Report to
The Vermont Legislature

Pharmacy Best Practices and Cost Control Program Report

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

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

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VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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INTRODUCTION

The purpose of this legislative report is to satisfy requirements in Act 130 of 2022 which updated 33 V.S.A. § 2001 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, effect of national trends on pharmacy programs, comparisons to other states, DVHA's administration of the pharmaceutical assistance programs, use of prior authorization requirements, regulatory efforts, and drug categorizations.

In SFY 2023 there was a growth in Medicaid enrollment and increased use of specialty medications. The higher utilization of expensive specialty medications drove up the average cost per claim and fiscal expenditures overall, these drugs accounted for 26.3% of the total drug costs. (Chart 1, Chart 11) A few specialty drugs that contribute to this spend in SFY 2023 included Trikafta®, Stelara®, and Taltz®. These three drugs accounted for over $22.6 million in gross spending and were commonly prescribed for cystic fibrosis, psoriasis, and inflammatory bowel diseases. (Chart 7) Additionally there were non-specialty drugs that contributed to the increase in total spend. Glucagon-like peptide-1 receptor agonist (GLP-1 RA) drugs, including Ozempic®, Trulicity®, Mounjaro™, and Victoza®, were the 4th ranked therapeutic class of drugs by gross spend, a 41% increase in claims volume over the previous year. (Chart 6A) Trulicity® accounted for over 10 million in gross spend and DVHA expects a continued growth with this category of drugs as their clinical benefits and popularity grows. (Chart 7) This legislative report details the specifics that contributed to Vermont Medicaid's fiscal expenditures for SFY 2023 and DVHA's efforts to manage the total drug spend.

ISSUES RELATED TO DRUG COST AND UTILIZATION

DVHA reimbursed pharmacies **$298.7 million** for all prescriptions for Medicaid members (including dual eligible members) in SFY 2023 compared to $266 million in SFY 2022. This represents an increase in gross expenditure of approximately **$32.7 million dollars, 12% over the previous fiscal year**. Net prescription costs (gross spend-rebates applied) for the same population increased from $89.7 million in SFY 2022 to **$103.1 million in SFY2023**, an increase in net cost of $13.4 million and almost 15% over the prior fiscal year. (Chart 1) When the spend is normalized for eligibility using a "per member per month" (PMPM) calculation, gross costs increased from $116.17 PMPM to $125.69 PMPM, an increase of 8%. Net costs rose from $39.07 PMPM to $43.26 PMPM, an increase of almost 11%. (Chart 5A)

Several factors contributed to this increase in drug spend; those eligible for Medicaid increased in SFY 2023 to an average monthly value of 194,299 people, a 4% increase over the prior year. (Chart 2) Specialty drug spending continues to be a driver of total drug costs, accounting for 26% of total drug costs. (Chart 11) However, the changes year over year in this category are slightly misleading. This is because some drugs that DVHA previously tagged as specialty were reclassified into the non-specialty category. In most cases this was done to increase access. In general, the increased use of specialty drugs means higher gross drug costs and lower rebates available for newer specialty drugs, resulting in higher average net cost per claim. (Chart 1) Spending on non-specialty drugs also increased, for example non-insulin drugs used to treat diabetes increased by $6.5 million. (Chart 6B)

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, diabetes, attention deficit hyperactivity disorder (ADHD), as well as asthma and COPD (albuterol inhalers/sympathomimetics). Chart 6A provides the list of the top 10 therapeutic classes by gross spend. Chart 7 lists the top 10 drugs by gross

spend, and Charts 8 and 9 rank therapeutic classes and drugs by utilization (numbers of prescriptions). Anti-tnf-alpha drugs, including Humira®, lead the way for highest gross spend at about $25 million for the category. Similar to what has been reported in the last 7 state fiscal years, opioid partial agonists including Suboxone® (buprenorphine/naloxone) are one of the highest utilization categories by spend and claim volume. (Chart 6A)

During SFY 2023, the number of members using prescriptions for both short-acting and long-acting opioids decreased over the previous year. (Chart 10A, Chart 10B) Further when the data is normalized for the increase in Medicaid eligibility during SFY 2023, short-acting opioid use per 1,000 members declined by 7.8% and long-acting opioid use declined by 20.5%. (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 continue to be a nationally recognized system of care for improving access to medication assisted treatment for opioid use disorder. Nationally the Substance Use Disorder Prevention that Promotes Opioid Recover 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.[1]

Glucagon-like peptide-1 receptor agonist (GLP-1 RA) drugs are again in the Top Therapeutic Categories by Gross Spend. (Chart 6A) These medications have grown in popularity for the treatment of type 2 diabetes and additionally provide cardiovascular, kidney, and weight benefits. According to the American Diabetes Association, GLP-1 RA drugs are recommended as initial or add-on therapy in most diabetic treatment regimens. GLP-1 RA medications have moved up to number 4 on the top 10 list of Top Therapeutic Categories by Gross Spend. (Chart 6A) This indicates a 49% gross spend increase from SFY 2022 ($5.2 million increase in spend). This category of drugs has also received a lot of attention for their use in weight loss, outside of a diagnosis for diabetes. At this time, Vermont Medicaid does not cover drugs used for weight loss per the Medicaid state plan. It is possible that some of the increased utilization is due to these drugs being used off-label for weight loss. In January 2023 clinical criteria was implemented that required the patient have a diagnosis of Type 2 Diabetes Mellitus to access these drugs.

Specialty Pharmacy

DVHA requires any pharmacy dispensing specialty drugs be certified by a national accreditation organization. This accreditation requires pharmacies that dispense specialty medications to have distinctions from standard pharmacies. Specialty pharmacies provide increased coordination of patient care and drug management. The list of specialty medications and certified 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 refer to the pharmacy provider manual. https://dvha.vermont.gov/providers/manuals

In SFY 2023, the gross amount spent on specialty medications increased by $1.4 million (2% over previous SFY), this was a nominal increase in specialty drug spending due to changes applied to DVHA's Specialty Drug List. (Chart 13) It was determined that certain drugs no longer meet criteria for inclusion on the Specialty Drug List including: Humira®, Enbrel®, Repatha®, and Praluent®. This is noteworthy because Humira® is regularly seen in the Top Drugs by Gross Spend chart. During SFY 2023, Humira® ranked as the number 1 gross paid drug for Vermont Medicaid. (Chart 7) The reclassification of these drugs has impacted specialty drug spending; however, the cost was moved to the non-specialty drug spend. This change allows for increased access to these drugs as they can now be dispensed at any enrolled pharmacy.

[1] 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-medicaid-provisions-in-the-support-act/

Pharmacy Care Management Program

The Department of Vermont Health Access, in collaboration with Vermont's Pharmacy Benefit Administrator, Change Healthcare, manages and enrolls patients in a Pharmacy Care Management (PCM) program. The primary goals of the PCM program are to optimize medication use and assure adherence to prescribed regimens.[2] 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.[3] The clinical team with Change Healthcare identifies and enrolls appropriate patients who initiate treatment of high-cost specialty medications into the program.

During the 4th quarter of SFY 2023, there were 481 active enrollees in the PCM program, 128 new members added during SFY 2023, and a total of 3,476 members enrolled since the program was initiated.[2] When measured, the adherence rates for enrolled members from October 25, 2016, through November 1, 2022, resulted in 91% of members satisfying acceptable measures of adherence (MPR value >80%).The estimated direct cost avoidance to the state for SFY 2023 was $1,055,661 and over $5.3 million since the program's initiation. Vermont Medicaid will continue to enroll patients in the PCM program in order to mitigate healthcare expenditures and obtain the highest level of patient care.

Medicaid Rebate Programs

The Department manages multiple rebate programs with the goal of reducing the total net drug spend for Vermont Medicaid. During SFY 2023 the Department invoiced 57% of the gross prescription drug spend using rebate programs. (Chart 20)

Federal Rebates

Federal rebates that manufacturers pay to states are calculated based on a federally mandated formula utilizing prices set by manufacturers, with financial concessions made available by manufacturers to all entities that purchase their drugs. The two most common calculations applied towards federal rebate are "best price" and the "average manufacturer price" (AMP). Vermont's Medicaid program does not directly influence the amount of federal rebate for a drug. Drugs that have large federal rebates may be preferred based on their lower net cost to the State. In general, federal rebate collection increases 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; the CPI penalty has always applied to brand drugs. In SFY 2023, Vermont Medicaid invoiced $139,298,106 in federal rebates from manufacturers. (Chart 17)

Supplemental and Diabetic Supply Rebates

Supplemental and diabetic supply rebates are negotiated by the State through its participation in the Sovereign States Drug Consortium (SSDC). Supplemental rebates are reimbursed in addition to the required federal rebates on a drug, while diabetic supply rebates are state-only rebates. The SSDC is a Medicaid buying group composed of the largest, independent, state-administered, Medicaid supplemental rebate program in the country. Vermont contracts for SSDC-negotiated supplemental rebates via its own supplemental rebate

[2]Change 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

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

agreement, enabling the State to retain control and flexibility in managing its preferred drug list while taking advantage of the additional leverage provided by the large number of members covered by the group. The group primarily focuses on negotiating and acquiring rebates, supplemental to federal Medicaid rebates, from drug manufacturers to obtain prescription drugs at a lower net cost to respective Medicaid programs. In SFY 2023, Vermont Medicaid invoiced $23,927,746 in supplemental rebates from manufacturers. (Chart 18)

Value Based Purchasing (VBP) Agreements

A CMS final rule, regarding value-based purchasing for drugs covered by Medicaid became effective July 1, 2022.[4,5] This rule allows State Medicaid Programs to enter into a new type of rebate agreement. Value based purchasing agreements link the net cost of the drug directly to the drug's efficacy or expected clinical outcomes. Prior to this rule, manufacturers were required to provide the best price to Medicaid for their drugs. The new rule provides manufacturers two options for reporting the best price. States have the option to participate in VBP agreements that manufacturers offer or accept the best price outside of the VBP agreement. DVHA evaluates VBP agreements using a multi-disciplinary approach.

THE EFFECT OF NATIONAL TRENDS AND COMPARISON TO OTHER STATES

Medicaid Net Prescription Drug Expenditure Forecast

From February 2020 to March 2023 of the Public Health Emergency (PHE), enrollment in Medicaid/CHIP programs will have grown by approximately 23.3 million to nearly 95 million. [3] The Families First Coronavirus Response Act required continuous Medicaid enrollment, in Vermont Medicaid the average monthly eligible members increased from 186,753 in SFY 2022 to 194,299 in SFY 2023. (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, 2023, Congress separated the continuous enrollment provision from the PHE, ending continuous enrollment on March 31, 2023. Estimates have pointed to an estimated 18% reduction in Medicaid enrollment during the disenrollment and "unwinding" phase.[6]

In the coming years from 2023-2030, national spending and utilization are expected to rise more rapidly due to increasing use of new, more expensive drugs in the market. This is in line with pre-pandemic expectations of net prescription drug expenditures which are anticipated to increase steadily with an annual growth rate of 5.2-5.9% for each of the next five years.[4,5] The most apparent driver of increased spending is in the recent trends around specialty drugs. In 2020, Medicaid specialty medications accounted for more than half of the net drug spend, even though they only made up roughly 1% of utilization. A number of these drugs have significant benefits on clinical outcomes, thus delivering value to Medicaid programs. Others are excessively priced relative to their limited effect on outcomes and overall health care expenditures.

The fiscal impact of high-cost orphan drugs (used to treat rare conditions) is difficult to predict for a program like Vermont Medicaid with a relatively small population. The rarity of the conditions for which these drugs are used may mean that Vermont Medicaid could have limited utilization. Alternatively, it would not take much utilization

[4]Medicaid Program. Center for Medicare and Medicaid Services. (2020). Available From: https://www.regulations.gov/document/CMS-2020-0072-30223
[5]Medicaid 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/
[4] National Health Expenditure Projections 2021–30: Growth to
Moderate as COVID-19 Impacts Wane. CMS. (2022) Available From: https://www.cms.gov/files/document/national-health-expenditure-projections-2021-30-growth-moderate-covid-19-impacts-wane.pdf
[5] National Health Expenditure Projections 2019-2028. CMS. (2019) Available From: https://www.cms.gov/files/document/nhe-projections-2019-2028-forecast-summary.pdf

of a few of these drugs to have an outsized impact on expenditures. This could be especially pronounced if a particular genetic condition or rare disease happens to be more prevalent in Vermont.

Hemophilia is an example of a genetic medical condition targeted by recently FDA approved gene therapies. The two gene therapies, Hemgenix® and Roctavian™, were FDA approved in SFY 2023 with one-time costs of $3.5 million and $2.9 million, respectively. High-cost, low-utilization drugs could account for 20-25% of the annual increase in net expenditures over the next five years. The Medicaid drug program implemented a high cost carve out plan for certain drugs that may be administered in an inpatient setting. The carve out allows Medicaid to pay hospitals separately for the drug ensuring adequate reimbursement to the hospital but also allowing the state to invoice the claim for rebate. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/22-002-Proposed-GCR-High-Investment-Drugs-SPA.pdf

Nationally, biosimilar FDA approvals are increasing. A biosimilar as defined by the FDA *as a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA approved reference product*.[9] Biosimilar use and availability are expected to reduce Medicaid drug expenditure.

Two therapeutic drug classes are anticipated to be the primary drivers in increased net expenditures over the next few years: oncology drugs and drugs for inflammatory conditions. Net expenditures for oncology drugs are projected to increase by 12% each year. This is due to the rapid approval of new drugs and expanded indications. In 2022, the FDA approved 37 new chemical entities, 20 of which were for oncology indications. Many of these new drugs are self-administered oral drugs that are taking the place of provider-administered infusions. Net expenditures for biologics and drugs used to treat inflammatory conditions are expected to increase by 9% per year, for each of the next five years. The increase in utilization is due to significantly improved outcomes seen with many of the newer drugs compared to older, traditional therapies, especially in patients with moderate-to-severe disease. Humira, the top drug by expenditure over the past several years will be facing a large amount of biosimilar competition in mid-2023 and extending in 2024.[6]

Effective January 1, 2024, as a result of the American Rescue Plan Act of 2021, the cap that limits mandatory Medicaid rebates at 100% will be removed. The change will have the largest impact on brand drugs that have reached the 100% cap. Manufacturers' response to this change is yet to be determined.[9]

ADMINISTRATION OF VERMONT'S PHARMACEUTICAL ASSISTANCE PROGRAMS

VPharm is Vermont's State Pharmaceutical Assistance Programs (SPAP). VPharm programs help Vermonters who do not qualify for Medicaid and are enrolled in Medicare pay for their Medicare Prescription Drug Plan (Medicare PDP) and related costs. How this works: When the members Medicare PDP pays for the medication, any balance due to the pharmacy can be billed to VPharm. VPharm will pay the balance, leaving the member with copays of $1 and $2, depending on the cost of the drug.

The Department coordinates and administers VPharm in accordance with 33 V.S.A. § 2073. The VPharm program was established in 2006 to provide supplemental pharmaceutical coverage to Medicare beneficiaries, paying for prescription medicines with affordable monthly premiums for individuals who meet income guidelines and are enrolled in Medicare Part D. The program was initiated with three separate tiers of coverage (VPharm 1, 2, and 3), varying by monthly income and household size. As a result of Vermont's new Global Commitment to Health 1115 Waiver, effective 07/01/2022, DVHA expanded the drug coverage available under

[8]Biosimilar and Interchangeable Biologics: More Treatment Choices. FDA. (2023) Available From: https://www.fda.gov/consumers/consumer-updates/biosimilar-and-interchangeable-biologics-more-treatment-choices
[9]Series of Changes to Drug Pricing Metrics Will Interact in Coming Years. Avalere. (2021) Available From: https://avalere.com/insights/series-of-changes-to-drug-pricing-metrics-will-interact-in-coming-years

VPharm 2 and VPharm 3 to be equivalent to the drug coverage available under VPharm 1. This change allowed all VPharm enrollees to receive reduced copays for more drugs through VPharm, not just "maintenance" drugs.

In SFY 2023, there were 258,916 claims through the VPharm benefit, with a total gross paid amount of $5,683,706. (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, reviews and reports the results of those activities performed by the Department 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 2023

REVIEW TOPIC	SFY 2023 TOTAL
Therapeutic Drug Classes: Periodic Review	48
Full New Drug Reviews	30
FDA Safety Alerts	3
New/Updated Clinical Guidelines	26
RetroDUR/ProDUR Reviews	6
New Managed Therapeutic Drug Classes	1
BioSimilar Drug Reviews	3

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) is a list of covered prescription drugs that identifies preferred choices within therapeutic classes for various diseases and conditions, including generic alternatives. The PDL can be found at https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria. The PDL is an important tool designed to reduce the cost of providing prescription drugs while maintaining access to clinically appropriate prescription drug therapies. The PDL includes a list of commonly used preferred and non-preferred drugs that are covered by the Department's drug benefit programs. Not all drugs DVHA covers are listed on the PDL; however, it does list over 180 different therapeutic categories representing thousands of drugs.

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 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 trial of or contraindication of a preferred drug. Other drugs are set up with automated criteria, in which the claims system identifies previous drug therapy or a pre-existing diagnosis and uses this information to approve or deny the claim. The automated prior authorizations help to reduce provider burden while assuring clinical and financial integrity of pharmacy programs.

The total number of prior authorizations increased by 9.6% in SFY 2023, an increase of 2,635 requests. (Chart 4) There was a growth in the number of prescriptions covered by Vermont Medicaid in SFY 2023; this increase in claims contributes to an increase in prior authorizations. Additionally, the greater complexity and expansion of high-cost therapies leads to a higher need for prior authorizations to manage the fiscal impact to the State. The overall prior authorization denial rate has slightly increased throughout SFY 2023 to 28.03%, a growth of 2.8%. (Chart 4) This represents an insignificant increase in denial rates and can be contributed to prior authorization changes related to glucagon-like peptide-1 receptor agonist (GLP-1 RA) antidiabetic drugs, implemented on January 1st, 2023. Due to the substantial amount of off-label prescribing, a requirement for a diagnosis of type 2 diabetes was added to this drug class as is FDA indicated for the covered drugs. Since this change, there has been an increase in prior authorization denials due to members not having a diagnosis of Type 2 diabetes. The prior authorization process helps the department direct utilization toward preferred rebatable products with similar efficacy, tolerability and expected outcomes.

APPENDIX: COST AND UTILIZATION CHARTS

Chart 1: Pharmacy Claims and Gross and Net Spend, SFY 2020-2023 (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
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	5.14%	$266,047,966	15.06%	$123.69	9.43%	$89,724,432	20.24%	$41.72	14.36%
2021	2,045,749		$231,234,782		$113.03		$74,623,891		$36.48	
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
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	6.75%	$260,333,840	15.30%	$138.00	8.00%	$87,551,115	20.16%	$46.41	12.56%
2021	1,767,158		$225,792,866		$127.77		$72,862,929		$41.23	
VPharm Claims										
SFY	Claims Paid	% Change	Gross Amount Paid	% Change	Gross Cost Per Claim	%Change	Net Paid Amount	% Change	Net Cost Per Claim	% Change
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	-5.10%	$5,714,126	5.00%	$21.61	10.65%	$2,173,317	23.42%	$8.22	30.05%
2021	278,591		$5,441,916		$19.53		$1,760,963		$6.32	

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).

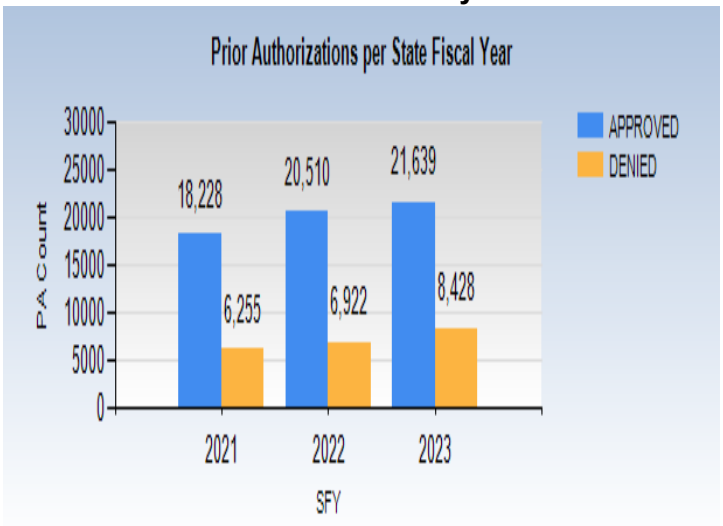
All	2021	2022	2023
Medicaid and Duals Eligible All Ages	173,206	186,753	194,299
Medicaid and Duals Utilizers All Ages	50,508	54,637	57,161
Medicaid and Duals Utilization Percent All Ages	29%	29%	29%
Adult			
Medicaid and Duals Eligible Adults	110,340	122,712	130,188
Medicaid and Duals Utilizers Adults	40,061	42,920	44,296
Medicaid and Duals Utilization Percent Adults	36%	35%	34%
Children			
Medicaid and Duals Eligible Children	62,866	64,040	64,111
Medicaid and Duals Utilizers Children	10,446	11,716	12,864
Medicaid and Duals Utilization Percent Children	17%	18%	20%

Chart 3: Generic Usage Rates

Medicaid (Includes Duals)			
Generic Indicator	2021	2022	2023
Generic Utilization Rate (GUR)	78.03%	77.73%	78.55%
Generic Substitution Rate (GSR)	81.51%	79.58%	79.42%
Vpharm			
Generic Indicator	2021	2022	2023
Generic Utilization Rate (GUR)	83.56%	84.06%	84.23%
Generic Substitution Rate (GSR)	92.60%	91.06%	90.60%

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
2021	25.55%
2022	25.23%
2023	28.03%

Charts 5A: Medicaid (including Duals) Gross and Net PMPM Trend by SFY

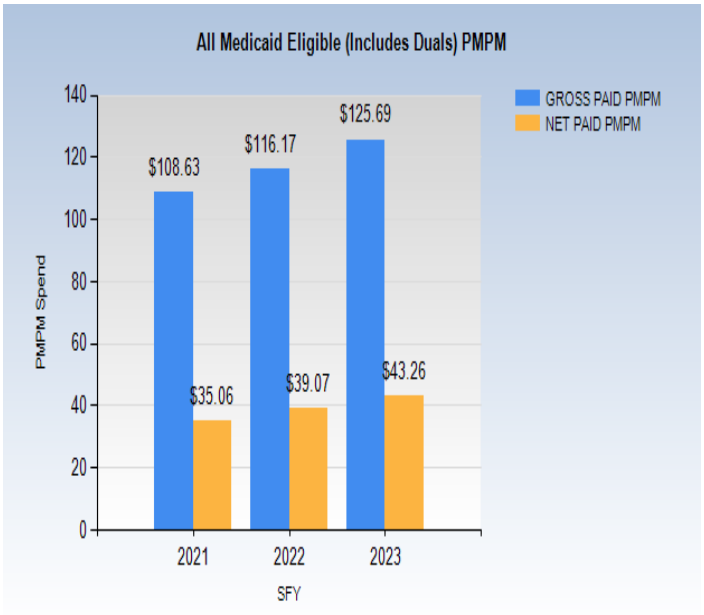


Chart 5B: VPharm: Gross and Net PMPM Trend by SFY

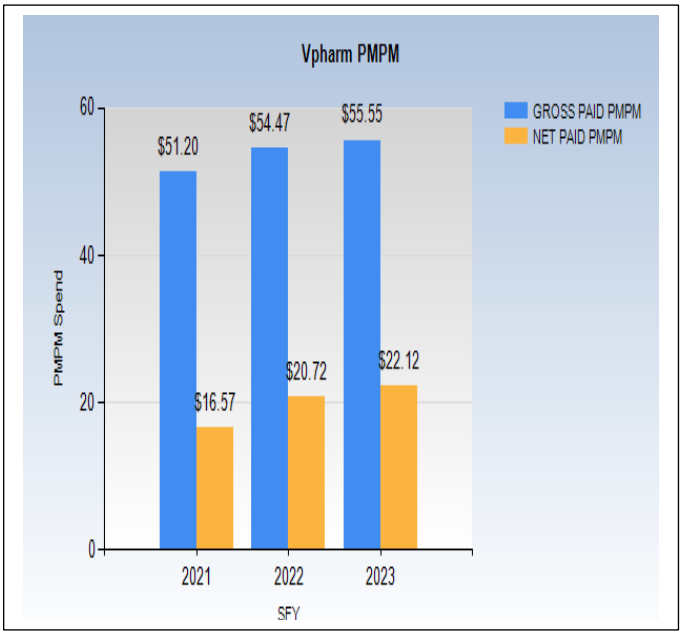


Chart 6A: Top Therapeutic Classes by Gross Spend

Therapeutic Class/Treatment Category	2022 Gross Paid	2023 Gross Paid	2022 Claim Count	2023 Claim Count	Total Amount Paid Change	Claim Count Change
Anti-Tnf-Alpha - Monoclonal Antibodies	$20,177,231	$25,310,220	2,818	3,258	25.44%	15.61%
Opioid Partial Agonists	$22,006,095	$23,136,147	134,326	126,471	5.14%	-5.85%
Antipsoriatics	$13,419,925	$17,482,993.	1,414	1,724	30.28%	21.92%
Glucagon-like peptide-1 Receptor Agonists	$10,717,308	$15,935,467	10,010	14,149	48.69%	41.35%
Sympathomimetics	$13,948,631	$14,292,925	71,382	75,601	2.47%	5.91%
Insulin	$13,528,609	$13,198,261	16,181	16,094	-2.44%	-0.54%
Amphetamines	$10,218,283	$12,698,398	66,527	71,907	24.27%	8.09%
Cystic Fibrosis Agents	$11,674,203	$12,348,836	796	801	5.78%	0.63%
Stimulants - Misc.	$12,341,583	$11,049,942	55,704	59,286	-10.47%	6.43%
Antineoplastic Enzyme Inhibitors	$6,404,720	$7,140,069	558	620	11.48%	11.11%

Chart 6B: Non-Insulin Antidiabetic Drugs

Non-Insulin Antidiabetic Drugs	2022 Claims	2023 Claims	2022 Gross Paid	2023 Gross Paid	Paid % Difference
Glucagon-like Peptide-1 Receptor Agonists	10,010	14,149	$ 10,717,308	$ 15,935,467	48.68%
Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	3,715	4,707	$ 4,312,607	$ 5,662,855	31.30%
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	1,318	1,197	$ 1,405,844	$ 1,318,463	-6.21%
Biguanides	14,066	14,668	$ 270,448	$ 272,442	0.73%
Diabetic Other	970	1047	$ 215,884	$ 274,153	26.99%
Antidiabetic Combinations	281	224	$ 240,001	$ 210,322	-12.36%
Sulfonylureas	3,402	3,133	$ 53,793	$ 49,835	-7.36%
Totals	**33,762**	**39,125**	**$ 17,215,885**	**$ 23,723,537**	37.80%

Chart 7 Top Drugs by Gross Spend

Current Rank	Drug Name	2022 Gross Paid	2023 Gross Paid	2022 Claim Count	2023 Claim Count	Total Amount Paid Change	Claim Count Change
1	Humira Pen (Adalimumab)	$17,552,263	$22,308,174	2,484	2,925	27.10%	17.75%
2	Suboxone (buprenorphine/naloxone)	$19,610,127	$19,516,334	101,782	89,215	-0.48%	-12.35%
3	Vyvanse (Lisdex amfetamine)	$8,660,564	$10,313,833	28,135	32,328	19.09%	14.90%
4	Trikafta (elexacaftor, tezacaftor, and ivacaftor)	$9,767,055	$10,276,467	419	442	5.22%	5.49%
5	Trulicity (dulaglutide)	$6,710,355	$10,085,526	6,254	8,928	50.30%	42.76%
6	Concerta (methylphenidate)	$7,596,973	$8,120,392	19,304	20,213	6.89%	4.71%
7	Stelara (ustekinumab)	$6,842,729	$8,042,151	322	371	17.53%	15.22%
8	Mavyret (glecaprevir, pibrentasvir)	$4,046,777	$4,990,220	316	400	23.31%	26.58%
9	Jardiance (empagliflozin)	$3,178,503	$4,358,131	2,778	3,657	37.11%	31.64%
10	Taltz (ixekizumab)	$2,222,313	$4,265,915	294	548	91.96%	86.39%

Chart 8 Top Therapeutic Classes by Utilization

Current Rank	Category Name	2022 Gross Paid	2023 Gross Paid	2022 Claim Count	2023 Claim Count	Gross Paid Change	Claim Count Change
1	Opioid Partial Agonists	$22,006,095	$23,136,147	134,326	126,471	5.14%	-5.85%
2	Selective Serotonin Reuptake Inhibitors (SSRIS)	$1,483,956	$1,524,805	99,924	103,085	2.75%	3.16%
3	Anticonvulsants misc.	$4,978,318	$4,732,989	77,397	79,435	-4.93%	2.63%
4	Sympathomimetics	$13,948,631	$14,292,925	71,382	75,601	2.47%	5.91%
5	Amphetamines	$10,218,283	$12,698,398	66,527	71,907	24.27%	8.09%
6	Stimulants -misc	$12,341,583	$11,049,942	55,704	59,286	-10.47%	6.43%
7	Proton Pump Inhibitors	$1,295,201	$1,226,514	40,346	41,053	-5.30%	1.75%
8	Oil soluble vitamins	$425,069	$445,335	39,181	40,539	4.77%	3.47%
9	Antihistamines - non-sedating	$473,031	$485,204	38,821	39,827	2.57%	2.59%
10	Antianxiety Agents- misc.	$415,65	$455,275	33,255	36,211	9.53%	8.89%

Chart 9: Top Drugs by Utilization

Current Rank	Category Name	2022 Gross Paid	2023 Gross Paid	2022 Claim Count	2023 Claim Count	Gross Paid Change	Claim Count Change
1	Suboxone (buprenorphine/naloxone)	$19,610,127.	$19,516,334	101,782	89,215	-0.48%	-12.35%
2	Gabapentin	$580,181.	$590,095	36,009	36,580	1.71%	1.59%
3	Amphetamine/ Dextroamphetamine	$980,238.	$891,214	36,183	34,070	-9.08%	-5.84%
4	Vyvanse (lisdexamfetamine)	$8,660,564.	$10,313,833	28,135	32,328	19.09%	14.90%
5	Ventolin HFA	$272,588.	$2,139,572	3,765	29,019	684.91%	670.76%
6	Fluoxetine HCL	$430,846.	$437,844	27,845	28,788	1.62%	3.39%
7	Bupropion HCL	$457,834	$440,914	27,207	27,624	-3.70%	1.53%
8	Omeprazole	$302,361	$306,473	24,262	24,572	1.36%	1.28%
9	Sertraline HCL	$240,017.55	$273,178	19,373	22,044	13.82%	13.79%
10	Amoxicillin	$181,910.52	$274,771	15,267	21,693	51.05%	42.09%

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

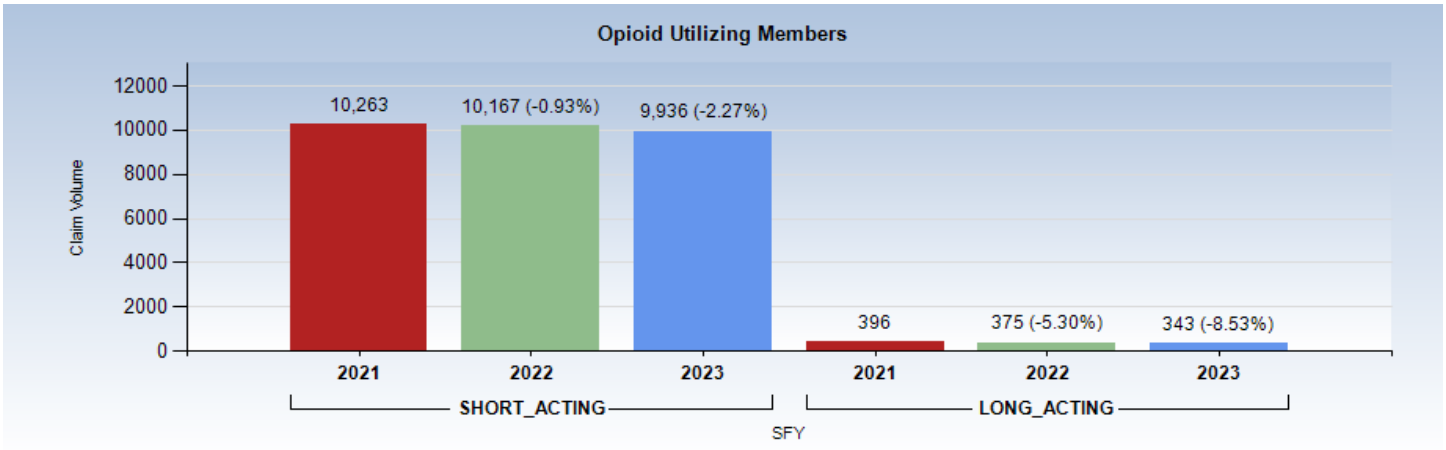


Chart 10B: of Prescriptions for Opioids: 3-yr Trend

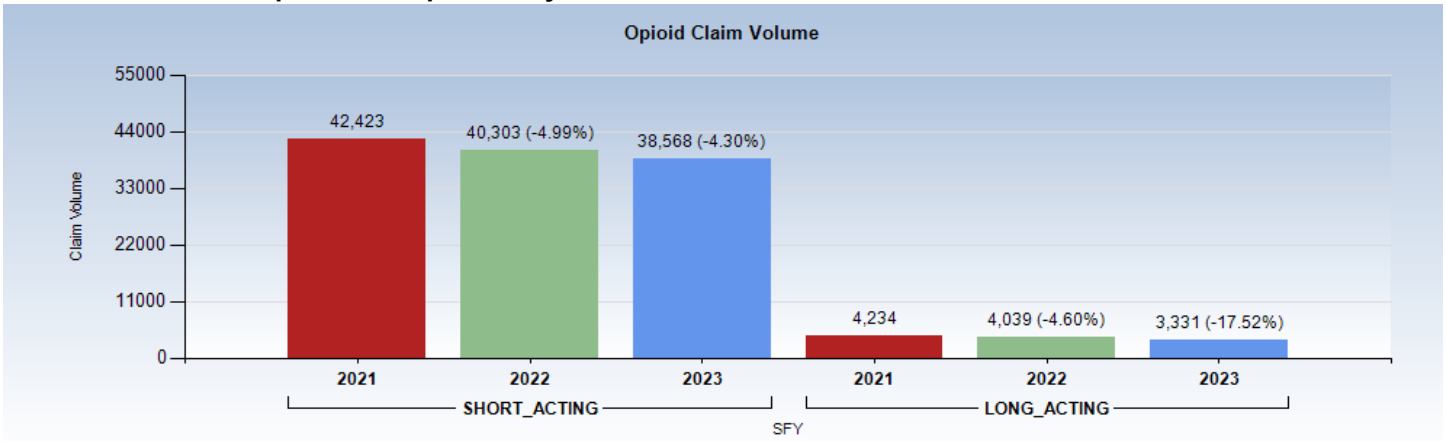


Chart 10C: Number of Prescriptions Per 1000 Members per Month for Opioids: 3-yr Trend

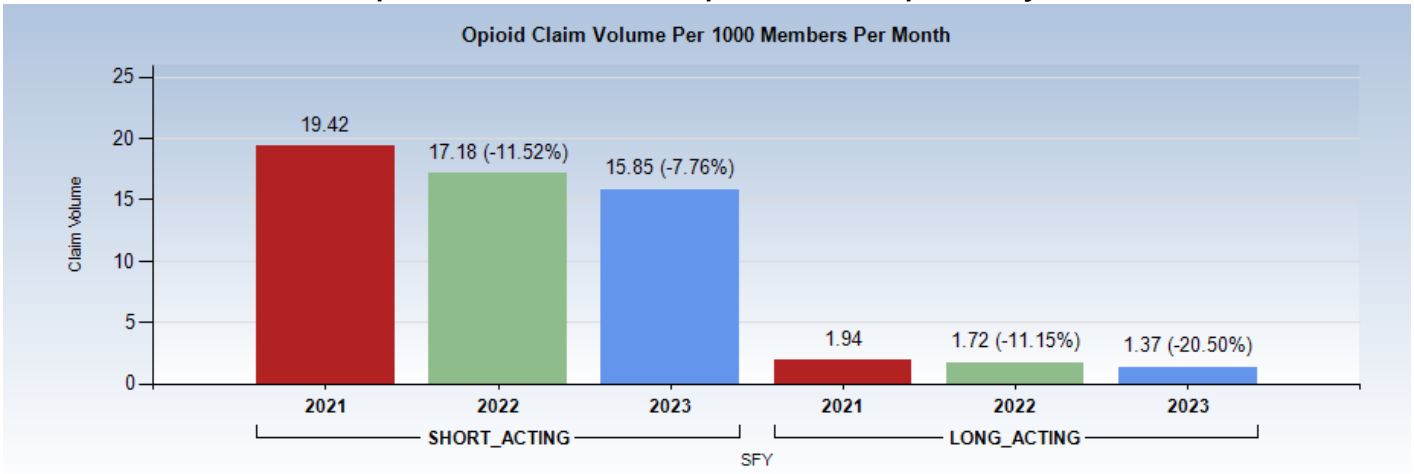


Chart 11: Specialty Drugs as a Percent of Total Gross Drug Cost

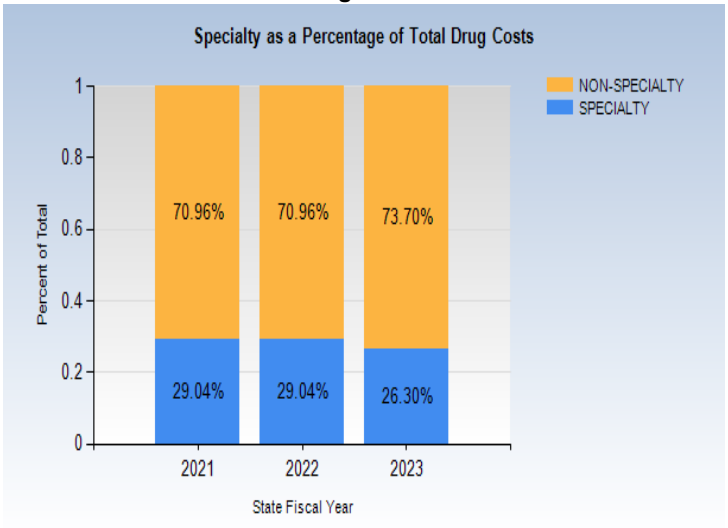


Chart 12A: Specialty Drugs-Amount Paid

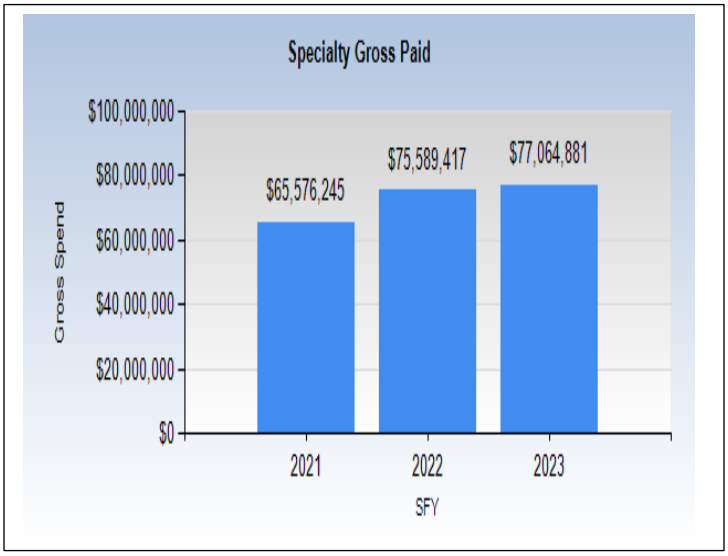


Chart 12B: Specialty Drugs – Number of Claims

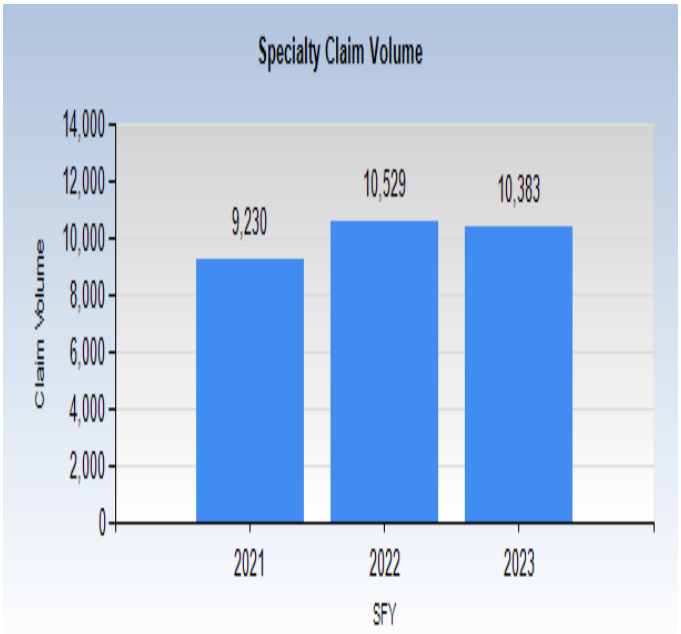


Chart 13: Specialty Drugs-Amount Paid Per Prescription

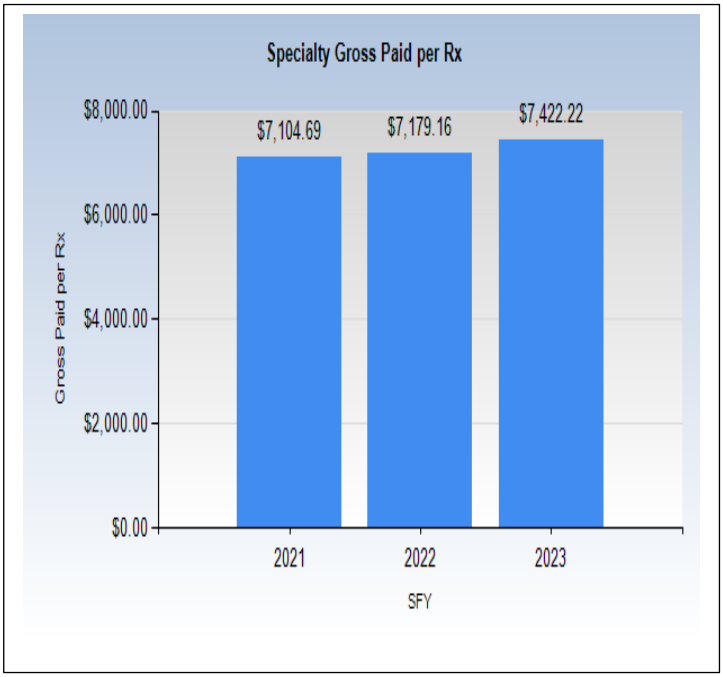


Chart 14: Hepatitis C, Cystic Fibrosis and Oral Cancer Category Total Spend

Drug Category	2022 RX Count	2023 RX Count	% Change	2022 Total Paid	2023 Total Paid	%Change
Hepatitis C DAA	476	565	16.81%	$ 5,588,300	$ 6,394,328	14.17%
Cystic Fibrosis	811	793	40.71%	$ 11,277,309	$ 11,501,084	38.86%
Oral Cancer	459	534	29.52%	$ 5,375,080	$ 6,412,395	32.91%

Chart 15: Medication-Assisted Treatment (MAT) for Opioid Use Disorder

Drug Name	2022 RX Count	2023 RX Count	RX Count Change	2022 Distinct Members	2023 Distinct Members	Distinct Member Change	2022 Gross Paid	2023 Gross Paid	Gross Paid Change
Suboxone Film (Brand)	101,782	89,215	-12.35%	4,578	4,431	-3.21%	$19,610,128	$19,516,334	-0.48%
Sublocade Injection	751	1,235	64.45%	170	233	37.06%	$1,295,907	$2,216,418	71.03%
Vivitrol Susr	507	567	11.83%	112	138	23.21%	$698,533	$848,372	21.45%
Buprenorphine HCL/Naloxon Subl Tablets	22,115	25,574	15.64%	1,219	1,537	26.09%	$675,173	$822,324	21.79%
Buprenorphine HCL Subl Tablets (Mono)	8,219	8,429	2.56%	358	400	11.73%	$211,666	$217,761	2.88%
Zubsolv Subl	392	680	73.47%	43	70	62.79%	$73,072	$141,145	93.16%
Naltrexone Hcl Tabs	2,316	2,773	19.73%	739	901	21.92%	$56,940	$67,781	19.04%
Acamprosate Calcium Dr Tbec	574	590	2.79%	222	224	0.90%	$50,094	$49,399	-1.39%
Disulfiram Tabs	570	532	-6.67%	216	183	-15.28%	$42,417	$39,234	-7.50%
Buprenorphine/Naloxone Film (Generic)	851	1,013	19.04%	97	127	30.93%	$12,980	$15,031	15.80%
TOTALS	**138,077**	**130,608**		**7,754**	**8,244**		**$ 22,726,911.25**	**$ 23,933,799.11**	

Chart 16: Rebates Invoiced: All Programs

Chart 17 Federal Rebates Invoiced

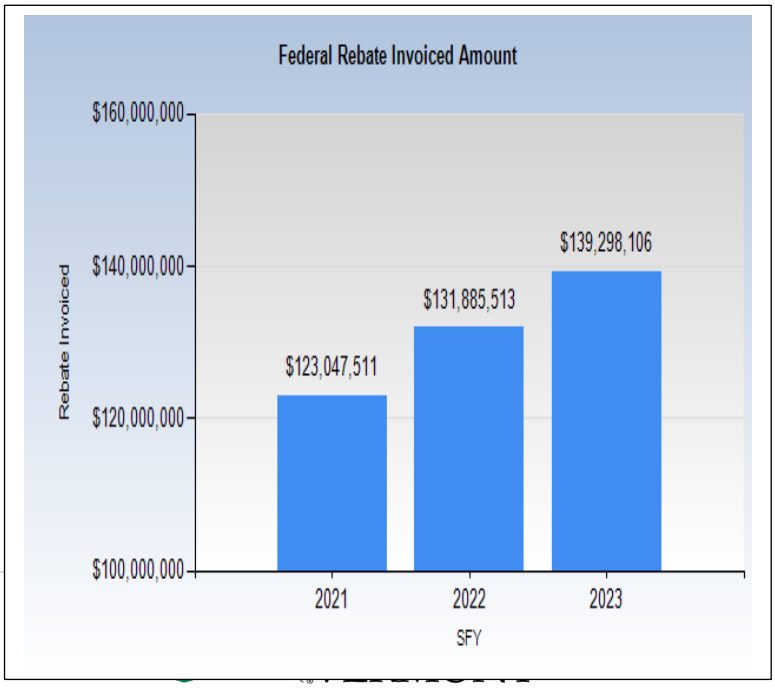


Chart 18: Total Supplemental Rebates Invoiced

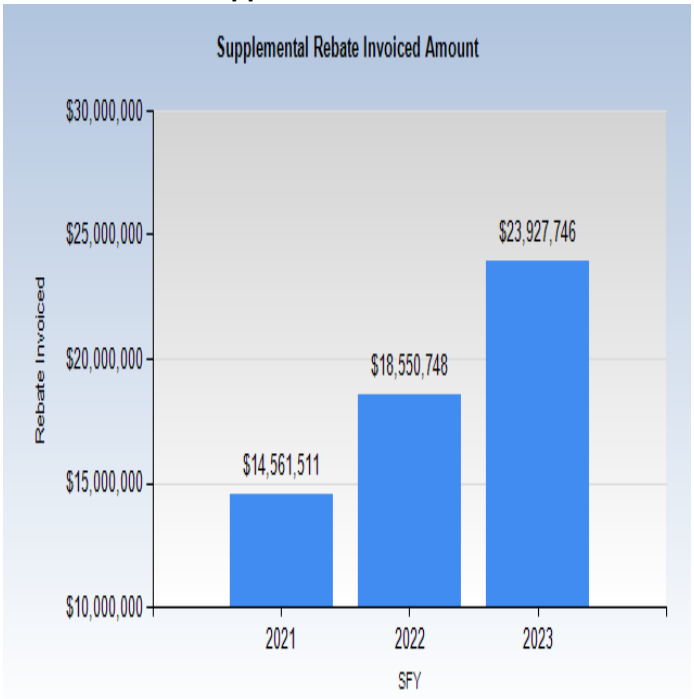


Chart 19: Total VPharm Rebates Invoiced

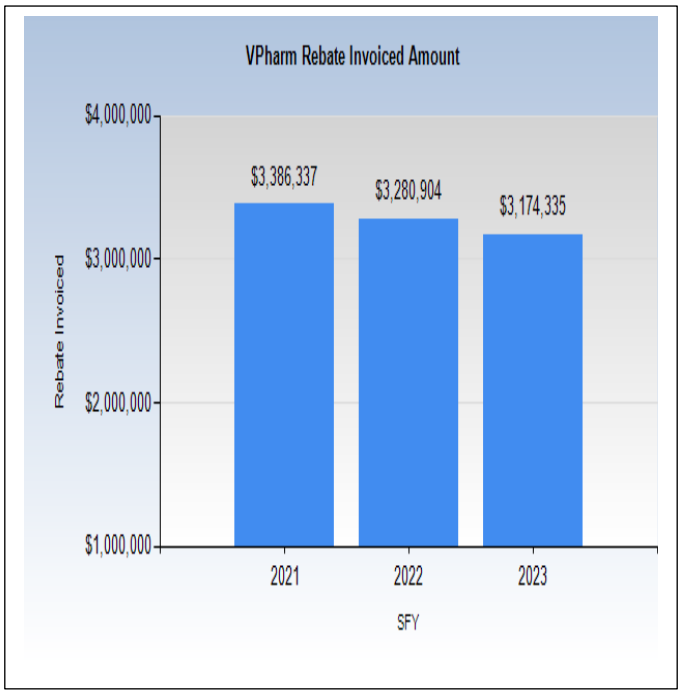
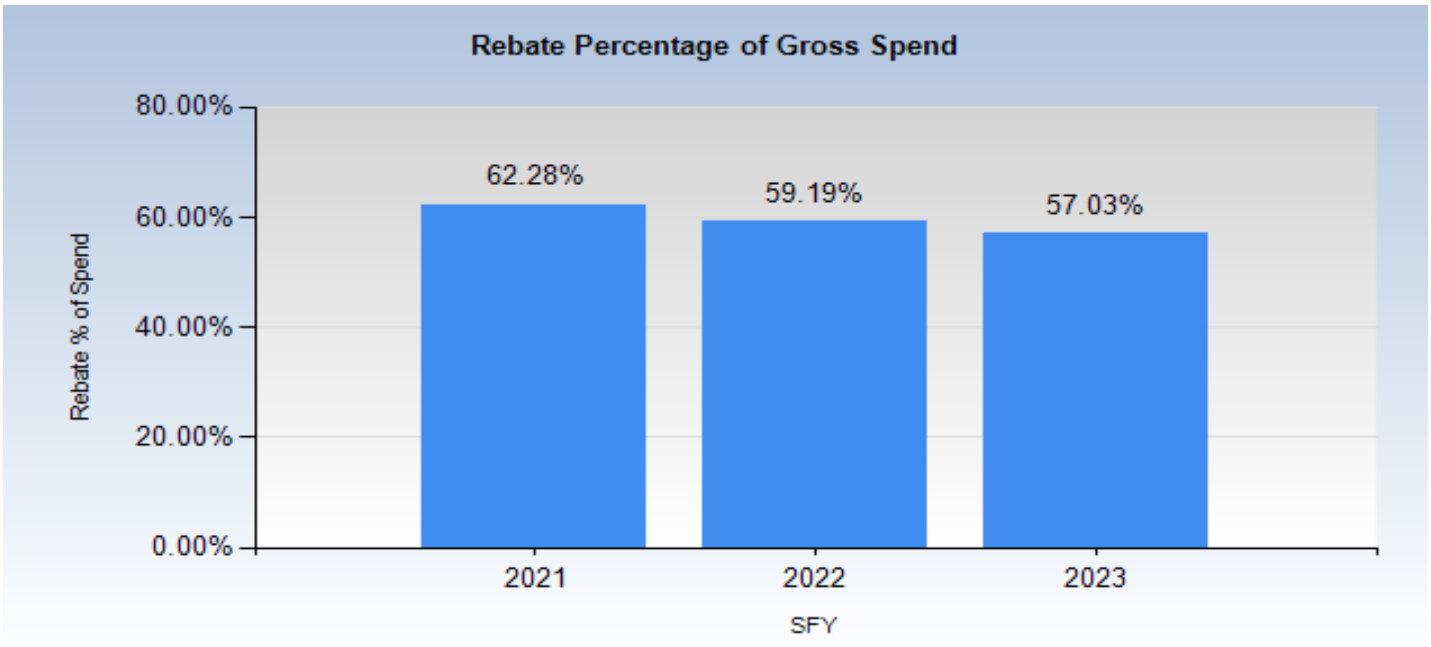


Chart 20: Rebate Percentage of Gross Spend



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Supplemental Charts:

Drug Names and Commonly used FDA Indications

Drug Name Brand (Generic)	Commonly used FDA indications
Amoxicillin	Antibiotic/Anti-infective
Amphetamine/ Dextroamphetamine	Attention-deficit/hyperactivity disorder
Bupropion HCL	Bipolar disorder, Major depressive disorder
Concerta (methylphenidate)	Attention-deficit/hyperactivity disorder
Fluoxetine HCL	Bipolar disorder, Generalized anxiety disorder, Major depressive disorder
Gabapentin	Fibromyalgia, Neuropathic pain, Seizures
Humira Pen (adalimumab)	Inflammatory bowel disease, Psoriasis, Rheumatoid arthritis
Jardiance (empagliflozin)	Type 2 Diabetes Mellitus
Mavyret (glecaprevir, pibrentasvir)	Hepatitis C
Omeprazole	Gastroesophageal reflux disease
Sertraline HCL	Bipolar disorder, Generalized anxiety disorder, Major depressive disorder
Stelara* (ustekinumab)	Inflammatory bowel disease, Psoriasis
Suboxone (buprenorphine/naloxone)	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
Vyvanse (Lisdexamfetamine)	Attention-deficit/hyperactivity disorder

*Indicates specialty drug designation

Therapeutic Classes	Associated FDA Indications
Anti-Tnf-Alpha - Monoclonal Antibodies	Inflammatory bowel disease, Psoriasis, Rheumatoid arthritis
Amphetamines	Attention-deficit/hyperactivity disorder
Antianxiety Agents- misc.	Generalized anxiety disorder
Anticonvulsants misc.	Epilepsy, Seizure disorders
Antidiabetic Combinations	Type 2 Diabetes Mellitus
Antihistamines - non-sedating	Seasonal allergies
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
Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	Type 2 Diabetes Mellitus
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Type 2 Diabetes Mellitus
Glucagon-like peptide-1 Receptor Agonists	Type 2 Diabetes Mellitus
Insulin	Type 1 and 2 Diabetes Mellitus
Oil soluble vitamins	Vitamin deficiency
Opioid Partial Agonists	Opioid use disorder
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