
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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INTRODUCTION

The purpose of this legislative report is to satisfy requirements in [33 V.S.A. § 2001](#) regarding prescription drug cost containment and to provide an overview of the scope of the Department of Vermont Health Access (DVHA) Pharmacy Benefit programs. This report covers issues related to drug cost and utilization, the effect of national trends on pharmacy programs, comparisons to other states, DVHA's administration of the pharmaceutical assistance programs, use of prior authorization requirements for prescription drugs, Drug Utilization Review Board management, and placement of drugs on the preferred drug list.

In state fiscal year 2024 (SFY24) Medicaid enrollment decreased due to the COVID "unwind" from Medicaid continuous coverage requirements. Utilization of expensive specialty medications continues to result in an increased gross and net cost per claim, with specialty drugs costing, on average, over \$7,300 per prescription. ([Chart 1](#), [Chart 12B](#)) Additionally, there were non-specialty drugs that contributed to the increase in total spend. Glucagon-like peptide-1 receptor agonist (GLP-1 RA) drugs (e.g., Ozempic®, Trulicity®, Mounjaro™) were the 4th ranked therapeutic class of drugs by gross spend. ([Chart 6A](#)) DVHA expects a sustained growth with this category of drugs as their overall health benefits continue to expand. ([Chart 7](#)) This legislative report details the specifics that contributed to Vermont Medicaid's fiscal expenditures for SFY24 and DVHA's efforts to manage the total drug spend.

ISSUES RELATED TO DRUG COST AND UTILIZATION

DVHA reimbursed pharmacies nearly **\$287 million** for all prescriptions for Medicaid members (including dual eligible members) in SFY24, compared to \$298 million in SFY23. This represents a small decrease in gross expenditure of approximately **\$11.8 million dollars, a decline of almost 4% over the previous fiscal year**. Net prescription costs (gross spend less rebates applied) for the same population continued to experience an increase from \$103 million in SFY 2023 to **\$122 million in SFY2024**. ([Chart 1](#))

As the Department of Vermont Health Access (DVHA) has previously reported, Change Healthcare/Optum, DVHA's pharmacy benefit administrator which operates Vermont's Medicaid pharmacy claims system, experienced a significant cybersecurity issue on February 21, 2024. This cyberattack halted pharmacy claims processing and many pharmacy benefit management functions. On March 18, 2024, pharmacy claims began processing again; however, restoration efforts are still ongoing. This outage may explain some of the data regarding spend and utilization illustrated in the charts throughout this report.

There were several variables during SFY24 that resulted in a decrease in gross paid amounts, but an unusual and continued increase in net cost per prescription claim. Medicaid enrollment declined in SFY24 to an average monthly value of 171,846 members, a 11% decrease over the prior SFY, resulting in lower gross costs. ([Chart 2](#)) Spending on specialty drugs has increased resulting in higher net drug costs. In general, the increased use of specialty drugs means higher gross and net costs due to lower rebates available for specialty drugs.

Top Drugs by Cost and Utilization

The Department continues to see the highest spending on drugs used to treat inflammatory conditions (rheumatoid arthritis, psoriasis, and Crohn's disease), opioid use disorder, cystic fibrosis, attention deficit hyperactivity disorder (ADHD), and diabetes. ([Chart 5](#)) Opioid partial agonists are commonly used to treat substance use disorder and Suboxone[®] has remained in the top gross spend and utilization charts for several of the previous state fiscal years. ([Chart 7](#), [Chart 9](#)) A few other noteworthy drugs include Trikafta[®] (cystic fibrosis), Ozempic[®] (diabetes), and Dupixent[®] (asthma/atopic dermatitis); [Chart 7](#) illustrates that all of these products were reported as substantial contributions to increases in gross spend. The top therapeutic classes by gross spend are provided in [Chart 5](#), anti-TNF antibodies, including Humira[®], remain the most prominent on this chart. [Chart 8](#) ranks the top therapeutic classes by utilization (prescriptions counts), the oil soluble vitamins (Vitamin D) and antihistamines that were previously on Chart 8 are no longer reported in the top 10. Effective August 1, 2023, the Department discontinued coverage for over-the-counter melatonin, vitamin D, and antihistamine products.¹ This change to coverage was a result of changes to the SFY24 Medicaid budget, spending on these products accounted for over \$900,000 in SFY23.²

Arguably the fastest-growing drug classes in the nation are the glucagon-like peptide-1 receptor agonists (GLP-1). This class of drugs includes the commonly recognized brand names Ozempic[®], Trulicity[®], Mounjaro[™], and Victoza[®]. These products have been FDA-approved to reduce the risk of major adverse cardiovascular events and improve glycemic control in those with type 2 diabetes. The American Diabetes Association now recommends GLP-1 drugs as first-line options for those with type 2 diabetes and these products continue to expand their indicated uses outside of diabetes (weight loss, sleep apnea, cardiovascular indications).³ The Department has seen a substantial increase in gross spending on GLP-1 drugs: Ozempic[®] resulted in a 150% increase in gross spending, a five million dollar increase over the previous SFY. ([Chart 7](#)) GLP-1 drugs have received a lot of attention for their use in weight loss, outside of a diabetes diagnosis. At this time, Vermont Medicaid does not cover drugs used for weight loss per the Medicaid State Plan. It is plausible that the increase in utilization can be attributed to prescriptions acquired for weight loss during the Change Healthcare/Optum cyber-security incident. Typically requests for non-covered indications would be managed through the prior authorization process. The cybersecurity incident resulted in the inability to implement prior authorizations for approximately 6 months, from February 21st - August 7th, 2024.

Throughout SFY24 the number of members using prescriptions for both short-acting and long-acting opioids decreased over the previous SFY. ([Chart 10A](#), [Chart 10B](#)) Further, when the data is normalized to a per member per month volume, short-acting opioid use per 1,000 members declined by 10% and long-acting opioid use declined by 9%. ([Chart 10C](#)) These results demonstrate Vermont's continued commitment to implementing and maintaining initiatives that address the opioid crisis, including expanded access for those who seek treatment. The Hub and Spoke programs

¹ IMPORTANT OVER THE COUNTER COVERAGE CHANGES, The Department of Vermont Health Access. (06/2023). Available from: [Pharmacycommunication OTC Drug Changes .pdf \(vermont.gov\)](#)

² Pharmacy Best Practices and Cost Control Program Report. The Department of Vermont Health Access. (2023) Available from: [Pharmacy Best Practices and Cost Control Report 30 October 2020 FINAL \(vermont.gov\)](#)

³ American Diabetes Association Professional Practice Committee; 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2024. Diabetes Care 1 January 2024; 47 (Supplement_1): S158–S178. <https://doi.org/10.2337/dc24-S009>

continue to provide a system of care for improving access to medication assisted treatment for opioid use disorder. Nationally the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT Act) was signed in 2018. The SUPPORT Act requires states to have specific drug utilization review safety edits in place for opioids and concurrent prescribing of opioids and other drugs.⁴

Specialty Pharmacy

DVHA requires any pharmacy dispensing specialty drugs to be certified by a national accreditation organization, this distinction from standard pharmacies includes more comprehensive patient care and drug management. The list of specialty medications and accredited pharmacies is updated quarterly and can be found on DVHA's provider resources and clinical programs website. More information about DVHA's classification of specialty drugs can be found in the pharmacy provider manual. <https://dvha.vermont.gov/providers/manuals>

In SFY24, the gross spend on specialty medications was \$67,561,719. ([Chart 11A](#), [Chart 11B](#)) The more significant drugs included in the specialty drug spend were Trikafta[®] for cystic fibrosis, Stelara[®] and Taltz[®] for psoriasis/Crohn's/ulcerative colitis/psoriatic arthritis, and Dupixent[®] for asthma/atopic dermatitis. These four drugs accounted for \$31,034,484 in gross spending (11% of the total gross spend). ([Chart 7](#)) The 9,202 prescription drug claims for specialty drugs represent 0.47% of total prescription claims, however these prescriptions accounted for 24% of the total gross drug spend. ([Chart 11A](#))

Pharmacy Care Management Program

The Department of Vermont Health Access, in collaboration with Vermont's pharmacy benefit administrator, Change Healthcare/Optum, manages and enrolls patients in a Pharmacy Care Management (PCM) program. The primary goals of the PCM program are to optimize medication use and assure adherence to prescribed regimens.⁵ Increased medication adherence leads to the highest likelihood of benefit from medications, either to cure an illness (i.e. Hepatitis C) or prevent adverse health events. It has been estimated that non-optimized medication regimens have resulted in an estimated \$528.4 billion in avoidable US healthcare expenditures annually.⁶ The clinical team with Change Healthcare identifies and enrolls appropriate patients who initiate treatment of high-cost specialty medications into the program.

During the 2nd quarter of SFY24, there were 452 active enrollees in the PCM program, 122 new members added during 2nd quarter of SFY24, and a total of 3,723 members enrolled since the program was initiated. The second quarter report demonstrated a direct cost avoidance of \$547,706 and \$5,921,187 since the program's initiation. A cybersecurity outage occurred in February 2024, and Change Healthcare/Optum lost the ability to manage the PCM program. Therefore, there is no reporting available for the 3rd and 4th quarters of SFY24.

⁴ Federal Legislation to Address the Opioid Crisis: Medicaid Provisions in the SUPPORT Act. KFF. (2018). Available from <https://www.kff.org/medicaid/issue-brief/federal-legislation-to-address-the-opioid-crisis-medicare-provisions-in-the-support-act/>

⁵Change Healthcare. (April 1, 2023, through June 30, 2023). Change Healthcare Pharmacy Care Management Reporting Suite by a collection of reports recording the process and progress of PCM

⁶Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug Related Morbidity and Mortality. *Annals of Pharmacotherapy*. 2018;52(9):829837. Doi:10.1177/1060028018765159

Medicaid Rebate Programs

The Department manages multiple rebate programs with the goal of reducing the total net drug spend for Vermont Medicaid. During SFY24 the Department invoiced 51% of the gross prescription drug spend using rebate programs. ([Chart 19](#))

Federal Rebates

Nearly all drug manufacturers provide federal rebates to states, the rebate amounts are calculated based on a federally mandated formula utilizing standardized price points set by the manufacturer. Federal financial concessions are made available by manufacturers to all Medicaid entities that cover their drugs. The two most common calculations applied towards federal rebate are “best price” and the “average manufacturer price” (AMP). Drugs that have large federal rebates may be preferred based on a lower net cost to the State. In general, federal rebate collection increases proportionally with overall drug utilization and time spent on the open market. 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 on generic covered outpatient drugs when the average manufacturer price (AMP) increased at a rate that exceeds the rate of inflation, effective January 1, 2017. This is commonly referred to as the “CPI Penalty” (Consumer Price Index) and is factored into the federal rebate calculation. In SFY24, the Department invoiced \$116,389,152 (41% of total gross spend) in federal rebates from manufacturers. ([Chart 16](#))

Supplemental and Diabetic Supply Rebates

Supplemental rebates are negotiated, optional payments made in addition to the mandated federal rebates on drugs. Diabetic supply rebates are provided as state-only discounts and are provided separately from federal requirements. Both rebate incentives are negotiated by the Department in conjunction with the Sovereign States Drug Consortium (SSDC). The SSDC is a Medicaid rebate pool composed of the largest, independent, state-administered, Medicaid supplemental rebate program in the country. The SSDC primarily focuses on negotiating and acquiring rebates from manufacturers to obtain prescription drugs at a lower net cost to state Medicaid programs. 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 15 million members covered by this group. See www.rxssdc.org. In SFY24, Vermont Medicaid invoiced \$23,694,940 (8% of total gross spend) in supplemental rebates from manufacturers. ([Chart 17](#))

Value Based Purchasing (VBP) Agreements

A CMS final rule regarding value-based purchasing for drugs covered by Medicaid, effective July 1, 2022, allowed State Medicaid Programs to enter Value-based rebate contracts with manufacturers.^{7,8}

⁷ Medicaid Program. Center for Medicare and Medicaid Services. (2020). Available From: <https://www.regulations.gov/document/CMS-2020-0072-30223>

⁸Medicaid Program. Center for Medicare and Medicaid Services. (2021). Available From: <https://www.federalregister.gov/documents/2021/11/19/2021-25009/medicaid-program-delay-of-effective-date-for-provision-relating-to-manufacturer-reporting-of>.

[federalregister.gov/documents/2021/11/19/2021-25009/medicaid-program-delay-of-effective-date-for-provision-relating-to-manufacturer-reporting-of-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/](https://www.federalregister.gov/documents/2021/11/19/2021-25009/medicaid-program-delay-of-effective-date-for-provision-relating-to-manufacturer-reporting-of-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/)

The concept of value-based agreements (VBA) tie the net cost of a drug to the efficacy or expected clinical outcomes after administration. DVHA utilizes a few mechanisms to participate in VBAs. This includes supplemental rebates negotiated by the SSDC. In addition, VBAs may be made available by a manufacturer on CMS' web-based Enterprise Portal and these offers are available to all state Medicaid programs. Finally, DVHA is interested in participating in a CMS-driven Cell and Gene Therapy Access Model (CGT). This access model was created to test whether a CMS led approach to negotiating and administering outcomes-based agreements will improve access for Medicaid members while reducing total costs. DVHA evaluates VBA agreements using a multi-disciplinary approach though each of these methods.

THE EFFECT OF NATIONAL TRENDS AND COMPARISON TO OTHER STATES

Medicaid Net Prescription Drug Expenditure Forecast

The Families First Coronavirus Response Act required continuous Medicaid enrollment for Vermont Medicaid, this resulted increases in eligibility from 186,75,283 in SFY22 to 194,067,299 in SFY23. ([Chart 2](#)) The increase in enrollment subsequently lead to an increase in drug expenditure and total healthcare costs. As part of the Consolidated Appropriations Act of 2023, Congress separated the continuous enrollment provision from the Public Health Emergency, ending continuous enrollment on March 31, 2023. As a result, Vermont has seen a decrease in the average monthly eligible members from 194,067 in SFY23 to 171,846 in SFY24, a 11% reduction in Medicaid enrollment. ([Chart 2](#)) This has equated to very little decrease in gross drug spend following the national trend that those in the most need of medical assistance remain in the Medicaid programs and net spending continues to increase.

On January 1, 2024, the Average Manufacturer Price Capitation was removed from drug pricing policy because of the Inflation Reduction Act. This "AMP Cap" removal reinstated the pharmaceutical manufacturers' risk of paying Medicaid programs rebates and penalties totaling more than 100% of the cost of their drugs. The AMP Cap removal caused manufactures to make aggressive decisions to limit that potential, including product discontinuations and dramatic decreases in average drug prices. We expect this change to result in unintended consequences of an increase to the overall net price to Medicaid programs by more than 10%. While some therapeutic classes have dramatically decreased in net price, several highly utilized products that were historically "free" to Medicaid have exponentially increased in net price.

In the coming years, from 2025-2030, national spending and utilization are expected to rise more rapidly due to increasing use of new, more expensive drugs. Net prescription drug expenditures are anticipated to increase steadily with an annual growth rate of 5.2% for each of the next five years.⁹ The most apparent driver of increased spending continues in the recent trends around specialty drugs and gene therapy. These high dollar, low volume products have the potential to be "budget busters." This fact is particularly true in a program like Vermont Medicaid with a small population and a rarity of the required diagnoses for these products. However, it would only take a few prescriptions for gene therapies to have a significant financial impact. National Health Expenditure data also points to the

⁹ National Health Expenditure Projections 2021–30: Growth to Moderate as COVID-19 Impacts Wane. Office of the Actuary Centers for Medicare & Medicaid Services. (2022). Available From: [National Health Expenditure Projections 2021–30: Growth to Moderate as COVID-19 Impacts Wane \(cms.gov\)](https://www.cms.gov/nhepprojections)

New England Region having higher level per capita health care spending at 25% higher than the national average.¹⁰

ADMINISTRATION OF VERMONT'S PHARMACEUTICAL ASSISTANCE PROGRAMS

VPharm is Vermont's State Pharmaceutical Assistance Programs (SPAP) that provides supplemental pharmaceutical coverage for Vermonters with Medicare drug coverage who are not eligible for Medicaid and who have a household income no greater than 225% of the federal poverty level (FPL). VPharm began January 1, 2006, and is codified in state statute at [33 V.S.A. § 2073](#). VPharm is also authorized through Vermont's [Global Commitment to Health 1115 Demonstration waiver](#).

VPharm covers Medicare prescription drug plan cost-sharing, including deductibles, co-payments, coinsurance, and the coverage gap (also called the donut hole, which will be eliminated nationally in 2025). VPharm also provides coverage for certain categories of Medicare excluded drug classes, such as certain prescription vitamins and mineral products, drugs used for weight gain or treatment of anorexia, and some over-the-counter drugs. These categories of drugs are covered for VPharm enrollees just as they are covered for Vermont Medicaid enrollees. In addition to this, VPharm 1 covers eye exams and diagnostic visits and tests related to vision, see [VPharm Rule 5450 – Coverage](#) for further details. In SFY24, there were 223,963 claims through the VPharm benefit, with a total gross paid amount of \$5,124,279. ([Chart 1](#)) More information about the VPharm program can be found here: <https://dvha.vermont.gov/members/vermont-medicaid-programs/member-information/member-handbooks>

DRUG UTILIZATION REVIEW BOARD, THE PREFERRED DRUG LIST AND PRIOR AUTHORIZATION

Drug Utilization Review Board

The Drug Utilization Review Board (DURB) in Vermont is required by federal law. The Board applies criteria and standards in the application of drug utilization review activities, analyzes and reports the results of those activities performed by the DVHA or the Department's pharmacy benefit administrator 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.

Drug Utilization Review Board Activities in 2024

| REVIEW TOPIC | SFY 2024 TOTAL |
|---|----------------|
| Therapeutic Drug Classes: Periodic Review | 47 |
| Full New Drug Reviews | 45 |
| FDA Safety Alerts | 1 |
| Newly Developed/Revised Criteria | 33 |
| RetroDUR/ProDUR Reviews | 4 |
| New Managed Therapeutic Drug Classes | 1 |
| BioSimilar Drug Reviews | 14 |

¹⁰ NHE Fact Sheet. Center For Medicare and Medicaid Services. Available from [research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet](https://www.cms.gov/research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet)

More information about the DURB along with detailed minutes of meetings and specific changes voted on by the Board can be found at <https://dvha.vermont.gov/advisory-boards/drug-utilization-review-board>.

Preferred Drug List and Prior Authorization

DVHA's Preferred Drug List (PDL) displays covered prescription drugs and identifies preferred and non-preferred choices within therapeutic classes for various diseases and conditions, including generic alternatives. The PDL is found here <https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria>. This tool is designed to reduce the cost of the pharmacy benefit program while maintaining access to clinically appropriate prescription drug therapies. The PDL is not a complete list of all drugs covered by the pharmacy benefit; however, it does contain over 180 different therapeutic categories representing thousands of drugs. If a drug is not listed as "preferred" in a category on the PDL, prescribers can submit a prior authorization (PA) for the drug to be covered. Most preferred drugs do not require PA unless there is a clinical or safety issue that warrants a review prior to dispensing to a patient. 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 trial of or contraindication to a preferred, equally effective drug. There are some drugs on the PDL that allow for automated criteria review, 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 PA process helps to reduce provider burden, expedites PA review, and assures clinical and financial integrity of DVHA's pharmacy programs.

The total number of prior authorizations substantially declined in SFY24. There were a total of 17,002 PAs, a 43% decrease from SFY23. ([Chart 4](#)) Historically the volume of PAs has increased slowly over the previous state fiscal years; however, due to the Change Healthcare/Optum cybersecurity outage there were almost 6 months that Vermont Medicaid was unable to implement PAs on pharmacy-billed prescription claims. Although providers were encouraged to continue to follow the preferred drug list, claims did not deny for PA to help direct providers to utilize lower net cost, equally effective drugs that DVHA prefers on the PDL. After substantial preparation and provider notifications, prior authorizations were reinstated on August 7, 2024.

The overall prior authorization denial rate slightly increased throughout SFY24 to 32.5%, a growth of 4.5%. ([Chart 4](#)) The increase in the denied PA percentage may be attributed to requests for glucagon-like peptide-1 receptor agonist (GLP-1 RA) drugs used off-label for weight loss. The PDL requires members to have a diagnosis of type 2 diabetes for coverage of GLP-1 drugs, as weight loss is not a covered service, as described in the Vermont Medicaid State Plan. The increased denial rate may also be attributed to the manufacturer's discontinuation of brand Flovent on December 31, 2023.¹¹ There were a number of members utilizing the branded, covered formulation of this drug. Due to the abrupt discontinuation, DVHA directed providers and members to preferred, guideline-recommended alternatives. The prior authorization process helps the Department direct utilization toward preferred rebatable products with similar efficacy, tolerability, and expected outcomes.

¹¹ Update to Coverage of Fluticasone HFA and Asmanex HFA, The Department of Vermont Health Access (2024). Available From: [https://dvha.vermont.gov/sites/dvha/files/documents/Flovent%20Discontinuation Update%20for%20kids%20under%206%20.pdf](https://dvha.vermont.gov/sites/dvha/files/documents/Flovent%20Discontinuation%20Update%20for%20kids%20under%206%20.pdf)

APPENDIX: COST AND UTILIZATION CHARTS

Chart 1: Pharmacy Claims and Gross and Net Spend, SFY 2022-2024 (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 |
|------|-------------|----------|-------------------|----------|----------------------|----------|-----------------|----------|--------------------|----------|
| 2024 | 1,942,532 | -12.82% | \$286,845,571 | -3.98% | \$147.67 | 10.13% | \$121,812,489 | 18.12% | \$62.71 | 35.49% |
| 2023 | 2,228,147 | 3.59% | \$298,745,291 | 12.29% | \$134.08 | 8.40% | \$103,126,669 | 14.94% | \$46.28 | 10.95% |
| 2022 | 2,150,888 | | \$266,047,966 | | \$123.69 | | \$89,724,432 | | \$41.72 | |

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 |
|------|-------------|----------|-------------------|----------|----------------------|----------|-----------------|----------|--------------------|----------|
| 2024 | 1,718,569 | -12.73% | \$281,721,292 | -3.87% | \$163.93 | 10.15% | \$119,577,239 | 18.55% | \$69.58 | 35.84% |
| 2023 | 1,969,231 | 4.38% | \$293,061,586 | 12.57% | \$148.82 | 7.84% | \$100,864,055 | 15.21% | \$51.22 | 10.37% |
| 2022 | 1,886,508 | | \$260,333,840 | | \$138.00 | | \$87,551,115 | | \$46.41 | |

Vpharm Claims

| SFY | Claims Paid | % Change | Gross Amount Paid | % Change | Gross Cost Per Claim | % Change | Net Paid Amount | % Change | Net Cost Per Claim | % Change |
|------|-------------|----------|-------------------|----------|----------------------|----------|-----------------|----------|--------------------|----------|
| 2024 | 223,963 | -13.50% | \$5,124,279 | -9.84% | \$22.88 | 4.23% | \$2,235,250 | -1.21% | \$9.98 | 14.21% |
| 2023 | 258,916 | -2.07% | \$5,683,706 | -0.53% | \$21.95 | 1.57% | \$2,262,614 | 4.11% | \$8.74 | 6.31% |
| 2022 | 264,380 | | \$5,714,126 | | \$21.61 | | \$2,173,317 | | \$8.22 | |

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 09/28/2023 (excludes VPharm).

| All | 2022 | 2023 | 2024 |
|---|---------|---------|---------|
| Medicaid and Duals Eligible All Ages | 175,283 | 192,067 | 171,846 |
| Medicaid and Duals Utilizers All Ages | 54,206 | 57,143 | 50,251 |
| Medicaid and Duals Utilization Percent All Ages | 31% | 30% | 29% |
| Adult | | | |
| Medicaid and Duals Eligible Adults | 114,315 | 128,772 | 113,639 |
| Medicaid and Duals Utilizers Adults | 42,526 | 44,290 | 37,930 |
| Medicaid and Duals Utilization Percent Adults | 37% | 34% | 33% |
| Children | | | |
| Medicaid and Duals Eligible Children | 60,968 | 63,295 | 58,206 |
| Medicaid and Duals Utilizers Children | 11,680 | 12,853 | 12,321 |
| Medicaid and Duals Utilization Percent Children | 19% | 20% | 21% |

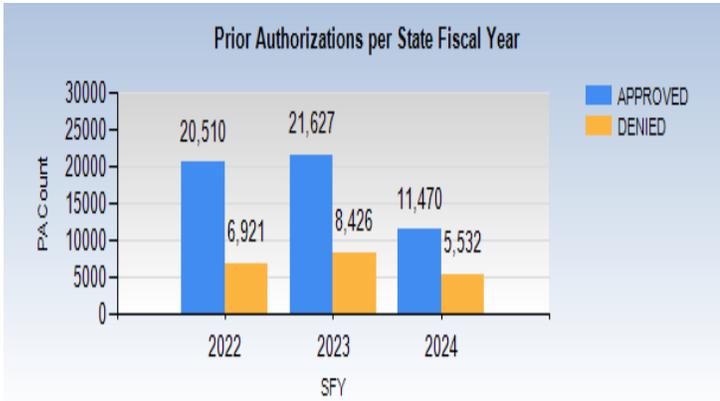
Chart 3: Generic Usage Rates

| Medicaid (Includes Duals) | | | |
|---------------------------------|--------|--------|--------|
| Generic Indicator | 2022 | 2023 | 2024 |
| Generic Utilization Rate (GUR) | 77.73% | 78.55% | 79.77% |
| Generic Substitution Rate (GSR) | 79.58% | 79.42% | 79.67% |
| Vpharm | | | |
| Generic Indicator | 2022 | 2023 | 2024 |
| Generic Utilization Rate (GUR) | 84.06% | 84.23% | 83.17% |
| Generic Substitution Rate (GSR) | 91.06% | 90.60% | 89.62% |

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:



| SFY | PA DENIAL RATE |
|------|----------------|
| 2022 | 25.23% |
| 2023 | 28.04% |
| 2024 | 32.54% |

Chart 5: Top Therapeutic Classes by Gross Spend

| Therapeutic Class/Treatment Category | 2023 Gross Paid | 2024 Gross Paid | 2023 Claim Count | 2024 Claim Count | Total Amount Paid Change | Claim Count Change |
|---|-----------------|-----------------|------------------|------------------|--------------------------|--------------------|
| Anti-Tnf-Alpha - Monoclonal Antibodies | \$25,196,941 | \$25,444,725 | 3,244 | 2,967 | 0.98% | -8.54% |
| Opioid Partial Agonists | \$23,054,186 | \$22,372,174 | 126,080 | 105,347 | -2.96% | -16.44% |
| Antipsoriatics | \$17,422,051 | \$19,861,103 | 1,719 | 1,837 | -14% | 6.86% |
| Glucagon-like peptide - 1 Receptor Agonists | \$15,884,401 | \$17,221,546 | 14,103 | 14,729 | 8.42% | 4.44% |
| Amphetamines | \$12,650,725 | \$12,982,004 | 71,664 | 70,410 | 2.62% | -1.75% |
| Cystic Fibrosis Agents | \$12,300,874 | \$12,956,764 | 799 | 751 | 5.33% | -6.01% |
| Sympathomimetics | \$14,245,661 | \$11,727,254 | 75,328 | 70,483 | -17.68% | -6.43% |
| Stimulants - Misc. | \$11,013,476 | \$10,757,908 | 59,098 | 55,882 | -2.32% | -5.44% |
| Insulin | \$13,165,566 | \$8,382,356 | 16,043 | 14,559 | -36.33% | -9.25% |
| Antineoplastic Enzyme Inhibitors | \$7,129,341 | \$7,825,454 | 618 | 579 | 9.76% | -6.31% |

Chart 6: Non-Insulin Antidiabetic Drugs

| Non-Insulin Antidiabetic Drugs | 2023 Claims | 2024 Claims | 2023 Gross Paid | 2024 Gross Paid | Paid % Difference |
|--|---------------|---------------|---------------------|---------------------|-------------------|
| Glucagon-like Peptide-1 Receptor Agonists | 14,149 | 14,746 | \$15,935,468 | \$17,239,780 | 8.18% |
| Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors | 4,704 | 4,967 | \$5,660,715 | \$6,116,788 | 8.06% |
| Dipeptidyl Peptidase-4 (DPP-4) Inhibitors | 1,195 | 964 | \$1,317,513 | \$1,065,621 | -19.12% |
| Biguanides | 14,667 | 13,258 | \$272,432 | \$269,537 | -1.06% |
| Diabetic Other | 605 | 577 | \$264,276 | \$259,950 | -1.64% |
| Antidiabetic Combinations | 224 | 195 | \$210,323 | \$188,584 | -10.34% |
| Sulfonylureas | 3,133 | 2,429 | \$49,835 | \$40,325 | -19.08% |
| Totals | 38,677 | 37,136 | \$23,710,562 | \$25,180,586 | 6.20% |

Chart 7 Top Drugs by Gross Spend

| Current Rank | Drug Name | 2023 Gross Paid | 2024 Gross Paid | 2023 Claim Count | 2024 Claim Count | Total Amount Paid Change | Claim Count Change |
|--------------|---|-----------------|-----------------|------------------|------------------|--------------------------|--------------------|
| 1 | Humira Pen (Adalimumab) | \$22,201,034 | \$22,879,828 | 2,912 | 2,706 | 3.06% | -7.07% |
| 2 | Suboxone (buprenorphine/naloxone) | \$19,448,067 | \$16,775,297 | 88,937 | 68,863 | -13.74% | -22.57% |
| 3 | Trikafta (elixacaftor, tezacaftor, and ivacaftor) | \$10,228,505 | \$11,898,418 | 440 | 510 | 16.33% | 15.91% |
| 4 | Vyvanse (Lisdex amfetamine) | \$10,276,655 | \$10,632,484 | 32,208 | 31,245 | 3.46% | -2.99% |
| 5 | Ozempic (semaglutide) | \$3,325,124 | \$8,338,330 | 3,214 | 7,282 | 150.77% | 126.57% |
| 6 | Stelara (ustekinumab) | \$8,016,785 | \$8,319,627 | 370 | 360 | 3.78% | -2.70% |
| 7 | Concerta (methylphenidate) | \$8,093,279 | \$7,450,575 | 20,150 | 18,518 | -7.94% | -8.10% |
| 8 | Trulicity (dulaglutide) | \$10,046,742 | \$6,684,824 | 8,898 | 5,556 | -33.46% | -37.56% |
| 9 | Taltz (ixekizumab) | \$4,247,891 | \$5,627,294 | 546 | 667 | 32.47% | 22.16% |
| 10 | Dupixent (dupilumab) | \$3,781,744 | \$5,189,145 | 1,175 | 1,393 | 37.22% | 18.55% |

Chart 8 Top Therapeutic Classes by Utilization

| Current Rank | Category Name | 2023 Gross Paid | 2024 Gross Paid | 2023 Claim Count | 2024 Claim Count | Gross Paid Change | Claim Count Change |
|--------------|---|-----------------|-----------------|------------------|------------------|-------------------|--------------------|
| 1 | Opioid Partial Agonists | \$23,054,185.52 | \$22,372,174.19 | 126,080 | 105,347 | -2.96% | -16.44% |
| 2 | Selective Serotonin Reuptake Inhibitors (SSRIs) | \$1,521,625.94 | \$1,406,578.21 | 102,827 | 90,665 | -7.56% | -11.83% |
| 3 | Anticonvulsants misc. | \$4,703,342.03 | \$4,718,439.28 | 79,191 | 71,059 | 0.32% | -10.27% |
| 4 | Sympathomimetics | \$14,245,661.39 | \$11,727,254.00 | 75,328 | 70,483 | -17.68% | -6.43% |
| 5 | Amphetamines | \$12,650,724.64 | \$12,982,004.09 | 71,664 | 70,410 | 2.62% | -1.75% |
| 6 | Stimulants misc. | \$11,013,476.46 | \$10,757,908.45 | 59,098 | 55,882 | -2.32% | -5.44% |
| 7 | Proton Pump Inhibitors | \$1,222,632.33 | \$1,080,885.04 | 40,917 | 37,305 | -11.59% | -8.83% |
| 8 | Antianxiety Agents misc. | \$453,877.52 | \$446,520.67 | 36,104 | 33,698 | -1.62% | -6.66% |
| 9 | Antiadrenergic Antihypertensives | \$491,131.09 | \$457,664.45 | 28,563 | 27,624 | -6.81% | -3.29% |
| 10 | Nonsteroidal Anti-Inflammatory Agents (NSAIDs) | \$535,890.21 | \$492,195.49 | 31,257 | 26,800 | -8.15% | -14.26% |

Chart 9: Top Drugs by Utilization

| Current Rank | Category Name | 2023 Gross Paid | 2024 Gross Paid | 2023 Claim Count | 2024 Claim Count | Gross Paid Change | Claim Count Change |
|--------------|-----------------------------------|-----------------|-----------------|------------------|------------------|-------------------|--------------------|
| 1 | Suboxone (buprenorphine/naloxone) | \$19,448,067.36 | \$16,775,297.31 | 88,937 | 68,863 | -13.74% | -22.57% |
| 2 | Amphetamine/Dextroamphetamine | \$888,963.03 | \$876,605.51 | 33,976 | 32,694 | -1.39% | -3.77% |
| 3 | Gabapentin | \$588,127.41 | \$524,134.04 | 36,457 | 31,599 | -10.88% | -13.33% |
| 4 | Vyvanse (lisdexamfetamine) | \$10,276,654.93 | \$10,632,483.57 | 32,208 | 31,245 | 3.46% | -2.99% |
| 5 | Ventolin HFA | \$2,130,433.06 | \$2,026,083.18 | 28,893 | 27,096 | -4.90% | -6.22% |
| 6 | Fluoxetine HCL | \$436,925.32 | \$409,761.40 | 28,714 | 25,588 | -6.22% | -10.89% |
| 7 | Sertraline HCL | \$365,739.67 | \$351,830.13 | 28,872 | 25,549 | -3.80% | -11.51% |
| 8 | Bupropion HCL | \$439,766.27 | \$422,340.68 | 27,550 | 24,749 | -3.96% | -10.17% |
| 9 | Omeprazole | \$305,368.94 | \$288,861.74 | 24,488 | 22,408 | -5.41% | -8.49% |
| 10 | Amoxicillin | \$273,796.09 | \$290,058.72 | 21,619 | 21,990 | 5.94% | 1.72% |

Chart 10A: Number of Members Using Opioids: 3-yr Trend

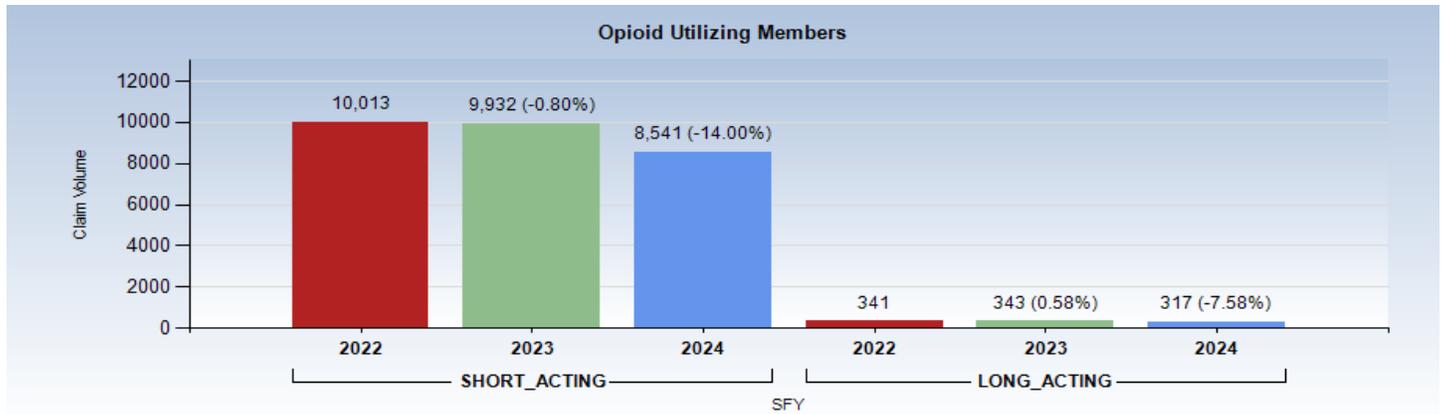


Chart 10B: of Prescriptions for Opioids: 3-yr Trend

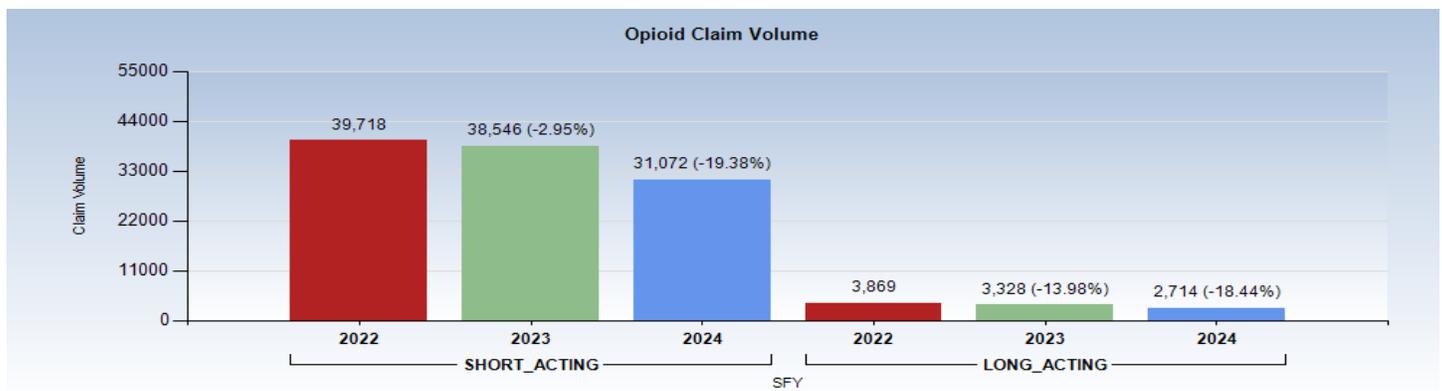


Chart 10C: Number of Prescriptions Per 1000 Members per Month for Opioids: 3-yr Trend

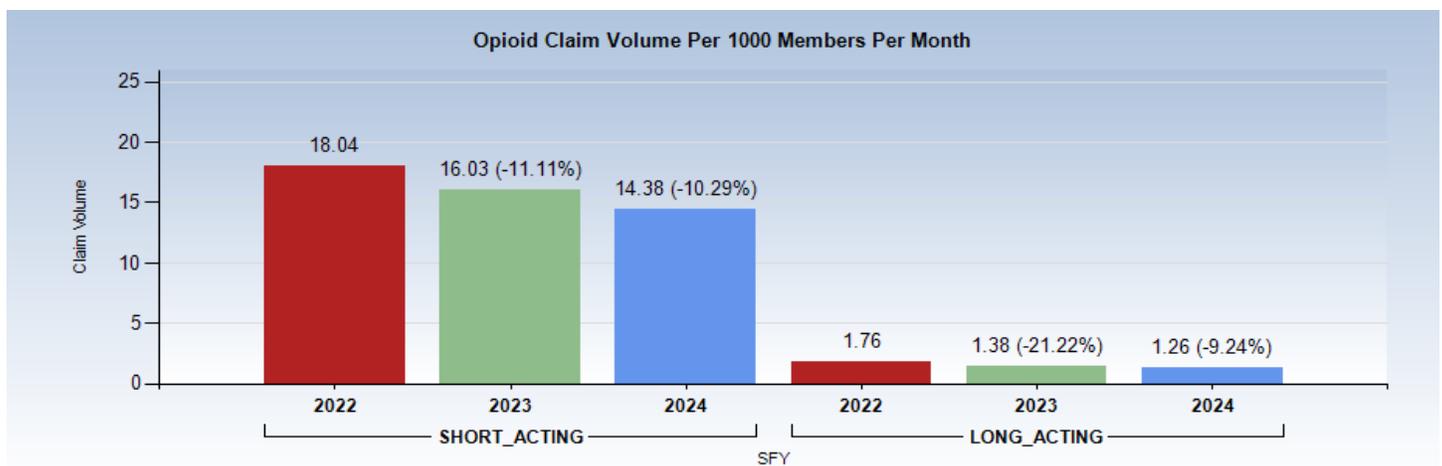


Chart 11A: Specialty Drugs as a Percent of Total Gross Drug Cost

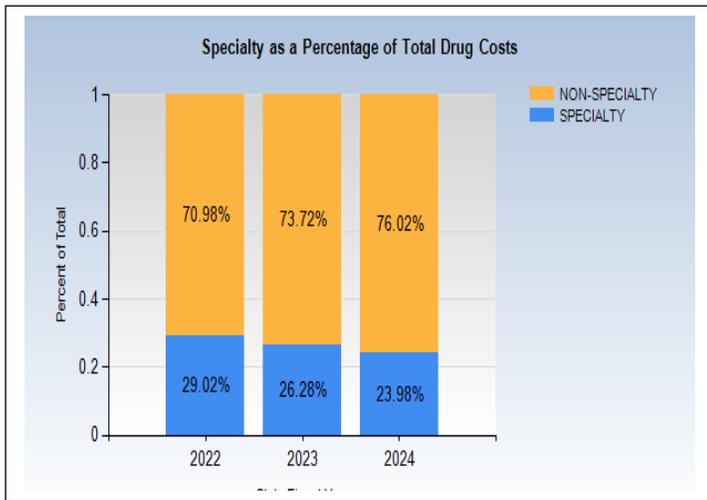


Chart 11B: Specialty Drugs-Amount Paid

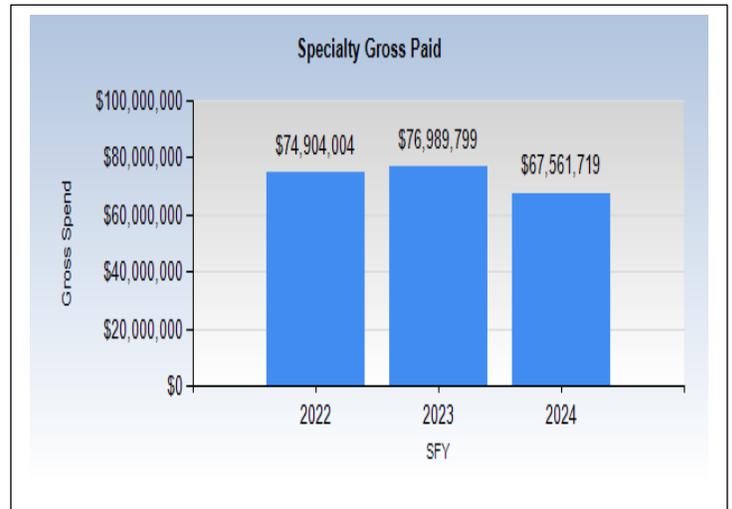


Chart 12A: Specialty Drugs by Number of Claims



Chart 12B: Specialty Drugs-Amount Per RX

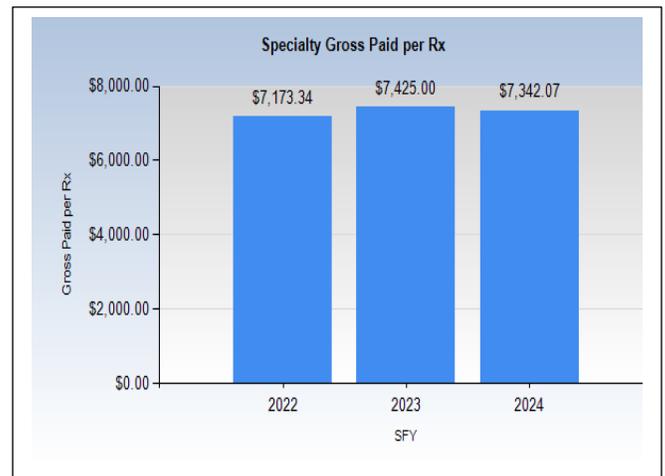


Chart 13: Hepatitis C, Cystic Fibrosis and Oral Cancer Category Total Spend

| Drug Category | 2023 RX Count | 2024 RX Count | % Change | 2023 Total Paid | 2024 Total Paid | % Change |
|-----------------|---------------|---------------|----------|-----------------|-----------------|----------|
| Hepatitis C DAA | 565 | 442 | -21.77% | \$ 6,394,328 | \$ 5,262,376 | -17.70% |
| Cystic Fibrosis | 838 | 781 | -6.80% | \$ 12,589,861 | \$ 13,039,737 | 3.57% |
| Oral Cancer | 328 | 473 | 44.21% | \$ 4,539,064 | \$ 7,037,942 | 55.05% |

Chart 14: Medication-Assisted Treatment (MAT) for Opioid Use Disorder

| Drug Name | 2023 RX Count | 2024 RX Count | Claim Count Change | 2023 Distinct Members | 2024 Distinct Members | Distinct Member Change | 2023 Gross Paid | 2024 Gross Paid | Gross Paid Change |
|--|---------------|---------------|--------------------|-----------------------|-----------------------|------------------------|-----------------|-----------------|-------------------|
| Suboxone Film (Brand) | 89,201 | 68,895 | -22.76% | 4,431 | 3,902 | -11.94% | \$19,512,055 | \$16,785,544 | -13.97% |
| Sublocade Injection | 1,235 | 1,614 | 30.69% | 233 | 329 | 41.20% | \$2,216,418 | \$3,077,639 | 38.86% |
| Brixadi Sosy | 0 | 764 | 0.00% | 0 | 193 | 0.00% | \$0 | \$1,036,861 | 0.00% |
| Vivitrol Susr | 567 | 613 | 8.11% | 138 | 165 | 19.57% | \$848,372 | \$958,680 | 13.00% |
| Buprenorphine HCL/Naloxon Subl Tablets | 25,574 | 21,426 | -16.22% | 1,537 | 1,448 | -5.79% | \$822,324 | \$741,464 | -9.83% |
| Buprenorphine HCL Subl Tablets (Mono) | 8,429 | 9,623 | 14.17% | 400 | 624 | 56.00% | \$217,761 | \$264,558 | 21.49% |
| Zubsolv Subl | 680 | 593 | -12.79% | 70 | 62 | -11.43% | \$141,145 | \$148,606 | 5.29% |
| Buprenorphine/Naloxone Film (Generic) | 1,013 | 2,166 | 113.82% | 127 | 760 | 498.43% | \$15,031 | \$144,565 | 861.79% |
| Naltrexone Hcl Tabs | 2,773 | 2,577 | -7.07% | 901 | 911 | 1.11% | \$67,781 | \$67,729 | -0.08% |
| Acamprosate Calcium Dr Tbec | 590 | 673 | 14.07% | 224 | 229 | 2.23% | \$49,399 | \$53,359 | 8.02% |

Chart 15: Rebates Invoiced: All Programs
Does not include medical drugs, or 340B discounts

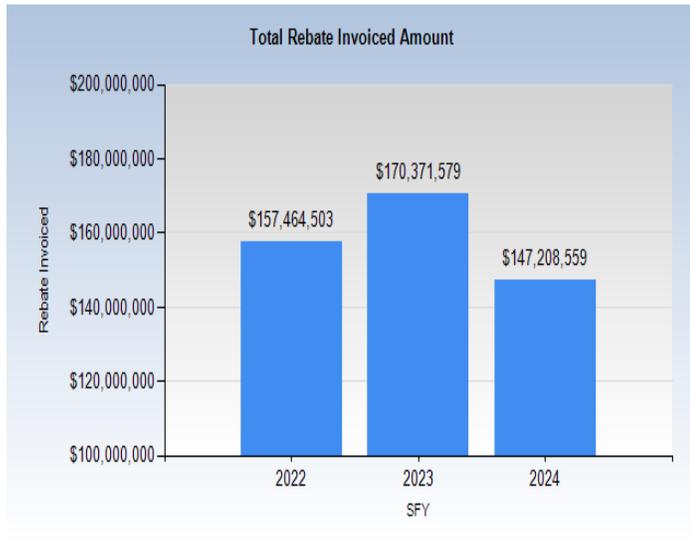


Chart 16: Federal Rebates Invoiced

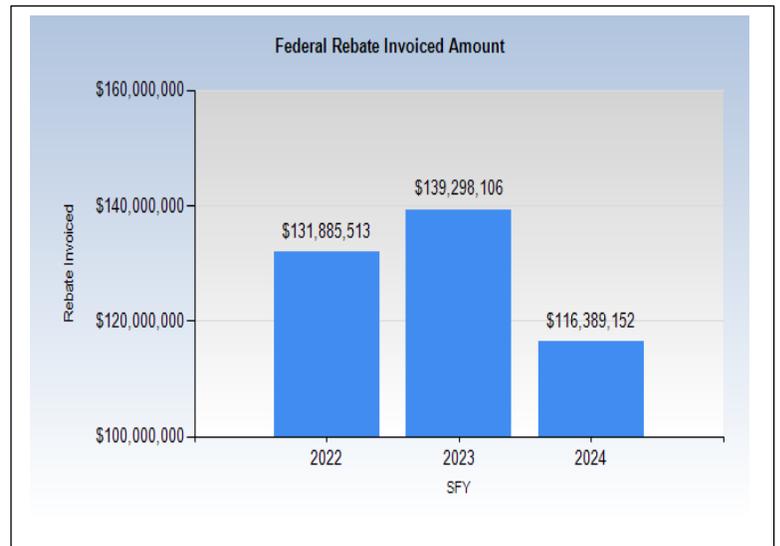


Chart 17: Total Supplemental Rebates Invoiced

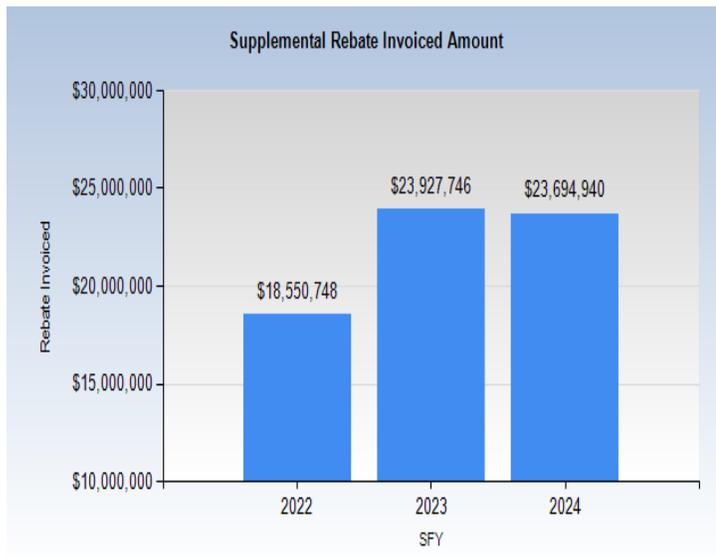
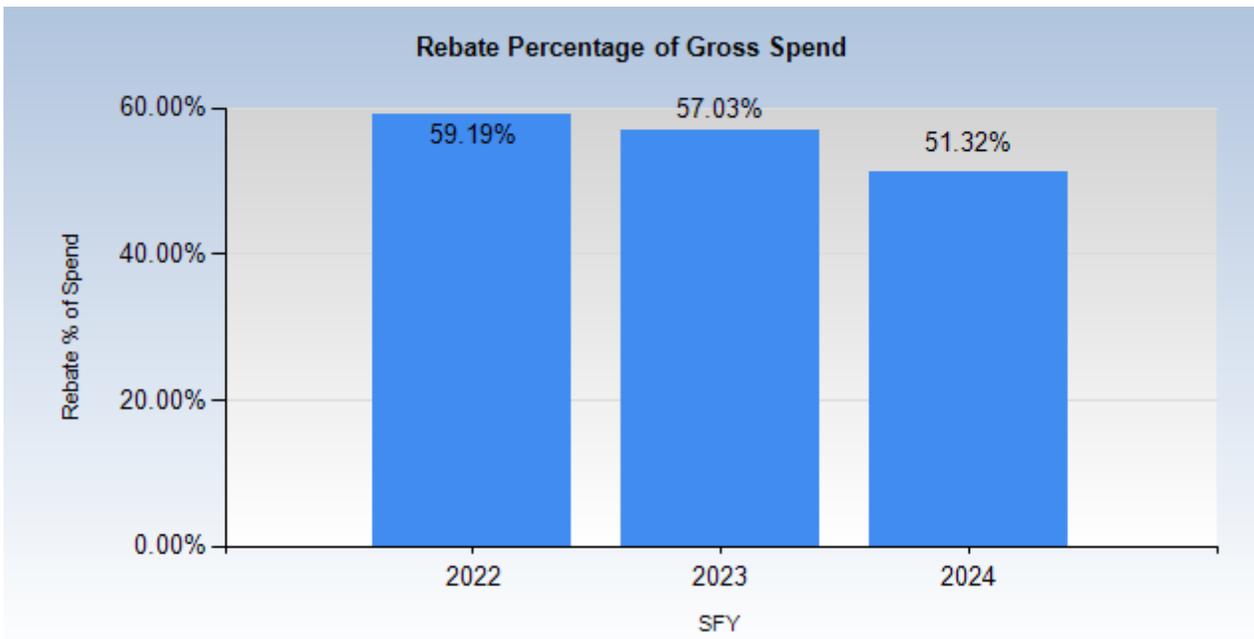


Chart 18: Total VPharm Rebates Invoiced



Chart 19: Rebate Percentage of Gross Spend



**Supplemental Charts:
Drug Names and Commonly used FDA Indications**

| Drug Name Brand (Generic) | Commonly used FDA indications |
|--|---|
| Acromprosate | Alcohol use disorder |
| Amoxicillin | Antibiotic/Anti-infective |
| Amphetamine/ Dextroamphetamine | Attention-deficit/hyperactivity disorder |
| Brixadi* (buprenorphine) | Opioid use disorder |
| Buprenorphine/Naloxone | Opioid use disorder |
| Bupropion HCL | Bipolar disorder, Major depressive disorder |
| Concerta (methylphenidate) | Attention-deficit/hyperactivity disorder |
| Dupixent* (dupilumab) | Asthma, Atopic Dermatitis, Eosinophilic esophagitis |
| Fluoxetine HCL | Bipolar disorder, Generalized anxiety disorder, Major depressive disorder |
| Gabapentin | Fibromyalgia, Neuropathic pain, Seizures |
| Humira Pen (adalimumab) | Inflammatory bowel disease, Psoriasis, Rheumatoid arthritis |
| Naltrexone | Alcohol use disorder, Opioid use disorder |
| Omeprazole | Gastroesophageal reflux disease |
| Ozempic (semaglutide) | Type 2 Diabetes Mellitus |
| Sertraline HCL | Bipolar disorder, Generalized anxiety disorder, Major depressive disorder |
| Stelara* (ustekinumab) | Inflammatory bowel disease, Psoriasis |
| Suboxone (buprenorphine/naloxone) | Opioid use disorder |
| Sublocade* (buprenorphine) | Opioid use disorder |
| Taltz* (ixekizumab) | Psoriasis |
| Trikafta* (elexacaftor, tezacaftor, and ivacaftor) | Cystic fibrosis |
| Trulicity (dulaglutide) | Type 2 Diabetes Mellitus |
| Ventolin HFA | Asthma, Chronic obstructive pulmonary disorder |
| Vivitrol (naltrexone) | Alcohol use disorder, Opioid use disorder |
| Vyvanse (Lisdexamfetamine) | Attention-deficit/hyperactivity disorder |
| Zubsolv (buprenorphine) | Opioid use disorder |

*Indicates specialty drug designation

| Therapeutic Classes | Associated FDA Indications |
|--|---|
| Anti-Tnf-Alpha - Monoclonal Antibodies | Inflammatory bowel disease, Psoriasis, Rheumatoid arthritis |
| Antiadrenergic Antihypertensives | Hypertension, Benign Prostatic Hyperplasia |
| Amphetamines | Attention-deficit/hyperactivity disorder |
| Antianxiety Agents- misc. | Generalized anxiety disorder |
| Anticonvulsants misc. | Epilepsy, Seizure disorders |
| Antidiabetic Combinations | Type 2 Diabetes Mellitus |
| Antineoplastic Enzyme Inhibitors | Oncology and various cancer diagnoses |
| Antipsoriatics | Psoriasis |
| Biguanides | Type 2 Diabetes Mellitus |
| Cystic Fibrosis Agents | Cystic Fibrosis |
| Diabetic Other | Type 2 Diabetes Mellitus |
| Dipeptidyl Peptidase-4 (DPP-4) Inhibitors | Type 2 Diabetes Mellitus |
| Glucagon-like peptide-1 Receptor Agonists | Type 2 Diabetes Mellitus |
| Hepatitis C Direct Acting Antivirals (DAA) | Hepatitis C |
| Insulin | Type 1 and 2 Diabetes Mellitus |
| Nonsteroidal Anti-Inflammatory Agents | Inflammatory Conditions, Pain Reliever |
| Opioid Partial Agonists | Opioid use disorder |
| Proton Pump Inhibitors | Gastroesophageal reflux disease |
| Selective Serotonin Reuptake Inhibitors (SSRIS) | Bipolar disorder, Generalized anxiety disorder, Major depressive disorder |
| Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors | Type 2 Diabetes Mellitus |
| Stimulants -misc | Attention-deficit/hyperactivity disorder |
| Sulfonylureas | Type 2 Diabetes Mellitus |
| Sympathomimetics | Asthma, Chronic obstructive pulmonary disorder |