RIDER 26 REPORT

Annual Performance Report for the Prescription Drug Rebate Program

As Required By
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Executive Summary

The *Annual Performance Report for the Prescription Drug Rebate Program* details the outstanding prescription drug rebate balances for the Texas Medicaid program, Children's Health Insurance Program (CHIP), Department of State Health Services (DSHS) Kidney Health Care program (KHC), and DSHS Children with Special Health Care Needs (CSHCN) program. This report is required by the 2008-09 General Appropriations Act (Article II, Health and Human Services Commission, Rider 26, H.B. 1, 80th Legislature, Regular Session, 2007).

The federal Medicaid drug rebate program requires drug manufacturers to enter into a national rebate agreement with the United States Department of Health and Human Services in order for a drug to be included in a state's Medicaid formulary. The contracted drug manufacturers must report their current product and pricing information to the federal government and pay the agreed-upon rebate amount for each outpatient drug dispensed to a Medicaid patient. The rebate amount is based on the manufacturers' reported product and pricing information. States also may collect Medicaid rebates for drugs administered by physicians in their offices. States share the rebates with the federal government at the same rate as the Federal Medical Assistance Percentage (FMAP).

In January 2004, Texas implemented a supplemental rebate program. Supplemental rebates are cash or services provided in lieu of cash (Program Benefit Agreement). Manufacturers who enter into supplemental rebate contracts with the Texas Medicaid program have their products considered for the Preferred Drug List (PDL). The HHSC Pharmaceutical and Therapeutics Committee, composed of pharmacists and clinicians from around the state that provide services to Medicaid clients, recommends which products are assigned a "preferred" or "non-preferred" PDL status. Non-preferred products require prior authorization before the drugs can be dispensed, while preferred products do not require prior authorization. This provides an incentive for manufacturers to participate in the supplemental rebate program. The rebate dollars collected from the supplemental rebate program are also shared with the federal government at the FMAP rate.

A number of manufacturers also voluntarily participate in separate CHIP, KHC, and CSHCN rebate programs. While CHIP rebates are shared with the federal government at an enhanced FMAP rate, collected rebate dollars for the KHC and CSHCN programs are returned entirely to the state program budgets.

Rebate collection rates are subject to change because rebate programs allow retroactive adjustments to pricing and utilization data. When manufacturers provide late or updated pricing information to the Centers for Medicare and Medicaid Services (CMS) or HHSC, rebate rates are changed retroactively. Additionally, collection rates can temporarily exceed 100 percent when manufacturers report pricing changes after rebate invoices are sent.

For calendar year 2008, HHSC invoiced $411,237,564 and collected $384,266,235 – a collection rate of 93.4 percent. This amount represents rebates on claims paid only during the first two calendar quarters of 2008, as of October 31, 2008. From 1991 through October 31, 2008, HHSC collected a total of $5,644,693,345 in rebates – a collection rate of 98.0 percent.

Introduction

Summary

The *Annual Performance Report for the Prescription Drug Rebate Program* is required pursuant to the 2008-09 General Appropriations Act (Article II, Health and Human Services Commission, Rider 26, H.B. 1, 80th Legislature, Regular Session, 2007). Rider 26 requires the following:

> "The Commission shall report on an annual basis the following information to the Legislative Budget Board, the State Auditor's Office and the Governor: the outstanding prescription drug rebate balances for the Medicaid, CHIP, Kidney Health, and Children with Special Health Care Needs programs. The report shall include rebate principal and interest outstanding, age of receivables, and annual collection rates. The reports shall specify amounts billed, the dollar value of pricing and utilization adjustments, and dollars collected. The Commission shall report these data on each year for which the Prescription Drug Rebate program has collected rebates and also on a cumulative basis for all years."

This report details the outstanding prescription drug rebate balances for the Texas Medicaid program, Children's Health Insurance Program (CHIP), Department of State Health Services (DSHS) Kidney Health Care (KHC) program, and Children with Special Health Care Needs (CSHCN) program. These programs include the following rebate programs:

- Medicaid
  - OBRA '90 rebates (Appendix A-3)
  - Medicaid supplemental rebates (Appendix A-4)
  - Medicaid physician-administered rebates (Appendix A-5)
- Children's Health Insurance Program
  - Federal-State Funded (Appendix A-6)
  - State Funded (Appendix A-7)
- DSHS – Kidney Health Care (Appendix A-8)
- DSHS – Children with Special Health Care Needs (Appendix A9)

For each of the rebate programs, appendices A-1 through A-9 include the following information, through October 31, 2008:

- Amounts billed
- Cumulative dollar value of pricing and utilization adjustments
- Dollars collected
- Outstanding principal and interest
- Annual collection rates

Background

The federal Medicaid drug rebate program, which began as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), requires drug manufacturers to enter into a national rebate agreement with the United States Department of Health and Human Services. The

contracted manufacturers must report their current product and pricing information to the federal government. Rebates are calculated and paid to state Medicaid programs by the drug manufacturers based on the reported pricing information. State drug programs are required to include all of the contracted manufacturers' drug products in their Medicaid formularies. States are also required to invoice and collect rebates from these manufacturers for all quantities of their products dispensed to Medicaid recipients by outpatient pharmacies. Additionally, states may collect Medicaid rebates for single-source, brand name products administered by physicians in their offices. Effective January 1, 2008, there are new federal rebate guidelines for Medicaid physician-administered drugs which require states to share the rebates with the federal government at the same rate as the Federal Medical Assistance Percentage (FMAP).

In addition to the federally-mandated Medicaid rebates, Texas implemented a supplemental rebate program in January 2004. Manufacturers who enter into supplemental rebate contracts with the Texas Medicaid program have their products considered for the Preferred Drug List (PDL). The HHSC Pharmaceutical and Therapeutics Committee applies clinical, safety, and cost effectiveness criteria to determine which products are assigned a "preferred" or "non-preferred" PDL status. Non-preferred products require prior authorization before the drugs can be dispensed. Preferred products require no prior authorization, which provides an incentive for manufacturers to participate in the supplemental rebate program. HHSC invoices and collects rebates from manufacturers for their preferred products. These rebate dollars are also shared with the federal government at the FMAP rate.

A number of manufacturers also voluntarily participate in separate CHIP, KHC, and CSHCN rebate programs. While CHIP rebates are shared with the federal government at an enhanced FMAP rate, collected rebate dollars for the KHC and CSHCN programs are returned entirely to the state program budgets.

On February 13, 2006, First Health Services Corporation (First Health) assumed responsibility for HHSC's rebate administration. First Health is responsible for rebate billing, collections, dispute resolution, and data integrity. Invoices are processed every calendar quarter using paid claims data and the contractual rebate rates for each program.

Rebate Process

Manufacturers submit their Medicaid rebate pricing to the Centers for Medicare and Medicaid Services (CMS) 30 days after the end of the calendar quarter. CMS uses the pricing data from the manufacturers to calculate the rebate rate and sends the data to the states. In compliance with federal law, HHSC matches the rate from CMS and the utilization based on claims paid during the quarter. HHSC sends invoices within 60 days after the end of the quarter. Manufacturers have 38 days to pay the balance before interest accrues. The following chart illustrates the rebate process timeline:

Claims Paid	Invoices Sent	Payment Due
January – March	May 30	July 7
April – June	August 28	October 6
July – September	November 30	January 7
October – December	February 28	April 5

Manufacturers are required to calculate and pay rebates based on their most current pricing and sales information. The rebate rate can change between the time HHSC submits the invoices and the time the manufacturer makes payment. In those cases, the payments will include price adjustments and will differ from the invoiced amounts, which will appear as an under or overpayment in the rebate reporting system. For Medicaid rebates, the difference will remain in the system until CMS receives the pricing changes from the manufacturer and transmits the changes to the state with their next quarterly update. Manufacturers can make retroactive price adjustments for up to 12 calendar quarters after their original submission to CMS; although CMS recently made some exceptions and approved retroactive price changes for periods more than 12 calendar quarters past. The net result of these exceptions will be that the manufacturers granted the retroactive price changes will be reducing their current quarter payments by about 25 percent until they have recovered the overpayments from Texas. For CHIP and CSHCN, HHSC relies on manufacturers to provide rebate pricing information. If the data submitted by a manufacturer contains errors, the rebate amount per unit can be overstated or understated, and may result in large rebate adjustments when corrected.

Retroactive changes can be made to utilization data as well. If a claim has been reversed, or research shows that a pharmacy made an error in a claim affecting an earlier invoice, the invoice is changed retroactively. For some of HHSC's older rebate data and for drugs administered in a physician's office, some outstanding balances were due to incorrect product package sizes and unit conversions. First Health rebate staff corrected the unit conversions for most of the drugs, which went as far back as 1991.

Since manufacturers have the right to dispute the number of units that a state invoices, they may withhold payment pending resolution of the dispute. The most common reasons manufacturers cite for disputes are: (1) the state did not reimburse pharmacies at a rate that should cover the pharmacies' cost for their product, and (2) the manufacturer's sales records do not substantiate the number of units invoiced.

The last calendar year for which HHSC has a full year of data is 2007. As of October 31, 2008, only the first two quarters of 2008 are complete.

In appendices A-1 through A-9, the principal outstanding (column H) represents the total receivables, which is the difference between the adjusted billed amount (column E) and cumulative rebates collected (column G), and is aged based on the calendar year.

HHSC Medicaid Programs – Drug Rebate Collections

Medicaid – OBRA '90 Rebate Program

The federal Medicaid drug rebate program, which began as part of OBRA '90, requires a drug manufacturer to enter into a national rebate agreement with the Department of Health and Human Services in order for a drug to be included in a state's Medicaid formulary. The manufacturer pays the state an agreed-upon rebate amount for each outpatient drug dispensed to a Medicaid patient.

In January 2006, approximately 30 percent of Medicaid clients moved into Medicare Part D prescription drug plans and rebate revenues dropped. Rebate revenues have climbed as Medicaid enrollment and utilization have increased in subsequent years.

As shown in Appendix A-3, as of October 31, 2008, Texas had collected $4,924,092,053 for the federal Medicaid rebate program, which is a 99.6 percent collection rate.

Medicaid – Supplemental Rebate Program

Texas implemented a supplemental rebate program in January 2004. Manufacturers who offer a supplemental rebate to the Texas Medicaid program have their products considered for the Preferred Drug List (PDL). A supplemental rebate is cash or a Program Benefit Agreement (PBA), which is services provided in lieu of cash. Products included in the PDL do not require prior authorization. HHSC submitted the first supplemental rebate invoices to manufacturers at the end of May 2004.

The supplemental Medicaid rebate rate is particularly volatile, because it is dependent on the regular Medicaid rebate rate. Manufacturers often provide updated pricing information to CMS that retroactively changes the regular Medicaid OBRA '90 rebate rate. This causes a change in the amount owed in the supplemental Medicaid rebate program. As manufacturers adjust their payments to these retroactive price adjustments, the OBRA '90 rebates and supplemental Medicaid rebates debits and credits will balance.

From the first invoice in May 2004 through October 31, 2008, HHSC had collected $540,756,690 in supplemental rebates (see Appendix A4). Several manufacturers had not adjusted their payments (due to rate changes) between OBRA '90 Medicaid rebates and their supplemental rebates, resulting in a portion of the outstanding balances. Additionally, some manufacturers have chosen to provide PBAs that run for a full year. Rebate balances are settled with the PBA benefits at the end of the contract period; until that time, the rebate system shows the balances as unpaid. Collection rates for supplemental rebates are expected to run at the same rate as federal Medicaid rebates. The current collection rate is 93.7 percent.

Medicaid – Physician-Administered Drug Rebate Program

In fiscal year 2003, HHSC began invoicing and collecting federal Medicaid rebates on outpatient drugs provided in a physician's office, clinic, or hospital outpatient setting. The Vendor Drug Program pays for pharmacy-dispensed drugs identified by their NDC. However, Texas' acute care claims administrator, the Texas Medicaid & Healthcare Partnership, pays for drugs provided in physicians' offices. Drugs administered by physicians are identified by Healthcare Common Procedure Coding System (HCPCS) codes that generally start with the letter 'J' and are commonly referred to as 'J-codes'.

Since Medicaid rebate billing is based on NDCs, HHSC must convert (i.e., crosswalk) physician-administered drug HCPCS codes into NDCs in order to bill and collect rebates. This crosswalk can only occur when there is a one-to-one relationship between the HCPCS and the NDC number, as with single source drugs. For multiple source drugs (for example, generic drugs with

more than one manufacturer and/or package size), HCPCS does not provide a sufficient means to identify the specific NDC dispensed. As a result, multiple source drugs have not been eligible for rebates.

Beginning January 1, 2008, as part of the DRA, providers were required to submit the NDC of the specific drug dispensed, in addition to the HCPCS code, for all single-source drugs and the top 20 multiple-source drugs. Hospitals were granted an extension until January 1, 2009. Due to the addition of the NDC on invoices submitted by providers, the rebate amounts invoiced and collected have increased slightly in calendar year 2008. The first invoice for claims containing NDCs was sent in May 2008.

HHSC has collected $88,242,707 for physician-administered drugs as of October 31, 2008, (see Appendix A-5). But, rebate invoices on drugs provided in physicians' offices have been subject to numerous disputes. The 64.2 percent collection rate for physician-administered drugs is a result of the following issues:

- Manufacturers dispute a large portion of their physician-administered drug invoices because they question the cross-walk procedure used to map the HCPCS to a specific NDC. This should decrease beginning with the 2008 first quarter invoices because of the DRA requirement that providers include the NDC on invoices.
- The quantities of billable units of physician-administered drugs must be converted from the dosage-based unit of measure used to pay the claims (HCPCS units) to the rebate unit of measure, based on NDC. For example, a claim for a single 5 ml dose of penicillin should be billed by the physician as a HCPCS quantity of "1" dose, but converted and billed to the manufacturer as an NDC quantity of "5" ml. Manufacturers often dispute the conversion process because they understand that the conversion process can inflate physician's occasional billing mistakes; e.g. submitting 5 instead of 1, in this example.
- Physicians do not consistently submit claims using the correct HCPCS unit of measure. This results in the incorrect conversion to rebate units and can cause tens of millions of dollars in disputes.

HHSC CHIP Program – Drug Rebate Collections

Children's Health Insurance Program (CHIP) – Federal-State Funded

The CHIP rebate program is a voluntary state rebate program that began in March 2002. CHIP is divided into two subprograms, depending on the funding source: the federally matched federal-state funded (FSF) and the state funded only (SF). For the CHIP-FSF program, HHSC had collected $62,874,508 in rebates as of October 31, 2008 (see Appendix A-6).

HHSC cannot receive the same rebate levels for CHIP drugs as it does for Medicaid drugs due to the federal Medicaid best price requirements included in Section 1927 of the federal Social Security Act. Because of this federal law, if they paid higher CHIP rebates, they might have to pay higher federal Medicaid rebates nationwide. Therefore, manufacturers are only willing to pay a certain level of CHIP rebates.

For CHIP, manufacturers are required to report rebate pricing to HHSC on a quarterly basis. If a manufacturer fails to comply with price reporting requirements, HHSC mails an invoice that reports the utilization of each NDC, but does not calculate an amount due, because the current rate in the system is zero. Pursuant to the terms of the contract, the manufacturer is responsible for calculating the rebate amount and paying. As a result, it appears in the rebate system as though HHSC has been overpaid (greater than 100 percent collections) until the manufacturer corrects/provides the pricing data from the previous quarter. If a manufacturer's pricing file contains errors, it could result in large price adjustments when corrected. In 2005, there were two manufacturers whose rebate amounts per unit were overstated, and this caused invoices to be overstated by approximately $20 million. The rates were subsequently corrected (see column B in Appendix A6 for the pricing adjustment).

Children's Health Insurance Program (CHIP) – State Funded

The CHIP-SF rebate program covers prescriptions for legal immigrants. This program is funded entirely from general revenue. This program is much smaller than the CHIP-FSF program. HHSC had collected $984,853 in rebates as of October 31, 2008 (see Appendix A-7). Like CHIP-FSF, CHIP-SF faces challenges related to manufacturer data, including the overstatement of certain manufacturers' rebate amounts per unit in 2005.

DSHS Programs – Drug Rebate Collections

Kidney Health Care (KHC) Program

In 1997, KHC approached drug manufacturers to participate in its new, voluntary drug rebate program. Because KHC qualifies as a State Pharmaceutical Assistance Program (SPAP), it is able to achieve the same level of rebates as Medicaid for participating manufacturers, without jeopardizing the manufacturers' Medicaid rate. HHSC's Vendor Drug Program administers this program for the Department of State Health Services (DSHS).

HHSC had collected $24,325,978 in KHC drug rebates as of October 31, 2008, (see Appendix A-8). Collections have averaged 82 percent of the amount invoiced, because KHC invoices for rebates on 'covered products' that included non-drug items, such as lancets and syringes. Since manufacturers are not calculating rates or paying rebates on non-drug products under Medicaid, their systems have not been modified to include non-drug products for the KHC program.

Children with Special Health Care Needs (CSHCN) Program

Like KHC, CSHCN began collecting voluntary rebates in 1997 and HHSC's Vendor Drug Program administers this program for DSHS. Prior to June 2003, the CSHCN program was considered an SPAP. In June 2003, CMS issued new guidance clarifying what type of programs qualified as an SPAP.

With the clarification, CSHCN no longer qualified as an SPAP and was no longer eligible to receive Medicaid-level rebate rates. At that time, DSHS contacted the manufacturers that had existing contracts and requested that these manufacturers re-contract at a new rate for CSHCN

rebates. Many manufacturers did not respond to the request from DSHS to re-contract, nor did they cancel their existing contracts with Texas. As a result, HHSC continues to send zero-rate, utilization invoices and the manufacturers are responsible for calculation and payment. If a manufacturer fails to submit rates, but pays the invoice, the outstanding balance in the system appears to be a credit to the manufacturer until the manufacturer submits the required rates.

HHSC had collected $3,416,556 in CSHCN rebates as of October 31, 2008 (see Appendix A-9).

Conclusion

From 1991 through October 31, 2008, HHSC had collected a total of $5,644,693,345 in rebates. Appendix A-1 contains the summary breakdown by year. Appendix A-2 contains the summary breakdown by program.

The table below shows the total collections for all years (calendar years 1991 through partial calendar year 2008), totaling $5,644,693,345 in rebate revenue. The outstanding principle is $114,348,557. The average collection rate calculated for all programs is 98 percent for this period.

Table 1
Total Rebate Collections by Program (All Funds)
As of October 31, 2008

Program	Adjusted Billed Amounts	Cumulative Rebate Collections	Principle Outstanding	Interest Outstanding	Collection Rate
Medicaid – OBRA '90	$4,944,644,022	$4,924,092,053	$20,551,969	$14,032,875	99.6%
Medicaid – Supplemental	577,097,023	540,756,690	36,340,333	3,442,064	93.7%
Medicaid – Physician Administered	137,403,845	88,242,707	49,161,138	3,619,630	64.2%
CHIP – Federal/State Funded	65,462,476	62,874,508	2,587,968	665,227	96.0%
CHIP – State Funded	1,029,510	984,853	44,657	12,656	95.7%
DSHS – Kidney Health	29,750,722	24,325,978	5,424,744	521,389	81.8%
DSHS – CSHCN	3,654,304	3,416,556	237,748	74,968	93.5%
Totals	**$5,759,041,902**	**$5,644,693,345**	**$114,348,557**	**$22,368,809**	**98.0%**

The table below provides the total rebates billed and collected for each calendar year for all programs combined. Rebates are tracked on an accrual basis and are tied to the calendar year.

Table 2
Rebate Collections by Calendar Year for All Programs (All Funds)
As of October 31, 2008

Year	Adjusted Billed Amounts	Cumulative Rebate Collections	Principle Outstanding	Interest Outstanding	Collection Rate
1991	$42,046,380	$40,835,952	$1,210,428	$854,483	97.1%
1992	76,127,106	76,066,959	60,147	759,024	99.9%
1993	93,998,156	92,534,809	1,463,347	2,498,020	98.4%
1994	100,645,389	100,067,195	578,194	846,132	99.4%
1995	110,886,609	110,139,277	747,332	607,894	99.3%
1996	121,303,611	121,286,721	16,890	547,738	100.0%
1997	142,522,408	141,685,481	836,927	404,899	99.4%
1998	171,965,178	171,921,177	44,001	306,441	100.0%
1999	215,734,070	215,050,855	683,215	617,381	99.7%
2000	258,097,204	257,710,420	386,784	829,964	99.9%
2001	311,354,468	309,299,958	2,054,510	756,803	99.3%
2002	388,654,183	384,781,456	3,872,727	1,324,627	99.0%
2003	491,664,883	481,308,246	10,356,637	1,774,477	97.9%
2004	712,761,271	692,945,357	19,815,914	3,700,035	97.2%
2005	849,034,568	829,869,023	19,165,545	4,360,301	97.7%
2006	564,325,043	549,905,874	14,419,169	1,639,507	97.4%
2007	696,683,811	685,018,350	11,665,461	470,871	98.3%
2008	411,237,564	384,266,235	26,971,329	70,212	93.4%
Totals	**$5,759,041,902**	**$5,644,693,345**	**$114,348,557**	**$22,368,809**	**98.0%**

It is important to note that collection rates for all years are subject to change because rebate programs allow retroactive adjustments to pricing and utilization data. Manufacturers regularly provide late and/or updated pricing information to CMS or HHSC. These updates to pricing information may retroactively change the rebate rates. Additionally, collection rates can exceed 100 percent when manufacturers report pricing changes after rebate invoices are sent.

Looking forward, the DRA provision, which required providers to begin submitting NDCs on their drug claims beginning in 2008 should continue to increase the invoice amounts and collection rates on physician-administered drugs. This should result in fewer disputes from drug manufacturers.

Appendix A-1
Summary by Calendar Year

	A	B	C	D	E	F	G	H	I	J
	Amounts Billed					Collections		Outstanding Balances		
Calendar Year	Original	Total Dollar Value of Pricing Adjustments since billing	Total Dollar Value of Utilization Adjustments since billing	Other Adjustments	Total Billed =A+B+C+D (Current Value of Invoices)	Collections Prior to Current SFY	Total Collected	Principle Outstanding = E - G	Interest Outstanding	Collection Rate = G / E
1991	$176,786,863	($4,322,863)	($128,378,423)	($2,039,197)	$42,046,380	$40,824,116	$40,835,952	$1,210,428	$854,483	97.1%
1992	517,266,130	22,910,986	(460,852,476)	(3,197,534)	76,127,106	76,072,598	76,066,959	60,147	759,024	99.9%
1993	144,986,905	(11,600,978)	(36,261,146)	(3,126,625)	93,998,156	92,523,665	92,534,809	1,463,347	2,498,020	98.4%
1994	101,905,748	803,594	(2,108,281)	44,328	100,645,389	100,052,242	100,067,195	578,194	846,132	99.4%
1995	110,901,521	1,084,627	(997,665)	(101,874)	110,886,609	110,137,692	110,139,277	747,332	607,894	99.3%
1996	120,089,393	2,719,660	(436,323)	(1,069,119)	121,303,611	121,277,589	121,286,721	16,890	547,738	100.0%
1997	139,403,644	6,605,411	(3,429,091)	(57,556)	142,522,408	141,669,211	141,685,481	836,927	404,899	99.4%
1998	168,020,894	7,251,356	(3,329,376)	22,304	171,965,178	171,875,146	171,921,177	44,001	306,441	100.0%
1999	205,954,375	20,901,386	(10,859,046)	(262,645)	215,734,070	215,044,764	215,050,855	683,215	617,381	99.7%
2000	257,121,092	15,603,262	(14,571,621)	(55,529)	258,097,204	257,713,394	257,710,420	386,784	829,964	99.9%
2001	323,086,302	13,333,907	(25,249,697)	183,956	311,354,468	309,298,848	309,299,958	2,054,510	756,803	99.3%
2002	471,942,054	18,116,932	(104,401,338)	2,996,535	388,654,183	384,738,138	384,781,456	3,872,727	1,324,627	99.0%
2003	511,605,438	8,490,553	(135,337,651)	106,906,543	491,664,883	480,931,340	481,308,246	10,356,637	1,774,477	97.9%
2004	734,650,848	(2,284,227)	(281,241,887)	261,636,537	712,761,271	691,255,590	692,945,357	19,815,914	3,700,035	97.2%
2005	1,012,787,515	150,752,071	(440,708,688)	126,203,670	849,034,568	825,114,656	829,869,023	19,165,545	4,360,301	97.7%
2006	634,626,923	126,563,380	(81,285,515)	(115,579,745)	564,325,043	546,492,604	549,905,874	14,419,169	1,639,507	97.4%
2007	688,187,269	23,120,515	(7,326,031)	(7,297,942)	696,683,811	684,488,151	685,018,350	11,665,461	470,871	98.3%
2008	777,114,215	11,769,758	(6,665,194)	(370,981,215)	411,237,564	196,274,909	384,266,235	26,971,329	70,212	93.4%
Totals	**$7,096,437,129**	**$411,819,330**	**($1,743,439,449)**	**($5,775,108)**	**$5,759,041,902**	**$5,445,784,653**	**$5,644,693,345**	**$114,348,557**	**$22,368,809**	**98.0%**

Appendix A-2
Summary by Program

	A	B	C	D	E	F	G	H	I	J
	Amounts Billed					**Collections**		**Outstanding Balances**		
Program	**Original**	**Total Dollar Value of Pricing Adjustments since billing**	**Total Dollar Value of Utilization Adjustments since billing**	**Other Adjustments**	**Total Billed =A+B+C+D (Current Value of Invoices)**	**Collections Prior to Current SFY**	**Total Collected**	**Principle Outstanding = E - G**	**Interest Outstanding**	**Collection Rate = G / E**
Medicaid – OBRA '90	$5,410,950,984	$132,314,962	($555,433,547)	($43,188,377)	$4,944,644,022	$4,778,653,973	$4,924,092,053	$20,551,969	$14,032,875	99.6%
Medicaid – Supplemental	$583,439,690	($9,674,679)	($2,261,624)	$5,593,636	$577,097,023	$510,504,857	$540,756,690	$36,340,333	$3,442,064	93.7%
Medicaid – Physician-Administered	$651,501,257	$285,205,443	($1,177,196,172)	$377,893,317	$137,403,845	$69,423,796	$88,242,707	$49,161,138	$3,619,630	64.2%
CHIP – Federal/State Funded	$418,264,438	($1,905,532)	($6,908,735)	($343,987,695)	$65,462,476	$59,600,684	$62,874,508	$2,587,968	$665,227	96.0%
CHIP – State Funded	$1,664,643	($54,716)	($8,804)	($571,613)	$1,029,510	$961,108	$984,853	$44,657	$12,656	95.7%
DSHS – Kidney Health	$27,094,289	$4,737,521	($939,584)	($1,141,504)	$29,750,722	$23,321,950	$24,325,978	$5,424,744	$521,389	81.8%
DSHS – CSHCN	$3,521,828	$1,196,331	($690,983)	($372,872)	$3,654,304	$3,318,285	$3,416,556	$237,748	$74,968	93.5%
Totals	**$7,096,437,129**	**$411,819,330**	**($1,743,439,449)**	**($5,775,108)**	**$5,759,041,902**	**$5,445,784,653**	**$5,644,693,345**	**$114,348,557**	**$22,368,809**	**98.0%**

Appendix A-3
Medicaid OBRA '90 Rebates

	A	B	C	D	E	F	G	H	I	J
	Amounts Billed					Collections		Outstanding Balances		
Calendar Year	Original	Total Dollar Value of Pricing Adjustments since billing	Total Dollar Value of Utilization Adjustments since billing	Other Adjustments	Total Billed =A+B+C+D (Current Value of Invoices)	Collections Prior to Current SFY	Total Collected	Principle Outstanding = E - G	Interest Outstanding	Collection Rate = G / E
1991	$176,786,852	($4,322,872)	($128,378,414)	($2,039,197)	$42,046,369	$40,824,107	$40,835,943	$1,210,426	$854,483	97.1%
1992	517,265,213	22,910,969	(460,851,858)	(3,197,534)	76,126,790	76,072,302	76,066,661	60,129	759,023	99.9%
1993	144,986,033	(11,600,978)	(36,260,704)	(3,126,625)	93,997,726	92,523,438	92,534,511	1,463,215	2,497,987	98.4%
1994	101,661,513	803,594	(1,990,429)	43,774	100,518,452	99,926,728	99,940,248	578,204	845,768	99.4%
1995	110,137,651	1,084,627	(647,065)	(107,261)	110,467,952	109,727,898	109,721,838	746,114	606,365	99.3%
1996	119,577,283	2,719,659	(1,286,465)	(1,070,925)	119,939,552	119,931,427	119,939,473	79	508,057	100.0%
1997	136,237,230	6,604,070	(2,353,731)	(58,752)	140,428,817	139,542,700	139,552,620	876,197	343,679	99.4%
1998	160,716,058	7,191,134	827,152	8,113	168,742,457	168,686,877	168,732,848	9,609	196,877	100.0%
1999	190,469,105	20,173,634	(7,009)	(232,053)	210,403,677	209,936,545	209,942,579	461,098	433,829	99.8%
2000	232,465,787	15,778,093	2,595,735	(87,081)	250,752,534	250,769,525	250,759,005	(6,471)	348,867	100.0%
2001	288,657,871	12,609,009	792,694	(68,135)	301,991,439	301,576,733	300,747,227	1,244,212	441,705	99.6%
2002	355,794,358	14,752,123	(2,163,938)	(657,267)	367,725,276	365,722,735	364,346,254	3,379,022	633,459	99.1%
2003	424,135,367	4,033,380	34,010,310	(29,082)	462,149,975	459,126,755	458,515,719	3,634,256	979,877	99.2%
2004	546,033,657	(8,214,894)	26,629,574	(783,681)	563,664,656	563,560,761	562,865,284	799,372	1,268,094	99.9%
2005	630,608,298	14,209,872	817,440	(17,809,730)	627,825,880	628,524,278	628,696,126	(870,246)	2,243,320	100.1%
2006	398,623,430	6,773,756	20,692,322	(5,226,640)	420,862,868	418,878,762	419,420,574	1,442,294	859,361	99.7%
2007	550,007,812	25,565,314	(6,597,281)	(7,222,465)	561,753,380	567,893,559	563,929,404	(2,176,024)	186,960	100.4%
2008	326,787,466	1,244,472	(1,261,880)	(1,523,836)	325,246,222	165,428,843	317,545,739	7,700,483	25,164	97.6%
Totals	**$5,410,950,984**	**$132,314,962**	**($555,433,547)**	**($43,188,377)**	**$4,944,644,022**	**$4,778,653,973**	**$4,924,092,053**	**$20,551,969**	**$14,032,875**	**99.6%**

Appendix A-4
Medicaid Supplemental Rebates

	A	B	C	D	E	F	G	H	I	J
	Amounts Billed					Collections		Outstanding Balances		
Calendar Year	Original	Total Dollar Value of Pricing Adjustments since billing	Total Dollar Value of Utilization Adjustments since billing	Other Adjustments	Total Billed =A+B+C+D (Current Value of Invoices)	Collections Prior to Current SFY	Total Collected	Principle Outstanding = E - G	Interest Outstanding	Collection Rate = G / E
2004	$112,973,266	($3,009,056)	($756,970)	$1,268,888	$110,476,128	$109,977,362	$110,310,204	$165,924	$1,236,015	99.8%
2005	190,687,412	(1,912,591)	(4,997,971)	2,429,194	186,206,044	177,656,845	177,575,752	8,630,292	1,632,213	95.4%
2006	99,595,054	2,660,794	4,763,205	1,881,437	108,900,490	104,341,834	104,336,910	4,563,580	419,755	95.8%
2007	114,437,529	(7,685,952)	(1,034,285)	(16,497)	105,700,795	95,360,775	97,992,848	7,707,947	119,663	92.7%
2008	65,746,429	272,126	(235,603)	30,614	65,813,566	23,168,041	50,540,976	15,272,590	34,418	76.8%
Totals	**$583,439,690**	**($9,674,679)**	**($2,261,624)**	**$5,593,636**	**$577,097,023**	**$510,504,857**	**$540,756,690**	**$36,340,333**	**$3,442,064**	**93.7%**

Appendix A-5
Medicaid Physician-Administered Rebates

	A	B	C	D	E	F	G	H	I	J
	Amounts Billed					Collections		Outstanding Balances		
Calendar Year	Original	Total Dollar Value of Pricing Adjustments since billing	Total Dollar Value of Utilization Adjustments since billing	Other Adjustments	Total Billed =A+B+C+D (Current Value of Invoices)	Collections Prior to Current SFY	Total Collected	Principle Outstanding = E - G	Interest Outstanding	Collection Rate = G / E
1991	$11	$9	($9)	$0	$11	$9	$9	$2	$0	81.8%
1992	917	17	(618)	0	316	296	298	18	1	94.3%
1993	872	0	(442)	0	430	227	298	132	33	69.3%
1994	244,235	0	(117,852)	554	126,937	125,514	126,947	(10)	364	100.0%
1995	763,870	0	(350,600)	5,387	418,657	409,794	417,439	1,218	1,529	99.7%
1996	512,110	1	850,142	1,806	1,364,059	1,346,162	1,347,248	16,811	39,681	98.8%
1997	3,125,968	0	(1,074,888)	2,837	2,053,917	2,087,005	2,093,352	(39,435)	60,978	101.9%
1998	6,783,031	86	(4,148,605)	14,014	2,648,526	2,621,464	2,621,502	27,024	100,630	99.0%
1999	13,883,666	(82,213)	(10,467,697)	(26,267)	3,307,489	3,135,938	3,135,947	171,542	152,397	94.8%
2000	21,860,808	(189,820)	(17,143,262)	32,158	4,559,884	4,204,583	4,211,584	348,300	468,663	92.4%
2001	31,972,781	(69,609)	(25,934,638)	251,586	6,220,120	4,727,691	5,553,690	666,430	288,094	89.3%
2002	105,399,279	(356,361)	(95,679,712)	149,133	9,512,339	7,991,121	9,411,600	100,739	536,356	98.9%
2003	76,819,805	248,633	(169,277,974)	107,007,929	14,798,393	7,730,029	8,714,853	6,083,540	603,901	58.9%
2004	63,407,482	8,775,724	(306,677,387)	261,477,935	26,983,754	6,952,985	8,976,435	18,007,319	989,806	33.3%
2005	178,639,442	154,896,291	(436,124,509)	124,604,144	22,015,368	5,989,373	10,553,771	11,461,597	213,448	47.9%
2006	125,554,567	111,761,666	(106,534,152)	(108,847,140)	21,934,941	12,453,714	15,136,234	6,798,707	147,338	69.0%
2007	7,346,371	438,403	565,838	3,174,964	11,525,576	6,463,812	8,451,121	3,074,455	15,189	73.3%
2008	15,186,042	9,782,616	(5,079,807)	(9,955,723)	9,933,128	3,184,079	7,490,379	2,442,749	1,222	75.4%
Totals	**$651,501,257**	**$285,205,443**	**($1,177,196,172)**	**$377,893,317**	**$137,403,845**	**$69,423,796**	**$88,242,707**	**$49,161,138**	**$3,619,630**	**64.2%**

Appendix A-6
CHIP - Federal-State Funded Rebates

	A	B	C	D	E	F	G	H	I	J
	Amounts Billed					Collections		Outstanding Balances		
Calendar Year	Original	Total Dollar Value of Pricing Adjustments since billing	Total Dollar Value of Utilization Adjustments since billing	Other Adjustments	Total Billed =A+B+C+D (Current Value of Invoices)	Collections Prior to Current SFY	Total Collected	Principle Outstanding = E - G	Interest Outstanding	Collection Rate = G / E
2002	$7,687,147	$2,895,278	($6,237,996)	$3,417,387	$7,761,816	$7,467,814	$7,467,425	$294,391	$124,043	96.2%
2003	6,860,401	2,854,518	463,621	(89,605)	10,088,935	9,935,996	9,938,575	150,360	98,025	98.5%
2004	9,150,732	(19,242)	(396,834)	(334,399)	8,400,257	8,240,283	8,267,255	133,002	88,031	98.4%
2005	9,546,158	(16,443,833)	(383,248)	16,850,958	9,570,035	9,648,168	9,733,518	(163,483)	158,331	101.7%
2006	8,292,629	5,044,028	(190,658)	(3,157,409)	9,988,590	8,914,769	9,079,785	908,805	122,720	90.9%
2007	11,724,464	3,376,971	(124,768)	(1,962,866)	13,013,801	11,882,874	11,771,121	1,242,680	69,947	90.5%
2008	365,002,907	386,748	(38,852)	(358,711,761)	6,639,042	3,510,780	6,616,829	22,213	4,130	99.7%
Totals	**$418,264,438**	**($1,905,532)**	**($6,908,735)**	**($343,987,695)**	**$65,462,476**	**$59,600,684**	**$62,874,508**	**$2,587,968**	**$665,227**	**96.0%**

Appendix A-7
CHIP - State Funded Rebates

	A	B	C	D	E	F	G	H	I	J
	Amounts Billed					Collections		Outstanding Balances		
Calendar Year	Original	Total Dollar Value of Pricing Adjustments since billing	Total Dollar Value of Utilization Adjustments since billing	Other Adjustments	Total Billed =A+B+C+D (Current Value of Invoices)	Collections Prior to Current SFY	Total Collected	Principle Outstanding = E – G	Interest Outstanding	Collection Rate = G / E
2002	$96,654	($42,529)	($264)	$41,629	$95,490	$102,801	$102,799	($7,309)	$1,293	107.7%
2003	119,278	55,804	38	(3,850)	171,270	158,434	158,431	12,839	2,233	92.5%
2004	241,068	(29,375)	(3,148)	(4,376)	204,169	203,888	203,916	253	2,468	99.9%
2005	240,587	(144,550)	(458)	154,467	250,046	241,525	245,311	4,735	4,438	98.1%
2006	101,267	61,517	(3,939)	(35,128)	123,717	111,025	111,493	12,224	1,389	90.1%
2007	127,548	42,698	(960)	(24,344)	144,942	121,558	119,529	25,413	813	82.5%
2008	738,241	1,719	(73)	(700,011)	39,876	21,877	43,374	(3,498)	22	108.8%
Totals	**$1,664,643**	**($54,716)**	**($8,804)**	**($571,613)**	**$1,029,510**	**$961,108**	**$984,853**	**$44,657**	**$12,656**	**95.7%**

Appendix A-8
DSHS - Kidney Health Care Rebates

	A	B	C	D	E	F	G	H	I	J
	Amounts Billed					Collections		Outstanding Balances		
Calendar Year	Original	Total Dollar Value of Pricing Adjustments since billing	Total Dollar Value of Utilization Adjustments since billing	Other Adjustments	Total Billed =A+B+C+D (Current Value of Invoices)	Collections Prior to Current SFY	Total Collected	Principle Outstanding = E - G	Interest Outstanding	Collection Rate = G / E
1997	$33,803	$820	($4)	($1,636)	$32,983	$33,056	$33,056	($73)	$196	100.2%
1998	450,019	49,234	(1,487)	181	497,947	491,158	491,175	6,772	7,478	98.6%
1999	1,369,917	229,724	161,325	(4,232)	1,756,734	1,715,124	1,715,150	41,584	24,007	97.6%
2000	2,350,455	(3,403)	(10,975)	(561)	2,335,516	2,298,491	2,298,997	36,519	10,085	98.4%
2001	2,003,143	775,430	(69,470)	0	2,709,103	2,571,478	2,576,088	133,015	18,135	95.1%
2002	2,530,553	916,539	(308,976)	9,751	3,147,867	3,026,440	3,026,146	121,721	20,948	96.1%
2003	3,418,245	1,255,963	(494,667)	2	4,179,543	3,718,223	3,718,969	460,574	81,359	89.0%
2004	2,610,790	199,659	(33,603)	9,922	2,786,768	2,093,058	2,094,965	691,803	107,004	75.2%
2005	2,720,625	133,726	(8,937)	(1,663)	2,843,751	2,751,748	2,753,485	90,266	96,341	96.8%
2006	2,179,323	71,953	3,592	(105,149)	2,149,719	1,437,847	1,462,076	687,643	79,149	68.0%
2007	4,128,721	1,113,534	(129,551)	(1,047,870)	4,064,834	2,337,732	2,327,353	1,737,481	72,186	57.3%
2008	3,298,695	(5,658)	(46,831)	(249)	3,245,957	847,595	1,828,518	1,417,439	4,501	56.3%
Totals	**$27,094,289**	**$4,737,521**	**($939,584)**	**($1,141,504)**	**$29,750,722**	**$23,321,950**	**$24,325,978**	**$5,424,744**	**$521,389**	**81.8%**

Appendix A-9
DSHS - Children with Special Health Care Needs Rebates

	A	B	C	D	E	F	G	H	I	J
	Amounts Billed					Collections		Outstanding Balances		
Calendar Year	Original	Total Dollar Value of Pricing Adjustments since billing	Total Dollar Value of Utilization Adjustments since billing	Other Adjustments	Total Billed =A+B+C+D (Current Value of Invoices)	Collections Prior to Current SFY	Total Collected	Principle Outstanding = E - G	Interest Outstanding	Collection Rate = G / E
1997	$6,643	$521	($468)	($5)	$6,691	$6,450	$6,453	$238	$46	96.4%
1998	71,786	10,902	(6,436)	(4)	76,248	75,647	75,652	596	1,456	99.2%
1999	231,687	580,241	(545,665)	(93)	266,170	257,157	257,179	8,991	7,148	96.6%
2000	444,042	18,392	(13,119)	(45)	449,270	440,795	440,834	8,436	2,349	98.1%
2001	452,507	19,077	(38,283)	505	433,806	422,946	422,953	10,853	8,869	97.5%
2002	434,063	(48,118)	(10,452)	35,902	411,395	427,227	427,232	(15,837)	8,528	103.8%
2003	252,342	42,255	(38,979)	21,149	276,767	261,903	261,699	15,068	9,082	94.6%
2004	233,853	12,957	(3,519)	2,248	245,539	227,253	227,298	18,241	8,617	92.6%
2005	344,993	13,156	(11,005)	(23,700)	323,444	302,719	311,060	12,384	12,210	96.2%
2006	280,653	189,666	(15,885)	(89,716)	364,718	354,653	358,802	5,916	9,795	98.4%
2007	414,824	269,547	(5,024)	(198,864)	480,483	427,841	426,974	53,509	6,113	88.9%
2008	354,435	87,735	(2,148)	(120,249)	319,773	113,694	200,420	119,353	755	62.7%
Totals	**$3,521,828**	**$1,196,331**	**($690,983)**	**($372,872)**	**$3,654,304**	**$3,318,285**	**$3,416,556**	**$237,748**	**$74,968**	**93.5%**