate the creation and operation of a Preferred Drug List (PDL) within the Virginia Medicaid program. To facilitate this process, the General Assembly may wish to authorize DMAS to appoint a Pharmacy and Therapeutics committee qualified to evaluate drugs for inclusion. The PDL should be based on safety and efficacy, and then price, rather than solely on price. In order to successfully implement**

a PDL, the General Assembly may wish to streamline the prior authorization statute, including the removal of the dual public comment period.

Options for Savings: Reduce Payments to Pharmacies

Medicaid's pharmacy payments consist of a drug cost, which is based on the cost of the drug and shipping and handling fees, and a dispensing fee, which is based on the pharmacy's cost to distribute the drug. For example, for brand-name drugs, DMAS currently reimburses pharmacies at the lower of average wholesale price (AWP) less 10.25 percent or the usual and customary charges paid by cash customers (see Appendix A for greater detail). The current dispensing fee is $4.25.

DMAS could reduce pharmacy expenditures through any of four options: (1) lowering the current reimbursement rate for drug costs based on average wholesale price (AWP), (2) re-establishing the reimbursement rate based on wholesale acquisition cost (WAC), (3) changing the definition of usual and customary (U&C) rate to the price charged to any other provider, and (4) decreasing the dispensing fee.

Lower the Reimbursement Rate for Drug Costs Based on Average Wholesale Price (AWP). DMAS's current reimbursement rates for drug costs are set by the General Assembly at average wholesale price (AWP) minus a discount of 10.25 percent. Based on a JLARC survey of all 50 states, 33 states receive a higher discount rate than 10.25 percent (Appendix B). (Five states were excluded from the count because they use a different method to calculate ingredient reimbursement.) Only ten states have lower discount rates (or, pay more) than Virginia.

The average state ingredient reimbursement cost is AWP less 12 percent. Increasing the discount rate would result in substantial savings for DMAS. For example, applying the current FFS reimbursement rate of AWP less 10.25 percent to FY 2002 actual expenditures, JLARC staff estimates that a change from AWP less 10.25 percent to AWP less 12 percent (national average) would have saved Medicaid approximately $7.7 million ($3.8 million in direct savings to the Commonwealth). Table 5 displays the potential annual savings associated with the application of increased discounts to FY 2002 expenditures.

Reimburse Pharmacies Based on Wholesale Acquisition Cost (WAC). Although the majority of state Medicaid programs reimburse brand-name drugs based on AWP, some state programs have started to use another method to determine acquisition costs, the wholesale acquisition cost (WAC) plus a specific percentage. Unlike the AWP rate, which is based on the *suggested* retail price or the drug manufacturer's sticker price, WAC is determined by the *actual* price paid to the wholesaler. When using a WAC rate, states add on a percentage to allow pharmacies to cover shipping and handling costs.

Currently, six state Medicaid programs use the WAC pricing system rather than the AWP, or in addition to AWP, as part of determining the best method for achieving the lowest acquisition costs. Maryland reported that, in terms of brand-name drug pricing, AWP less 10 percent and WAC plus 10 percent appear to be approximately equal. With regard to generic drugs, however, Maryland has reported achieving substantial savings by using WAC in place of AWP.

Table 5

Potential Annual General Fund Savings of Changing Average Wholesale Price (AWP) Paid to Pharmacies
($Millions)

AWP minus 11 percent	$1.6
AWP minus 12 percent (national average)	**$3.8**
AWP minus 13 percent	$6.0
AWP minus 14 percent	$8.2
AWP minus 15 percent	$10.4

Note: Cost savings are based on actual FY 2002 fee-for-service pharmacy expenditures. DMAS estimates that 10 percent of FY 2002 FFS spending was the dispensing fee. For the purposes of this analysis, the dispensing fee was removed from the FY 2002 total. All estimates are based on FY 2002 Average Wholesale Price.

Source: JLARC staff analysis based on Department of Medical Assistance Services claims data from FY 2002 for single-source and brand-name drugs from 1998-2002.

Recommendation (2). **The General Assembly may wish to direct the Department of Medical Assistance Services (DMAS) to conduct an analysis to determine the average wholesale price (AWP) and the wholesale acquisition cost (WAC). Based upon the results of the analysis, DMAS should develop and implement a plan to: (1) increase the AWP discount rate to more accurately reflect national averages and (2) determine whether to incorporate or replace the AWP reimbursement rate with the use of the WAC plus a percentage.**

Change the Definition of the Usual and Customary (U&C) Rate. Currently, DMAS defines U&C as the price paid by a cash-paying customer. However, cash paying customers typically pay the highest rate for retail drugs. Therefore, several states, including Georgia, have defined U&C as the lowest or best price a pharmacist charges to any other payer (including HMO customers). For example, Georgia's reimbursement rate for pharmaceuticals is AWP less ten percent with a $4.63 dispensing fee. However, with this "best price" provision, the state has been able to pay reimbursements as low as AWP less 45 percent with a $1.25 dispensing fee. Maine, Massachusetts, and Rhode Island also have this "best price" definition in their state Medicaid regulations. DMAS should consider defining the U&C rate as the best price paid by any other payer in order to ensure that Medicaid reimbursements accurately reflect the best price paid by health insurers.

Recommendation (3). **The General Assembly may wish to direct the Department of Medical Assistance Services to promulgate regulations to change the definition for its Usual and Customary reimbursement rate to the lowest price a pharmacist charges to any other payer.**

Lower the Dispensing Fee Paid to Pharmacies. According to JLARC staff analysis, 28 states pay lower Medicaid dispensing fees than Virginia. Additionally, all surveyed Virginia State agencies pay lower dispensing fees than DMAS. While Virginia's dispensing fee is on par with the national average (approximately $4.23), a study conducted by the Heinz Family Foundation indicated that commercial managed care dispensing fees range from $1.75 to $2.50. As illustrated in Table

6, decreasing the dispensing fee could save up to $15 million (State and federal funds) annually. Even a modest reduction, from $4.25 to $4.00, would have saved approximately $2.1 million (State and federal funds) in FY 2002.

Recommendation (4). **The General Assembly may wish to decrease the pharmacy dispensing fee for Medicaid prescription drugs to be more consistent with Virginia's private payer dispensing fees.**

Table 6

Potential Annual General Fund Savings Associated with Changing Pharmacy Dispensing Fees ($Millions)

Dispensing Fee	Potential Savings
$4.00	$1.1
$3.50	$3.2
$3.00	$5.3
$2.50	$7.5

Source: JLARC staff analysis based on Department of Medical Assistance Services data for FY 2002 for single-source and brand-name drugs.

OPTIONS FOR SAVINGS THROUGH THE FEDERAL 340B DRUG PRICING PROGRAM

The 340B Drug Pricing Program, also known as the Public Health Service Act (PHS) drug discount program, was established through the Veterans Health Care Act of 1992. Designed to offer federal drug purchasers outpatient pharmaceuticals at discounted rates, the program limits the cost of drugs to federal purchasers and to selected grantees of federal agencies. Currently, only a fraction of Virginia's eligible entities participate in the program. Discounts are, on average, approximately 20 percent below average Medicaid rates.

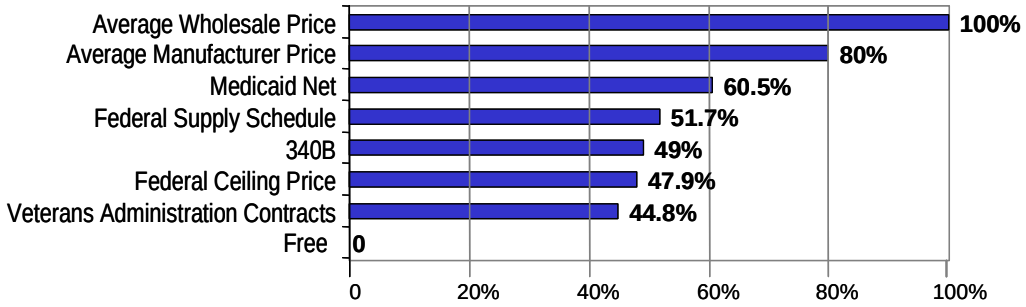
The 340B Drug Pricing Program Offers Substantial Discounts on Outpatient Pharmaceuticals for Eligible Entities

Administered by the Office of Pharmacy Affairs within the federal Health Resource and Services Administration, 340B entitles covered entities to discounted prices on outpatient pharmaceuticals. Under the terms of the law, manufacturers agree to provide eligible public health and government-supported facilities with Medicaid pricing discounts. Covered entities include: disproportionate share hospitals owned by, or under contract with, a state government; federally qualified health centers (FQHC); FQHC look-alikes; AIDS and tuberculosis clinics; the Ryan White CARE Act Title I, Title II, and Title III programs; black lung, family planning, and sexually transmitted disease clinics; hemophilia treatment centers; homeless clinics; and public housing primary care clinics.

Although the federal law establishes Medicaid prices as a ceiling, 340B entities are not restricted from negotiating larger discounts. As shown in Figure 4, 340B prices are estimated to be approximately 51 percent lower than average wholesale prices (the suggested retail price) and approximately 20 percent lower than Medicaid rates.

Figure 4

Estimated Relative Price Compared to AWP for Prescription Drugs at Manufacturer Level



Source: Stephen Schondelmeyer, PRIME Institute, University of Minnesota (2001).

Public Safety and Other State Agencies May Be Able to Save Up to 22 Percent of Their Pharmaceutical Costs Through the 340B Program. Virginia's State agencies are currently procuring pharmaceuticals through independent contracts with entities such as Diamond Pharmacy, Secure Pharmacy Plus, and Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP). While these entities are able to procure drugs at rates lower than AWP, the discounts these contracted organizations offer are still substantially smaller than those provided through the 340B program. Most State agencies, however, cannot qualify for 340B on their own. This does not preclude them from participation, as options for involvement are available.

One unique approach to decreasing State pharmaceutical expenditures through the 340B program has been implemented in Texas. Legislation (Senate Bill 347 of the 2001 session) mandated that the Texas Department of Criminal Justice (TDCJ), the University of Texas Medical Branch (UTMB), the Correctional Managed Health Care Committee, and the Texas Tech University Health Sciences Center (TTUHSC) make necessary contract and administrative changes such that the TDCJ inmates can be considered "patients" of 340B providers and, consequently, qualify for 340B pricing.

The Federal Register Notice, "Patient and Entity Eligibility" states that an individual can receive 340B-priced outpatient drugs as long as the individual is a patient of the covered entity. It defines a patient as follows:

> An individual is a "patient" of a covered entity (with the exception of State-operated or funded AIDS drug purchasing assistance programs) only if: (1) the covered entity has established a relationship with the individual, such that the covered entity maintains records

> of the individual's health care: and (2) the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g. referral for consultation) such that responsibility for the care provided remains for the covered entity; and (3) the individual receives a health care service or range of services from the covered entity which is consistent with the service or range of services for which grant funding or Federally-qualified health center look-alike status has been provided to the entity. Disproportionate share hospitals are exempt from this requirement. An individual will not be considered a "patient" of the entity for purposes of 340B if the only health care service received by the individual from the covered entity is the dispensing of a drug or drugs for subsequent self-administration or administration in the home setting. An individual registered in a State operated or funded AIDS drug purchasing assistance program receiving financial assistance under title XXVI of the Public Health Service Act will be considered a "patient" of the covered entity for purposes of this definition if so registered as eligible for the State program.

In order to meet the requirements of the federal regulations, the Texas bill stipulates that the TDCJ establish correctional health contracts with the two university medical centers (340B providers). These contracts stipulate that employees of the 340B entities provide health care services above and beyond pharmaceuticals for the inmates. Once the inmates become patients of the 340B providers, they are eligible to receive drugs from those facilities at 340B prices. The TDCJ estimates savings associated with this program to be approximately 22 percent.

The program developed in Texas could serve as a template for savings in Virginia. Creating contractual relationships for inmate health care with 340B eligible entities, or establishing a contractual link between the 340B entities and the correctional health care providers, may enable both DOC and DJJ to take advantage of 340B pricing for their inmate populations. Programs similar to the one implemented in Texas would require substantial effort to implement. However, the potential for 22 percent savings, approximately $2.86 million for DOC and $176,000 for DJJ (approximately $3.0 million total), indicates that the option should be explored.

In the following case study, JLARC staff applied 340B pricing to a selected population at DOC.

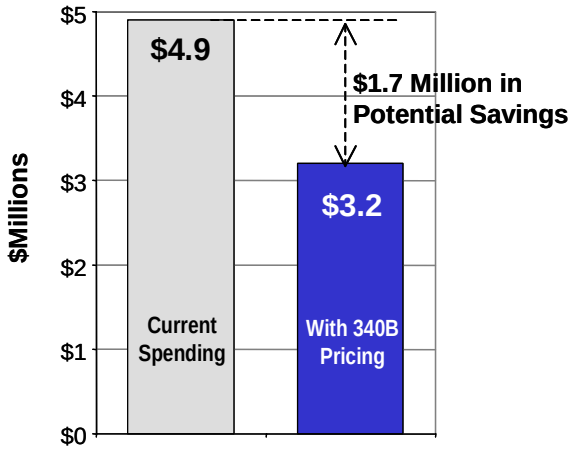
> *To illustrate the potential savings for State agencies through participation in 340B, JLARC staff applied 340B pricing to DOC's HIV and anti-retroviral pharmaceutical usage. This population was selected because of their high cost as a percentage of DOC pharmaceutical spending and because DOC identified this group as an area for potential savings.*
>
> *DOC currently spends approximately $4.8 million per year (37 percent of total pharmaceutical spending) on 21 HIV and anti-retroviral medicines for approximately two percent of the inmate*

population. As illustrated in Figure 5, utilizing 340B drug-level data from UVA, VCU and VDH, JLARC staff estimate that a pilot project designed to qualify DOC inmates being treated for HIV/AIDS for 340B pricing could save approximately $1.6 to 1.7 million per year, or 33 to 35 percent of current spending for these medicines (see Appendix D for more detail). (As total potential savings is contingent on the rate negotiated by the hospital and the DOC, the savings reported here may be somewhat high.)

Other agencies, aside from DOC and DJJ, could also use programs like the one in Texas as templates for 340B participation. For example, current federal legislation does not incorporate mental health hospitals or community-based mental health entities into the list of eligible 340B entities. However, this does not preclude their participation in the program. Rather DMHMRSAS should utilize models available from other states, such as the Texas model, to explore options for participation. Specifically, DMHMRSAS may wish to explore options available to allow community service boards (CSBs) to establish formal relationships with and procure anti-depressants and anti-psychotics through one of the State's 340B-eligible entities.

Figure 5

Potential Savings at DOC (FY 2002) through Applying 340B Pricing to HIV/Anti-Retroviral Medicines



Source: JLARC staff analysis of DOC, UVA, VCU, and VDH drug prices.

Use of 340B for Target Populations May Provide an Option for Increased Savings. There are several small, but disproportionately expensive, disease groups that could be targeted for 340B inclusion. One example, explored earlier, are HIV patients in the DOC. Similar populations within the Medicaid population include HIV patients, hemophilia patients, patients on high-cost narcotic medicines like Oxycontin, and some patients suffering from mental illness. While it is unclear at this time what type of savings may be possible, significant savings opportunities exist because 340B prices are generally 20 percent lower than Medicaid prices.

Utah provides an example of a cooperative agreement through a Medicaid agency and a 340B hospital for a targeted population. In an effort to control the rising costs associated with treating hemophilia patients, Utah's Medicaid agency developed a hemophilia case management contract with the University of Utah. The program consists of a nurse whose sole responsibility is to serve as the case manager for Utah's Medicaid-eligible hemophiliacs. The nurse travels around the State monitoring the well-being of the patients as well as their factor drug (the pharmaceutical used to treat hemophilia) usage. Because the University of Utah is a 340B provider and because the university provides case management to the patients in addition to outpatient pharmaceuticals, this arrangement allows Medicaid to purchase high-priced factor drugs at 340B rates. While the total amount spent on factor prescriptions for this population has not decreased, Utah reports that the rate of price acceleration has decreased.

Virginia could consider a similar approach. For example, while DMAS is currently exploring options that would enable their hemophilia patients to receive factor drugs at 340B prices through a program similar to Utah's, it may wish to explore such an option for other patient groups. For example, in addition to hemophilia patients, DMAS may wish to explore a relationship with a 340B provider that would enable Medicaid eligible individuals to procure HIV prescriptions at 340B prices.

Recommendation (5). **The General Assembly may wish to direct DOC, DJJ, DMHMRSAS, UVA and VCU to examine the potential for cooperative arrangements that would allow entire agencies or targeted populations within the agencies to procure pharmaceuticals through 340B drug-pricing program and report the results to the General Assembly prior to the 2004 session.**

Increased Hospital Participation Could Save Virginia up to $1.7 Million. The savings associated with hospital participation in the 340B program are substantial. For example, each hospital that participates in the 340B program saves the State money through the Medicaid program. The 340B rules state that a hospital can only bill Medicaid at the 340B acquisition rate. Because the acquisition rate is estimated to be approximately 20 percent below average Medicaid prices, this translates into sizeable Medicaid savings. For example, VCU estimates that it bills Medicaid approximately $495,000 per year less than it would without 340B pricing. As the federal Medicaid funding rate is approximately 50 percent of total expenditures, general fund savings are approximately $250,000. More conservatively, the Public Hospital Pharmacy Coalition estimates that every 340B participating hospital would save Medicaid approximately $300,000 per year, or $150,000 per year in general fund savings for the Commonwealth, through reduced billing.

The potential for a hospital to achieve internal cost savings provides an incentive for participation in 340B. Because a participating hospital can use the 340B pricing for their entire outpatient population, hospital savings are not limited to the Medicaid-eligible indigent population. VCU, a Virginia participating provider, estimates that participation in the 340B program saves the Health System approximately $7.5 million per year.

Currently, only two of Virginia's 13 hospitals meeting the primary qualifying criteria - Medicare disproportionate share adjustments greater than 11.75 percent - participate in the program. (Appendix C provides a listing of eligible hospitals with their respective Medicare disproportionate share adjustments.) The lack of participation by hospitals occurs for a variety of reasons. The most significant obstacle, however, is qualifying under the federal statute.

Hospitals must meet three eligibility criteria to participate in the 340B program. First, they must have a Medicare disproportionate share adjustment percentage greater than 11.75 percent for the most recent cost reporting period. Second, they must be government-owned or affiliated. And third, they must certify that they do not obtain covered outpatient drugs through a group purchasing entity.

The largest impediment to participation in Virginia is the second criteria – government affiliation. Very few Virginia hospitals are government-owned. This does not mean that other disproportionate share hospitals cannot participate, however. The federal 340B language provides options for private, not-for-profit hospitals. The requirements state that:

> [a hospital must be] owned or operated by a unit of state or local government, [be] a public or private non-profit corporation which has been formally granted governmental powers by a unit of state or local government, or [be] a private non-profit hospital with a contract with a state or local government to provide health care services to low-income individuals who are not entitled to benefits under [Medicaid or Medicare].

To overcome the government-affiliation obstacle, Maryland has implemented a program whereby its not-for-profit hospitals can become government "affiliated" and, therefore, qualify for 340B pricing. Through a formalized memorandum of understanding, Maryland not-for-profit hospitals agree to continue providing indigent care, regardless of a patient's ability to pay. In addition, the hospital agrees to submit quarterly 340B reports and submit to independent audits of their programs. In return, the Maryland Health Service Cost Review Commission certifies that the entity is government affiliated. This certification is used to verify eligibility to the federal administrators of 340B.

Using the Public Hospital Pharmacy Coalition savings estimates, enrollment of ten additional Virginia hospitals in the 340B program could save Medicaid approximately $3.3 million per year - $1.7 million per year of which would be general fund savings.

Recommendation (6). **The General Assembly may wish to direct the Secretary of Health and Human Resources to establish formal relationships with interested not-for-profit hospitals to enable them to become 340B eligible. In addition, the Secretary should report back to the General Assembly prior to the 2004 session with the results of the effort.**

OPPORTUNITIES FOR PHARMACEUTICAL SAVINGS AT THE DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

The Department of Human Resource Management (DHRM) administers the Commonwealth's self-insured health care plans (Key Advantage and Cost Alliance). More than 75,000 active State employees are enrolled in Key Advantage and approximately 12,000 in Cost Alliance. The Commonwealth and plan participants in Key Advantage share the cost of the premiums (79 percent paid by the Commonwealth and 21 percent paid by the employee). In Cost Alliance, the Commonwealth pays the total premiums for Cost Alliance plan participants. Retirees pay the entire premium for their plans, but the VRS health care credit may offset this cost.

Premiums are based on demographics, claims experience, and health care trends. Due to increased utilization of medical services and prescription drugs, higher drug costs, and an aging workforce, the Commonwealth, as well as employers nationwide, is experiencing double digit premium increases. For example, the average cost per prescription for active State employees in the Key Advantage and Cost Alliance plans increased from $34.87 in FY 1998 to $52.58 in FY 2002. As a result of increased utilization, higher costs, and workforce demographics, total program costs will grow from $448 million in FY 2001 to a projected $529 million for FY 2003. DHRM has taken steps to contain these rising costs, including the use of a pharmacy benefit manager or PBM, drug monitoring, mandatory generic substitution, and prior authorization for some high-cost drugs. Several additional cost savings options are available to DHRM, specifically the use of a tiered co-payment system for prescription drugs.

Prescription Drug Costs Continue to Increase

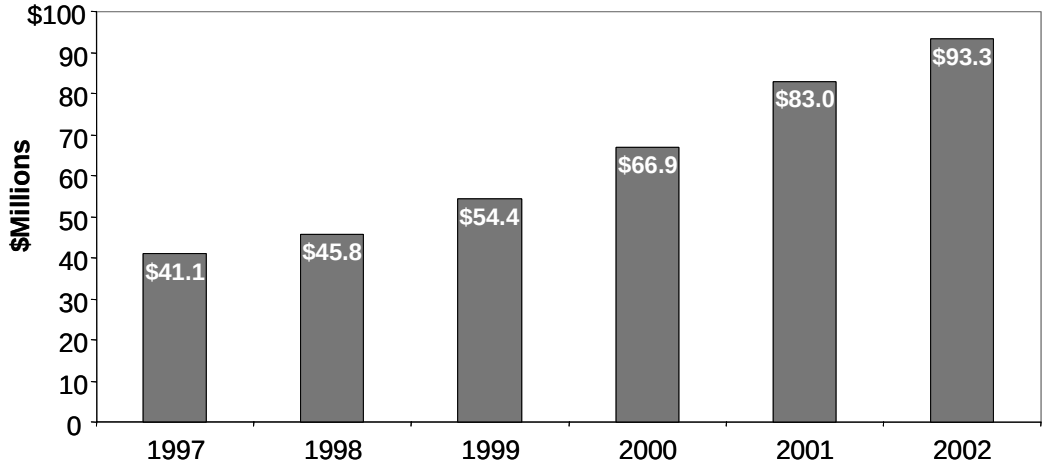
In FY 2002, the Department of Human Resource Management (DHRM) spent approximately $125 million for pharmaceuticals. As illustrated in Figure 6, from FY 1997 to FY 2002 DHRM's annual prescription drug spending for active State employees has increased by 127 percent. Similarly, the overall cost of prescription drugs has increased by 24 percent from FY 2000 to FY 2001 and by 12 percent from FY 2001 to FY 2002. During the same period in Key Advantage, for example, the co-payment for a 34-day retail supply of prescription drugs has increased by 54 percent.

Current and Proposed Cost Saving Alternatives

In order to control costs and maintain the same level of services in the State health care plans, DHRM is considering the implementation of a plan-year deductible (the amount paid out-of-pocket before the insurer starts paying), a higher out-of-pocket maximum, co-insurance for most services, higher office visit co-payments, and a three-tier drug program. There are two general methods for achieving cost savings within a prescription drug plan: decreasing utilization or reducing the number of prescriptions; and decreasing the amount paid per prescription. A tiered co-payment structure for prescription drugs decreases the amount that the State pays for drugs and may impact utilization patterns.

Figure 6

Prescription Drug Benefit Expenses
FY 1997 to FY 2002



Source: Department of Human Resource Management.

DHRM Has Implemented Several Cost Saving Initiatives. First, the State maintains a strict mandatory generic substitution provision whereby any drug for which there is a generic substitute must be filled as a generic. If an individual opts for the brand name drug – regardless of the reason – he or she must pay the $17 co-pay as well as the difference between the price of the generic and the brand-name drug. Second, the health insurance plans utilize a formulary. The formulary is relatively open, requiring only that a drug must demonstrate medical necessity and appropriateness to a diagnosis. However, cosmetic and experimental drugs are excluded from the formulary. Pre-authorization is required for some very high cost drugs and if specified quantity limitations are exceeded. Third, DHRM contracts with a Pharmacy Benefit Manager (PBM) to procure pharmaceuticals for the State's self-insured health plans. One of the main functions of a PBM is to obtain rebates and thereby decrease the cost of the drugs. For FY 2002, the PBM obtained $3 million in rebates on behalf of the State's self-insured plans.

The Implementation of Tiered Co-payments for Prescription Drugs Could Achieve Savings for the State's Self-insured Health Plans. Currently, a Virginia State employee pays a $17 co-payment regardless of the actual cost of the drug. Accordingly, there is little incentive for the employee to utilize lower cost alternatives to high cost therapies. Many commercial providers employ tiered co-payments to induce this type of incentive. Tiered co-payments are a method used by many commercial providers to steer utilization away from high cost brand-name drugs toward appropriate lower cost alternatives. For example, Aetna, one of the private managed care options currently offered to State employees, uses a tiered co-pay system in which generics cost $5, Tier 2 drugs cost $15, and Tier 3 drugs cost $30.

In tiered prescription drug co-payment structures, the first tier is generally reserved for the least expensive drugs, usually generics. The second tier is generally low to mid-cost brand-name drugs and some generics. The third tier is for higher cost brand-name drugs. Table 7 lists DHRM's proposed tiered co-payment structure

Table 7

Proposed DHRM Three-Tier Drug Plan

	Tier 1	Tier 2	Tier 3
Retail Pharmacy (34 day supply)	$15	$20	$35
Mail Order (90 day supply)	$18	$33	$63

Source: Department of Human Resource Management.

for prescription drugs. DHRM estimates that 10 percent of drugs will fall into Tier 3. Using FY 2002 utilization data along with DHRM's ten percent Tier 3 assumption, total estimated savings to the program would be $4.2 million. Similarly, based on an analysis conducted by Trigon and the agency's actuary using prescription drug experience and industry standards, DHRM cautiously estimates a five percent savings from cost shifting resulting from a tiered co-payment system for drugs ($15, $20, and $35). Applying a five percent estimated reduction in cost to FY 2002 drug expenditures for active State employees and retirees would yield approximately $5.7 million in potential savings. In addition to the immediate savings from cost shifting, DHRM reported that associated savings from changing utilization patterns might also be achieved.

Recommendation (7). **The General Assembly may wish to direct the Department of Human Resource Management to implement the proposed tiered co-payment structure for prescription drugs across the State's self-insured plans.**

BULK PURCHASING AND GROUP PURCHASING ORGANIZATIONS

Bulk purchasing and group purchasing arrangements generally offer lower prices, volume discounts, process efficiencies, and reduced contracting costs by aggregating or consolidating purchasing functions and leveraging the volume of participating entities in the negotiation of contracts. Currently, the UVA and VCU Health Systems, as well as other State agencies involved in the purchase of pharmaceuticals, are engaged in some form of group purchasing. However, several agencies independently contract with private entities for pharmacy services. In addition, other states have developed unique interagency and interstate bulk purchasing arrangements in order to increase volume and achieve savings through additional rebates.

Group Purchasing Organizations Are Designed to Achieve Efficiencies

A significant share of medical facility, State agency, and hospital non-labor costs includes such goods as pharmaceuticals and medical supplies and equipment. Hospitals and other provider entities buy these goods through their own purchasing departments, and many, in addition to contracting on their own with vendors, use group purchasing organization (GPO) negotiated contracts. In general, even large

hospital chains or other high volume entities do at least some of their purchasing through a GPO.

GPOs are generally owned by their members (hospitals or other health care providers) and vary in size and scope of services. GPOs use volume purchasing as leverage in negotiating with vendors. In exchange for administrative services and the ability to sell through a GPO to its members, vendors pay administrative fees based on the volume of member purchases under contract. These fees, sanctioned under Medicare law, help finance the administration of the GPO.

Often prices through a GPO-negotiated contract vary based on the volume of purchases and the extent to which a member delivers on its "commitment" to buy an agreed on share of its purchases from a particular manufacturer. For example, according to a General Accounting Office study, a hospital that buys only 25 percent of its cardiac stents from one manufacturer may pay three times more per stent than one that purchases all of its stents from that manufacturer.

In addition to lower prices for products, GPOs offer indirect savings in the form of reduced contracting costs and increased process efficiencies. For example, by using a GPO, hospitals are able to reduce the size of purchasing departments. GPOs also offer assistance with product-comparison analysis, product standardization, and market monitoring.

As a cost containment tool, a number of State agencies and organizations utilize group-purchasing organizations. For example, the University of Virginia Health System (UVA), the Virginia Commonwealth University Health System (VCU), the Department of Health (VDH), and the Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS) participate in some form of group purchasing.

Both UVA and VCU purchase medical supplies and pharmaceuticals through Novation, one of the nation's largest GPOs, with annual purchases by member facilities of approximately $17.6 billion. Novation is the second largest buying group nationally and is comprised of two large hospital groups – Voluntary Hospitals of America (VHA) and University Hospital Consortium (UHC). UVA and VCU are members of UHC.

UVA procures approximately 82 percent of pharmaceuticals and medical supplies through Novation. According to officials at UVA, the majority of the savings achieved by Novation comes through vendor rebates and purchasing dividends. For example, UVA reported achieving approximately $420,000 in refunds in FY 2001 through Novation. UVA officials noted that the Medical Center staff evaluates the overall advantages and disadvantages of group purchasing arrangements on an ongoing basis. In some cases (the majority of the remaining 18 percent of medical supplies and pharmaceuticals not purchased through Novation), the hospital is able to negotiate a lower price independently and, consequently, will step outside of the Novation arrangement.

VCU reports that the vast majority of its purchasing is done through the Novation group purchasing agreement, stating that it attempts to maximize its use of group purchasing arrangements. According to officials at VCU, Novation not only

saves the system money through discounted prices and rebates, but it also generates savings by reducing the time and resources necessary to negotiate hundreds of contracts for medical supplies and pharmaceuticals. Specifically, VCU reported that if it withdrew from Novation and established the same contracts independently, the additional annual personnel expenses (for buyers, a manager and support staff) would be approximately $450,000.

The Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP) Applies Group Purchasing Techniques for Use with Governmental Entities

Membership in Novation and many other GPOs is limited to hospitals. As a result, Virginia State agencies and many other non-hospital providers utilize a GPO called the Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP). MMCAP is a group of state agencies and non-federal governmental units that are eligible to obtain pharmaceuticals and allied supplies and services using contracts established with pharmaceutical manufacturers and other vendors.

MMCAP includes more than 2,500 participating facilities in 40 states. The annual pharmaceutical sales volume is $600 million. MMCAP currently has contracts with over 130 manufacturers for more than 6,000 pharmaceutical items. The MMCAP prime wholesale vendor provides credits or rebates based on volume to users of the contract. For example, DMHMRSAS estimated that last year's rebate totaled approximately $97,000 in free products.

State agencies and nonfederal governmental units participating in MMCAP receive a number of benefits, including free membership, eligibility to obtain pharmaceutical items, wholesaler services, pharmaceutical containers, returned goods processing, and medical supplies at a reduced contract price. Minnesota state staff negotiate the MMCAP contracts through competitive sealed bids, and administer all MMCAP contracts. Although MMCAP members generally buy pharmaceuticals from the MMCAP contracts, MMCAP staff indicated that they do not prohibit the purchasing of drugs from other sources. In other words, agencies may be able to "cherry pick" or use the MMCAP contracts for some items and independently contract for others.

While MMCAP is administered by the Minnesota Department of Administration, Materials Management Division, each participating state, including Virginia, is represented by one pharmacist and one state purchasing agency official who serve as state coordinators. Funding is provided through administrative fees collected from contracted manufacturers and is used solely to support this program.

While DMHMRSAS and VDH use the MMCAP contract and have reported general satisfaction with it, other agencies do not use MMCAP. DOC and DJJ, for example, have reported that agency-specific concerns, primarily the lack of an in-house pharmacy, preclude effective use of the MMCAP contract. In addition, Piedmont Geriatric Hospital contracts with a full-service pharmacy administrator and does not use MMCAP.

Due to agency-specific issues, including the lack of in-house pharmacies, DOC and DJJ have developed contracts for pharmacy services with full-service mail-order pharmacies. Both agencies also contract with another vendor for off-site prescription drugs and for claims processing services. Under the contracts, the vendors provide DOC and DJJ with access to more favorable rates for pharmaceuticals and services than the agencies could negotiate on their own. DJJ estimates saving approximately 46 percent over the last nine months by using its contract. Similarly, DOC reports that its use of the vendor as a claims administrator has saved the agency not only on pharmaceutical costs, but also on claims processing.

There is some evidence to suggest that in addition to MMCAP there may be other bulk purchasing alternatives that could be considered. For example, Piedmont Geriatric Hospital contracts with McKesson for pharmacy services, including the procurement of drugs. Piedmont reports savings of approximately seven percent over the MMCAP contract prices. While Piedmont represents only a small portion of total State pharmacy purchases, the case illustrates the need to periodically and systematically review contracts in order to ensure competitive pricing.

Other States Have Adopted the Use of Bulk Purchasing Techniques to Achieve Savings

Two relatively new group or bulk purchasing options employed in other states include interagency bulk purchasing and pooled purchasing across several states. Interagency bulk purchasing is being used in Arkansas, Georgia, Texas, and West Virginia, and is being considered in other states.

Aggregate purchasing provides an opportunity to generate direct and indirect savings. Three basic components where direct savings can be achieved are: ingredient costs and dispensing fees, administrative expenses, and pharmaceutical rebates. Rebates are achieved through the use of a prescription drug formulary or PDL. Discounts are negotiated with pharmaceutical companies based on the aggregate purchaser's ability to influence market share. Indirect savings can be achieved by aligning management strategies across agencies, specifically through the use of a common formulary and managed prior authorization.

Georgia, for example, implemented an interagency bulk purchasing program. In 1999, the Georgia Department of Community Health was created, merging Georgia's Medicaid, State Employee Health Plan, and State Children's Health Insurance Program (SCHIP). The purpose of the merger was to establish interagency bulk purchasing between these three groups. A Pharmacy Benefit Manager (PBM), Express Scripts, was selected to manage the program. The bulk purchasing is based on a common preferred drug list (the same preferred drug list – with a few exceptions – is used for all three programs). Prior authorization of drugs is conducted in the same way for each program. Through bulk purchasing, supplemental rebates and volume discounts are achieved. Georgia reported that since the inception of the program, the rate of growth in pharmaceutical expenditures has slowed from approximately 22 percent per year to approximately 18 percent per year.

In September 2001, Texas enacted similar legislation that combined pharmaceutical purchases for the departments of health and mental health services, state employees, retirees, teachers, prison system, and any other agency that pur-

chases pharmaceuticals. The state also established an Interagency Council on Pharmaceutical Bulk Purchasing, which is required to explore other purchasing options including expanding Medicaid purchases. Texas estimated approximately $13 million in cost savings during the first two years of implementation.

Vermont, Maine, and New Hampshire have recently developed a pooled purchasing arrangement. This arrangement is unique in that it goes beyond interagency cooperation within a state, and crosses state borders to encompass three states. These three states have joined together to pool purchases for Medicaid recipients, state employees, and the uninsured, thereby increasing the volume of pharmaceuticals purchased and enhancing their purchasing power. A group of states including West Virginia, Georgia, Arkansas, Missouri, New Mexico, and Delaware are considering pooling their purchases in a manner similar to the Vermont, Maine, and New Hampshire program. With enhanced purchasing power, these states may receive lower reimbursement rates and supplemental rebates. However, states considering pool purchasing will need to determine whether all participating states will adopt a common formulary, whether each state will maintain separate tracking systems, and how to select a program administrator.

All of these programs are fairly new and the advantages and disadvantages are somewhat unclear. While there may be potential for savings, it is too soon to determine the amount of current or future savings that may be achieved. The Commonwealth should continue to monitor efforts used in other states to contain costs. Where appropriate, the Commonwealth should consider exploring some of these arrangements more fully.

The Heinz Family Foundation, in conjunction with the actuarial firm William M. Mercer, is conducting a study of aggregate purchasing across a number of Virginia State agencies. They plan to conduct an actuarial analysis and present options for savings. The results of the study will be presented to the Secretary of Health and Human Resources prior to the 2003 General Assembly Session.

OPTIONS FOR SAVINGS WITHIN MEDICAL SUPPLY PROCUREMENT

The Department of Accounts (DOA) reports that State agencies, excluding VCU, spent approximately $129 million on medical supplies in FY 2002. (VCU Health System was excluded from this portion of the analysis because of its status as an independent authority.) UVA Health System and Academic Campuses accounted for 63 percent of all State medical supply purchases. Approximately 60 percent of total State spending on medical supplies was accounted for by five selected entities (excluding DHRM and DMAS because DHRM and DMAS listed relatively low expenditures for medical supplies. This is because, as reimbursement agencies, neither DHRM nor DMAS is directly involved in the procurement of medical supplies). The remaining 40 percent was procured by a variety of agencies including community colleges, the State Police, and several colleges and universities including the academic campuses of UVA and VCU.

Medical supply spending is accounted for through three sub-object codes:

(1) Laboratory Supplies (sub-object code 1341) includes expenses for animals used in research, blood or blood components used in analysis, chemicals, gases, reagents, specimen slides, test tubes, and similar laboratory supplies;
(2) Medical and Dental Supplies (sub-object code 1342), includes expenses for bandages, biologics, braces, chemicals, contraceptive devices, crutches, eyeglasses, hearing aids, prostheses, surgical blades, and similar medical and dental supplies; and

(3) Field Supplies (sub-object code 1343) includes expenses for items such as sample bottles, chart paper and ink, and similar supplies designed for use in or with field-testing and monitoring equipment.

Table 8 reports the expenditures across the five agencies considered in this report. UVA is the largest with annual spending of over $61 million.

Table 8

Medical Supply Spending Across Selected Agencies
(All Funds FY 2002)
($Millions)

Agency	Laboratory Supplies (1341)	Medical & Dental Supplies (1342)	Field Supplies (1343)	**Total Medical Supply Spending**
UVA	$5.1	$56.8	$0	$61.9
VDH	1.0	7.5	0.3	8.8
DMHMRSAS	0.6	2.8	0	3.4
DOC	0.3	3.3	0	3.6
DJJ	0.1	0.2		0.3
Total across selected agencies (excluding DHRM and DMAS)				**$78.0**
Total across all State agencies				**$129.3**

Note: Medical Supply figures represent expenditures in the three sub-object codes across the entire agency. Figures are not specific to a particular program within an agency.

Source: Department of Accounts.

Approximately 63 Percent of All State Medical Supply Purchases Were Made By UVA Health System and Academic Campus

The top ten medical supplies procured by UVA include isolation gowns, coronary stents, intravenous pumps, implants, and defibrillators. UVA purchases approximately 82 percent of its medical supplies through the group purchasing organization (GPO), Novation. Novation, discussed earlier in the report, provides UVA with volume-based savings in the form of rebates and purchasing dividends. Last year, UVA achieved approximately $420,000 in refunds through Novation. UVA regularly evaluates the Novation contracts to ensure cost efficiency. Similarly, VCU estimates that use of Novation contracts for medical supplies saves approximately $500,000 annually.

While UVA has implemented several cost savings initiatives with regard to medical supplies including continued value analysis, retaining small inventories, dispensing controls, and pack management for medical procedures, some aspects of medical supply procurement are difficult to control. This is primarily due to a rapidly changing marketplace and technological improvements, but also due, in part, to physician preference, patient needs, and medical necessity.

Additionally, UVA's teaching philosophy contributes to the high cost of medical supplies. UVA reported that, in some instances, the Health System may utilize more expensive, "breakthrough" technologies than would otherwise be necessary because the hospital has a responsibility to teach students and residents the procedures that will be common practice when they become medical professionals. For example, UVA could procure less expensive stents than the breakthrough drug-coated stents. However, the philosophy of the Health System suggests that these stents will be part of common practice in the future, and so they have an obligation to provide students with an opportunity to use them. UVA considers this a cost of the teaching business.

The University Health Consortium (UHC) recently completed a review of the UVA Health System, which was submitted to the Secretaries of Health and Human Resources and Education. The report indicated that UVA was spending a below-average amount per patient discharge on medical supplies. Specifically, the report indicated that UVA's "supply index per case mix adjusted discharge" was approximately $1,322. As the UHC's 50th percentile was $1,676, no annualized savings opportunities for medical supplies were indicated. Additionally, a recent study of medical supply purchases at VCU, conducted by the Hunter Group, found that only 360 items out of more that 24,000 could be obtained at a lower cost.

DJJ, DMHMRSAS, and VDH Procure More Than Half of Their Medical Supplies Through State Contracts

VDH reports it procures greater than 95 percent of medical supplies through State contracts negotiated and maintained by the Department of General Services (DGS). Similarly, DJJ reports that 75 percent of medical supplies are purchased through State contracts. DMHMRSAS reports that approximately 52 percent of all medical supply purchases are made through State contracts (including MMCAP medical supply purchases).

State contracts are negotiated for a period of approximately five years and come in two primary forms: mandatory and voluntary. Medical supply mandatory contracts, required through Virginia statute, come from three sources: Sheltered Workshops, Correctional Enterprises, and Virginia Industries for the Blind. Virginia Industries for the Blind accounts for the majority of mandatory contracts for medical supplies, including surgical dressings, dental equipment and dental supplies, and both vinyl and latex exam gloves.

Voluntary contracts include a wide variety of supplies from syringes to x-ray film to medication cups. A majority of State medical supply contracts come through the Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP) group purchasing coalition. A portion of the remaining contracts are negotiated

through the Novation GPO, as the various State agencies have been able to piggyback on UVA's relationship with Novation for some medical supplies.

DGS has not recently evaluated the MMCAP contract to ensure that the prices are competitive. DGS reported, however, that, in some instances, the agencies may not be comparing "apples to apples." While the item an agency is procuring on a State contract may not be the least expensive available, the prices are negotiated to ensure that the Commonwealth, as a whole, gets the best overall deal.

With regard to mandatory contracts, DGS reported that these contracts are competitively bid. The mandatory sources are required to be within ten percent of the other bids to maintain their mandatory status.

The remaining medical supplies are considered small purchases and procured independently by the agencies. The small item purchases are more difficult for agencies to track as many agencies have decentralized procurement processes. For example, all facilities within the DMHMRSAS procure medical supplies independently. This is true for all DOC facilities, as well. Because these procurement processes are decentralized, there appears to be very little centralized accountability. This makes it difficult for the State to accurately estimate the volume of supplies it procures, and to subsequently negotiate favorable contracts.

While this continues to be a problem, many of these issues may be addressed by the new eVA system. EVA is a computerized procurement system through which an agency places its supply orders. While current reporting to DOA only categorizes expenditures at the sub-object code level, eVA has the potential to track purchases at the more detailed individual commodity level. The commodity-level data should provide DGS with information necessary to negotiate better contracts and attract new vendors. While MMCAP orders are excluded from eVA, all other medical supplies will be part of this system. As agency and individual facility participation in this procurement system increases, eVA may help DGS to accurately assess volume and need across the Commonwealth and to develop contracts accordingly.

CONCLUSION

The Commonwealth spends significant resources procuring pharmaceuticals and medical supplies. While agencies have implemented a number of strategies to curb rising costs, there are additional options available to achieve further savings.

This report discussed several options for savings at DMAS, including implementation of a preferred drug list, changing the discount on the average wholesale price paid to pharmacies, redefining usual and customary charge to reflect the lowest price paid by any payer, and decreasing the pharmacy dispensing fee. Implementation of these programs could generate general fund savings ranging from $20.5 million to $40 million.

Expanding participation in the federal Public Health Service 340B drug-pricing program could generate savings up to $4.7 million, including up to approximately $3 million at the DOC. Additionally, using 340B participating entities to ad-

dress high cost populations at DJJ and DMHMRSAS may result in additional savings to the Commonwealth.

In order to address double digit annual increases in pharmaceutical costs for the Commonwealth's self-insured plans, a tiered co-payment structure could be implemented. Estimated annual program savings resulting from a tiered co-payment could exceed $4 million.

While the State's agencies are currently using group purchasing techniques for medical supplies and pharmaceuticals, increased use of eVA may enhance the Commonwealth's ability to negotiate contracts and assess utilization.

Taken together, these options present a total potential savings ranging from $26.5 million to $50.3 million to the Commonwealth. In order to fully implement these options and achieve savings, however, a number of statutory, regulatory, and policy changes will be needed.

Appendix A

Virginia Medicaid Pharmacy Payments and Definitions

VIRGINIA MEDICAID PHARMACY PAYMENTS: ACQUISITION COSTS PLUS THE DISPENSING FEES	
Generic Equivalent/ Multi-Source Drug	Lower of • Federal Upper Limits (FUL) + $4.25 dispensing fee • Virginia Maximum Allowable Cost (VMAC) + $4.25 dispensing fee • Usual and Customary Costs (U&C) • Average Wholesale Price-10.25% (AWP-10.25%) + $4.25 dispensing fee
Brand Name/ Single Source Drug	Lower of • AWP-10.25% + $4.25 dispensing fee • U&C
Source: DMAS staff definitions.	

- **Average Wholesale Price (AWP)**: AWP is the drug manufacturer's sticker price for a product. However, the sticker price is routinely discounted to pharmacies. In order to share in the additional savings that the pharmacies gain between the sticker price and the discounted price, state Medicaid programs, HMOs, and state health programs reimburse pharmacies at AWP less a specific percentage. In Virginia, the percentage is 10.25 percent.

- **Federal Upper Limits (FUL)**: FUL prices are for multiple source drugs that have at least three sources of supply. In general, the FUL price is 150 percent of the lowest price available nationally for a drug.

- **Virginia Maximum Allowable Cost (VMAC)**: VMAC applies to generic or multiple-source prescription drugs that have two sources of supply and are therapeutically and chemically interchangeable.

- **Usual and Customary Costs (U&C):** Virginia's U&C costs equal the price a cash-paying customer would pay at a pharmacy.

Appendix B

State Medicaid Pharmacy Reimbursement Rates and Dispensing Fees

State	Ingredient Reimbursement Rate	Dispensing Fee
Alabama	WAC+9.2% or AWP-10%	$5.40
Alaska	AWP-5%	$3.45 to $11.46
Arizona***	AWP-15%	$2.00
Arkansas	Brand: AWP-14% Generic: AWP-20%	$5.51
California	AWP-10% (effective 12/02)	$4.05
Colorado	Brand: AWP-13.5% Generic: AWP-35%	$4.00
Connecticut	AWP-12%	$3.85
Delaware	AWP-12.9%	$3.65
District of Columbia	AWP-10%	$3.75
Florida	AWP -13.25% or WAC+ 7%	$4.23
Georgia	AWP-10%	$4.63
Hawaii	AWP-10.5%	$4.67
Idaho	AWP-12%	$4.94
Illinois	Brand: AWP-12% Generic: AWP-25%	Brand: $3.40 Generic: $4.60
Indiana	Brand: AWP-13.5% Generic: AWP-20%	$4.90
Iowa	AWP-10%	$5.17
Kansas	Brand: AWP-11% Generic: AWP-27%	$3.40
Kentucky	AWP -12%	$4.51
Louisiana	Independent Pharmacies: AWP-13.5% Chains: AWP-15%	$5.77
Maine	AWP-13%	$3.35
Maryland	AWP-10% or WAC+10%	$4.21
Massachusetts	WAC+6%	Generic: $5.00 Brand: $3.50
Michigan	Independent Pharmacies: AWP-13.5% Chains: AWP-15.1%	$3.77
Minnesota	AWP-9%	$3.65
Mississippi	AWP-12%	$3.91
Missouri	AWP-10.43% or WAC+10%	$4.09
Montana	AWP-15%	In-State: $4.70 Out-of-State: $3.50
Nebraska	AWP-11%	$4.65
Nevada	AWP-15%	$4.76
New Hampshire	AWP -12%	$2.50
New Jersey	AWP-10%	$3.73-$4.09
New Mexico	AWP-12.5%	$3.65
New York	AWP-10%	Brand: $3.50 Generic: $4.50
North Carolina	AWP-10%	Brand: $4.00 Generic: $5.60
North Dakota	AWP-10%	$4.60
Ohio	WAC+9%	$3.70
Oklahoma	AWP-12%	$4.15
Oregon	AWP-14%	$3.50-$3.91 (based on annual # of Rx)
Pennsylvania	AWP-10%	$4.00
Rhode Island	WAC + 5%	$3.40
South Carolina	AWP-10%	$4.05
South Dakota	AWP-10.5%	$4.75-$5.55 (for unit dose)
Tennessee	APW-13%	$2.50
Texas	AWP-15% or WAC+12%	$5.27
Utah	AWP-12%	$3.90-$4.40 (based on geographic area)
Vermont	AWP-11.9%	$4.25
Virginia	***AWP-10.25%***	***$4.25***
Washington	Brand: AWP-14% Generic: AWP-50% (if >4 mfg)	$4.20-$5.20 (based on annual # of Rx)
West Virginia	AWP-12%	$3.90
Wisconsin	AWP-11.25%	$4.88
Wyoming	AWP-11%	$5.00

Note: States slightly shaded have lower ingredient reimbursement rates and/or lower dispensing fees than Virginia.
*** Arizona ingredient reimbursement and dispensing fee are based on their Indian Health Services program. 100 percent of the remainder of the Arizona Medicaid population participates in Medicaid managed care.

Appendix C

Virginia Hospitals with Medicare Disproportionate Share (DSH) Adjustments Greater than 11.75 Percent

Hospital Name	DSH Adjustment
Richmond Community Hospital	38.16%
MCV Hospital	23.84%
Smyth County Community Hospital	18.82%
Southside Community Hospital	17.84%
Norton Community Hospital	17.19%
Sentara Norfolk General Hospital	16.00%
Shore Memorial Hospital	15.95%
Clinch Valley Medical Center	15.47%
Southside Regional Medical Center	13.32%
UVA Hospital	13.14%
Maryview Medical Center/Portsmouth	13.07%
Halifax-South Boston Community Hospital	12.75%
Danville Regional Medical Center	11.94%

Source: Centers for Medicaid and Medicare Services

Appendix D

Detailed Explanation of Savings DOC Could Achieve by Using 340b for HIV Prescription Drugs

This appendix provides a detailed explanation of how JLARC staff estimated that DOC could achieve $1.6 to $1.7 million in savings by applying 340B pricing to its purchases of HIV prescription drugs. While DOC may not be able to become 340B eligible independently, this formula suggests savings that could be achieved if DOC entered into a contract with a 340B eligible entity, and, consequently, was able to procure the 21 drugs listed below at 340B prices. Five basic steps were used to calculate the savings: (1) identifying the pharmaceuticals utilized by DOC to care for this inmate population, (2) estimating DOC's current expenditures for the 21 identified drugs, (3) determining the 340B prices for the identified drugs, (4) calculating a range of total costs if DOC procured the identified drugs at 340B prices, and (5) calculating the savings.

Step 1 – Identifying the Pharmaceuticals

The HIV/AIDS population was selected for this illustration for several reasons. First, they represent a small percentage of the inmate population (approximately 2 percent), but account for approximately 40 percent of DOC's total pharmaceutical costs. Second, there is a relatively small group of drugs used to treat this illness, making it possible to calculate estimates for the entire population of the drug class. Third, this drug class was suggested by DOC as one in which costs were high and savings were needed. Table 9 lists the 21 drugs identified by DOC as those used to treat HIV/AIDS in the inmate population.

Step 2 – Estimating DOC's Current Expenditures

DOC provided JLARC with a spreadsheet of FY 2002 utilization data for the 21 selected drugs. Total units utilized are in column A. DOC's per unit prices are listed in column B. To find total cost, JLARC staff multiplied column A by column B. Total cost for each drug is listed in column C. Total expenditures for the entire class are listed in bold at the bottom of column C.

Step 3 - Determining 340B Prices for the Identified Drugs

Three entities included in the JLARC study currently use 340B prices for their outpatient drugs. These entities include VCU, UVA and VDH. To identify 340B prices for the selected drugs, JLARC staff asked these three entities to supply a list of the 340B prices paid for the 21 selected drugs. All three entities were surveyed because 340B drug prices fluctuate periodically as a result of a changing market (price changes are very small – generally within a few of cents).

Once the 340B prices were compiled, JLARC staff selected the low and high price for each drug. The lowest of the three prices is listed in column D; the highest of the three prices is listed in column F. Due to low usage, UVA, VCU, and VDH were unable to provide JLARC staff with 340B prices for two of the identified drugs (Invirase and Rescriptor). For these two drugs, the DOC prices were applied to both columns D and F.

Step 4 - Calculating a Range of Total Costs if DOC Procured the Identified Drugs at 340B Prices

JLARC staff next estimated a range of total costs if DOC procured the identified drugs at 340B prices. The base of the range was calculated by multiplying the total units (column A) by the 340B price in column D. The lowest estimated total cost is listed in column E, with total cost for that column in bold. JLARC staff multiplied the total units (column A) by the 340B price in column F to calculate the highest estimated total cost, listed in column G. Total cost for column G is in bold.

Step 5 - Calculating a Range of Savings

In this instance, the range of estimated savings is relatively narrow: between $1.6 million and $1.7 million. To calculate the bottom of the range of savings (associated with the highest 340B prices), JLARC staff subtracted the bolded total cost listed in column G from the DOC current total cost listed at the bottom of column C. The top of the range of savings (associated with the lowest 340B prices) was calculated by subtracting the bolded total costs listed in column E from the DOC current total cost. The range of net savings is listed on the bottom of the page.

Table 9

Range of DOC HIV Pharmaceuticals Total Cost at 340B Prices

	DOC			Lowest 340B Prices		Highest 340B Prices	
DRUG NAME	Total Units	DOC	Total Cost	340B	Total Cost	340B	Total Cost
	A	B	C	D	E	F	
AGENERASE 150mg	27386	1.31	35875.66	0.89	24373.54	0.92	25195.12
COMBIVIR	97,221.05	11.42	1110264.40	6.34	616381.46	6.5	631936.8301
CRIXIVAN 400mg	96,247.05	2.59	249279.87	1.83	176132.11	1.87	179981.9911
EPIVIR	74,421.82	4.5	334898.18	2.84	211357.96	2.9	215823.2716
FORTOVASE	52,498.68	1.18	61948.44	0.81	42523.93	0.81	42523.92915
HIVID	4,624.74	2.43	11238.13	1.78	8232.05	1.78	8232.045844
HYDROXYUREA	3,438.25	0.61	2097.33	0.62	2131.71	0.62	2131.712459
INVIRASE	17,893.42	2.13	38112.98	2.13	38112.98	2.13	38112.98
KALETRA	90,628.74	3.33	301793.69	2.43	220227.83	2.52	228384.4141
NORVIR	101,385.01	1.83	185534.56	1.26	127745.11	1.28	129772.807
RESCRIPTOR	1,256.96	1.5	1885.44	1.50	1885.44	1.5	1885.44
RETROVIR 100mg	8,319.94	5.26	43762.86	1.25	10399.92	1.3	10815.91597
SUSTIVA 200mg	123,545.28	4.09	505300.20	2.98	368164.94	3.2	395344.8998
TRIZIVIR	11,177.82	15.75	176050.68	11.40	127427.16	11.72	131004.0616
VIDEX 100mg	35,641.90	1.97	70214.54	1.14	40631.76	1.17	41701.02122
VIDEX EC	17,356.11	8.92	154816.54	6.47	112294.06	6.7	116285.9661
VIRACEPT	347,153.53	2.15	746380.08	1.52	527673.36	1.55	538087.9647
VIRAMUNE 200mg	37,335.53	5.13	191531.27	3.06	114246.72	3.14	117233.5649
VIREAD	2,643.28	12.29	32485.88	9.12	24106.69	9.25	24450.31652
ZERIT 40mg	90,952.44	4.95	450214.57	2.88	261943.02	2.95	268309.6932
ZIAGEN	31,581.87	6.04	190754.48	4.16	131380.57	4.27	134854.5744
			$4,894,439.78		**$3,187,372.32**		**$3,282,068.52**

Savings	**Highest price:**	**$1,612,371.26**
	Lowest price:	**$1,707,067.46**

DEC 11 2002

COMMONWEALTH of VIRGINIA

Office of the Governor

Jane H. Woods
Secretary of Health and Human Resources

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December 6, 2002

Mr. Phil Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

I appreciate the opportunity to comment on the Joint Legislative Audit and Review Commission's report, State Spending on Medical Supplies and Pharmaceuticals. As you are aware, Virginia is presently in the throes of the State's worst budget crisis on record. In the 12-month period since Governor Warner assumed office, the administration has proposed reductions in general fund spending of more than $5 billion. Further, it is anticipated that another $1 billion in general fund reductions will have to be made during the next session of the General Assembly in order to balance the State's budget in FY 03 and FY 04.

Because of the size and cost of the pharmacy program in Virginia's Medicaid program, reductions in State expenditures on pharmaceuticals are being actively considered by the Administration as we wrestle with the Commonwealth's budget problems. As your report accurately points out, I have engaged the Heinz Family Philanthropy, in conjunction with the Mercer Corporation to present options for savings in this area. Both the JLARC report and the work of Heinz and the Mercer Corporation will be of great benefit to my office as we develop a savings plan in our pharmacy program.

Please allow me to offer my appreciation to JLARC for its analysis of this issue and the professionalism and courtesy shown by your staff in conducting this study.

Best Regards,

Jane H. Woods

P.O. Box 1475 • Richmond, Virginia 23218

DEC 09 2002

COMMONWEALTH of VIRGINIA

Department of Corrections

GENE M. JOHNSON
DIRECTOR

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December 4, 2002

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100
General Assembly Building, Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for giving my staff an opportunity to review your 11/27/02 draft report entitled "Special Report: State Spending on Medical Supplies & Pharmaceuticals" with your staff yesterday. As you indicated in your report, the Virginia Department of Corrections has implemented numerous pharmacy cost containment initiatives, and we will continue to pursue other savings measures.

Although I agree with your staff that the assumption of using Section 340B, Public Health Service Act (42 U.S.C. Section 256b) Pharmacy Program does have possibilities, the Virginia Department of Corrections is not qualified to be a 340B provider. I can assure you we will diligently investigate its implementation through VCU and UVA hospitals.

In regard to Table 2, page 4 of the report, please review the pricing input data for consistency. Are medications full (ingredient, dispensing fee) cost or ingredient only? Are the prices for the same time period? The Department of Corrections and Department of Juvenile Justice both use Trigon for off-formulary medication yet you show prices to be different.

Additionally, we do not understand how the DMAS prices are lower than the DOC prices since the Trigon reimbursement rate and dispensing fees are lower than the Virginia Medicaid rates reported in Appendix B of your draft report.

We commend you for a thoughtful proposal and again we thank you for the opportunity to comment.

Sincerely,

Gene M. Johnson

GMJ/FS/cfg

DEC 10 2002

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

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COMMISSIONER

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December 3, 2002

Philip A. Leone, Director
Joint Legislative Audit & Review Commission
General Assembly Building, Capitol Square
Suite 1100
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you very much for giving me the opportunity to comment on your exposure draft report entitled State Spending on Medical Supplies and Pharmaceuticals.

This report is very interesting; covering a wide range of practices in procuring pharmaceuticals and medical supplies by different state departments and higher education institutions. It is very comprehensive. In addition, your recommendations are practical and reasonable.

I only have one comment related to DMHMRSAS. On page 8, first paragraph, please note that our Aftercare Pharmacy is located on the Campus of Hiram W. Davis Medical Center (HDMC), not Central State Hospital.

If you have any questions or if we can assist you in any way, please let me know.

Sincerely,

James Reinhard

James S. Reinhard, M.D.

JSR/bm

UNIVERSITY of VIRGINIA HEALTH SYSTEM

VICE PRESIDENT *and* CHIEF EXECUTIVE OFFICER
of the MEDICAL CENTER

DEC 19 2002

December 6, 2002

Philip A. Leone, Director
Commonwealth of Virginia
Joint Legislative Audit & Review Committee
Suite 1100, General Assembly Building
Capitol Square
Richmond, VA 23219

Dear Mr. Leone:

Thank you for the opportunity to review the draft special report, State Spending on Medical Supplies and Pharmaceuticals. I would like to offer a few observations and commentary. In the interest of brevity, I will list comments on the exposure draft in bulleted fashion.

We support the desire of the State to pursue means to lower the burden to the Commonwealth for pharmaceutical and medical supplies. The plan to reduce costs to purchasers, by use of available plans is most noteworthy. Further, we believe there are controls such as a preferred drug list, otherwise known in our system as a "formulary" that can prove effective in reducing costs. We would be pleased to provide more indepth comments on the final report when it is released.

- Page 3

  Table 1 Note—it is not clear to us why reported total pharmaceutical expenditures at VCU would be one third less than UVA when the inpatient and outpatient volumes at VCU exceed that of UVA. (Also referenced in text page 10, second paragraph.)

- Page 9

  Last paragraph, line 3 at the end—technical correction, UVA does not have "licensed" beds. (delete the word licensed)

- Page 10

  UVA supports the use of a preferred drug list (formulary) for Medicaid beneficiaries and would welcome the opportunity to participate in an authorized Pharmacy and Therapeutics Committee convened to devise and implement such a list. We

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believe it could also improve the current situation with three different Medicaid HMO formularies. Also stated on Page 14 as a recommendation.

- Pages 16 & 17

  Wholesale Acquisition Cost (WAC)
  Lower Dispensing Fee Paid to Pharmacies

  - We would appreciate the opportunity to participate in further review to evaluate current costs and help determine savings that would not result in a burden to those pharmacies who serve Medicaid patients.

- Page 24

  Enabling other hospitals to become 340B eligible

  - UVA can support this action; it is assumed this would be accomplished through establishment of a "state-affiliation" mechanism as described.
  - Prescription Drug Costs Continue to Increase
    We believe the rate of growth in future years will slow due to the lack of new "block-buster" drugs in development.

Thank you again for the opportunity for review and comment prior to finalization of this document. We believe the information contained about the University of Virginia Medical Center to be accurate and presented in a factual manner.

Sincerely,

R. Edward Howell
Vice President and Chief Executive Officer

cc: Leonard W. Sandridge, Jr.
Pamela F. Cipriano, Ph.D., R.N., FAAN