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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Commissioner

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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 authorization 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 **$198.8 million in gross drug spend** in State Fiscal Year (SFY) 2019 (Chart 1), which includes data from July 1, 2018, through June 30, 2019. 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 2019, $5.59 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 2.8% decline in the total number of claims (prescriptions) processed and a 3.7% increase in the average gross cost per prescription. A similar trend occurred in state fiscal year 2018 when there was a slight decrease in the number of claims processed but a 3.6% increase in the gross cost per prescription when compared to state fiscal year 2017. The 2-year trend is a 7.3% rise in gross spend for all plans. Net spend rose by 4.7% and net cost per prescription rose by 7.7% from $33.15 to $35.72 in state fiscal year 2019. However, when looking at the 3-year trend, net costs have declined overall by 1.8% (Chart 1). For Medicaid plans (excluding VPharm), the trend is similar, with an increase in the gross cost per prescription of 3.4% in state fiscal year 2019 and an increase in net cost per prescription of 7.3% from $38.62 to $41.45. Once again, the 3-year trend in net cost per prescription shows an overall decline of 2% (Chart 1). Finally, approximately 37% of adults and 21% 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
    - Over 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 03/20/19 Created by Vermont Legal Aid's Office of Health Care Advocate** 1-800-917-7787			
PROGRAM	**WHO IS ELIGIBLE**	**BENEFITS**	**COST-SHARING**
MABD Medicaid[3] **Medicaid Working Disabled** **MCA[4] (Expanded Medicaid)**	Aged, blind, disabled at or below the PIL[5]. Disabled working adults at or below 250% FPL[6]. 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 ($510 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. • $3.40 -$8.50 co-pays if have Part D. (if beneficiary is under 100% FPL $1.25 to $3.80) 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.
Medicare Savings Programs: **QMB 100%FPL** Qualified Medicare Beneficiaries **SLMB 120% FPL** Specified Low-Income Beneficiaries **QI-1 135% FPL** Qualified Individuals	• QMB & SLMB: Medicare beneficiaries w/ Part A • QI-1: Medicare bens. who are not on other fed. med. benefits e.g. Medicaid (LIS for Part D OK).	• QMB covers Medicare Part B (and A if not free) premiums; Medicare A & B cost-sharing. • SLMB and QI-1 cover Medicare Part B premiums only.	No cost / no monthly premium.
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.

**Excerpted from Legal Aid Overview of GMC and VHC program outline

[1] MABD: Medicaid for the Aged, Blind, and Disabled. [2] 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.

[3] MCA: Medicaid for Children and Adults PIL: Protected Income Limit. [4] FPL: Federal Poverty Level

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.[7] 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 utilization of generic drugs is 76%, and they represent 15% of gross costs;
  - More than 98% of generics are preferred on the PDL, with some exceptions when the net cost of the brand drug is lower;

[7] 33 V.S.A. § 1998

- Most generics do not require prior authorization.

- Brand Drugs
  - DVHA's overall utilization of brand drugs is 24%;
  - Brand drugs represent 85% 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 of these categories there may be drugs or drug classes that are subject to quantity limits to assure appropriate dosing and dose consolidation.

Generic Dispensing and Substitution Rates

The "generic dispensing rate" of 76% reflects the use of generics as a percentage of all drugs dispensed whereas the "generic substitution rate" of 79% reflects the percentage of time generics are utilized when a generic equivalent is available for a given drug. Chart 3 identifies these rates of dispensing for state fiscal years 2017 through 2019. Unlike commercial insurance and Part D plans, Medicaid generic utilization rates are typically somewhat lower since brands that lose patent protection are often more cost-effective for the State for a period after generics enter the market. This is especially true for the first six months to a year after patent expiration and is reflected in the use of "brand-preferred" products on the Department's PDL. Our generic dispensing rates dropped 3% in SFY2019 from 79% to 76%. This decline was mainly due to generic buprenorphine film entering the market, but DVHA continued to prefer the brand Suboxone film due to its **lower net cost**. Since this is the number one drug in terms of both gross

spend and numbers of prescriptions, it significantly affected the generic dispensing and substitution rates in SFY2019.

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 (Social Security Act 1927) 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.

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. 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. 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 2019 included: concurrent use of buprenorphine with opiates and/or benzodiazepines,

Sildenafil use without a pulmonary arterial hypertension diagnosis, evaluation of opioid prescribing for chronic pain, and medication adherence to anti-retroviral therapy for human immunodeficiency virus (HIV).

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 2019 activities of the Drug Utilization Review Board.

Drug Utilization Review Board Activities in 2019

Review Topic	SFY 2019 Total
Therapeutic Drug Classes: Periodic Review	43
Full New Drug Reviews	54
FDA Safety Alerts	10
New/Updated Clinical Guidelines	21
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 will continue to monitor manual and automated prior authorization volume and implement additional automated edits over the next few years. The goal continues to be reduced provider burden while assuring clinical and financial integrity of pharmacy programs. Chart 4 reports the incidence of prior authorization requests and denial rates for state fiscal year 2019. The total number of clinical prior authorizations declined by 14.7% in state fiscal year 2019. The decrease was due to the ongoing development of automated prior authorizations (e.g. medications used to treat Cystic Fibrosis) and the removal of prior authorizations (e.g. medications used to treat substance use disorders) for certain therapeutic classes. The overall prior authorization denial rate has remained relatively constant (between 22-25%) over the last several years.

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 2019, the following provider types were enrolled in the portal. The Department is continuing to perform provider outreach to maximize provider enrollment in the Portal.

Pharmacy Managers	27
Pharmacy Delegates	18
Prescribers	40
Prescriber Delegates	10
Total Providers with Access:	**95**

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 program updates the old paradigm of "the right drug to the right patient at the right time" to address this new era of pharmacotherapy with "the most appropriate drug taken correctly by the informed patient achieving optimal outcomes," representing a tremendous cultural change focused on patient-centered care. A very large percentage of patients fail to take their medications correctly, resulting in both inappropriate or inadequate treatment as well as substantial loss of financial resources. Incorrectly using medicines can have a negative impact on the well-being of the patient and the overall health care system; improving medication adherence is closely tied to attainment of the best clinical outcomes. 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

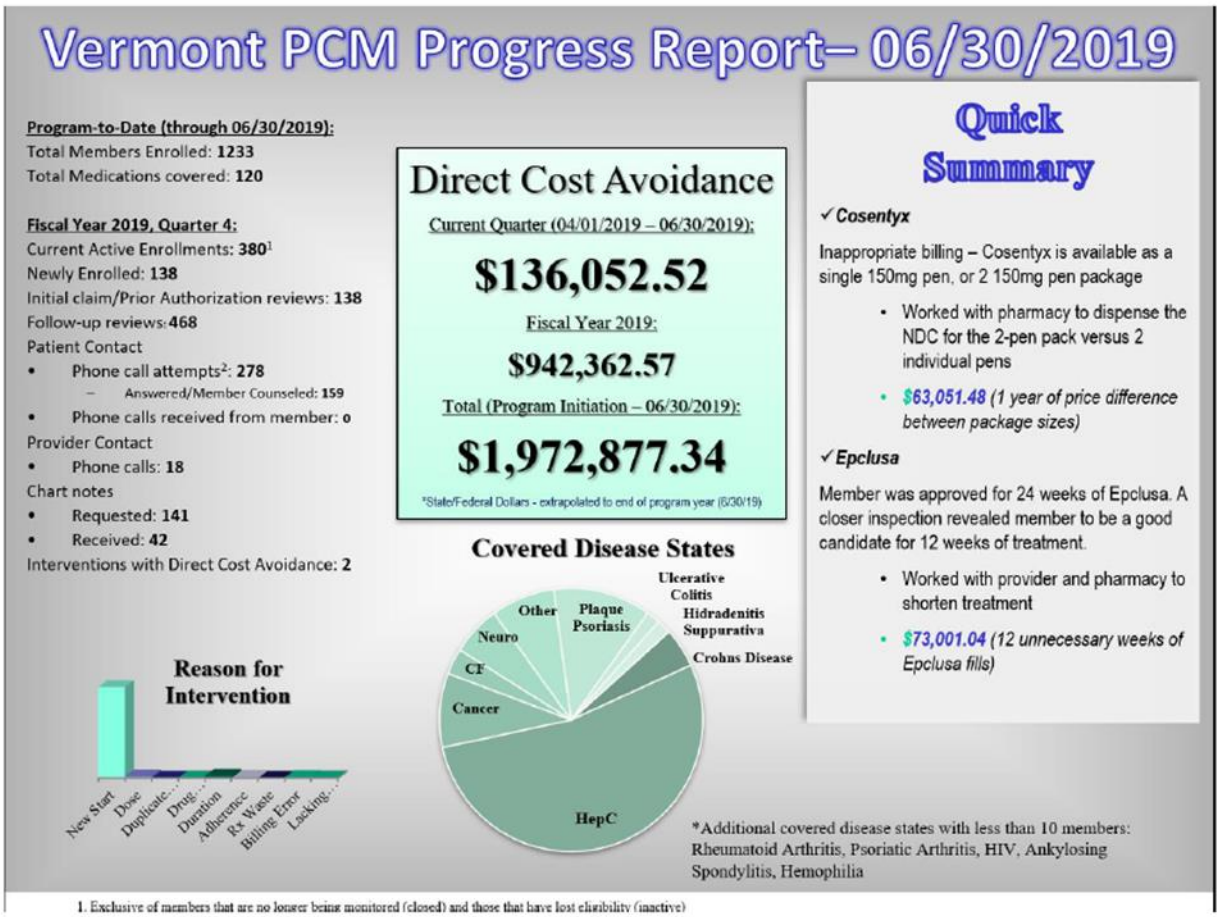
As part of this program, the Change Health Care pharmacist provides direct patient outreach, consultation and education to patients enrolled in the program. This includes reviewing the correct storage and proper dosage of the medication with the patient. Additionally, patients are educated on what to 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).

Provider Outreach and Coordination

The Program pharmacist provides direct outreach to prescribers and pharmacies to discuss the goals of therapy as well as the appropriateness of drug, dose, and duration of therapy and

follow up. The pharmacist works directly with prescribers to choose the most cost-effective treatment regimens for each patient with consideration of age, gender, co-morbidities and, when pertinent, biologic and genetic markers. In addition, they communicate directly with pharmacies to ensure that the medications are dispensed to the patients at the correct times and are billed appropriately. Prescribers are notified when a patient demonstrates poor adherence.



Outcomes

Through the appropriate utilization of high-cost drugs, clinical outcomes can be improved and medical expenditures can be reduced. To assess the overall impact of the Pharmacy Cost Management program, medical utilization data is collected, monitored and analyzed. While the program may have some impact on drug expenditures, significant value is achieved through reduced utilization of medical services (hospitalization, provider visits and ancillary services) and improvement in clinical outcomes and patients' qualify of life. To that end, the Vermont Medicaid Pharmacy Cost Management Program documented savings of $942,360 for the Department during state fiscal year 2019. The program currently has 380 active enrollments. Program interventions may not always result in direct drug cost avoidance; however, they are

in place to encourage adherence and ultimately improve member outcomes and avoid future health spending. The program continues to grow, identifying new members and including more specialty medications as they come to market and usage increases.

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 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.

After the implementation of the new pricing rules based on the National Average Drug Acquisition Cost (NADAC) in state fiscal year 2017, the number of claims pricing off Estimated Acquisition Cost (EAC) dropped from 21% to 0.5% as expected and claims being priced off

Actual Acquisition Cost (NADAC) rose from zero to 30%.[8] MAC rates rose from approximately 40% to 47% in state fiscal year 2019, while claims pricing off the Federal Upper Limit (FUL) dropped from 20% to zero due to the NADAC replacing the FUL. Essentially, this illustrates the shift from using a formula that estimates acquisition cost to one that more accurately reflects a pharmacy's acquisition cost. This change can be seen in Charts 5A and 5B.

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), Hepatitis C, Attention Deficit Hyperactivity Disorder (stimulants, amphetamines), inflammatory conditions such as Rheumatoid Arthritis and Crohn's Disease, Diabetes, Depression, and neuropathic pain disorders. 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 2018, 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 7% for state fiscal year 2019 and increased a total of 15.3% 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 38% and those using chronic opioids decreased by 44% over the last 2 fiscal years (Chart 11A). The number of prescriptions for short-acting and long-acting opioids declined by 35% and 38%, 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 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 program continues to be a system of care for improving access to medication assisted treatment for opioid use disorder.

[8] http://dvha.vermont.gov/for-providers/pharmacy-reimbursement-change-notice-draft-03132017.pdf

Of note, an increase in utilization of Mavyret and Concerta was observed from 2018-2019 which is due to changes in the preferred products on the PDL (Chart 8) for both the Hepatitis C drugs and 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 Categories by Gross Spend chart (Chart 7), it is important to keep in mind that the therapeutic category titled Hepatitis Agents includes treatments for Hepatitis B and Hepatitis C, although the vast majority of prescriptions and spend is related to Hepatitis C treatment. Please see below for further discussion of the Hepatitis C class of drugs.

Specialty Pharmacy

The list of specialty medications is updated quarterly and can be found on the DVHA website.[9] In addition, DVHA maintains a list of specialty pharmacies enrolled with the State.[10]
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 which 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
- Hereditary Angioedema
- Immune Deficiency
- Inflammatory Conditions (e.g. Crohn's, Ulcerative Colitis, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, and Psoriasis)

[9] http://dvha.vermont.gov/for-providers/specialtydrugweblist.pdf
[10] http://dvha.vermont.gov/for-providers/specialty-pharmacy-dvha-list-08102018.pdf

- Multiple Sclerosis
- Muscular Dystrophy
- Pulmonary Arterial Hypertension
- Respiratory Syncytial Virus (RSV)

DVHA defines a specialty pharmacy as outlined by the Academy of Managed Care Pharmacy (AMCP) in a recent publication entitled Format for Formulary Submission, version 3.1, 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 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." (NASP 2016)

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 2019, specialty drugs represented 25.5% of the Department's overall drug spend. This was a small increase of 1.3% over state fiscal year 2018, when specialty drug spend represented 24.2% of DVHA's drug spend. Chart 12 provides the 3-year gross trend.

The Pharmacy unit expects continued drug price growth due to trends in new, expensive specialty drugs. For example, the world's most expensive drug was approved in May 2019. Zolgensma is a one-time gene therapy for spinal muscular atrophy in infants and toddlers at a gross cost of $2.1 million dollars per treatment. To date, the Department has not received a request for this drug, but it is reasonable to expect some utilization in the future. In addition, there are several other very expensive drugs (often indicated for rare diseases) that have received FDA-approval and there are many in the approval pipeline. Some utilization of these new therapies has been observed and due to their high cost, even low utilization results in high spend. Recent data shows that Vermont Medicaid had utilization of a number of these costly new drugs for rare diseases including Emflaza for Duchenne muscular dystrophy, Crysvita for an inherited disorder characterized by low levels of phosphate in the blood, Palyniziq for phenylketonuria (PKU), and Epidiolex, a purified form of cannabidiol (CBD) for seizure disorders due to Dravet's or Lennox-Gastault syndrome. These products totaled approximately $575,000 in state fiscal year 2019.

Medicaid Net Prescription Drug Expenditure Forecast

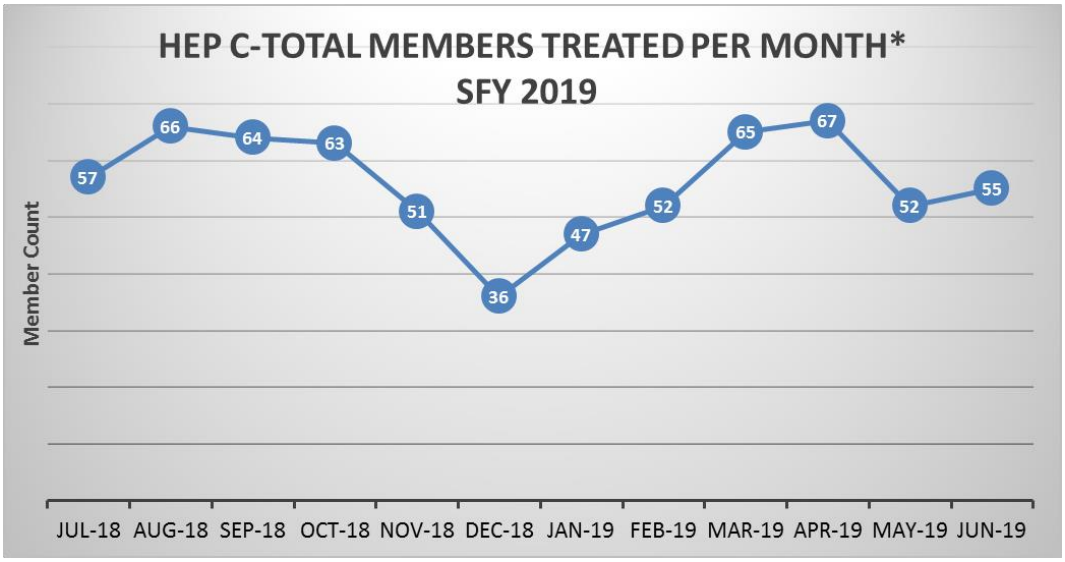
Prescription drug expenditures are forecasted to increase at about same rate as overall Medicaid expenditures (CMS' National Health Expenditure (NHE) Projections). According to the National Health Expenditure projections for state fiscal years 2020 and 2021, the Medicaid prescription drug expenditure trend is projected to increase between 5.6% - 6.8% per year. 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. Additionally, increased utilization of the Non-Vitamin K Oral Anticoagulants (NOAC) is expected 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 10 percent. This is due to an increase in overall prescribing and increased utilization of new higher cost interleukin agents. Net spend for oncology drugs is projected to increase about 11% each year as

utilization of newer products with expanded indications continues to increase. 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 almost 10% per year as utilization shifts away from older multiple-tablet regimens to newer single-tablet regimens. Finally, an increase in net spend for diabetes, of about 8% in state fiscal year 2020, is expected due to a shift to new higher cost drugs often used in combination for both type 1 and type 2 diabetes.

Hepatitis C Drugs

Direct Acting Antivirals are very effective drugs and competition has driven the cost down considerably. The Pharmacy unit continues to observe more people treated for Hepatitis C Virus (HCV) and a significant financial impact. There were two Direct Acting Antivirals (DAA) for treating Hepatitis C on the top 10 list by Gross Spend, Mavyret and Epclusa. Harvoni is no longer a preferred drug and was replaced by Mavyret toward the middle of state fiscal year 2018 and into state fiscal year 2019. 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=2 or more 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. Direct Acting Antivirals continue to be high on the Top Therapeutic Categories by gross spend list. These drugs are a focus of Pharmacy Cost Management program services in order to facilitate patient follow-up and support medication adherence, ultimately enabling the best clinical outcomes.

Although the Hepatitis C antiviral drug prescription count and gross spend declined in state fiscal year 2019 (Chart 7), the data is misleading: the number of patients treated is actually increasing over time. The decrease in prescriptions is due to a policy change late in 2018 (previously, two 14-day prescriptions as a starting course of therapy were required; this changed to one 28-day prescription). The policy change decreased the overall prescription count but not the number of capsules or tablets dispensed. In addition, the preferred product Mavyret had a lower wholesale acquisition cost, so payments to the pharmacy were lower overall. Thus, spend looks lower on a gross basis. The number of unique members utilizing Direct Acting Antivirals for treatment of Hepatitis C actually increased from **267** in state fiscal year 2018 to **348** in state fiscal year 2019 (Chart 16).



*Most members are counted in more than one month depending on length of treatment

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 and test strips) 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 and represented its membership for the first rebate calendar year (RCY) of 2006. Utah enrolled as of RCY 2007 followed by Wyoming in RCY 2008; West Virginia and Oregon in RCY 2009; Mississippi in RCY 2012; North Dakota in RCY 2015; Delaware and Ohio in RCY 2016; and the newest member, Oklahoma, enrolled as of RCY 2017. Due to the success of the SSDC, it is now the largest and only independent, state-owned rebate pool in the country. The 12 states, as of rebate calendar year 2019, 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 Annual Drug Spend

In 2019, a total of 7.2 million members, and nearly $7 billion in drug expenditures is represented by the 12 participating states providing substantial leverage in manufacturer negotiations.

State	PDL Lives*	Annual Medicaid Drug Spend
DE	247,278	$208,000,000
IA	618,000	$350,000,000
ME	265,000	$251,738,192
MS	760,000	$457,865,178
ND	90,000	$72,002,188
OH	2,385,000	$3,830,000,000
OK	830,361	$554,157,830
OR	985,195	$164,367,199
UT	308,700	$124,000,000
VT	158,000	$194,748,701
WV	500,447	$619,071,643
WY	84,785	$49,445,160
TOTAL	**7,232,766**	**$6,875,396,091**

*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, 2019

COST AND UTILIZATION CHARTS

Chart 1A: Pharmacy Claims and Gross and Net Spend, SFY 2017-2019 (All Programs)

ALL PHARMACY CLAIMS

SFY	CLAIMS PAID	% CHANGE CLAIMS PAID	GROSS AMOUNT PAID	% CHANGE GROSS AMOUNT PAID	GROSS COST PER CLAIM	% CHANGE GROSS COST PER CLAIM	NET AMOUNT PAID	NET AMOUNT PAID % CHG	NET COST PER CLAIM	% CHANGE NET COST PER CLAIM
2019	2,010,107	-2.77%	$ 198,783,933	0.82%	$98.89	3.69%	$ 71,799,969	4.74%	$35.72	7.72%
2018	2,067,382	-2.22%	$ 197,174,623	1.32%	$95.37	3.62%	$ 68,552,038	-6.28%	$33.16	-4.16%
2017	2,114,280		$ 194,600,997		$92.04		$ 73,147,304		$34.60	

MEDICAID CLAIMS (includes Duals)

SFY	CLAIMS PAID	% CHANGE CLAIMS PAID	GROSS AMOUNT PAID	% CHANGE GROSS AMOUNT PAID	GROSS COST PER CLAIM	% CHANGE GROSS COST PER CLAIM	NET AMOUNT PAID	NET AMOUNT PAID % CHG	NET COST PER CLAIM	% CHANGE NET COST PER CLAIM
2019	1,693,497	-2.35%	$ 193,198,884	0.99%	$114.08	3.42%	$ 70,194,490	4.79%	$41.45	7.31%
2018	1,734,254	-1.41%	$ 191,311,440	1.52%	$110.31	2.97%	$ 66,984,199	-6.47%	$38.62	-5.13%
2017	1,759,012		$ 188,448,212		$107.13		$ 71,617,246		$40.71	

VPHARM CLAIMS

SFY	CLAIMS PAID	% CHANGE CLAIMS PAID	GROSS AMOUNT PAID	% CHANGE GROSS AMOUNT PAID	GROSS COST PER CLAIM	% CHANGE GROSS COST PER CLAIM	NET AMOUNT PAID	NET AMOUNT PAID % CHG	NET COST PER CLAIM	% CHANGE NET COST PER CLAIM
2019	316,610	-4.96%	$ 5,585,049	-4.74%	$17.64	0.23%	$ 1,605,478	2.40%	$5.07	7.74%
2018	333,128	-6.23%	$ 5,863,183	-4.71%	$17.60	1.63%	$ 1,567,839	2.47%	$4.71	9.28%
2017	355,268		$ 6,152,785		$17.32		$ 1,530,059		$4.31	

Note: Net spend is based on rebates invoiced, not rebates collected. 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

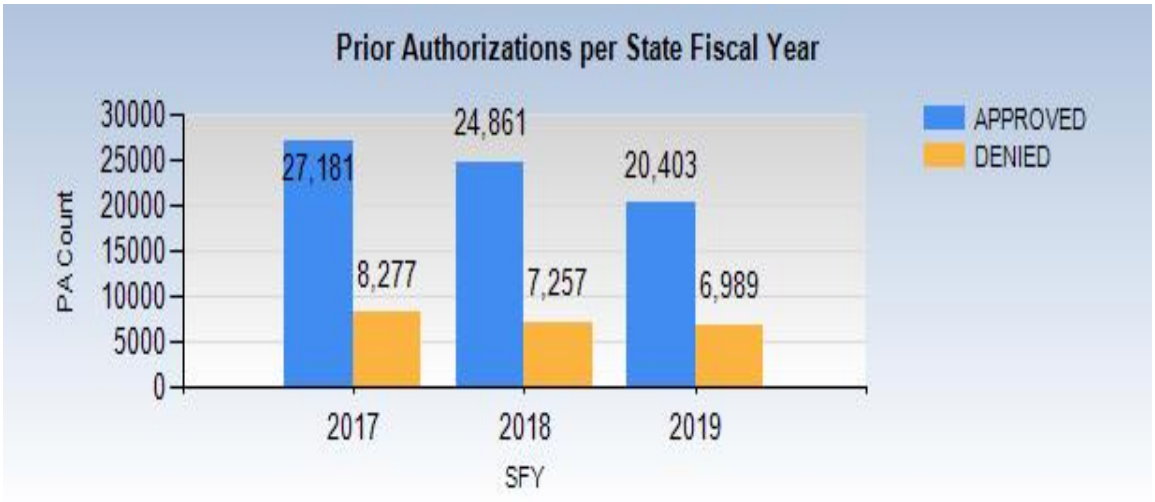
ALL	2017	2018	2019
Medicaid and Duals Eligible All Ages	172,951	167,008	161,264
Medicaid and Duals Utilizers All Ages	51,965	50,946	49,112
Medicaid and Duals Utilization Percent All Ages	30%	31%	30%
ADULTS			
Medicaid and Duals Eligible Adults	109,235	103,882	99,434

Medicaid and Duals Utilizers Adults	38,660	37,645	36,372
Medicaid and Duals Utilization Percent Adults	35%	36%	37%
CHILDREN			
Medicaid and Duals Eligible Children	63,715	63,126	61,829
Medicaid and Duals Utilizers Children	13,305	13,300	12,740
Medicaid and Duals Utilization Percent Children	21%	21%	21%

Chart 3: Generic Usage Rate (SFY 2017-2019)

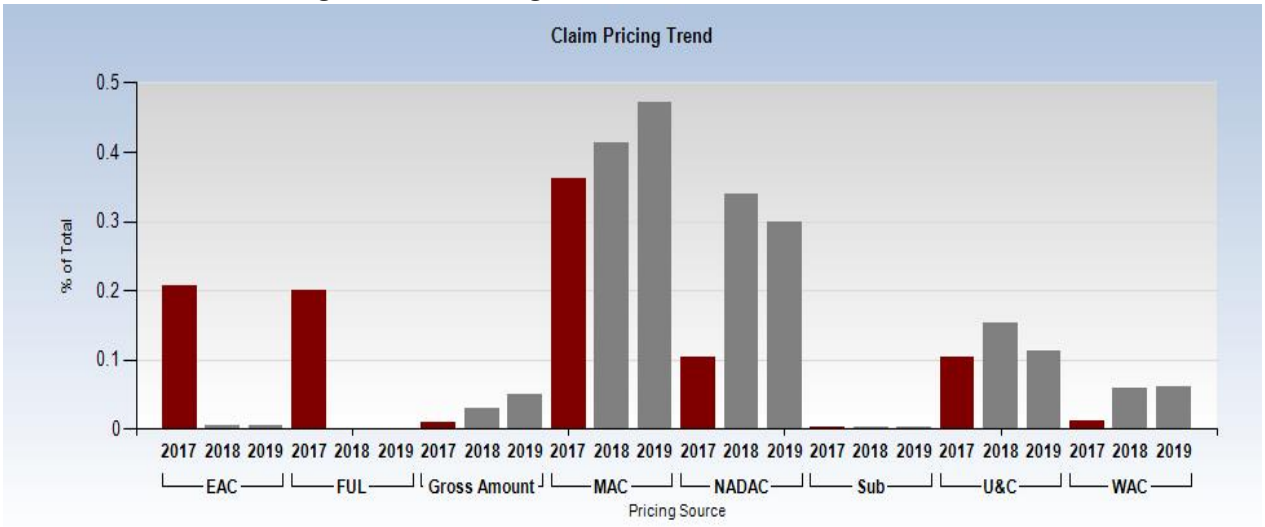
Generic Indicator	2017	2018	2019
Generic use as a percentage of prescriptions for all drugs dispensed	**79%**	**79%**	**76%**
Generic use as a percentage of prescriptions when a generic equivalent is available	**88%**	**88%**	**79%**

Chart 4: Prior Authorization Summary



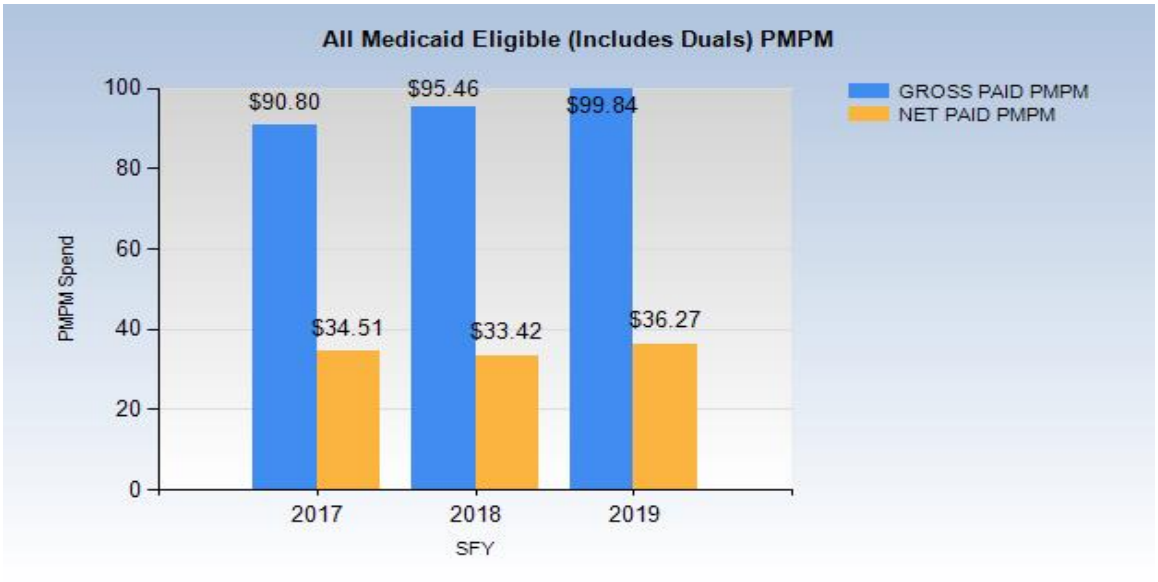
SFY	PA DENIAL RATE
2017	23.3%
2018	22.6%
2019	25.5%

Chart 5A and 5B: Pricing Source of Drugs



PRICING SOURCE CODE	2017	2018	2019
EAC (AWP)	20.7%	0.5%	0.5%
FUL	20.0%	0.0%	0.0%
Gross Amount Due	1.0%	3.0%	5.1%
SMAC	36.3%	41.4%	47.2%
NADAC	10.4%	33.9%	29.8%
U&C	10.3%	15.3%	11.4%
WAC	1.1%	5.9%	6.1%

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



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

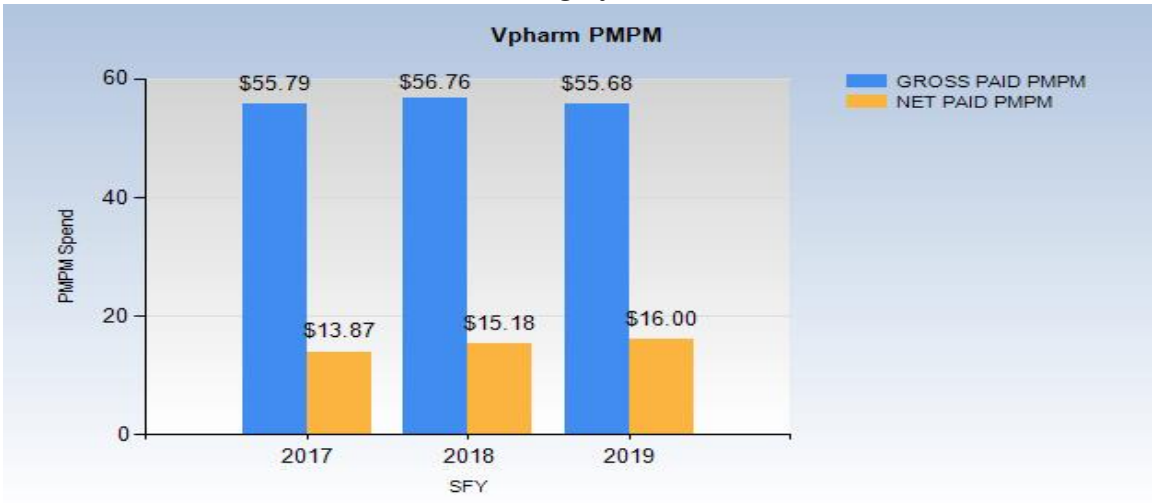


Chart 7: Top Therapeutic Classes by Gross Spend

Therapeutic Class/Treatment Category	2018 Gross Paid	2019 Gross Paid	2018 Claim Count	2019 Claim Count	Total Amount Paid Change	Claim Count Change
Opioid Partial Agonists/Substance Use Treatments	$14,060,327.98	**$16,379,462.54**	125,547	**134,425**	16.49%	7.07%
Insulin	$11,838,049.18	**$11,769,343.54**	15,512	**14,344**	-0.58%	-7.53%
Hepatitis Agents	$12,006,594.10	**$11,648,986.09**	877	**866**	-2.98%	-1.25%
Stimulants - Misc. ADHD	$10,558,556.36	**$11,141,916.52**	49,854	**49,545**	5.52%	-0.62%
Sympathomimetics-Asthma/COPD	$10,191,297.89	**$10,112,483.26**	65,748	**64,062**	-0.77%	-2.56%
ANTI-TNF-ALPHA - Monoclonal Antibodies - Rheumatoid Arthritis, UC, Crohn's	$9,174,851.15	**$9,806,107.95**	1,737	**1,707**	6.88%	-1.73%
Amphetamines- ADHD	$11,645,403.64	**$9,000,804.02**	55,244	**55,851**	-22.71%	1.10%
Anticonvulsants - MISC.	$7,101,943.51	**$7,559,343.31**	68,919	**69,350**	6.44%	0.63%
Cystic Fibrosis Agents	$4,735,130.36	**$5,468,797.13**	561	**613**	15.49%	9.27%
Antiretrovirals – HIV Tx	$5,140,765.56	**$5,339,306.93**	2,627	**2,373**	3.86%	-9.67%

Chart 8: Top Drugs by Gross Spend

Current Rank	Previous Rank	Drug Name	2018 Gross Paid	2019 Gross Paid	2018 Claim Count	2019 Claim Count	Total Amount Paid Change	Claim Count Change
1	1	Suboxone	$13,299,728.80	$15,387,788.47	108,601	116,996	15.70%	7.73%
2	2	Humira pen	$7,908,683.77	$8,166,550.96	1,503	1,445	3.26%	-3.86%
3	3	Vyvanse	$6,596,885.71	$6,857,566.30	25,003	25,058	3.95%	0.22%
4	14	Mavyret	$2,769,889.60	$5,954,012.94	320	531	114.95%	65.94%
5	5	Epclusa	$5,050,470.01	$5,283,168.50	289	237	4.61%	-17.99%
6	122	Concerta	$249,724.37	$4,653,349.87	734	12,954	1763.39%	1664.85%
7	7	Lyrica	$4,113,534.19	$4,311,692.88	7,485	7,769	4.82%	3.79%
8	8	Lantus Solostar	$3,762,649.25	$3,837,683.60	6,120	5,667	1.99%	-7.40%
9	10	Focalin XR	$3,323,642.48	$3,662,659.68	8,571	8,785	10.20%	2.50%
10	11	Proair HFA	$3,043,919.31	$3,136,432.05	39,287	37,778	3.04%	-3.84%

Chart 9: Top Therapeutic Classes by Utilization

Therapeutic Class	2018 Gross Paid	2019 Gross Paid	2018 Claim Count	2019 Claim Count	Total Amount Paid Change	Claim Count Change
Opioid Partial Agonists/Substance Abuse Treatments	$14,060,327.98	$16,379,462.54	125,547	134,425	16.49%	7.07%
Selective Serotonin Reuptake Inhibitors (SSRIS)-Antidepressants	$1,318,939.89	$1,303,556.52	87,210	84,029	-1.17%	-3.65%
Anticonvulsants – Misc.	$7,101,943.51	$7,559,343.31	68,919	69,350	6.44%	0.63%
Sympathomimetics-Asthma/COPD	$10,191,297.89	$10,112,483.26	65,748	64,062	-0.77%	-2.56%
Amphetamines -ADHD	$11,645,403.64	$9,000,804.02	55,244	55,851	-22.71%	1.10%
Stimulants – Misc.-ADHD	$10,558,556.36	$11,141,916.52	49,854	49,545	5.52%	-0.62%
Antihistamines –Non-Sedating	$469,588.44	$426,727.14	37,199	35,903	-9.13%	-3.48%
Opioid Agonists- Acute and Chronic Pain	$2,063,918.56	$1,547,520.24	42,817	34,916	-25.02%	-18.45%
Nonsteroidal Anti-Inflammatory Agents (NSAIDS)	$672,130.06	$577,450.91	39,536	34,396	-14.09%	-13.00%
Proton Pump Inhibitors - Acid Reflux/GERD	$2,412,597.67	$1,669,897.20	35,241	33,502	-30.78%	-4.93%

Chart 10: Top Drugs by Utilization

Current Rank	Previous Rank	Drug name	2018 Gross Paid	2019 Gross Paid	2018 Claim Count	2019 Claim Count	Total Amount Paid Change	Claim Count Change
1	1	Suboxone	$13,299,728.80	$15,387,788.47	108,601	116,996	15.70%	7.73%
2	2	Proair HFA	$3,043,919.31	$3,136,432.05	39,287	37,778	3.04%	-3.84%
3	4	Gabapentin	$531,296.51	$531,858.63	30,834	31,288	0.11%	1.47%
4	30	Amphetamine/Dextroampheta	$393,469.64	$1,497,103.46	12,618	28,016	280.49%	122.03%
5	5	Vyvanse	$6,596,885.71	$6,857,566.30	25,003	25,058	3.95%	0.22%
6	3	Methylphenidate HCL	$5,356,621.93	$1,820,083.70	35,816	22,610	-66.02%	-36.87%
7	7	Bupropion HCL	$562,296.01	$475,079.32	23,105	22,539	-15.51%	-2.45%
8	6	Amoxicillin	$286,594.17	$271,007.18	23,628	22,538	-5.44%	-4.61%
9	8	Omeprazole	$313,749.39	$273,002.12	21,924	20,360	-12.99%	-7.13%
10	10	Fluoxetine HCL	$223,034.24	$214,845.55	19,048	17,877	-3.67%	-6.15%

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

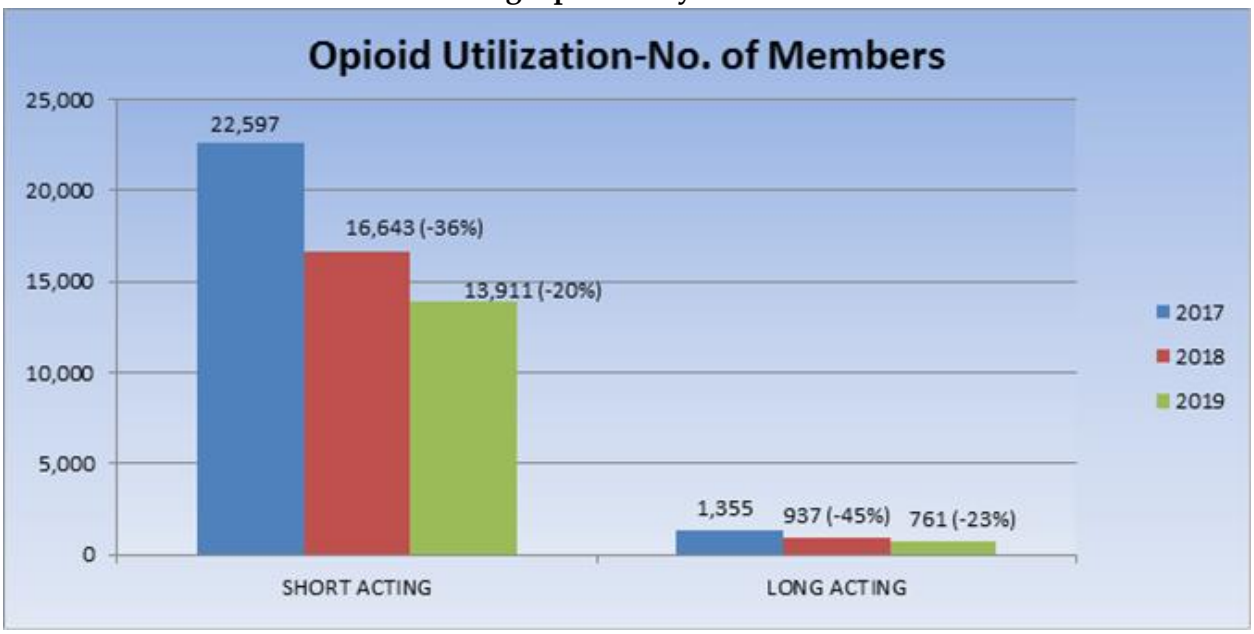


Chart 11B: Number of Prescriptions for Opioids: 3-yr Trend

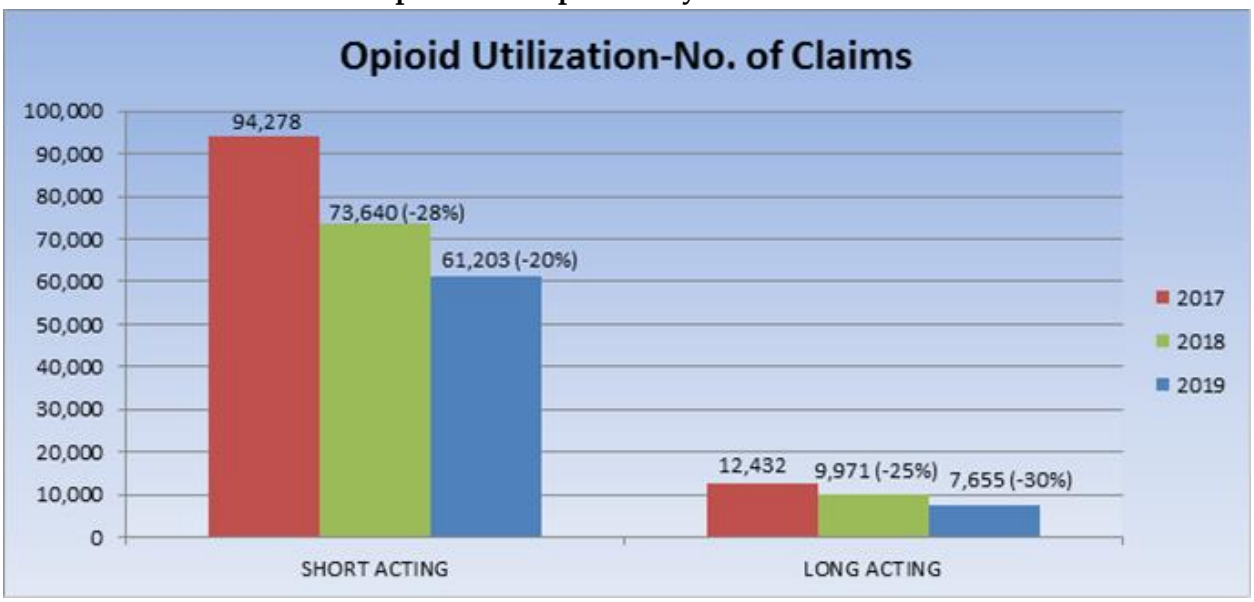


Chart 12: Specialty Drugs as a Percent of Total Gross Drug Cost

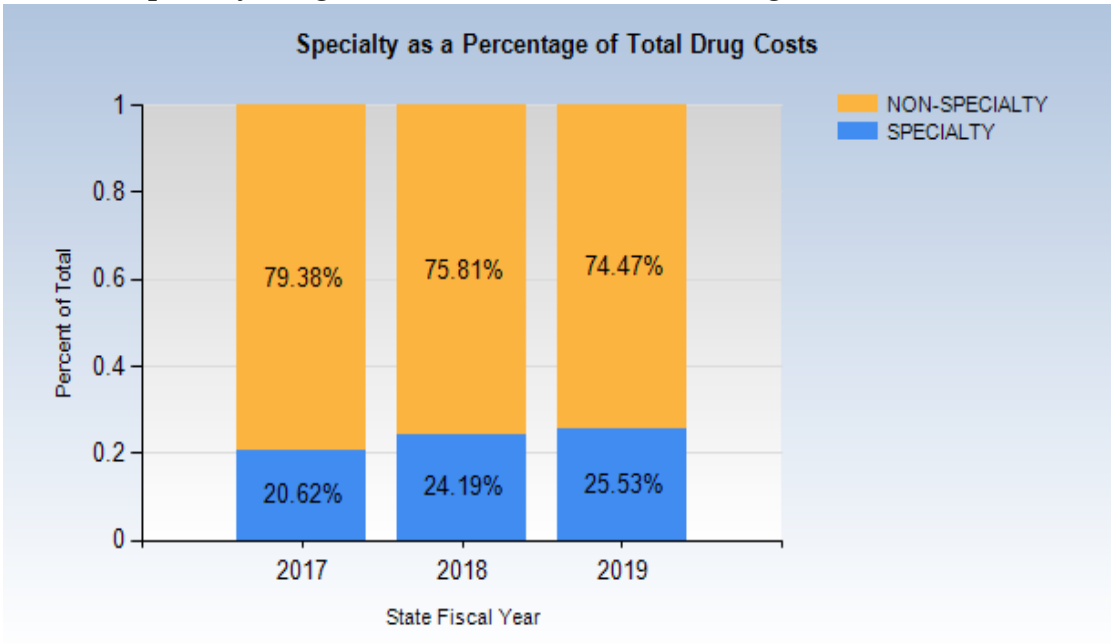


Chart 13: Specialty Drugs-Amount Paid

Chart 14: Specialty Drugs-Amount Paid Per Prescription

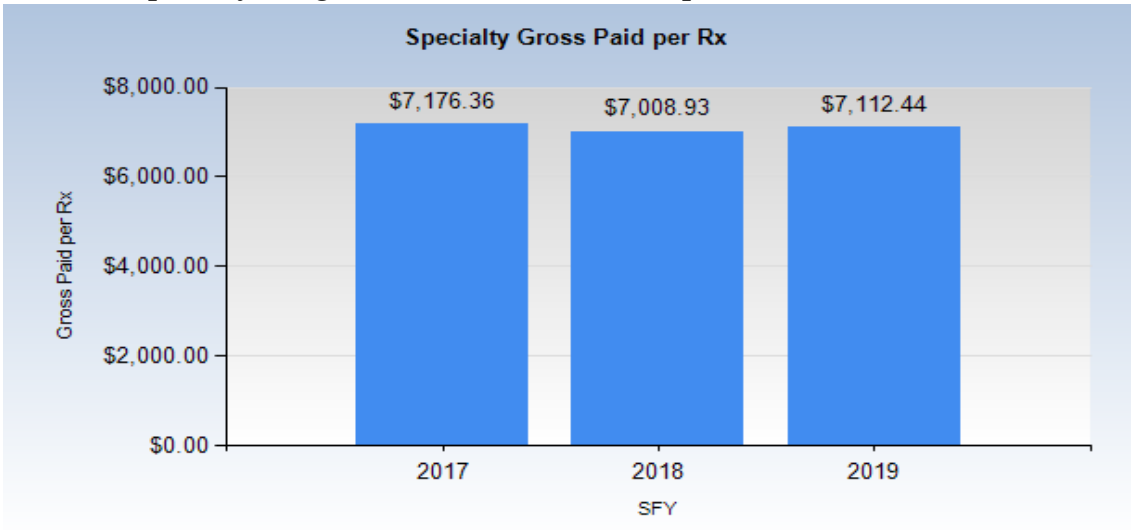


Chart 15: Top 10 Oral Cancer Drugs by Spend*

Drug Name	2018 RX Count	2019 RX Count	Claim Count Change	2018 Distinct Members	2019 Distinct Members	Distinct Member Change	2018 Gross Paid	2019 Gross paid	Gross Paid Change
Revlimid	39	44	12.82%	8	8		$449,101	$610,622	35.97%
Imbruvica	39	49	25.64%	6	6		$415,250	$541,464	30.39%
Ibrance	27	46	70.37%	3	6	100.00%	$290,461	$483,364	66.41%
Sprycel	30	52	73.33%	4	8	100.00%	$252,142	$463,352	83.77%
Jakafi	32	39	21.88%	3	4	33.33%	$342,398	$417,298	21.88%
Afinitor	18	24	33.33%	4	2	-50.00%	$251,009	$365,371	45.56%
Zytiga	25	28	12.00%	4	3	-25.00%	$240,217	$283,469	18.01%
Cabometyx	10	17	70.00%	2	2		$141,628	$277,026	95.60%
Pomalyst	15	18	20.00%	4	2	-50.00%	$214,652	$254,236	18.44%
Rydapt	3	8	166.67%	1	2	100.00%	$93,580	$231,468	147.35%

*Includes pharmacy benefit spend only

Chart 16: Hepatitis C Direct Acting Antivirals*

Drug Name	2018 RX Count	2019 RX Count	% Change	2018 Unique Members	2019 Unique Members	% Change	2018 Total Paid	2019 Total Paid	%Change
Mavyret	320	531	65.94%	123	246	100.00%	$2,769,890	$5,954,013	114.95%
Epclusa	289	237	-17.99%	83	90	8.43%	$5,050,470	$5,283,169	4.61%
Vosevi	14	10	-28.57%	4	4		$249,396	$200,632	-19.55%
Zepatier	19	20	5.26%	6	7	16.67%	$257,767	$183,543	-28.80%
Harvoni	164	0		51	0		$3,657,474	$0	
Totals:	**806**	**799**	**-0.87%**	**267**	**348**	**30.34%**	**11,984,997**	**11,6221,356**	**-3.03%**

*** Please review discussion on Pages 19-20 of this Report.**

Chart 17: Rebates Invoiced: All Programs

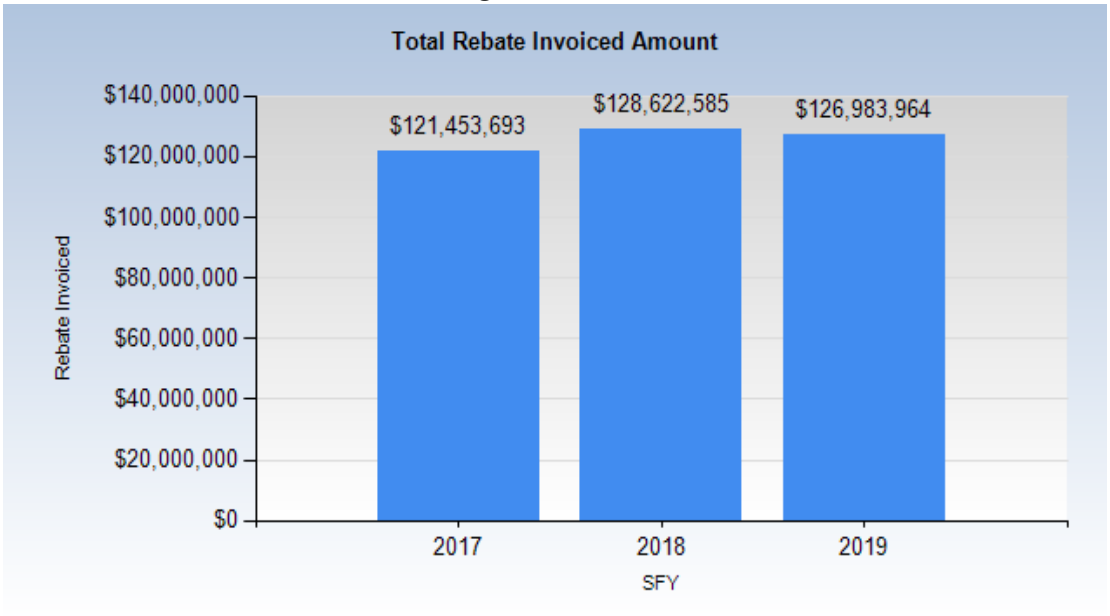


Chart 18: Rebates as a Percent of Spend: All Programs

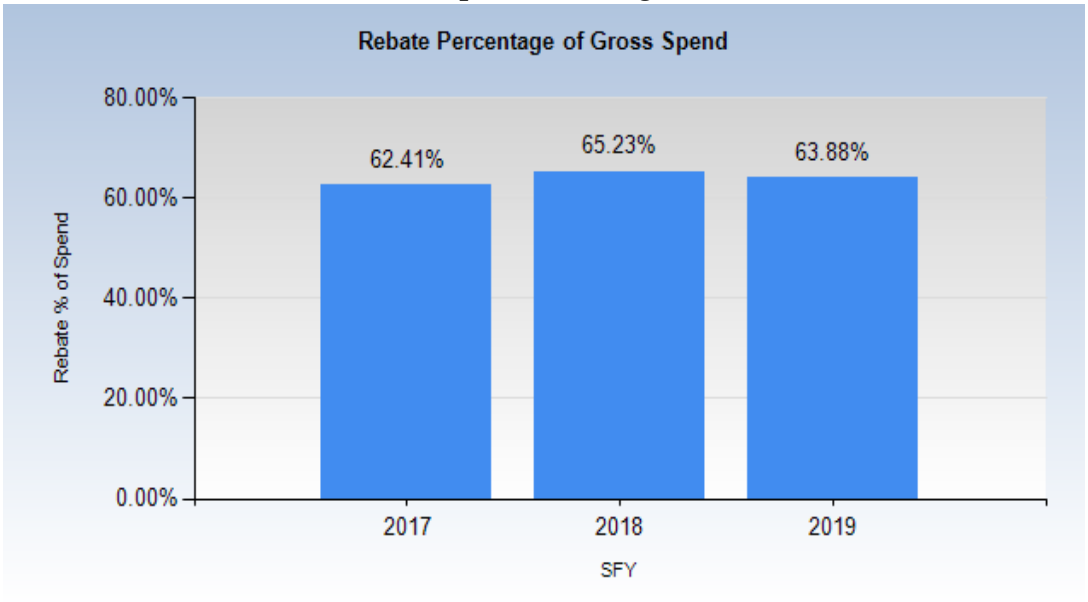


Chart 19: Federal Rebates Invoiced

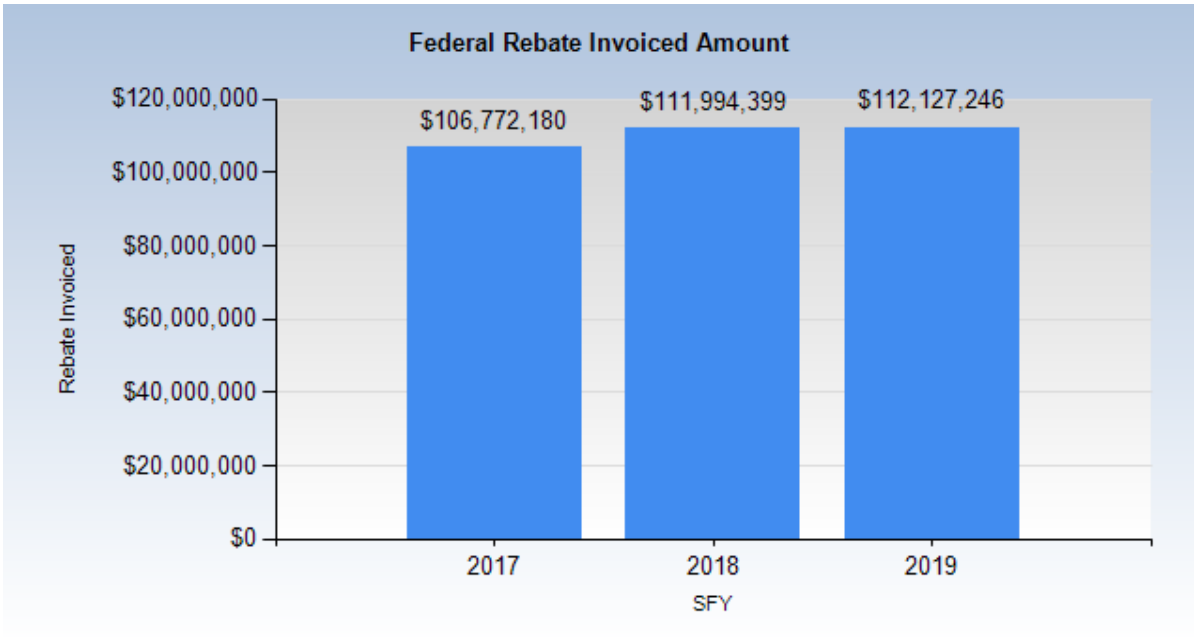
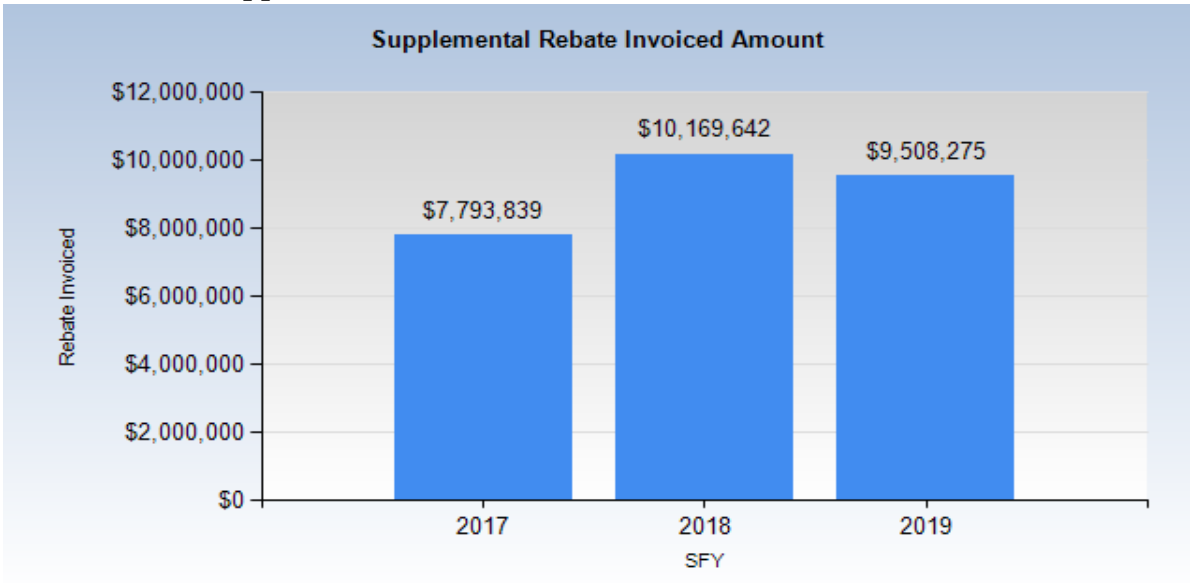


Chart 20: Total Supplemental Rebates Invoiced



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