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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Report Date: October 30th, 2020

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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EXECUTIVE SUMMARY

In 2002, the Pharmacy Best Practices and Cost Control Program was established and DVHA was authorized to establish a Preferred Drug List, utilization review procedures, a supplemental rebate program, and other strategies intended to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies.[1] In accordance with 33 V.S.A. § 2001(c), an annual report is required to be submitted as described below:

> The Commissioner of Vermont Health Access shall report annually on or before October 30 to the House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations and on Health and Welfare concerning the Pharmacy Best Practices and Cost Control Program. Topics covered in the report shall include issues related to drug cost and utilization; the effect of national trends on the pharmacy program; comparisons to other states; and decisions made by the Department's Drug Utilization Review Board in relation to both drug utilization review efforts and the placement of drugs on the Department's preferred drug list. [2]

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

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

[1] 33 V.S.A. § 1998

[2] 33 V.S.A. § 2001

The Pharmacy unit managed **$200.4 million in gross drug spend** in state fiscal year (SFY) 2020 (Chart 1), which includes data from July 1, 2019, through June 30, 2020. Gross drug spend reflects what DVHA paid to both in-state and out-of-state pharmacies enrolled in the network. This amount represents a modest increase in gross expenditures of approximately $1.6 million dollars or a 0.82% increase over the previous fiscal year. In state fiscal year 2020, $5.3 million was spent on the Vermont pharmaceutical assistance program (VPharm), reflecting a 4.7% decrease in VPharm spending from the prior year.

There was a 3.0% decline in the total number of claims (prescriptions) processed and a 3.96% increase in the average gross cost per prescription. A similar trend occurred in state fiscal year 2019 when there was a small decline in the number of claims processed but a 3.7% increase in the gross cost per prescription when compared to state fiscal year 2018. The 2-year trend is a 7.7% rise in gross cost per prescription for all plans. Net cost per prescription rose by 6.3% from $32.72 to $34.81 between state fiscal year 2018 and state fiscal year 2020. However, overall net costs have only increased by 0.34% over that two-year period (Chart 1).

For Medicaid plans (excluding VPharm), there was an increase in the gross cost per prescription of 3.3% in state fiscal year 2020 and an increase in net cost per prescription of 2.8% from $38.90 to $40.00. However, the 2-year trend for Medicaid overall net costs have remained steady at 0.02% (Chart 1).

In summary, for Medicaid, there was a decline in the number of prescriptions paid, a modest increase in gross spend, which was driven by an increase in both gross and net cost per claim. This is further supported by reviewing the gross and net per-member-per-month (PMPM) data which shows that gross PMPM costs rose by $3.80 dollars from $99.92 in State fiscal year 2019 to $103.72 in State fiscal year 2020, and net PMPM costs rose by $1.13 from $34.08 in State fiscal year 2019 to $35.21 in state fiscal year 2020. (Chart 6A). Finally, approximately 37% of adults and 19% of children utilize the drug benefit programs each month (Chart 2).

DVHA'S PHARMACY BENEFIT MANAGEMENT PROGRAMS

The Department of Vermont Health Access' Pharmacy unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefits program and for assuring 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.

A primary role of the Pharmacy unit is oversight of the contract with the Department's pharmacy benefits manager (PBM), Change Healthcare. Change Healthcare provides operational and clinical services to DVHA, its providers, and members. Change Healthcare is responsible for processing all pharmacy claims, assuring correct pricing and coordination of benefits, operating a provider-focused clinical call center in South Burlington for making drug coverage determinations for pharmacy claims and physician-administered drugs (typically processed through the medical benefit which are not reflected in any costs in this report), managing the federal, state, and supplemental drug rebate programs, assisting DVHA with performing both prospective and retrospective drug utilization review analyses and procedures, managing the Preferred Drug List (PDL) through activities of the Drug Utilization Review Board, and operating a suite of software programs that support all activities including a clinical, operational and financial reporting suite.

In addition to monitoring and oversight of all aspects of the PBM contract, the Pharmacy unit also assists with drug appeals and exception requests, manages all pharmacy provider communications, oversees all rebate contracts and programs, resolves drug-related pharmacy provider issues, oversees and manages the Drug Utilization Review Board policies and membership, and assures compliance with all state and federal pharmacy and pharmacy benefits reporting and regulations.

Pharmacy Benefit Management (PBM) Services

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

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

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

Drug Benefit Program Designs

Of the DVHA programs that include full health insurance coverage, all of them include a pharmacy benefit. These programs are described below by a summary table produced by

the Office of the Health Care Advocate for ease of visualization:

Overview of Green Mountain Care as of 9/28/20*			
PROGRAM	WHO IS ELIGIBLE	BENEFITS	COST-SHARING
MABD Medicaid[1] Medicaid Working Disabled MCA[2] (Expanded Medicaid)	Aged, blind, disabled at or below the PIL[3]. Disabled working adults at or below 250% FPL[4]. Vermonters at or below 138% of FPL who are: • Parents or caretaker relatives of a dependent child; or • Adults under age 65 and not eligible for Medicare	• Covers physical and mental health, dental ($1000 cap/yr), prescriptions, chiro (limited), transportation (limited). • Not covered: eyeglasses (except youth 19-20); dentures. • Additional benefits listed under Dr. Dynasaur (below) covered for youth 19-20. • Covers excluded classes of Medicare Part D drugs for dual-eligible individuals.	• No monthly premium. • $1/$2/$3 prescription co-pay if no Medicare Part D coverage. • $3.60 -$8.95 co-pays if have Part D. (if beneficiary is under 100% FPL $1.30 to $3.90) Medicare Part D is primary prescription coverage for dual-eligible individuals. • $3 dental co-pay. • $3/outpatient hospital visit.
Dr. Dynasaur	Pregnant women at or below 213% FPL.	Same as Medicaid, but with full dental.	No premium or prescription co-pays.
Dr. Dynasaur	Children under age 19 at or below 317% FPL.	Same as Medicaid but covers eyeglasses, full dental, & additional benefits.	• Up to 195% FPL: no premium. • Up to 237% FPL: $15/family/month. • Up to 317% FPL: $20/family/month . ($60/family/mo. w/out other insurance) • No prescription co-pays.
VPharm1 150% FPL VPharm2 175% FPL VPharm3 225% FPL	Medicare Part D beneficiaries	• VPharm1 covers Part D cost-sharing & excluded classes of Part D meds, diabetic supplies, eye exams. • VPharm 2&3 cover maintenance meds & diabetic supplies only.	• VPharm1: $15/person/mo. pd to State • VPharm2: $20/person/mo. pd to State • VPharm3: $50/person/mo. pd to State • $1/$2 prescription co-pays. • VPharm1 must apply for Part D Low Income Subsidy.
Healthy Vermonters 350% FPL/400% FPL if aged or disabled	Anyone who has exhausted or has no prescription coverage	• Discount on medications. (NOT INSURANCE)	Beneficiary pays the Medicaid rate for all prescriptions.

[1] MABD: Medicaid for the Aged, Blind, and Disabled. MABD is the only program w/ resource limits: $2000/person, $3000/couple (Medicaid for the Working Disabled is $$10,000/person, $15,000/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
*Adapted from document created by Vermont Legal Aid, Office of the Health Care Advocate. (2020). Overview of Green Mountain Care and Vermont Health Connect Plans. Retrieved from: https://vtlawhelp.org/health

STRATEGIES UTILIZED TO MANAGE THE PHARMACY BENEFIT

Operational Strategies of the Program

The Pharmacy Best Practices and Cost Control Program encompasses the following operational strategies:

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

Preferred Drug List

The Preferred Drug List (PDL) is a preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives.[3] 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. DVHA's Preferred Drug List (PDL) includes a list of commonly used preferred and non-preferred drugs that are covered by Department's drug benefit programs. Not all drugs DVHA 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:

- Generics
  - DVHA's overall Medicaid utilization of generic drugs is 77.5%, and they represent 13.7% of gross costs;

[3] 33 V.S.A. § 1998

- More than 98% of generics are preferred on the PDL, with some exceptions when the net cost of the brand drug is lower;
- Most generics do not require prior authorization.

- Brand Drugs
  - DVHA's overall Medicaid utilization of brand drugs is 22.5%;
  - Brand drugs represent 86.3% of gross costs;
  - 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 makes 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;
    - May require 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 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;
    - 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.

Generic Utilization and Substitution Rates

The generic utilization rate of 77.5% for state fiscal year 2020 measures the use of generics as a percentage of all drugs dispensed whereas the generic substitution rate of 79% in state fiscal year 2020 measures the percentage of time generics are utilized when a generic equivalent is available for a given drug. The data in Chart 3 identifies these rates of dispensing for state fiscal years 2018 through 2020 for both Medicaid and VPharm. Unlike commercial insurance and Medicare Part D plans, Medicaid generic indicators are typically lower because brands that lose patent protection often remain more cost-effective for the State after generics enter the market. This is especially true for the first six months to a year after brand drug patent expiration and drives the use of "brand-preferred" products on our PDL. As a result, the generic utilization

rate for Medicaid is 77.5% compared to VPharm (e.g., Medicare Part D) which is 83%. Likewise, the generic substitution rate for Medicaid is 79% versus 91% in VPharm. However, a positive trend can be seen for Medicaid since both the generic utilization rate and generic substitution rate are higher in state fiscal year 2020 compared to state fiscal year 2019.

One significant driver of a lower generic utilization rate and generic substitution rate is that over the last several years, 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 the generic films. Since this drug is our number one drug for both gross spend and number of prescriptions, it significantly affects our generic dispensing and substitution rates. We expect to see an upward trend in both indicators in state fiscal year 2021 since we added generic buprenorphine/naloxone tablets to preferred status on the PDL in August 2020.

Drug Utilization Review (DUR) Board

The Drug Utilization Review Board in Vermont serves a dual function. The first function of the Board is fulfilling the drug utilization review component required by federal law[4] whereby 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 second role of the Drug Utilization Review Board is to provide drug coverage guidance and assist the Department in the development of its Preferred Drug List. While some states have two boards for each purpose, the Department of Vermont Health Access (DVHA) elected to utilize the already established Drug Utilization Review Board to guide its decisions on drug coverage and prior authorization criteria.

In September 2019, Governor Scott signed a new Executive Order which allows Drug Utilization Review Board terms to be structured in 3-year staggered terms, all ending on August 31st. The Drug Utilization Review Board term limits allow us to better manage the turnover and reappointment of Board members and aligns with term limits for other state-appointed boards.

The Drug Utilization Review Board of the Department of Vermont Health Access is a committee composed of Vermont prescribers and pharmacists. The Board membership currently includes five physicians, five pharmacists, and one nurse practitioner who also served as chairperson through state fiscal year 2020. The Board Chairperson is elected by the Board. The Board meets approximately every six weeks, and there are seven meetings per year with robust agendas.

[4] Social Security Act 1927

Agendas are 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 DVHA's drug benefit programs.

Additionally, the Board routinely reviews patterns in the prescribing, dispensing and consumption of medications. The Board may help the Department 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 the Department, with the Board's guidance, to optimize the pharmaceutical care received by our members.

Some topics of discussion at the Drug Utilization Review Board meetings in state fiscal year 2020 included: PrEP (pre-exposure prophylaxis) therapy to prevent HIV in people at-risk, co-prescribing of opioids and benzodiazepines, appropriate use of asthma controller medications, use of gabapentin, inappropriate use of antibiotics, blood pressure medication adherence and long-term nonsteroidal anti-inflammatory drug (NSAID) use in chronic kidney disease, and concurrent use of opioids and antipsychotics.

The Department of Vermont Health Access also creates and distributes provider communications when certain changes are made to clinical criteria or dosing limitations, or if an educational communication is appropriate based on a drug utilization review. For example, if a preferred drug is changed to a non-preferred status and specific beneficiaries are affected, prescribers are provided with a list of all their patients who were prescribed the specific drug that is being changed and a profile unique to each patient with the drug change listed. This creates a record for use in the patient's file and provides notice to provider offices of the upcoming change. The Department's Pharmacy unit uses various forms of communication, including letters to providers, "fax blasts" to pharmacies, banners on the provider payment remittance advice, newsletters, and website postings. The chart below lists some of the state fiscal year 2020 activities of the Drug Utilization Review Board.

Drug Utilization Review Board Activities in 2020

Review Topic	SFY 2020 Total
Therapeutic Drug Classes: Periodic Review	56
Full New Drug Reviews	42
FDA Safety Alerts	9
New/Updated Clinical Guidelines	20
RetroDUR/ProDUR reviews	6
New Managed Therapeutic Drug Classes	4
BioSimilar Drug Reviews	2

Prior Authorization Program

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

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" to 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 prior authorization process is completed by the POS system, which is invisible to the providers and member. To reduce provider burden, the Department implemented an automated prior authorization program for drugs. This implementation has eliminated a number of manual prior authorizations that had to be completed by provider staff. The pharmacy claims processing system checks the member's record for the required medical diagnosis on the claim's date of service. The system can also automatically calculate the daily dose based on medication history and the quantity and day supply submitted.

These "auto-prior authorization" edits were implemented in response to feedback received from providers and have had a positive impact on both providers and members. The Department continues to monitor manual and automated prior authorization volume and implement additional automated edits as appropriate. The goal continues to be reduced provider burden while assuring clinical and financial integrity of pharmacy programs. Chart 4 reports prior authorization requests by approval and denial rates for state fiscal year 2020. The total number of prior authorizations declined by 7.5% in state fiscal year 2020 due to an overall decline in the number of prescriptions processed, in addition to automated

extensions of PAs from March through the end of June, 2020 during the COVID-19 Public Health Emergency. Although the number of PAs processed has declined by 21% since state fiscal year 2018, the overall PA denial rate has increased somewhat from 23% in state fiscal year 2018 to 26.7% in state fiscal year 2020 . This is consistent with our review and removal of PAs for some "high approval rate" drugs which lowers the overall approval rate.

Provider Portal

A pharmacy provider portal was launched in April 2018, allowing pharmacists and prescribers access to a secure, web-based application that offers features such as a pharmacy and member eligibility, drug queries, electronic submission of prior authorizations, uploading of clinical documentation into a document management system, and status updates for submitted prior authorization requests. As of September 2020, the following provider types were enrolled in the Portal:

Pharmacy Managers	35
Pharmacy Delegates	19
Prescribers	63
Prescriber Delegates	18
Total Providers with Access:	**135**

The Department is continuing to perform provider outreach to maximize provider enrollment in the Portal.

Pharmacy Cost Management Program

In late state fiscal year 2017, the Department of Vermont Health Access, in collaboration with Change Healthcare, implemented the Pharmacy Cost Management program. The goal of the program is to mitigate the impact of high-cost specialty drugs on pharmaceutical expenditures while ensuring that the full value of these medications in improving patient outcomes and reducing medical expenditures can be realized. Achieving this goal requires focused and attentive oversight and management of the drugs and supportive practices for the patients receiving them to ensure that patients are not only prescribed the optimal drug for their specific condition, but that they are taking the drug(s) as prescribed and are receiving the appropriate monitoring, testing and follow-up care.

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, the Change Healthcare pharmacist provides direct patient outreach, consultation and education to patients enrolled in the program. This includes reviewing the correct storage and proper dosage of the medication with the patient. Additionally, patients are educated on what to do if a dose is missed, common medication side effects and how best to manage them, and the importance of adhering with the directions on the prescription and also with behavioral/lifestyle changes that may increase quality of life.

This program tracks patient adherence to medication regimens by measuring Medication Possession Ratio (MPR), which is the number of dispensed medication doses divided by the number of days in a unit of time (e.g., one year). The MPR can be used to estimate the degree to which patients with chronic medical conditions comply with prescribed drug therapies. Patient outreach not only emphasizes the importance of taking the medication as prescribed, but also aims to identify and rectify any potential barriers to adherence (such as transportation, work schedule, dexterity/vision problems). The primary goals of the program are decreasing inappropriate use and assuring adherence to medication regimens of patients on these high cost drugs. The importance of adherence cannot be emphasized enough to obtain the highest likelihood of benefit from medications (for example, a cure of Hepatitis C). Beyond the immediate health concern that the medication is treating, high levels of adherence can also improve health outcomes which can result in a decrease of other medical care utilization.

A 2003 World Health Organization report estimated that 50% of patients do not take medications as prescribed. 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 the cause of 125,000 deaths related to treatment failure. To demonstrate improved adherence, we analyzed the 90-day period after members were enrolled into the Pharmacy Cost Management (PCM) program for all members enrolled through March 1, 2020. Medication Possession Ratio (MPR) is calculated as the sum of the days-supply of prescriptions divided by the number of days on treatment. An MPR of 0.8 means the patient has medication on hand for 80% of the time during the measured period, which is considered good medication adherence.

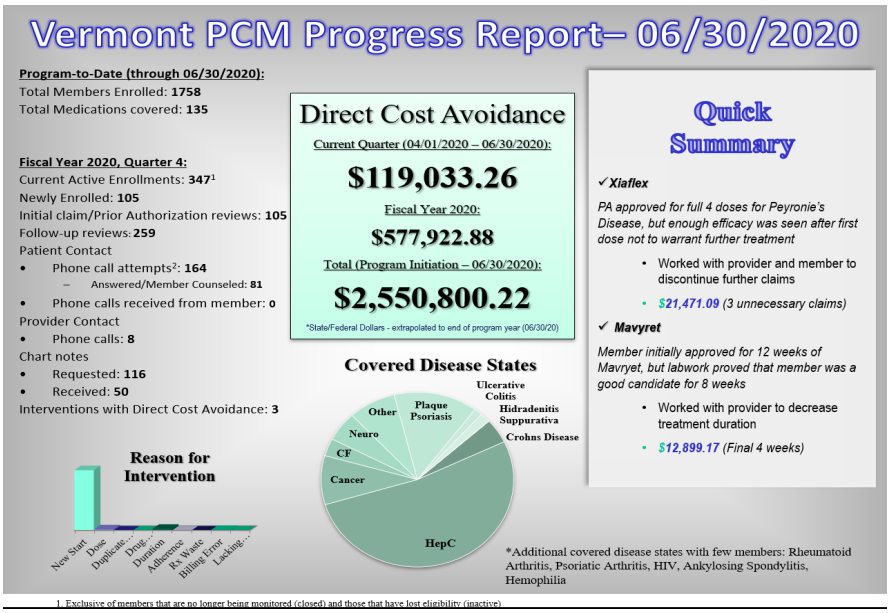
The results demonstrate that nearly 90% of the members enrolled in PCM had an MPR of at least 0.8, satisfying this measure of good medication adherence. Our full report provides us with per-member data which we use to identify patients that are currently non-adherent and focus our efforts where they are most needed.

Vermont Pharmacy Cost Management (PCM) Member Adherence Assessment	**Total**
Total Number of Vermont PCM Members	**1096**

Number of Members Adherent to Targeted Medications (MPR ≥0.8)	**972**
Percent of Vermont PCM Members Adherent to Targeted Medications	**89%**

The Vermont Medicaid Pharmacy Cost Management (PCM) program continued throughout state fiscal year 2020. The entire fourth quarter took place during the COVID-19 pandemic and social distancing protocols, and the PCM program adapted to these changes. The clinical pharmacist continued outreach to members and providers although making connection has been more challenging during the Public Health Emergency. We are now seeing a gradual transition from telehealth appointments back to in-person laboratory and provider visits, although not to pre-pandemic levels. The PCM program continues to operate normally while allowing for longer response times from providers.

In the fourth quarter, the PCM program enrolled an additional 105 members for a total of 1,758 members on 135 unique medications. The program is actively monitoring 347 enrollees. A total of 164 outgoing telephone calls were placed to members, 81 of which resulted in member counseling. During this quarter of the Vermont PCM program, three 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. Through interventions in the PCM program, unnecessary drug spend of nearly $578,000 was avoided in state fiscal year 2020, and more than $2.5 million in unnecessary drug spend was avoided over the duration of the program.[5]



[5] Change Healthcare. (April 1, 2020 through June 30, 2020). Change Healthcare Pharmacy Management Reporting Suite by a collection of reports recording the process and progress of PCM.

State Maximum Allowable Cost Program

Vermont's State Maximum Allowable Cost program is similar to CMS' Federal Upper Limit program. The intent is to provide a maximum price that the State of Vermont will pay for a given generic pharmaceutical regardless of its package size or manufacturer. The State Maximum Allowable Cost (MAC) program is designed to promote the efficient purchasing of generic pharmaceuticals within the pharmacy provider network to ensure that the Medicaid program is effectively managing the cost of prescription drugs. In developing the state MAC pricing list, the State of Vermont relies on Change Healthcare's data and expertise 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. Examples of the benchmarks used include wholesale acquisition cost (WAC), federal upper limit (FUL), and national average drug acquisition cost (NADAC) prices.

A full review of the state Maximum Allowable Cost (MAC) pricing list is performed monthly and is reviewed and approved by the Department. 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 and drug shortages in Vermont that may affect the price or availability of drug products, so we can proactively adjust MAC pricing to assure fair and accurate reimbursement to DVHA-enrolled pharmacies. DVHA fully complies with Title 18 of the Vermont Statutes regarding maximum allowable cost prices effective July 1, 2015, which requires pharmacy benefit managers to make MAC listing available 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 MAC appeal request form found on the DVHA website. Appeals must be received within 10 calendar days of the claim adjudication date, and DVHA must respond within 10 calendar days of the receipt of a timely appeal request.

The distribution of claims pricing off a State Maximum Allowable Cost or another pricing benchmark can be seen in Chart 5.

DRUG UTILIZATION HIGHLIGHTS

Top Drugs by Cost and Utilization

The Department continues to see the highest spending on drugs used to treat substance use disorder (opioid partial agonists), Attention Deficit Hyperactivity Disorder (stimulants, amphetamines), diabetes, inflammatory conditions such as rheumatoid arthritis and Crohn's Disease, Hepatitis C, etc. Chart 7 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.

Consistent with reporting for state fiscal year 2019, opioid partial agonists including Suboxone® are on the top of the charts by both spend and utilization. The number of claims for all buprenorphine containing drugs increased by 6% for state fiscal year 2020 (Chart 9) and increased a total of 13% for the last 2 fiscal years supporting the trend toward more patients with opioid use disorder accessing treatment. At the same time, the number of members using short-acting opioids decreased by 20% and those using long-acting opioids decreased by nearly 20% as well during fiscal year 2020 (Chart 11A). The number of prescriptions for short-acting and long-acting opioids declined by nearly 18% and 20%, respectively (Chart 11B). These results are indicative of Vermont's continued commitment to implementing and maintaining initiatives that address the opioid crisis. Vermont has developed Rules and prescribing guidelines intended to limit the quantities of opioids that are prescribed and provided academic detailing[6] for prescribers to improve care provided for patients. Educational initiatives and awareness around treating chronic pain differently without the use of opioids is also a contributing factor. 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 system of care for improving access to medication assisted treatment for opioid use disorder.

Of note, an increase in utilization of Concerta was observed from 2019-2020 and is due to changes in the preferred products on the PDL (Chart 8) for the Attention Deficit Hyperactivity Disorder (ADHD) class of drugs. Overall, the utilization of ADHD drugs has remained relatively constant over the last year. In the Top Therapeutic Classes by Utilization chart (Chart 9), the Gross Amount Paid in the anticonvulsant class dropped significantly from state fiscal

[6] https://www.med.uvm.edu/ahec/vermontacademicdetailing

year 2019 to state fiscal year 2020 from $7.5 million to $4.7 million. This is primarily due to the shift from brand Lyrica at $555 per claim to the less expensive generic pregabalin at $22 per claim. Although classified and used as an anticonvulsant, pregabalin is more commonly prescribed for neuropathic pain associated with diabetic neuropathy, postherpetic neuralgia, and fibromyalgia. The number of prescriptions of pregabalin remained relatively constant. For the first time, oil soluble vitamins also show up as one of the top therapeutic classes by utilization (Chart 9). Most of this utilization is for vitamin D. A vitamin D deficiency is linked to brittle, weak bones and research is ongoing supporting its role in immune function and cancer prevention. Some people may have lower levels of vitamin D because of their diets, and particularly in Vermont, due to lack of exposure to the sun.

Specialty Pharmacy

The list of specialty medications is updated quarterly and can be found on the DVHA website.[7] In addition, DVHA maintains a list of specialty pharmacies enrolled with the State.[8]
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 REMS requirements requiring training, certifications or ongoing monitoring for the drug to be distributed.
- The medication requires specialized handling, storage or inventory reporting requirements.

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

- Cancer
- Contraceptive implants and IUDs
- Cystic Fibrosis
- Endocrine Disorders
- Enzyme Deficiencies
- Hemophilia
- Hepatitis C

[7] https://dvha.vermont.gov/providers/pharmacy/drug-coverage-lists

[8] https://dvha.vermont.gov/providers/provider-network-info

- Hereditary Angioedema
- Immune Deficiency
- Inflammatory Conditions (e.g. Crohn's, ulcerative colitis, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, and psoriasis)
- Multiple Sclerosis
- Muscular Dystrophy
- Pulmonary Arterial Hypertension
- Respiratory Syncytial Virus (RSV)
- Spinal Muscular Atrophy (SMA)

DVHA defines a specialty pharmacy as outlined by the Academy of Managed Care Pharmacy (AMCP) in a publication entitled Format for Formulary Submission, version 4.1,[9] and the National Association of Specialty Pharmacies definition below.

> "Specialty pharmacies are distinct from traditional pharmacies in coordinating many aspects of patient care and disease management. They are designed to efficiently deliver medications with specialized handling, storage, and distribution requirements with standardized processes that permit economies of scale. Specialty pharmacies are also designed to improve clinical and economic outcomes for patients with complex, often chronic and rare conditions, with close contact and management by clinicians. Health care professionals employed by specialty pharmacies provide patient education, help ensure appropriate medication use, promote adherence, and attempt to avoid unnecessary costs. Other support systems coordinate sharing of information among clinicians treating patients and help patients locate resources to provide financial assistance with out of pocket expenditures."

The National Association of Specialty Pharmacy defines a specialty pharmacy as follows:

> "A specialty pharmacy is a state-licensed pharmacy that solely or largely provides only medications for people with serious health conditions requiring complex therapies. These include conditions such as cancer, hepatitis C, rheumatoid arthritis, HIV/AIDS, multiple sclerosis, cystic fibrosis, organ transplantation, human growth hormone deficiencies, and hemophilia and other bleeding disorders. In addition to being state-licensed and regulated, specialty pharmacies should be accredited by independent third parties such as URAC®, the Accreditation Commission for Health Care (ACHC), the Center for Pharmacy Practice Accreditation (CPPA) or the Joint Commission in order to

[9] AMCP Formulary Format Version 4.1

ensure consistent quality of care.

Specialty pharmacies connect patients who are severely ill with the medications that are prescribed for their conditions, provide the patient care services that are required for these medications, and support patients who are facing reimbursement challenges for these highly needed but also frequently costly medications. Specialty medications have a complex profile that require intensive patient management. Some specialty medications also require special handling. Though some are taken orally, many of these medications need to be injected or infused, some in a doctor's office or hospital. Specialty pharmacies provide services that include training in how to use these medications, comprehensive treatment assessment, patient monitoring, and frequent communication with caregivers and the patient's physician or other healthcare providers."[10]

DVHA requires any specialty pharmacy dispensing specialty drugs to DVHA Members to be Certified by the Utilization Review Accreditation Commission (URAC), the Accreditation Commission for Health Care (ACHC) or the Center for Pharmacy Practice Accreditation (CPPA). In state fiscal year 2020, specialty drugs represented 26.7% of the Department's overall drug spend. This was a small increase of 1.2% over State Fiscal Year 2019, when specialty drugs represented 25.5% of the Department's drug spend. In contrast, recent Express Scripts data (includes a mix of commercial, Medicare, Exchange, and Medicaid managed care plans) reveals that nearly half (47.7%) of all drug spending in 2019 was on specialty drugs.[11] However, many specialty drugs are administered in the doctor's office or other provider settings (i.e., they are not taken orally and not self-injected) and are also a factor in drug spend increases although most of these drugs are covered through the medical benefit. It is important to recognize that 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.

We continue to see increases in the spend and utilization for specialty medications used to treat Cystic Fibrosis (CF). Cystic Fibrosis is a hereditary disease that damages the lungs, digestive system and other organs of the body. Treatment for Cystic Fibrosis continues to evolve and advance. In recent years, cystic fibrosis transmembrane conductance regulator (CFTR) modulator therapies have been developed; these are designed to correct the malfunctioning protein made by the CFTR gene. Called "CFTR modulators," they function more as disease modifying agents rather than other treatments that target just symptoms. In October 2019, a new CFTR drug, Trikafta, was approved and is expected to have a significant impact on the treatment of Cystic Fibrosis since it targets a gene mutation found in nearly 90% of Cystic

[10] NASP 2016

[11] Express Scripts data

Fibrosis patients. Previous treatments, particularly other CFTR modulators including Kalydeco, Orkambi, and Symdeko target mutations that are found in fewer than 50% of patients. Trikafta is a combination of three drugs that target the defective CFTR protein and helps it function more effectively. It is part of first line therapy in most Cystic Fibrosis patients who qualify based on their age and genotype. Some adverse effects include headache, upper respiratory tract infections, abdominal pain, diarrhea, rash, and liver function test increases. CFTR modulators are specialty medications and drugs like Trikafta are very expensive, as much as $300,000 per year.[12] The CFTR modulators Trikafta, Symdeko, and Kalydeco are expected to receive approval in SFY2021 for an expanded indication for a rare mutation which would allow treatment for an additional 600 patients nationally.

Other therapies for Cystic Fibrosis include symptomatic treatment and may include pancreatic enzymes, systemic antibiotics, inhaled antibiotics such as inhaled tobramycin, and medications that thin the mucus to improve lung function such as dornase alpha (Pulmozyme). The list of Top 10 Cystic Fibrosis Drugs by Spend (Chart 17) demonstrates that Trikafta uptake has been strong in the Vermont Cystic Fibrosis population with 143 prescriptions since it was brought to market. However, it is worth noting that all other drugs on the Cystic Fibrosis top ten list by spend have declined in member count and gross paid amount. This decline demonstrates that members have switched from previous CFTR treatments to the new drug Trikafta; and importantly, patients seem to be using fewer medications for symptomatic treatment. This may be due in part to the efficacy of the newer CFTR agents.[13] The Pharmacy unit expects continued specialty drug price growth due to the FDA-approval of many new, expensive specialty drugs.

Medicaid Net Prescription Drug Expenditure Forecast

Prescription drug expenditures between 2021-2023 are projected to increase, averaging 5.4 percent per year, influenced by both faster drug price increases and higher growth in the use and intensity of prescription drugs related to an increasing number of new drugs entering the market.[14] According to Steve Liles, Pharm.D., Senior Director of Industry Relations for DVHA's pharmacy benefit administrator, Change Healthcare, it is projected that the net spend on anticoagulants will increase an average of 11% per year with a continued shift to utilization of the Non-Vitamin K Oral Anticoagulants (NOAC) due to expanded indications and increased prescriber familiarity. Drugs used to treat various inflammatory conditions, such as ulcerative colitis, Crohn's disease, and arthritis, are projected to increase by approximately 9 percent. This is due to an increase in overall prescribing and utilization of new higher cost interleukin agents

[12] https://www.fda.gov/news-events/press-announcements
[13] Pharmacist's Letter-February 2020
[14] https://www.cms.gov/files/document/nhe-projections-2019-2028-forecast-summary.pdf

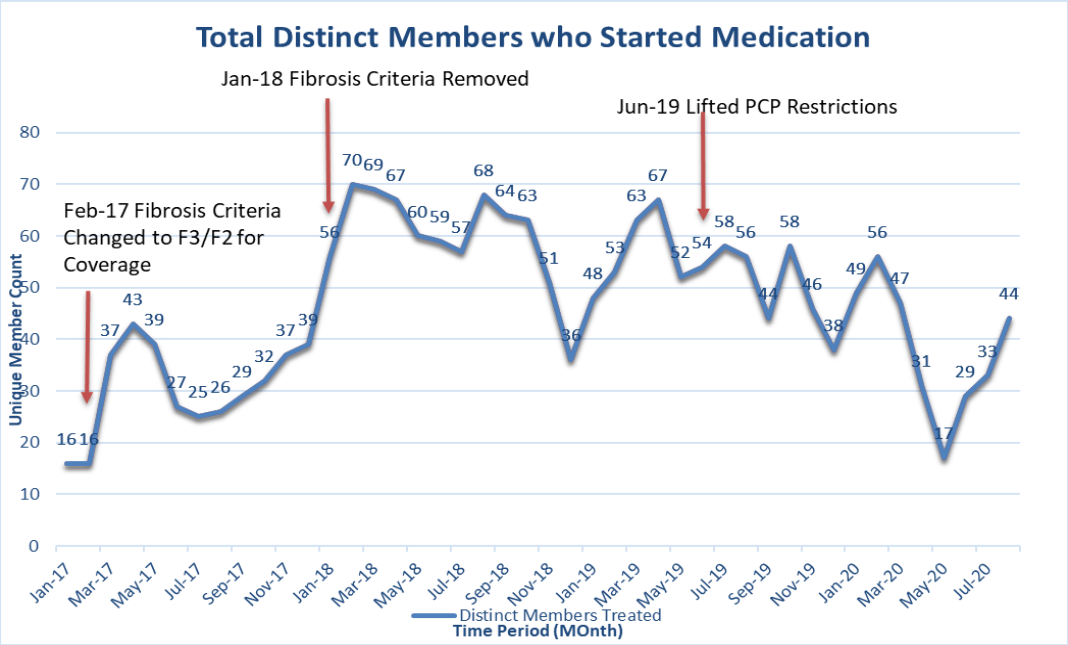
for psoriasis. Net spend for oncology drugs is projected to increase about 11% each year due to utilization of newer products with expanded indications and increased use of self-administered medications as maintenance therapy. The projected increase is also in part due to increased overall utilization as cancer becomes more of a chronic disease and more people live with cancer. Net spend on HIV-related drugs is expected to increase by about 10% in state fiscal year 2021 due mainly to increased prescribing of prophylactic regimens. However, we should see a significant decline in gross spend as some highly utilized drugs lose patent protection in state fiscal year 2022. Finally, we expect an increase in net spending for diabetes medications of 8% in state fiscal year 2021 due to increased utilization of newer insulin products, and expanded indications for cardiovascular disease and heart failure for patients who are not diabetic.

Hepatitis C Drugs

Direct Acting Antivirals are very effective drugs and competition has driven the cost down considerably. The Pharmacy unit continues to see a significant financial impact as more people are treated for Hepatitis C Virus (HCV). Two Direct Acting Antivirals (DAA) for treating Hepatitis C are on the Top 10 Drugs by Gross Spend list; Mavyret and Epclusa continue to appear on the top ten list for gross spend. Mavyret is very effective, can be used for all genotypes, can have an 8-week course of therapy versus 12 weeks for some other DAA agents, and has a lower cost of treatment. In January 2018, the Fibrosis Score requirement was removed, and in February 2019, several other requirements were removed, opening the door for broader access to treatment for people with Hepatitis C. In June 2019, the requirement for a specialist to prescribe a DAA was removed for patients who are treatment naïve, non-cirrhotic, Hepatitis B negative and HIV negative which further expanded access to treatment of Hepatitis C by primary care providers. Direct Acting Antivirals continue to be high on the Top Therapeutic Classes by Gross Spend list. These drugs are a focus of Pharmacy Cost Management program services to facilitate patient follow-up and support medication adherence, ultimately enabling the best clinical outcomes.

While the number of unique members utilizing Direct Acting Antivirals for treatment of Hepatitis C increased from **267** in state fiscal year 2018 to **348** in state fiscal year 2019, we did see a decline to **283** in the number of members treated in state fiscal year 2020. (Chart 16). There appears to be a correlation with the COVID-19 pandemic that may have impacted new treatment starts, demonstrated by a significant decline in members who started medication

between March and June of 2020.



MEDICAID REBATE PROGRAMS

Federal Rebates

Federal rebates that manufacturers pay to states are calculated based on a federally mandated formula and on prices manufacturers set, with 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 Department'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 is due to the rebates being based, in part, on the Consumer Price Index to account for inflation.

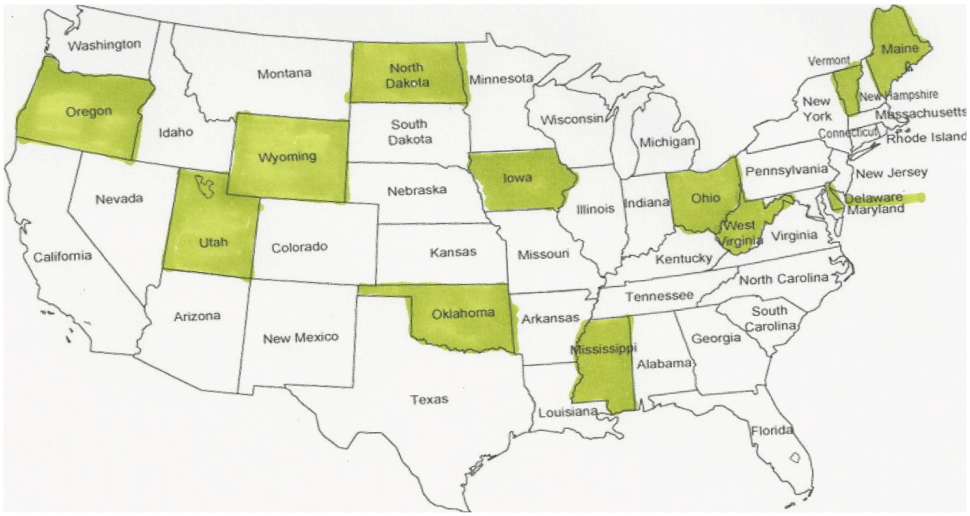
The Bipartisan Budget Act (BBA) of 2015 required manufacturers to pay additional rebates when their generic covered outpatient drugs' average manufacturer prices (AMPs) increase at a rate that exceeds the rate of inflation. This is commonly referred to as the "CPI Penalty" (Consumer Price Index) and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

Supplemental and Diabetic Supplies Rebates

Supplemental rebates are negotiated by the State through its participation in the Sovereign States Drug Consortium (SSDC). Supplemental rebates are those rebates in addition to the required federal rebates on a drug, while diabetic supply rebates are state-only rebates on diabetic supplies (such as lancets, test strips, and glucose monitors) for which the State does not receive 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 the State to retain control and flexibility in the management of its preferred drug list while taking advantage of the additional leverage provided by the large number of members covered by the pool.

The SSDC was founded in the fall of 2005 by the States of Iowa, Maine and Vermont to obtain prescription drugs at a lower cost for members of their respective Medicaid programs. The SSDC uses a multi-state administered collaboration to create a purchasing pool. The pool primarily focuses on negotiating and acquiring rebates supplemental to federal Medicaid rebates from drug manufacturers. At the same time, the SSDC preserves each state's ability to manage its pharmacy benefit by customizing its own preferred drug list and prior approval programs. The States of Iowa, Maine and Vermont were the founding members of the SSDC in 2005. Due to the success of the SSDC, many other states have joined the consortium. In SFY2020, the SSDC added its thirteenth member state, Pennsylvania. Due to the success of the SSDC, it is now the largest and only independent, state-owned rebate pool in the country. The 13 states are illustrated in the map below.

The Sovereign States Drug Consortium is the largest and only state-managed rebate pool in the nation. Vermont was one of three founding members.



Sovereign States Drug Consortium Membership and Annual Drug Spend

In 2020, a total of 10.3 million members, and nearly $11.6 billion in drug expenditures is represented by the 13 participating states providing substantial leverage in manufacturer negotiations.

State	PDL Lives*	Annual Medicaid Drug Spend
DE	249,750	$267,000,000
IA	548,543	$522,000,000
ME	295,421	$292,027,908
MS	762,711	$567,976,986
ND	90,000	$75,000,000
OH	2,617,000	$4,178,521,139
OK	989,209	$620,900,000
OR	970,790	$193,557,064
PA	2,767,752	$3,790,000,000
UT	292,778	$193,527,491
VT	161,007	$198,549,001
WV	510,476	$690,774,612
WY	76,964	$47,336,051
TOTAL	**10,332,401**	**$11,637,170,252**

*Number of Medicaid lives covered under state Medicaid PDL including MCO enrollees in states with Unified PDLs for some or all covered drug classes, Sovereign States Drug Consortium, 2020[15]

[15] https://rxssdc.org

COST AND UTILIZATION CHARTS

Chart 1A: Pharmacy Claims and Gross and Net Spend, SFY 2019-2020 (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
2020	1,949,562	-3.02%	$200,401,603	0.82%	$102.79	3.96%	$67,860,006	0.76%	$34.81	3.91%
2019	2,010,344	-2.76%	$198,763,711	0.81%	$98.87	3.67%	$67,351,149	-0.42%	$33.50	2.38%
2018	2,067,375		$197,174,792		$95.37		$67,634,958		$32.72	
Medicaid Claim (includes Duals)										
SFY	Claims Paid	% Change	Gross Amount Paid	% Change	Gross Cost Per Claim	% Change	Net Paid Amount	% Change	Net Cost Per Claim	% Change
2020	1,655,345	-2.26%	$195,078,926	0.98%	$117.85	3.32%	$66,218,094	0.51%	$40.00	2.83%
2019	1,693,690	-2.34%	$193,178,701	0.98%	$114.06	3.40%	$65,884,865	-0.49%	$38.90	1.89%
2018	1,734,251		$191,311,623		$110.31		$66,210,512		$38.18	
Vpharm Claims										
SFY	Claims Paid	% Change	Gross Amount Paid	% Change	Gross Cost Per Claim	% Change	Net Paid Amount	% Change	Net Cost Per Claim	% Change
2020	294,217	-7.09%	$5,322,677	-4.70%	$18.09	2.55%	$1,641,912	11.98%	$5.58	20.52%
2019	316,654	-4.94%	$5,585,010	-4.74%	$17.64	0.23%	$1,466,284	2.94%	$4.63	8.18%
2018	333,124		$5,863,168		$17.60		$1,424,446		$4.28	

Note: Net spend is based on rebates invoiced, not rebates collected and does not reflect 340B Acquisition Cost Discounts. Dual-Eligible: DVHA only pays for non-Part D drugs, primarily over-the-counter (OTC) drugs. VPharm: DVHA pays secondary to Part D, and for non-Part D drugs, primarily OTC drugs.

Chart 2: Pharmacy Services: Utilizing Members

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

ALL	2018	2019	2020
Medicaid and Duals Eligible All Ages	166,638	161,115	156,731
Medicaid and Duals Utilizers All Ages	50,946	49,117	46,867
Medicaid and Duals Utilization Percent All Ages	31%	30%	30%
ADULTS			
Medicaid and Duals Eligible Adults	103,475	99,181	96,239
Medicaid and Duals Utilizers Adults	37,645	36,378	35,214
Medicaid and Duals Utilization Percent Adults	36%	37%	37%
CHILDREN			
Medicaid and Duals Eligible Children	63,162	61,934	60,492
Medicaid and Duals Utilizers Children	13,300	12,739	11,653
Medicaid and Duals Utilization Percent Children	21%	21%	19%

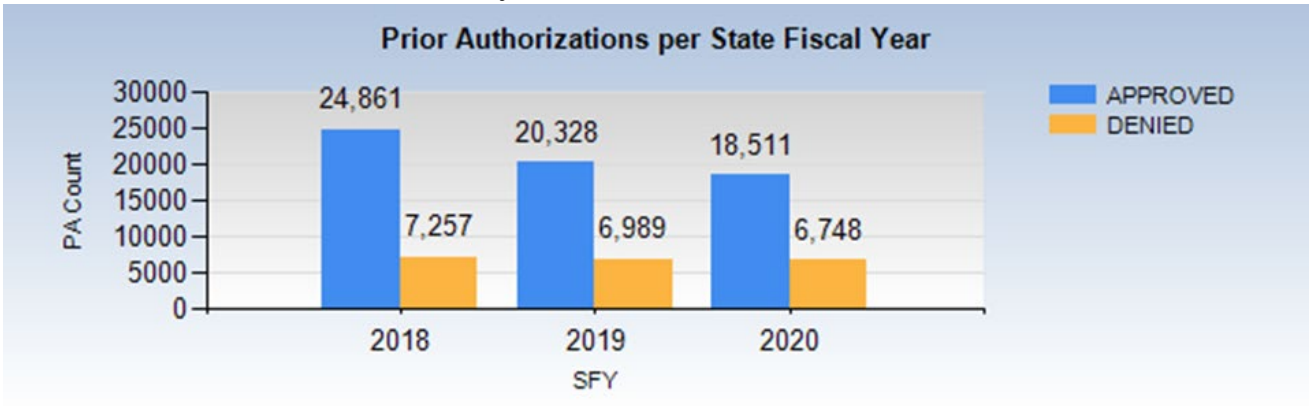
Chart 3: Generic Usage Rates

Medicaid (Includes Duals)			
Generic Indicator	2018	2019	2020
Generic Utilization Rate (GUR)	76.7%	76.3%	77.5%
Generic Substitution Rate (GSR)	86.3%	78.6%	79.1%
VPharm			
Generic Indicator	201800.0%	201900.0%	202000.0%
Generic Utilization Rate (GUR)	85.3%	85.5%	83.1%
Generic Substitution Rate (GSR)	89.0%	89.7%	91.1%

GUR: Generic use as a percentage of prescriptions for all drugs dispensed

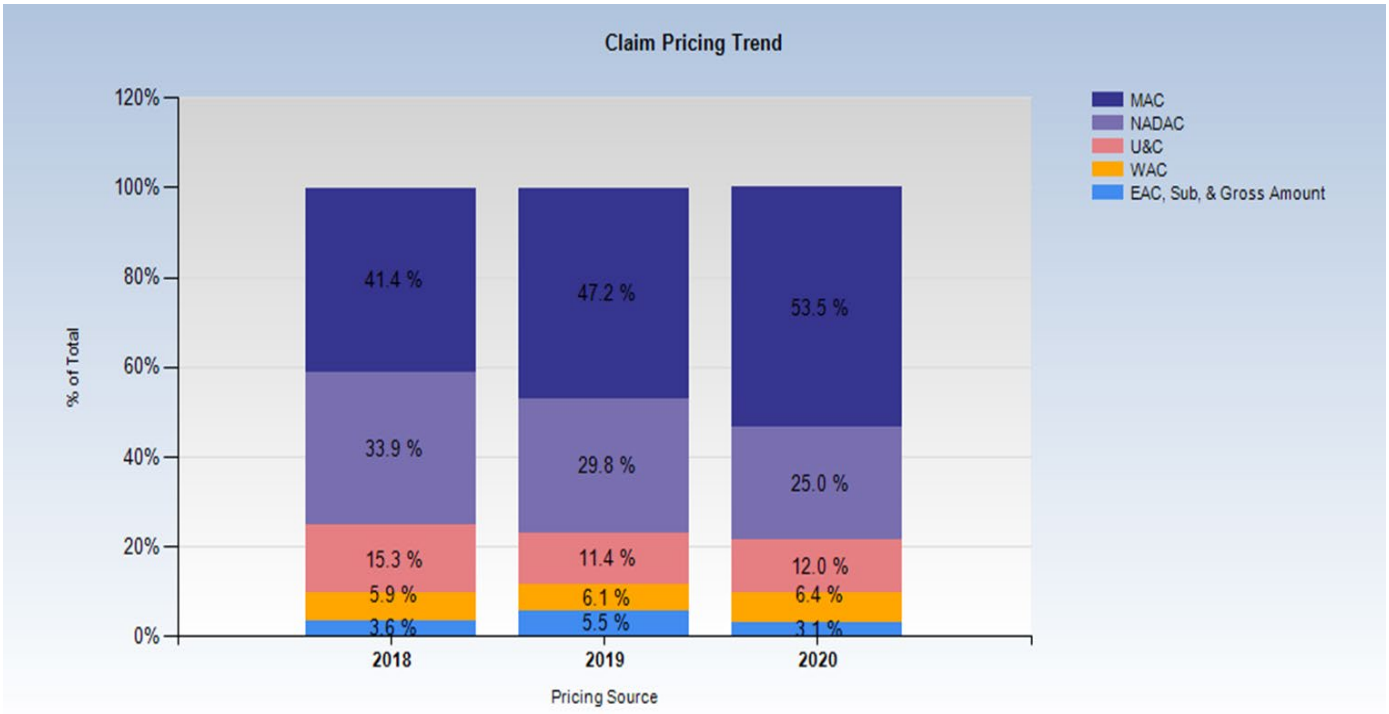
GSR: Generic use as a percentage of prescriptions when a generic equivalent is available

Chart 4: Prior Authorization Summary



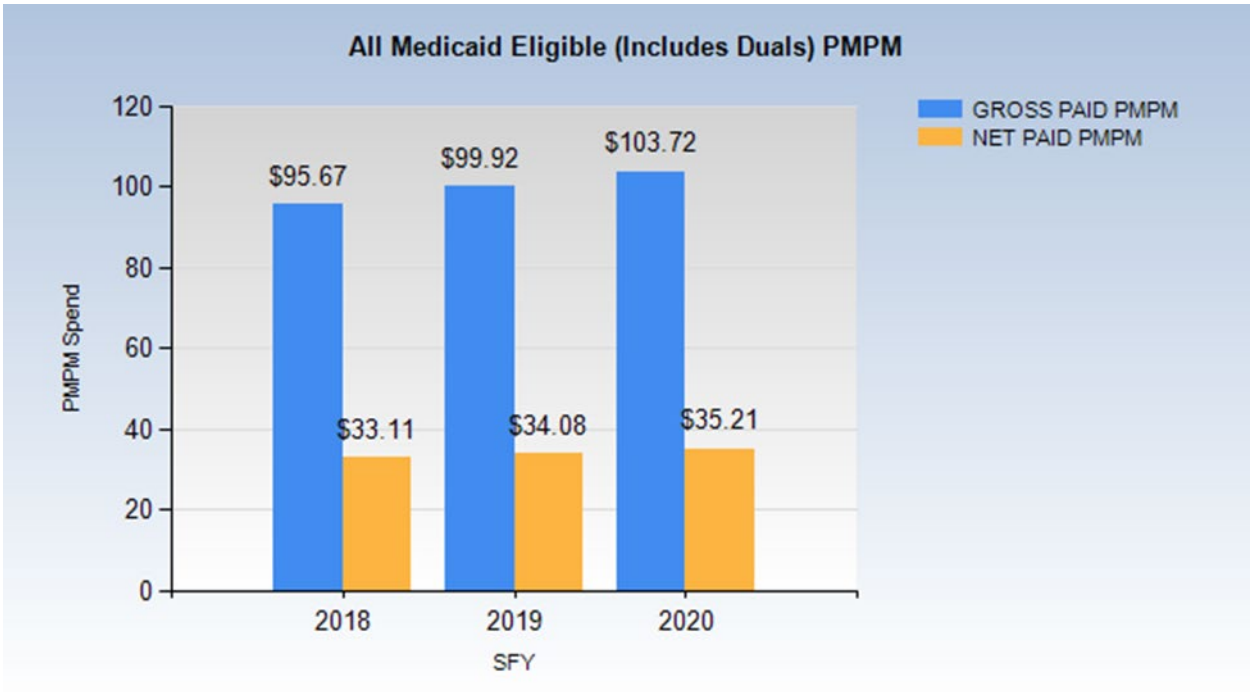
SFY	PA DENIAL RATE
2018	22.6%
2019	25.6%
2020	26.7%

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

Charts 6A: Gross and Net PMPM Trend by SFY Medicaid (Includes Duals)



Charts 6B: Gross and Net PMPM Trending by SFY (VPharm)

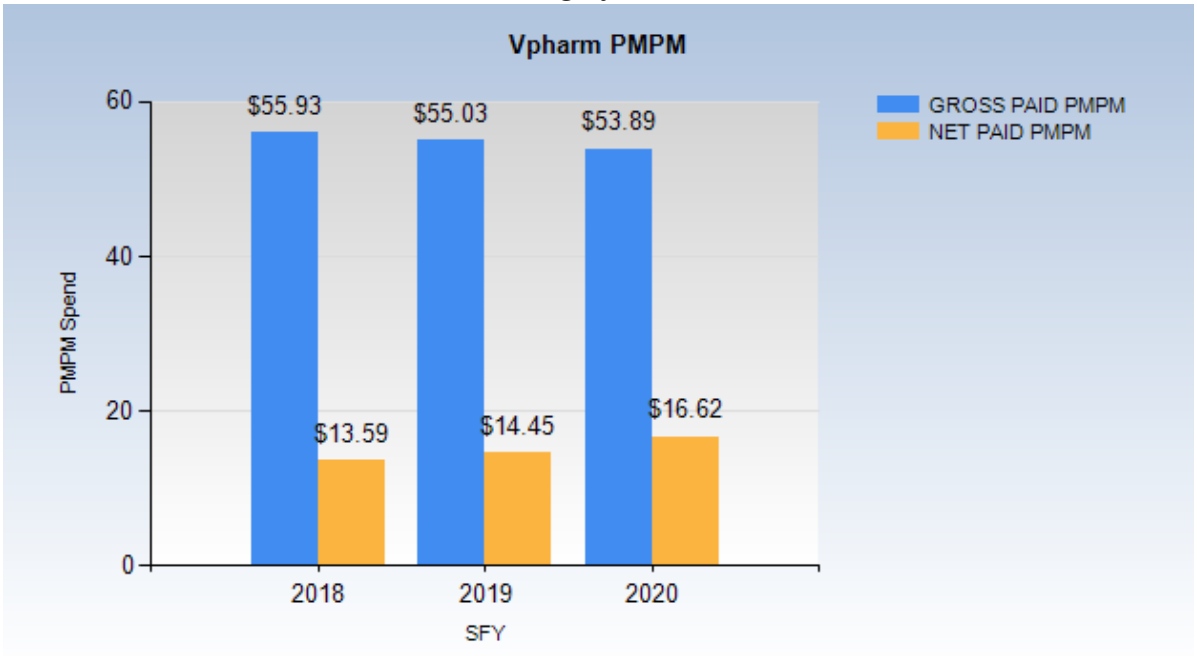


Chart 7: Top Therapeutic Classes by Gross Spend

Therapeutic Class/Treatment Category	2019 Gross Paid	2020 Gross Paid	2019 Claim Count	2020 Claim Count	Total Amount Paid Change	Claim Count Change
Opioid Partial Agonists/Substance Use Treatments	$16,378,657.43	$19,480,478.09	134,421	142,512	18.9%	6.0%
Stimulants - Misc. ADHD	$11,139,441.95	$11,729,120.61	49,535	49,769	5.3%	0.5%
Insulin	$11,766,593.90	$11,489,684.94	14,342	14,009	-2.4%	-2.3%
ANTI TNF ALPHA Monoclonal Antibodies -Rheumatoid Arthritis, UC, Crohn's	$9,806,107.95	$10,919,809.91	1,707	1,826	11.4%	7.0%
Sympathomimetics-Asthma/COPD	$10,112,435.26	$9,994,263.27	64,085	64,777	-1.2%	1.1%
Hepatitis Agents	$11,648,986.09	$9,435,885.81	866	646	-19.0%	-25.4%
Amphetamines -ADHD	$9,000,069.57	$9,039,396.66	55,845	56,151	0.4%	0.6%
Cystic Fibrosis Agents	$5,468,797.13	$6,789,279.29	613	617	24.2%	0.7%
Antiretrovirals -HIV Tx	$5,332,492.47	$5,462,495.68	2,371	1,944	2.4%	-18.0%
Antipsoriatics	$4,378,093.60	$5,021,516.97	701	710	14.7%	1.3%

Chart 8: Top Drugs by Gross Spend

Current Rank	Previous Rank	Drug Name	2019 Gross Paid	2020 Gross Paid	2019 Claim Count	2020 Claim Count	Total Amount Paid Change	Claim Count Change
1	1	**Suboxone Film** (buprenorphine/naloxone)	$15,386,983.36	$18,229,210.81	116,992	122,507	18.5%	4.7%
2	2	**Humira Pen** (Adalimumab)	$8,166,550.96	$9,159,076.20	1,445	1,587	12.2%	9.8%
3	3	**Vyvanse** (Lisdexamfetamine)	$6,857,223.11	$7,301,821.74	25,064	25,727	6.5%	2.7%
4	6	**Concerta** (methylphenidate)	$4,651,728.33	$6,181,806.73	12,950	16,416	32.9%	26.8%
5	4	**Mavyret** (glecaprevir,pibrentasvir)	$5,954,012.94	$5,059,167.47	531	394	-15.0%	-25.8%
6	5	**Epclusa** (sofosbuvir,velpatasvir)	$5,283,168.50	$4,170,101.63	237	172	-21.1%	-27.4%
7	9	**Focalin XR** (dexmethylphenidate HCl)	$3,662,326.31	$3,705,299.82	8,784	8,714	1.2%	-0.8%
8	8	**Lantus Solostar** (insulin glargine)	$3,837,683.60	$3,701,498.02	5,667	5,618	-3.6%	-0.9%
9	N/A	**Trikafta** (elexacaftor, tezacaftor, and ivacaftor)	N/A	$3,298,882.00		143	%	%
10	10	**Proair HFA** (albuterol)	$3,136,294.09	$2,945,886.98	37,776	33,762	-6.1%	-10.6%

Chart 9: Top Therapeutic Classes by Utilization

Therapeutic Class	2019 Gross Paid	2020 Gross Paid	2019 Claim Count	2020 Claim Count	Total Amount Paid Change	Claim Count Change
Opioid Partial Agonists/Substance Abuse Treatments	$16,378,657.43	$19,480,478.09	134,421	142,512	18.9%	6.0%
Selective Serotonin Reuptake Inhibitors (SSRIS) Antidepressants	$1,303,445.17	$1,287,585.93	84,022	82,481	-1.2%	-1.8%
Anticonvulsants - Misc..	$7,559,509.94	$4,730,738.45	69,362	69,123	-37.4%	-0.3%
Sympathomimetics – Asthma/COPD	$10,112,435.26	$9,994,263.27	64,085	64,777	-1.2%	1.1%
Amphetamines - ADHD	$9,000,069.57	$9,039,396.66	55,845	56,151	0.4%	0.6%
Stimulants – Misc. ADHD	$11,139,441.95	$11,729,120.61	49,535	49,769	5.3%	0.5%
Antihistamines – Non-Sedating	$426,732.43	$418,075.89	35,907	34,766	-2.0%	-3.2%
Oil Soluble Vitamins*	$343,989.98	$362,243.70	33,375	34,690	5.3%	3.9%
Proton Pump Inhibitors	$1,669,864.35	$1,319,081.62	33,500	33,639	-21.0%	0.4%
Nonsteroidal Anti-Inflammatory Agents (NSAIDS)	$577,477.05	$561,876.41	34,398	30,457	-2.7%	-11.5%

- Primarily Vitamin D

Chart 10: Top Drugs by Utilization

Current Rank	Previous Rank	Drug Name	2019 Gross Paid	2020 Gross Paid	2019 Claim Count	2020 Claim Count	Gross Paid Change	Claim Count Change
1	1	**Suboxone Film** (buprenorphine/naloxone)	$15,386,983.36	$18,229,210.81	116,992	122,507	18.5%	4.7%
2	2	**Proair HFA** (albuterol)	$3,136,294.09	$2,945,886.98	37,776	33,762	-6.1%	-10.6%
3	3	Gabapentin	$532,154.69	$537,814.35	31,287	31,022	1.1%	-0.9%
4	4	Amphetamine/Dextroamphetamine	$1,496,712.20	$1,444,342.04	28,004	29,080	-3.5%	3.8%
5	6	**Vyvanse** (Lisdexamfetamine)	$6,857,223.11	$7,301,821.74	25,064	25,727	6.5%	2.7%
6	5	Fluoxetine HCL	$402,946.14	$404,384.11	25,191	23,902	0.4%	-5.1%
7	9	Bupropion Hydrochloride	$474,977.91	$407,419.84	22,534	21,154	-14.2%	-6.1%
8	10	Omprezole	$272,969.37	$259,500.00	20,357	20,003	-4.9%	-1.7%
9	7	Methylphenidate Hydrochlo	$1,819,936.00	$716,204.21	22,606	18,488	-60.7%	-18.2%
10	11	Trazodone Hydrochloride	$225,422.86	$226,493.17	17,727	17,454	0.5%	-1.5%

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

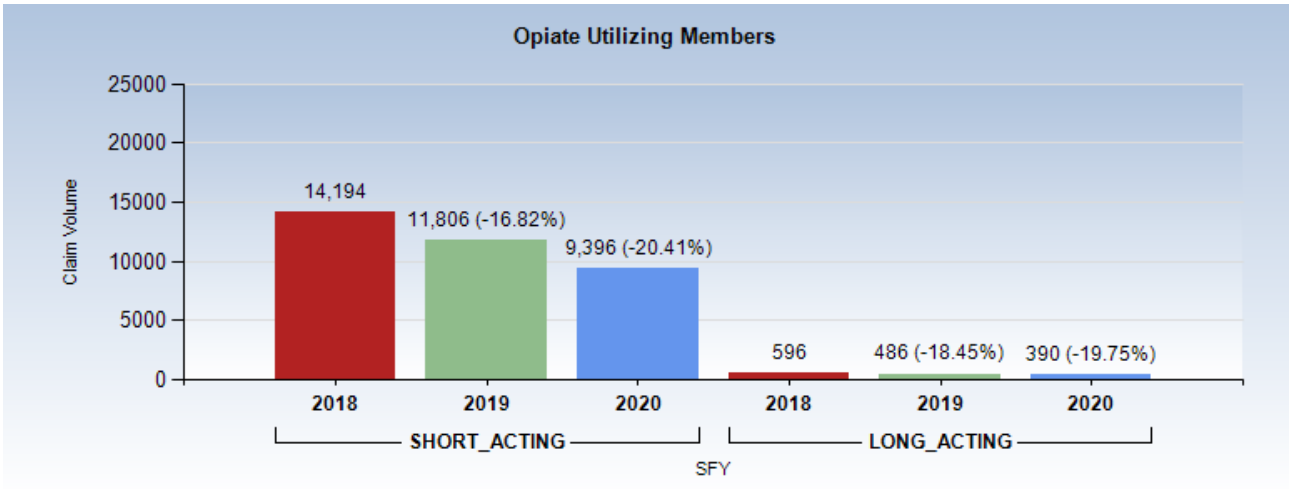


Chart 11B: Number of Prescriptions for Opioids: 3-yr Trend

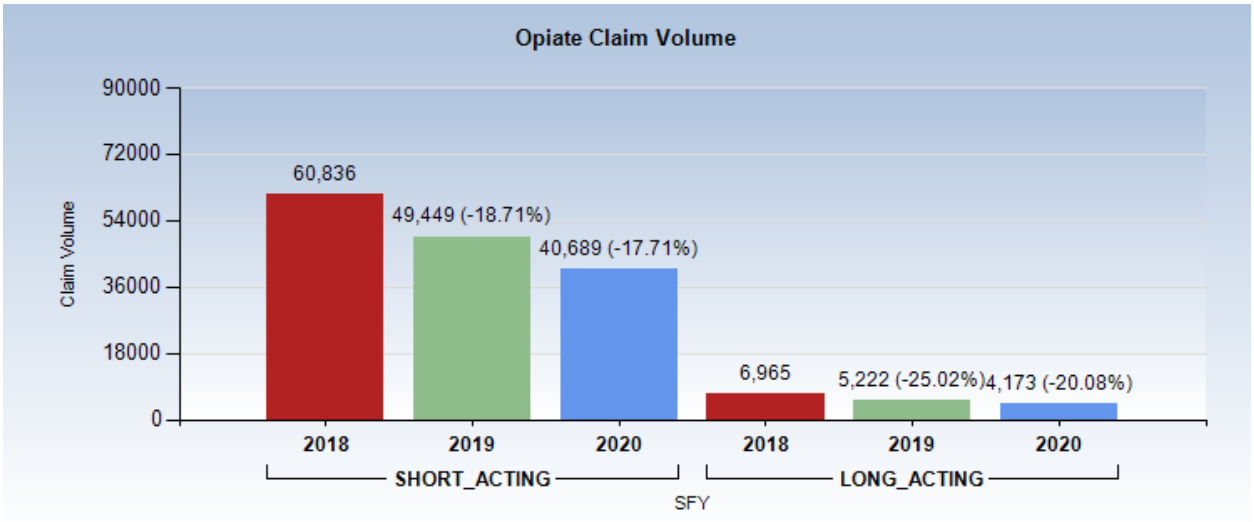


Chart 11C: Number of Prescriptions Per 1000 Members per Month for Opioids: 3-yr Trend

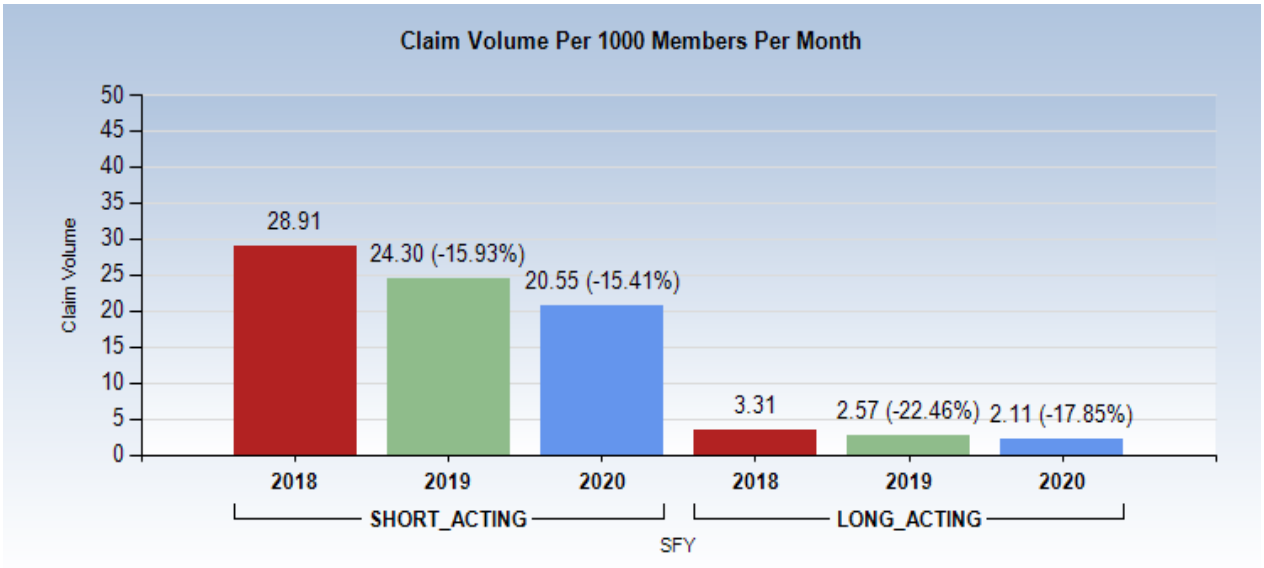


Chart 12: Specialty Drugs as a Percent of Total Gross Drug Cost

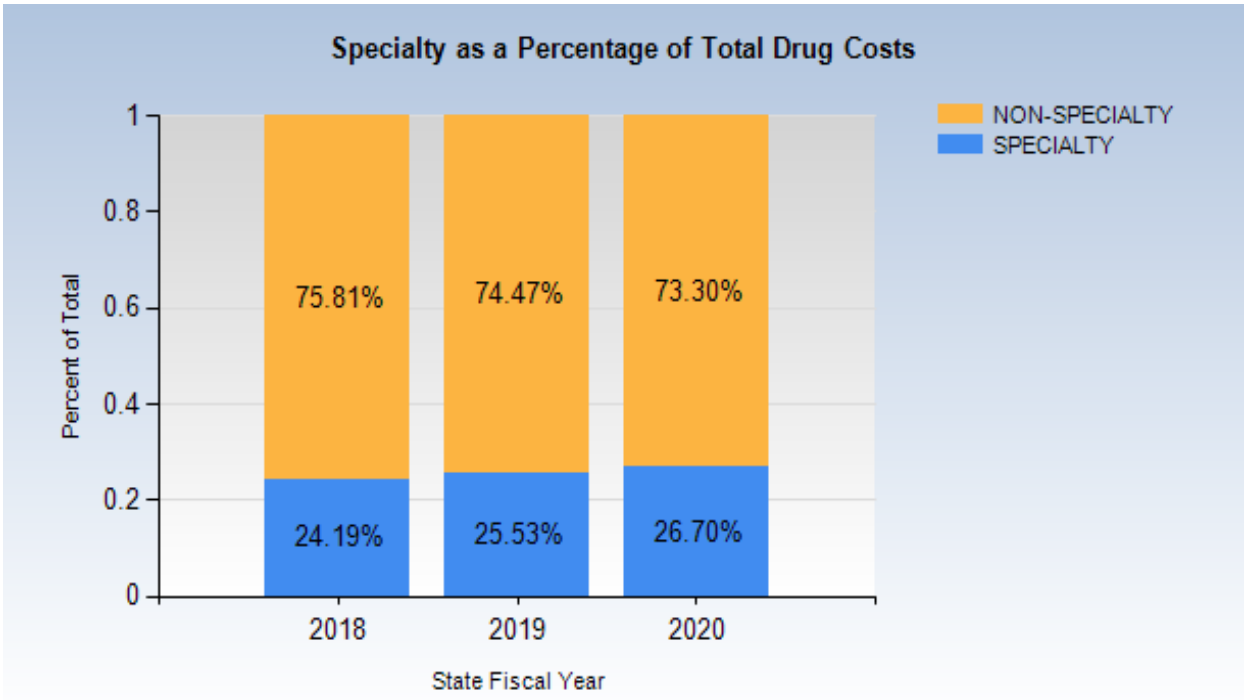


Chart 13A: Specialty Drugs-Amount Paid

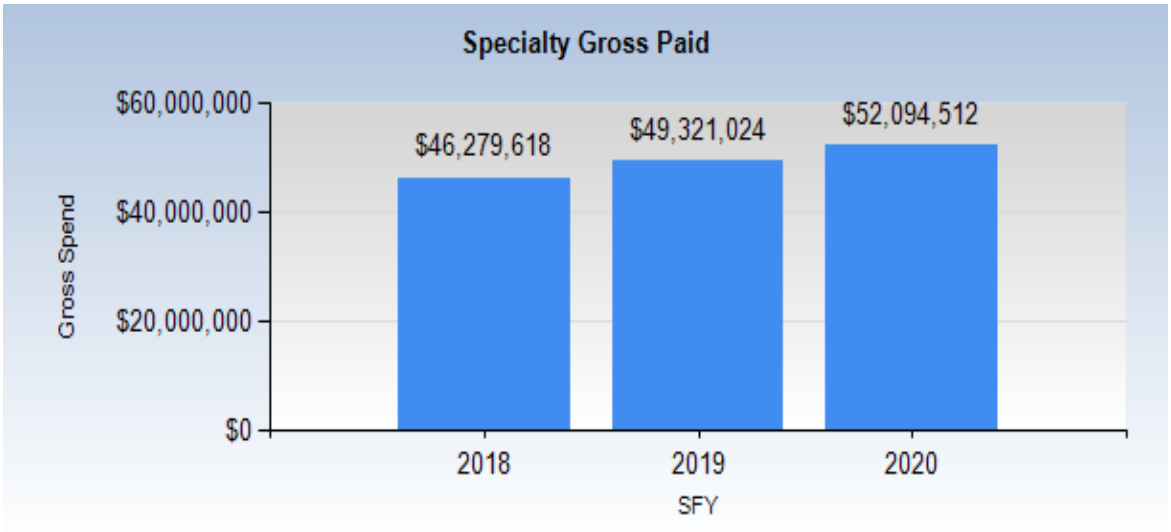


Chart 13B: Specialty Drugs-Number of Claims

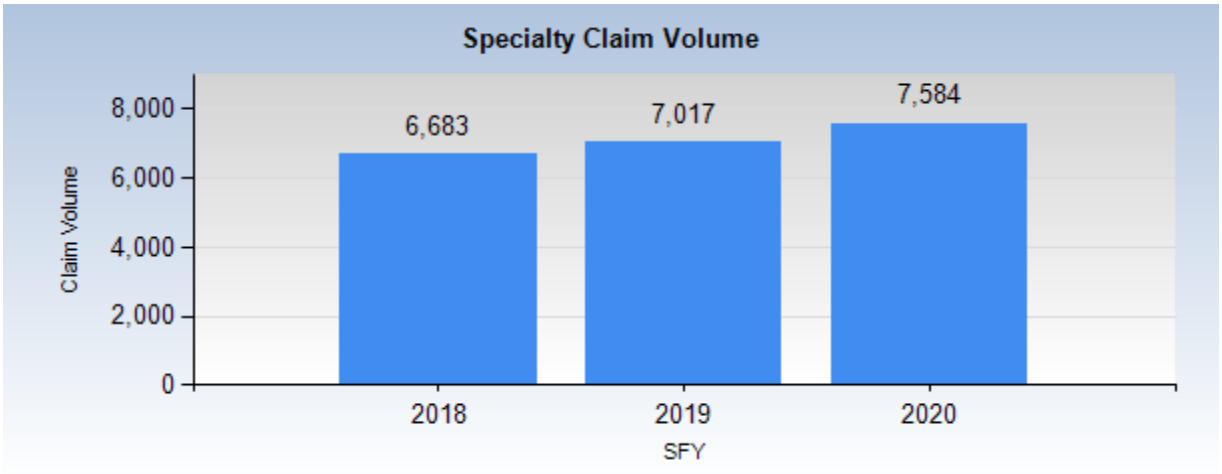


Chart 14: Specialty Drugs-Amount Paid Per Prescription

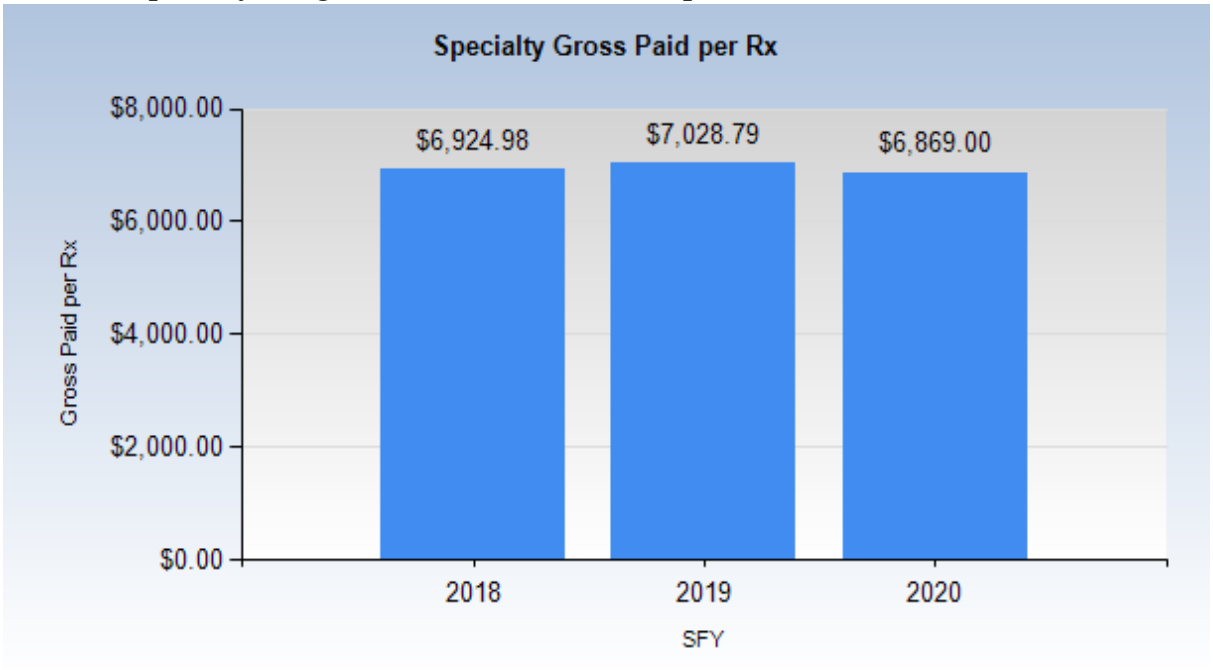


Chart 15: Top 10 Oral Cancer Drugs by Spend

Drug Name	2019 RX Count	2020 RX Count	Claim Count Change	2019 Gross Paid	2020 Gross Paid	Gross Paid Change
Revlimid (lenalidomide)	44	43	-2.3%	$610,622	$666,151	9.1%
Sprycel (dasatinib)	52	60	15.4%	$463,352	$609,925	31.6%
Ibrance (palbociclib)	46	52	13.0%	$483,364	$527,658	9.6%
Jakafi (ruxolitinib)	39	40	2.6%	$417,298	$422,655	1.3%
Pomalyst (pomalidomide)	18	29	61.1%	$254,236	$412,248	62.2%
Imbruvica (ibrutinib)	49	34	-30.6%	$541,464	$390,640	-27.9%
Lynparza (olaparib)	12	25	108.3%	$153,279	$304,057	98.4%
Zytiga (abiraterone acetate)	28	20	-28.6%	$283,469	$218,021	-23.1%
Afinitor (everolimus)	24	14	-41.6%	$365,371	$182,196	-50.1%
Venclexta (venetoclax)	4	22	450.0%	$32,515	$169,686	421.9%

Chart 16: Hepatitis C Direct Acting Antivirals

Drug Name	2019 RX Count	2020 RX Count	% Change	2019 Unique Members	2020 Unique Members	2019 Total Paid	2020 Total Paid	% Change
Mavyret (Glecaprevir and Pibrentasvir)	531	394	-25.8%	246	212	$5,954,013	$5,059,167	-15.0%
Epclusa (Sofosbuvir and Velpatasvir)	237	172	-27.4%	90	68	$5,283,169	$4,170,102	-21.1%
Vosevi (Sofosbuvir, Velpatasvir, and Voxilaprevir)	10	6	-40.0%	4	2	$200,632	$148,906	-25.8%
Ledipasvir/Sofosbuvir	0	3	N/A	0	1	$0	$36,051	N/A
Sofobuvir/Velpatasvir	1	0	-100.0%	1	0	$0	$0	0.0%
Zepatier (Elbasvir and Grazoprevir)	20	0	-100.0%	7	0	$183,543	$0	-100.0%
Totals:	**799**	**575**	**-28.0%**	**348**	**283**	**$11,621,356**	**$9,414,227**	**-19.0%**

Chart 17: Cystic Fibrosis Treatments

Drug Name	2019 RX Count	2020 RX Count	Claim Count Change	2019 Gross Paid	2020 Gross Paid	Gross Paid Change
Trikafta (elexacaftor/tezacaftor/ivacaftor and ivacaftor)	0	143	NA	$0	$3,298,882	NA
Symdeko (tezacaftor/ivacaftor and ivacaftor)	101	70	-30.7%	$2,175,029	$1,254,693	-42.3%
Orkambi (lumacaftor/ivacaftor)	84	43	-48.8%	$1,589,724	$866,756	-45.5%
Kalydeco (ivacaftor)	13	6	-53.8%	$304,658	$140,611	-53.8%
CFTR TOTALs	**198**	**262**		**$4,069,411**	**$5,560,942**	
Pulmozyme (dornase alfa)	415	355	-14.5%	$1,399,387	$1,228,337	-12.2%
MISC TOTALS	**415**	**355**		**$1,399,387**	**$1,228,337**	
Kitabis Pak (tobramycin)	27	16	-40.7%	$124,654	$74,511	-40.2%
Bethkis (tobramycin)	7	9	28.6%	$42,303	$32,051	-24.2%
Tobramycin	0	4	NA	$0	$436	NA
Tobi Podhaler (tobramycin)	26	17	-34.6%	$235,034	$162,720	-30.8%
TOBRAMYCIN TOTALS	**60**	**46**		**$401,990**	**$269,719**	

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

Drug Name	2019 RX Count	2020 RX Count	Claim Count Change	2019 Distinct Members	2020 Distinct Members	Distinct Member Change	2019 Gross Paid	2020 Gross Paid	Gross Paid Change
Suboxone Film (Brand)	116,992	122,507	4.7%	4,248	4,578	7.8%	$15,386,983	$18,229,211	18.5%
Vivitrol Injection	783	589	-24.8%	194	151	-22.2%	$990,556	$750,160	-24.3%
Sublocade Injection	134	298	122.4%	39	53	35.9%	$213,531	$486,010	127.6%
Buprenorphine HCL/Naloxone SL Tablets	9,043	10,584	17.0%	360	403	11.9%	$408,402	$385,972	-5.5%
Buprenorphine HCL SL Tablets (Mono)	7,291	7,706	5.7%	274	301	9.9%	$213,908	$186,381	-12.8%
Zubsolv SL Tabs	249	314	26.1%	19	31	63.2%	$31,778	$51,023	60.6%
Naltrexone HCL Tabs	1,781	1,933	8.5%	644	656	1.9%	$49,845	$48,936	-1.8%
Acamprosate Calcium Tabs	407	425	4.4%	187	196	4.8%	$38,106	$40,030	5.1%
Disulfiram Tabs	708	447	-36.9%	277	204	-26.4%	$36,515	$19,920	-45.5%
Buprenorphine/Naloxone Film (generic)	195	653	234.9%	45	85	88.9%	$3,090	$13,458	335.6%

*Zubsolv and buprenorphine/naloxone generic films-Medicaid is secondary payer for all claims

Chart 19: Rebates Invoiced: All Programs

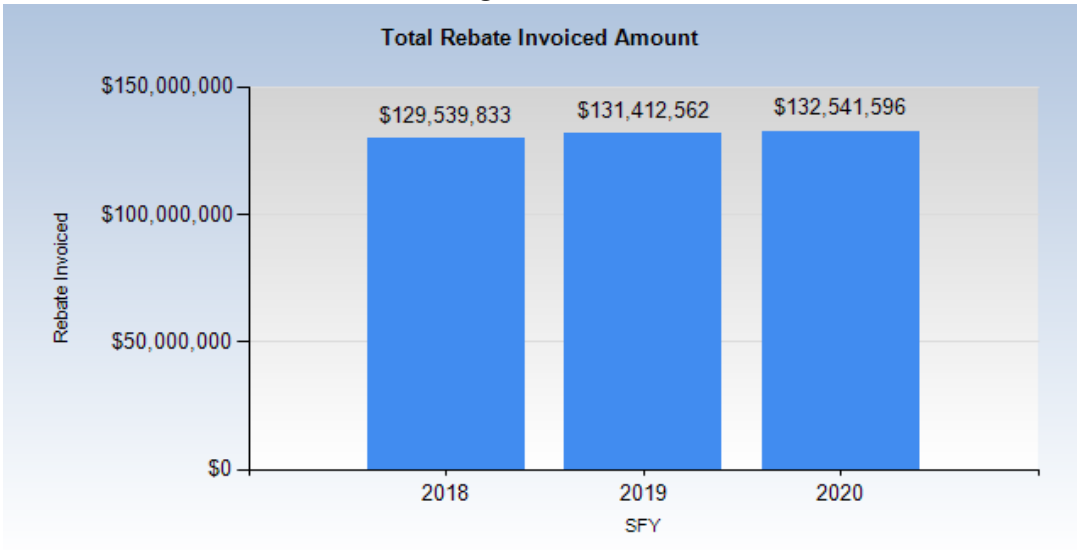


Chart 20: Rebates as a Percent of Spend: All Programs

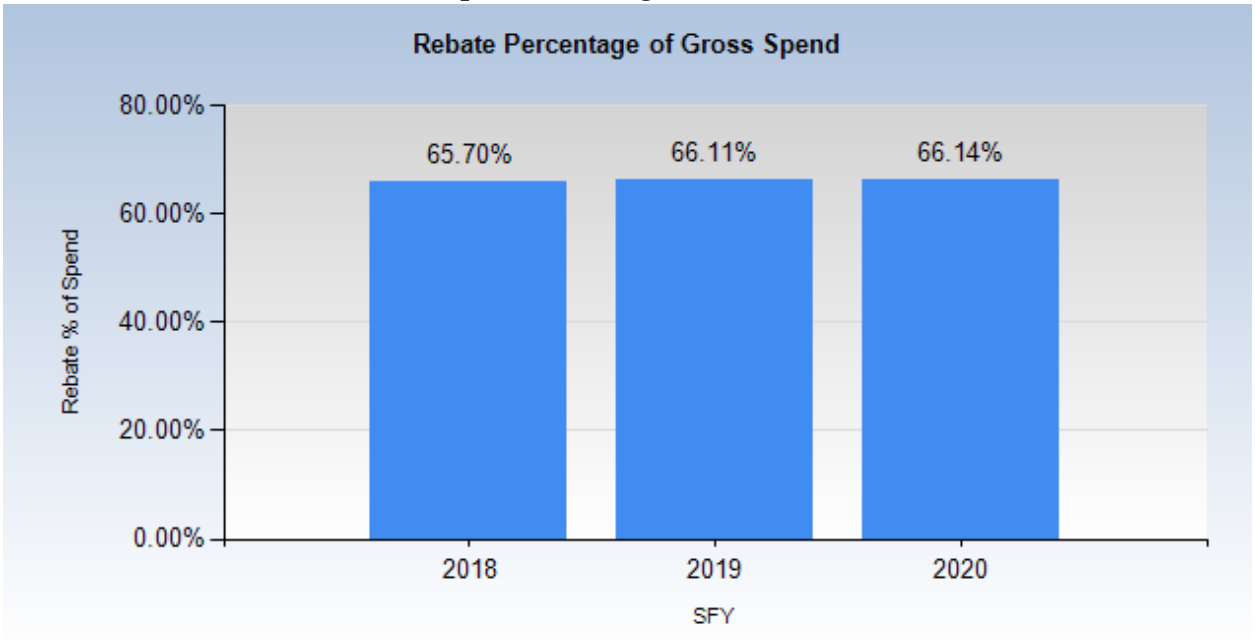


Chart 21: Federal Rebates Invoiced

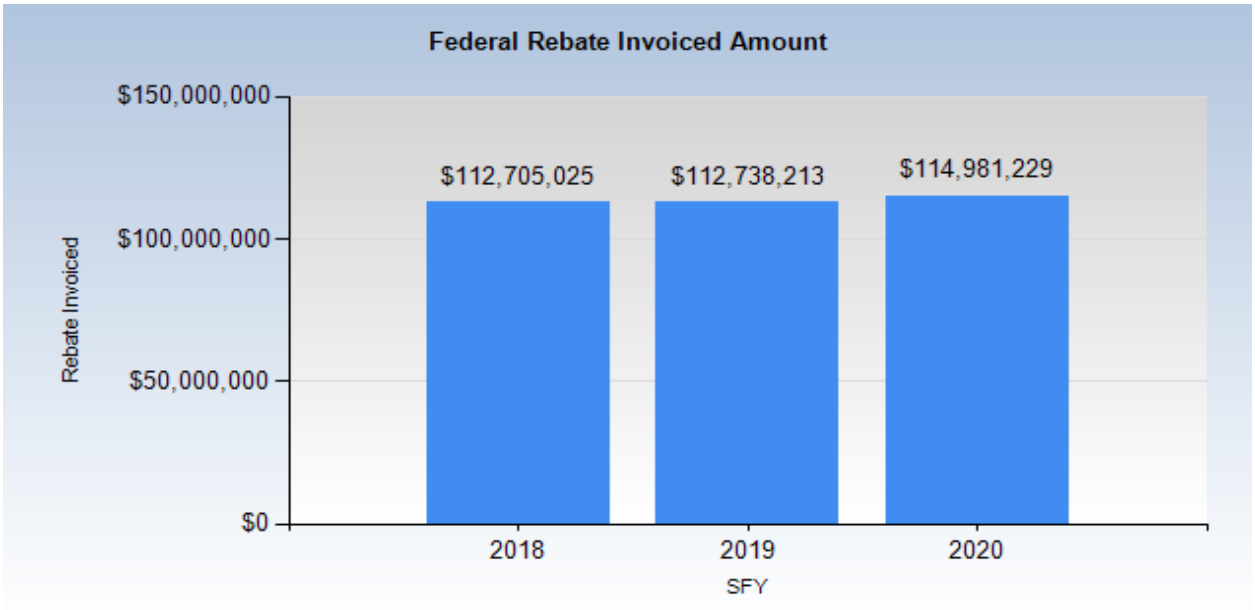


Chart 22: Total Supplemental Rebates Invoiced

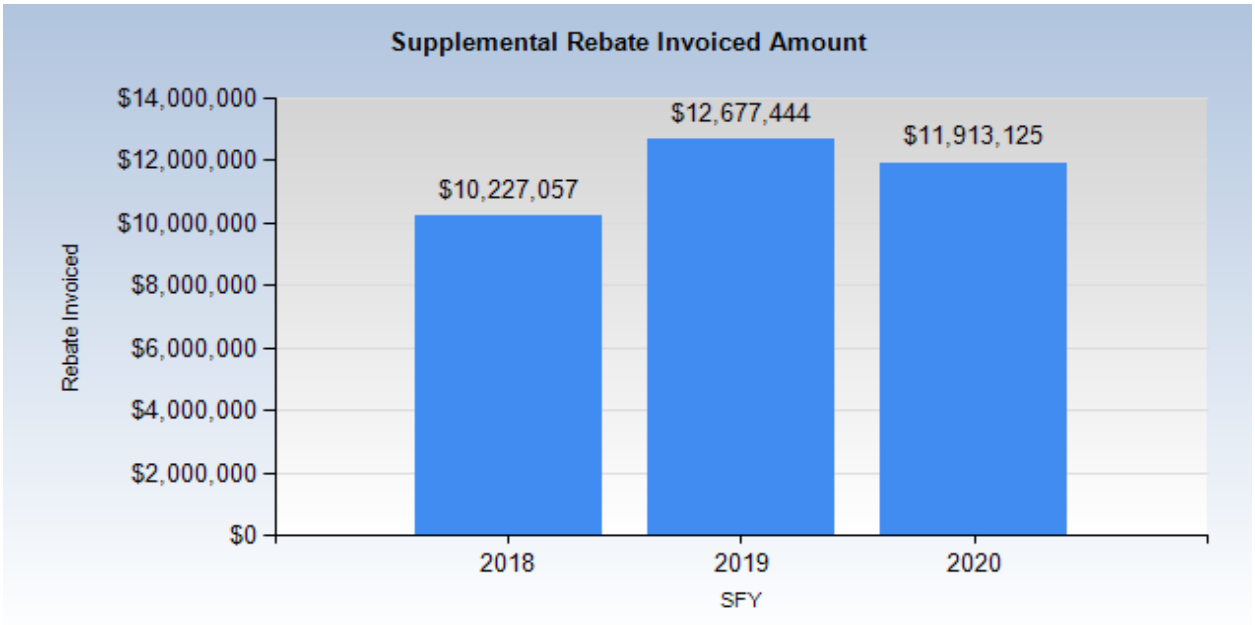


Chart 23: Total VPharm Rebates Invoiced