Program Report:

Pharmacy Best Practices and

Cost Control Program

State Fiscal Year 2017

Legislative Report

Pursuant to 33 V.S.A. § 2001(c)

Agency of Human Services

Department of Vermont Health Access

Pharmacy Unit

Prepared by:
Cory Gustafson, Commissioner
Nancy J. Hogue, BS, Pharm.D., Director of Pharmacy Services
Carrie Germaine, EMT, CPC, Health Programs Administrator

October 30, 2017

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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; a financial summary of current drug spend, gross and net; clinical and cost strategies that DVHA employs to manage drug utilization; and future pharmacy trends.

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 nearly **$194 million** in gross drug spend in **State Fiscal Year (SFY) 2017 (July 1, 2016, through June 30, 2017)**. Gross drug spend reflects what DVHA paid to both in-state and out-of-state pharmacies enrolled in our network. This represented a decrease in gross expenditures of approximately $13 million dollars. Approximately $9 million dollars of this reduction can be attributed to decreases in Medicaid enrollment, while $4 million can be attributed to improved pharmacy

management and cost control programs. Overall, there was a 1% decrease in gross cost per prescription.

Chart #1: Gross Pharmacy Claims and Spend, SFY 2015-2017

(All Programs, prior to application of rebates)

ALL PHARMACY CLAIMS					
SFY	CLAIM_COUNT	GROSS_AMOUNT_PAID	GROSS_AMT PAID_% CHG	GROSS_COST_PER_CLAIM	GROSS_CPC_% CHG
2017	2,110,704	$ 193,945,217.63	-6.29%	$ 91.89	-1.08%
2016	2,228,000	$ 206,953,924.29	10.15%	$ 92.89	4.69%
2015	2,117,531	$ 187,883,405.16		$ 88.73	

*A detailed breakout by program appears on Page 24

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

Pharmacy Benefit Administration

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 2017, 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, Preferred Drug List management, retrospective and prospective drug utilization review, and drug rebate processing. On behalf of DVHA, it operates a call center in South Burlington, Vermont, servicing DVHA providers and staffed by Vermont pharmacists and pharmacy technicians. This 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
- Claims processing services
    - Point-of-Service claims processing platform
    - Help Desk provider support
- Clinical pharmacy management services
    - Drug Utilization Review Board (DURB) support
    - Preferred Drug List (PDL) management
    - Drug utilization review (DUR) activities
    - Prior Authorization (PA) programs
        - Clinical review and processing of Prior Authorizations (PA)
        - Help Desk provider support
        - Quality improvement
            - Automated PA
            - Electronic submission
            - EMR-PA (2018)
- 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

- Pharmacy Cost Management (PCM) Program
- Provider Portal (4th Q 2017)
- E-prescribing interface (1st Q 2018)

Pharmacy Cost Management (PCM) Program

In late SFY 2017, DVHA, in collaboration with CHC, 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.

Patient Identification: 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 which is the number of dispensed medication doses divided by the number of days in a unit of time (e.g., 1 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 best clinical outcome.

Outcomes:

Through appropriate utilization of high cost pharmaceuticals, 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 pharmaceutical expenditures, significant value is achieved through reduced utilization of medical services (hospitalization, provider visits, ancillary services) and, of course, improvement in clinical outcomes and patients' qualify of life.

In other states where the PCM program is utilized, it has demonstrated a significant reduction in total spending for all medical services, including hospital admission rates, total spending for hospital inpatient services, and emergency room utilization, including spending for ER services. We will have Vermont specific data regarding these measures in SFY2018.

Provider Portal

A new provider portal is being launched in December 2017, allowing pharmacists and prescribers access to a secure, web-based application that offers features such as a pharmacy and member eligibility and drug queries, electronic submission of prior authorizations (PA), uploading of clinical documentation into a document management system, and status updates for submitted PA requests. Training is scheduled to begin in November with a full rollout in December 2017.

The Pharmacy Unit and CHC routinely collaborate to analyze national and DVHA drug trends, review drug utilization and seek innovative solutions to delivering high-quality customer service. This assures optimal drug therapy for DVHA members, while managing drug utilization and cost.

Drug Benefit Program Designs

For the DVHA programs that include full health insurance coverage, all included a pharmacy benefit in SFY 2017. These programs are described below and on the following page:

Overview of Green Mountain Care and Vermont Health Connect Programs as of 1/3/17 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. • $3.30 -$8.25 co-pays if have Part D. (if beneficiary is under 100% FPL $1.20 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: $50/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. MABD is the only program w/ resource limits: $2000/person, $3000/couple (Medicaid for the Working Disabled is $5000/person, $6000/couple). Long Term Care Medicaid (nursing home care; waiver services) is not included in this chart.
[1] MCA: Medicaid for Children and Adults PIL: Protected Income Limit. FPL: Federal Poverty Level

(Vermont Legal Aid's Office of Health Care Advocate, 2016)

The chart below identifies how many eligible members utilize the pharmacy benefit based on a monthly average. Approximately 35% of adults and 21% of children utilize the drug benefit on average each month.

Chart #2: Pharmacy Services: Utilizing Members

Member Type	2015	2016	2017
Medicaid and Duals Eligible - All	153,143	191,823	173,551
Medicaid and Duals Utilizers - All	52,862	56,116	51,944
% Utilizing Members	35%	29%	30%
ADULTS			
Medicaid and Duals Eligible - Adult	97,971	123,280	108,323
Medicaid and Duals Utilizers - Adult	38,414	41,566	38,160
% Utilizing Members	39%	34%	35%
CHILDREN			
Medicaid and Duals Eligible - Children	55,171	68,542	65,229
Medicaid and Duals Utilizers - Children	14,459	14,563	13,797
% Utilizing Members	26%	21%	21%

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

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

DVHA's Preferred Drug List (PDL) includes a list of preferred and non-preferred drugs that are covered by DVHA's drug benefit programs. Currently, DVHA's PDL manages over 180 different therapeutic categories representing thousands of drugs. The PDL is designed to reduce the cost of providing prescription drugs and is one of the most effective tools used 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**
    - Approximately 79% of DVHA's overall drug use is generic drugs, leaving 21% brand drug use based on volume.
    - Nearly all generics are preferred, with some exceptions where the net cost of the brand drug is lower.
    - Most generics do not require PA.

- **Preferred Brand Drugs:**

- Represent 74% of the 21% of DVHA's brand-drug utilization. This represents an increase of 8.5% from last year.
- 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 pay Vermont 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:**
  - Represent approximately 26% of brand drug utilization (see chart below).
  - 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 that makes the net cost of the drug higher compared to other products in the drug's therapeutic class; and the manufacturer does not offer rebates supplemental to the required federal rebates.
  - All require prior authorization.

Within these categories, there may be drugs or even drug classes that are subject to Quantity Limit parameters to assure appropriate dosing and dose consolidation.

Preferred Drug List Compliance

The following charts display the percentage of time a preferred brand or generic drug is used, as compared to a non-preferred product.

Chart #3: Preferred Drug List Compliance for Generic Drugs

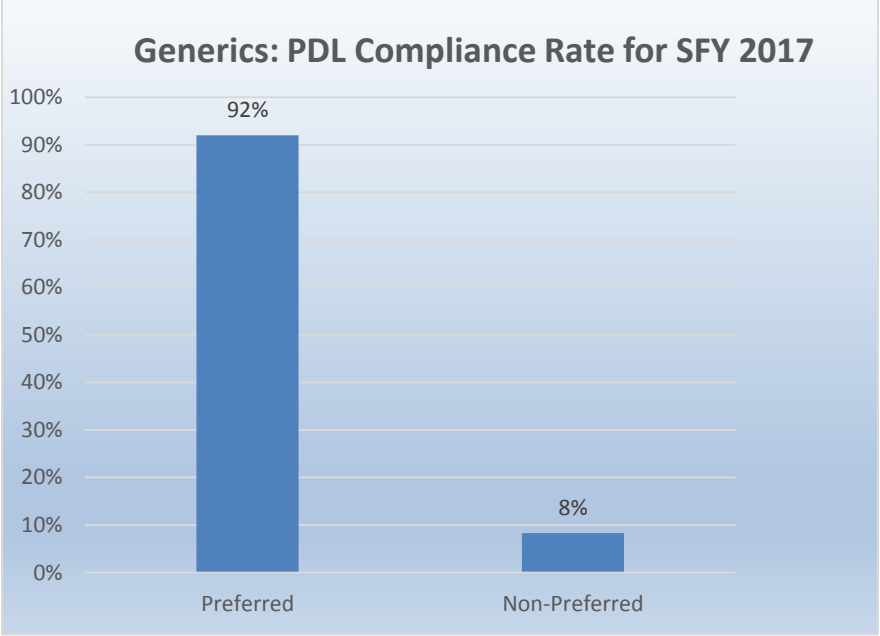
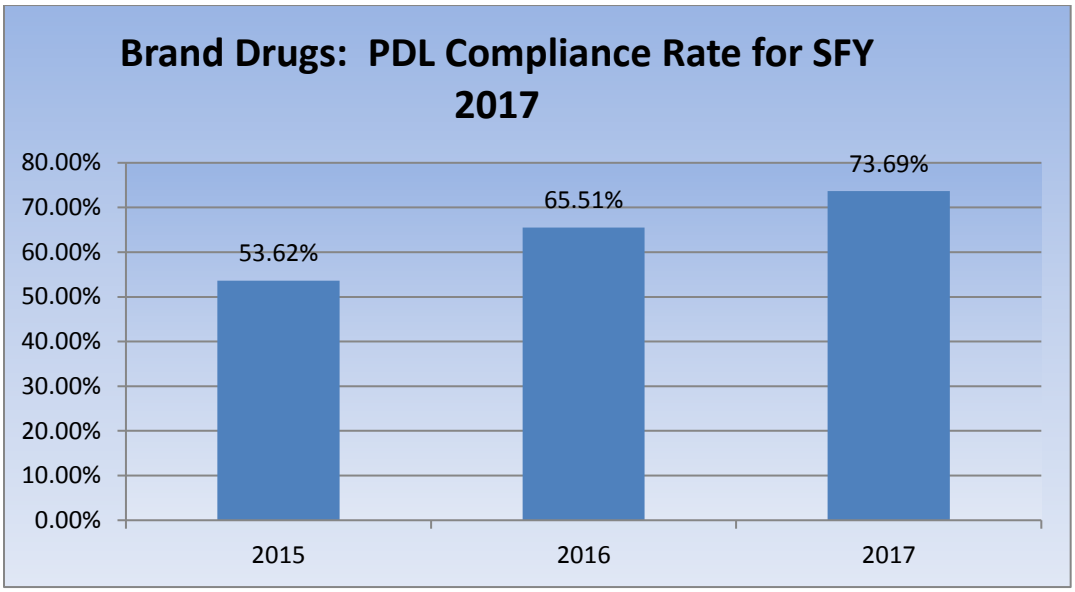


Chart #4: Preferred Drug List Compliance for Brand Drugs



Generic Dispensing Rates

The rate of **generic dispensing** reflects the use of generics as a percentage of all drugs dispensed whereas the rate of **generic substitution** reflects the percentage of time generics are utilized when a generic equivalent is available for a drug. The following chart identifies these rates of dispensing for state fiscal years 2015 through 2017. 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.

The generic substitution rate has gradually improved from 88% to 92%. This was a result of moving a number of drugs from "brand-preferred" to "generic-preferred" due to reductions in those generic drugs' net costs.

Chart #5: Generic Usage Rate (SFY 2015-2017)

Generic Indicator	**2015**	**2016**	**2017**
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%**	**90%**	**92%**

Drug Utilization Review (DUR) Board

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 includes five physicians, one nurse practitioner and five 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. The chart below lists some of the SFY2017 activities of the DUR Board:

Review Topic	SFY 2017 Total
Therapeutic Drug Classes-Periodic Review	53
Full New Drug Reviews	50
FDA Safety Alerts	32
New/Updated Clinical Guidelines	27
RetroDur/Prior Authorization Quality Asurance Analysis	16
New Managed Therapeutic Drug Classes	2
Abbreviated New Drug Review	1

Some topics of discussion at the DUR Board meeting in SFY 2017 included opiate dependence agents, immunologic therapies for asthma, benign prostatic hypertrophy agents and growth hormones. Topics also included drug utilization reviews of antifungals; antivirals; anti-parasitic topical and oral agents; bone resorption suppression and related agents; hypoglycemics (incretin mimetics/enhancers, insulins, meglitinides and TZD's); along with bile salts and biliary agents.

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 statements and website postings. In SFY 2018, the provider portal will offer an excellent option for direct provider communication.

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.

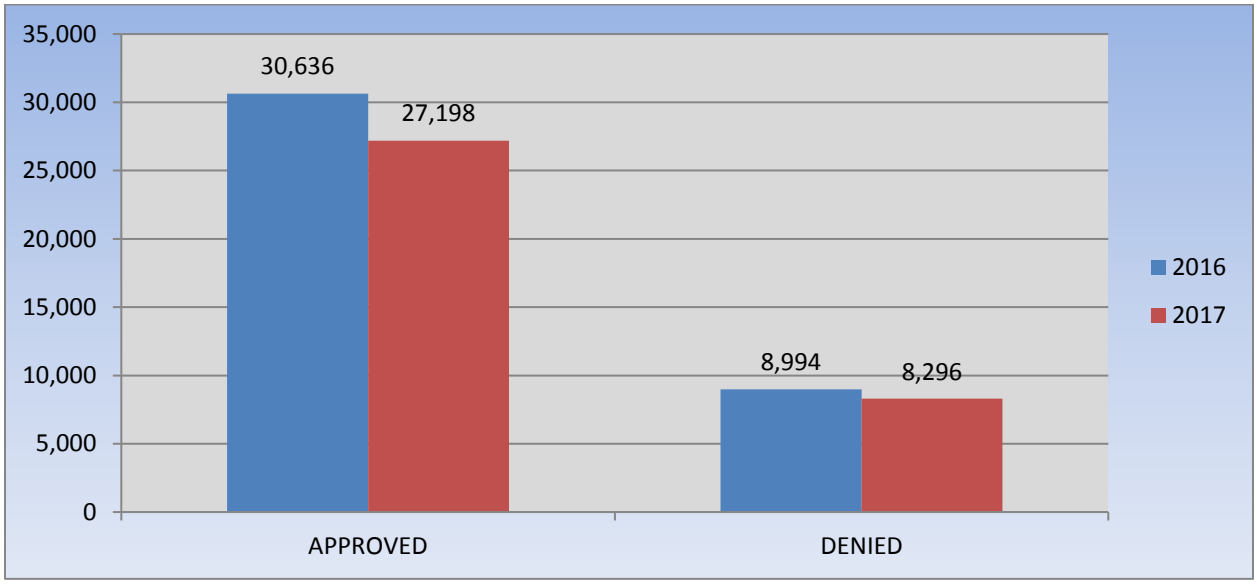
To reduce provider burden, the Department of Vermont Health Access (DVHA) implemented an automated prior authorization (PA) program for drugs which has

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.

The following charts reports the incidence of prior authorization requests and denial rates for SFY 2017:

Chart #6: Prior Authorizations for SFY 2017



SFY	PA Denial Rate %
2016	20.9%
2017	19.7%

Pharmacy Reimbursement Changes for SFY 2017

In SFY2017, State Medicaid agencies were directed by the federal Centers for Medicare and Medicaid Services (CMS) to adopt fee-for service pharmacy payment policies designed to pay pharmacies for the actual acquisition cost of drugs plus a reasonable professional dispensing fee, based on the actual cost to the pharmacy of dispensing drugs to Medicaid members. (Centers for Medicare and Medicaid Services, 2016)

As part of this directive, beginning in September 2016, DVHA invited all Medicaid enrolled pharmacies to participate in a pharmacy cost-of-dispensing survey that was designed to analyze the cost of dispensing prescription medications to Vermont Medicaid members. DVHA partnered with the New England States Consortium Systems Organization (NESCSO) and the accounting firm of Myers and Stauffer LC, a reputable firm with extensive experience in pharmacy costs and reimbursement. That survey can be found on the following link: http://dvha.vermont.gov/for-providers/pharmacy

Based on the results of this survey, Vermont determined that the new "Professional Dispensing Fee" for retail community pharmacies, institutional or long-term care pharmacies, and non-FQHC 340B pharmacies is $11.13, and for specialty pharmacies, the dispensing fee is $17.03. The dispensing fee was adjusted accordingly from $4.75 (in-state) and $2.50 (out-of-state) on April 1, 2017.

In addition, the Department of Vermont Health Access (DVHA) conducted extensive analysis to determine the ingredient cost benchmarks needed to more accurately reflect actual pharmacy acquisition cost for ingredient cost reimbursement. DVHA now uses a "lower-of" methodology utilizing the benchmark of National Average Drug Acquisition Cost (NADAC) in place of the previous methodology. The NADAC is based on the Centers for Medicare and Medicaid Services' (CMS) monthly surveys of retail pharmacies to determine average acquisition cost for covered outpatient drugs. This additional federal pricing source is updated by DVHA each month upon being published by CMS. Beginning on April 1, 2017, CHC implemented the first of the monthly updated NADAC prices and incorporated those into the "lower-of logic" when calculating the reimbursement, consistent with the pharmacy pricing reimbursement policy. Payment of covered outpatient drugs, including over-the-counter drugs, dispensed by an enrolled pharmacy, includes the reimbursement for the Actual Acquisition Cost (AAC) of the drug plus a professional dispensing fee.

AAC is defined as the lower of:

a. The National Drug Average Acquisition Cost (NADAC);

b. The Wholesale Acquisition Cost (WAC) + 0%;

c. The State Maximum Allowable Cost (SMAC);

d. The Federal Upper Limit (FUL)

e. AWP-19%;

f. Submitted Ingredient Cost;

g. The provider's Usual and Customary (U&C) charges; or

h. The Gross Amount Due (GAD)

Based on extensive analysis of DVHA's claims, this change was expected to be largely cost-neutral to total drug reimbursement, creating an overall reduction of one-half of one percent (0.5%) in reimbursement to all pharmacies. A 3-month post-NADAC analysis found that, in fact, the overall reimbursement to all pharmacies rose by 3.3%. DVHA will continue to monitor the impact of the reimbursement change.

DRUG_TYPE	CLAIM_COUNT	INGREDIENT_COST_PAID	DISPENSING_FEE_PAID	TOTAL_AMOUNT_PAID
PRE_NADAC	444,299	$ 46,309,131.96	$ 1,831,900.00	$ 47,213,669.45
POST_NADAC	441,109	$ 46,431,134.24	$ 3,739,150.87	$ 48,794,476.98
% CHANGE		0.3%	104.1%	3.3%

Additional details on these changes can be found on the CMS Fact Sheet at this link: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-21.html. and DVHA's website at http://dvha.vermont.gov/for-providers/2pharmacy-reimbursement-project-frequently-asked-questions-04172017.pdf.

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.

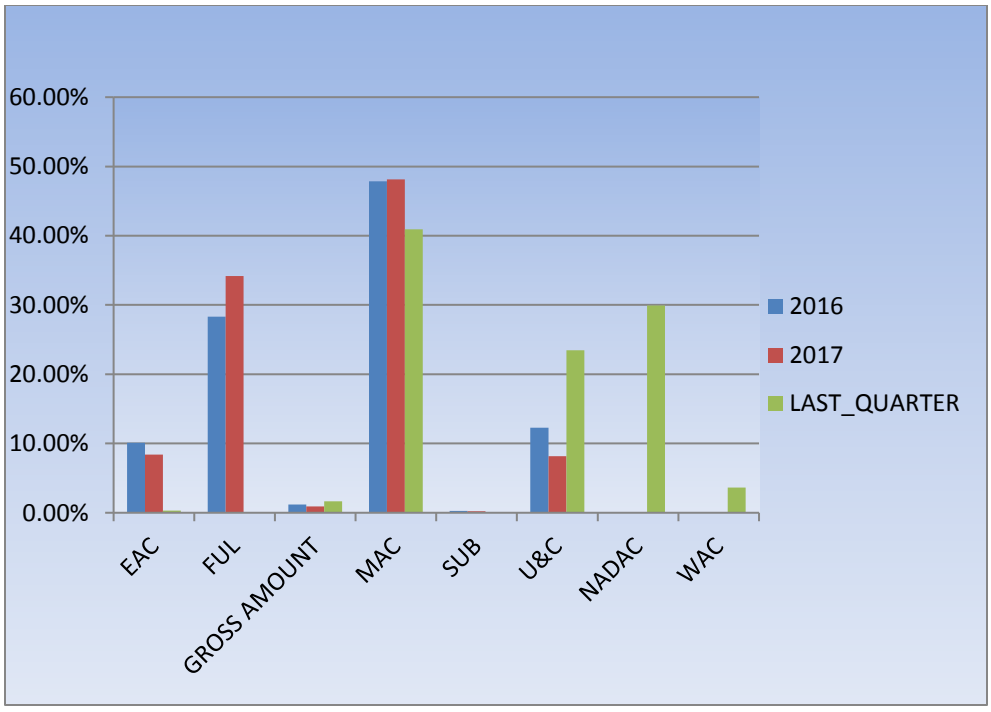
A full review of the SMAC pricing list is performed monthly. These reviews include reviewing any new generics that have entered the market and obtaining acquisition cost to determine if a MAC can be applied or needs to be adjusted on a drug. CHC also monitors changes in product availability and drug 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 available the maximum allowable cost (MAC) listing in a readily accessible format. Vermont's MAC 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 special request form found on the DVHA website. Appeals must be received within 10 calendar days of the claim adjudication date and DVHA responds within 10 calendar days of receipt of a timely appeal request.

The percentage of generic drug claims pricing off SMAC remained relatively stable through the end of the first calendar quarter of 2017, at approximately 48%, as shown in the chart below. However, after the implementation of the new pricing rules based on NADAC on April 1, 2017, the SMAC rate dropped significantly to 40% due to a high percentage of drugs now pricing off the federal NADAC pricing benchmark.

Chart #7: Pricing Source for Generic Drugs



Section IV: Pharmacy Program Statistics

Chart #8: Pharmacy Claims and Gross Spend, SFY 2015-2017

ALL PHARMACY CLAIMS					
SFY	CLAIM_COUNT	GROSS_AMOUNT_PAID	GROSS_AMT_PAID_%_CHG	GROSS_COST_PER_CLAIM	GROSS_CPC_%_CHG
2017	2,110,704	$193,945,217.63	-6.29%	$91.89	-1.08%
2016	2,228,000	$206,953,924.29	10.15%	$92.89	4.69%
2015	2,117,531	$187,883,405.16		$88.73	

MEDICAID CLAIMS (includes Duals)					
SFY	CLAIM_COUNT	GROSS_AMOUNT_PAID	GROSS_AMT_PAID_%_CHG	GROSS_COST_PER_CLAIM	GROSS_CPC_%
2017	1,755,455	$187,795,018.33	-6.32%	$106.98	-1.06%
2016	1,853,942	$200,461,674.08	10.53%	$108.13	3.50%
2015	1,736,085	$181,370,733.40		$104.47	

VPHARM CLAIMS					
SFY	CLAIM_COUNT	GROSS_AMOUNT_PAID	GROSS_AMT_PAID_%_CHG	GROSS_COST_PER_CLAIM	GROSS_CPC_%_CHG
2017	355,249	$6,150,199.30	-5.27%	$17.31	-0.25%
2016	374,058	$6,492,250.21	-0.31%	$17.36	1.66%
2015	381,446	$6,512,671.76		$17.07	

NOTE:

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

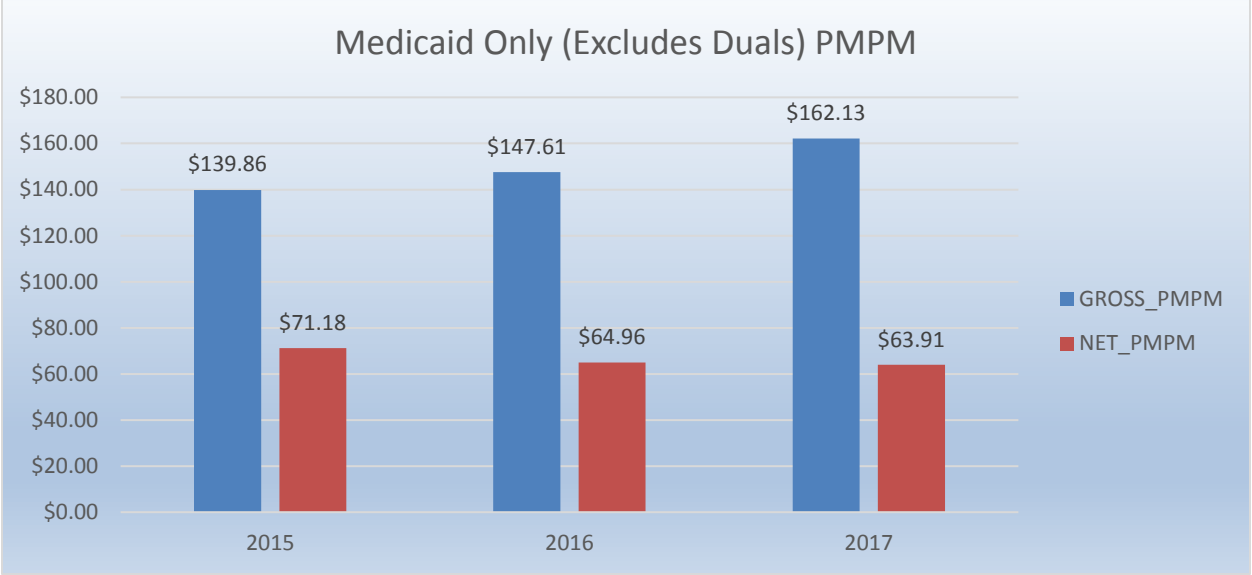
VPharm: DVHA pays secondary to Part D, and for non-Part D drugs, primarily OTC drugs

Chart #9: Pharmacy Claims and Net Spend, SFY 2015-2017 (after application of rebates)

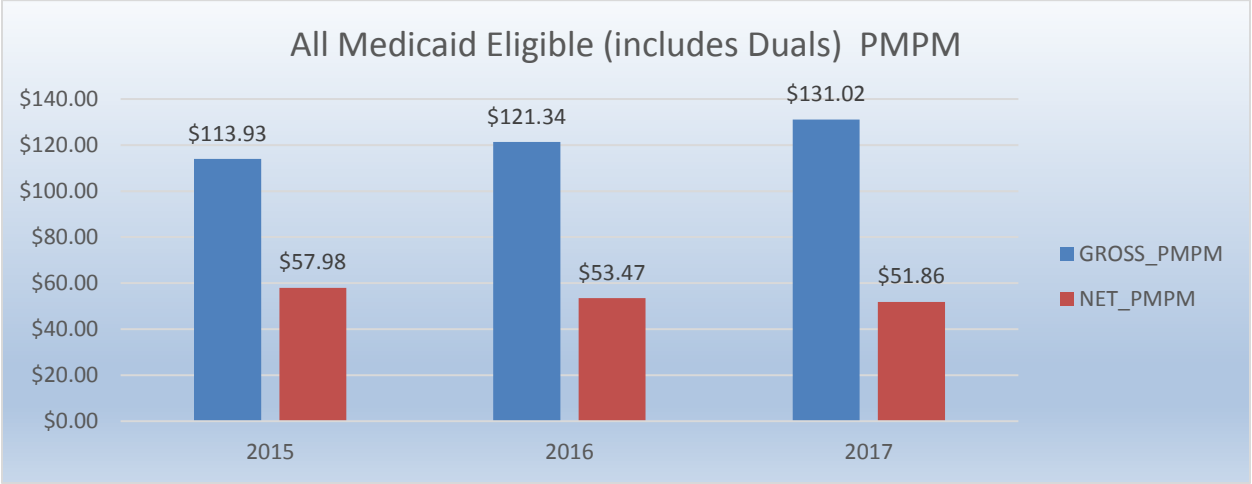
ALL PHARMACY CLAIMS								
SFY	CLAIM_COUNT	GROSS_AMOUNT_PAID	NET_AMOUNT_PAID	NET_PAID_%CHG	TOTAL_MEMBER_MONTHS	MEMBER_MONTHS_%	NET PAID PMPM	NET_PAID_CHG
2017	2,110,704	$193,945,217.63	$ 75,708,249.00	-16.00%	1,546,967	-12.61%	$ 48.94	-4.04%
2016	2,228,000	$206,953,924.29	$ 90,131,521.34	-4.98%	1,770,124	3.34%	$ 50.92	-8.76%
2015	2,117,531	$187,883,405.16	$ 94,857,222.11		1,712,947		$ 55.38	

Net Paid Amount is calculated by subtracting all rebates from the gross paid amount.

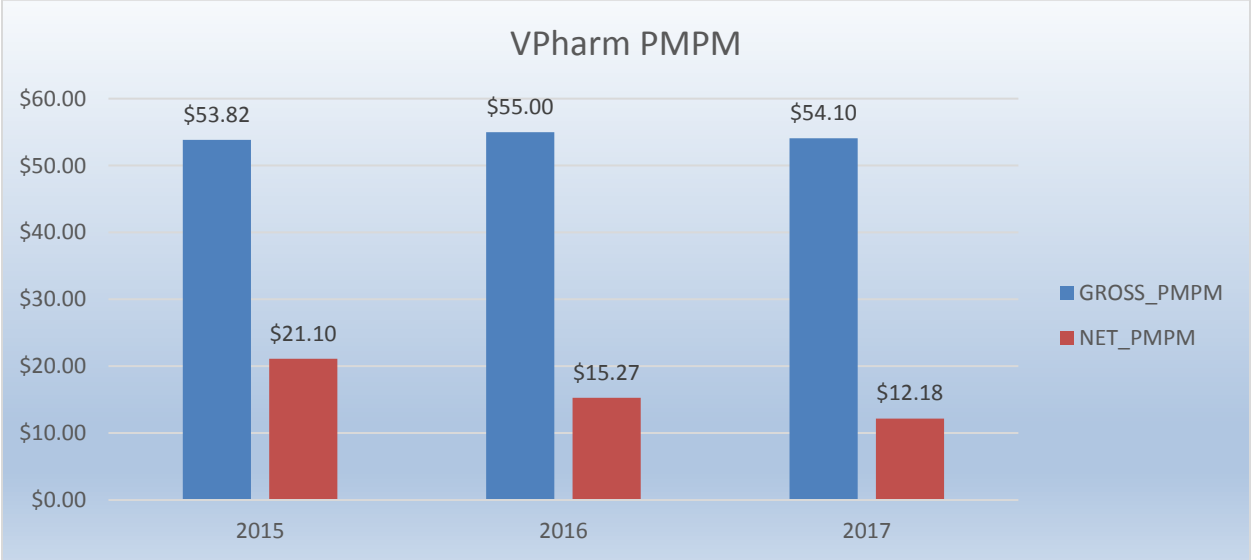
Charts #10A: Gross and Net PMPM Trending by SFY



Charts #10B: Gross PMPM Spend for SFY 2015 – 2017 (Medicaid)



Charts #10C: Gross PMPM Spend for SFY 2015 – 2017 (VPharm)



Top Drugs by Cost and Utilization

This chart illustrates DVHA's top 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.

Chart #11A: Top Therapeutic Categories by Gross Spend

Current Rank	Previous Rank	Drug Name	2016 Gross Paid	2017 Gross Paid	2016 Claim Count	2017 Claim Count	Total Aount Paid Change	Claim Count Change
1	4	Opiod Partial Agonist	$ 11,052,628.98	$ 12,010,471.37	107,174	115,743	8.67%	8.00%
2	1	Insulin	$ 11,821,932.71	$ 11,903,321.73	16,505	15,554	0.69%	-5.76%
3	5	Stimulants - Misc.	$ 10,768,667.69	$ 11,209,192.62	50,719	49,140	4.09%	-3.11%
4	3	Amphetamines	$ 11,116,526.00	$ 11,205,686.81	53,257	53,890	0.80%	1.19%
5	2	Hepatitis Agents	$ 11,290,466.07	$ 10,163,836.97	586	528	-9.98%	-9.90%
6	6	Sympathomimetics	$ 9,999,243.25	$ 9,955,645.98	69,015	66,512	-0.44%	-3.63%
7	7	Anticonvulsants - Misc.	$ 6,895,964.85	$ 6,502,094.50	68,291	67,932	-5.71%	-0.53%
8	10	Anti-TNF-Alpha-Monoclonal Antibodies	$ 4,918,262.60	$ 6,500,330.73	1,284	1,375	32.17%	7.09%
9	9	Antiretrovirals	$ 5,062,948.30	$ 4,888,712.90	2,932	2,582	-3.44%	-11.94%
10	16	Cystic Fibrosis Agents	$ 3,368,576.58	$ 4,480,148.50	554	564	33.00%	1.81%
Totals:			**$ 86,295,217.03**	**$ 88,819,442.11**	**370,317**	**373,820**	**2.84%**	**0.95%**

Chart#11B: Top Drugs by Gross Spend

Current Rank	Previous Rank	Drug Name	2016 Gross Paid	2017 Gross Paid	2016 Claim Count	2017 Claim Count	Total Amount Paid Change	Claim Count Change
1	1	Suboxone	$ 9,785,753.18	$ 11,168,897.73	90,208	98,021	14.13%	8.66%
2	2	Harvoni	$ 8,858,465.26	$ 7,292,327.30	361	310	-17.68%	-14.13%
3	4	Vyvanse	$ 5,089,396.05	$ 5,901,049.03	22,003	23,612	15.95%	7.31%
4	8	Humira Pen	$ 3,786,743.46	$ 5,129,291.03	1,006	1,105	35.45%	9.84%
5	6	Methylphenidate HCL ER	$ 4,891,670.27	$ 5,023,648.71	23,062	21,930	2.70%	-4.91%
6	5	Adderall XR	$ 5,062,407.16	$ 4,746,810.78	17,910	17,281	-6.23%	-3.51%
7	7	Lantus Solostar	$ 4,036,714.59	$ 3,724,704.36	6,253	6,021	-7.73%	-3.71%
8	9	Lyrica	$ 3,253,637.60	$ 3,529,207.05	7,244	7,132	8.47%	-1.55%
9	3	Abilify	$ 6,492,739.40	$ 3,493,955.53	5,501	2,967	-46.19%	-46.06%
10	13	Focalin XR	$ 2,462,674.51	$ 2,930,299.64	7,351	7,729	18.99%	5.14%
Totals:			**$ 53,720,201.48**	**$ 52,940,191.16**	**180,899**	**186,108**	**-1.47%**	**2.88%**

CHART # 11C: Top Therapeutic Categories by Utilization

Current Rank	Previous Rank	Drug Name	2016 Rx Count	2017 Rx Count	Percent Change	2016 Gross Paid Ranking	2017 Gross Paid Ranking
1	1	Opioid Partial Agonists	107,174	115,743	8.00%	1	4
2	2	Selective Serotonin Reuptake Inhibitors (SSRIS)	93,190	88,318	-5.23%	31	22
3	4	Anticonvulsants-Misc.	68,291	67,932	-0.53%	7	7
4	3	Sympathomimetics	69,015	66,512	-3.63%	6	6
5	6	Amphetamines	53,257	53,890	1.19%	4	3
6	5	Opioid Agonists	63,475	53,291	-16.04%	17	14
7	7	Stimulants- Misc.	50,719	49,140	-3.11%	3	5
8	9	Nonsteroidal Anti-inflammatory Agents (NSAIDS)	46,648	41,763	-10.47%	51	40
9	11	Antihistamines - Non-sedating	38,268	37,618	-1.70%	70	59
10	10	Proton Pump Inhibitors	41,312	37,088	-10.22%	15	15
Totals:			**631,349**	**611,295**	**-3.18%**		

CHART #11D: Top Drugs by Utilization

Current Rank	Previous Rank	Drug Name	2016 Rx Count	2017 Rx Count	Percent Change	2016 Gross Paid Ranking	2017 Gross Paid Ranking
1	1	Suboxone	90208	98021	8.66%	1	1
2	2	Proair HFA	41072	39536	-3.74%	13	10
3	4	Gabapentin	28479	30117	5.75%	67	52
4	3	Sertraline HCL	29882	29292	-1.97%	103	122
5	5	Fluoxetine HCL	26963	26628	-1.24%	100	49
6	13	Vyvanse	22003	23612	7.31%	3	4
7	7	Omeprazole	25420	22831	-10.18%	110	95
8	8	Amoxicillin	25338	22572	-10.92%	140	134
9	10	Methylphenidate HCL ER	23062	21930	-4.91%	5	6
10	9	Clonazepam	24009	21708	-9.58%	211	171
Totals:			**336436**	**336247**	**-0.06%**		

Specialty Pharmacy

During most of SFY 2017, Vermont Medicaid utilized the services of BriovaRx®, a full-service specialty pharmacy located in South Portland, Maine, that partnered with our pharmacy benefits manager, CHC. Some examples of specialty drugs managed by BriovaRx® include drugs used to treat Multiple Sclerosis; Hepatitis C; Cancer; Rheumatoid, Psoriatic and Juvenile Arthritis; Psoriasis; Crohn's Disease; Ankylosing Spondylitis; growth hormone deficiencies; and Ulcerative Colitis. Dispensing of identified specialty medications was limited to this pharmacy for Medicaid beneficiaries (when Medicaid was the primary insurer) until April 30, 2017.

Effective May 1st, 2017, DVHA expanded the number of pharmacies that can dispense specialty medications. In conjunction with this change, DVHA and CHC performed an extensive review of specialty medications. Because of that review, the following medications are no longer designated as specialty medications and may now be dispensed by any pharmacy enrolled with Vermont Medicaid:

Amicar®, Botox®, Epogen®, Gleevec®, Neupogen®, Neulasta®, Procrit®, Sprycel®, Xeljanz®, and select growth hormones (Genotropin®, Humatrope®, Norditropin®, Nutropin®, Omnitrope®, and Zomacton®)

The list of specialty medications is updated quarterly and can be found on the DVHA website at http://dvha.vermont.gov/for-providers/specialtydrugweblist-20170421.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)

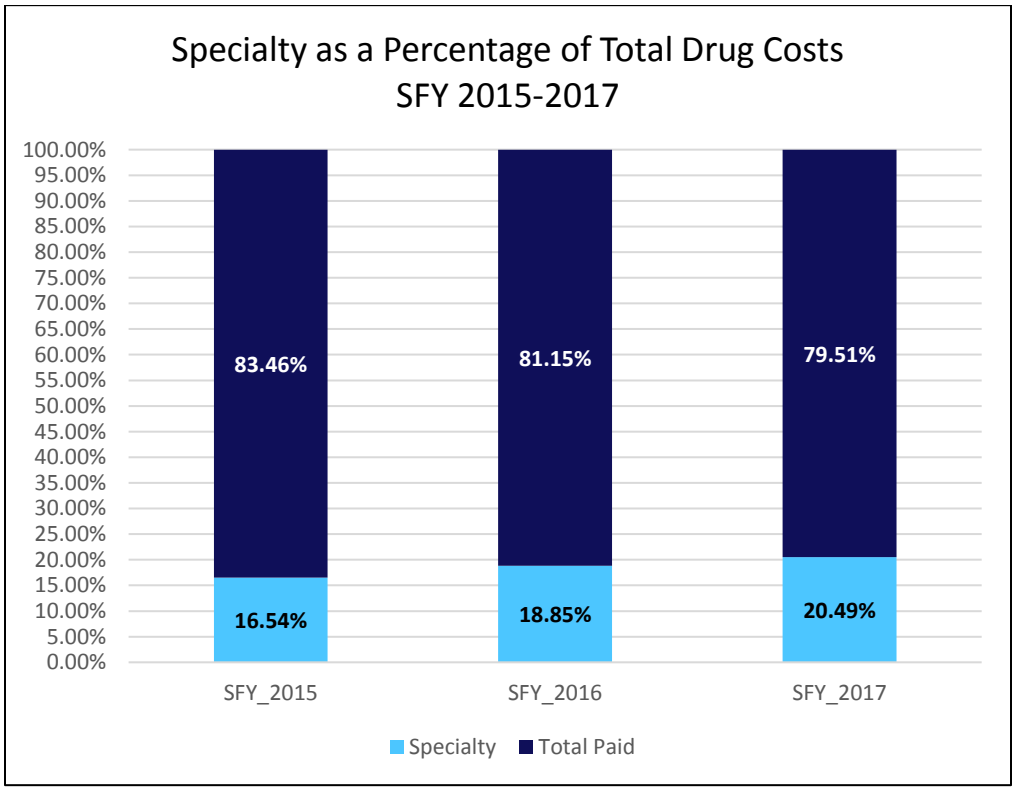
DVHA defines a specialty pharmacy as outlined by the Academy of Managed Care Pharmacy (AMCP) in a recent publication entitled Format for Formulary Submission, version 3.1 and the Specialty Pharmacy Association of America's definition below. "Specialty pharmacies are distinct from traditional pharmacies 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) URAC, the Accreditation Commission for Health Care (ACHC) or the Center for Pharmacy Practice Accreditation (CPPA).

In SFY 2017, specialty drugs represented 20.5% of DVHA's overall drug spend. This was a 1.6% increase over SFY 2016, when specialty drug spend represented 18.85% of DVHA's drug spend.

CHART # 12: Specialty Drugs as a Percent of Total Drug Cost



Specialty gross spend increased by approximately 3% between SFY 2016 and SFY 2017, while cost per prescription rose by 4.4%.

CHART # 13: Specialty Paid

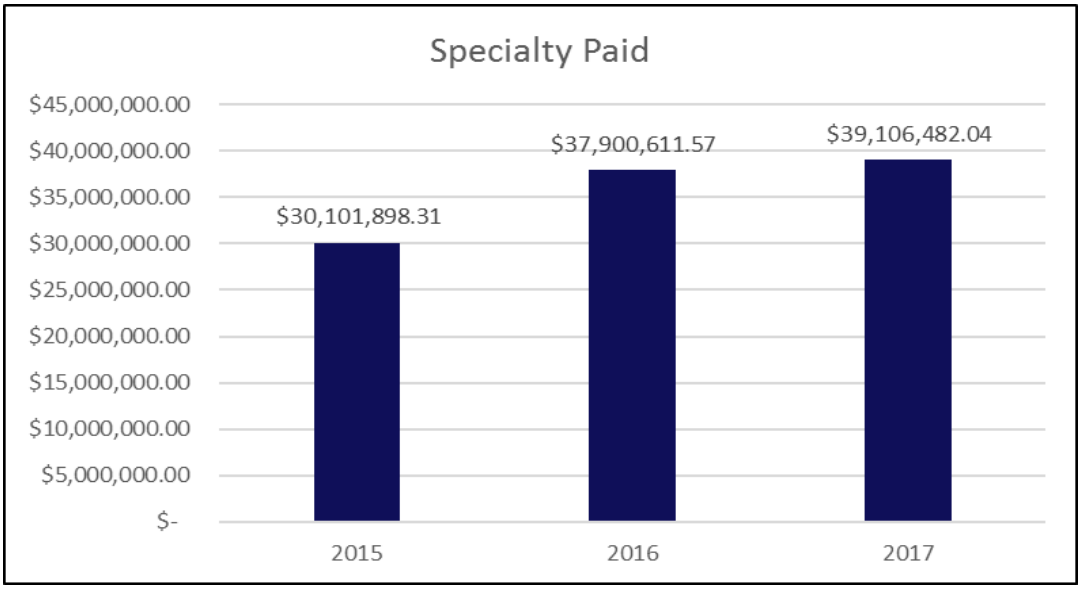
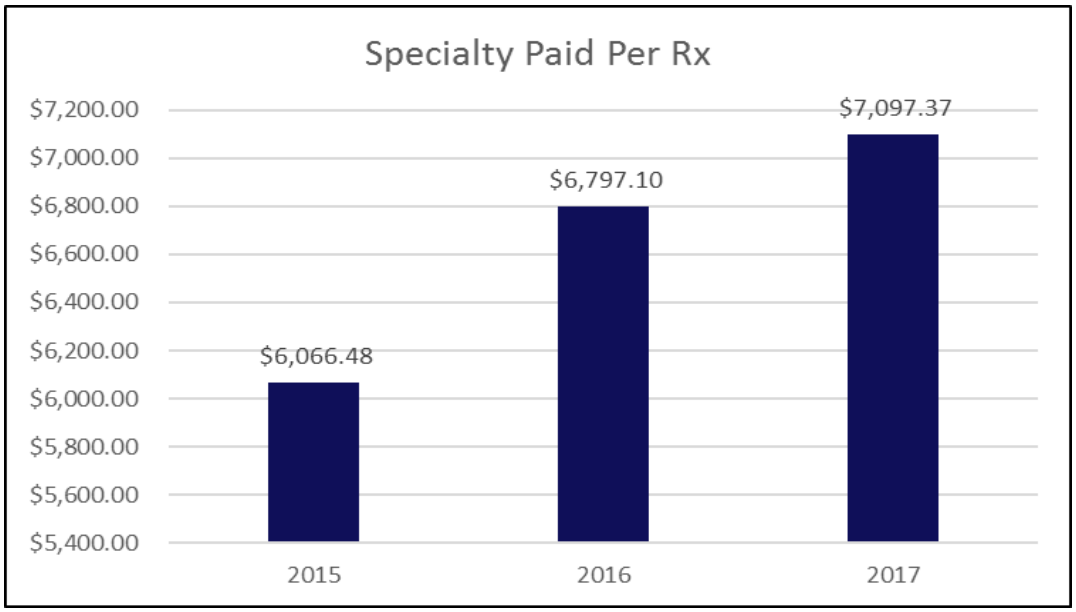


CHART # 14: Specialty Paid Per Rx



According to Steve Liles, Pharm.D., Senior Director of Pharmacy Services at DVHA's contracted pharmacy benefits manager, CHC, the areas that will continue to see the largest increases in net expenditures are inflammatory conditions with a 20-25% average annual increase, followed by Cystic Fibrosis, oncology and Hemophilia, each with an average 15-20% annual increase.

Cystic Fibrosis (CF) is a progressive, genetic disease that causes persistent lung infections and limits the ability to breathe over time. In people with CF, a defective gene causes a thick, sticky buildup of mucus in the lungs, pancreas, and other organs. In the lungs, the mucus clogs the airways and traps bacteria leading to infections, extensive lung damage, and eventually, respiratory failure. In the pancreas, the mucus prevents the release of digestive enzymes that allow the body to break down food and absorb vital nutrients.

In recent years, new drug treatments called CFTR modulator therapies have become available. CFTR (cystic fibrosis transmembrane conductance regulator) modulator therapies are designed to correct the function of the defective protein made by the CF gene. Because different mutations cause different defects in the protein, the medications that have been developed so far are effective only in people with specific mutations. There are currently two FDA-approved CFTR modulators: ivacaftor (Kalydeco®) and lumacaftor/ivacaftor (Orkambi®). It is expected that these CFTR agents will continue to place financ pressures on DVHA's drug spend, as they are very new and no competition exists in the class.

Chart #15: Drugs Used to Treat Cystic Fibrosis

Cystic Fibrosis Drugs	2016 RX Count	2017 RX Count	% Change	2016 Unique Members	2017 Unique Membes	% Change	2016 Total Paid	2017 Total Paid	% Change
Orkambi	86	150	74%	18	23	28%	$ 1,577,507.66	$ 2,859,876.47	81%
Kalydeco	15	7	-53%	2	1	-50%	$ 271,592.42	$ 171,056.00	-37%
Total CFTR Products	**101**	**157**	**55%**	**20**	**24**	20%	**$ 1,849,100.08**	**$ 3,030,932.47**	**64%**
Pulmozyme	453	407	-10%	74	59	-20%	$ 1,519,476.50	$ 1,449,216.03	-5%
Cayston	34	38	12%	11	12	9%	$ 235,304.07	$ 262,400.96	12%
Tobi Podhaler	38	56	47%	14	17	21%	$ 297,052.13	$ 500,808.06	69%
Kitabis Pak	21	35	67%	11	11	0%	$ 97,290.70	$ 161,219.14	66%
Bethkis	0	1	-	0	1	-	$ -	$ 5,842.48	-
Tobramycin	4	1	-75%	3	1	-67%	$ 24,742.92	$ 842.31	-97%
TOBI	7	0	-100%	4	0	-100%	$ 52,877.57	$ -	-100%
Total Tobramycin Prod	**70**	**93**	**33%**	**32**	**30**	-6%	**$ 471,963.32**	**$ 668,711.99**	42%
GRAND TOTALS	**658**	**695**	**6%**	**137**	**125**	-9%	**$ 4,075,843.97**	**$ 5,411,261.45**	**33%**

Chart #16: Cancer Drugs

Cancer drug expenditures paid through the pharmacy benefit have risen 22% in SFY2017 compared to the prior year. This is likely attributable to the availability of more oral cancer treatments that do not require administration in a cancer center or outpatient hospital setting. All the top ten drugs on the list below are oral therapies for cancer.

Many costly new drugs have resulted in significant breakthroughs, but in some cases for a small increase in life expectancy. As these drugs receive FDA approval to treat more types of cancer, DVHA may be able to take advantage of competition to drive down costs or to enter into outcomes-based contracts.

Drug Name	2016 RX Count	2017 RX Count	% Change	2016 Unique Members	2017 Unique Members	% Change	2016 Total Paid	2017 Total Paid	% Change
Ibrance	50	89	78.00%	13	10	-23.08%	$ 525,187.88	$ 951,228.22	81.12%
Imatinib Mesylate	33	50	51.52%	8	8	0.00%	$ 306,108.94	$ 394,724.76	28.95%
Sprycel	47	41	-12.77%	8	6	-25.00%	$ 320,602.50	$ 367,015.20	14.48%
Xtandi	22	37	68.18%	3	7	133.33%	$ 199,678.59	$ 344,843.86	72.70%
Revlimid	68	27	-60.29%	11	5	-54.55%	$ 779,428.30	$ 326,659.17	-58.09%
Imbruvica	26	28	7.69%	4	4	0.00%	$ 236,281.81	$ 264,290.46	11.85%
Zytiga	18	27	50.00%	3	6	100.00%	$ 154,653.78	$ 243,468.60	57.43%
Afinitor	15	19	26.67%	3	5	66.67%	$ 171,067.43	$ 239,713.16	40.13%
Sutent	12	15	25.00%	1	3	200.00%	$ 153,147.66	$ 203,232.70	32.70%
Targretin	3	12	300.00%	1	1	0.00%	$ 46,104.84	$ 182,217.69	295.22%
Totals	**294**	**345**	**17.35%**	**55**	**55**	**0.00%**	**$ 2,892,261.73**	**$ 3,517,393.82**	**21.61%**

Chart #17: Hepatitis C Drugs

Hepatitis C utilization stabilized in SFY2017, likely due to the anticipation of new products entering the marketplace, and fibrosis level F3 restrictions, which were changed to F2 in February of 2017. The guidelines no longer recommended the use of Sovaldi®, and Harvoni® became the treatment of choice in SFY2017. New drugs and guidelines are always evolving in this class, and recently the American Association for the Study of Liver Diseases (AASLD) updated their recommendations to include a new drug called Mavyret®, which is very effective; can be used for all genotypes; can be given for eight weeks versus 12 weeks of Harvoni® for most genotypes; and has a lower cost of treatment. This drug is very new, so currently DVHA does not have any utilization of Mavyret®, but it is expected to significantly impact utilization in SFY2018.

The new Direct Acting Antivirals are very effective drugs and competition has driven the cost down significantly. We will continue to see a significant financial impact of these drugs because more people will continue to be treated for Hepatitis C Virus (HCV). If

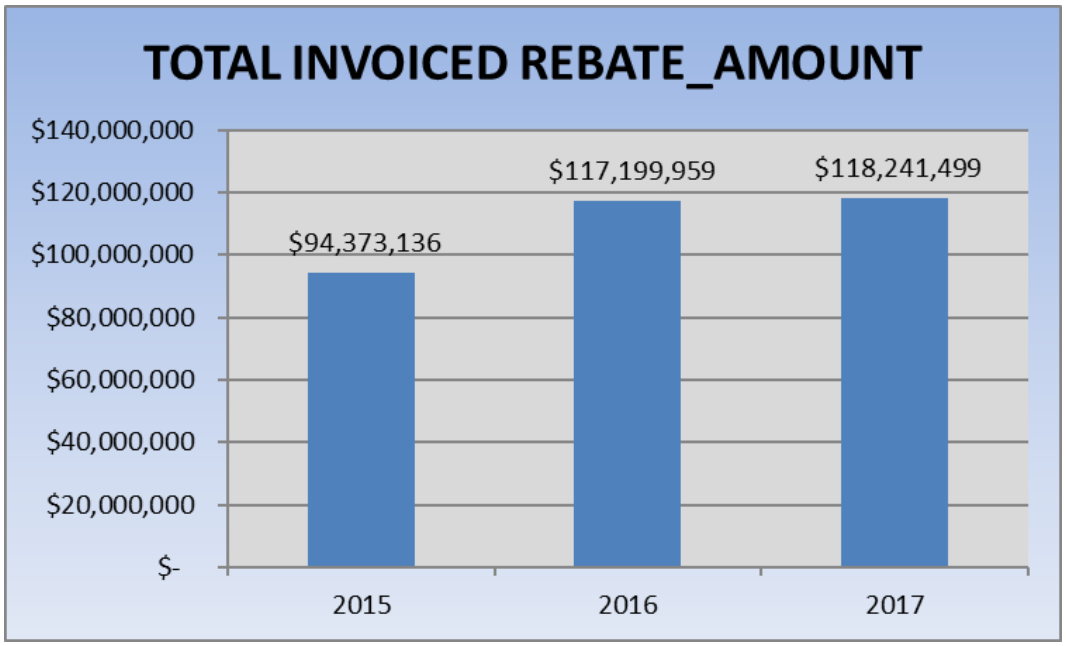
fibrosis restrictions are lowered or lifted, we can expect significant increases in HCV costs for SFY2018.

Drug Name	2016 RX Count	2017 RX Cont	% Change	2016 Unique Members	2017 Unique Members	% Change	2016 Total Paid	2017 Total Paid	% Change
Harvoni	361	310	-14.13%	108	94	-12.96%	$ 8,858,465.26	$ 7,292,327.30	-17.68%
Epclusa	0	123	0.00%	0	33	0.00%	$ -	$ 2,292,252.36	0.00%
Sovaldi	87	15	-82.76%	20	4	-80.00%	$ 2,005,743.00	$ 364,683.00	-81.82%
Daklinza	23	10	-56.52%	7	3	-57.14%	$ 357,645.00	$ 189,348.00	-47.06%
Ribavirin	9	24	166.67%	3	8	166.67%	$ 1,136.87	$ 2,375.24	108.93%
Ribasphere	71	10	-85.92%	20	4	-80.00%	$ 8,522.40	$ 710.27	-91.67%
Viekira Pak	1	0	-100.00%	1	0	-100.00%	$ 28,592.08	$ -	-100.00%
Totals	**552**	**492**	**-10.87%**	**159**	**146**	**-8.18%**	**$ 11,260,104.61**	**$ 10,141,696.17**	**-9.93%**

Rebate Programs

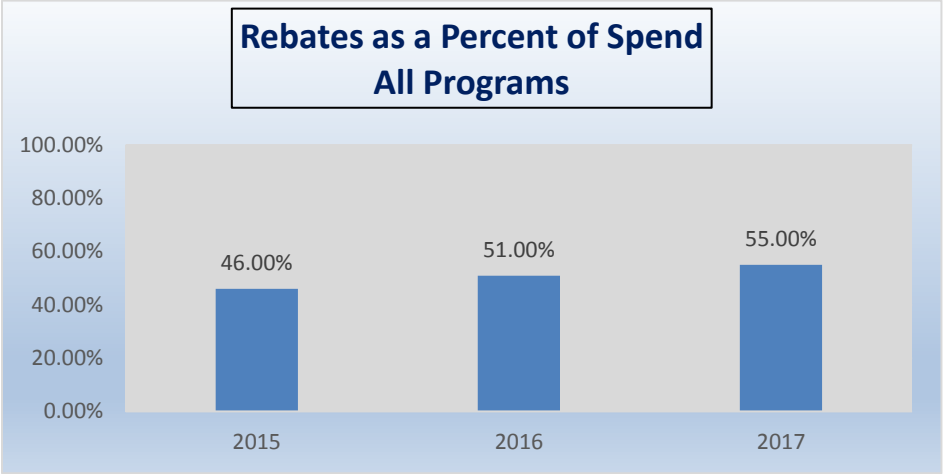
The federal Medicaid drug rebate largely protects Medicaid from price increases on existing drugs. Increases in Medicaid net drug expenditures are primarily due to new therapies or classes of drugs for which it has been difficult to stimulate competitive forces to bring the costs down.

CHART # 18: Rebates Invoiced: All Programs



*This does not reflect rebates collected during SFY2017

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



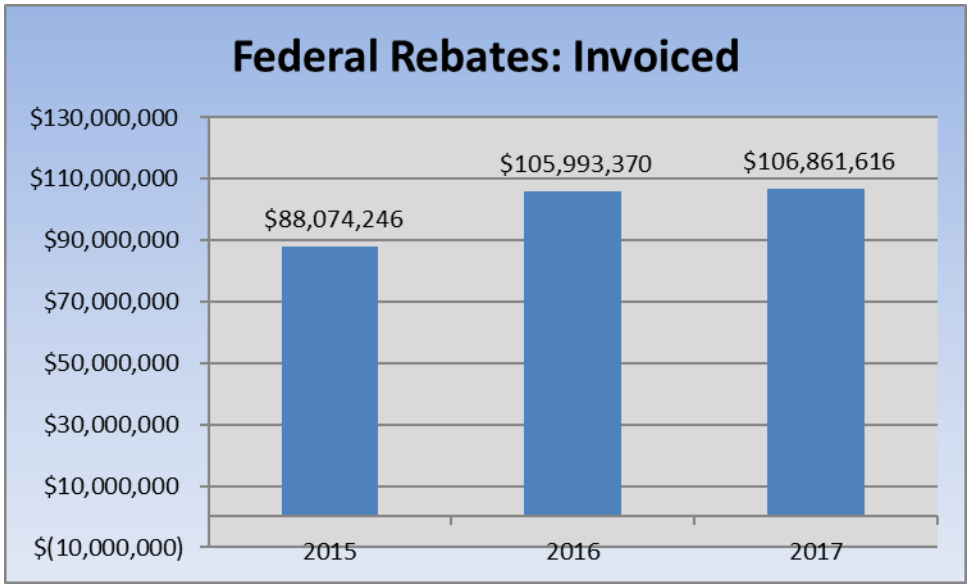
Federal Rebates

Federal rebates that manufacturers pay to states are calculated based 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. For the first quarter of 2017, DVHA invoiced an additional $211,355 because of this new additional rebate adjustment based on CPI. Based on this trend, we can expect to invoice approximately $850,000 dollars in additional rebates in SFY2018 for generic drugs.

CHART # 20: Federal Rebates Invoiced (SFY2015-2017)



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 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 SSDC pool.

CHART #21: Total Supplemental Rebates Invoiced (SFY 2015-2017)

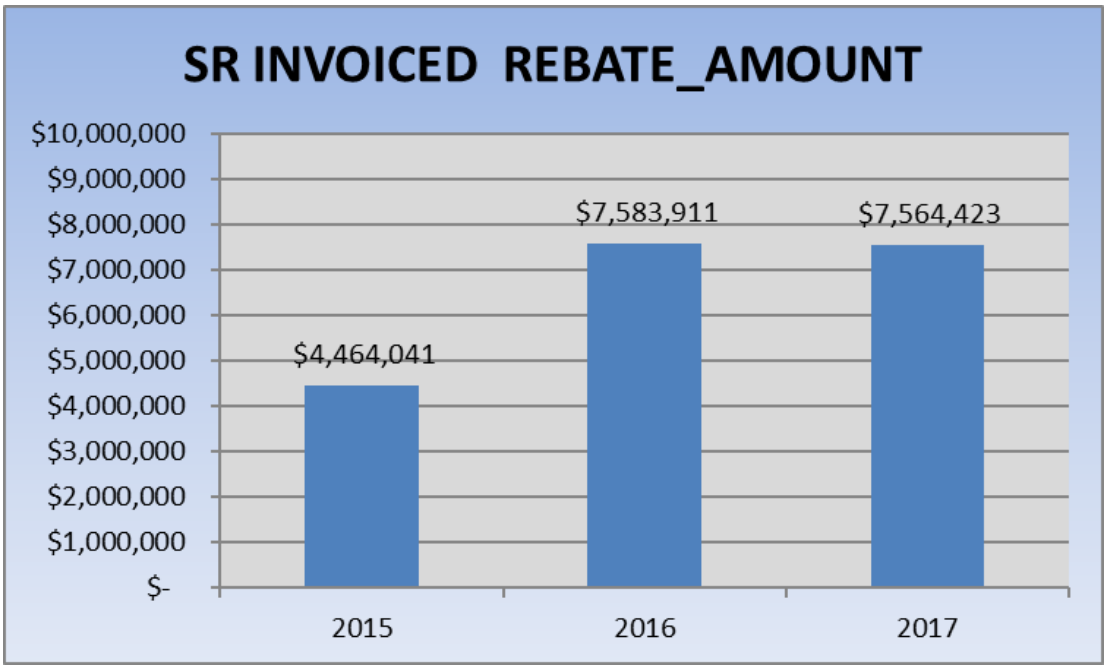
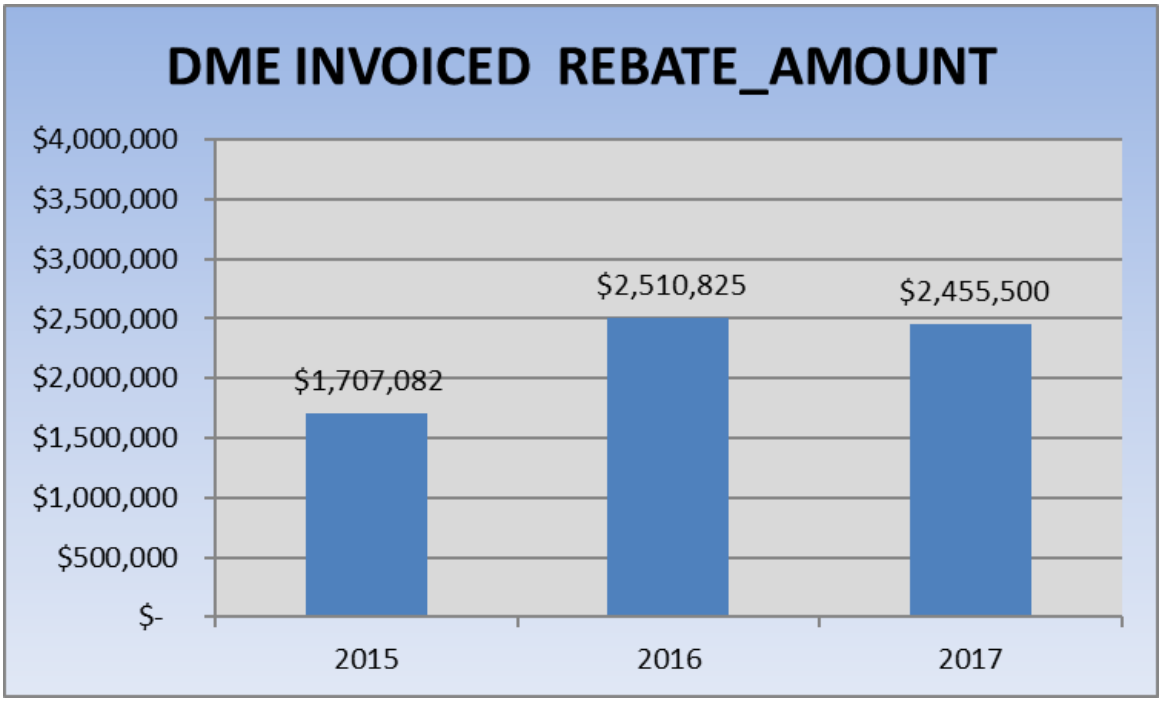


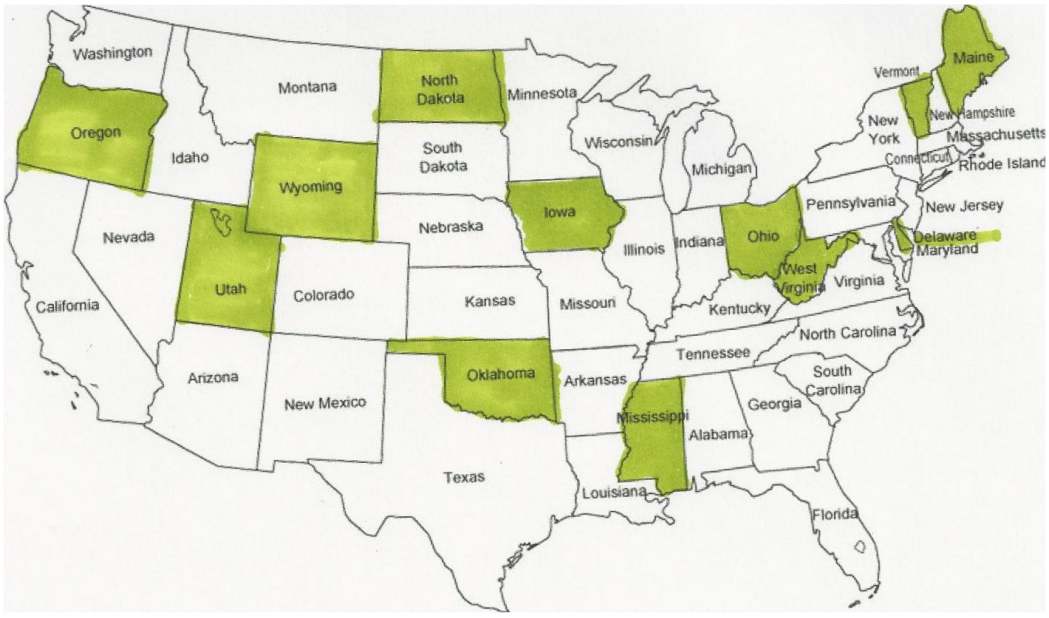
CHART # 22: Diabetic Supply Rebates Invoiced (SFY 2015-2017)



The SSDC was founded in the fall of 2005 by the States of Iowa, Maine, and Vermont to obtain prescription drugs for beneficiaries in their Medicaid programs at a lower cost. 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 RCY2007 followed by Wyoming in RCY 2008, West Virginia and Oregon in RCY 2009, Mississippi in RCY2012, North Dakota in

RCY2015, Delaware and Ohio in RCY2016, and our newest member, Oklahoma enrolled as of RCY2017. Due to the success of the SSDC, we are now the largest and only independent state-owned rebate pool in the country. The twelve states as of RCY 2017 are illustrated in the map below.



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

In 2016, a total of nearly 5 million members, and $3 billion in drug expenditures is represented by the 12 participating states providing substantial leverage in manufacturer negotiations.

CHART # 23: SSDC Annual Drug Spend

State	Average Monthly PDL Lives	Annual Medicaid Drug Spend
DE	230,000	$208,000,000
IA	570,720	$426,197,744
ME	291,105	$232,315,231
MS	537,696	$255,943,031
ND	66,041	$39,215,361
OH	514,000	$340,000,000
OK	837,000	$505,000,000
OR	1,049,644	$171,289,720
UT	115,063	$139,640,000
VT	167,890	$179,340,168
WV	516,000	$446,971,859
WY	75,325	$47,946,923
TOTAL	4,970,484	$2,991,860,037

(Sovereign States Drug Consortium, 2017)

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