Report to
The Vermont Legislature

Pharmacy Best Practices and Cost Control Program Report

In Accordance with 33 V.S.A. § 2001(c)

Submitted to: House Committee on Appropriations
House Committee on Health Care
House Committee on Human Services
Senate Committee on Appropriations
Senate Committee on Health and Welfare

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VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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EXECUTIVE SUMMARY

The purpose of this legislative report is to satisfy requirements in Act 130 of 2022 which updates 33 V.S.A. § 2001 and to provide an overview of the scope of Department of Vermont Health Access (DVHA) Pharmacy Benefit programs. This report covers issues related to drug cost and utilization, effect of national trends on pharmacy programs, comparisons to other states, DVHA's administration of the pharmaceutical assistance programs, use of Prior Authorization requirements, regulatory efforts, and drug categorizations.

DVHA's Pharmacy Unit managed **$266 million in total gross drug spend** in state fiscal year (SFY) 2022, an increase of 15% over the previous fiscal year (Chart 1). Gross drug spend includes what DVHA paid to pharmacies for all publicly funded pharmacy benefit programs, including Medicaid for Children and Adults, those dually eligible for Medicare and Medicaid, and Vermont's Pharmaceutical Assistance Program (VPharm). Physician-administered drugs are typically processed through the medical benefit which are not reflected in any cost or utilization figures in this report.

The significant spending increase was driven largely by three factors: increases in caseload and utilization, changes in drug mix, and increased costs per claim. COVID-19 vaccinations also played a role, albeit a lesser one.

Federal law passed during the early days of the pandemic prevents states from disenrolling Medicaid members until the federal government declares the end of the Public Health Emergency. As anticipated, Prior Authorizations numbers increased in SFY 2022 due to increases in Medicaid enrollment and increased use of specialty medications. Increases in expensive specialty medications also drove up the average cost per claim. From 2023-2030, national spending and utilization are expected to rise more rapidly due to increasing utilization of new drugs in the market, reaching a projected $65.6 billion aggregate prescription drug expenditure in 2030 compared to $34.5 billion in 2020. This is in line with pre-pandemic expectations of net prescription drug expenditures which are projected to continue to increase steadily with an annual growth rate of 5.2-5.9% each year for the next five years.

The Drug Utilization Review Board helps support the goals of the Agency of Human Services and DVHA. The pharmacy program's goal is to ensure that members receive medically necessary medications in the most efficient and cost-effective manner.

Effective July 1, 2022, VPharm expanded the drug coverage available under two of the program's three levels - which allows enrollees to pay $1 or $2 copays for additional drugs through VPharm, including maintenance drugs.

ISSUES RELATED TO DRUG COST AND UTILIZATION

DVHA reimbursed pharmacies **$266 million** for all prescriptions for Medicaid members (including dual eligible members) in SFY 2022 compared to $231 million in SFY 2021. This represents an increase in gross expenditures of approximately **$35 million dollars, 15% over the previous fiscal year**. Net prescription costs (gross spend-rebates applied) for the same population increased from $75 million in SFY 2021 to **$89 million in SFY2022**, an increase in net cost of $14.8 million and almost 20% over the prior fiscal year (Chart 1).

Several factors contributed to this increase in drug spend; Medicaid eligibility by total average monthly eligible Medicaid members increased in SFY 2022 to 187,025 people, an almost 8% increase over the prior year (Chart 2). When the spend is normalized for eligibility using a "per member per month" (PMPM) calculation, gross costs increased from $108.34 PMPM to $116.01 PMPM, an increase of 7.1%, while net costs rose from $34.93 PMPM to $38.88 PMPM, an 11.3% increase (Chart 6A). Gross cost per prescription rose 9.46% and net cost rose 14.1% per prescription (Chart 1).

Specialty drug spending increased significantly (e.g., drug mix), accounting for 29% of total drug costs (Chart 12) and increased by $10 million in SFY2022 (Chart 13A). The number of specialty drug claims paid increased by 14% (Chart 13B) and the average gross cost per claim for all drugs increased by 9.5%, while the average net cost per claim increased by 14%. This is indicative of higher gross drug costs and lower rebates available for newer specialty drugs resulting in higher average net cost per claim (Chart 1).

Spending on non-specialty drugs also increased. Non-insulin drugs used to treat diabetes increased by $5.7 million (Chart 7B).

Top Drugs by Cost and Utilization

The Department continues to see the highest spending on drugs used to treat substance use disorder, diabetes, attention deficit hyperactivity disorder (ADHD), inflammatory conditions such as rheumatoid arthritis, psoriasis, and Crohn's disease. Chart 7A provides the list of the top 10 therapeutic classes by gross spend, Chart 8 lists the top 10 drugs by gross spend, and Charts 9 and 10 rank therapeutic classes and drugs by utilization (numbers of prescriptions).

Consistent with reporting for at least the last six state fiscal years, opioid partial agonists including Suboxone® (buprenorphine/naloxone) are on the top of the charts by both spend and utilization. Number of claims for all buprenorphine-containing drugs decreased during SFY2022 (Chart 9). This is likely due to fewer prescriptions because the Department increased the number of days allowed per prescription from 14 to 30 days due to the federal COVID-19 Public Health Emergency, and the Drug Utilization Review Board (DURB) voted to keep this change in place.

During SFY2022, the number of members using short-acting opioids decreased by 0.93% and those using long-acting opioids decreased by 5% (Chart 11A). The number of prescriptions for short-acting and long-acting opioids decreased by 4.9% and 4.6%, respectively (Chart 11B). However, when the data is normalized for the increase in Medicaid eligibility during SFY 2022, short-acting opioid use per 1,000 members declined by 11.4% and long-acting opioid use declined by 11% during this time (Chart 11C). These results are indicative of Vermont's continued commitment to implementing and maintaining initiatives that address the opioid crisis. Vermont recognizes and treats opioid use disorder as a chronic, relapsing medical condition, resulting in expanded access for those who seek treatment and, in most counties, greatly decreased wait times for those

patients. The Hub and Spoke programs continue to be a nationally recognized system of care for improving access to medication assisted treatment for opioid use disorder.

Newly included in the Top Therapeutic Categories by Gross Spend report, Chart 7A, are the glucagon-like peptide-1 receptor agonists (GLP-1 RA) drugs. These medications have increased in use for treatment of type 2 diabetes. These medications not only help with type 2 diabetes management, but additionally provide cardiovascular, kidney, and weight benefits. According to the American Diabetes Association, GLP-1 RA drugs are recommended as initial or add-on therapy in most diabetic treatment regimens. GLP-1 RA medications have moved to number 8 on the top 10 list of Top Therapeutic Categories by Gross Spend report and this indicates a 63% gross spend increase from last year ($4.2 million increase in spend) (Chart 7A). We expect spending to continually increase on GLP-1 RA drugs in the future as their clinical benefits outweigh those of most other diabetic medications.

Specialty Pharmacy

Specialty pharmacies are distinct from traditional pharmacies in coordinating many aspects of patient care and disease management. They are designed to efficiently deliver medications with specialized handling, storage, and distribution requirements. Health care professionals employed by specialty pharmacies provide patient education, help ensure appropriate medication use, promote adherence, and attempt to avoid unnecessary costs. Some conditions treated with specialty medications include cancer, multiple sclerosis, cystic fibrosis, organ transplantation, human growth hormone deficiencies, and hemophilia or bleeding disorders. DVHA requires any specialty pharmacy dispensing specialty drugs to be Certified by the Utilization Review Accreditation Commission (URAC), the Accreditation Commission for Health Care (ACHC) or the Center for Pharmacy Practice Accreditation (CPPA).

The list of specialty medications and pharmacies is updated quarterly and can be found in the Pharmacy Provider manual.[1] A specialty drug must meet a minimum of two (2) of the following requirements:

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

In SFY 2022, the gross amount spent on specialty medications increased by $10 million; however, the percentage of total drug spending spent on specialty medications has not changed and remains at 29% for the current and previous years. (Chart 12) In comparison2, recent data from CVS/Caremark, a major Pharmacy Benefit Manager (PBM), reveals that specialty medications drove about 54% of overall drug spending in the first three quarters of 2021.[2] Many specialty drugs, especially those that are neither taken orally nor self-injected, are administered in the doctor's office or other provider settings and are also a factor in drug spend increases. Most of these drugs are covered through the Medicaid medical benefit, not the Pharmacy benefit. The specialty drug numbers accounted for in this report only include those paid under the pharmacy benefit. Chart 12 provides the Department's 3-year gross trend for specialty drug spend as a percentage of total drug costs.

[1] Manuals | Department of Vermont Health Access Pharmacy Provider Manual_1.pdf (vermont.gov)
[2] https://insightslp.cvshealth.com/rs/161-LXO-491/images/CVS-Drug-Trend-Report_PDF_2.23.22.pdf

Pharmacy Cost Management Program

The Department of Vermont Health Access, in collaboration with Vermont's Pharmacy Benefit Administrator, Change Healthcare, manages and enrolls patients in a Pharmacy Cost Management (PCM) program. The goal of the program is to mitigate the impact of high-cost specialty drugs while ensuring that the full value of these medications in improving patient outcomes can be realized. The Change Healthcare clinical team identifies and enrolls appropriate patients who initiate treatment on specialty medications (where the cost exceeds $5,000 per prescription) into the program. Enrollment can also occur during the prior authorization approval process.

Patient Outreach and Education

As part of this program, a Change Healthcare pharmacist provides direct patient outreach, consultation, and education to enrolled patients. The program tracks patient adherence to medication regimens by measuring Medication Possession Ratio (MPR). The MPR can be used to estimate the degree to which patients with chronic medical conditions comply with prescribed drug therapies. Patient outreach not only emphasizes the importance of taking the medication as prescribed, but also aims to identify and rectify any potential barriers to adherence (such as transportation, work schedule, and dexterity/vision problems).[3]

The primary goals of the program are to decrease inappropriate use and assure adherence to medication regimens of patients on these high-cost drugs. Medication adherence is of utmost importance given that the direct cost of non-adherence to the U.S. health-care system is estimated at $100 billion to $289 billion annually and is the cause of 125,000 deaths related to treatment failure. [4,5] To demonstrate improved adherence, the Department analyzed the 90-day period after members were enrolled into PCM for all members enrolled through March 1, 2022.

The results demonstrate that 91% of the members enrolled in PCM had an MPR of at least 0.8. The internal program report provides per-member data which is used to identify patients that are currently non-adherent and focus efforts where they are most needed.

Vermont PCM Member Adherence Assessment	Total
Total Number of Vermont PCM Members	**1,558**
Number of Members Adherent to Targeted Medications (MPR≥0.8)	**1,419**
Percent of Vermont PCM Members Adherent to Targeted Medication	**91 %**

The PCM program enrolled an additional 128 members through SFY 2022 for a total of 2,866 members since program initiation. A total of 77 contacts were made with members for counseling. During quarter 4 of the Vermont PCM program, four interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. The estimated direct cost avoidance to the state for SFY2022 was $1,010,596, and over $4 million since the program's initiation.

[3] Change Healthcare. (April 1, 2022, through June 30, 2022). Change Healthcare Pharmacy Management Reporting Suite by a collection of reports recording the process and progress of PCM.

[4] Sabaté E, editor., ed. Adherence to Long-Term Therapies: Evidence for Action. Geneva, Switzerland: World Health Organization; 2003

[5] Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005;353(5):487-497

Medicaid Rebate Programs

Federal Rebates

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

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

Supplemental and Diabetic Supplies Rebates

Supplemental rebates are negotiated by the State through its participation in the Sovereign States Drug Consortium (SSDC). Supplemental rebates are those rebates in addition to the required federal rebates on a drug, while diabetic supply rebates are state-only rebates. The SSDC is the largest, independent, only state-administered Medicaid supplemental drug rebate pool in the country. Vermont contracts for SSDC-negotiated supplemental rebates via its own supplemental rebate agreement, enabling the State to retain control and flexibility in managing its preferred drug list while taking advantage of the additional leverage provided by the large number of members covered by the pool. The pool primarily focuses on negotiating and acquiring rebates supplemental to federal Medicaid rebates from drug manufacturers to obtain prescription drugs at a lower cost for members of their respective Medicaid programs.

THE EFFECT OF NATIONAL TRENDS AND COMPARISON TO OTHER STATES

Medicaid Net Prescription Drug Expenditure Forecast

From February 2020 to January 2022 of the Public Health Emergency (PHE), total Medicaid/CHIP enrollment increased by 15.7 million nationally. However, when the PHE and continuous enrollment requirement from the Families First Coronavirus Response Act ends, overall Medicaid enrollment could decrease between 5.3 million and 14.2 million.[6] In Vermont Medicaid, enrollment increased from 156,000 in SFY20 to 187,000 in SFY22. Future drug expenditures will be impacted both by timing for when the PHE ends and by how much Vermont's Medicaid caseload subsequently drops.

While caseload changes could put downward pressure on spending, utilization is expected to create even greater upward pressure. In the ensuing years from 2023-2030, national spending and utilization are expected to rise more rapidly due to increasing utilization of new drugs in the market, reaching a projected $65.6 billion

[6] https://www.kff.org/medicaid/issue-brief/unwinding-the-phe-what-we-can-learn-from-pre-pandemic-enrollment-patterns/

aggregate prescription drug expenditure in 2030 compared to $34.5 billion in 2020.[7] This is in line with pre-pandemic expectations of net prescription drug expenditures which are projected to continue to increase steadily with an annual growth rate of 5.2-5.9% each of the next five years.[8]

The primary driver of this increase is a shift in utilization from older, less costly drugs, to newer, higher net cost drugs. This is most apparent in the recent trends around specialty drugs. In 2020, Medicaid specialty medications accounted for more than half of the net drug spend, even though they only made up roughly 1% of utilization. Some of these newer drugs have significant incremental benefits on clinical outcomes, thus delivering value to the Medicaid program. Others, however, are excessively priced relative to their effect on outcomes and overall health care expenditures.

The impact of price increases on net expenditures is expected to be minimal because the trend of manufacturer price increases has declined considerably, although 2021 did see a minor rise in drug prices, bucking the recent trend. In addition, the federal Medicaid Drug Rebate Program and State Supplemental Rebate Agreements provide protection against price increases in the form of increased federal rebate due to excessive price inflation or increased supplemental rebates for newer products with competitors already in the market.

The fiscal impact of high-cost orphan drugs (drugs used to treat rare conditions) is difficult to predict for a program like Vermont Medicaid with a relatively small population. On one hand, the rarity of the conditions for which many of these drugs are used may mean that Vermont Medicaid could have no utilization of some of them over a period of years. On the other hand, it would not take much utilization of a few of these drugs to have an outsized impact on expenditures. This could be especially pronounced if a particular genetic condition for which one of these drugs is used happens to be more prevalent in Vermont. For example, newer gene therapies such as Skysona (elivaldogene autotemcel) for treatment of cerebral adrenoleukodystrophy (CALD) has a price of $3 million dollars per treatment, expected to be administered once per lifetime. In addition, the recent FDA approvals of “one-time” gene therapies along with many similar products in the pipeline across various disease states increases the likelihood of utilization even in smaller markets. Budgetary concerns arise in relation to the high net cost of these products as well as the longevity of these treatments, and whether patients may eventually have to be retreated. Such high-cost, low-utilization drugs could account for 20-25% of the annual increase in net expenditures over the next five years. This assumes that per-recipient utilization of such drugs will be in line with projected national averages.

Nationally, biosimilar FDA approvals are increasing. A biosimilar, as defined by the FDA, is *a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA approved reference product*.[9] There are currently 38 FDA-approved biosimilars with roughly 75% of those available currently in the market. In 2022 we saw the approval of the first interchangeable biosimilars which have additional requirements outlined by the Biologics Price Competition and Innovation Act and can be substituted at the pharmacy level without the need for intervention of the prescribing provider. Biosimilar use and availability are expected to reduce Medicaid drug expenditure; however, the extent to which this occurs will be primarily driven by provider familiarity and uptake, as well as the amount of biosimilars entering a particular market segment and the length of time before these drugs compete in price with the reference products with higher federal rebates.

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[7] https://www.cms.gov/files/document/national-health-expenditure-projections-2021-30-growth-moderate-covid-19-impacts-wane.pdf

[8] https://www.cms.gov/files/document/nhe-projections-2019-2028-forecast-summary.pdf

[9] https://www.fda.gov/drugs/biosimilars/biosimilar-and-interchangeable-products#biological

As in the prior year, two therapeutic drug classes are anticipated to be the primary drivers in increased net expenditures over the next few years: oncology drugs and drugs for inflammatory conditions. Net expenditures for oncology drugs are projected to increase by 12% each year. This is due to the rapid approval of new drugs and expanded indications. In 2021, the FDA approved 50 new chemical entities, 12 of which were for oncology indications and from May 2021-May 2022, 46 oncology medications had new or expanded label indications approved by the FDA.[10] Many of these new drugs are self-administered oral drugs that are taking the place of provider-administered infusions. Some of this increase in expenditures is being offset by competition among biosimilars of some injectable biologics as well as new generics.

Net expenditures for biologics and drugs used for treatment of inflammatory conditions (such as rheumatoid arthritis, plaque psoriasis and ulcerative colitis) are expected to increase by 9% per year for each of the next five years. This is due to increased utilization and a shift away from older, highly rebated products to newer products with lower rebates. The increase in utilization is due to significantly improved outcomes seen with many of the newer drugs compared to older, traditional therapies, especially in patients with moderate-to-severe disease. The incremental clinical benefit is less significant for some of the more recently approved biologics compared to earlier generic biologics that now, due to high rebates, have much lower net costs to the Medicaid program. Potentially helping to offset some of this rise, adalimumab, the top drug by expenditure over the past several years, will be facing a large amount of biosimilar competition in mid-2023 and extending in 2024.

Other therapeutic classes expected to increase in utilization but likely to have less net drug expenditure impact are cardiovascular and renal, specifically the SGLT-2 inhibitors and GLP-1 agonists products. Recent expansions in indications for these products around their additional benefits outside of diabetic care will increase utilization.

Comparisons to other states' Drug Utilization Review (DUR) reporting including nature and scope of the prospective and retrospective drug use review programs, summary of DUR interventions, cost savings generated from their DUR programs, program's operations, adoption of innovative DUR practices, and description of DUR board activities, can be found here: State Drug Utilization Review Reporting | Medicaid.

ADMINISTRATION OF VERMONT'S PHARMACEUTICAL ASSISTANCE PROGRAMS

The Pharmacy Unit manages all aspects of Vermont's publicly funded pharmacy benefits program and assures that members receive high-quality, clinically appropriate, evidence-based medications in the most efficient and cost-effective manner possible. In addition, the Pharmacy Unit is focused on improving health information exchange and reducing provider burden through e-prescribing, automating prior authorizations, and other efforts related to administrative simplification for the Department and for providers. This includes administration of Vermont Pharmaceutical Assistance programs 33 V.S.A. § 2073 Vermont Laws.

The VPharm program was established in 2006 to provide supplemental pharmaceutical coverage to Medicare beneficiaries. VPharm helps pay for prescription medicines with affordable monthly premiums for individuals who meet income guidelines and are enrolled in Medicare Part D. In SFY 2022, there were 264,339 VPharm claims with a total gross paid amount of $5,714,202 (Chart 1). Beginning 07/01/2022, DVHA expanded the

[10] https://www.fda.gov/drugs/new-drugs-fda-cders-new-molecular-entities-and-new-therapeutic-biological-products/novel-drug-approvals-2021

drug coverage available under VPharm 2 and VPharm 3 to be equivalent to the drug coverage available under VPharm 1. These changes result from Vermont's new Global Commitment to Health 1115 Waiver which will allow VPharm 2 and VPharm 3 enrollees to receive $1 and $2 copays for more drugs through VPharm, not just "maintenance" drugs. Previously, VPharm 2 and VPharm 3 coverage was limited to maintenance medications, over-the-counter medications, and diabetic supplies. This change will result in lower out-of-pocket costs for VPharm members. For prescriptions with DVHA cost share of $29.99 or less, the patient will pay a $1.00 co-payment. Prescriptions with DVHA cost share of $30.00 or more will receive a $2.00 co-payment. VPharm 1 is not changing. This is an expansion of drug coverage for people who are enrolled in VPharm 2 and VPharm 3. More information about the VPharm program can be found at:
https://dvha.vermont.gov/sites/dvha/files/doc_library/Pharmacy_2022_0.pdf

PRIOR AUTHORIZATION REQUIREMENTS

Prior Authorization Program

The Department's prior authorization program is an important tool in managing clinical appropriateness of medications dispensed in Vermont and reducing total cost to the state's Medicaid program. Vermont Medicaid maintains a list of covered, evidence-based, rebatable medications for preferred use. Prescribers can submit a prior authorization to request coverage of a non-preferred drug on the Preferred Drug List. 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" of 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 and uses this information to approve or deny the claim. The automated prior authorizations help to reduce provider burden while assuring clinical and financial integrity of pharmacy programs.

The total number of prior authorizations increased by 12.1% in SFY2022, an increase of 2,963 requests. (Chart 4) The increase in number of prior authorizations can be attributed to various factors involved in the Medicaid drug program. Medicaid's pharmacy benefit covered an increased number of prescriptions for 2022; this increase in claims contributes to an increase in prior authorizations. Additionally, the greater complexity and expansion of high-cost therapies leads to a higher need for prior authorizations to manage the fiscal impact to the State. The prior authorization process helps the Department direct utilization toward preferred rebatable products with equal efficacy. The overall prior authorization approval and denial rate percentages have remained the same over recent years, with the denial rate from 25.5% in SFY2021 to 25.2% in SFY2022. The greater number of prior authorizations during SFY 2022 represents the State's increased efforts to monitor complex high-cost medications. The approval rates of 75% ensure that Vermont patients still have access to non-preferred medication when medically necessary (Chart 4).

DRUG UTILIZATION REVIEW BOARD AND THE PREFERRED DRUG LIST

Drug Utilization Review Board

The Drug Utilization Review Board in Vermont is required by federal law.[11] The Board applies criteria and standards in the application of drug utilization review activities, reviews and reports the results of those activities performed by the Department or the Department's pharmacy benefit administrator (Change Healthcare) and recommends and evaluates interventions such as provider education or other types of provider communications. The Board also provides drug coverage guidance and assistance with the development of the Preferred Drug List.

[11] Social Security Act 1927

Drug Utilization Review Board Activities in 2022

Review Topic	SFY 2022 Total
Therapeutic Drug Classes: Periodic Review	50
Full New Drug Reviews	36
FDA Safety Alerts	2
New/Updated Clinical Guidelines	23
RetroDUR/ ProDUR Reviews	6
New Managed Therapeutic Drug Classes	23
BioSimilar Drug Reviews	0

More information about the Drug Utilization Review Board can be found at https://dvha.vermont.gov/advisory-boards/drug-utilization-review-board. Here you can find detailed minutes of DURB meetings, including specific changes voted on by the Board.

Preferred Drug List

DVHA's Preferred Drug List (PDL) is a list of covered prescription drugs that identifies preferred choices within therapeutic classes for various diseases and conditions, including generic alternatives.[12] The preferred drug list is an important tool designed to reduce the cost of providing prescription drugs while maintaining access to clinically appropriate prescription drug therapies. The PDL includes a list of commonly used preferred and non-preferred drugs that are covered by the Department's drug benefit programs. Not all drugs the Department covers are listed on the PDL; however, it does list over 180 different therapeutic categories representing thousands of drugs.

The Preferred Drug List is one of the most effective tools available to DVHA 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. Most preferred drugs do not require prior authorization unless there is a clinical or safety issue that warrants prior authorization. Prescribers often refer to the PDL to identify which drugs are most appropriate to prescribe for DVHA members. It features clinically appropriate, low-cost options including:

- DVHA's overall Medicaid utilization of **Generic Drugs** is 77.7%. (Chart 3) Most generics do not require prior authorization and are preferred on the PDL (exceptions when the net cost of the brand drug is lower)
- DVHA's overall Medicaid utilization of **Brand Drugs** is 22.3%. (Chart 3)

Preferred Brand Drugs may have clinical superiority to other drugs in the class, or in some instances may be the only drug available to treat a medical condition; includes brands for which manufacturers pay a level of federal Medicaid rebates that make the net cost of the drug lower compared to other products in the drug's therapeutic class; includes brands for which manufacturers pay additional negotiated (supplemental) rebates to make their products more affordable. For example: the Medicaid program has preferred the brand drug Suboxone Film for the treatment of opioid use disorder, due to its **lower net cost** compared to generic films. Since this drug is the number one drug for both gross spend and number of prescriptions, it significantly affects the generic dispensing and substitution rates, and the generic formulation requires a prior authorization for clinical or safety reasons.

Non-Preferred Brand Drugs do not have clinical superiority to other drugs in the class. They have similar or inferior clinical efficacy or safety and offer no clinical advantage; includes brands for which manufacturers pay a lower level of federal Medicaid rebates, which makes the net cost of the drug higher compared to preferred

[12] 33 V.S.A. § 1998

products in the drug's therapeutic class; includes brands for which manufacturers do not offer additional negotiated (supplemental) rebates to make their products more affordable, or those offers are not high enough; and all require prior authorization.

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

APPENDIX: COST AND UTILIZATION CHARTS

Chart 1: Pharmacy Claims and Gross and Net Spend, SFY 2020-2022 (All Programs)

All Pharmacy Claims										
SFY	Claims Paid	% Change	Gross Amount Paid	% Change	Gross Cost Per Claim	% Change	Net Paid Amount	% Change	Net Cost Per Claim	% Change
2022	2,150,667	5.13%	$266,085,028	15.07%	$123.72	9.46%	$89,414,648	19.92%	$41.58	14.07%
2021	2,045,750	4.94%	$231,234,586	15.42%	$113.03	9.99%	$74,564,984	20.45%	$36.45	14.79%
2020	1,949,499		$200,345,009		$102.77		$61,903,114		$31.75	
Medicaid Claims (includes Duals)										
SFY	Claims Paid	% Change	Gross Amount Paid	% Change	Gross Cost Per Claim	% Change	Net Paid Amount	% Change	Net Cost Per Claim	% Change
2022	1,886,328	6.74%	$260,370,825	15.31%	$138.03	8.03%	$87,248,159	19.84%	$46.25	12.27%
2021	1,767,158	6.76%	$225,792,628	15.78%	$127.77	8.45%	$72,802,606	20.64%	$41.20	13.01%
2020	1,655,264		$195,010,289		$117.81		$60,344,609		$36.46	
Vpharm Claims										
SFY	Claims Paid	% Change	Gross Amount Paid	% Change	Gross Cost Per Claim	% Change	Net Paid Amount	% Change	Net Cost Per Claim	% Change
2022	264,339	-5.12%	$5,714,202	5.00%	$21.62	10.66%	$2,166,489	22.93%	$8.20	29.56%
2021	278,592	-5.32%	$5,441,958	2.01%	$19.53	7.74%	$1,762,378	13.08%	$6.33	19.43%
2020	294,235		$5,334,721		$18.13		$1,558,505		$5.30	

Note: Gross Spend reflects pharmacy payments only, excludes refunds such as 340B. Net spend is based on rebates invoiced, not rebates collected and reflects an estimated 340B Acquisition Cost Discount. Dual-Eligible: DVHA only pays for non-Part D drugs, primarily over the counter (OTC) drugs. VPharm: DVHA pays secondary to Part D, and for non-Part D drugs, primarily OTC drugs.

Chart 2: Pharmacy Services: Eligible and Utilizing Members

*Calculated as average monthly eligible members vs. average monthly utilizers, enrollment run as of 8/27/2021(excludes VPharm).

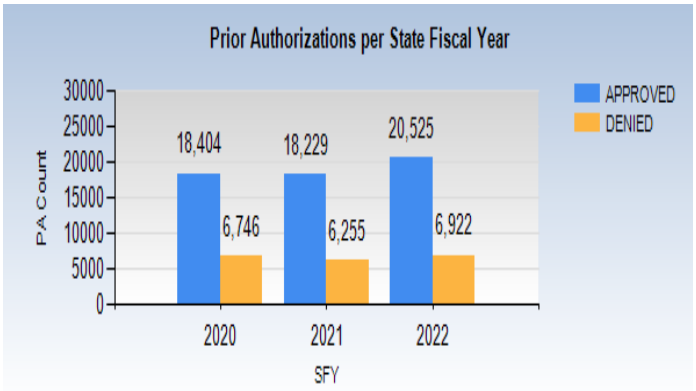
All	2020	2021	2022
Medicaid and Duals Eligible All Ages	156,383	173,674	187,025
Medicaid and Duals Utilizers All Ages	46,868	50,508	54,635
Medicaid and Duals Utilization Percent All Ages	30%	29%	29%
Adult			
Medicaid and Duals Eligible Adults	95,755	110,887	123,135
Medicaid and Duals Utilizers Adults	35,216	40,061	42,918
Medicaid and Duals Utilization Percent Adults	37%	36%	35%
Children			
Medicaid and Duals Eligible Children	60,628	62,786	63,890
Medicaid and Duals Utilizers Children	11,651	10,446	11,716
Medicaid and Duals Utilization Percent Children	19%	17%	18%

Chart 3: Generic Usage Rates

Medicaid (Includes Duals)			
Generic Indicator	2020	2021	2022
Generic Utilization Rate (GUR)	77.53%	78.03%	77.73%
Generic Substitution Rate (GSR)	79.09%	81.51%	79.58%
VPharm			
Generic Indicator	2020	2021	2022
Generic Utilization Rate (GUR)	83.07%	83.56%	84.06%
Generic Substitution Rate (GSR)	91.11%	92.60%	91.06%

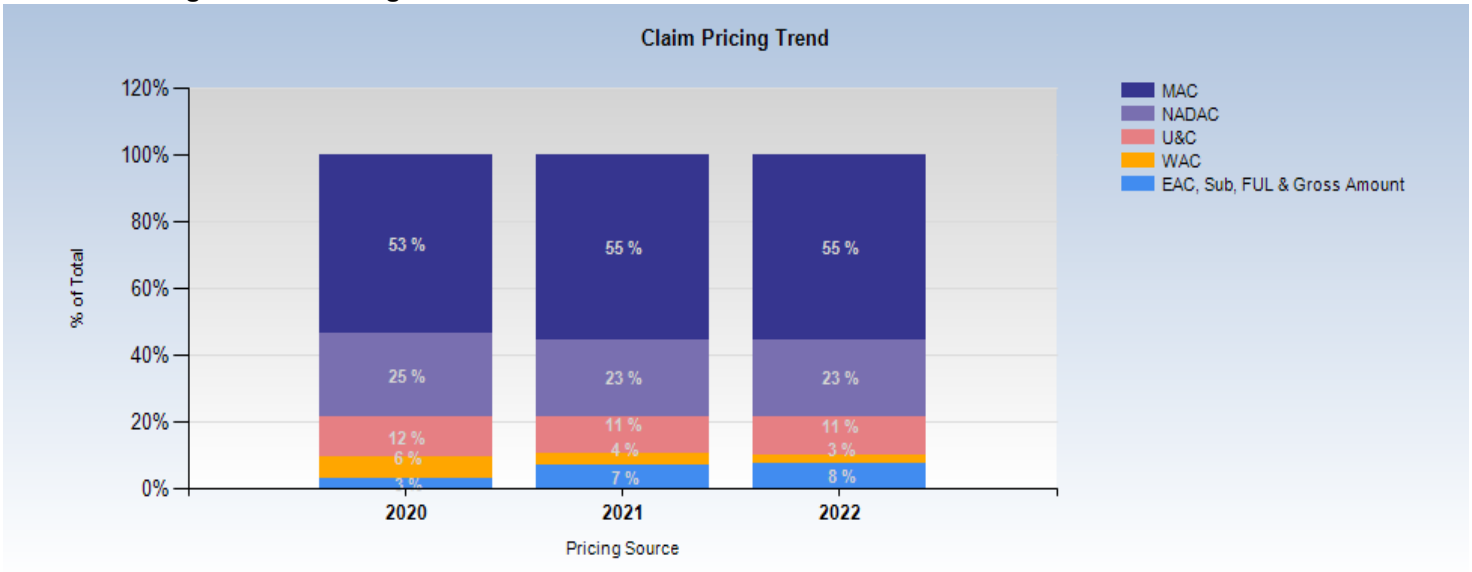
GUR: Generic use as a percentage of prescriptions for all drugs dispensed.
GSR: Generic use as a percentage of prescriptions when a generic equivalent is available.

Chart 4: Prior Authorization Summary



SFY	PA DENIAL RATE
2020	26.82%
2021	25.55%
2022	25.22%

Chart 5: Pricing Source of Drugs



MAC=Maximum Allowable Cost, NADAC=National Average Drug Acquisition Cost, U&C=Usual and Customary, WAC=Wholesale Acquisition Cost, EAC=Estimated Acquisition Cost (AWP-19%), Sub=Submitted Amount, Gross Amount=Gross Amt Due

Chart 6A: Medicaid (including Duals) Gross and Net PMPM Trend by SFY

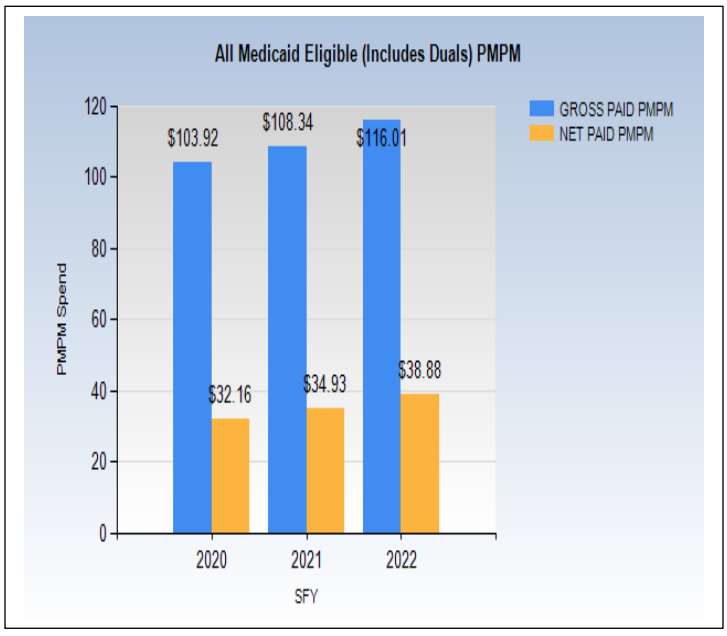


Chart 6B: VPharm: Gross and Net PMPM Trend by SFY

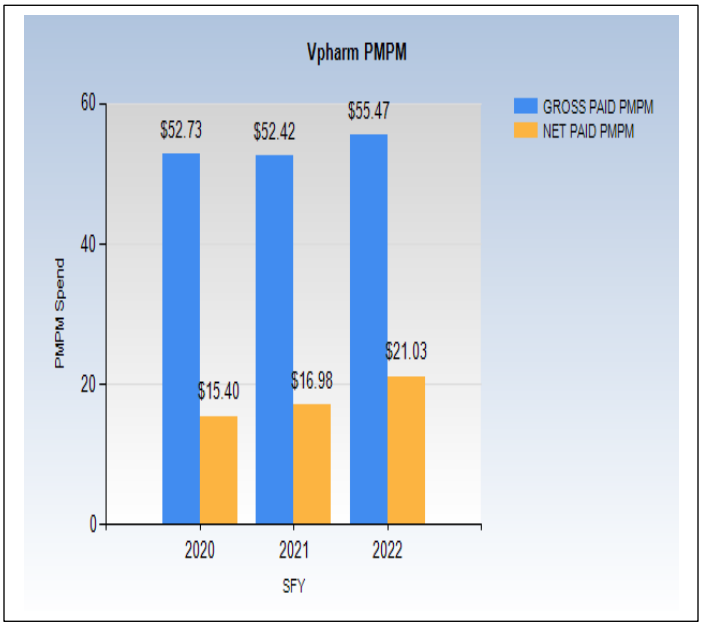


Chart 7A: Top Therapeutic Classes by Gross Spend

Therapeutic Class/Treatment Category	2021 Gross Paid	2022 Gross Paid	2021 Claim Count	2022 Claim Count	Total Amount Paid Change	Claim Count Change
Opioid Partial Agonists	$21,620,422	$22,009,093	139,325	134,329	1.8%	-3.6%
Anti-Tnf-Alpha - Monoclonal Antibodies	$15,876,024	$20,177,231	2,389	2,818	27.1%	18.0%
Sympathomimetics	$11,262,152	$13,949,295	63,951	71,388	23.9%	11.6%
Insulin	$12,912,635	$13,529,027	15,377	16,182	4.8%	5.2%
Antipsoriatics	$9,084,423	$13,419,926	1,014	1,414	47.7%	39.4%
Stimulants - Misc.	$11,655,543	$12,342,258	51,158	55,706	5.9%	8.9%
Cystic Fibrosis Agents	$8,839,028	$11,707,453	717	801	32.5%	11.7%
Incretin Mimetic Agents (Glp-1 Receptor Agonists)	$6,562,112	$10,717,370	6,405	10,011	63.3%	56.3%
Amphetamines	$9,353,276	$10,218,303	60,322	66,527	9.2%	10.3%
Antineoplastic Enzyme Inhibitors	$4,810,987	$6,404,720	440	558	33.1%	26.8%

Chart 7B: Non-Insulin Antidiabetic Drugs

Non-Insulin Antidiabetic Drugs	2021 Claims	2022 Claims	2021 Gross Paid	2022 Gross Paid	% Difference
Incretin Mimetic Agents (GLP-1 Receptor Agonists)	6,405	10,011	$6,562,112	$10,717,370	63.3%
Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	2,543	3,714	$2,703,211	$4,312,061	59.5%
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	1,411	1,318	$1,466,220	$1,405,845	-4.1%
Biguanides	12,885	14,064	$233,791	$270,438	-15.7%
Diabetic Other	926	970	$232,166	$215,884	7.0%
Antidiabetic Combinations	289	281	$209,011	$240,002	-14.8%
Sulfonylureas	3,632	3,402	$58,925	$53,793	-8.7%
Totals	**24,032**	**29,899**	**$11,465,436**	**$17,215,392**	**50.2%**

Chart 8 Top Drugs by Gross Spend

Current Rank	Drug Name	2021 Gross Paid	2022 Gross Paid	2021 Claim Count	2022 Claim Count	Total Amount Paid Change	Claim Count Change
1	Suboxone (buprenorphine/naloxone)	$19,916,825	$19,610,128	112,479	101,782	-1.5%	-9.5%
2	Humira Pen (Adalimumab)	$13,555,895	$17,552,263	2,101	2,484	29.5%	18.2%
3	Trikafta (elexacaftor,tezacaftor,and ivacaftor)	$6,153,296	$9,800,304	278	424	59.3%	52.5%
4	Vyvanse (Lisdex amfetamine)	$7,816,232	$8,660,564	26,353	28,135	10.8%	6.8%
5	Concerta (methylphenidate)	$6,054,264	$7,597,648	15,736	19,306	25.5%	22.7%
6	Stelara (ustekinumab)	$4,619,357	$6,842,730	228	322	48.1%	41.2%
7	Trulicity (dulaglutide)	$2,704,661	$6,710,356	2,744	6,254	148.1%	127.9%
8	Mavyret (glecaprevir, pibrentasvir)	$4,726,847	$4,046,777	369	316	-14.4%	-14.4%
9	Lantus Solostar (insulin glargine)	$4,099,007	$4,040,593	6,130	6,413	-1.4%	4.6%
10	Proair HFA (albuterol sulfate)	$2,004,375	$3,827,002	21,567	38,637	90.9%	79.1%

Chart 9: Top Therapeutic Classes by Utilization

Current Rank	Category Name	2021 Gross Paid	2022 Gross Paid	2021 Claim Count	2022 Claim Count	Gross Paid Change	Claim Count Change
1	Opioid Partial Agonists	$21,620,423	$22,009,093	139,325	134,329	1.8%	-3.6%
2	Selective Serotonin Reuptake Inhibitors (SSRIS)	$1,383,557	$1,483,885	92,378	99,905	7.3%	8.1%
3	Anticonvulsants misc.	$4,486,025	$4,978,265	74,830	77,387	11.0%	3.4%
4	Sympathomimetics	$11,262,152	$13,949,295	63,951	71,388	23.9%	11.6%
5	Amphetamines	$9,353,276	$10,218,303	60,322	66,527	9.2%	10.3%
6	Stimulants -misc	$11,655,543	$12,342,258	51,158	55,706	5.9%	8.9%
7	Proton Pump Inhibitors	$1,349,399	$1,295,149	38,429	40,337	-4.0%	5.0%
8	Oil soluble vitamins[1]	$399,114	$424,956	36,992	39,159	6.5%	5.9%
9	Antihistamines - non-sedating	$443,486	$472,966	36,602	38,810	6.6%	6.0%
10	Antianxiety Agents- misc.	$374,270	$415,676	28,855	33,256	11.1%	15.3%

[1] Primarily Vitamin D

Chart 10: Top Drugs by Utilization

Current Rank	Drug Name	2021 Gross Paid	2022 Gross Paid	2021 Claim Count	2022 Claim Count	Gross Paid Change	Claim Count Change
1	Suboxone (buprenorphine/naloxone)	$19,916,825	$19,610,128	112,479	101,782	-1.5%	-9.5%
2	Proair HFA (albuterol)	$2,004,375	$3,827,002	21,567	38,637	90.9%	79.1%
3	Amphetamine/ Dextroamphetamine	$1,121,497	$980,258	32,265	36,183	-12.6%	12.1%
4	Gabapentin	$551,783	$580,131	34,320	36,005	5.1%	4.9%
5	Vyvanse (lisdexamfetamine)	$7,816,232	$8,660,564	26,353	28,135	10.8%	6.8%
6	Fluoxetine HCL	$411,698	$430,847	25,950	27,845	4.7%	7.3%
7	Bupropion HCL	$437,107	$457,835	24,377	27,207	4.7%	11.6%
8	Omeprazole	$289,155	$302,329	22,978	24,259	4.6%	5.6%
9	Cetirizine Hydrochloride	$222,402	$256,657	18,334	20,254	15.4%	10.5%
10	Trazodone Hydrochloride	$241,851	$241,711	18,938	19,665	-0.1%	3.8%

Chart 11A: Number of Members Using Opioids: 3-yr Trend

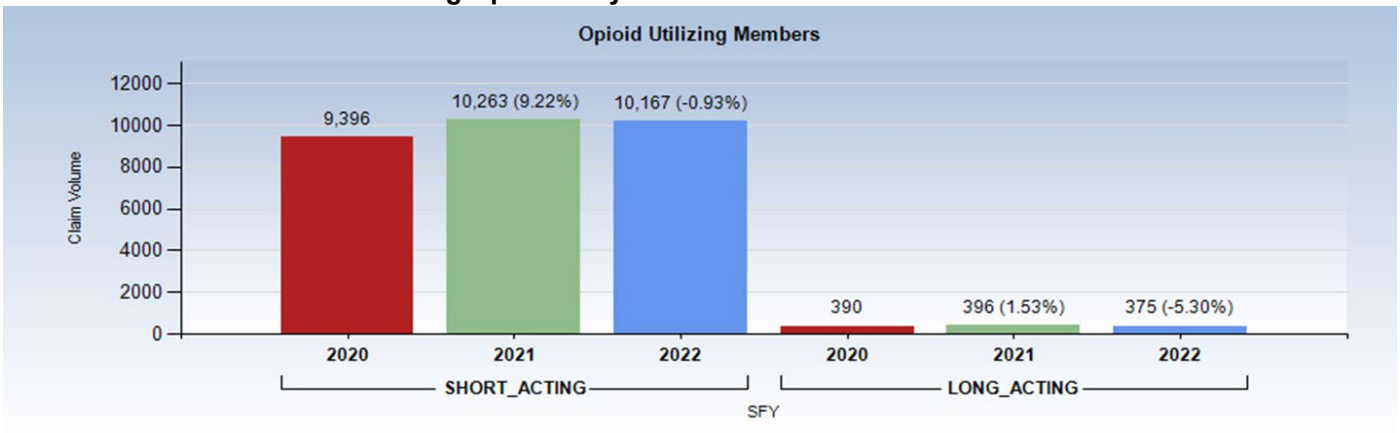


Chart 11B: Number of Prescriptions for Opioids: 3-yr Trend

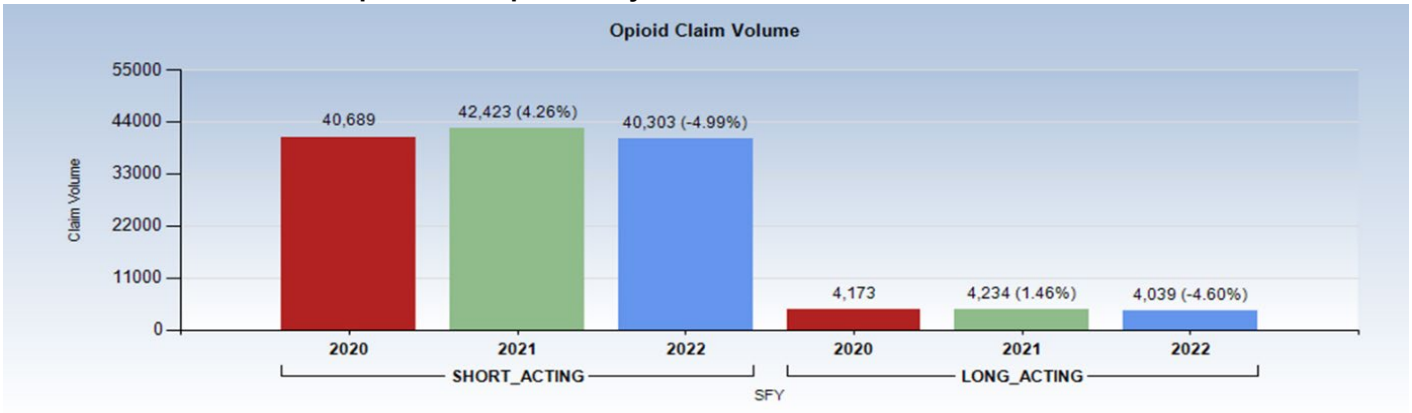


Chart 11C: Number of Prescriptions Per 1000 Members per Month for Opioids: 3-yr Trend

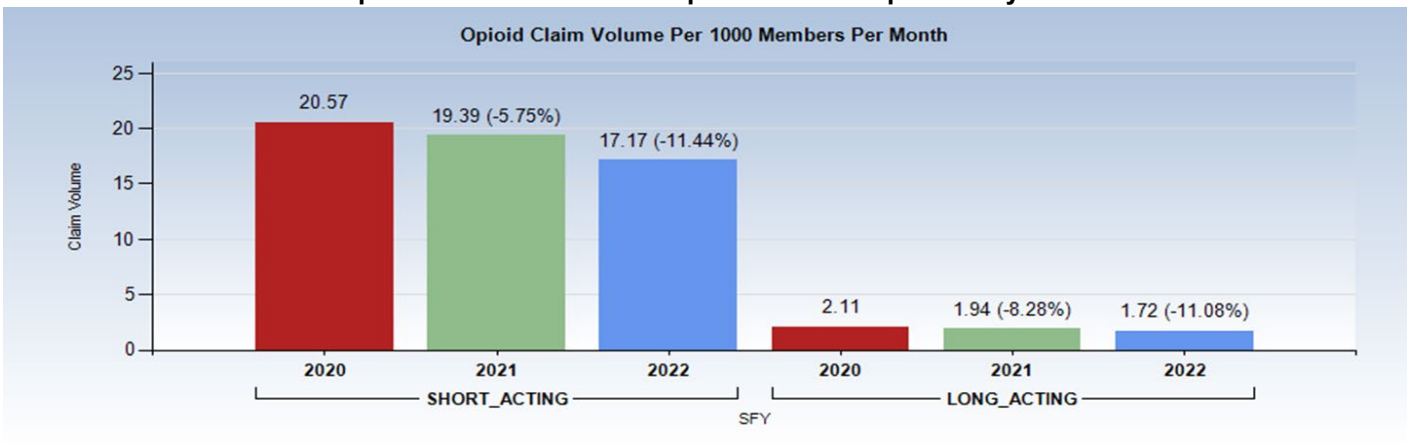


Chart 12: Specialty Drugs as a Percent of Total Gross Drug Cost

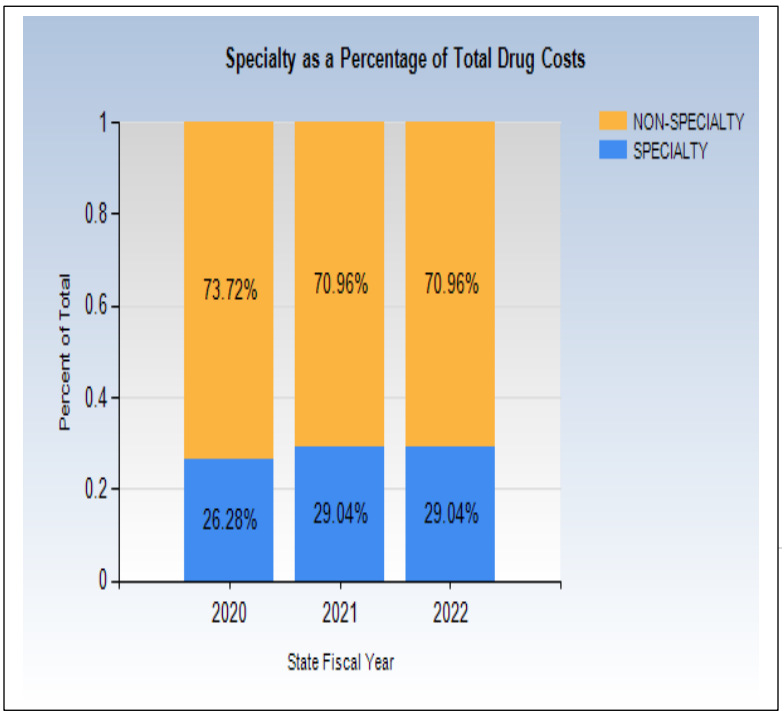


Chart 13A: Specialty Drugs-Amount Paid

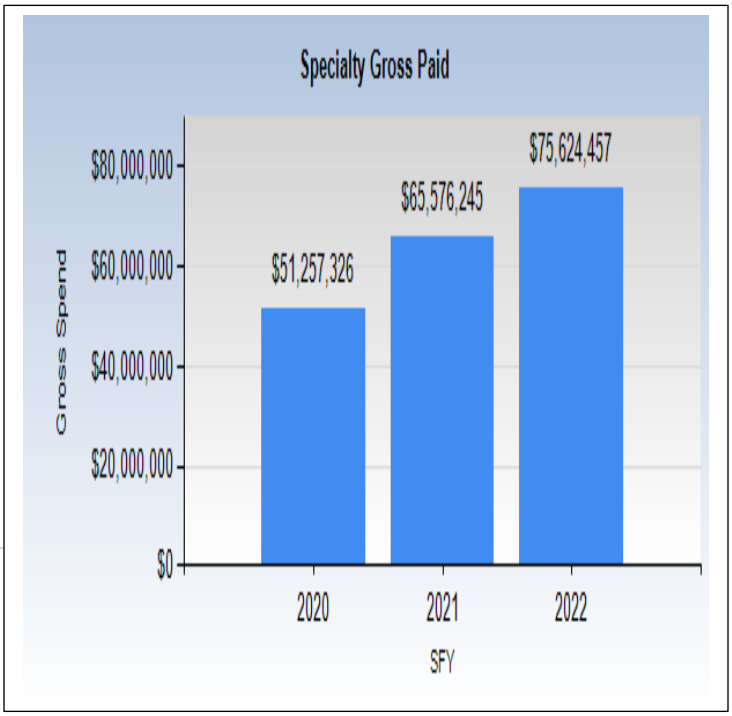


Chart 13B: Specialty Drugs-Number of Claims

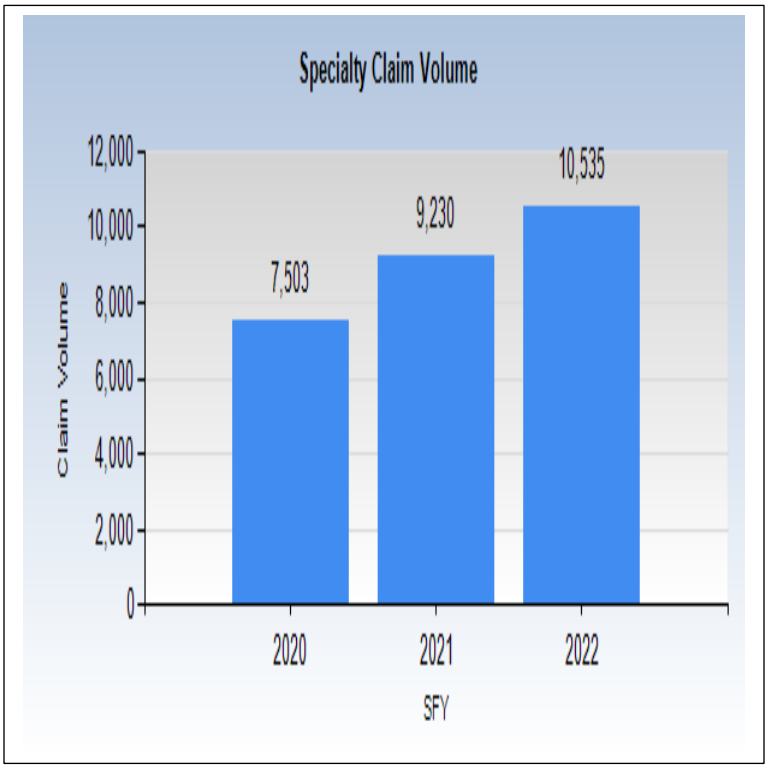
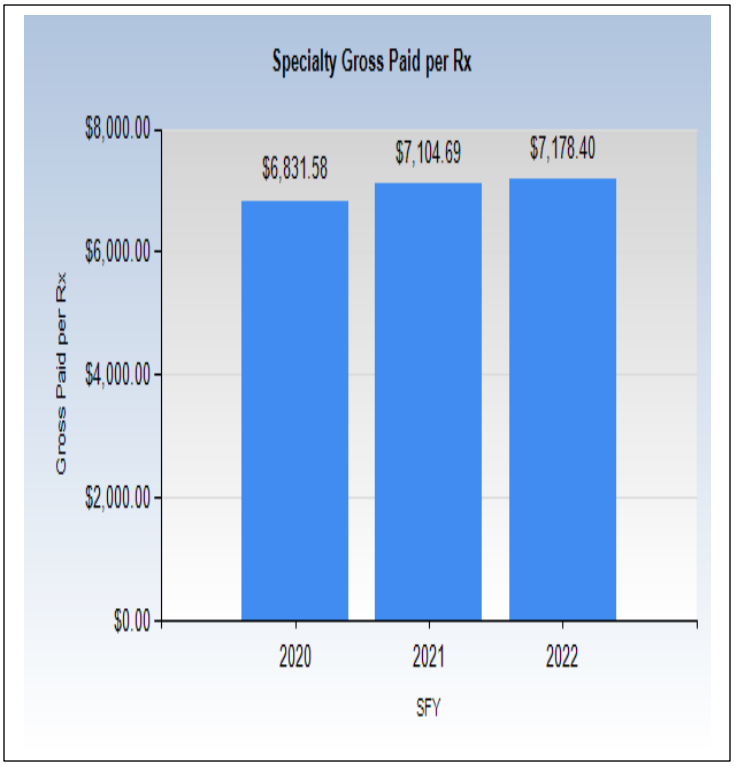


Chart 14: Specialty Drugs-Amount Paid Per Prescription



For the following charts, * indicates the count is less than 25.

Chart 15: Top 10 Oral Cancer Drugs by Spend

Drug Name	2021 RX Count	2022 RX Count	2021 Gross Paid	2022 Gross Paid	Gross Paid Change
Sprycel (dasatinib)	73	79	$818,634	$887,587	8.4%
Revlimid (lenalidomide)	*	51	$313,796	$774,105	146.7%
Ibrance (palbociclib)	59	62	$684,545	$772,646	12.9%
Afinitor (everolimus)	*	43	$214,585	$631,688	194.4%
Venclexta (venetoclax)	42	73	$341,944	$524,706	53.4%
Vitrakvi (larotrectinib)	*	*	$113,425	$518,062	356.7%
Jakafi (ruxolitnib)	63	46	$703,305	$470,826	-33.1%
Lynparza (olaparib)	40	33	$533,970	$465,541	-12.8%
Cabometyx (cabozantinib)	*	28	$93,669	$419,360	347.7%
Tasigna (nilotinib)	*	28	$41,681	$410,102	883.9%
All Oral Cancer Drugs			**$3,859,554**	**$5,874,622**	**52.2%**

Chart 16: Hepatitis C Direct Acting Antivirals (DAA)

Drug Name	2021 RX Count	2022 RX Count	2021 Total Paid	2022 Total Paid	% Change
Mavyret (glecaprevir/pibrentasvir)	369	316	$4,726,847	$4,046,777	-14.4%
Sofosbuvir/velpatasvir	*	142	$77,900	$1,105,376	1319.0%
Vosevi (sofosbuvir/velpatasvir/ voxilaprevir)	*	*	$121,181	$363,456	199.9%
Epclusa (sofosbuvir/velpatasvir)	144	*	$3,417,335	$72,691	-97.9%
Harvoni (ledipasavir/sofosbuvir)	*	*	$183,810	$0	-100.0%
Totals:			**$8,527,074**	**$5,588,300**	**-34.5%**

Chart 17: Cystic Fibrosis Medications

Drug Name	2021 RX Count	2022 RX Count	2021 Gross Paid	2022 Gross Paid	Gross Paid Change
Trikafta (elexacaftor/tezacaftor/ivacaftor and ivacaftor)	278	424	$6,153,296	$9,800,304	59.3%
Orkamba(lumacaftor/ivacaftor)	41	*	$829,518	$494,391	-40.4%
Symdeko (tezacaftor/ivacaftor and ivacaftor)	42	*	$697,625	$223,206	-68.0%
CFR Total	**361**	**458**	**$7,680,439.15**	**$10,517,900.02**	**36.9%**
Pulmozyme (dornase alfa)	356	343	$1,158,589	$1,189,553	2.7%
Cayston	*	*	$139,771	$77,738	-44.4%
MiscTotal	**371**	**351**	**$1,298,360.10**	**$1,267,290.35**	**-2.4%**
Kitabis Pak (tobramycin)	*	*	$83,421	$92,194	10.5%
Bethkis (tobramycin)	*	*	$48,523	$84,381	73.9%
Tobi Podhaler (tobramycin)	*	*	$128,307	$70,054	-45.4%
TOBRAMYCIN TOTAL	*	*	$954	$0	
Tobramycin Total	**46**	**42**	**$261,204.73**	**$246,628.49**	**-5.6%**
Grand Totals			**$9,240,003.98**	**$12,031,818.86**	**30.2%**

Chart 18: Medication-Assisted Treatment (MAT) for Opioid Use Disorder

Drug Name	2021 RX Count	2022 RX Count	Rx Count Change	2021 Distinct	2022 Distinct	Distinct Member	2021 Gross Paid	2022 Gross Paid	Gross Paid
Suboxone Film (Brand)	112,479	101,782	-9.5%	4,621	4,578	-0.9%	$19,916,825	$19,610,128	-1.5%
Sublocade Injection	470	752	60.0%	100	170	70.0%	$777,310	$1,297,699	66.9%
Vivitrol Susr	496	507	2.2%	135	112	-17.0%	$670,626	$698,533	4.2%
Buprenorphine HCL/Naloxon Subl Tablets	15,712	22,115	40.8%	915	1,219	33.2%	$517,377	$675,173	30.5%
Buprenorphine HCL Subl Tablets (Mono)	9,283	8,219	-11.5%	336	358	6.5%	$216,457	$211,666	-2.2%
Zubsolv Subl	489	392	-19.8%	33	43	30.3%	$78,272	$73,072	-6.6%
Naltrexone Hcl Tabs	2,130	2,316	8.7%	711	739	3.9%	$53,478	$56,940	6.5%
Acamprosate Calcium Dr Tbec	600	574	-4.3%	227	222	-2.2%	$54,981	$50,094	-8.9%
Disulfiram Tabs	540	570	5.6%	208	216	3.8%	$35,417	$42,417	19.8%
Buprenorphine/Naloxone Film (Generic)	624	851	36.4%	75	97	29.3%	$7,878	$12,980	64.8%
TOTALS	**142,823**	**138,078**	**-3.3%**	**7,361**	**7,754**	**5.3%**	**22,328,621**	**22,728,703**	**1.8%**

Chart 19: Rebates Invoiced: All Programs

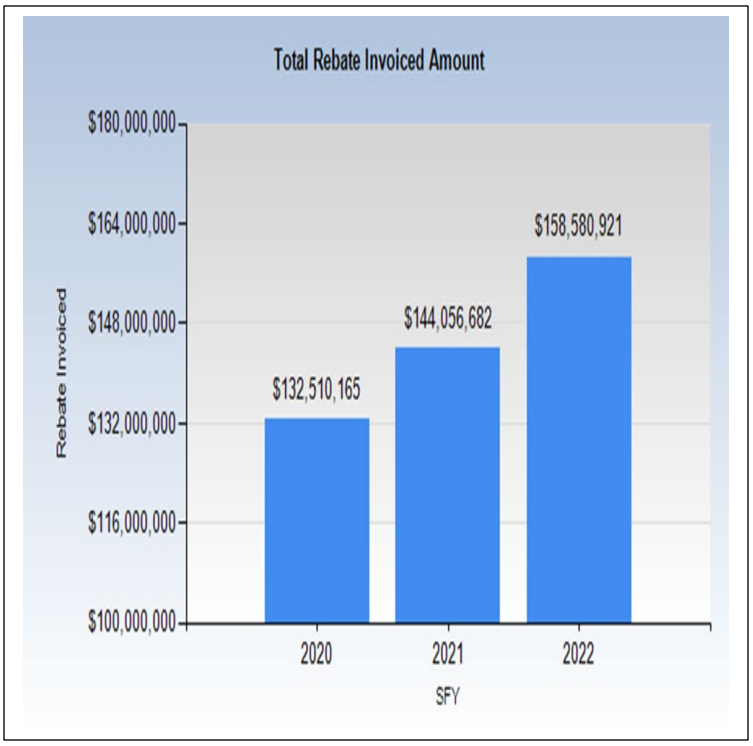


Chart 20: Federal Rebates Invoiced

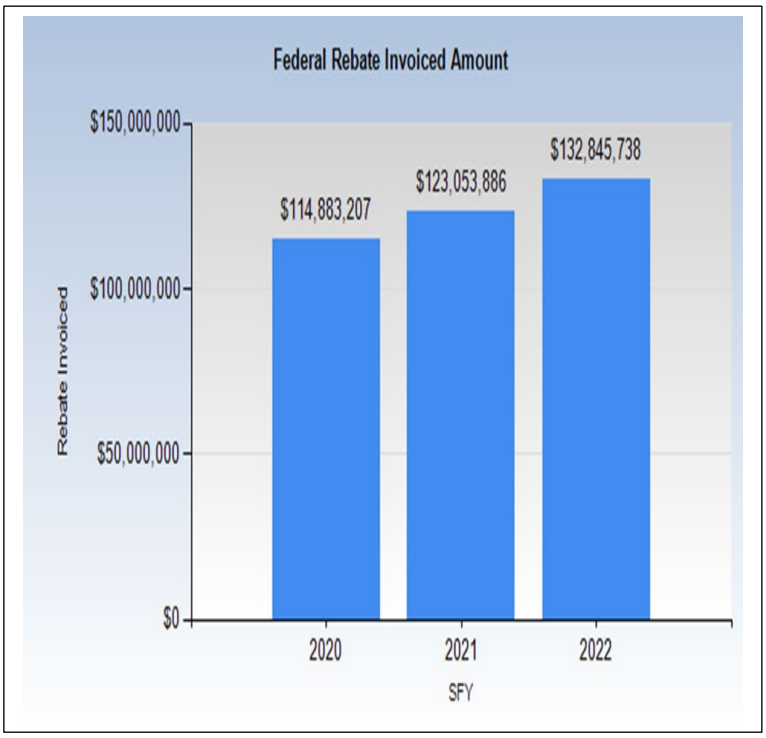


Chart 21: Total Supplemental Rebates Invoiced

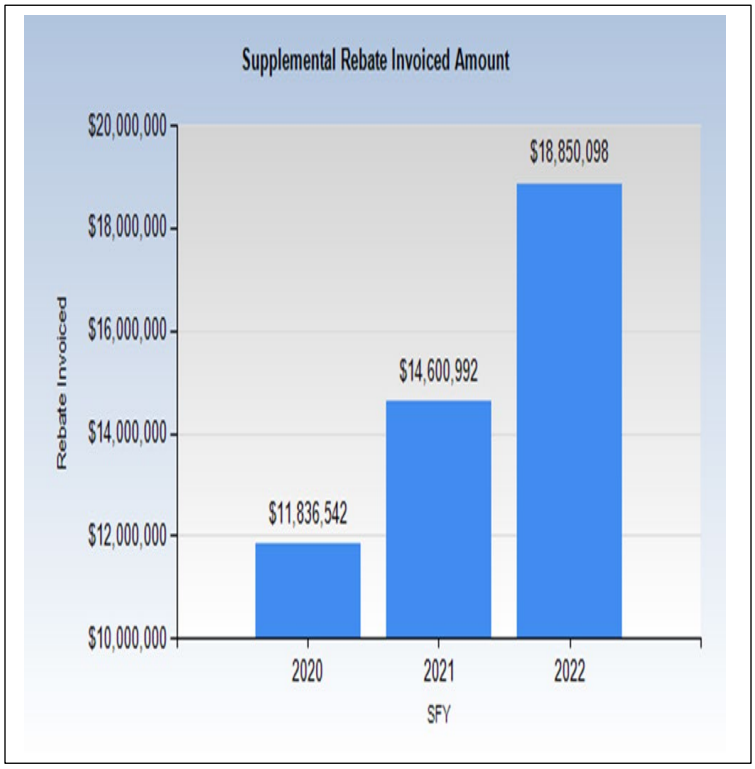


Chart 22: Total VPharm Rebates Invoiced

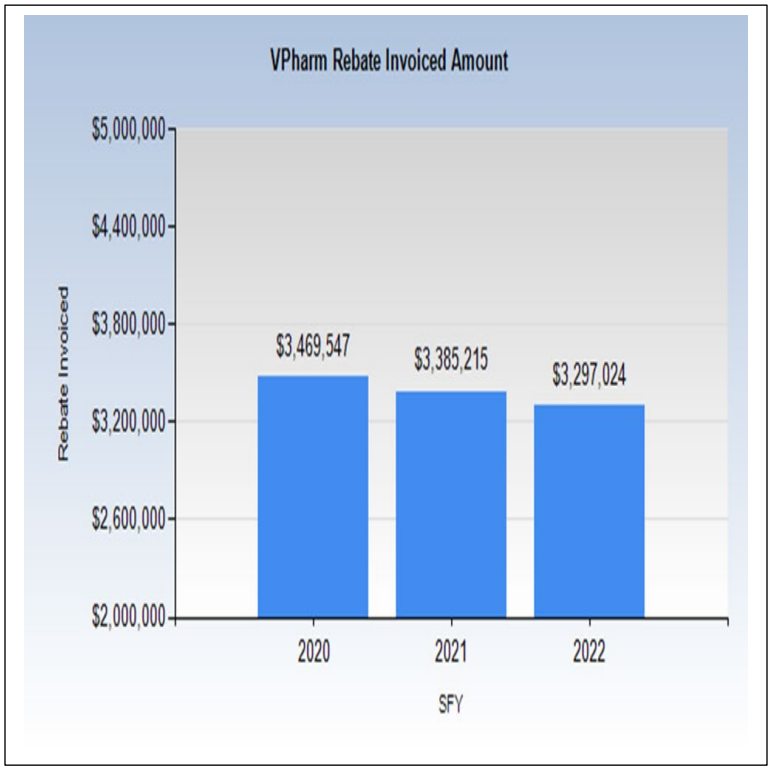


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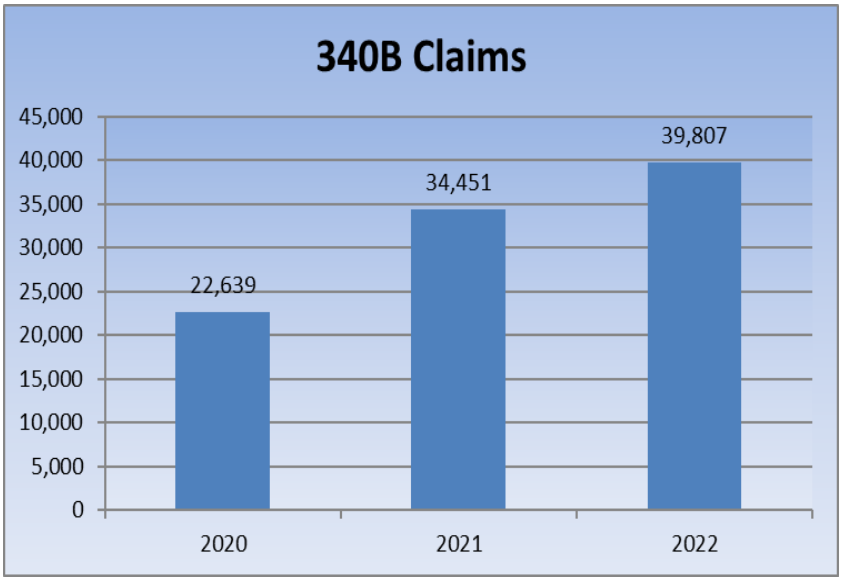
Chart 23: Number of 340B claims from 340B eligible pharmacies*



*Does not include medical drugs, or 340B discounts

Chart 24A: Covid -19 Vaccine Claims

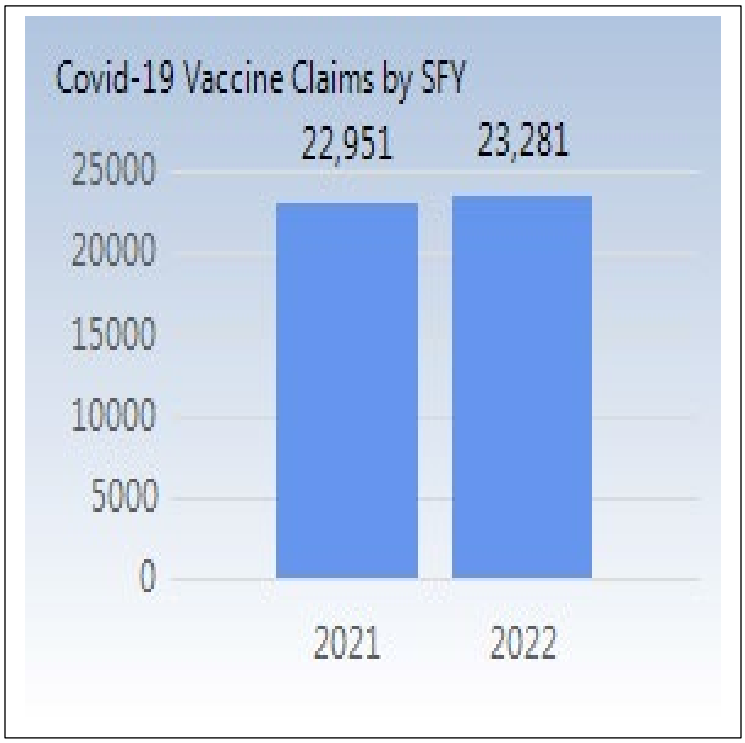


Chart 24B: Administration Fee Spend