Program Report:

Pharmacy Best Practices and

Cost Control Program

State Fiscal Year 2018

Legislative Report

Pursuant to 33 V.S.A. § 2001(c)

Agency of Human Services

Department of Vermont Health Access

Pharmacy Unit

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Section I: Executive Summary

The purpose of this legislative report is to provide an overview of the scope of DVHA's Pharmacy Benefit programs, including a description of the pharmacy programs provided to DVHA members; clinical and cost strategies that DVHA employs to manage drug utilization; a financial summary of current drug spend, gross and net; and pharmacy trends expected over the next year.

The Agency of Human Services (AHS) has the widest reach in state government and one of the most critical missions: to improve the conditions and well-being of Vermonters today and tomorrow and protect those who cannot protect themselves.

The Department of Vermont Health Access assists members in accessing clinically appropriate health services; administers Vermont's public health insurance system efficiently and effectively; and collaborates with other health care system entities in bringing evidence-based practices to Vermont Medicaid members. In support of the Agency and Department goals, the Pharmacy Benefit Management program goal is to ensure that members receive medically necessary medications in the most efficient and cost-effective manner. With ongoing fiscal challenges facing the state, at stake is preserving, to the greatest extent possible, the benefits that have evolved in Vermont's programs.

The Pharmacy unit managed **$196.5 million in gross drug spend** in State Fiscal Year (SFY) 2018, which includes data from July 1, 2017, through June 30, 2018. Gross drug spend reflects what DVHA paid to both in-state and out-of-state pharmacies enrolled in our network. This represented a small increase in gross expenditures of approximately $2.6 million dollars, and a 1.4% increase over the previous fiscal year.

There was a slight decrease in the number of claims processed and a 3.6% increase in the average cost per prescription. Compare this to SFY 2017, when there was a 1% decrease in the gross cost per prescription when compared to SFY 2016. The result is that we are seeing an overall upward trend in gross spend. For Medicaid Only plans (excluding VPharm), the overall trend is similar, with an increase in gross cost per prescription of 3%.

Section II: Overview of DVHA's Pharmacy Benefit Management Programs

The DVHA Pharmacy Unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefits program. Responsibilities include but are not limited to: processing pharmacy claims; making drug coverage determinations for pharmacy claims and physician-administered drugs (that are processed through the medical benefit and are not reflected in any costs in this report); assisting with drug appeals and exception requests; overseeing federal, state, and supplemental drug rebate programs and the manufacturer fee program; resolving drug-related pharmacy and medical provider issues; overseeing and managing the Drug Utilization Review (DUR) Board; managing of the Preferred Drug List (PDL); and assuring compliance with state and federal pharmacy and pharmacy benefits regulations. The Pharmacy Unit is responsible for seeing that members receive high-quality, clinically appropriate, evidence-based medications in the most efficient and cost-effective manner possible. In addition, we are focused on improving health information exchange and reducing provider burden through e-prescribing, automating prior authorizations, and other efforts related to administrative simplification for DVHA and our providers.

During SFY 2018, the DVHA Pharmacy Unit focused on ensuring that DVHA met the federal requirement to implement the Covered Outpatient Drug Rule (CMS-2345FC), continued its implementation of new services with the State's pharmacy benefits

administrator, Change Healthcare, and prepared for federal CMS certification of its PBM solution. (Centers for Medicare and Medicaid Services, 2016)

Pharmacy Benefit Management (PBM) Services

As mentioned above, the Pharmacy Unit has responsibility for overseeing the contract with DVHA's pharmacy benefit manager (PBM) Change Healthcare® (CHC), which encompasses many clinical and operational services. CHC became DVHA's contracted Pharmacy Benefit Manager (PBM) on January 1, 2015. They are a national leader in Medicaid health care management services with over 40 years of experience in developing Medicaid Pharmacy Benefit Management (PBM) solutions and providing Medicaid services in eighteen (18) other states. CHC's expertise includes clinical management of drug benefits, pharmacy analytics, pharmacy clinical and cost-management strategies, pharmacy claims processing, generic drug pricing programs, preferred drug list (PDL) management, retrospective and prospective drug utilization review, and drug rebate processing. On behalf of DVHA, CHC operates a call center in South Burlington, Vermont, servicing DVHA providers and staffed by Vermont pharmacists and pharmacy technicians. The call center assists pharmacies with claims processing issues and processes all drug prior authorization requests from prescribers for Medicaid members. This includes drugs dispensed by pharmacies, as well as physician-administered and hospital outpatient drugs to ensure the consistent applications of prior authorization requirements.

CHC provides the following support services to assist the State in managing the publicly funded pharmacy benefits programs:

- Drug benefit design management, assuring that:

  - DVHA's business rules are being followed
  - The appropriate edits are functioning in the system
  - Claims are pricing properly
  - Other insurance is considered in all claims processing
- Claims processing services
  - Over 2 million claims processed annually
  - A real-time (Point-of-Service) claims processing platform
    - Most claims adjudicate in less than one second
  - Help Desk provider support for claims or coverage questions
- Clinical pharmacy management services
  - Drug Utilization Review Board (DURB) support
  - Preferred Drug List (PDL) management
  - Drug utilization review (DUR) activities
  - Pharmacy Cost Management (PCM) Program
  - Prior Authorization (PA) programs
    - Clinical review and processing of Prior Authorizations (PA)
    - Help Desk provider support
    - Quality improvement
      - Automated PA
      - Electronic submission through Provider Portal
- Management of Federal, State, and Supplemental Rebate programs
  - Invoicing, Tracking, Collections, Disputes
- Management of the Manufacturer Fee Program
  - Invoicing, Tracking, Collections, Disputes
- Pharmacy Claims Analysis and Reporting
- Provider Portal
- E-prescribing support interface

These services and others are all described in "Section III: Strategies Utilized to Manage the Pharmacy Benefit."

Drug Benefit Program Designs

For the DVHA programs that include full health insurance coverage, all included a pharmacy benefit in SFY 2018. These programs are described below and on the following page:

Overview of Green Mountain Care and Vermont Health Connect Programs as of 1/30/18 Created by Vermont Legal Aid's Office of Health Care Advocate 1-800-917-7787			
PROGRAM	**WHO IS ELIGIBLE**	**BENEFITS**	**COST-SHARING**
MABD Medicaid[1] **Medicaid Working Disabled** **MCA[2] (Expanded Medicaid)**	Aged, blind, disabled at or below the PIL[3]. Disabled working adults at or below 250% FPL[4]. Vermonters at or below 138% of FPL who are: • Parents or caretaker relatives of a dependent child; or • Adults under age 65 and not eligible for Medicare	• Covers physical and mental health, dental ($510 cap/yr), prescriptions, chiro (limited), transportation (limited). • Not covered: eyeglasses (except youth 19-20); dentures. • Additional benefits listed under Dr. Dynasaur (below) covered for youth 19-20. • Covers excluded classes of Medicare Part D drugs for dual-eligible individuals.	• No monthly premium. • $1/$2/$3 prescription co-pay if no Medicare Part D coverage. • $3.35 -$8.35 co-pays if have Part D. (if beneficiary is under 100% FPL $1.25 to $3.70) Medicare Part D is primary prescription coverage for dual-eligible individuals. • $3 dental co-pay. • $3/outpatient hospital visit.
Dr. Dynasaur	Pregnant women at or below 213% FPL.	Same as Medicaid, but with full dental.	No premium or prescription co-pays.
Dr. Dynasaur	Children under age 19 at or below 317% FPL.	Same as Medicaid but covers eyeglasses, full dental, & additional benefits.	• Up to 195% FPL: no premium. • Up to 237% FPL: $15/family/month. • Up to 317% FPL: $20/family/month. ($60/family/mo. w/out other insurance) • No prescription co-pays.
VPharm1 150% FPL **VPharm2 175% FPL** **VPharm3 225% FPL**	Medicare Part D Beneficiaries	• VPharm1 covers Part D cost-sharing & excluded classes of Part D meds, diabetic supplies, eye exams. • VPharm 2&3 cover maintenance meds & diabetic supplies only.	• VPharm1: $15/person/mo. pd to State • VPharm2: $20/person/mo. pd to State • VPharm3: $42/person/mo. pd to State • $1/$2 prescription co-pays.

			• VPharm1 must apply for Part D Low Income Subsidy.
Medicare Savings Programs: **QMB 100%FPL** Qualified Medicare Beneficiaries **SLMB 120% FPL** Specified Low-Income Beneficiaries **QI-1 135% FPL** Qualified Individuals	• QMB & SLMB: Medicare beneficiaries w/ Part A • QI-1: Medicare bens. who are not on other fed. med. benefits e.g. Medicaid (LIS for Part D OK).	• QMB covers Medicare Part B (and A if not free) premiums; Medicare A & B cost-sharing. • SLMB and QI-1 cover Medicare Part B premiums only.	No cost / no monthly premium.
Healthy Vermonters 350% FPL/ 400% FPL if aged or disabled	Anyone who has exhausted or has no prescription coverage	• Discount on medications. (NOT INSURANCE)	Beneficiary pays the Medicaid rate for all prescriptions.

[1] MABD: Medicaid for the Aged, Blind, and Disabled. [2] MABD is the only program w/ resource limits: $2000/person, $3000/couple (Medicaid for the Working Disabled is $10,000/person, $15,000/couple). Long Term Care Medicaid (nursing home care; waiver services) is not included in this chart.
[3] MCA: Medicaid for Children and Adults PIL: Protected Income Limit. [4] FPL: Federal Poverty Level

Approximately 35% of adults and 21% of children utilize the drug benefit programs on average each month. Please refer to Chart 2 in the Appendix.

Section III: Strategies Utilized to Manage the Pharmacy Benefit

The Pharmacy Best Practices and Cost Control Program

The Pharmacy Best Practices and Cost Control Program was authorized in 2000 and established in SFY 2002 by Act 127. This program encompasses the following operational strategies:

- Partnering with a vendor with skills and expertise in pharmacy benefit administration
- Managing and processing claims
- Managing benefit design
- Monitoring and managing utilization through retrospective and prospective drug utilization review
- Evaluating new-to-market drugs and preferred drug list placement
- Procuring supplemental rebates on utilized drugs
- Managing reimbursement
- Responding to change

Preferred Drug List

The Preferred Drug List (PDL) is "A preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives" as defined in Act 127 passed in 2002. The preferred drug list is an important tool designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies.

DVHA's Preferred Drug List (PDL) includes a list of preferred and non-preferred drugs that are covered by DVHA's drug benefit programs, however not all drugs DVHA covers are listed on the PDL. Currently, DVHA's PDL manages over 180 different therapeutic categories representing thousands of drugs. The PDL is designed to reduce the State's cost of providing prescription drugs while assuring broad access to clinically appropriate medications. It is one of the most effective tools available to assure clinically appropriate and cost-effective prescribing. If a drug is not listed as "preferred" in a category on the PDL, it requires prior authorization for the drug to be covered. Prescribers can and do refer to the PDL to identify which drugs are most appropriate to prescribe for DVHA members. The PDL features clinically appropriate, low-cost options including:

- Generics
  - DVHA's overall utilization of generic drugs is 79%, which represents 17% of gross costs
  - More than 98% of generics are preferred, with some exceptions when the net cost of the brand drug is lower
  - Most generics do not require prior authorization

- Brand Drugs
  - DVHA's overall utilization of brand drugs is 21%
  - Brand drugs represent 83% of gross costs

  - Preferred Brand Drugs**:**
    - Are brand drugs that may have clinical superiority to other drugs in the class, or in some instances may be the only drug available to treat a medical condition.

    - Can include brands where manufacturers pay a level of federal Medicaid rebates that makes the net cost of the drug lower compared to other products in the drug's therapeutic class.
    - Can include brands where manufacturers pays rebates supplemental to required federal Medicaid rebates to make their products more affordable.
    - May require a PA for clinical or safety reasons.

- Non-Preferred Brand Drugs:
    - Do not have clinical superiority to other drugs in the class, have similar or inferior clinical efficacy and/or offer no clinical advantage.
    - Are brands for which manufacturers:
        - Pay a lower level of federal Medicaid rebates, which makes the net cost of the drug higher compared to preferred products in the drug's therapeutic class
        - Do not offer rebates supplemental to the required federal rebates.
    - All require prior authorization.

Within these categories there may be drugs or drug classes that are subject to quantity limits to assure appropriate dosing and dose consolidation.

Generic Dispensing Rates

The rate of **generic dispensing rate of 79%** reflects the use of generics as a percentage of all drugs dispensed whereas the rate of **generic substitution rate of 88%** reflects the percentage of time generics are utilized when a generic equivalent is available for a drug. Chart #3 in the Appendix identifies these rates of dispensing for state fiscal years 2016 through 2018. Unlike commercial insurance and Part D plans, Medicaid generic utilization rates are typically somewhat lower since brands that lose patent protection are often more cost-effective for the State for a period after generics enter the market. This is especially true for the first six months to a year after patent expiration, and is reflected in the use of “brand-preferred” products on our PDL. Our generic dispensing rates have remained steady at 79%, which is a few points lower than most non-Medicaid plans.

Drug Utilization Review (DUR) Board

The DVHA oversees the activities of the Drug Utilization Review Board. The DUR Board in Vermont serves a dual function. One is the drug utilization review component whereby the Board applies criteria and standards in the application of DUR activities, reviews and reports the results of Drug Utilization Review activities performed by the DVHA or its Pharmacy Benefits Manager (PBM) "Change Healthcare” on behalf of DVHA and/or recommends and evaluates educational intervention programs. The second and more time-consuming portion of the DUR Board meetings is the "Pharmacy and Therapeutics Committee" role of the Board whereby the Board provides guidance on the development of the Preferred Drug List or Drug Formulary for Medicaid patients. While some states have two Boards for each purpose, the Department of Vermont Health Access (DVHA) elected to utilize the already established DUR Board to obtain current clinical advice on the use of pharmaceuticals.

The Drug Utilization Review (DUR) Board of the Department of Vermont Health Access is a committee composed of Vermont prescribers and pharmacists. The Board membership currently includes four physicians, one nurse practitioner and four pharmacists.

The DUR Board meets approximately every six weeks, and there are eight meetings per year with a robust agenda. The agenda is composed of drug utilization review and analyses; reviews of new drugs, new indications and dosage forms; therapeutic class reviews, including recently published treatment guidelines and best practices that may influence clinical criteria; safety information; and other drug information pertinent to managing the drug benefit programs for DVHA.

The Board also routinely reviews therapy by examining patterns in prescribing, dispensing and consumption of medications. The Board may help DVHA select the most relevant drugs to target for review to ensure that clinical criteria and prescribing patterns are appropriate. As an outcome of these reviews, the Board identifies specific therapeutic and clinical behaviors that, if altered, may improve patient outcomes and lower costs. These activities allow DVHA, with the Board's guidance, to optimize the pharmaceutical care received by our members.

Some topics of discussion at the DUR Board meeting in SFY18 included concurrent use of buprenorphine with opiates and/or benzodiazepines; statin use in ASCVD and congested heart failure; chronic triptan use; naloxone intolerance; Vivitrol® adherence; antipsychotics in the treatment of major depressive order; short-acting opiate prescribing; overuse on long-acting stimulants and the use of fluoroquinolones.

DVHA also creates and distributes provider communications when certain changes are made to clinical criteria or dosing limitations, or if an educational communication is

appropriate based on a drug utilization review. For example, if a preferred drug is changed to a non-preferred status and specific beneficiaries are affected, prescribers are provided with a list of all their patients who were prescribed the specific drug that is being changed and a profile unique to each patient with the drug change listed. This creates a record for use in the patient's file and provides notice to provider offices of the upcoming change. DVHA's pharmacy unit uses various forms of communication, including letters to providers, "fax blasts," banners on the provider payment remittance advice and website postings. The chart below lists some of the SFY2018 activities of the DUR Board.

DUR Activities

Review Topic	SFY 2018 Total
Therapeutic Drug Classes: Periodic Review	47
Full New Drug Reviews	50
FDA Safety Alerts	22
New/Updated Clinical Guidelines	24
RetroDUR/Prior Authorization Quality Assurance Analysis	7
New Managed Therapeutic Drug Classes	4
Abbreviated new Drug Review	0

Prior Authorization Program

DVHA's prior authorization program is an extremely important tool in managing cost and clinical appropriateness of drug use. While most insurers can utilize high copays, high premiums, multiple drug tiers, and other forms of member cost sharing to shift utilization to preferred products, Medicaid programs are limited in that capacity, and therefore a prior authorization program becomes an even more important tool in managing utilization.

Prescribers can submit a prior authorization to request coverage of a non-preferred drug on the PDL. Many drugs have specific criteria, such as a specific diagnosis or lab test result, while other drugs have more general criteria and simply require a “step-through” a preferred drug. Other drugs are set up with automated criteria, in which the claims system identifies previous drug therapy or a pre-existing diagnosis. In these “automated” examples, the PA process is completed by the POS system, which is invisible to the providers.

To reduce provider burden, the Department of Vermont Health Access (DVHA) implemented an automated prior authorization (PA) program for drugs which has eliminated a substantial number of manual prior authorizations that have to be completed by provider staff. The pharmacy claims processing system checks the member’s record for the required medical diagnosis on the claim’s date of service. It can also automatically calculate the daily dose based on medication history and the quantity and days’ supply submitted. These “auto-PA” edits were implemented in response to feedback received from providers and have had a positive impact on both providers and patients. DVHA will continue to monitor manual and automated PA volume and implement additional automated edits over the next few years. Our goal is to reduce provider burden while assuring clinical and financial integrity of our pharmacy programs.

CHC staff, including physicians and clinical pharmacists, help DVHA structure and manage the application of the criteria. As explained above, the DUR Board helps DVHA create new criteria as new drugs enter the market or new classes are selected for management. All criteria and therapeutic classes are reviewed at least biennially. New criteria and proposed changes are reviewed, modified and approved by the DUR Board.

Chart #4 in the Appendix reports the incidence of prior authorization requests and denial rates for SFY 2018. The number of manual PA's has declined by 19% due to the ongoing development of automated PA's. In addition, the PA denial rate has declined by 2.3% over the last two years.

Provider Portal

A new provider portal was launched in April 2018, allowing pharmacists and prescribers access to a secure, web-based application that offers features such as a pharmacy and member eligibility, drug queries, electronic submission of prior authorizations (PA), uploading of clinical documentation into a document management system, and status updates for submitted PA requests. As of September 2018, the following provider types were enrolled in the portal. DVHA is continuing to perform provider outreach to maximize provider enrollment in the Portal.

Pharmacy Managers	27
Pharmacy Delegates	18
Prescribers	40
Prescriber Delegates	10
Total Providers with Access:	**95**

Pharmacy Cost Management (PCM) Program

In late SFY 2017, DVHA, in collaboration with Change Healthcare, implemented the Pharmacy Cost Management (PCM) Program. The goal of the program is to mitigate the impact of high-cost specialty drugs on pharmaceutical expenditures while ensuring that the full value of these medications in improving patient outcomes and reducing medical expenditures can be realized. Achieving this goal requires focused and attentive oversight and management of both the drugs and the patients receiving them

to ensure that patients are not only prescribed the optimal drug for their specific condition, but that they are taking the drug as prescribed and are receiving the appropriate monitoring, testing and follow-up care.

The PCM program updates the old paradigm of “the right drug to the right patient at the right time” to address this new era of pharmacotherapy with “the most appropriate drug taken correctly by the informed patient achieving optimal outcomes.” A very large percentage of patients fail to take their medications correctly, resulting in both inappropriate or inadequate treatment as well as substantial loss of precious financial resources. Increasing medication compliance is closely tied to the best clinical outcomes. The CHC clinical team identifies and enrolls appropriate patients who initiate treatment on specialty medications whose cost exceeds $5,000 per prescription. Enrollment can also occur during the Prior Authorization approval process.

Patient Outreach and Education:
The CHC PCM pharmacist provides direct patient outreach, consultation and education to patients enrolled in the program. This includes reviewing with the patient the correct storage and proper dosage of the medication. Additionally, patients are educated on what to do if a dose is missed; common medication side effects and how best to manage them; and the importance of complying not only with the directions on the prescription but also with behavioral/lifestyle changes that can increase their quality of life.

This program tracks patient adherence to medication regimens by measuring Medication Possession Ratio (MPR), which is the number of dispensed medication doses divided by the number of days in a unit of time (e.g., one year). The MPR can be used to estimate the degree to which patients with chronic medical conditions comply with prescribed drug therapies. Patient outreach not only emphasizes the importance of

taking the medication as prescribed, but also aims to identify and rectify any potential barriers to adherence (such as transportation, work schedule, dexterity/vision problems).

Provider Outreach and Coordination:

The PCM pharmacist provides direct outreach to prescribers and pharmacies to discuss the goals of therapy as well as the appropriateness of drug, dose, and duration of therapy and follow up. The pharmacist works directly with prescribers to choose the most cost-effective treatment regimens for each patient with consideration of age, gender, co-morbidities and, when pertinent, biologic and genetic markers. In addition, they communicate directly with pharmacies to ensure that the medications are dispensed to the patients at the correct times and are billed appropriately. Prescribers are notified when a patient demonstrates poor adherence. Lastly, for patients who are enrolled in DVHA's Vermont Chronic Care Initiative (VCCI) program, the PCM pharmacist coordinates with the VCCI nurses to assure coordination of care and provider outreach. By coordinating care with the team – the patient, prescriber, pharmacist, and VCCI nurse – treatment adherence is directly assessed and strengthened, enabling the achievement of the best clinical outcome.

Outcomes:

Through the appropriate utilization of high-cost drugs, clinical outcomes can be improved and medical expenditures can be reduced. To assess the overall impact of the PCM program, medical utilization data is collected, monitored and analyzed. While the PCM program may have some impact on drug expenditures, significant value is achieved through reduced utilization of medical services (hospitalization, provider visits and ancillary services) and improvement in clinical outcomes and patients' qualify of life.

The Vermont Medicaid Pharmacy Care Management documented savings of nearly $700,000 for DVHA during State Fiscal Year 2018. The PCM program enrolled 711 total members on 101 unique medications. PCM is now coordinating with VCCI caseworkers on several members over the past quarter, uniting efforts and sharing member information for improved care. PCM interventions may not always result in direct cost avoidance however are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. The program continues to grow, identifying new members and including more specialty medications as they come to market and usage increases.

State Maximum Allowable Cost (SMAC) Program

Vermont's state MAC or "SMAC" program is similar to CMS's Federal Upper Limit (FUL) program. The intent is to provide a maximum price that the State of Vermont will pay for a given generic pharmaceutical regardless of its package size or manufacturer. The SMAC program is designed to promote the efficient purchasing of generic pharmaceuticals within the pharmacy provider network to ensure that the Medicaid program is a frugal payer of prescription drugs. In developing the state MAC pricing list, the State of Vermont relies on CHC's data and expertise to determine the appropriate "average" price for a generic drug. CHC utilizes multiple sources for determining accurate pricing information. Some sources are based on actual acquisition cost data from pharmacy-submitted invoices, and CHC also reviews both state-specific and national industry data. Some examples of the benchmarks used include wholesale acquisition cost (WAC), federal upper limit (FUL), and national average drug acquisition cost (NADAC) prices.

A full review of the SMAC pricing list is performed monthly. These reviews include reviewing any new generics that have entered the market and obtaining acquisition cost

to determine if a SMAC can be applied or needs to be adjusted on a drug. CHC also monitors changes in product availability and drug shortages for the State of Vermont, which may affect the price of drug products, so we can proactively adjust SMAC pricing to assure fair and accurate reimbursement to Vermont pharmacies.

DVHA fully complies with Title 18 of the Vermont Statutes regarding maximum allowable cost (MAC) prices effective July 1, 2015, which requires pharmacy benefit managers to make SMAC listing available in a readily accessible format. Vermont's SMAC list has always been and is currently available on the DVHA pharmacy provider website. In addition, pharmacy providers who wish to appeal reimbursement on a claim may submit a SMAC appeal request form found on the DVHA website. Appeals must be received within 10 calendar days of the claim adjudication date, and DVHA must respond within 10 calendar days of the receipt of a timely appeal request.

After the implementation of the new pricing rules based on the National Average Drug Acquisition Cost (NADAC) in SFY2017 (http://dvha.vermont.gov/for-providers/pharmacy-reimbursement-change-notice-draft-03132017.pdf), the number of claims pricing off Estimated Acquisition Cost (EAC) dropped from 28% to 1%, and claims being priced off NADAC rose from zero to 34%. SMAC rates remained fairly consistent at approximately 40% for all drugs, while claims pricing off the Federal upper Limit (FUL) dropped from 22% to zero due to the NADAC replacing the FUL. A chart depicting this change can be seen in the Appendix, Charts 5A and 5B#.

Top Drugs by Cost and Utilization

DVHA continues to see the highest spending on drugs used to treat substance-use disorder (opioid partial agonists), Hepatitis C, Attention Deficit Hyperactivity Disorder (stimulants, amphetamines), inflammatory conditions such as Rheumatoid Arthritis and

Crohn's Disease, Diabetes, Depression, and neuropathic pain disorders. See Chart 8 which lists the top 10 therapeutic classes by gross spend, and 9 which lists the top 10 drugs by gross spend, and Charts 10 and 11 which rank therapeutic classes and drugs by utilization, in the Appendix.

Opioid partial agonists including Suboxone® are on the top of the charts by both spend and utilization. The number of claims for all buprenorphine containing drugs increased by 8.3%, while the utilization of Suboxone® increased by 10% in SFY18, supporting the trend toward more patients with Opiate Use Disorder accessing treatment. At the same time, we have seen opioid utilization decrease by 30% and the number of members using opiates decline by 36%. There continues to be a significant focus on initiatives and spend to tackle the opioid crisis. Vermont has put into place better prescribing practices and rules limiting the quantities of opioids that are prescribed. Educational initiatives and awareness around treating chronic pain differently without the use of opioids is also a contributing factor. Vermont is recognizing and treating opioid addiction as a chronic medical condition. This has expanded access for those who seek treatment and, in some counties, greatly decreased wait times for those patients. The Hub and Spoke program continues to be a valuable resource for improved access and treatment.

Also of note we are also seeing utilization of proton pump inhibitors such as omeprazole on a downward trend. Clonazepam utilization is showing a decrease as well. These are both notable and may be related to recent educational efforts aimed at prescribers to 'de-prescribe'. Office of Primary Care and Area Health Education (AHEC) Program has offered training and resources on discontinuing medication. Specific therapeutic classes targeted for de-prescribing efforts recently included both proton pump inhibitors and benzodiazepines. There is a growing body of evidence that demonstrates the risks of long-term use with both categories of medication.(https://www.med.uvm.edu/ahec/vermontacademicdetailing)

Number of amoxicillin prescriptions increased by about 1,000 prescriptions over SFY17. This increase is somewhat surprising since there has been a focus on antibiotic overuse and concerns about resistance. One theory of this increase is the high severity of flu season. It is possible that more amoxicillin was prescribed to treat bacterial co-infections, which can frequently occur with influenza.

Specialty Pharmacy

The list of specialty medications is updated quarterly and can be found on the DVHA website at http://dvha.vermont.gov/for-providers/specialtydrugweblist.pdf
In addition, DVHA maintains a list of specialty pharmacies enrolled with the State http://dvha.vermont.gov/for-providers/specialty-pharmacy-dvha-list-08102018.pdf.
A specialty drug must meet a minimum of two (2) of the following requirements:

- The cost of the medication exceeds $5,000 per month.
- The medication is used in the treatment of a complex, chronic condition. This may include but is not limited to drugs which require administration, infusion or injection by a health care professional.
- The manufacturer or FDA requires exclusive, restricted or limited distribution. This includes medications which have REMS requirements requiring training, certifications or ongoing monitoring for the drug to be distributed.
- The medication requires specialized handling, storage or inventory reporting requirements.

Specialty medications include, but are not limited to, drugs used in the treatment of the following conditions:

- Alpha-1 Antitrypsin Deficiency
- Cancer
- Contraceptive implants and IUD’s
- Cystic Fibrosis
- Endocrine Disorders
- Enzyme Deficiencies
- Hemophilia
- Hepatitis C

- Hereditary Angioedema
- Immune Deficiency
- Inflammatory Conditions (e.g. Crohn's, Ulcerative Colitis, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, and Psoriasis)
- Multiple Sclerosis
- Pulmonary Arterial Hypertension
- Respiratory Syncytial Virus (RSV)

DVHA defines a specialty pharmacy as outlined by the Academy of Managed Care Pharmacy (AMCP) in a recent publication entitled Format for Formulary Submission, version 3.1 and the Specialty Pharmacy Association of America's definition below.
"Specialty pharmacies are distinct from traditional pharmacies in coordinating many aspects of patient care and disease management. They are designed to efficiently deliver medications with specialized handling, storage, and distribution requirements with standardized processes that permit economies of scale. Specialty pharmacies are also designed to improve clinical and economic outcomes for patients with complex, often chronic and rare conditions, with close contact and management by clinicians. Health care professionals employed by specialty pharmacies provide patient education, help ensure appropriate medication use, promote adherence, and attempt to avoid unnecessary costs. Other support systems coordinate sharing of information among clinicians treating patients and help patients locate resources to provide financial assistance with out of pocket expenditures." (Academy of Managed Care Pharmacy, 2012)

The Specialty Pharmacy Association of America defines a specialty pharmacy as follows:
"Specialty pharmacy is a unique class of professional pharmacy practice that includes a comprehensive and coordinated model of care for patients with chronic illnesses and

complex medical conditions. This unparalleled, patient-centric model is organized to dispense/distribute typically high-cost, injectable/infusible/oral and other hard-to-manage therapies within a collaborative framework designed to achieve superior clinical, humanistic, and economic outcomes." (Drug Topics, 2013)

In addition to these definitions, DVHA requires any specialty pharmacy dispensing specialty drugs to DVHA Members to be Certified by the Utilization Review Accreditation Commission (URAC), the Accreditation Commission for Health Care (ACHC) or the Center for Pharmacy Practice Accreditation (CPPA).

In SFY18, specialty drugs represented 24.2% of DVHA's overall drug spend. This was a 17% increase over SFY 2017, when specialty drug spend represented 20.7% of DVHA's drug spend. Refer to Chart 13 for the 3-year gross trend.

For SFY19 and SFY20, it is projected that the net spend on anticoagulants will increase an average of 15% per year as we continue to see a shift from low-cost warfarin to the more expensive New Oral Anticoagulants (NOAC). Inflammatory conditions are projected to increase by approximately 14% as we start to see a shift away from the tumor necrosis factor inhibitors to the anti-interleukin (IL) products for plaque psoriasis. Net spend for oncology drugs is projected to increase about 12% each year as utilization of newer products continues to increase. Net spend on HIV drugs are expected to increase by almost 10% each year as utilization shifts away from older multiple-tablet regimens to newer single-tablet regimens. The impact of this shift on expenditures is being offset, to some extent, by an increase in the number of generics available for the older products. Finally, utilization of drugs used to treat Attention Deficit Hyperactivity Disorder (ADHD) is expected to drive up net expenditures by 4-6% each year.

Hepatitis C Drugs

Hepatitis C direct acting antiviral gross costs have increased by 65% over the last fiscal year. Interestingly although the number of patients treated doubled the total paid amount only increased by 24%. Direct Acting Antivirals are very effective drugs and competition has driven the cost down significantly. We continue to see a significant financial impact of these drugs and more people will continue to be treated for Hepatitis C Virus (HCV). There were two Direct Acting Antivirals (DAA) for treating Hepatitis C on the top 10 list by Gross Spend, Epclusa and Harvoni, the latter of which is being replaced by Mavyret toward the middle of SFY18 and into SFY19. Mavyret is very effective, can be used for all genotypes and can have an eight-week course of therapy versus 12 weeks for some other DAA agents, and has a lower cost of treatment. In January 2018 the Fibrosis Score=2 or more requirement was removed. This opened the door for broader access to treatment for Hepatitis C infected patients. DAA's are by far the lowest utilization on the list with the highest gross spend. These drugs are a focus of PCM services to facilitate adherence and follow up to enable the best clinical outcomes.

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Federal Rebates

Federal rebates that manufacturers pay to states are calculated based on a federally-mandated formula and on prices manufacturers set, and financial concessions manufacturers make available to all entities that purchase their drugs. The two prices used in the calculation are “best price” and the “average manufacturer price” (AMP). The DVHA Medicaid program does not directly influence the amount of federal rebate for a drug. Drugs that have large federal rebates may be preferred based on their lower net cost to the State. In general, federal rebate collection increases as overall drug utilization increases. Also, generally, the longer a drug is on the market, the larger its federal rebate due to the rebates being based in part on the Consumer Price Index to account for inflation.

The Bipartisan Budget Act (BBA) of 2015 required manufacturers to pay additional rebates when their generic covered outpatient drugs’ average manufacturer prices (AMPs) increase at a rate that exceeds the rate of inflation. This is commonly referred to as the “CPI Penalty” (Consumer Price Index) and has always applied to brand drugs, but only recently has applied to generic drugs. Manufacturers were required to pay the additional rebate effective January 1, 2017.

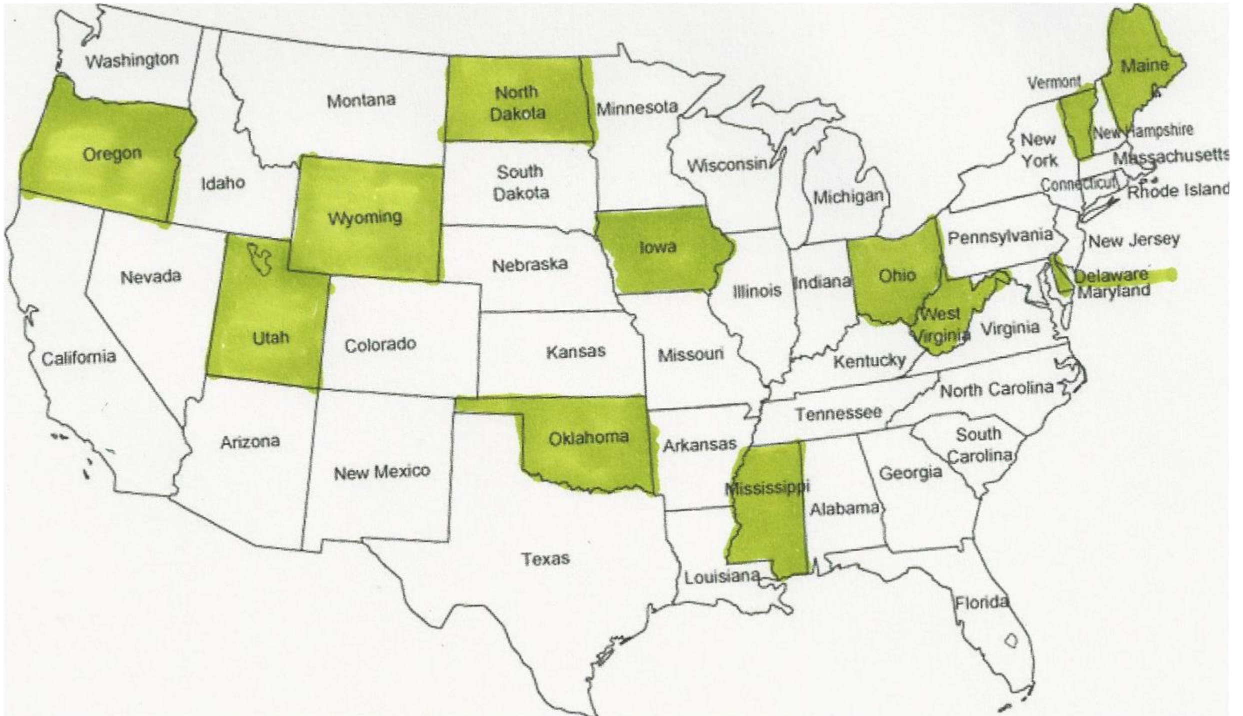
Supplemental and Diabetic Supplies Rebates

Supplemental rebates are negotiated by the State through its participation in the Sovereign States Drug Consortium (SSDC). Supplemental rebates are those rebates in addition to the required federal rebates on a drug, while diabetic supply rebates are state-only rebates on diabetic supplies such as lancets and test strips, for which we do not get federal rebates. Both programs provide substantial rebate value to the State. The SSDC is the only state-administered Medicaid supplemental drug rebate pool. Vermont contracts for SSDC-negotiated supplemental rebates via its own supplemental

rebate agreement, enabling us to retain control and flexibility in the management of our preferred drug list while taking advantage of the additional leverage provided by the large number of members covered by the pool.

The SSDC was founded in the fall of 2005 by the States of Iowa, Maine and Vermont to obtain prescription drugs at a lower cost for members of their respective Medicaid programs. The SSDC uses a multi-state administered collaboration to create a purchasing pool. The pool primarily focuses on negotiating and acquiring rebates supplemental to federal Medicaid rebates from drug manufacturers. At the same time, the SSDC preserves each state's ability to manage its pharmacy benefit by customizing its own preferred drug list and prior approval programs.

The States of Iowa, Maine and Vermont were the founding members of the SSDC and represented its membership for the first rebate calendar year (RCY) of 2006. Utah enrolled as of RCY 2007 followed by Wyoming in RCY 2008; West Virginia and Oregon in RCY 2009; Mississippi in RCY 2012; North Dakota in RCY 2015; Delaware and Ohio in RCY 2016; and our newest member, Oklahoma, which enrolled as of RCY 2017. Due to the success of the SSDC, it is now the largest and only independent, state-owned rebate pool in the country. The 12 states, as of RCY 2018, are illustrated in the map below.



The SSDC is the largest rebate pool in the nation, Vermont was one of three founding members.

In 2018, a total of nearly 7.2 million members, and nearly $7 billion in drug expenditures is represented by the 12 participating states providing substantial leverage in manufacturer negotiations.

SSDC Annual Drug Spend

State	PDL Lives*	Annual Medicaid Drug Spend	Fee-For-Service (FFS)& Managed Care (MCO) Unified PDL for 2019
DE	247,278	$208,000,000	Yes
IA	618,000	$350,000,000	Yes
ME	265,000	$251,738,192	No (FFS)
MS	760,000	$457,865,178	Yes
ND	90,000	$72,002,188	Yes
OH	2,385,000	$3,830,000,000	Yes, select classes
OK	823,787	$603,618,747	No
OR	985,195	$164,367,199	Yes, select classes
UT	299,000	$134,000,000	No
VT	158,000	$194,748,701	No (FFS)
WV	500,447	$620,33,421	No (MCO Carve Out)
WY	80,475	$49,716,062	No (FFS)
TOTAL	**7,212,182**	**$6,936,386,688**	

Number of Medicaid lives covered under state Medicaid PDL including MCO enrollees in states with Unified PDLs for some or all covered drug classes

(Sovereign States Drug Consortium, p. 2018)

Section IV: APPENDIX: COST AND UTILIZATION CHARTS

Chart #1: Gross Pharmacy Claims and Spend, SFY 2016-2018

(All Programs, prior to application of rebates)

ALL PHARMACY CLAIMS					
SFY	CLAIM COUNT	GROSS AMOUNT PAID	GROSS AMOUNT PAID % CHG	GROSS COST PER CLAIM	GROSS COST PER CLAIM % CHG
2018	2,064,317	$196,526,879	1.36%	$95.20	3.64%
2017	2,110,792	$193,887,215	-6.31%	$91.86	-1.11%
2016	2,227,991	$206,948,605		$92.89	4.69%

MEDICAID CLAIMS (includes Duals)					
SFY	CLAIM COUNT	GROSS AMOUNT PAID	GROSS AMOUNT PAID % CHG	GROSS COST PER CLAIM	GROSS COST PER CLAIM % CHG
2018	1,731,253	$190,682,710	1.57%	$110.14	2.99%
2017	1,755,569	$187,738,181	-6.34%	$106.94	-1.10%
2016	1,853,933	$200,456,289		$108.12	

VPHARM CLAIMS					
SFY	CLAIM COUNT	GROSS AMOUNT PAID	GROSS AMOUNT PAID % CHG	GROSS COST PER CLAIM	GROSS COST PER CLAIM % CHG
2018	333,064	$5,844,169	-4.96%	$17.55	1.37%
2017	355,223	$6,149,034	-5.29%	$17.31	-0.27%
2016	374,058	$6,492,316		$17.36	

NOTE:

Dual-Eligible: DVHA only pays for non-Part D drugs, primarily over-the-counter (OTC) drugs

VPharm: DVHA pays secondary to Part D, and for non-Part D drugs, primarily OTC drugs

Chart #2: Pharmacy Services: Utilizing Members

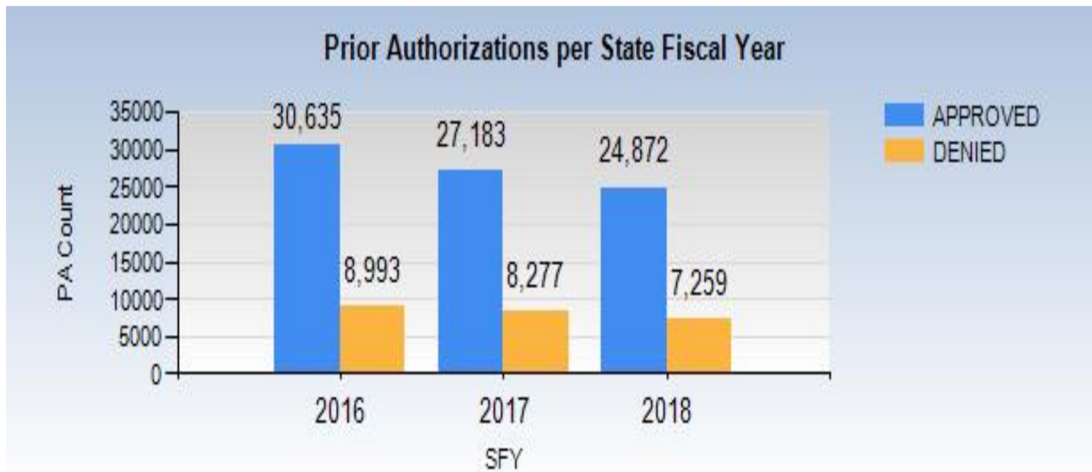
*Calculated as average monthly eligible members vs. average monthly utilizers

ALL	2016	2017	2018
Medicaid and Duals Eligible All Ages	201,091	180,527	172,324
Medicaid and Duals Utilizers All Ages	56,081	51,926	50,913
Medicaid and Duals Utilization Percent All Ages	28	29	30
ADULTS			
Medicaid and Duals Eligible Adults	132,144	115,317	108,688
Medicaid and Duals Utilizers Adults	42,059	38,648	37,632
Medicaid and Duals Utilization Percent Adults	32	34	35
CHILDREN			
Medicaid and Duals Eligible Children	68,947	65,209	63,635
Medicaid and Duals Utilizers Children	14,022	13,277	13,281
Medicaid and Duals Utilization Percent Children	20	20	21

Chart #3: Generic Usage Rate (SFY 2016-2018)

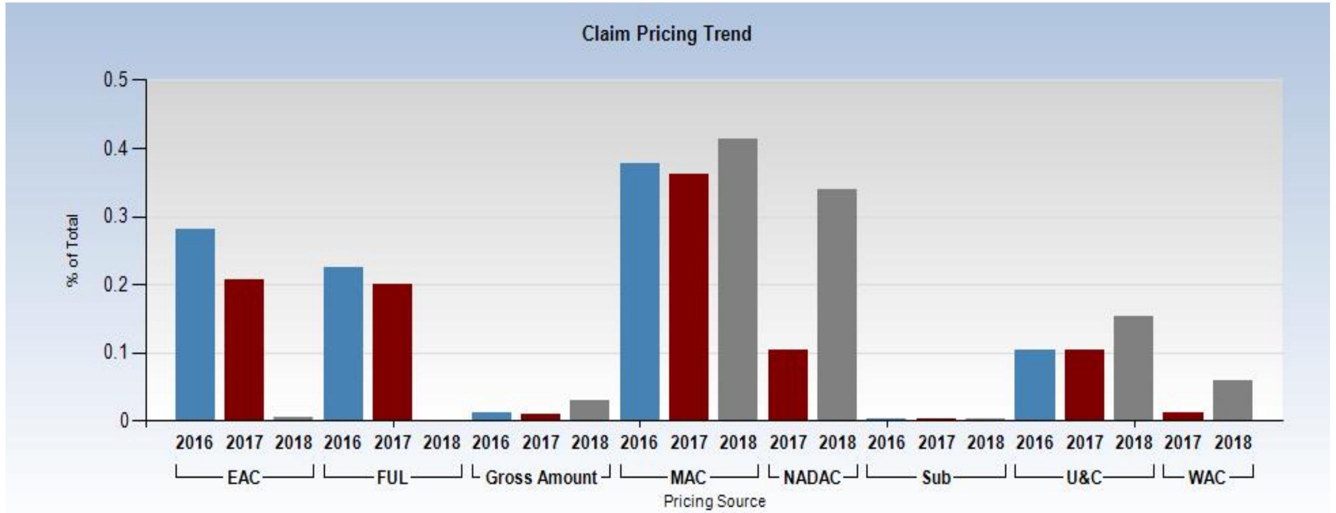
Generic Indicator	2016	2017	2018
Generic use as a percentage of prescriptions for all drugs dispensed	**79%**	**79%**	**79%**
Generic use as a percentage of prescriptions when a generic equivalent is available	**88%**	**88%**	**88%**

Chart #4: Prior Authorizations for SFY 2018



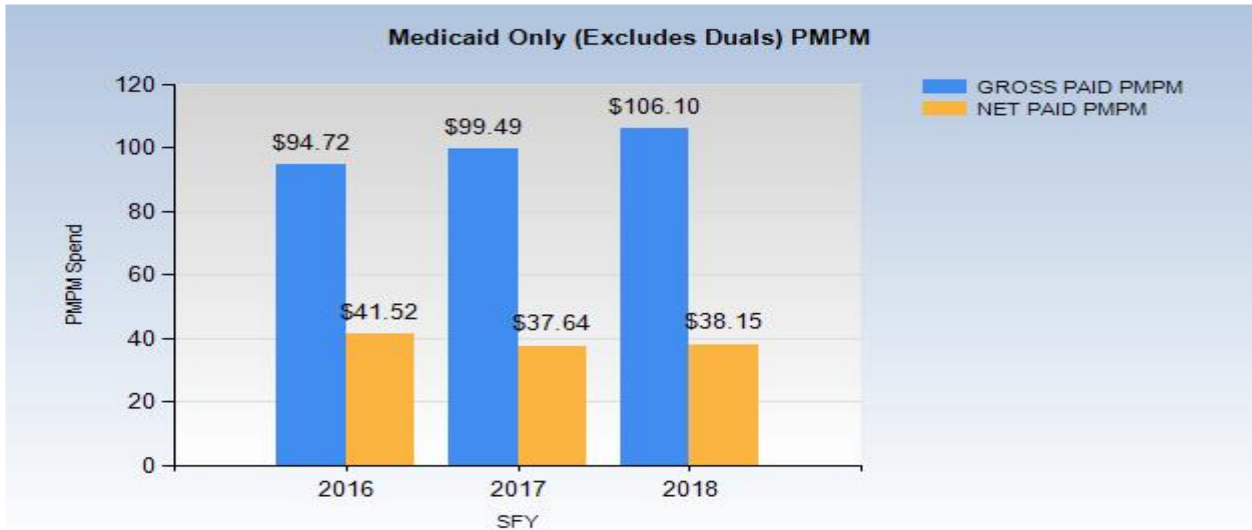
SFY	PA Denial Rate %
2016	20.93%
2017	19.87%
2018	18.60%

Chart #5A and 5B: Pricing Source of Drugs

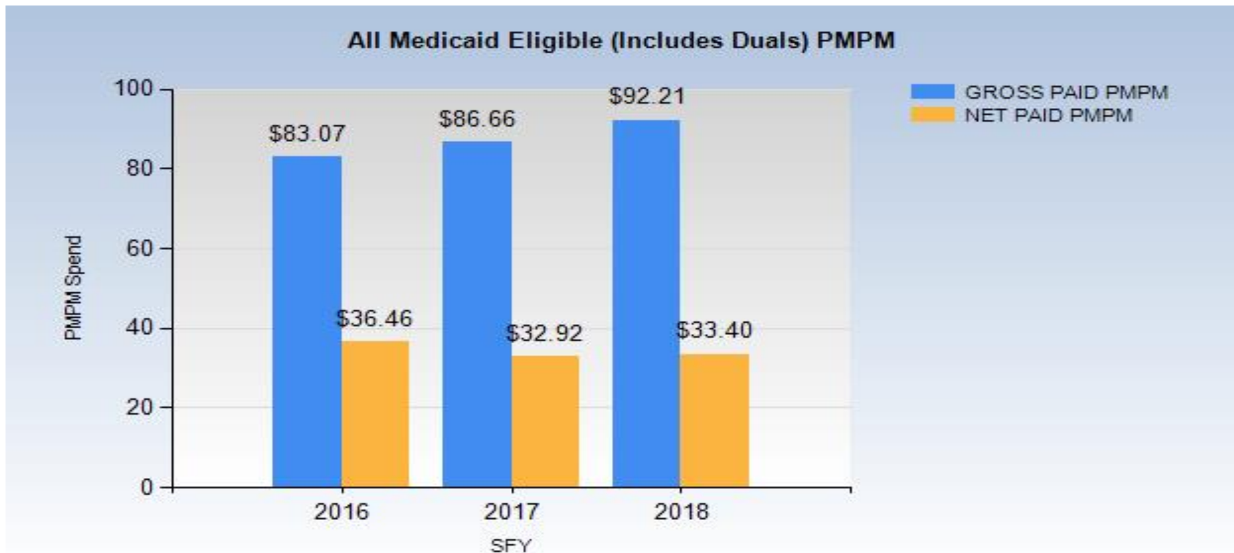


PRICING SOURCE CODE	2016	2017	2018
EAC	28%	21%	1%
FUL	22%	20%	0%
Gross Amount	1%	1%	3%
MAC	38%	36%	41%
NADAC	0%	10%	34%
Sub	0%	0%	0%
U&C	10%	10%	15%
WAC	0%	1%	6%

Charts #6A: Gross and Net PMPM Trending by SFY



Charts #6B: Gross Spend SFY 2016 – 2018



Charts #7: Gross Cost per Claim SFY 2016 – 2018

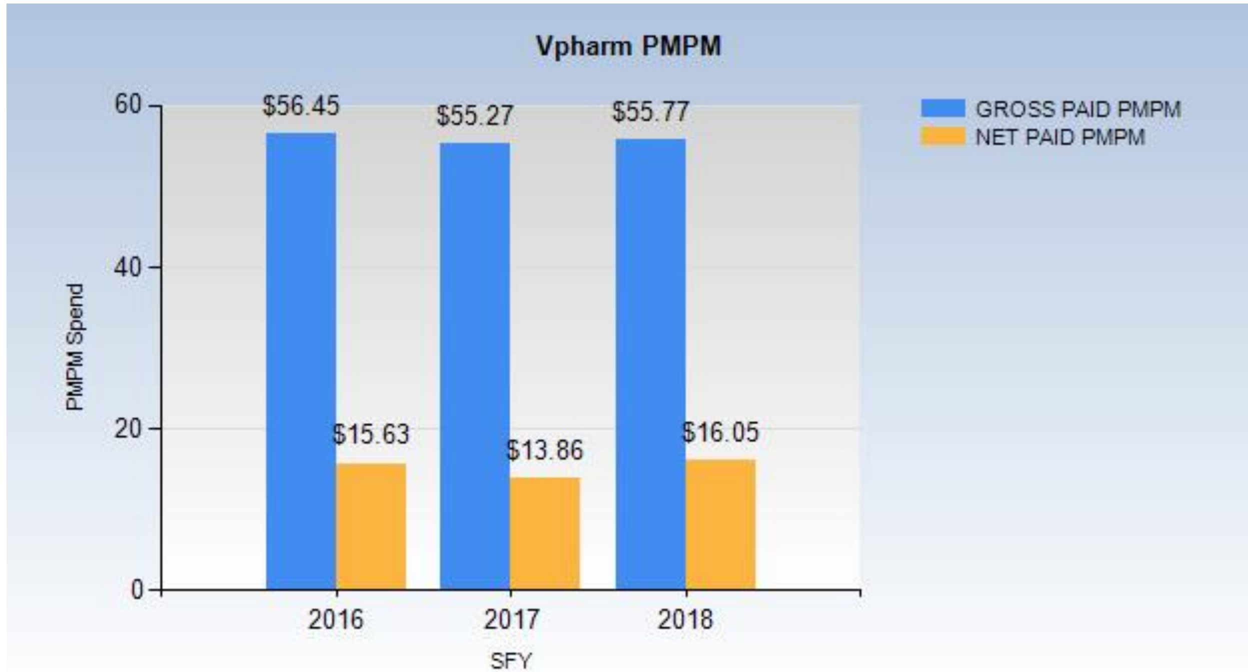


Chart #8: Top Therapeutic Classes by Gross Spend

Current Rank	Previous Rank	Drug Name	2017 Gross Paid	2018 Gross Paid	2017 Claim Count	2018 Claim Count	Total Amount Paid Change	Claim Count Paid
1	1	Opioid Partial Agonist	$12,038,870.18	$14,060,281.05	115,966	125,547	16.79%	8.26%
2	5	Hepatitis Agents	$10,163,836.97	$11,938,034.43	528	872	17.46%	65.15%
3	2	Insulin	$11,902,281.44	$11,838,769.70	15,554	15,508	-0.53%	-0.30%
4	4	Amphetamines	$11,211,854.03	$11,646,725.94	53,916	55,248	3.88%	2.47%
5	3	Stimulants – Misc.	$11,215,354.46	$10,560,261.27	49,171	49,860	-5.84%	1.40%
6	6	Sympathomimetics	$9,955,629.22	$10,192,620.08	66,520	65,739	2.38%	-1.17%
7	8	Anti-TNF-Alpha-Monoclonal Antibodies	$6,500,330.73	$9,174,851.15	1,375	1,737	41.14%	26.33%
8	7	Anticonvulsants-Misc.	$6,504,560.05	$7,102,910.87	67,974	68,918	9.20%	1.39%
9	9	Antiretrovirals	$4,881,763.74	$5,140,765.56	2,580	2,627	5.31%	1.82%
10	10	Cystic Fibrosis	$4,474,383.02	$4,735,130.36	568	561	5.83%	-1.23%

Chart#9: Top Drugs by Gross Spend

Current Rank	Previous Rank	Drug Name	2017 Gross Paid	2018 Gross Paid	2017 Claim Count	2018 Claim Count	Total Amount Paid Change	Claim Count Change
1	1	Suboxone	$11,194,619.81	$13,299,665.84	98,204	108,600	18.80%	10.59%
2	5	Humira Pen	$5,129,291.03	$7,908,683.77	1,105	1,503	54.19%	36.02%
3	3	Vyvanse	$5,904,769.94	$6,597,801.73	23,624	25,007	11.74%	5.85%
4	4	Methylphenidate HCl	$5,728,086.69	$5,356,793.96	36,413	35,820	-6.48%	-1.63%
5	17	Epclusa	$2,292,252.36	$5,001,738.40	123	286	118.20%	132.52%
6	6	Adderall XR	$4,749,045.87	$4,527,957.89	17,292	16,747	-4.66%	-3.15%
7	8	Lyrica	$3,531,328.64	$4,113,534.19	7,137	7,485	16.49%	4.88%
8	7	Lantus Solostar	$3,726,523.68	$3,762,338.27	6,024	6,118	0.96%	1.56%
9	2	Harvoni	$7,292,327.30	$3,657,473.50	310	164	-49.84%	-47.10%
10	10	Focalin XR	$2,932,161.47	$3,325,175.36	7,735	8,573	13.40%	10.83%

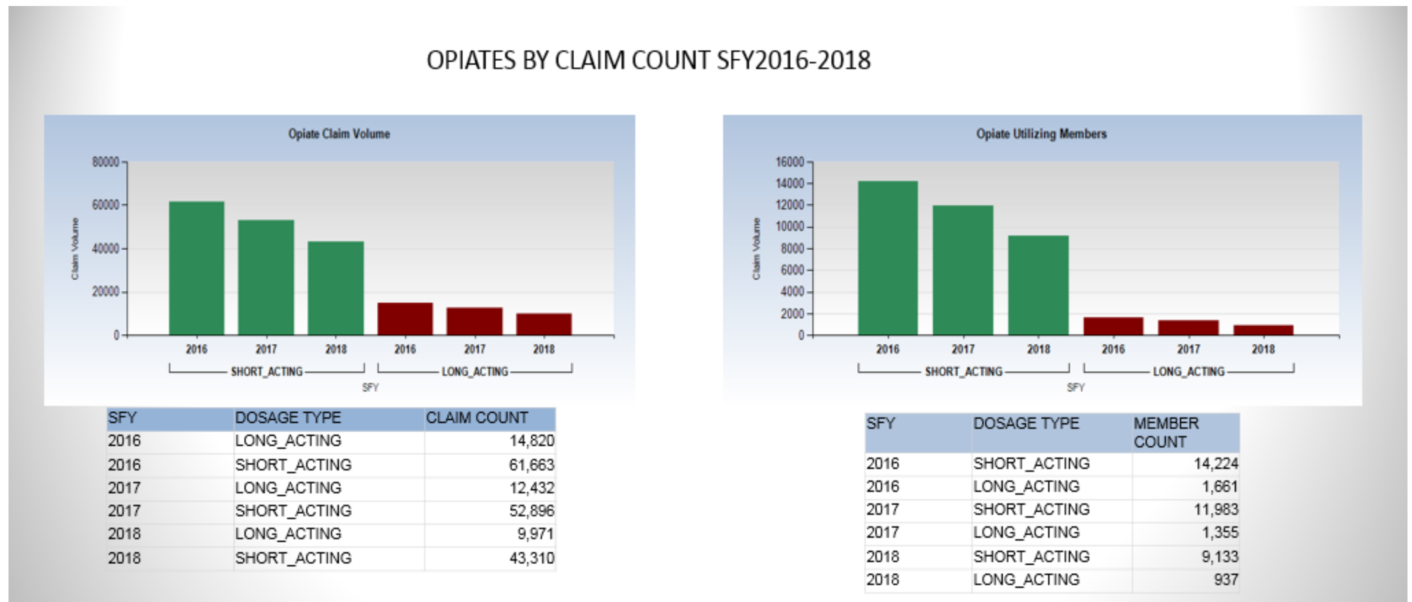
CHART # 10: Top Therapeutic Classes by Utilization

Current Rank	Previous Rank	Drug Name	2017 GROSS PAID	2018 GROSS PAID	2017 RX Count	2018 RX Count	GROSS PAID CHANGE	CLAIM COUNT CHANGE
1	1	Opioid Partial Agonists	$12,038,870.18	$14,060,281.05	115,966	125,547	16.79%	8.26%
2	2	Selective Serotonin Reuptake Inhibitors (SSRS)	$1,185,849.10	$1,318,956.64	88,358	87,208	11.22%	-1.30%
3	3	Anticonvulsants-Misc.	$6,504,560.05	$7,102,910.87	67,974	68,918	9.20%	1.39%
4	4	Sympathomimetics	$9,955,629.22	$10,192,620.08	66,520	65,739	2.38%	-1.17%
5	5	Amphetamines	$11,211,854.03	$11,646,725.94	53,916	55,248	3.88%	2.47%
6	7	Stimulants – Misc.	$11,215,354.46	$10,560,261.27	49,171	49,860	-5.84%	1.40%
7	6	Opioid Agonists	$2,431,410.26	$2,063,740.38	53,326	42,806	-15.12%	-19.73%
8	8	Nonsteroidal Anti-Inflammatory Agents (NSAIDS)	$644,219.60	$672,125.55	41,756	39,534	4.33%	-5.32%
9	9	Antihistamines-Non-Sedating	$407,216.44	$469,608.41	37,644	37,199	15.32%	-1.18%
10	10	Proton Pump Inhibitors	$2,915,044.95	$2,412,604.21	37,108	35,240	-17.24%	-5.03%

CHART #11: Top Drugs by Utilization

Current Rank	Previous Rank	Drug Name	2017 GROSS PAID	2018 GROSS PAID	2017 Rx Count	2018 Rx Count	GROSS PAID CHANGE	CLAIM COUNT CHANGE
1	1	Suboxone	$11,194,619.81	$13,299,665.84	98,204	108,600	18.80%	10.59%
2	2	Proair HFA	$2,818,110.06	$3,044,148.42	39,523	39,291	8.02%	-0.59%
3	3	Methylphenidate HCL	$5,728,086.69	$5,356,793.96	36,413	35,820	-6.48%	-1.63%
4	4	Gabapentin	$457,227.50	$531,295.78	30,132	30,834	16.20%	2.33%
5	5	Sertraline HCL	$290,370.22	$352,269.24	29,307	29,279	21.32%	-0.10%
6	6	Fluoxetine HCL	$244,960.75	$292,410.18	25,486	25,506	19.37%	0.08%
7	7	Vyvanse	$5,904,769.94	$6,597,801.73	23,624	25,007	11.74%	5.85%
8	9	Amoxicillin	$223,374.82	$286,588.67	22,600	23,627	28.30%	4.54%
9	8	Omeprazole	$275,942.24	$313,122.65	22,845	21,876	13.47%	-4.24%
10	10	Clonazepam	$144,919.23	$205,579.95	21,721	19,107	41.86%	-12.03%

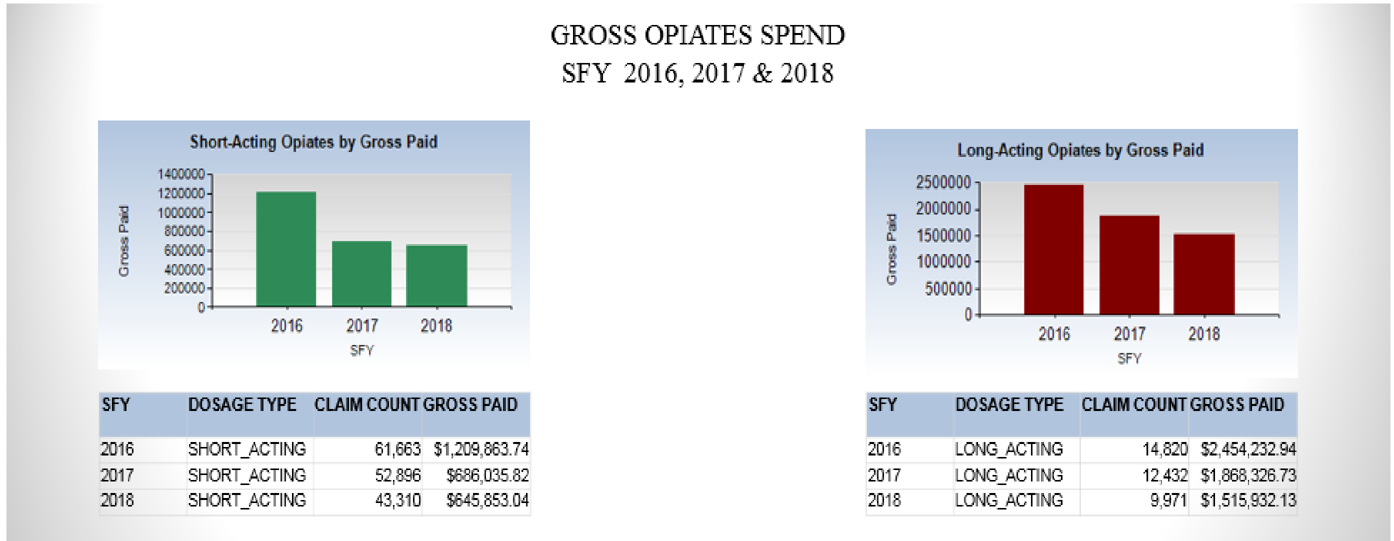
CHART #12A: Opiate Utilization SFY2016-2018



SFY	DOSAGE TYPE	CLAIM COUNT
2016	LONG_ACTING	14,820
2016	SHORT_ACTING	61,663
2017	LONG_ACTING	12,432
2017	SHORT_ACTING	52,896
2018	LONG_ACTING	9,971
2018	SHORT_ACTING	43,310

SFY	DOSAGE TYPE	MEMBER COUNT
2016	SHORT_ACTING	14,224
2016	LONG_ACTING	1,661
2017	SHORT_ACTING	11,983
2017	LONG_ACTING	1,355
2018	SHORT_ACTING	9,133
2018	LONG_ACTING	937

CHART #12B: Opiate Spend-Gross SFY2016-2018



SFY	DOSAGE TYPE	CLAIM COUNT	GROSS PAID
2016	SHORT_ACTING	61,663	$1,209,863.74
2017	SHORT_ACTING	52,896	$686,035.82
2018	SHORT_ACTING	43,310	$645,853.04

SFY	DOSAGE TYPE	CLAIM COUNT	GROSS PAID
2016	LONG_ACTING	14,820	$2,454,232.94
2017	LONG_ACTING	12,432	$1,868,326.73
2018	LONG_ACTING	9,971	$1,515,932.13

CHART # 13: Specialty Drugs as a Percent of Total Drug Cost

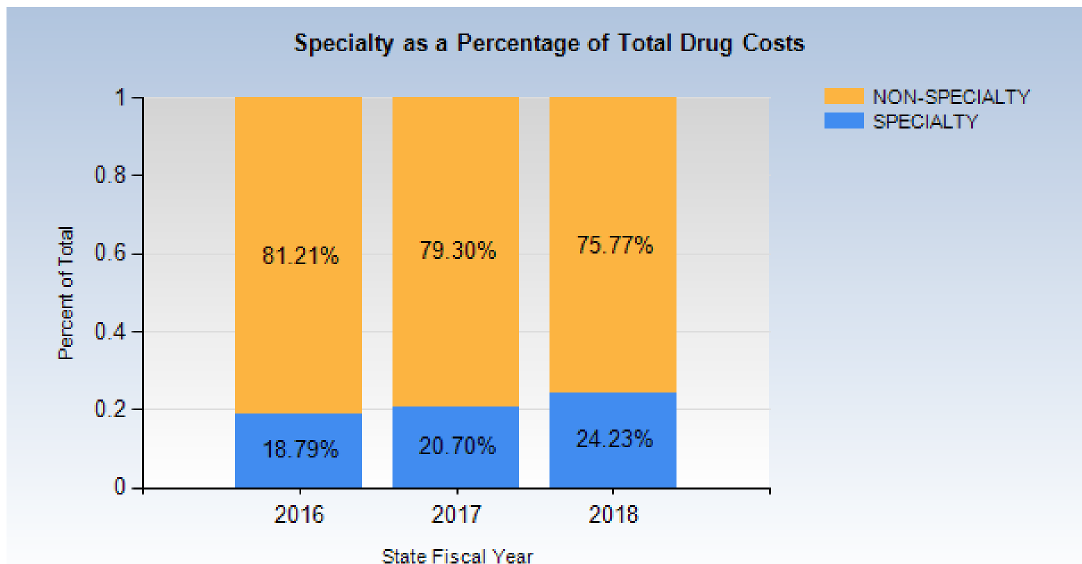


CHART # 14: Specialty Paid

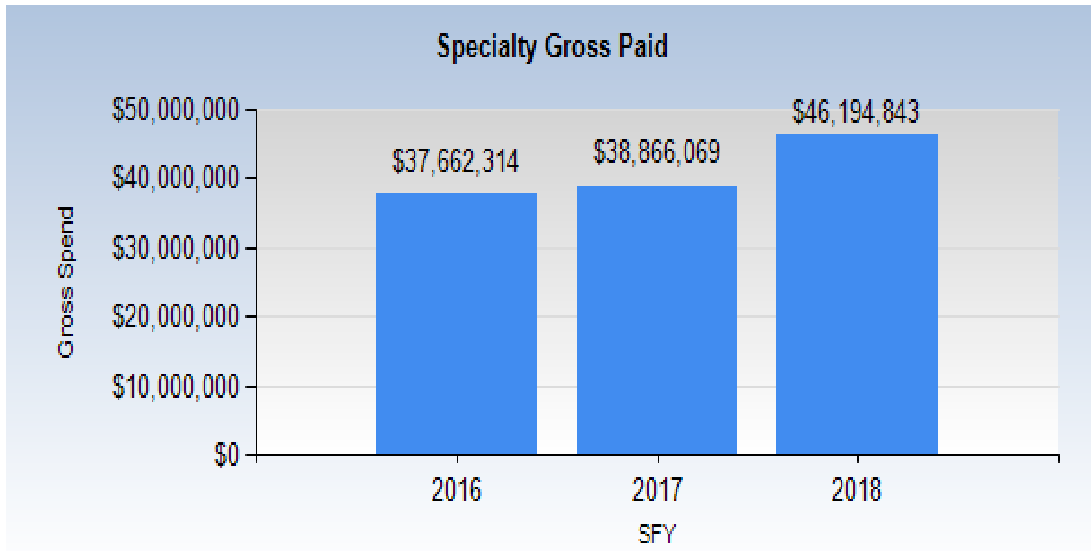


Chart # 15: Specialty Paid Per Prescription

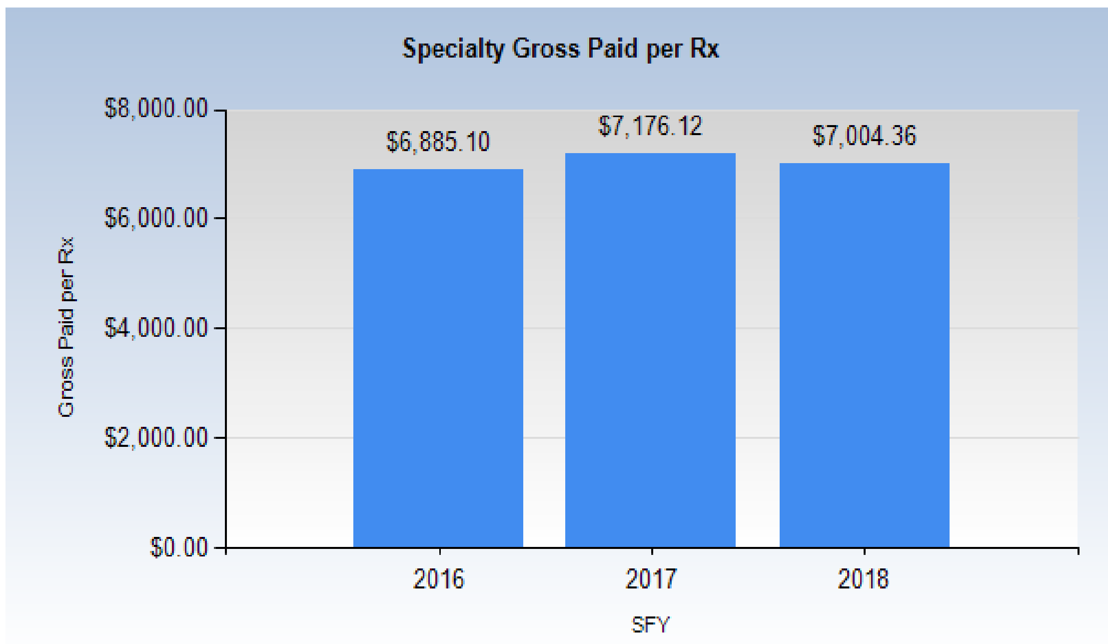


Chart #16: Top 10 Cancer Drugs by Gross Spend

Drugs Used to Treat Cancer									
PRODUCT NAME	**2017 RX Count**	**2018 RX Count**	**CLAIM COUNT CHANGE**	**2017 DISTINCT MEMBERS**	**2018 DISTINCT MEMBERS**	**DISTINCT MEMBER CHANGE**	**2017 GROSS PAID**	**2018 GROSS PAID**	**GROSS PAID CHANGE**
METHOTREXATE	1,610	1,527	-5.16%	394	354	-10.15%	$77,984	$66,305	-14.98%
TAMOXIFEN CITRATE	302	271	-10.26%	99	86	-13.13%	$8,887	$9,176	3.25%
MERCAPTOPURINE	243	234	-3.70%	39	39		$15,469	$11,565	-25.24%
LEUCOVORIN CALCIUM	203	204	0.49%	40	45	12.50%	$8,777	$6,872	-21.70%
ANASTROZOLE	188	196	4.26%	63	56	-11.11%	$2,763	$3,142	13.73%
METHOTREXATE SODIUM	161	145	-9.94%	47	48	2.13%	$3,980	$3,601	-9.53%
LETROZOLE	144	135	-6.25%	56	53	-5.36%	$2,187	$2,021	-7.59%
CAPECITABINE	100	134	34.00%	28	27	-3.57%	$142,762	$55,752	-60.95%
HYDROXYUREA	97	110	13.40%	19	20	5.26%	$1,996	$2,292	14.86%
MEGESTROL ACETATE	89	71	-20.22%	24	20	-16.67%	$2,524	$1,702	-32.57%
GRAND TOTALS	**3,137**	**3,027**		**809**	**748**		**$267,329**	**$162,429**	

Chart #17: Hepatitis C DAA Drugs

Drug name	2017 RX Count	2018 RX Count	% Change	2017 Unique Members	2018 Unique Members	% Change	2017 Total Paid	2018 Total Paid	% Change
Epclusa	123	286	132.5%	33	82	148.48%	$2,292,252	$5,001,738	118.2%
Harvoni	310	164	-47.1%	94	51	-45.74%	$7,292,327	$3,657,474	-49.8%
Mavyret	0	318		0	123		$0	$2,750,062	
Zepatier	0	19		0	6		$0	$257,767	
Vosevi	0	14		0	4		$0	$249,396	
Ribavirin	24	9	-62.5%	8	5	-37.50%	$2,375	$865	-63.6%
Totals:	**457**	**810**	**77.24%**	**135**	**271**	**100.74%**	**9,586,955**	**11,917,302**	**24.31%**

CHART # 18: Rebates Invoiced: All Programs

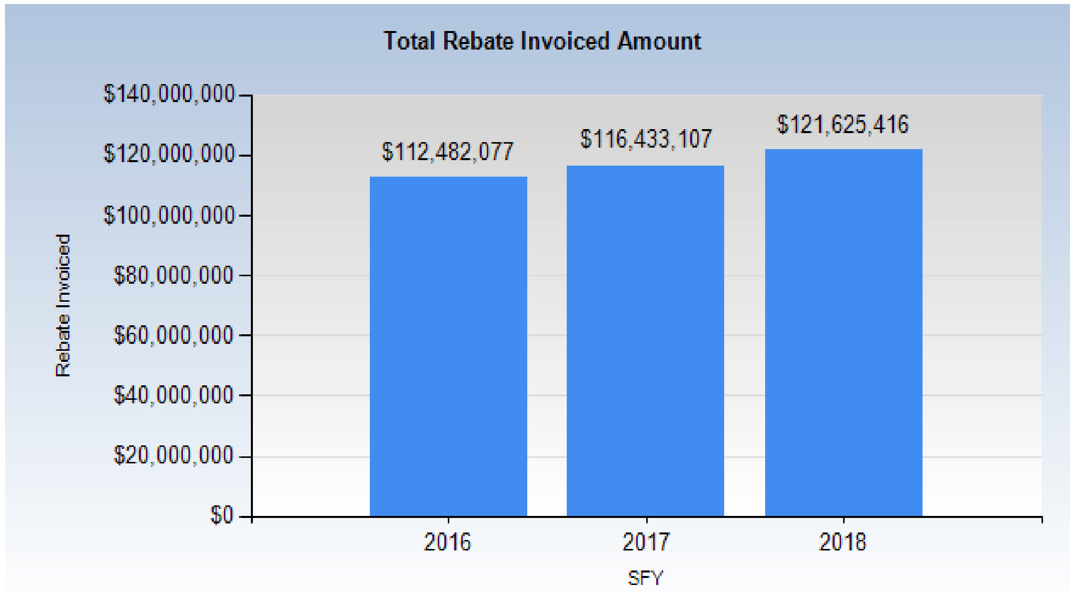


CHART # 19: Rebates as a Percent of Spend: All Programs

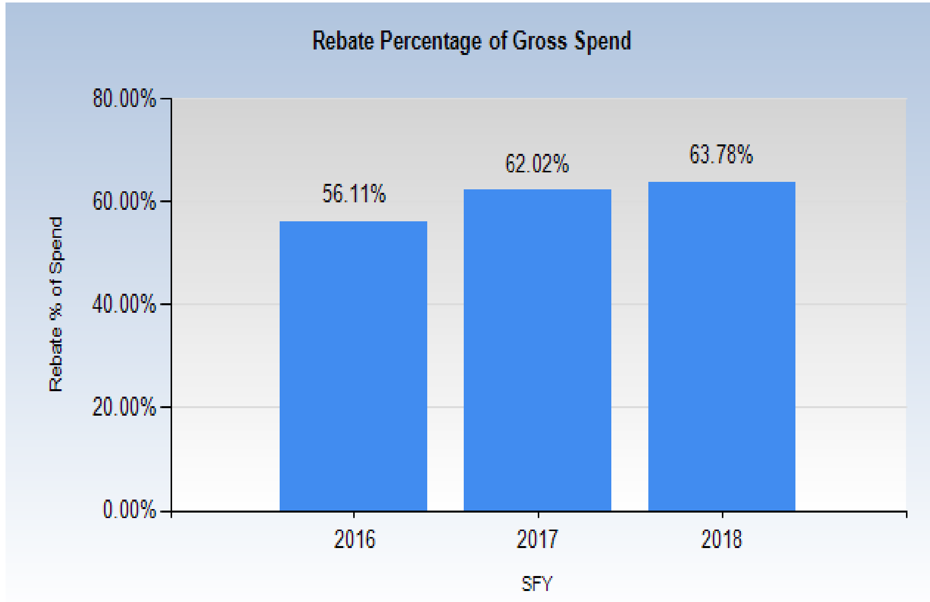


CHART # 20: Federal Rebates Invoiced (SFY2016-2018)

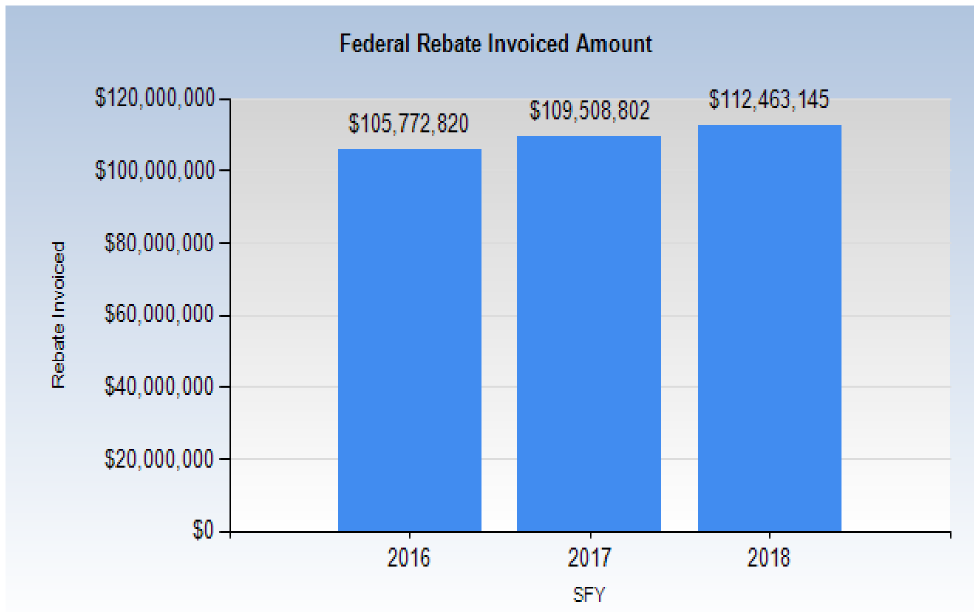
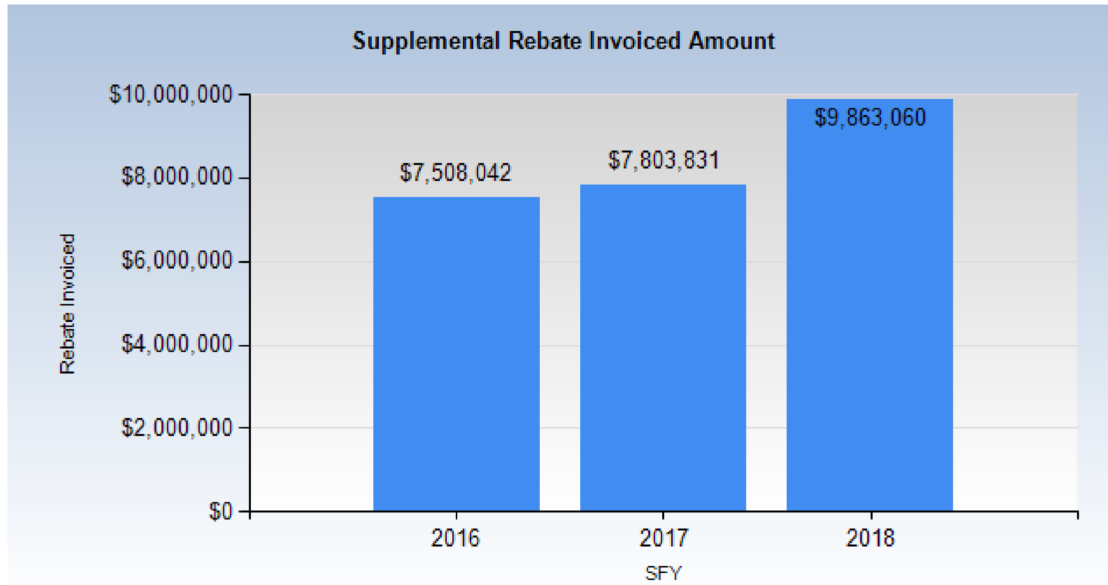


CHART #21: Total Supplemental Rebates Invoiced (SFY 2016-2018)



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