# Program Report:
# Pharmacy Best Practices and Cost Control Program
# SFY 2016

**Legislative Report**
Pursuant to 33 V.S.A. § 2001(c)

**Agency of Human Services**
**Department of Vermont Health Access**
**Pharmacy Unit**

**Prepared by:**

Steven Costantino, Commissioner
Nancy J. Hogue, BS, Pharm.D., Director of Pharmacy Services
Carrie Germaine, EMT, CPC, Health Programs Administrator

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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, both 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 beneficiaries 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 beneficiaries. In support of the Agency and Department goals, the Pharmacy Benefit Management Program goal is to ensure that beneficiaries receive medically necessary medications in the most efficient and cost-effective manner. With the fiscal challenges facing the state over the next few years, at stake is preserving, to the greatest extent possible, the benefits that have evolved in Vermont's programs.

## Drug Expenditure Outlook for SFY 2017 and Beyond

CMS' National Health Expenditures Projections estimate SFY17 US net Medicaid expenditures for prescription drugs to increase by approximately 4.2% compared to SFY16. This is significantly lower than the 11-21% trend seen in each of the previous three years that was the result of an increase in the number of Medicaid recipients and the launch of numerous high cost drugs, such as the direct acting antivirals for hepatitis C. For the following eight years (SFY18-SFY25), the annual trend is expected to stabilize in the range of 5-7% each year, similar to the projected increase in overall Medicaid expenditures.

The NHE estimates include expenditures for Medicaid recipients across all states. States that have already expanded Medicaid and those with effective pharmacy benefit management programs would be expected to have rates of growth in expenditures well below the national average. Nonetheless, the NHE projections do provide a relative, if not absolute, picture of where net pharmacy expenditures for Medicaid are heading.

The increase in pharmacy expenditures will continue to be driven by high-cost, complex pharmaceuticals (e.g. specialty drugs). In SFY17 and SFY18, the trend for drug spend is projected to average 7-8%. During the same period, the traditional pharmacy trend is projected to average 3%. (Centers for Medicare and Medicaid Services)

## Specialty Drugs

A medication considered a specialty pharmaceutical may have some or all of the following key characteristics:

- Treatment of complex, chronic, and/or rare conditions
- High cost; often exceeding $10,000 with some costing well over $100,000 annually
- Availability through exclusive, restricted, or limited distribution pharmacy channels
- Special storage, handling, and/or administration requirements
- High-touch, patient-centered management and monitoring for safety and/or efficacy
- A Risk Evaluation Mitigation Strategy (REMS)*

*The Food and Drug Administration Amendments Act of 2007 gave FDA the authority to require a Risk Evaluation and Mitigation Strategy (REMS) from manufacturers to ensure that the benefits of a drug or biological product outweigh its risks.

Although this category has historically focused on injectable and infused formulations, a significant number of specialty medications in oral dosage forms have entered the market recently. This trend is only expected to continue, especially among oral oncolytics (cancer drugs). Due to the complexities associated with specialty pharmaceuticals, patients receiving these medications require a significant degree of continuous patient education, ongoing monitoring, and medication management by well-qualified and skilled specialty pharmacy staff.

According to Steve Liles, Pharm.D., Senior Director of Pharmacy Services at DVHA's contracted pharmacy benefits manager, Change Healthcare, therapeutic areas that will see the biggest increases in net expenditures are inflammatory conditions with a 20% to 25% average annual increase, followed by cystic fibrosis, oncology and hemophilia, each with an average annual increase of approximately eighteen percent (18%). Increases in expenditures for the treatment of Human Immunodeficiency Virus

(HIV), Multiple Sclerosis (MS) and growth deficiency are projected to increase by 5-10% each year while expenditures for anticoagulants and hepatitis C drugs are projected to decrease slightly.

Pharmacy expenditures for drugs used for the treatment of inflammatory conditions, such as rheumatoid and psoriatic arthritis, Crohn's disease and psoriasis, are projected to increase. This is partly a result of shifting of some utilization from the medical to the pharmacy benefit. Additional factors, however, include the release of new drugs for the treatment of these conditions, expanded indications for existing products and increased utilization as more patients are diagnosed with an inflammatory disorder. The availability of effective, non-injectable, non-biologic agents will also result in at least some shift away from biologics that have a lower net cost to the state.

CFTR (cystic fibrosis transmembrane conductance regulator) modulator therapies are new drugs developed to treat Cystic Fibrosis (CF). They 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®). Expenditures for cystic fibrosis drugs will increase as a result of expanded indications for existing CFTR modulators and the expected approval and launch of additional CFTR modulators covering a broader range of gene mutations in CF patients.

The projected increase in expenditures for cancer drugs is the result of many factors but, in general, is due to the recent and near term launch of oral cancer drugs that are better tolerated and more effective than previously existing injectable drugs. Many of these new drugs treat cancers for which previously there were no or minimally effective treatments. Thus, the availability of these new drugs will increase overall

utilization due to expanded indications. Another result of the improved effectiveness of newer cancer drugs is that cancer chemotherapy has, in many cases, become a chronic therapy as progression free survival rates become increasingly longer. While increases in utilization and net cost of the newer agents are drivers in the overall increases in expenditures for cancer drugs, it should be noted that some of the projected increase in pharmacy expenditures is the result of a shift from utilization of older, injectable drugs covered under the medical benefit to the newer, oral products covered under the pharmacy benefit. Thus, not all of the projected increase in pharmacy expenditures represents "new" costs but, rather a shift in costs from one benefit to another.

Expenditures for hemophilia are expected to increase as a result of the approval and launch of several new long acting factor products. The impact of these new, more costly factor products is and will be mitigated by aggressive rebate negotiations and Preferred Drug List (e.g. formulary) management. (Lisle, 2016)

## Biosimilar Drug Products

The Patient Protection and Affordable Care Act (Affordable Care Act), through the Biologics Price Competition and Innovation Act (BPCI Act), created an abbreviated licensure pathway for biological products that are demonstrated to be "biosimilar" to or "interchangeable" with an FDA-licensed biological product (Center for Drug Evaluation and Research). Biological products are generally derived from a living organism and can come from many sources, including humans, animals, microorganisms or yeast.

The FDA defines a biosimilar as "a biological product that is highly similar to the reference product notwithstanding minor differences in clinically inactive components, and there are no clinically meaningful differences between the biologic product and the reference product in terms of safety, purity and potency. A biosimilar is interchangeable if it has been shown to be biosimilar to the reference product and can be expected to

produce the same clinical result as the reference product in any given patient." (Valbh, 2016)

At the time of this report, there were four approved biosimilar products for the following innovator drugs: etanercept-szzs (Erelzi) biosimilar to Enbrel; adalimumab-atto (Amjevita), biosimilar to Humira; filgrastim-sndz (Zarxio), biosimilar to Neupogen; and infliximab-dyyb (Inflectra), biosimilar to Remicade. (Center for Drug Evaluation and Research)

Although biosimilars have a lower gross list price, due to the high rebates and lower net cost of originator biologics in this class, the approval of biosimilars is not expected to have a mitigating impact on Medicaid expenditures at this time.

**Traditional Pharmaceuticals**

Net expenditures for diabetes drugs are projected to increase by 15-20% in each of the next two years. This increase is due to higher utilization of newer diabetes therapies, including longer acting SGLT2 inhibitors and GLP-1 receptor agonists. Type 2 diabetes drugs called sodium-glucose co-transporter 2 (SGLT2) inhibitors, stop glucose from reentering the blood in the kidneys. Some examples include Invokana (canagliflozin) and Farxiga (dapagliflozin). The glucagon-like peptide-1 (GLP-1) receptor agonists are a newer class of injectable drugs for the treatment of type 2 diabetes. They mimic the action of GLP-1 and increase the incretin effect in patients with type 2 diabetes, stimulating the release of insulin. Some examples include Byetta (exenatide) and Tanzeum (albiglutide).

This increased utilization of these two classes of drugs will stem from a more aggressive approach to the treatment of type 2 diabetes and a shift away from older, less costly therapies. In addition to changes in the treatment paradigm for diabetes, the

significant federal rebates on older insulin products that has historically resulted in them having a very low net cost for Medicaid have substantially been reduced, thus increasing overall net cost of diabetic drug expenditures.

(Lisle, 2016)

## 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; 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 Unit also has responsibility for overseeing the contract with DVHA's prescription benefit manager (PBM) Change Healthcare, which encompasses many clinical and operational services in addition to managing a call center in South Burlington, Vermont, for pharmacies and prescribers. The Pharmacy unit manages over $185 million in gross drug spend, and routinely analyzes national and DVHA drug trends, reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members, and managing drug utilization and cost.

During SFY 2016, the DVHA Pharmacy Unit continued its focus on ensuring that members receive high-quality, clinically appropriate, evidence-based medications in the most efficient and cost-effective manner possible. In addition, the unit focused on improving health information exchange through e-prescribing, automated prior authorizations, and other efforts related to administrative simplification for DVHA and our providers.

## 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 drug and preferred drug list placement
- Procuring supplemental rebates on utilized drugs
- Managing reimbursement
- Responding to change

## Pharmacy Benefit Management (PBM) Services

The DVHA procured a new PBM contract in May 2014. Change Healthcare was chosen as the new Pharmacy Benefit Manager (PBM) effective January 1, 2015. Change Healthcare is a national leader in Medicaid health care management services with over 40 years of experience in developing Medicaid Pharmacy Benefit Management (PBM) solutions and provides Medicaid services in sixteen (16) other states.

Change Healthcare expertise includes clinical management, account management, analytics, pharmacy cost management strategies, claims processing, formulary management, and rebate processing. It operates a local Call Center in a South Burlington, Vermont, location, servicing DVHA providers and staffed by Vermont pharmacists and pharmacy technicians. A new provider portal is being launched in SFY17, 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.

Pharmacy benefit management (PBM) services support the program in the following areas:

- Claims processing platform and operational support
- E-prescribing support
- Drug benefit management
- Drug utilization review activities
- Preferred Drug List management
- Drug Prior Authorization programs

  - Manual PA
  - Auto PA
  - EMR PA (SFY17)
- Drug Utilization Review Board coordination
- Federal, State, and Supplemental Rebate management
- Analysis and reporting
- Provider Portal (SFY17)
- Pharmacy and Provider Call Center
- Medication Therapy Management Program (SFY17)

## Drug Benefit Program Designs

For the DVHA programs that include full health insurance coverage, all included a pharmacy benefit in SFY 2016. These programs are described on the following page.

## DVHA Pharmacy Programs for Members Eligible for Medicare

| **Overview of Green Mountain Care and Vermont Health Connect Programs as of 1/1/2015 – Last Revised 1/5/16<br>Created by Vermont Legal Aid's Office of Health Care Advocate<br>1-800-917-7787** | | | |
|---|---|---|---|
| **PROGRAM** | **WHO IS ELIGIBLE** | **BENEFITS** | **COST-SHARING** |
| **MABD Medicaid**[1]<br><br>**Medicaid Working Disabled**<br><br>**MCA**[2] **(Expanded Medicaid)** | Aged, blind, disabled at or below the PIL[3].<br><br>Disabled working adults at or below 250% FPL[4].<br><br>Vermonters at or below 138% of FPL who are:<br>• Parents or caretaker relatives of a dependent child; or<br>• Adults under age 65 and not eligible for Medicare | • Covers physical and mental health, dental ($510 cap/yr), prescriptions, chiro (limited), transportation (limited).<br><br>• Not covered: eyeglasses (except youth 19-20); dentures.<br><br>• Additional benefits listed under Dr. Dynasaur (below) covered for youth 19-20.<br><br>• Covers excluded classes of Medicare Part D drugs for dual-eligible individuals. | • No monthly premium.<br><br>• $1/$2/$3 prescription co-pay if no Medicare Part D coverage.<br><br>• $1.20 -$6.60 co-pays if have Part D.<br><br>Medicare Part D is primary prescription coverage for dual-eligible individuals.<br><br>• $3 dental co-pay.<br><br>• $3/outpatient hospital visit. |
| **Dr. Dynasaur** | Pregnant women at or below 213% FPL. | Same as Medicaid, but<br><br>with full dental. | No premium or prescription co-pays. |
| **Dr. Dynasaur** | Children under age 19 at or below 317% FPL. | Same as Medicaid but<br><br>covers eyeglasses, full dental, & additional benefits. | • Up to 195% FPL: no premium.<br><br>• Up to 237% FPL: $15/family/month.<br><br>• Up to 317% FPL: $20/family/month. ($60/family/mo. w/out other insurance) |

| | | | |
|---|---|---|---|
| | | | • No prescription co-pays. |
| **VPharm1 150% FPL**<br><br>**VPharm2 175% FPL**<br><br>**VPharm3 225% FPL** | Medicare Part D<br><br>beneficiaries | • VPharm1 covers Part D cost-sharing & excluded classes of Part D meds, diabetic supplies, eye exams.<br><br>• VPharm 2&3 cover maintenance meds & diabetic supplies only. | • VPharm1: $15/person/mo. pd to State<br><br>• VPharm2: $20/person/mo. pd to State<br><br>• VPharm3: $50/person/mo. pd to State<br><br>• $1/$2 prescription co-pays.<br><br>• VPharm1 must apply for Part D Low Income Subsidy. |
| **Medicare Savings Programs:**<br><br>**QMB 100%FPL**<br><br>Qualified Medicare Beneficiaries<br><br>**SLMB 120% FPL**<br><br>Specified Low-Income Beneficiaries<br><br>**QI-1 135% FPL**<br><br>Qualified Individuals | • QMB & SLMB: Medicare beneficiaries w/ Part A<br><br>• 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.<br><br>• 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.<br><br>(NOT INSURANCE) | Beneficiary pays the Medicaid rate for all prescriptions. |
| **Qualified Health Plan (QHP)** | Legally present Vermonters who do not have Medicare<br><br>Legally present Vermonters from 100-400% FPL[5] who do | Choice of QHPs on Vermont Health Connect (VHC)<br><br>Covers all or part of premium on VHC. | Individual pays full premium unless s/he qualifies for tax credits, or employer pays a portion |

| | | | |
|---|---|---|---|
| **[Advance] Premium Tax Credits (APTC / PTC)** | not have an offer of affordable[6] MEC.[7] | | |
| **Cost-Sharing Reduction (CSR)** | Legally present Vermonters up to 300% FPL who do not have an offer of affordable[5] MEC.[6] Must purchase silver plan on VHC. | Reduces cost-sharing burden. | |

[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.
[2] MCA: Medicaid for Children and Adults
[3] PIL: Protected Income Limit.
[4] FPL: Federal Poverty Level
[5] Lawfully present non-citizens with FPL below 100% are also eligible for APTC, since they are not eligible for Medicaid until they have lived in the United States for at least 5 years. Their FPL will be treated as 100% FPL for the purposes of determining APTC eligibility.
[6] "Affordable": employee's contribution for a self-only plan is less than 9.56% of household's MAGI (Modified Adjusted Gross Income).
[7] MEC: Minimum Essential Coverage. Vermont Health Connect (VHC) will disregard offers of certain insurance, including student health plans, TRICARE, and Medicare coverage that requires the beneficiary to pay a Part A premium.

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

# Section III: Strategies Utilized to Manage the Pharmacy Benefit

## 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 175 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:

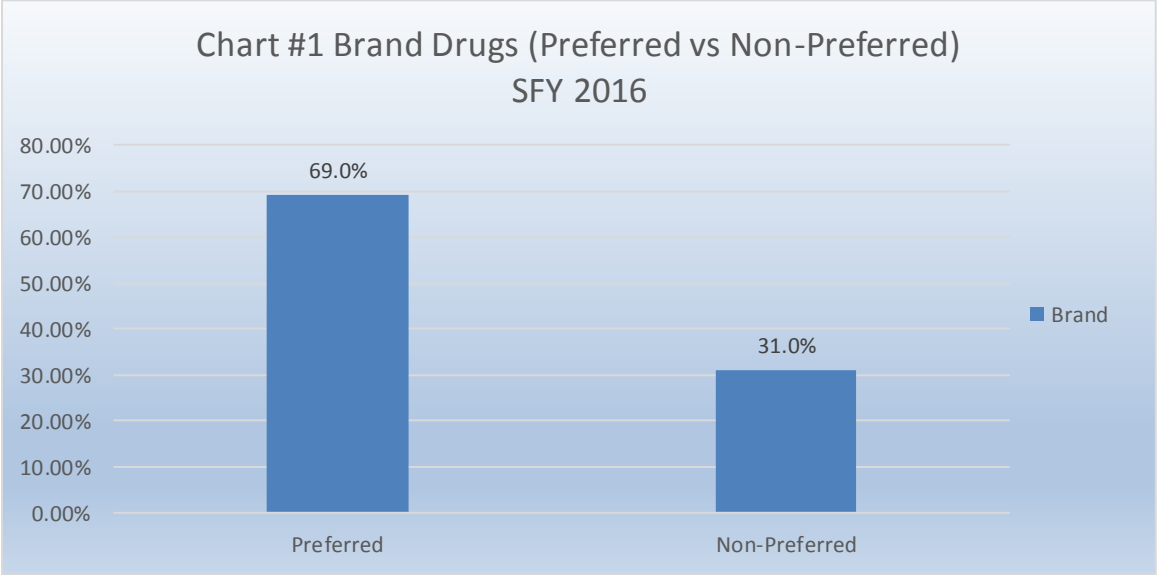
- Generics
    - Approximately 79% of DVHA's overall drug use is generic drugs, leaving 21% in brand drug use based on volume
    - Nearly all generics are preferred, with some exceptions where the net cost of the brand drug is lower
    - Most generics do not require PA
- Preferred Brand Drugs
    - Compose nearly 70% of the 21% of DVHA's brand drug utilization - See chart below
    - Brand drugs that have clinical superiority to other drugs in the class, or in some cases for which only one drug is available to treat a medical condition

  - 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; and
  - Brands where manufacturers pay Vermont rebates supplemental to required federal Medicaid rebates to make their products more affordable.
  - A limited number of preferred brands require PA for clinical reasons
- Non-Preferred brand drugs
  - Approximately 31% of the 21% brand drug utilization (see chart below)
  - Brand drugs that do not have clinical superiority to other drugs in the class, have similar clinical efficacy and/or offer no clinical advantage
  - Brands where manufacturers pay a lower level of federal Medicaid rebates that make 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 non-preferred brands require prior authorization

Within all these categories, there may be drugs or even drug classes that are subject to Quantity Limit parameters.

**Preferred Drug List Compliance**

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




## Generic Dispensing Rates

The rate of generic dispensing reflects the use of generics as a percentage of all drugs dispensed. 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 2014 through 2016:

**Chart #2: Generic Usage Rate (SFY 2014-2016)**

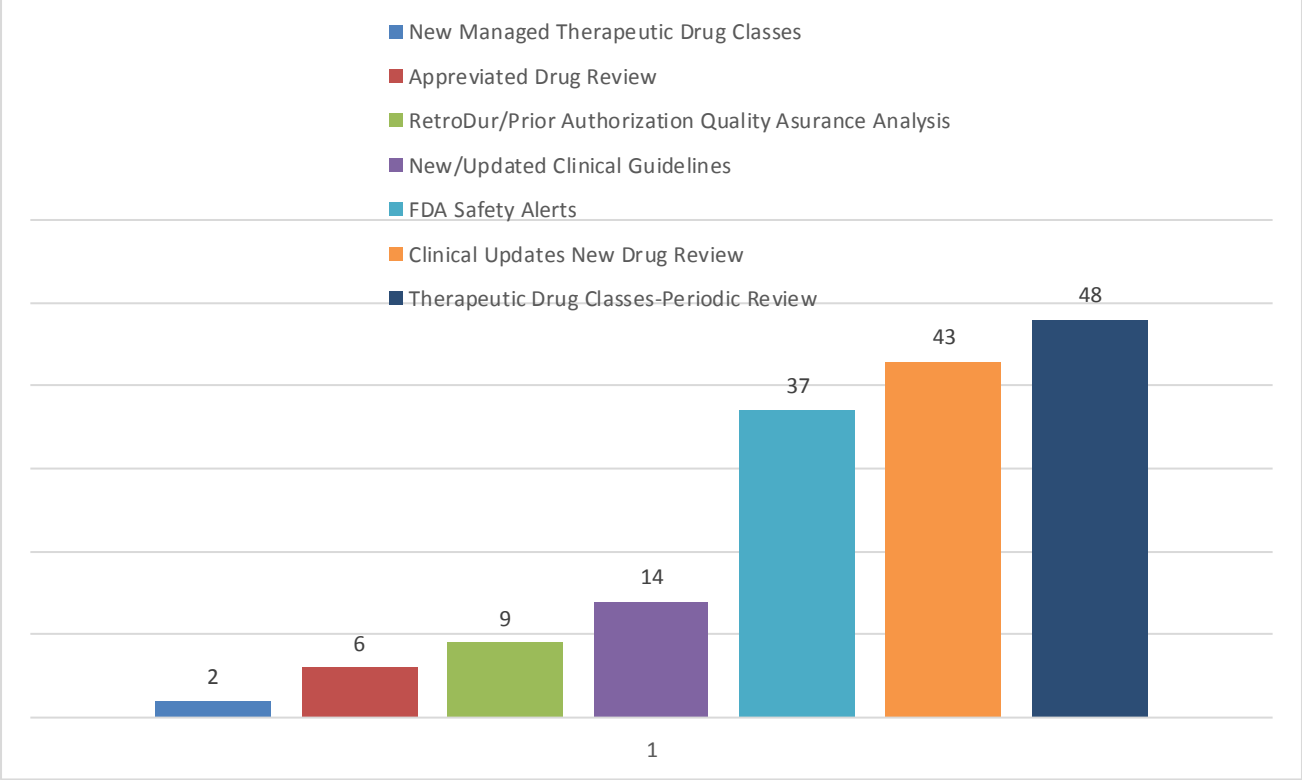
| Generic Indicator | 2016 | 2015 | 2014 |
|---|---|---|---|
| Generic use as a percentage of prescriptions for all drugs dispensed | 79% | 79% | 77% |
| Generic use as a percentage of prescriptions when a generic equivalent is available | 90% | 88% | 87% |

## Drug Utilization Review (DUR) Board

The Drug Utilization Review (DUR) Board of the Department of Vermont Health Access (DVHA) is a committee composed of Vermont physicians 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 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 describes some of the SFY2016 activities of the DUR Board:

**Chart #3, DUR Board Activities, SFY 2016**




Some topics of discussion at DUR Board meetings in SFY 2016 included Benzodiazepines and "Z" drugs (hypnotics), Suboxone® Film, Fluoxetine Tablets, Escitalopram Tablets and Advair Diskus®. Topics also included drug utilization reviews of Harvoni (ledipasvir-sofosbuvir combination), Entresto tab, Kalydeco tab, Ophthalmic antibiotics, glaucoma agents and anti-inflammatory agents, Naloxone Hydrochloride and Alzheimer's 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 the 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 advance 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 2017, 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, DVHA is 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) recently implemented an automated prior authorization (PA) for Suboxone® film effective in September 2016. The pharmacy claims processing system began checking the member's record for the required medical diagnosis on the claim's date of service. It then automatically calculates the daily dose based on medication history and the quantity and days' supply submitted. If a diagnosis of opiate dependency is found, and the total maximum daily dose does not exceed 16mg, the claim will pay without the need for a manual PA submission. Other criteria also remain in place, such as the pharmacy home and Data 2000 waiver requirement of prescribers.

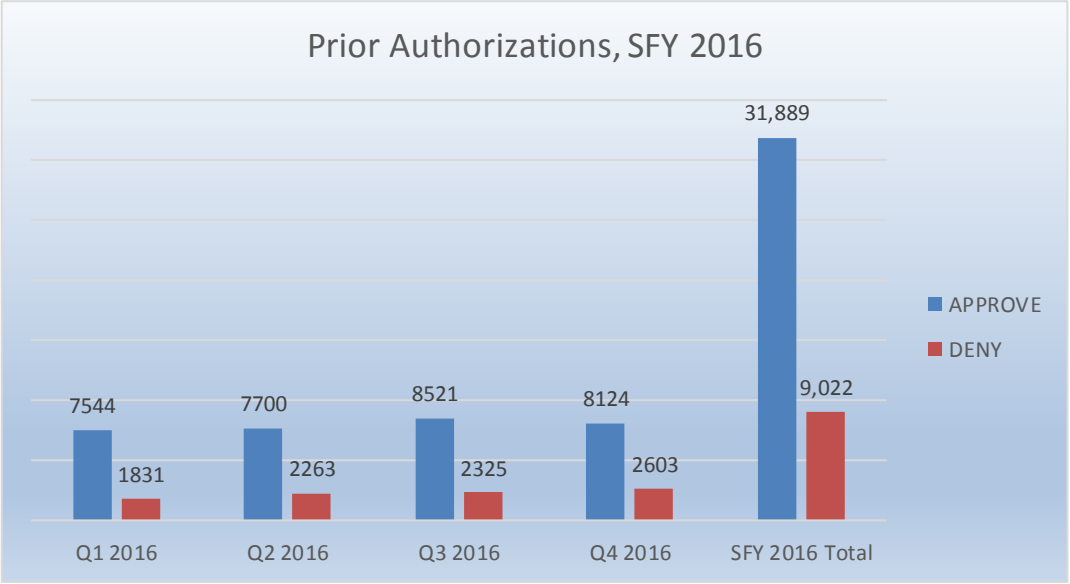
In the three months preceding the implementation, partial opioid agonists represented 23% of total PA volume. In reviewing our first quarter SFY2017 data, the number had decreased to 16%. While looking at a three-week time frame before and after the automated Suboxone® Film PA, the total percentage of claims paid by automated system edits had increased from 8.76% to 12.57%. This represents a 30% increase in claims being paid with no manual interventions. These "auto-PA" changes are in response to feedback received from providers, and they 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 year. Our goal is to reduce provider burden while assuring clinical and financial integrity of our pharmacy programs.

Change Healthcare 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 by quarter and for the entire year in SFY 2016:

**Chart #4: PA Authorizations Report for SFY 2016**




**State Maximum Allowable Cost (SMAC) Program**

Vermont's state MAC or "SMAC" program is similar to the Centers for Medicare & Medicaid Services (CMS) Federal Upper Limit (FUL) program. The intent is to provide a maximum price the State of Vermont will pay for a given generic pharmaceutical

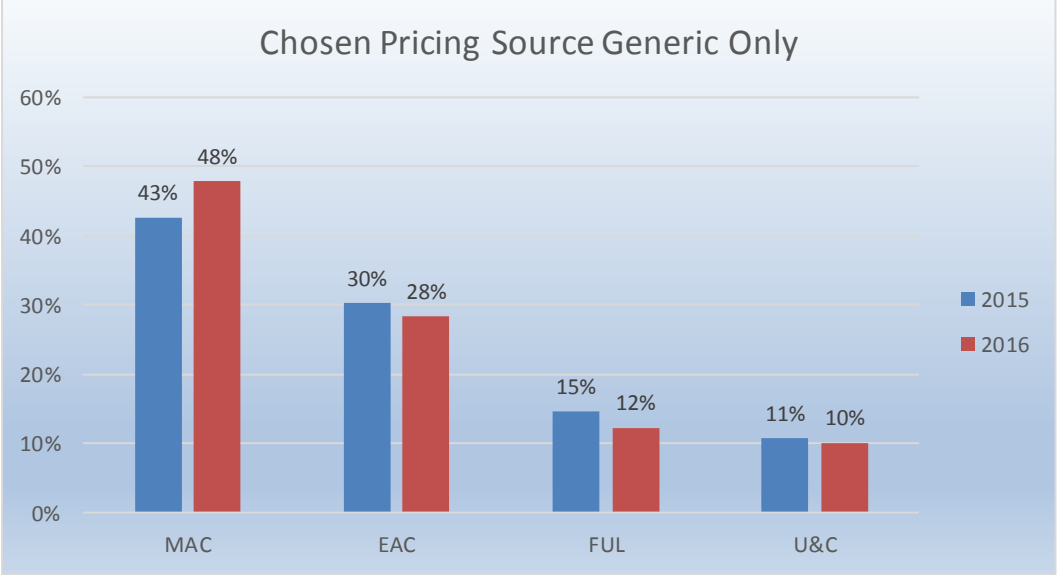
regardless of its package size or manufacturer. The MAC program is designed to promote the efficient purchasing of generic pharmaceuticals within the pharmacy provider network to ensure that the Medicaid program is a frugal payer of prescription drugs.

In developing the state MAC pricing list the State of Vermont utilizes Change Healthcare to determine the appropriate "average" price for a generic drug. Change Healthcare utilizes multiple sources for determining accurate pricing information, some sources are based on actual acquisition cost data from pharmacy submitted invoices and Change Healthcare also reviews both state-specific and national industry data. Some examples of the benchmarks used include wholesale acquisition cost (WAC), federal upper limit (FUL), post-Affordable Care Act FULs, 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. Change Healthcare also monitors changes in product availability & 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.

Due to improvements in our SMAC program managed by Change Healthcare, the percentage of generic drug claims pricing off SMAC has increased from 43% in 2015 to 48% in 2016, as shown in the chart below. This is due to both more drugs being added to the list, as well as more competitive pricing limits.

**Chart #5: Chosen Pricing Source Generic Only**




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.

# Section IV: Pharmacy Program Statistics

## Chart #6: Gross Pharmacy Claims and Spend, SFY 2014-2016

## (Prior to application of rebates)

**All Claims**

| SFY | CLAIM_COUNT | Year to Year Difference | GROSS AMOUNT PAID | Year to Year Difference | GROSS COST/CLAIM | Year to Year Difference |
|---|---|---|---|---|---|---|
| 2016 | 2,232,669 | 5.0% | $207,914,031 | 10.3% | $93.12 | 4.9% |
| 2015 | 2,124,656 | 3.5% | $188,585,742 | 18.9% | $88.76 | 15.0% |
| 2014 | 2,053,945 | | $158,576,110 | | $77.21 | |

**Medicaid**

| SFY | CLAIM_COUNT | Year to Year Difference | GROSS AMOUNT PAID | Year to Year Difference | GROSS COST/CLAIM | Year to Year Difference |
|---|---|---|---|---|---|---|
| 2016 | 1,744,680 | 6.7% | $199,483,022 | 10.5% | $114.34 | 3.6% |
| 2015 | 1,635,217 | 8.3% | $180,538,278 | 20.2% | $110.41 | 10.9% |
| 2014 | 1,509,517 | | $150,241,886 | | $99.53 | |

**VPharm**

| SFY | CLAIM_COUNT | Year to Year Difference | GROSS AMOUNT PAID | Year to Year Difference | GROSS COST/CLAIM | Year to Year Difference |
|---|---|---|---|---|---|---|
| 2016 | 376,546 | -1.5% | $6,835,824.90 | 3.9% | $18.15 | 5.5% |
| 2015 | 382,347 | -11.9% | $6,578,743.06 | -4.2% | $17.21 | 8.8% |
| 2014 | 434,050 | | $6,865,241.13 | | $15.82 | |

**Dual Eligible**

| SFY | CLAIM_COUNT | Year to Year Difference | GROSS AMOUNT PAID | Year to Year Difference | GROSS COST/CLAIM | Year to Year Difference |
|---|---|---|---|---|---|---|
| 2016 | 111,443 | 4.1% | $1,595,183.85 | 8.6% | $14.31 | 4.4% |
| 2015 | 107,092 | -3.0% | $1,468,720.73 | -0.02% | $13.71 | 3.1% |
| 2014 | 110,378 | | $1,468,982.25 | | $13.31 | |

**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 #7: Net Pharmacy Claims Cost – Medicaid Only

## (after application of rebates), SFY 2014-2016

**Medicaid**

| SFY | Claim Count | Gross Amount Paid | Cost/ Claim | Total Rebates Invoiced* | Net Amount Paid | Year to Year Difference | Eligible Member Count | Year-to- Year Difference | Net Spend PMPM | Year-to-Year Difference |
|---|---|---|---|---|---|---|---|---|---|---|
| 2016 | 1,744,680 | $199,483,022 | $114.34 | $107,489,511.83 | $91,993,519.87 | 4.16% | 1,998,044 | 8.02% | $46.04 | -3.58% |
| 2015 | 1,635,217 | $180,538,278 | $110.41 | $92,215,132,01 | $88,323,153.90 | 11.98% | 1,849,638 | 13.7% | $47.75 | -0.96% |
| 2014 | 1,509,517 | $150,241,886 | $99.53 | $71,367,425.58 | $78,874,468.75 | | 1,635,859 | | $48.22 | |

## Chart #8 Top Therapeutic Classes by Plan Paid (DVHA)

| 2016 RANK | 2015 RANK | THERAPY CLASS | 2016 CLAIM COUNT | 2015 CLAIM COUNT | % CHANGE | 2016 TOTAL PAID | 2015 TOTAL PAID | TOTAL PAID % CHANGE |
|---|---|---|---|---|---|---|---|---|
| 1 | 1 | INSULIN | 16,444 | 15,606 | 5.37% | $11,814,473.80 | $9,819,463.02 | 20.32% |
| 2 | 4 | HEPATITIS AGENTS | 586 | 510 | 14.90% | $11,290,466.07 | $9,262,930.14 | 21.89% |
| 3 | 5 | AMPHETAMINES | 53,258 | 47,331 | 12.52% | $11,116,759.28 | $9,253,183.38 | 20.14% |
| 4 | 3 | OPIOID PARTIAL AGONISTS | 107,196 | 90,047 | 19.04% | $11,055,622.53 | $9,416,527.02 | 17.41% |
| 5 | 2 | STIMULANTS - MISC. | 50,713 | 49,046 | 3.40% | $10,768,579.18 | $9,491,282.78 | 13.46% |
| 6 | 6 | SYMPATHOMIMETICS | 68,977 | 64,776 | 6.49% | $9,997,840.56 | $9,080,583.38 | 10.10% |
| 7 | 8 | ANTICONVULSANTS - MISC. | 68,222 | 60,601 | 12.58% | $6,893,775.70 | $5,721,091.04 | 20.50% |
| 8 | 7 | QUINOLINONE DERIVATIVES | 6,352 | 6,592 | -3.64% | $6,888,886.65 | $6,632,182.23 | 3.87% |
| 9 | 9 | ANTIRETROVIRALS | 2,930 | 2,891 | 1.35% | $5,064,202.59 | $4,118,753.32 | 22.95% |
| 10 | 10 | ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES | 1,284 | 1,235 | 3.97% | $4,918,262.60 | $4,026,990.73 | 22.13% |
| 11 | 11 | MULTIPLE SCLEROSIS AGENTS | 771 | 785 | -1.78% | $4,474,999.43 | $3,989,801.65 | 12.16% |
| 12 | 22 | ANTINEOPLASTIC ENZYME INHIBITORS | 417 | 237 | 75.95% | $3,910,721.28 | $2,000,645.59 | 95.47% |
| 13 | 16 | STEROID INHALANTS | 13,742 | 12,575 | 9.28% | $3,646,416.16 | $3,367,023.61 | 8.30% |
| 14 | 14 | OPIOID AGONISTS | 63,409 | 61,677 | 2.81% | $3,572,251.70 | $3,811,864.49 | -6.29% |
| 15 | 12 | PROTON PUMP INHIBITORS | 41,291 | 38,682 | 6.74% | $3,426,445.83 | $3,924,681.50 | -12.69% |
| 16 | 31 | CYSTIC FIBROSIS AGENTS | 554 | 432 | 28.24% | $3,368,576.58 | $1,302,029.81 | 158.72% |
| 17 | 23 | SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS | 854 | 650 | 31.38% | $3,060,924.23 | $1,991,170.80 | 53.72% |
| 18 | 18 | DIAGNOSTIC TESTS | 13,298 | 13,067 | 1.77% | $2,532,998.52 | $2,340,078.98 | 8.24% |
| 19 | 13 | (ADHD) AGENTS | 12,423 | 12,349 | 0.60% | $2,367,032.73 | $3,848,815.38 | -38.50% |
| 20 | 25 | BRONCHODILATORS - ANTICHOLINERGICS | 4,392 | 3,638 | 20.73% | $2,289,309.52 | $1,967,597.27 | 16.35% |

## CHART # 9A: Top Drugs by Spend

| Current Rank | Previous Rank | Drug Name | 2015 Paid | 2016 Paid | 2015 Claim Count | 2016 Claim Count | Total Amount Paid Change | Claim Count Change |
|---|---|---|---|---|---|---|---|---|
| 1 | 1 | Suboxone | $ 8,128,960.64 | $9,802,448.92 | 74837 | 90696 | 20.59% | 21.19% |
| 2 | 3 | Harvoni | $ 5,827,009.50 | $8,860,554.71 | 238 | 374 | 52.06% | 57.14% |
| 3 | 2 | Abilify | $ 6,577,578.56 | $6,505,262.17 | 7046 | 5627 | -1.10% | -20.14% |
| 4 | 5 | Vyvanse | $ 3,994,007.47 | $5,094,265.08 | 19646 | 22121 | 27.55% | 12.60% |
| 5 | 7 | Adderall XR | $ 3,563,242.45 | $5,062,653.35 | 12816 | 17913 | 42.08% | 39.77% |
| 6 | 4 | Methylphenidate HCL ER | $ 4,134,715.73 | $4,904,460.62 | 22322 | 23306 | 18.62% | 4.41% |
| 7 | 6 | Lantus Solostar | $ 3,693,533.75 | $4,342,592.13 | 8288 | 9097 | 17.57% | 9.54% |
| 8 | 9 | Humira Pen | $ 3,101,033.71 | $3,855,339.85 | 1097 | 1175 | 24.32% | 7.11% |
| 9 | 13 | Lyrica | $ 2,301,647.72 | $3,362,352.86 | 7926 | 8607 | 46.08% | 8.59% |
| 10 | 12 | Proair HFA | $ 2,505,591.17 | $2,823,941.03 | 42898 | 44986 | 12.71% | 4.87% |
| 11 | 11 | Flovent HFA | $ 2,520,638.47 | $2,734,449.56 | 10944 | 11839 | 8.48% | 8.18% |
| 12 | 19 | Enbrel Sureclick | $ 1,683,004.78 | $2,670,294.53 | 649 | 854 | 58.66% | 31.59% |
| 13 | 16 | Focalin XR | $ 1,816,879.25 | $2,462,674.51 | 6397 | 7351 | 35.44% | 15.24% |
| 14 | 8 | Advair Diskus | $ 3,110,511.45 | $2,359,778.44 | 8754 | 7104 | -24.14% | -18.85% |
| 15 | 15 | Spiriva Handihaler | $ 2,091,846.53 | $2,345,864.63 | 6501 | 6453 | 12.14% | -0.74% |
| 16 | 17 | Novolog Flexpen | $ 1,779,037.64 | $2,321,848.47 | 3495 | 3726 | 30.51% | 6.61% |
| 17 | 10 | Solvaldi | $ 2,721,129.00 | $2,005,743.00 | 101 | 87 | -26.29% | -13.86% |
| 18 | 20 | Crestor | $ 1,504,354.21 | $1,760,170.93 | 4149 | 4714 | 17.01% | 13.62% |
| 19 | 27 | Symbicort | $ 1,284,865.07 | $1,695,882.65 | 4729 | 6121 | 31.99% | 29.44% |
| 20 | 48 | Advair HFA | $ 815,601.66 | $1,649,554.62 | 2081 | 3790 | 102.25% | 82.12% |
| | **Totals:** | | **$ 63,155,188.76** | **$76,620,132.06** | **244914** | **275941** | | |

## CHART # 9B, Top Drugs by Volume

| Current Rank | Previous Rank | Drug Name | 2015 Paid | 2016 Paid | 2015 Claim Count | 2016 Claim Count | Total Amount Paid Change | Claim Count Change |
|---|---|---|---|---|---|---|---|---|
| 1 | 1 | Suboxone | $ 8,128,960.64 | $ 9,802,448.92 | 74837 | 90696 | 21% | 21% |
| 2 | 2 | Proair HFA | $ 2,505,591.17 | $ 2,823,941.03 | 42898 | 44986 | 13% | 5% |
| 3 | 3 | Omeprazole | $ 752,574.87 | $ 411,904.11 | 35776 | 36224 | -45% | 1% |
| 4 | 6 | Gabapentin | $ 835,238.66 | $ 729,626.00 | 30301 | 35166 | -13% | 16% |
| 5 | 5 | Sertraline HCL | $ 297,213.05 | $ 314,901.29 | 30397 | 33238 | 6% | 9% |
| 6 | 4 | Hydrocodone/Acetaminophen | $ 615,159.16 | $ 491,254.22 | 35667 | 30898 | -20% | -13% |
| 7 | 9 | Fluoxetine HCL | $ 729,537.82 | $ 728,922.93 | 26011 | 28802 | 0% | 11% |
| 8 | 8 | Lisinopril | $ 196,936.42 | $ 190,923.76 | 27941 | 28732 | -3% | 3% |
| 9 | 7 | Clonazepam | $ 227,832.70 | $ 224,850.74 | 28474 | 27622 | -1% | -3% |
| 10 | 10 | Levothyroxine Sodium | $ 424,772.65 | $ 520,697.21 | 25767 | 27026 | 23% | 5% |
| 11 | 11 | Amoxicillin | $ 281,177.76 | $ 281,166.67 | 24794 | 26172 | 0% | 6% |
| 12 | 12 | Citalopram Hydrobromide | $ 269,132.05 | $ 252,571.59 | 24792 | 25270 | -6% | 2% |
| 13 | 13 | Lorazepam | $ 150,141.65 | $ 150,030.02 | 24225 | 24407 | 0% | 1% |
| 14 | 19 | Oxycodone HCL | $ 752,922.92 | $ 624,454.40 | 21591 | 24045 | -17% | 11% |
| 15 | 14 | Ibuprofen | $ 175,971.08 | $ 183,786.37 | 23491 | 23913 | 4% | 2% |
| 16 | 16 | Methylphenidate HCL ER | $ 4,134,715.73 | $ 4,904,460.62 | 22322 | 23306 | 19% | 4% |
| 17 | 18 | Trazodone HCL | $ 194,148.31 | $ 184,180.83 | 21717 | 22517 | -5% | 4% |
| 18 | 17 | Tramadol HCL | $ 204,148.71 | $ 174,850.97 | 22058 | 22463 | -14% | 2% |
| 19 | 21 | Vyvanse | $ 3,994,007.47 | $ 5,094,265.08 | 19646 | 22121 | 28% | 13% |
| 20 | 22 | Prednisone | $ 86,398.95 | $ 99,858.60 | 19471 | 20302 | 16% | 4% |
| | | | $ 24,956,581.77 | $ 28,189,095.36 | 582176 | 617906 | | |

## Chart #10: Drugs Used to Treat Cystic Fibrosis

| CYSTIC FIBROSIS DRUGS | 2015 #RXS | 2016 RXS | % Change | 2015 Unique Members | 2016 Unique Members | % Change2 | 2015_TOTAL_PAID | 2016_TOTAL_PAID | % Change3 |
|---|---|---|---|---|---|---|---|---|---|
| ORKAMBI | 0 | 88 | 0.00% | 0 | 19 | 0.00% | $0.00 | $1,579,500.06 | N/A |
| PULMOZYME | 432 | 453 | 4.86% | 72 | 74 | 2.78% | $1,302,029.81 | $1,519,476.50 | 16.70% |
| TOBI PODHALER | 41 | 39 | -4.88% | 21 | 15 | -28.57% | $294,912.31 | $297,058.53 | 0.73% |
| KALYDECO | 0 | 15 | 0.00% | 0 | 2 | 0.00% | $0.00 | $271,592.42 | N/A |
| CAYSTON | 39 | 37 | -5.13% | 11 | 12 | 9.09% | $223,392.02 | $235,304.07 | 5.33% |
| KITABIS PAK | 0 | 21 | 0.00% | 0 | 11 | 0.00% | $0.00 | $97,290.70 | N/A |
| TOBI | 22 | 7 | -68.18% | 10 | 4 | -60.00% | $162,344.25 | $52,877.57 | -67.43% |
| TOBRAMYCIN | 12 | 4 | -66.67% | 8 | 3 | -62.50% | $44,489.52 | $24,742.92 | -44.38% |
| TOTALS | **546** | **664** | | | | | **$2,027,167.91** | **$4,077,842.77** | |

## Chart #11: Cancer Drugs

| DRUG NAME | 2015_RX_COUNT | 2016_RX_COUNT | % CHANGE | 2015_UNIQUE_MEMBERS | 2016_UNIQUE_MEMBERS | % CHANGE3 | 2015_TOTAL_PAID | 2016_TOTAL_PAID | % CHANGE2 |
|---|---|---|---|---|---|---|---|---|---|
| Imatinib Mesylate | 67 | 108 | 61.19% | 8 | 12 | 50.00% | $503,459.74 | $987,781.53 | 96.20% |
| Lenalidomide | 87 | 68 | -21.84% | 14 | 11 | -21.43% | $746,467.45 | $779,428.30 | 4.42% |
| Palbociclib | 4 | 50 | 1150.00% | 1 | 13 | 1200.00% | $40,554.24 | $525,187.88 | 1195.03% |
| Trametinib Dimethyl Sulfoxide | 30 | 39 | 30.00% | 5 | 9 | 80.00% | $282,395.94 | $387,727.59 | 37.30% |
| Dabrafenib Mesylate | 29 | 39 | 34.48% | 4 | 9 | 125.00% | $197,554.42 | $326,243.63 | 65.14% |
| Dasatinib | 37 | 48 | 29.73% | 4 | 9 | 125.00% | $234,629.81 | $320,608.90 | 36.64% |
| Capecitabine | 165 | 199 | 20.61% | 39 | 35 | -10.26% | $390,475.93 | $293,558.83 | -24.82% |
| Ibrutinib | 23 | 26 | 13.04% | 5 | 4 | -20.00% | $211,548.36 | $236,281.81 | 11.69% |
| Enzalutamide | 6 | 23 | 283.33% | 2 | 4 | 100.00% | $52,656.79 | $199,684.99 | 279.22% |
| Temozolomide | 93 | 103 | 10.75% | 12 | 16 | 33.33% | $215,634.96 | $197,049.36 | -8.62% |
| Crizotinib | 5 | 14 | 180.00% | 1 | 2 | 100.00% | $64,877.85 | $193,576.32 | 198.37% |
| Everolimus | 2 | 17 | 750.00% | 1 | 4 | 300.00% | $3,361.54 | $172,100.37 | 5019.69% |
| Abiraterone Acetate | 7 | 23 | 228.57% | 3 | 6 | 100.00% | $46,830.64 | $154,672.18 | 230.28% |
| Sunitinib Malate | 9 | 12 | 33.33% | 5 | 1 | -80.00% | $82,074.86 | $153,147.66 | 86.60% |
| Pazopanib HCl | 9 | 20 | 122.22% | 2 | 4 | 100.00% | $74,926.43 | $139,252.52 | 85.85% |
| Leuprolide Acetate (3 Month) | 44 | 45 | 2.27% | 29 | 25 | -13.79% | $116,618.74 | $138,056.65 | 18.38% |
| Sorafenib Tosylate | 4 | 13 | 225.00% | 1 | 3 | 200.00% | $38,373.23 | $132,521.23 | 245.35% |
| Methotrexate Sodium | 2,685 | 2,711 | 0.97% | 575 | 596 | 3.65% | $110,434.87 | $125,850.98 | 13.96% |
| Leuprolide Acetate | 94 | 90 | -4.26% | 27 | 28 | 3.70% | $87,080.53 | $91,538.46 | 5.12% |
| Lenvatinib Mesylate | 3 | 6 | 100.00% | 1 | 1 | 0.00% | $41,925.54 | $76,013.94 | 81.31% |
| TOTALS | 3,403 | 3,654 | | | | | $3,541,881.87 | $5,630,283.13 | |

## Pharmacy Claims

A total of 2,232,669 pharmacy drug claims were paid for all of Vermont's publicly funded pharmacy programs during SFY 2016. This represents a 4.8% increase in the number of pharmacy claims paid in SFY 2015.

**Chart #12 Pharmacy Claim Count SFY 2014 - 2016**

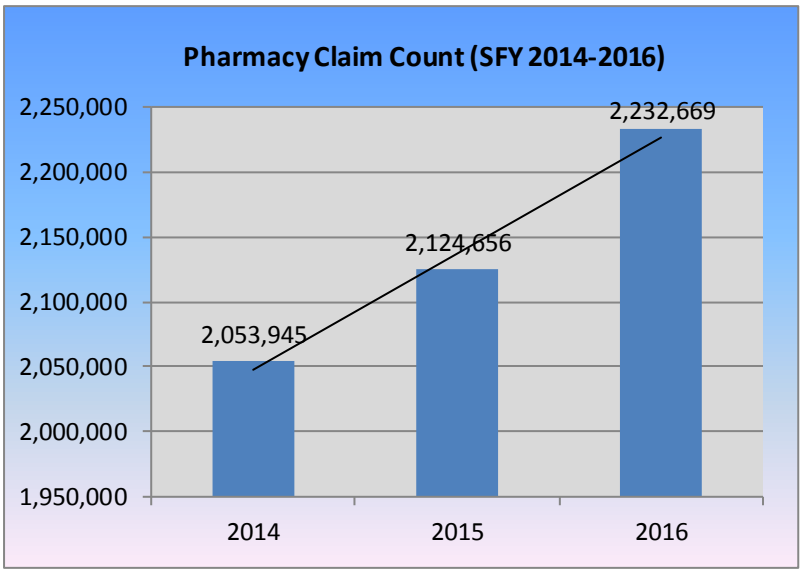
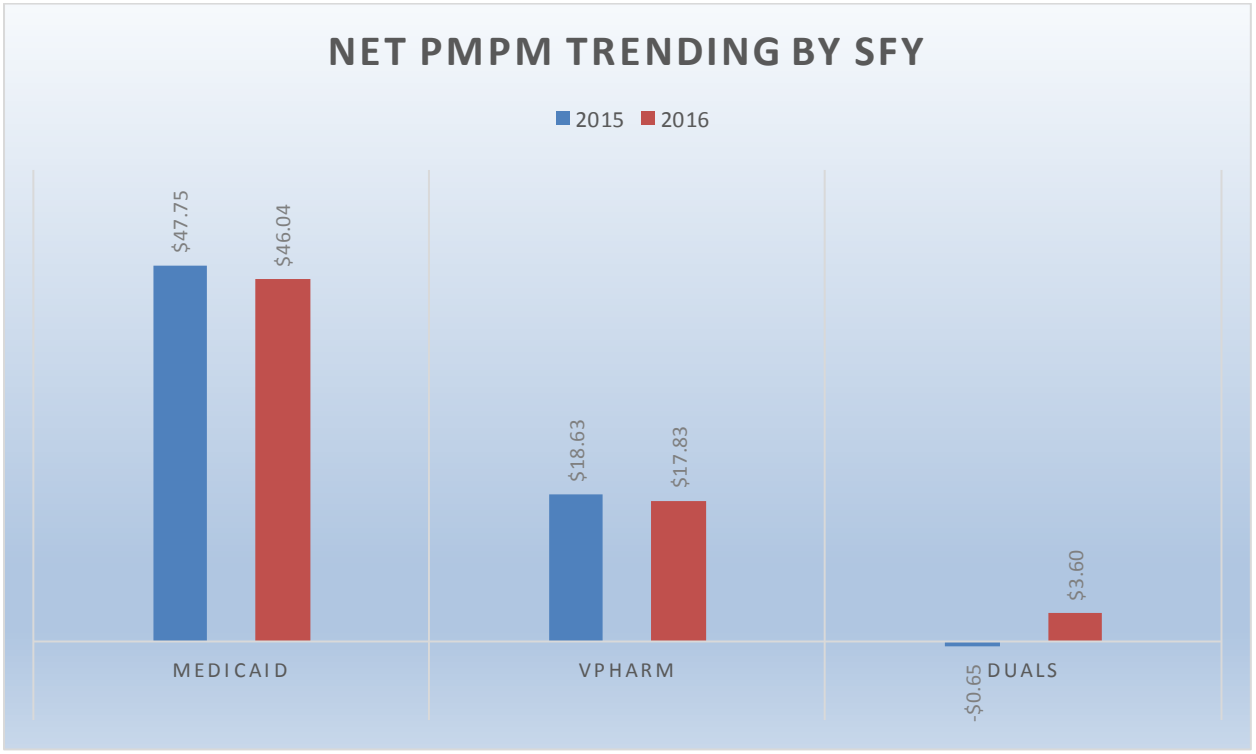
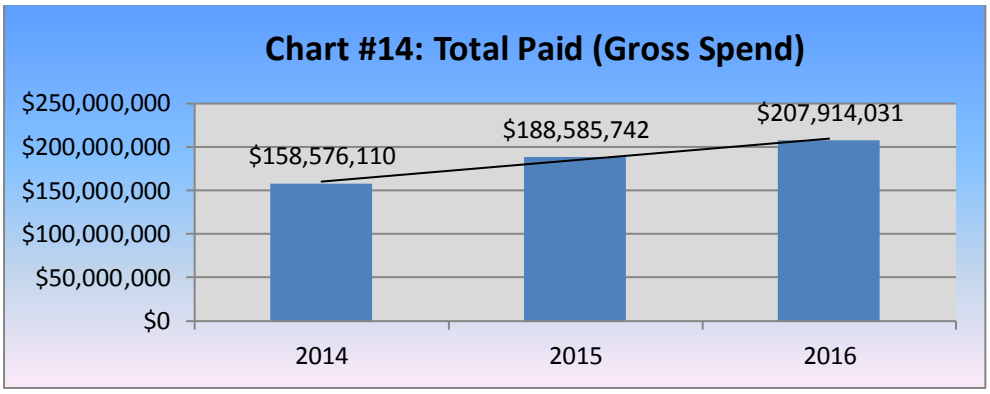



**Chart #13 Gross PMPM Trending by SFY**



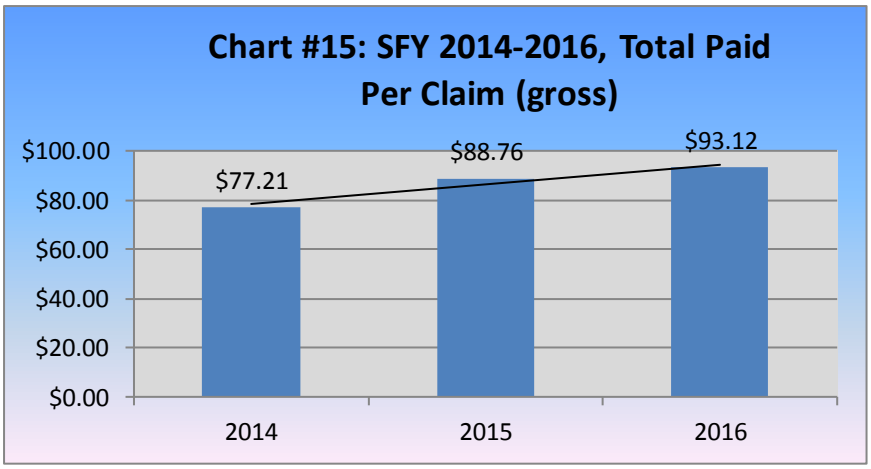
## Gross Spend – SFY 2016

Gross spending prior to rebates for pharmacy drug claims was just under $208 million for SFY 2016. This represents a 9.3% increase in gross spending on pharmacy claims from SFY 2015.




## Gross Cost Per Claim – SFY 2016

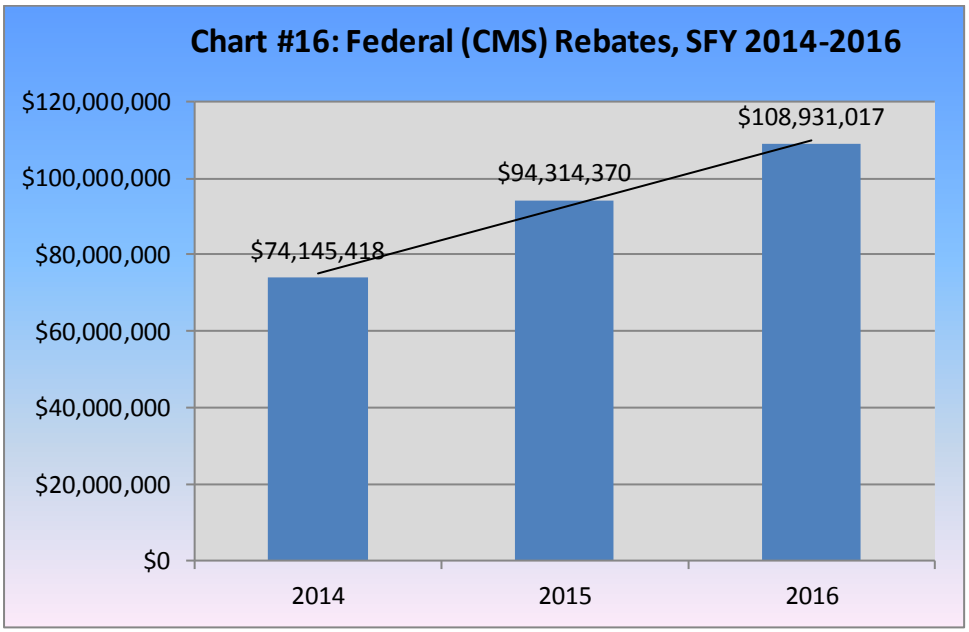
The average gross cost per claim increased from $88.8 in SFY 2015 to $93.1 in SFY 2016, a year-to-year increase of 4.7%.



## 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 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.

Federal rebates invoiced in SFY 2016 totaled $108.9 million versus $94.3 million in 2015, representing a 13% increase.



## Supplemental and Diabetic Supplies Rebates

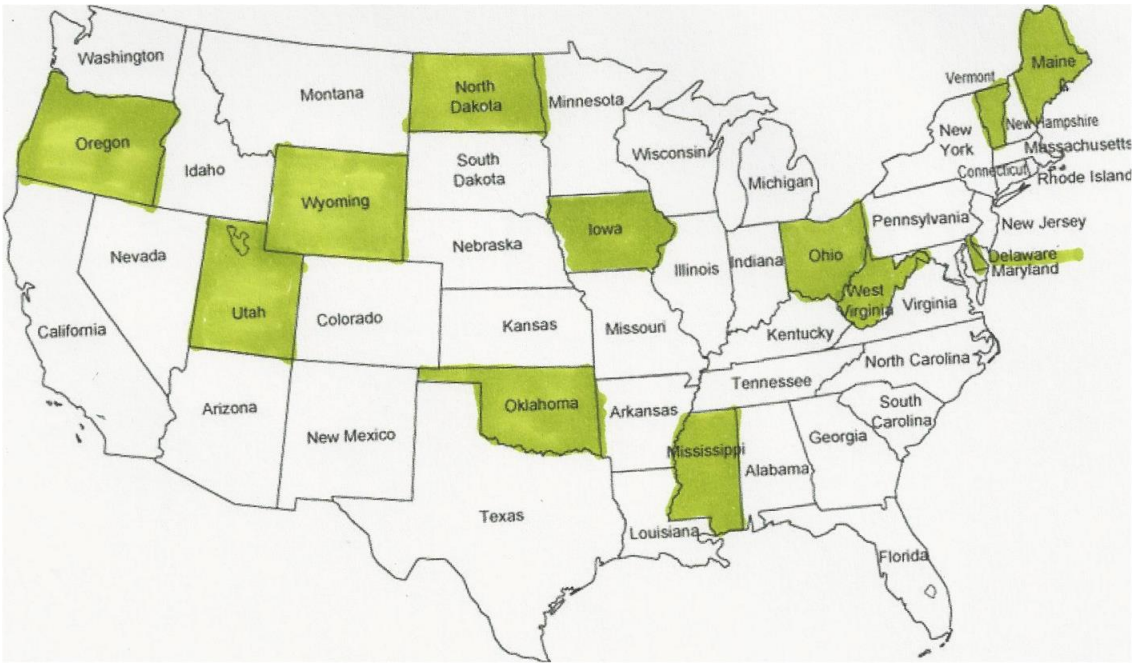
Supplemental rebates are negotiated by the State through its participation in the Sovereign States Drug Consortium (SSDC). Supplemental rebates are those rebates in addition to the required federal rebates on a drug, while Diabetic supply rebates are state-only rebates on Diabetic Supplies for which 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.

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 has 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 12 states as of RCY 2017 are illustrated in the map below.



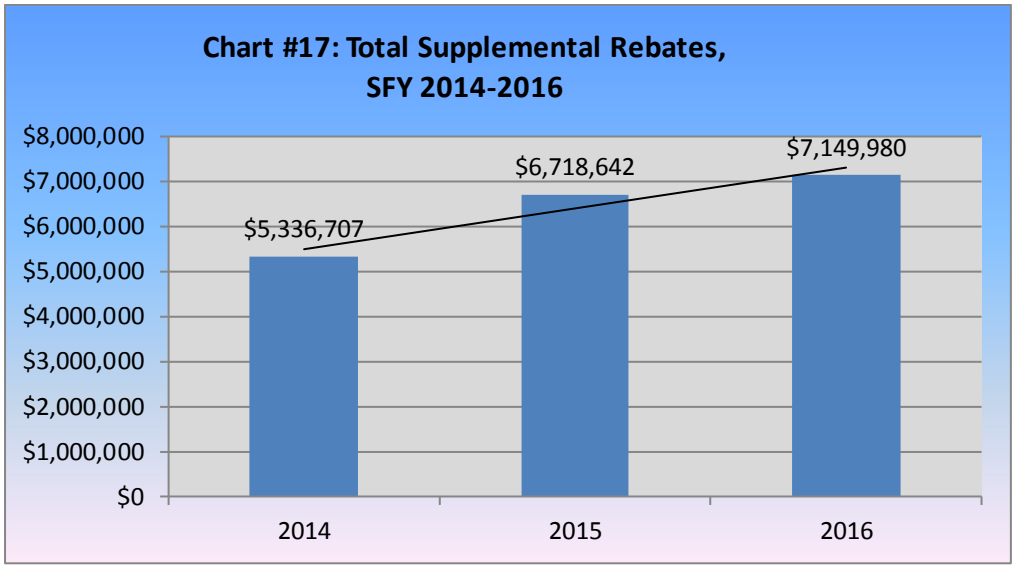

In 2017, a total of 4,970,484 members and $2,991,860,037 in drug expenditures is represented by the 12 participating states providing substantial leverage in manufacturer negotiations.

(Sovereign States Drug Consortium, 2016)

| 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, 2016)

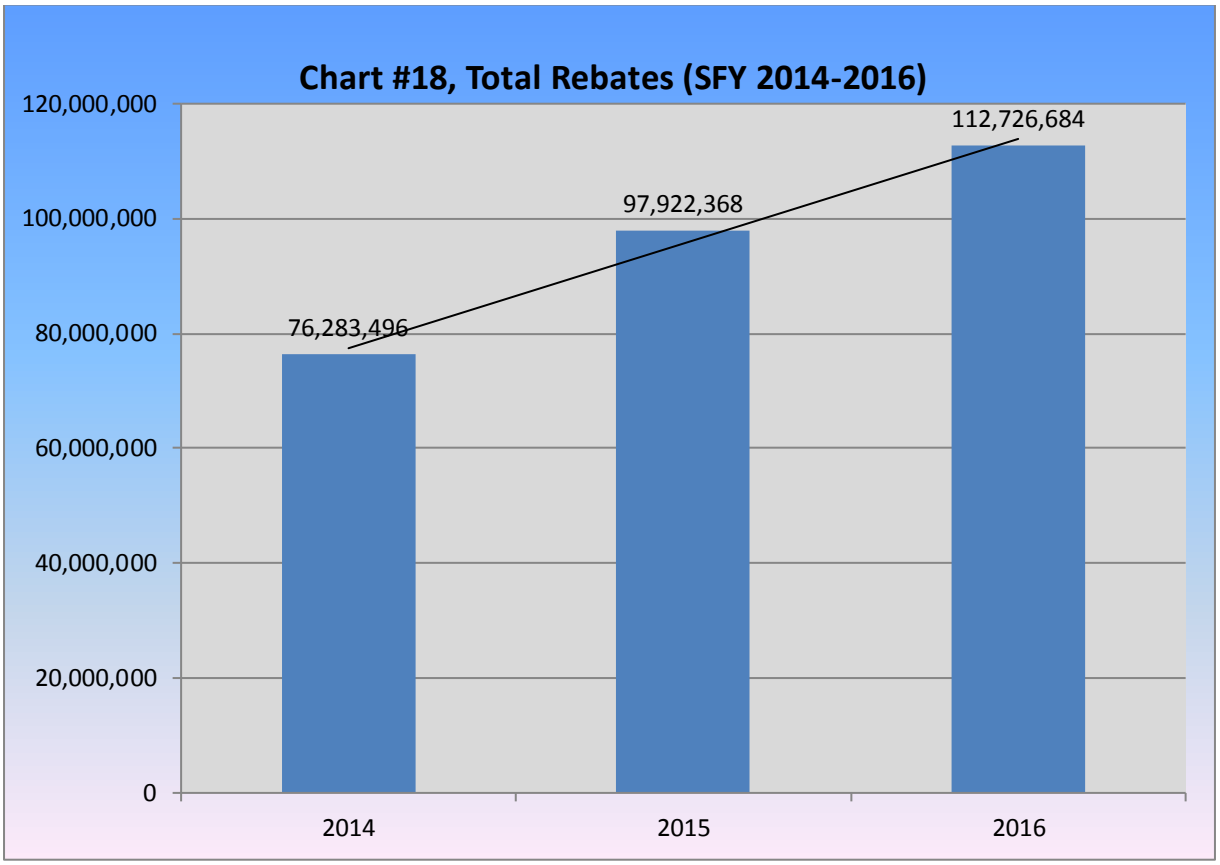
Supplemental rebates invoiced in SFY 2016 for Vermont totaled $7.1 million, representing a 6.3% increase over SFY 2015.




These increases are due to an improvement in rebate contracting on a variety of drug products as well as increases in utilization. In some cases, the Sovereign States Drug Consortium (SSDC) aggressively negotiated more substantial supplemental rebates. For other drugs, new drug categories were added to the Preferred Drug List for drug management to be able to accept and realize the supplemental rebates being offered. Rebate amounts for Diabetic Supplies totaled $2,097,490 in SFY 2016.

## Total Rebates

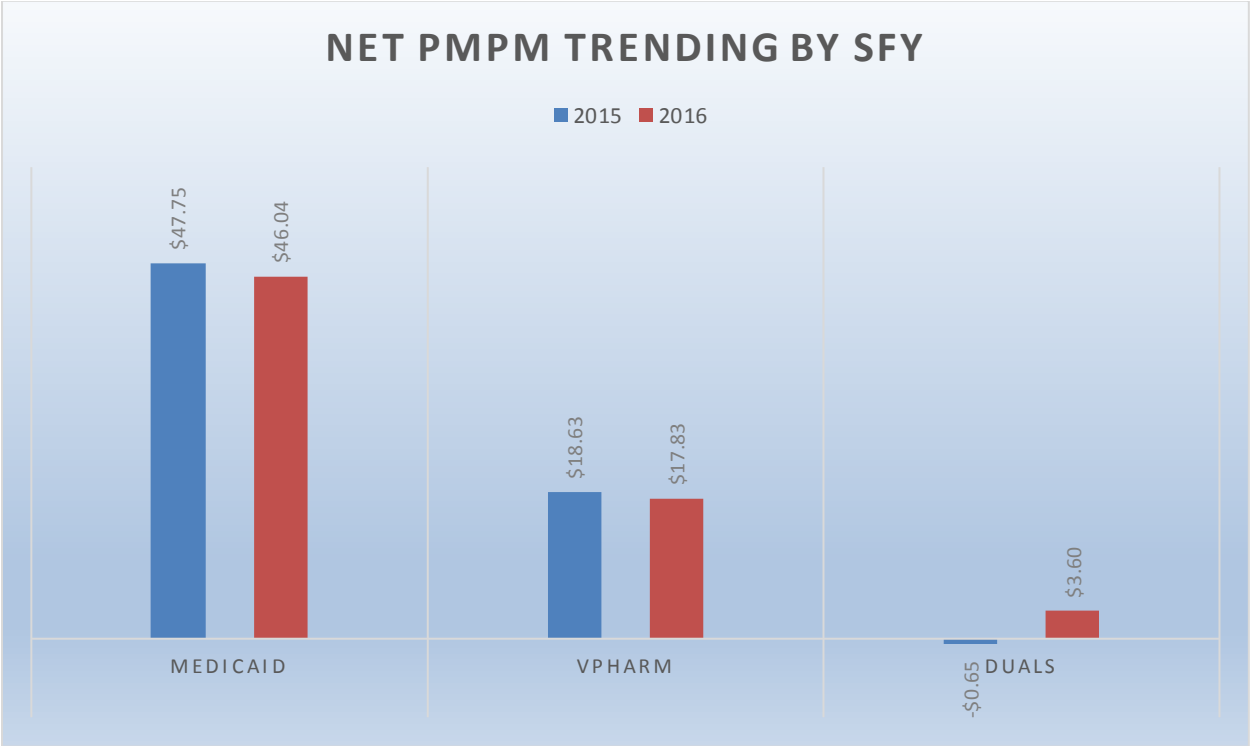
Total rebates for all rebate programs have grown 13.1% from SFY 2015 to SFY 2016.



## Total Net PMPM Cost

Net of all rebates, per-member, per-month spending for Medicaid decreased by 3.6%.

**Chart #19 Total Net Cost PMPM (SFY 2015-2016)**




## Generic Dispensing Rates

The rate of generic dispensing reflects the use of generics as a percentage of all drugs dispensed. Unlike commercial insurance and Part D plans, Medicaid generic utilization rates are typically lower since brands that lose patent protection are often more cost-effective for the State for a period of time

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 "brand-preferred" products on our PDL. This is a result of the impact of the federal rebate program.

The following chart illustrates this observation, where our generic utilization rate substantially increased due to patent expirations and the so-called patent cliff evident in between 2011 and 2013, it has stabilized around 78% for the last few years. By comparison, Part D plans average a generic utilization rate in the low eighties.

**Chart #20: Generic Dispensing Rates, SFY 2011 – 2016**

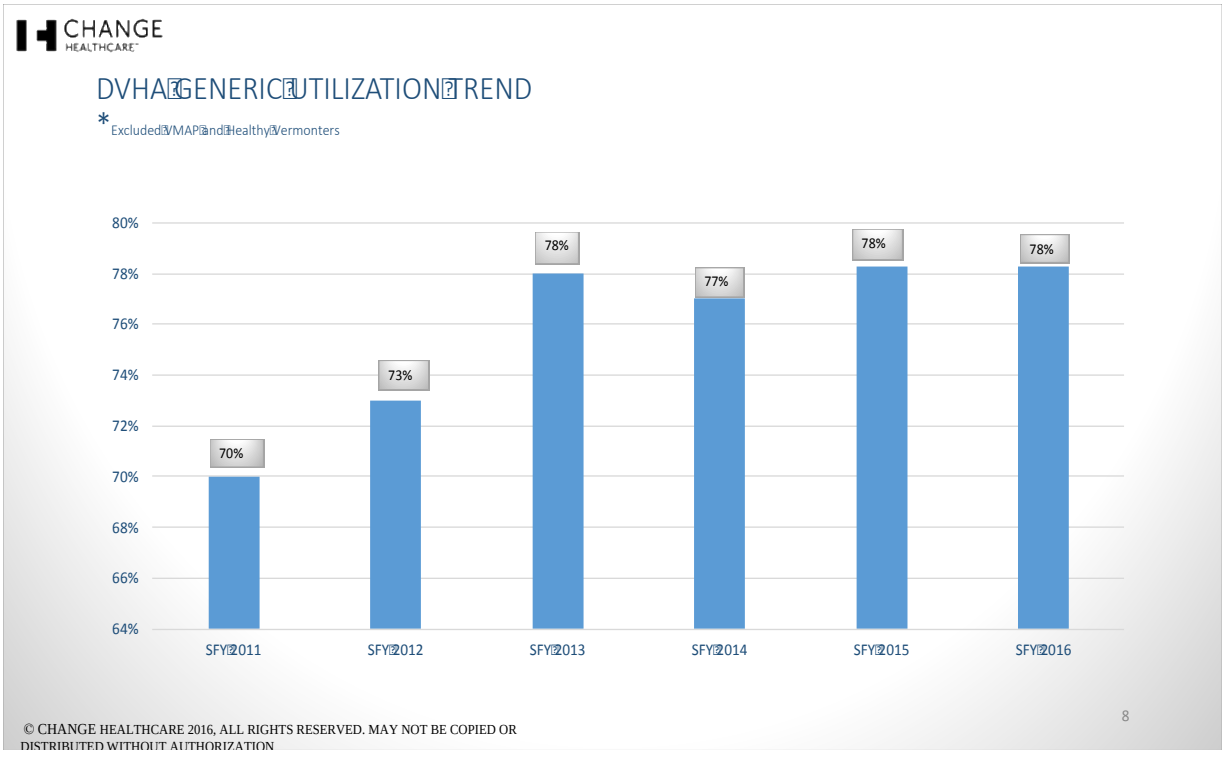


**Chart #21 Generic Dispensing Rates, Medicaid and Part D**

| | | Medicaid | | | VPharm and Dual Eligible | | |
|---|---|---|---|---|---|---|---|
| | 2014 | 2015 | 2016 | | 2014 | 2015 | 2016 |
| Generic use as a percentage of prescriptions for all drugs dispensed | 77% | 78% | 78% | | 84% | 84% | 83.0% |
| Generic use as a percentage of prescriptions when a generic equivalent is available | 87% | 88% | 89% | | 91% | 92% | 93% |

## Specialty Pharmacy

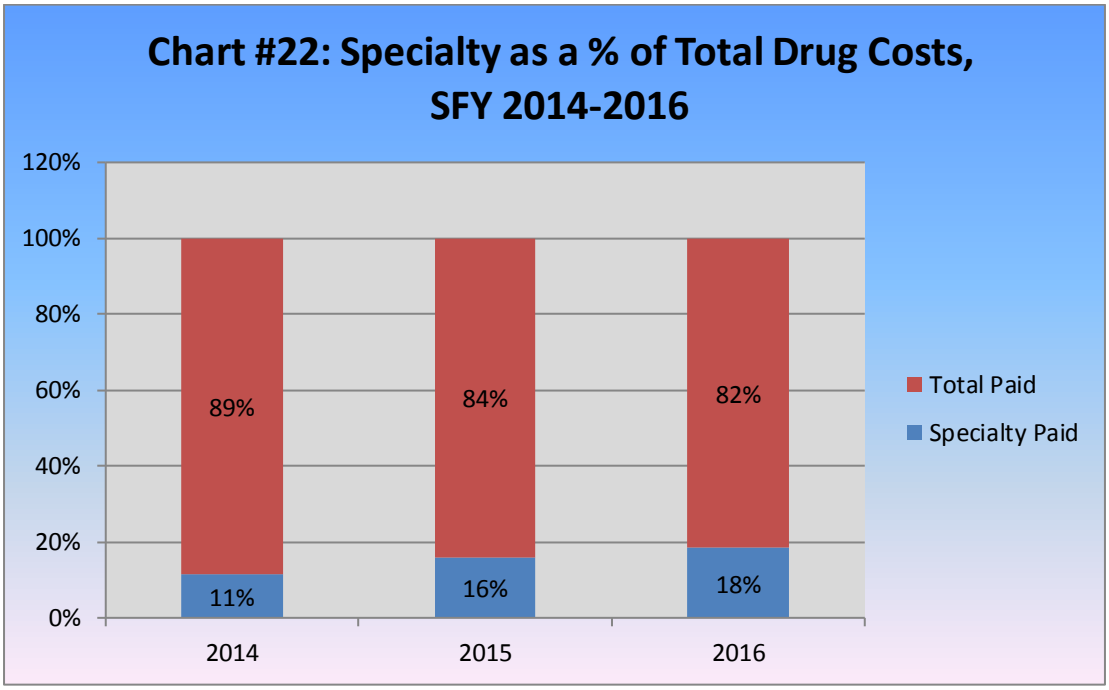
In SFY 2016, Vermont Medicaid utilized the services of two specialty pharmacies. Wilcox Medical is a home infusion pharmacy and home medical equipment supplier owned by BioScrip ®, and BriovaRx® is a full-service specialty pharmacy located in South Portland, Maine partnering with our pharmacy benefits manager, Change Healthcare®.

Wilcox Medical is the specialty pharmacy for the specialty drug Synagis ® used to prevent respiratory syncytial virus (RSV) in at-risk infants, and BriovaRx™ is the specialty pharmacy for most other specialty drugs.

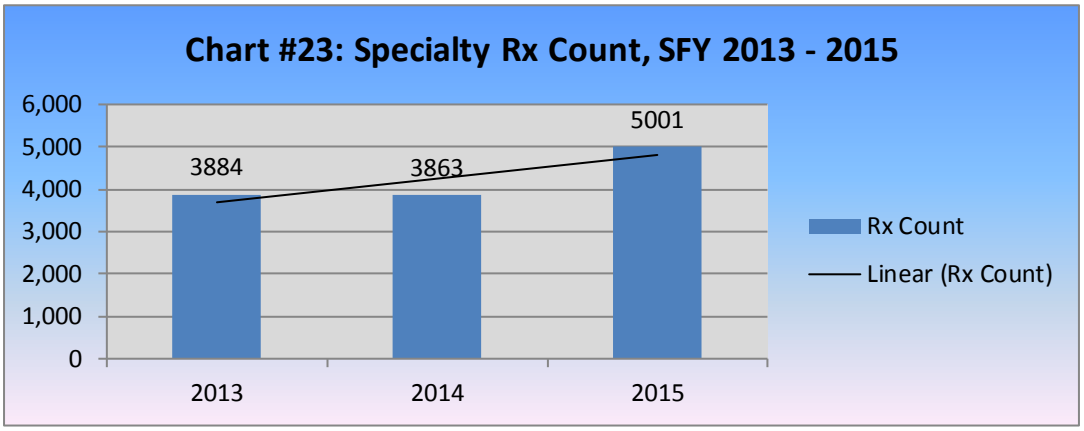
Some examples of specialty drugs managed by BriovaRx® include drugs used to treat multiple sclerosis; hepatitis C; cancer; rheumatoid, psoriatic and juvenile arthritis; psoriasis; Crohn's Disease; ankylosing spondylitis; growth hormone deficiencies; and ulcerative colitis. Dispensing of identified specialty medications is limited to these pharmacies for Medicaid beneficiaries where Medicaid is the primary insurer. Both providers were selected based on a

combination of the quality and the value of the services they offered and the competitive pricing of the products involved.

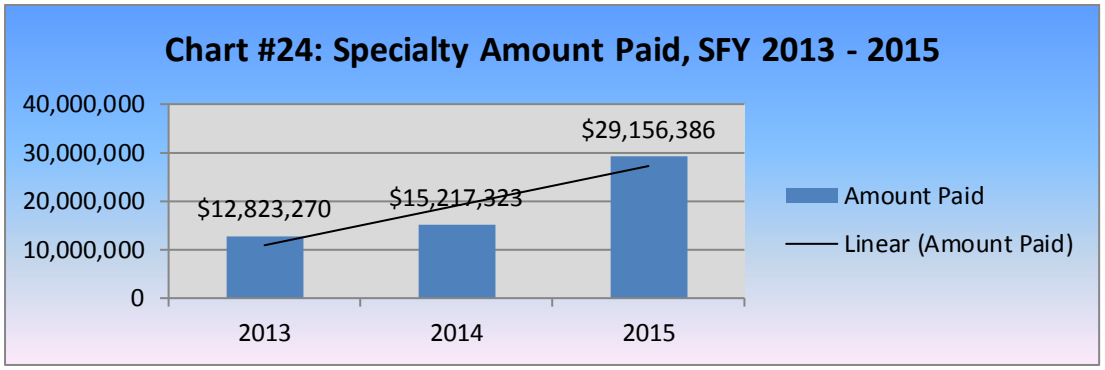
In SFY 2016, specialty drugs represented 18% of DVHA's overall drug spend. This was a 12.5% increase over SFY 2015, when specialty drug spend represented 16% of DVHA's drug spend.



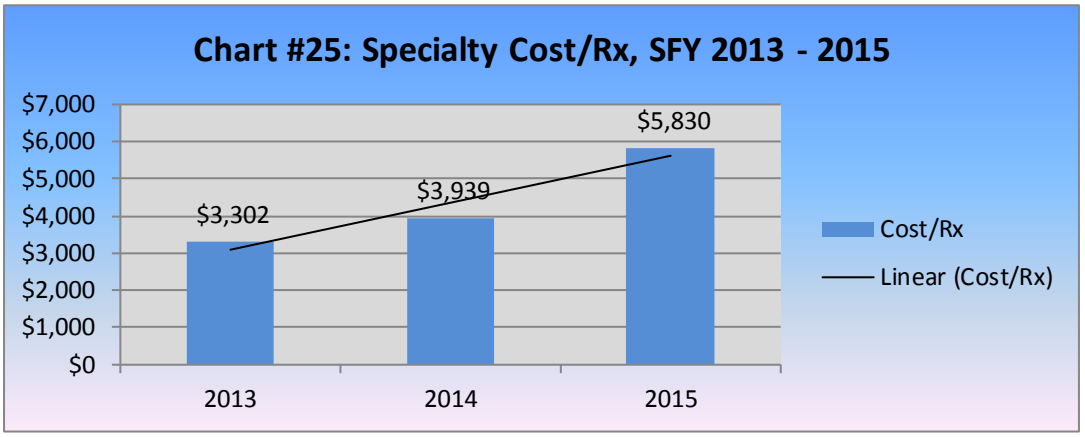

In SFY2016, DVHA paid 5,001 specialty prescriptions. This was a 29% increase over SFY 2015, when DVHA paid 3,863 specialty prescriptions.



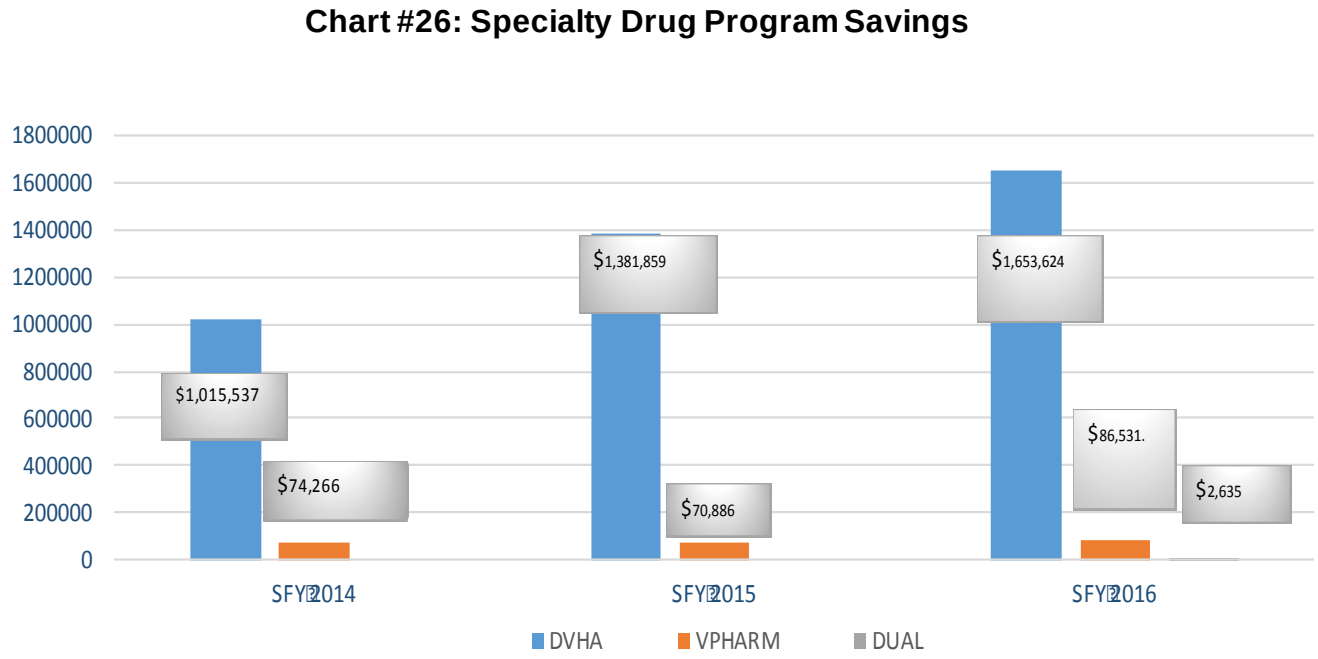

In SFY 2016, DVHA spent $29,156,386 on specialty drugs. This is a 92% increase over SFY2015, when specialty costs were $15,217,323.




In SFY 2016, DVHA spent an average cost of $5,830 per specialty drug prescription. This is a 48% increase over SFY 2015, when the average specialty prescription cost was $3,939.




In SFY2016, savings to Medicaid (DVHA) attributable to DVHA's preferred specialty pharmacies totaled $1,653,624, a 19.6% increase over SFY 2015.



## Section IV:

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