

TABLE OF CONTENTS

SECTION 1: INTRODUCTION	1-1
SECTION 2: THE MEDICAID PROGRAM	2-1
Medicaid Program Overview	2-3
- Total Medicaid Eligibles by Maintenance Assistance Status, 2003.....	2-11
- Total Medicaid Eligibles by Age Group, 2003.....	2-12
- Total Medicaid Eligibles by Gender, 2003.....	2-13
- Total Medicaid Eligibles by Race/Ethnicity 2003.....	2-14
- Total Medicaid Eligibles by Basis of Eligibility, 2003	2-15
- Total Medicaid Eligibles by per 1000 Population, 2003	2-16
- Total Net U.S. Medical Assistance Expenditures by Type of Service, FY 2003 and FY 2004	2-17
- Federal Medical Assistance Percentages (FMAP), FY 2006 and FY 2007	2-18
- Medicaid Total Net Expenditures and Eligibles, 2003	2-19
- Total Medicaid Program Expenditures, 2004	2-20
- Total SCHIP Enrollment, 2004	2-21
- Total SCHIP Enrollment, 2005	2-22
- Total SCHIP Expenditures, 2004	2-23
- Total Medicaid/Medicare Dual Eligibles by Dual Eligibility Type, 2003	2-24
- Total Medicaid Medical Vendor Payments and Dual Eligibility Status, 2003	2-26
Medicaid Managed Care Enrollment	2-29
- Medicaid Managed Care Enrollment, As of June 30, 2005.....	2-31
- Pharmaceutical Benefits Under Managed Care Plans	2-32
- Medicaid Managed Care Enrollment Trends, 2000-2005	2-33
- Medicaid Managed Care Plan Type, As of June 30, 2005	2-34
- Medicaid Managed Enrollment by Plan Type, As of June 30, 2005.....	2-35
- Medicaid Managed Care Enrollment by Payment Arrangement, As of June 30, 2005	2-36
Medicaid Managed Care Waivers	2-37
- Section 1915(b) and 1115 Waivers	2-39
SECTION 3: STATE CHARACTERISTICS	3-1
- Age Demographics, 2005	3-5
- Race Demographics, 2005	3-6
- Hispanic Demographics, 2005	3-7
- Insurance Status-Populations, 2005	3-8
- Insurance Status-Percentages, 2005	3-9
- Poverty Status-Populations, 2005.....	3-10
- Poverty Status-Percentages, 2005.....	3-11
- Employment Status, 2005.....	3-12
- Medicaid/Medicare Certified Facilities, 2004/2006.....	3-13
- Licensed Pharmacies, As of June 30, 2005	3-14
- Physicians, 2004	3-16
- Other Providers, 2004/2005	3-17

SECTION 4: PHARMACY PROGRAM CHARACTERISTICS.....	4-1
The Medicaid Drug Program.....	4-3
- Drug Expenditures Trends, 2003-2004	4-5
- Ranking Based on Drug Expenditures, 2003-2004	4-6
- Drugs as a Percentage of Total Net Expenditures, 2004	4-7
- Drugs as a Percentage of Total Net Expenditures, 2002-2004.....	4-8
- Drug Expenditures by Category, 2003	4-9
- Prescriptions Processed by Category, 2003.....	4-12
- Medicaid Average Cost per Prescription, 2003.....	4-15
- Drug Expenditures by Category, 2004	4-16
- Prescriptions Processed by Category, 2004.....	4-19
- Medicaid Average Cost per Prescription, 2004.....	4-22
- Drug Expenditures by Category, 2005	4-23
- Prescriptions Processed by Category, 2005.....	4-26
- Medicaid Average Cost per Prescription, 2005.....	4-29
Medicaid Drug Rebates	4-31
- Medicaid Drug Rebates, 2004	4-32
- Medicaid Drug Rebate Trends, 2000-2004	4-33
- Medicaid Drug Rebate Trends, Annual Percent Change, 1999-2004	4-34
- Rebates as a Percent of Drug Expenditures, 2004.....	4-35
Medicaid Drug Coverage	4-37
- Pharmacy Advisory Committees	4-39
- Pharmacy Benefit Design – Coverage.....	4-40
- Coverage of Injectables	4-43
- Coverage of Vaccines and Unit Dose.....	4-44
- Coverage of Over-the-Counter Medications	4-45
- Prior Authorization Process and Procedures	4-47
- Prior Authorization.....	4-50
- Drug Utilization Review.....	4-53
- Prescribing/Dispensing Limits	4-54
Pharmacy Payment and Patient Cost Sharing.....	4-55
- Pharmacy Payment and Patient Cost Sharing.....	4-56
- Maximum Allowable Cost (MAC) Programs.....	4-57
- Mandatory Substitution	4-58
- Counseling Requirements and Payment for Cognitive Services	4-59
- Prescription Price Updating.....	4-60
 SECTION 5: STATE PHARMACY PROGRAM PROFILES	 5-1
 SECTION 6: STATE PHARMACY ASSISTANCE PROGRAMS	 6-1
 APPENDIXES	
Appendix A: State and Federal Medicaid Contacts.....	A-1
Appendix B: Medicaid Program Statistics – CMS MSIS Tables	B-1
Appendix C: Medicaid Rebate Law.....	C-1
Appendix D: Federal Upper Limits for Multiple Source Products.....	D-1
Appendix E: Glossary	E-1

Section 1: Introduction

INTRODUCTION

The 2005/2006 edition of *Pharmaceutical Benefits under State Medical Assistance Programs* marks the 40th year that the National Pharmaceutical Council (NPC) has compiled and published one of the largest sources of information on pharmacy programs within the State Medical Assistance Programs (Title XIX) and expanded pharmacy programs for the elderly and disabled. Due to the hard work of a skilled team and countless contributors, the “Medicaid Compilation” has become a standard reference and invaluable resource in government offices, research libraries, consultancies, the pharmaceutical industry, numerous businesses, and policy organizations.

The data used to create each edition of the Compilation are assembled from numerous sources. The Compilation incorporates information on each State pharmacy program from an annual NPC survey of State Medicaid program administrators and pharmacy consultants, statistics from the Centers for Medicare and Medicaid Services (CMS), and information from other Federal agencies and organizations.

In order to give a better understanding of the content of the “Medicaid Compilation,” the information contained in this version of the book is summarized below by section:

- Section 2: Contains an overview of the Medicaid program (*which is current at press time and has not been revised to reflect any future changes that may result from the Deficit Reduction Act*), details about Medicaid managed care enrollment, including a breakdown by plan type and enrollment by plan type, and a synopsis of 1915(b) waivers and 1115 demonstrations.
- Section 3: Consists of sociodemographic statistics, by age, race, insurance, income, and employment, for the fifty States and the District of Columbia. Additionally, a description of the Medicaid certified facilities in each State, including the number of hospitals, skilled nursing facilities, and intermediate care facilities for the mentally retarded (ICFs-MR), home health agencies, and rural health clinics are presented.
- Section 4: Provides Medicaid pharmacy program characteristics, drawn largely from the 2005/2006 NPC annual survey of State pharmacy program administrators. In addition, this section provides Medicaid eligibility statistics from CMS for fiscal year 2003 and program expenditure data for fiscal years 2003 and 2004. Medicaid pharmacy programs are characterized by estimates of total expenditures, drug payments, drug benefit design, and pharmacy payment and patient cost sharing.
- Section 5: Contains detailed profiles of the States’ Medicaid pharmacy programs. This section contains a description of medical assistance benefits and eligibles, drug payments and recipients, benefit design, pharmacy payment and patient cost sharing, use of managed care, and State contacts.
- Section 6: Profiles State pharmaceutical assistance programs.

The book also contains a series of appendices. Appendix A features a list of State contacts, CMS regional offices and Medicaid program personnel. Appendix B provides a national level summary on total Medicaid program recipients by type of service for FY 2002 and FY 2003 and data on total number of drug recipients for each State and the nation as a whole for the period 1997-2003.

Appendix C provides the current Medicaid drug rebate law (*which is current at press time and has not been revised to reflect any future changes that may result from the Deficit Reduction Act*). Appendix D contains the list of CMS upper limits on multiple source products. Appendix E is a glossary and list of acronyms.

As we continue to update and discover data, we are able to improve the Compilation with new tables and sources that we believe enhance its overall significance to the user. These new tables and sources include:

- Data on Medicaid eligibles by gender and race/ethnicity;
- Total SCHIP enrollment by State;
- Information on the number of Medicaid/Medicare dual eligibles and Medicaid medical vendor payments for dual eligibles by State.

NPC gratefully acknowledges the cooperation and assistance of the many State and Federal program officials and their staffs. With their cooperation, we were able to achieve an 86 percent response rate to the 2005/2006 Survey. Unfortunately, not all States were able to submit revised/updated information. In such instances, we have incorporated the most recently available data from other sources. However, for these States, much of the information may reflect data that have been presented in previous versions of the Compilation.

We would also like to thank United BioSource Corporation and their subcontractor Total Compensation Solutions for administering the survey and compiling the information, as well as Linda Schofield and Kimberley Fox for their survey work of State pharmaceutical assistance programs. We hope you continue to find the information contained in this compilation useful and, as always, we welcome your suggestions and comments.

Gary Persinger
Vice President, Health Care Systems
National Pharmaceutical Council

Section 2: The Medicaid Program

MEDICAID PROGRAM OVERVIEW

Medicaid (Title XIX of the Federal Social Security Act) is a Federal-State funded program of national health assistance that provides health care coverage to certain individuals and families with low-incomes and resources. The 50 States, the District of Columbia, and Puerto Rico, Guam, Virgin Islands, American Samoa, and Northern Mariana Islands each operate medical assistance programs according to State or territorial rules and criteria that vary within a broad framework of Federal guidelines.

MEDICAID ELIGIBILITY

Medicaid Eligibility: Medicaid is a “means tested program for low-income individuals.” To qualify, a Medicaid recipient must not have “income” or “resources” that exceed the applicable limits prescribed in the law and regulations.

Every State, in order to receive Federal funding under Title XIX, must provide Medicaid benefits to certain “categorically needy” persons. These are the “mandatory” categorically needy. In addition, the State has the option of providing Medicaid benefits to certain additional categories of persons. These are the “optional” categorically needy. An additional category of Medicaid recipients that a State may choose to include in its program is the “medically needy.”

Mandatory Categorically Needy: There are numerous and detailed categories under which the “categorically needy” may qualify for Medicaid benefits. The principal categories of the mandatory categorically needy are:

- Low-income families with children;
- Recipients of Supplemental Security Income (SSI) for the Aged, Blind, and Disabled (this includes disabled children);
- Individuals qualified for adoption assistance agreements or foster care maintenance payments under Title IV-E of the Social Security Act;
- Qualified pregnant women;
- Newborn children of Medicaid-eligible women;
- Various categories of low-income children; and
- Certain low-income Medicare beneficiaries.

Optional Categorically Needy: These are groups of individuals who meet the characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. For example, in determining their incomes and resources, they are allowed to exclude certain kinds of income. The “optional categorically needy” include individuals who are aged, blind, disabled, caretaker relatives, and pregnant women who meet the SSI income and resources requirements but are not receiving SSI cash payments.

Medically Needy: The “medically needy” are those individuals who meet the definitional requirements described above, except that their income or resources exceed the limitations applicable to the categorically needy. These individuals can “spend down” to qualify. That is, they can deduct their medical bills from their income and resources until they meet the applicable income and resources requirements. Their Medicaid benefits can then begin.

Special Categories: The Medicaid statute also authorizes limited Medicaid benefits to special categories of individuals. In general, these are individuals whose income and resources would otherwise be too high to qualify for full Medicaid benefits under the regular provisions.

For example, a “Qualified Medicare Beneficiary” (QMB) is an individual who qualifies for Medicare Part A, whose income does not exceed 100 percent of the Federal poverty level, and whose resources do not exceed twice the SSI resource-eligibility standard. Medicaid coverage of QMBs is limited to payment of their Medicare cost-sharing charges, such as the Medicare premiums, coinsurance, and co-payment amounts.

Non-Eligibles: A State can include in its Medicaid program individuals who do not meet the statutory eligibility criteria. However, the State must pay the full costs for these individuals. There are no Federal matching payments.

MEDICAID SERVICES

Title XIX lists the many types of medical care that a State may select for inclusion into its Medicaid State Plan, thus qualifying for Federal matching payments. However, the law requires that certain basic benefits must be available to all “categorically needy” recipients. These services include:

- Inpatient and outpatient hospital services;
- Physician services;
- Medical and surgical dental services;
- Laboratory and X-ray services;
- Nursing facility services (for persons 21 years of age or older);
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21;
- Family planning services and supplies;
- Home health services for persons eligible for nursing facility services;
- Rural health clinic services and any other ambulatory services offered by a rural health clinic that are otherwise covered under the State Plan;
- Nurse-midwife services (to the extent authorized under State law);
- Pediatric and family nurse practitioners services; and
- Federally-qualified health center (FQHC) services and any other ambulatory services offered by an FQHC that are otherwise covered under the State Plan.

If a State chooses to include the “medically needy” population, the State Plan must provide, as a minimum, the following services:

- Prenatal care and delivery services for pregnant women;
- Ambulatory services to individuals under age 18 and individuals entitled to institutional services;
- Home health services to individuals entitled to nursing facility services; and
- If the State Plan includes services either in institutions for mental diseases or in intermediate care facilities for the mentally retarded (ICFs/MR), it must offer medically needy groups certain specified services provided to the categorically needy.

States may also receive Federal funding if they elect to provide other optional services. The most commonly covered optional services under the Medicaid program include:

- Clinic services;
- Services of ICFs/MR;
- Nursing facility services (children under 21 years old);
- Prescribed drugs;
- Optometrist services and eyeglasses;

- TB-related services for TB infected persons;
- Prosthetic devices; and
- Dental services.

States may provide home and community-based care waiver services to certain individuals who are eligible for Medicaid. The services to be provided to these persons may include case management, personal care services, respite care services, adult day health services, homemaker/home health aide, habilitation, and other services requested by the State and approved by CMS.

CHARACTERISTICS OF BENEFITS PROVIDED

Inpatient Hospital Services

Inpatient hospital services are those ordinarily furnished in a hospital for the care and treatment of inpatients. The facility is one maintained primarily for the care and treatment of patients with disorders other than mental diseases. There are several general Federal limitations on inpatient hospital services that apply to all States with Medicaid programs (42 CFR 440.10):

- The facility must be licensed or formally approved as a hospital by an officially designated authority for State standard setting;
- The facility must meet the requirements for participation in Medicare as a hospital;
- The care and treatment of inpatients must be under the direction of a physician or dentist; and
- The facility must have in effect an approved utilization review plan, applicable to all Medicaid patients, unless a waiver has been granted by the Secretary of Health and Human Services, because the State's own utilization review procedures are adequate.
- A peer review organization (PRO) may satisfy these requirements.

In addition to the Federal limitations, each State may impose further limitations on inpatient hospital services.

Outpatient Hospital Services

Outpatient hospital services refer to preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient. Three Federal limitations are imposed on these services, though States are free to specify other limits on outpatient hospital services and many have chosen to do so.

- The services must be provided under the direction of a physician or dentist;
- The facility must be licensed or formally approved as a hospital by an officially designated authority for State standard setting; and
- The facility must meet the requirements for participation in Medicare as a hospital.

Rural Health Clinic Services

Rural health clinic (RHC) services are a mandatory service for the categorically needy. Each RHC is required to have a nurse practitioner (NP) or physician's assistant (PA) on its staff. Therefore, a clinic can be certified to participate in the Medicaid program only if State law permits the delivery of primary care by an NP or PA.

Services in RHCs must be provided by a physician or by a PA, NP, nurse-midwife, or other specialized nurse practitioner. Services and supplies are furnished as "incident to" the professional services of such a practitioner are also covered. Part-time or intermittent visiting nurse services and related medical supplies are provided if the RHC is located in an area which the Department of Health

and Human Services (DHHS) has determined has a shortage of home health agencies, the services are furnished by nurses employed by the RHC, and the services are furnished to a homebound recipient under a written plan of treatment.

Other Laboratory and X-Ray Services

Other laboratory and X-ray services are professional and technical laboratory and radiological services. These services must be:

- Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined by State law, or ordered and billed by a physician but provided by an independent laboratory;
- Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and
- Provided by a laboratory that meets the requirements for participation in Medicare.
- In addition, the States can place limitations on “other laboratory and X-ray services.”

Nursing Facility Services

Nursing facility (NF) services are provided to individuals age 21 or older. They do not include services provided in institutions for mental diseases. These services must be needed on a daily basis and must be provided in an inpatient facility. Federal regulations require that the services be:

- Provided by a facility or a distinct part of a facility that is certified to meet the requirements for participation in the Medicaid program as a NF; and
- Ordered by and furnished under the direction of a physician.

Early and Periodic Screening, Diagnostic and Treatment Services

Early and periodic screening, diagnostic and treatment (EPSDT) refers to screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care, treatment and other measures to correct or ameliorate any defects and chronic conditions discovered (42 CFR 440.40(b)). Certain basic screening and treatment services must be provided by each State as a minimum (42 CFR 441.56). These services include:

Screening:

- Comprehensive health and developmental history screening;
- Comprehensive unclothed physical examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Appropriate laboratory tests;
- Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.

Diagnosis and Treatment:

In addition to any diagnostic and treatment services included in the State Medicaid Plan, the State must provide to eligible EPSDT recipients the following services, the need for which is indicated by screening, even if the services are not included in the Plan:

- Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids;
- Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and

- Appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to administer at the time of screening, then immunization treatment must be provided at that time.)

The State Medicaid agency may provide for any other medical or remedial care specified as a Medicaid service even if the agency does not otherwise provide for these services to other recipients or provides for them in a lesser amount, duration, or scope. This is an exception to the general rule that the amount, duration, and scope of benefits must be the same for all categorically eligible recipients, and reflects the importance attached to EPSDT services.

Family Planning Services

Federal Requirements: States are required to provide family planning services and supplies to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State Medicaid Plan and who desire such services and supplies. Specifically, family planning services must be made available to categorically needy Medicaid recipients, and the State has the option of furnishing these services to the medically needy.

Defined: The term “family planning services” is not defined in the law or in regulations. However, the Senate Report accompanying the law stresses Congress’ intent of placing emphasis on the provision of services to “aid those who voluntarily choose not to risk an initial pregnancy,” as well as those families with children who desire to control family size. In keeping with Congressional intent, the State may choose to include in its definition of Medicaid family planning services only those services which either prevent or delay pregnancy, *or* the State may more broadly define the term to include services for the treatment of infertility. However, the Medicaid definition must be consistent with overall State policy and regulation regarding the provision of family planning services.

The State is free to determine the specific services and supplies that will be covered as Medicaid family planning services as long as those services are sufficient in amount, duration, and scope to reasonably achieve their purpose. It must also establish procedures for identifying individuals who are sexually active and eligible for family planning services.

Federal Matching Payments: Federal Financial Participation (FFP) is available at the “enhanced” rate of 90 percent for the cost of family planning services. These include counseling services and patient education, examination and treatment by medical professionals in accordance with applicable State requirements, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception, and infertility services, including sterilization reversals.

FFP at the enhanced rate of 90 percent is also available for the cost of a sterilization if a properly completed sterilization informed consent form, in accordance with the requirements of 42 CFR Part 441, Subpart F, is submitted to the State prior to payment of the claim.

FFP at the 90 percent rate is *not* available for the cost of a hysterectomy or for the costs related to other procedures performed for medical reasons, such as removal of an intrauterine device due to infection. Only items and procedures clearly provided or performed for family planning purposes may be matched at the 90 percent rate. Transportation to a family planning service is not eligible for the 90 percent match. Transportation must be claimed as either an administrative cost or a State Plan service, in accordance with the State’s approved Medicaid State Plan.

Abortions: Abortions may *not* be claimed as a family planning service. For more than 20 years, Congressional restrictions have been placed on appropriated funds for DHHS programs that fund abortions. FFP is available only in expenditures for an abortion when a physician has found, and so certified in writing to the Medicaid agency, that on the basis of his/her professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient. Congress has prohibited the use of Federal funds for victims of rape or incest.

Voluntary Sterilizations: FFP is available in expenditures for the sterilization of an individual only if she is at least age 21, has voluntarily given informed consent in accordance with Medicaid regulations, and is not a mentally incompetent individual.

Physicians' Services

Physicians' services are covered, whether provided in the office, the patient's home, a hospital, a nursing facility, or elsewhere. Such services must be within the physicians' scope of practice of medicine or osteopathy as defined by State law, and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

Prescribed Drugs

Prescribed drugs are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, which are prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional practice, as defined and limited by Federal and State law (42 CFR 440.120). The drugs must be dispensed by licensed authorized practitioners on a written prescription that is recorded and maintained in the pharmacist's or the practitioner's records.

Home Health Services

Home health services are provided to a recipient at his or her place of residence. This does not include a hospital, nursing facility, or (ordinarily) an ICF/MR. Services provided must be on physicians' orders as part of a written plan of care that is reviewed by the physician every 60 days. Home health services include three mandatory services (part-time nursing, home health aide, medical supplies and equipment) and four optional services (physical therapy, occupational therapy, speech pathology, and audiology services) (42 CFR 440.70). These services are defined as follows:

- **Part-Time Nursing:** Nursing that is provided on a part-time or intermittent basis by a home health agency. If there is no home health agency in the area, services may be provided by a registered nurse who is currently licensed to practice in the State, receives written orders from the patient's physician, documents the care and services provided, and has had orientation to acceptable clinical and administrative record keeping from a health department nurse.
- **Home Health Aide:** Home health aide services provided by a home health agency.
- **Medical Supplies and Equipment:** Medical supplies, equipment, and appliances that are suitable for use in the home.
- **Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology and Audiology Services:** PT, OT, speech and hearing services provided by a home health agency or a facility licensed by the State to provide medical rehabilitation.
- Home health services are provided to categorically needy recipients age 21 and over and to those under 21 only if the State Plan provides SNF services for them.

Personal Support Services

Personal support services consist of a variety of services including personal care, targeted case management, home and community-based care for functionally disabled elderly, rehabilitative services, hospice services, and nurse-midwife, nurse practitioner, and private duty nursing. Details of some of these services are provided below:

1. **Personal Care Services:** Services provided to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally

retarded, or institution for mental disease. Services are authorized by a physician in accordance with a treatment plan, are provided by a qualified individual who is not a member of the recipient's family, and are furnished in a home or (at the State's option) in another location.

2. **Rehabilitative Services:** These services include any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts within the scope of State law. Services are for the maximum reduction of physical or mental disability and restoration of a recipient to their best possible functional level.
3. **Hospice Services:** Hospice services can be received in a hospice facility or elsewhere. Services are provided to terminally ill individuals by an authorized hospice program under a written plan established and reviewed by the attending physician, medical director or physician designee of the program, and an interdisciplinary group.

Nurse-Midwife Services

Nurse-midwife services are those concerned with management of the care of mothers and newborns throughout the maternity cycle. The Omnibus Budget Reconciliation Act of 1980 required that payment be made providing for nurse-midwife services to categorically needy recipients (42 CFR 440.165). These provisions require States to provide coverage for nurse-midwife services to the extent that the nurse-midwife is authorized to practice under State law or regulation. The statute also requires that States offer direct reimbursement to nurse-midwives as one of the payment options. Nurse-midwives must be registered nurses who are either certified by an organization recognized by the Secretary of DHHS or who have completed a program of study and clinical experience that has been approved by the Secretary.

Pediatric Nurse Practitioner and Family Nurse Practitioner Services

The Omnibus Budget Reconciliation Act of 1989 provides for the availability and accessibility of services furnished by a certified pediatric nurse practitioner (CPNP) or a certified family nurse practitioner (CFNP) to Medicaid recipients. These provisions require that services be covered to the extent that the CPNPs or CFNPs are authorized to practice under State law or regulation, regardless of whether they are supervised by or associated with a physician or other health care provider. States are required to offer direct payment to CPNPs and CFNPs as one of their payment options.

CPNP and CFNP certification requirements include a current license to practice as a registered nurse in the State, meet the applicable state requirements for qualification of pediatric nurse practitioners or family nurse practitioners, and be currently certified by the American Nurses' Association as a pediatric nurse practitioner or a family nurse practitioner.

Federally Qualified Health Center and Other Ambulatory Services

Medicaid programs must offer Federally Qualified Health Center (FQHC) services and other ambulatory services offered by an FQHC under the provisions of the Omnibus Budget Reconciliation Act of 1989. The definition of FQHC services is the same as that of the services provided by rural health clinics (RHC). FQHC services include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to services normally covered if furnished by a physician or if incident to a physician's services.

FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless. These centers may qualify as providers of service under Medicaid, under the following conditions:

- The facility receives a grant under sections 329, 330, or 340 of the Public Health Service Act;
- The Health Resources and Services Administration (HRSA) recommends, and the DHHS Secretary determines, that the facility meets the requirements of the grant; or
- The Secretary determines that a facility may qualify through waivers of the requirements. Such a waiver cannot exceed two years.

AMOUNT AND DURATION OF SERVICES

Within broad Federal guidelines and certain limitations, States may determine the amount and duration of services offered under their Medicaid programs. Federal regulations require that the amount and/or duration of each type of medical and remedial care and services furnished under a State's program must be specified in the State Plan, and that these types of care and services must be sufficient in amount, duration, and scope to "reasonably achieve" their purpose. States are required to provide Medicaid coverage for comparable amounts, duration, and scope of service to all "categorically needy" and categorically-related eligible persons.

Each State Plan must include a description of the methods that will be used to assure that the medical and remedial care and services delivered are of high quality, as well as a description of the standards established by the State to assure high quality care. The regulations also require that the fee structures developed must result in participation of a sufficient number of providers so that eligible persons can receive the medical care and services included in the Plan, at least to the extent that these are available to the general population. The law further requires that services provided under the Plan be available throughout the State. Recipients are to have freedom of choice with regard to where they receive their care, including an option to obtain their care through organizations that provide services or arrange for their availability on a prepayment basis, such as health maintenance organizations.

MEDICAID PAYMENT FOR SERVICES

The Medicaid program operates on the basis of a division of responsibilities between the Federal government and the States with the Federal government paying States for a portion of State medical expenditures and administrative costs. Funding for the program is shared between the two bodies, with the Federal government matching State health care provider reimbursements at an authorized rate, depending on the State's per capita income (see the Federal Medical Assistance Percentage (FMAP) table, page 2-18).

The FMAP is based upon the State's per capita income; if a State's per capita income is equal to or greater than the national average, the Federal share is 50%. If a State's per capita income is below the national average, the Federal share is increased

The percentages apply to State expenditures for assistance payments and medical services. Federal statute provides separate Federal matching amounts for administrative costs. Cost sharing for administrative expenditures vary with the services, i.e., 75% for training, 90% for designing, developing or installing mechanized claims processing and information retrieval, etc. (Federal Medicaid Law (Section 1903(a)(2) et seq.)).

In 2003, the Medicaid program enrolled 55.2 million eligible individuals with vendor payments for medical care services totaling \$233.2 billion. The vendor payments reported in the 2003 MSIS Report do not include Disproportionate Share Hospital (DSH), Medicare premium payments made by State Medicaid programs, and other Medicaid program expenditures. The CMS-64 Report, which does include such expenditures, shows total net expenditures for 2003 of \$260 billion. When administrative costs are added to total net expenditures, total Medicaid program expenditures in 2003 were \$272.9 billion. For FY 2004, total program expenditures, including those for administration, were \$295.3 billion.

Total Medicaid Eligibles by Maintenance Assistance Status, 2003¹

State	Total Eligibles	Receiving Cash Assistance	Medically Needy	Poverty Related	Other	1115 Demonstration	MAS Unknown
National Total	55,157,775	19,633,486	3,474,069	16,779,429	9,299,449	5,970,373	969
Alabama	893,115	282,632	0	452,986	36,946	120,551	0
Alaska	126,587	51,162	0	64,478	10,947	0	0
Arizona	1,278,894	516,680	0	324,311	247,921	189,982	0
Arkansas	675,552	163,360	14,293	284,718	53,120	160,061	0
California	10,047,498	4,416,245	976,367	592,217	1,721,467	2,341,196	6
Colorado	473,880	239,225	0	176,168	58,486	0	1
Connecticut	502,265	84,218	41,238	95,564	281,245	0	0
Delaware	156,721	76,085	0	14,993	40,577	25,066	0
District of Columbia	157,101	85,097	34,409	28,639	8,956	0	0
Florida	2,841,305	1,155,325	87,194	1,058,289	412,309	128,188	0
Georgia	1,640,500	580,415	14,330	754,319	291,436	0	0
Hawaii	216,167	104,412	3,178	50,309	16,773	41,459	36
Idaho	208,748	56,017	0	120,298	32,433	0	0
Illinois	2,177,724	262,908	398,331	1,135,842	154,232	226,411	0
Indiana	945,267	377,695	0	351,299	216,273	0	0
Iowa	378,708	156,196	11,058	122,058	89,396	0	0
Kansas	325,177	122,198	6,192	139,623	57,164	0	0
Kentucky	810,159	370,242	34,273	326,771	78,873	0	0
Louisiana	1,054,455	347,291	12,475	592,303	102,386	0	0
Maine	378,346	55,941	4,957	127,059	75,834	114,555	0
Maryland	825,493	214,411	94,688	400,708	55,454	60,231	1
Massachusetts	1,193,533	311,880	23,003	470,973	138,932	248,745	0
Michigan	1,572,356	453,521	101,236	527,867	489,568	0	164
Minnesota	730,195	363,841	30,280	71,170	143,772	121,132	0
Mississippi	730,995	322,947	0	385,410	22,592	0	46
Missouri	1,157,231	705,494	0	148,764	184,176	118,797	0
Montana	110,549	48,765	8,872	28,948	23,964	0	0
Nebraska	269,331	65,739	36,741	135,816	30,528	0	507
Nevada	236,211	111,657	0	54,915	69,639	0	0
New Hampshire	129,685	26,070	12,092	63,339	28,184	0	0
New Jersey	974,601	368,957	5,152	373,677	139,596	87,219	0
New Mexico	492,830	208,153	0	203,151	67,217	14,308	1
New York	4,583,362	2,005,614	935,774	581,854	216,858	843,262	0
North Carolina	1,450,218	566,405	42,466	713,317	128,030	0	0
North Dakota	76,677	31,693	16,346	8,397	20,241	0	0
Ohio	1,938,785	415,332	0	427,527	1,095,926	0	0
Oklahoma	666,529	185,010	2,515	422,976	56,028	0	0
Oregon	625,704	159,070	1,938	178,537	139,136	146,822	201
Pennsylvania	1,787,059	732,419	115,120	608,972	330,548	0	0
Rhode Island	211,136	81,522	4,409	33,899	50,690	40,616	0
South Carolina	992,090	296,549	0	436,350	204,719	54,472	0
South Dakota	119,693	41,987	0	52,165	25,540	0	1
Tennessee	1,651,486	544,616	210,832	272,370	172,855	450,811	2
Texas	3,661,163	913,188	101,475	1,974,148	672,352	0	0
Utah	278,232	93,089	4,975	99,356	56,617	24,195	0
Vermont	159,701	28,353	14,345	49,682	15,171	52,150	0
Virginia	736,672	141,570	7,131	452,537	134,588	845	1
Washington	1,160,614	268,010	19,329	408,005	362,139	103,129	2
West Virginia	366,787	119,538	6,553	204,364	36,332	0	0
Wisconsin	903,902	285,005	40,502	134,687	187,593	256,115	0
Wyoming	76,786	19,737	0	43,304	13,690	55	0

¹Eligibles are defined as individuals who were on the Medicaid rolls at least one month during the year.

Source: CMS, MSIS Report, FY 2003.

Total Medicaid Eligibles by Age Group, 2003¹

State	Total Eligibles	<20 Years	21-64 Years	65 Years and Older	Age Unknown
National Total	55,157,775	29,699,167	19,449,590	5,881,164	127,854
Alabama	893,115	476,740	289,561	126,814	0
Alaska	126,587	86,159	32,972	7,456	0
Arizona	1,278,894	664,579	534,714	79,599	2
Arkansas	675,552	405,103	205,797	64,615	37
California	10,047,498	4,549,115	4,625,966	872,403	14
Colorado	473,880	286,274	137,735	49,869	2
Connecticut	502,265	265,476	172,084	64,705	0
Delaware	156,721	78,864	65,836	12,021	0
District of Columbia	157,101	85,666	57,230	14,191	14
Florida	2,841,305	1,614,681	869,747	356,648	229
Georgia	1,640,500	1,029,494	446,695	164,310	1
Hawaii	216,167	106,346	87,457	22,363	1
Idaho	208,748	145,334	50,327	13,086	1
Illinois	2,177,724	1,190,113	613,392	374,143	76
Indiana	945,267	593,433	270,517	81,317	0
Iowa	378,708	215,022	121,899	41,786	1
Kansas	325,177	202,762	89,674	32,741	0
Kentucky	810,159	442,743	272,580	94,801	35
Louisiana	1,054,455	699,151	246,440	108,858	6
Maine	378,346	131,274	171,132	75,920	20
Maryland	825,493	480,696	267,488	77,301	8
Massachusetts	1,193,533	529,391	517,969	146,173	0
Michigan	1,572,356	962,803	477,277	132,106	170
Minnesota	730,195	395,306	244,240	90,648	1
Mississippi	730,995	437,265	196,591	97,139	0
Missouri	1,157,231	656,976	398,218	102,025	12
Montana	110,549	62,690	36,973	10,885	1
Nebraska	269,331	172,521	67,430	23,800	5,580
Nevada	236,211	141,289	72,305	22,617	0
New Hampshire	129,685	80,226	35,007	14,438	14
New Jersey	974,601	530,346	302,355	141,900	0
New Mexico	492,830	320,329	140,406	32,093	2
New York	4,583,362	2,012,353	1,949,590	499,996	121,423
North Carolina	1,450,218	815,159	456,244	178,814	1
North Dakota	76,677	39,247	27,281	10,149	0
Ohio	1,938,785	1,104,800	672,353	161,579	53
Oklahoma	666,529	446,269	154,477	65,783	0
Oregon	625,704	289,938	284,987	50,769	10
Pennsylvania	1,787,059	957,069	611,893	218,091	6
Rhode Island	211,136	106,084	80,035	25,016	1
South Carolina	992,090	553,149	301,357	137,578	6
South Dakota	119,693	78,133	29,184	12,375	1
Tennessee	1,651,486	760,541	724,034	166,911	0
Texas	3,661,163	2,426,974	833,348	400,835	6
Utah	278,232	165,094	99,206	13,932	0
Vermont	159,701	73,285	65,346	21,065	5
Virginia	736,672	438,519	197,868	100,285	0
Washington	1,160,614	701,532	377,088	81,994	0
West Virginia	366,787	198,702	134,385	33,694	6
Wisconsin	903,902	444,157	311,605	148,036	104
Wyoming	76,786	49,995	21,295	5,491	5

¹ Eligibles are defined as individuals who were on the Medicaid rolls at least one month during the year.

Source: CMS, MSIS Report, FY 2003.

Total Medicaid Eligibles by Gender, 2003¹

State	Total Eligibles	Female	Male	Gender Unknown
National Total	55,157,775	32,759,792	22,296,737	101,246
Alabama	893,115	563,974	322,607	6,534
Alaska	126,587	70,045	56,539	3
Arizona	1,278,894	712,338	566,556	0
Arkansas	675,552	421,546	252,798	1,208
California	10,047,498	6,407,389	3,640,096	13
Colorado	473,880	282,794	191,086	0
Connecticut	502,265	298,346	203,919	0
Delaware	156,721	93,531	63,190	0
District of Columbia	157,101	93,990	63,102	9
Florida	2,841,305	1,682,165	1,157,050	2,090
Georgia	1,640,500	980,379	660,105	16
Hawaii	216,167	116,546	99,621	0
Idaho	208,748	118,117	90,631	0
Illinois	2,177,724	1,302,332	875,392	0
Indiana	945,267	558,240	387,027	0
Iowa	378,708	219,875	158,833	0
Kansas	325,177	187,921	137,210	46
Kentucky	810,159	468,812	341,339	8
Louisiana	1,054,455	606,015	448,353	87
Maine	378,346	201,796	175,648	902
Maryland	825,493	495,463	330,030	0
Massachusetts	1,193,533	689,050	504,483	0
Michigan	1,572,356	892,798	679,558	0
Minnesota	730,195	420,410	309,785	0
Mississippi	730,995	432,121	298,858	16
Missouri	1,157,231	672,798	484,432	1
Montana	110,549	63,594	46,953	2
Nebraska	269,331	149,172	112,729	7,430
Nevada	236,211	136,674	98,821	716
New Hampshire	129,685	75,264	54,421	0
New Jersey	974,601	583,904	390,697	0
New Mexico	492,830	290,492	202,320	18
New York	4,583,362	2,564,620	1,937,295	81,447
North Carolina	1,450,218	874,821	575,397	0
North Dakota	76,677	45,058	31,618	1
Ohio	1,938,785	1,128,414	810,371	0
Oklahoma	666,529	388,168	278,361	0
Oregon	625,704	346,637	279,066	1
Pennsylvania	1,787,059	1,042,778	744,281	0
Rhode Island	211,136	124,366	86,770	0
South Carolina	992,090	618,912	373,010	168
South Dakota	119,693	67,883	51,809	1
Tennessee	1,651,486	951,816	699,669	1
Texas	3,661,163	2,129,742	1,531,377	44
Utah	278,232	161,697	116,155	380
Vermont	159,701	88,580	71,121	0
Virginia	736,672	436,355	300,299	18
Washington	1,160,614	698,903	461,687	24
West Virginia	366,787	209,646	157,141	0
Wisconsin	903,902	549,057	354,845	0
Wyoming	76,786	44,448	32,276	62

¹ Eligibles are defined as individuals who were on the Medicaid roles at least one month during the year.

Source: CMS, MSIS Report, FY 2003.

Total Medicaid Eligibles by Race/Ethnicity, 2003¹

State	Total Eligibles	White	Black/African American	American Indian/Alaska Native	Asian	Hispanic or Latino	Other
National Total	55,157,775	24,173,610	12,873,454	806,211	1,395,907	11,812,757	1,490
Alabama	893,115	415,338	429,826	2,407	3,946	16,687	9,215
Alaska	126,587	53,863	6,575	46,012	6,236	4,686	24,911
Arizona	1,278,894	456,871	72,776	149,420	15,350	550,988	5,596
Arkansas	675,552	420,974	207,998	5,366	6,015	29,603	33,489
California	10,047,498	2,219,779	967,266	45,556	489,096	5,503,661	822,140
Colorado	473,880	219,457	34,263	3,489	4,512	178,513	33,646
Connecticut	502,265	235,000	109,667	988	11,584	144,816	210
Delaware	156,721	68,412	66,619	319	2,322	19,033	4,393
District of Columbia	157,101	2,650	136,450	35	1,393	12,180	16
Florida	2,841,305	1,063,322	836,412	1,494	16,097	599,713	324,267
Georgia	1,640,500	692,088	802,807	1,418	19,549	21,173	103,465
Hawaii	216,167	48,689	3,476	583	65,537	7,490	90,392
Idaho	208,748	181,115	1,868	5,462	1069	18,961	73,688
Illinois	2,177,724	915,187	788,452	4,151	51,709	394,155	273
Indiana	945,267	650,500	210,280	588	3,597	69,992	24,070
Iowa	378,708	259,799	28,025	1,913	3,382	11,901	10,310
Kansas	325,177	210,191	52,829	4,304	3,939	109	53,805
Kentucky	810,159	654,377	100,805	322	2,106	14,740	37,809
Louisiana	1,054,455	380,370	596,953	2,563	5,082	7,516	61,971
Maine	378,346	363,958	6,483	3,797	2,757	1,351	231,257
Maryland	825,493	276,744	434,457	1,469	23,422	58,689	30,712
Massachusetts	1,193,533	599,544	129,009	2,925	39,709	191,089	0
Michigan	1,572,356	902,228	531,055	8,220	23,534	86,295	21,024
Minnesota	730,195	441,540	114,840	28,705	46,103	942	98,065
Mississippi	730,995	254,521	433,413	2,869	2,930	5,623	41,465
Missouri	1,157,231	813,427	290,745	3,601	7,926	67	31,639
Montana	110,549	80,787	901	25,138	462	3,246	15
Nebraska	269,331	180,109	33,370	9,258	2,949	76	84,496
Nevada	236,211	132,179	43,903	3,652	7,944	48,533	53
New Hampshire	129,685	119,152	2,359	143	970	4,038	43,569
New Jersey	974,601	361,135	303,940	3,553	19,775	176,774	3,023
New Mexico	492,830	123,356	10,699	92,967	2,755	252,755	109,424
New York	4,583,362	1,583,046	1,085,992	76,864	242,392	666,886	10,298
North Carolina	1,450,218	634,399	585,665	24,299	13,428	107,931	0
North Dakota	76,677	58,120	1,493	16,716	295	0	928,182
Ohio	1,938,785	1,287,946	575,505	2,077	12,879	58,635	1,743
Oklahoma	666,529	413,822	106,462	85,684	6,433	0	54,128
Oregon	625,704	452,894	27,228	14,605	17,479	106,109	7,389
Pennsylvania	1,787,059	1,067,784	480,250	2,098	34,189	129,640	73,098
Rhode Island	211,136	91,995	18,360	405	5,107	38,798	56,471
South Carolina	992,090	395,276	492,621	1,530	2,834	20,659	79,170
South Dakota	119,693	72,701	2,572	41,032	674	2,440	274
Tennessee	1,651,486	1,090,586	451,422	2,791	11,415	36,964	58,308
Texas	3,661,163	971,341	680,068	13,943	51,093	1,908,648	36,070
Utah	55,157,775	24,173,610	12,873,454	806,211	1,395,907	11,812,757	1,490
Vermont	893,115	415,338	429,826	2,407	3,946	16,687	9,215
Virginia	126,587	53,863	6,575	46,012	6,236	4,686	24,911
Washington	1,278,894	456,871	72,776	149,420	15,350	550,988	5,596
West Virginia	675,552	420,974	207,998	5,366	6,015	29,603	33,489
Wisconsin	10,047,498	2,219,779	967,266	45,556	489,096	5,503,661	822,140
Wyoming	473,880	219,457	34,263	3,489	4,512	178,513	33,646

¹ Eligibles are defined as individuals who were on the Medicaid rolls at least one month during the year.

Source: CMS, MSIS Report, FY 2003.

Total Medicaid Eligibles by Basis of Eligibility, 2003¹

State	Total Eligibles	Aged	Blind/ Disabled	Children	Adults	Foster Care Children	BCCA Women	BOE Unknown
National Total	55,157,775	5,101,111	8,405,100	26,366,202	14,352,073	918,824	13,334	1,131
Alabama	893,115	105,048	197,087	431,577	152,325	6,784	294	0
Alaska	126,587	6,829	13,005	76,918	27,608	2,127	100	0
Arizona	1,278,894	64,862	115,615	585,992	503,951	8,474	0	0
Arkansas	675,552	50,654	122,160	337,428	159,139	6,130	0	41
California	10,047,498	700,243	1,041,513	3,764,945	4,380,161	155,838	4792	6
Colorado	473,880	48,662	66,101	241,678	99,205	17,989	132	113
Connecticut	502,265	63,663	61,476	262,458	107,845	6,693	130	0
Delaware	156,721	11,475	18,559	67,300	57,460	1,879	48	0
District of Columbia	157,101	10,647	29,679	73,762	38,234	4,779	0	0
Florida	2,841,305	282,213	517,489	1,417,109	578,619	45,700	175	0
Georgia	1,640,500	139,339	273,064	920,863	284,163	21,012	2058	1
Hawaii	216,167	21,397	24,013	91,805	72,368	6,519	29	36
Idaho	208,748	12,994	28,560	132,879	32,025	2,290	0	0
Illinois	2,177,724	332,849	306,897	1,083,466	375,431	78,669	412	0
Indiana	945,267	80,763	132,350	547,706	170,861	13,277	310	0
Iowa	378,708	41,451	63,008	188,110	75,222	10,917	0	0
Kansas	325,177	32,639	52,856	171,792	55,200	12,606	84	0
Kentucky	810,159	71,942	220,868	385,715	120,905	10,472	257	0
Louisiana	1,054,455	109,866	183,396	628,621	122,822	9,425	325	0
Maine	378,346	74,004	99,876	111,704	88,761	3,885	116	0
Maryland	825,493	65,039	125,492	437,377	180,192	17,392	0	1
Massachusetts	1,193,533	117,067	255,925	480,534	339,338	669	0	0
Michigan	1,572,356	105,249	302,074	844,079	280,423	40,367	0	164
Minnesota	730,195	71,442	100,461	362,023	186,917	9,100	252	0
Mississippi	730,995	75,869	166,169	394,359	91,195	3,357	0	46
Missouri	1,157,231	100,220	167,827	598,712	264,744	25,728	0	0
Montana	110,549	9,920	18,172	55,283	23,197	3,858	119	0
Nebraska	269,331	23,380	30,525	153,772	50,194	10,783	170	507
Nevada	236,211	21,364	34,855	121,157	52,813	6,017	0	5
New Hampshire	129,685	14,325	17,482	77,099	18,087	2,692	0	0
New Jersey	974,601	111,637	182,900	457,769	197,914	24,239	142	0
New Mexico	492,830	24,239	56,505	299,696	108,348	3,839	202	1
New York	4,583,362	403,101	699,479	1,955,958	1,453,232	71,222	370	0
North Carolina	1,450,218	177,992	245,171	734,480	275,533	17,042	0	0
North Dakota	76,677	10,053	10,058	35,054	19,640	1,872	0	0
Ohio	1,938,785	149,145	319,592	1,001,316	432,260	36,472	0	0
Oklahoma	666,529	61,923	87,603	409,229	91,489	16,285	0	0
Oregon	625,704	48,604	74,019	248,606	238,528	15,605	141	201
Pennsylvania	1,787,059	217,044	409,097	809,934	299,857	50,387	740	0
Rhode Island	211,136	20,753	40,906	90,271	53,438	5,497	271	0
South Carolina	992,090	133,834	134,227	485,999	228,519	9,372	139	0
South Dakota	119,693	10,284	16,859	71,246	19,216	2,061	26	1
Tennessee	1,651,486	94,493	330,246	708,468	502,674	15,600	0	5
Texas	3,661,163	397,251	422,621	2,214,082	589,382	37,364	463	0
Utah	278,232	13,012	29,877	145,734	82,433	6,966	210	0
Vermont	159,701	19,449	19,757	66,343	51,492	2,621	39	0
Virginia	736,672	97,260	137,395	391,602	96,506	13,684	224	1
Washington	1,160,614	81,800	152,019	603,911	305,831	17,051	0	2
West Virginia	366,787	29,996	96,397	172,616	60,689	6,697	392	0
Wisconsin	903,902	128,380	145,143	372,872	240,276	17,059	172	0
Wyoming	76,786	5,446	8,675	44,793	15,411	2,461	0	0

¹Eligibles are defined as individuals who were on the Medicaid rolls at least one month during the year.

Source: CMS, MSIS Report, FY 2003.

Total Medicaid Eligibles Per 1000 Population, 2003

State	Total State Population	Total Eligibles ¹	Eligibles per 1000 Population
National Total	293,656,842	55,157,775	187.8
Alabama	4,525,375	893,115	197.4
Alaska	657,755	126,587	192.5
Arizona	5,739,879	1,278,894	222.8
Arkansas	2,750,000	675,552	245.7
California	35,842,038	10,047,498	280.3
Colorado	4,601,821	473,880	103.0
Connecticut	3,498,966	502,265	143.5
Delaware	830,069	156,721	188.8
District of Columbia	554,239	157,101	283.5
Florida	17,385,430	2,841,305	163.4
Georgia	8,918,129	1,640,500	184.0
Hawaii	1,262,124	216,167	171.3
Idaho	1,395,140	208,748	149.6
Illinois	12,712,016	2,177,724	171.3
Indiana	6,226,537	945,267	151.8
Iowa	2,952,904	378,708	128.2
Kansas	2,733,697	325,177	119.0
Kentucky	4,141,835	810,159	195.6
Louisiana	4,506,685	1,054,455	234.0
Maine	1,314,985	378,346	287.7
Maryland	5,561,332	825,493	148.4
Massachusetts	6,407,382	1,193,533	186.3
Michigan	10,104,206	1,572,356	155.6
Minnesota	5,096,546	730,195	143.3
Mississippi	2,900,768	730,995	252.0
Missouri	5,759,532	1,157,231	200.9
Montana	926,920	110,549	119.3
Nebraska	1,747,704	269,331	154.1
Nevada	2,332,898	236,211	101.3
New Hampshire	1,299,169	129,685	99.8
New Jersey	8,685,166	974,601	112.2
New Mexico	1,903,006	492,830	259.0
New York	19,280,727	4,583,362	237.7
North Carolina	8,540,468	1,450,218	169.8
North Dakota	636,308	76,677	120.5
Ohio	11,450,143	1,938,785	169.3
Oklahoma	3,523,546	666,529	189.2
Oregon	3,591,363	625,704	174.2
Pennsylvania	12,394,471	1,787,059	144.2
Rhode Island	1,079,916	211,136	195.5
South Carolina	4,197,892	992,090	236.3
South Dakota	770,621	119,693	155.3
Tennessee	5,893,298	1,651,486	280.2
Texas	22,471,549	3,661,163	162.9
Utah	2,420,708	278,232	114.9
Vermont	621,233	159,701	257.1
Virginia	7,481,332	736,672	98.5
Washington	6,207,046	1,160,614	187.0
West Virginia	1,812,548	366,787	202.4
Wisconsin	5,503,533	903,902	164.2
Wyoming	505,887	76,786	151.8

¹ Eligibles are defined as individuals who were on the Medicaid rolls at least one month during the year.

Source: U.S. Department of Commerce, Bureau of the Census, Population Estimates, July 1, 2004; CMS, MSIS Report, FY 2003.

Total Net U.S. Medical Assistance Expenditures by Type of Service, FY 2003 & FY 2004

Service	FY 2004	Percent of Total	FY 2003	Percent of Total	Percent Change
Inpatient Acute Care Hospital	\$53,369,218,290	19.0%	\$45,839,127,080	17.6%	16.4%
Nursing Facility	\$46,500,694,515	16.6%	\$44,345,682,144	17.1%	4.9%
Pharmaceuticals	\$40,065,314,592	14.3%	\$33,794,520,738	13.0%	18.6%
HCBS Waivers	\$21,765,416,501	7.8%	\$19,302,698,045	7.4%	12.8%
ICF-Mentally Retarded	\$12,132,969,504	4.3%	\$11,614,424,195	4.5%	4.5%
Hospital Outpatient	\$11,615,651,583	4.1%	\$9,394,646,018	3.6%	23.6%
Personal Care Services	\$8,237,712,957	2.9%	\$7,881,552,380	3.0%	4.5%
Physicians	\$ 9,689,801,589	3.5%	\$7,863,653,436	3.0%	23.2%
Clinic*	\$8,141,919,807	2.9%	\$7,582,867,230	2.9%	7.4%
Inpatient Mental Health Hospital	\$7,658,041,454	2.7%	\$7,299,165,193	2.8%	4.9%
Dental	\$3,112,152,041	1.1%	\$3,015,702,590	1.2%	3.2%
Home Health Care	\$3,445,105,331	1.2%	\$2,886,980,643	1.1%	19.3%
Other Practitioners	\$2,001,837,788	0.7%	\$1,438,109,885	0.6%	39.2%
EPSDT	\$1,045,523,675	0.4%	\$1,079,836,415	0.4%	-3.2%
Lab/X-ray	\$1,170,828,366	0.4%	\$856,521,207	0.3%	36.7%
Other**	\$50,819,666,983	18.1%	\$55,700,409,296	21.4%	-8.8%
Total Expenditures	\$280,771,854,976	100% ‡	\$259,895,896,495	100% ‡	8.0%

‡ Values may not add to 100% due to rounding. American Samoa, Guam, N. Mariana Islands, Puerto Rico, and Virgin Islands excluded.

* Clinic includes clinics, FQHCs, and rural health clinics.

** Other includes hospice, other care services, payments to managed care organizations, etc.

Source: CMS, CMS-64 Report, FY 2003 and FY 2004.

Federal Medical Assistance Percentage (FMAP), FY 2006 and FY 2007

State	2006 FMAP	2006 Enhanced FMAP*	2007 FMAP	2007 Enhanced FMAP*
Alabama	69.51%	78.66%	68.85%	78.20%
Alaska	50.16%	65.11%	51.07%	65.75%
Arizona	66.98%	76.89%	66.47%	76.53%
Arkansas	73.77%	81.64%	73.37%	81.36%
California	50.00%	65.00%	50.00%	65.00%
Colorado	50.00%	65.00%	50.00%	65.00%
Connecticut	50.00%	65.00%	50.00%	65.00%
Delaware	50.09%	65.06%	50.00%	65.00%
District of Columbia**	70.00%	79.00%	70.00%	79.00%
Florida	58.89%	71.22%	58.76%	71.13%
Georgia	60.00%	72.42%	61.97%	73.38%
Hawaii	58.81%	71.17%	57.55%	70.29%
Idaho	69.91%	78.94%	70.36%	79.25%
Illinois	50.00%	65.00%	50.00%	65.00%
Indiana	62.98%	74.09%	62.61%	73.83%
Iowa	63.61%	74.53%	61.98%	73.39%
Kansas	60.41%	72.29%	60.25%	72.18%
Kentucky	69.26%	78.48%	69.58%	78.71%
Louisiana	69.79%	78.85%	69.69%	78.78%
Maine	62.90%	74.03%	63.27%	74.29%
Maryland	50.00%	65.00%	50.00%	65.00%
Massachusetts	50.00%	65.00%	50.00%	65.00%
Michigan	56.59%	69.61%	56.38%	69.47%
Minnesota	50.00%	65.00%	50.00%	65.00%
Mississippi	76.00%	83.20%	75.89%	83.12%
Missouri	61.93%	73.35%	61.60%	73.12%
Montana	70.54%	79.38%	69.11%	78.38%
Nebraska	59.68%	71.78%	57.93%	70.55%
Nevada	54.76%	68.33%	53.93%	67.75%
New Hampshire	50.00%	65.00%	50.00%	65.00%
New Jersey	50.00%	65.00%	50.00%	65.00%
New Mexico	71.15%	79.81%	71.93%	80.35%
New York	50.00%	65.00%	50.00%	65.00%
North Carolina	63.49%	74.44%	64.52%	75.16%
North Dakota	65.85%	76.10%	64.72%	75.30%
Ohio	59.88%	71.92%	59.66%	71.76%
Oklahoma	67.91%	77.54%	68.14%	77.70%
Oregon	61.57%	73.10%	61.07%	72.75%
Pennsylvania	55.05%	68.54%	54.39%	68.07%
Rhode Island	54.45%	68.12%	52.35%	66.65%
South Carolina	69.32%	78.52%	69.54%	78.68%
South Dakota	65.07%	75.55%	62.92%	74.04%
Tennessee	63.99%	74.79%	63.65%	74.56%
Texas	60.66%	72.46%	60.78%	72.55%
Utah	70.76%	79.53%	70.14%	79.10%
Vermont	58.49%	70.94%	58.93%	71.25%
Virginia	50.00%	65.00%	50.00%	65.00%
Washington	50.00%	65.00%	50.12%	65.08%
West Virginia	72.99%	81.09%	72.82%	80.97%
Wisconsin	51.65%	70.36%	57.47%	70.23%
Wyoming	54.23%	67.96%	52.91%	67.04%

* The "Enhanced Federal Medical Assistance Percentages" are for use in State Children's Health Insurance Program under Title XXI, and for some or all of children's medical assistance under Medicaid sections 1905(u)(2) and 1905(u)(3).

** The values for the District of Columbia in the table were set for the state plan under titles XIX and XXI and for capitation payments and DSH allotments under those titles. For other purposes, including programs remaining in Title IV of the Act the Percentage for the District of Columbia is 50.00%.

Source: Federal Register, November 24, 2004, Vol. 69, No. 226, pages 68370-68373 and November 30, 2005, Vol. 70, 229, pages 71856-71857.

Medicaid Total Net Expenditures and Eligibles, 2003

State	Total Net Medical Assistance Expenditures	Total Eligibles ¹	Average Per Eligible
National Total	\$261,753,241,307	55,157,775	\$4,746
Alabama	\$3,477,832,931	893,115	\$3,894
Alaska	\$829,578,423	126,587	\$6,553
Arizona	\$4,219,198,403	1,278,894	\$3,299
Arkansas	\$2,329,593,600	675,552	\$3,448
California	\$30,097,054,276	10,047,498	\$2,995
Colorado	\$2,552,159,860	473,880	\$5,386
Connecticut	\$3,506,583,946	502,265	\$6,982
Delaware	\$718,470,271	156,721	\$4,584
District of Columbia	\$1,076,136,978	157,101	\$6,850
Florida	\$10,925,528,712	2,841,305	\$3,845
Georgia	\$6,300,856,479	1,640,500	\$3,841
Hawaii	\$766,109,972	216,167	\$3,544
Idaho	\$809,931,820	208,748	\$3,880
Illinois	\$9,253,097,164	2,177,724	\$4,249
Indiana	\$4,282,435,701	945,267	\$4,530
Iowa	\$2,136,386,901	378,708	\$5,641
Kansas	\$1,764,536,608	325,177	\$5,426
Kentucky	\$3,697,230,708	810,159	\$4,564
Louisiana	\$4,423,174,011	1,054,455	\$4,195
Maine	\$1,776,817,309	378,346	\$4,696
Maryland	\$4,343,054,613	825,493	\$5,261
Massachusetts	\$7,680,882,159	1,193,533	\$6,435
Michigan	\$7,967,828,590	1,572,356	\$5,067
Minnesota	\$4,841,448,099	730,195	\$6,630
Mississippi	\$2,853,086,305	730,995	\$3,903
Missouri	\$5,541,604,705	1,157,231	\$4,789
Montana	\$511,474,712	110,549	\$4,627
Nebraska	\$1,325,133,485	269,331	\$4,920
Nevada	\$1,015,796,455	236,211	\$4,300
New Hampshire	\$916,422,038	129,685	\$7,067
New Jersey	\$7,858,368,246	974,601	\$8,063
New Mexico	\$2,006,492,205	492,830	\$4,071
New York	\$39,902,769,357	4,583,362	\$8,706
North Carolina	\$7,050,804,888	1,450,218	\$4,862
North Dakota	\$468,522,734	76,677	\$6,110
Ohio	\$10,177,517,569	1,938,785	\$5,249
Oklahoma	\$2,311,939,159	666,529	\$3,469
Oregon	\$2,678,357,318	625,704	\$4,281
Pennsylvania	\$12,772,008,268	1,787,059	\$7,147
Rhode Island	\$1,436,618,006	211,136	\$6,804
South Carolina	\$3,538,462,013	992,090	\$3,567
South Dakota	\$536,195,894	119,693	\$4,480
Tennessee	\$6,357,163,063	1,651,486	\$3,849
Texas	\$15,420,026,696	3,661,163	\$4,212
Utah	\$1,092,519,199	278,232	\$3,927
Vermont	\$705,028,688	159,701	\$4,415
Virginia	\$3,524,849,814	736,672	\$4,785
Washington	\$4,992,068,397	1,160,614	\$4,301
West Virginia	\$1,857,747,927	366,787	\$5,065
Wisconsin	\$4,789,052,234	903,902	\$5,298
Wyoming	\$337,284,398	76,786	\$4,393

¹Eligibles are defined as individuals who were on the Medicaid rolls at least one month during the year.

Source: CMS, CMS-64 Report, FY 2003 and CMS-MSIS Report, FY 2003.

Total Medicaid Program Expenditures, 2004

State	Total Net Medical Assistance Expenditures	Administrative Expenditures	Total Program Expenditures
National Total	\$280,771,854,976	\$14,407,458,139	\$295,179,313,115
Alabama	\$3,636,777,895	\$105,702,103	\$3,742,479,998
Alaska	\$884,037,863	\$64,364,449	\$948,402,312
Arizona	\$4,933,111,255	\$189,481,692	\$5,122,592,947
Arkansas	\$2,585,068,063	\$113,974,604	\$2,699,042,667
California	\$30,677,337,285	\$2,849,519,924	\$33,526,857,209
Colorado	\$2,648,577,338	\$115,782,794	\$2,764,360,132
Connecticut	\$3,875,748,955	\$147,221,008	\$4,022,969,963
Delaware	\$792,028,808	\$46,913,662	\$838,942,470
District of Columbia	\$1,116,037,028	\$75,524,607	\$1,191,561,635
Florida	\$12,789,934,905	\$578,830,618	\$13,368,765,523
Georgia	\$7,044,051,167	\$368,841,269	\$7,412,892,436
Hawaii	\$907,974,098	\$62,053,936	\$970,028,034
Idaho	\$938,680,696	\$70,854,669	\$1,009,535,365
Illinois	\$9,991,310,983	\$570,657,574	\$10,561,968,557
Indiana	\$4,889,329,727	\$238,507,932	\$5,127,837,659
Iowa	\$2,239,281,593	\$84,784,627	\$2,324,066,220
Kansas	\$1,782,435,217	\$105,873,748	\$1,888,308,965
Kentucky	\$4,086,404,587	\$104,002,696	\$4,190,407,283
Louisiana	\$4,933,031,400	\$165,305,982	\$5,098,337,382
Maine	\$2,021,194,249	\$84,864,997	\$2,106,059,246
Maryland	\$4,586,430,658	\$267,847,856	\$4,854,278,514
Massachusetts	\$8,725,068,052	\$372,523,414	\$9,097,591,466
Michigan	\$8,224,940,371	\$367,670,914	\$8,592,611,285
Minnesota	\$5,550,210,439	\$282,644,008	\$5,832,854,447
Mississippi	\$3,284,724,191	\$85,111,250	\$3,369,835,441
Missouri	\$6,082,476,995	\$270,611,871	\$6,353,088,866
Montana	\$666,602,722	\$32,531,754	\$699,134,476
Nebraska	\$1,430,800,678	\$108,824,162	\$1,539,624,840
Nevada	\$1,037,927,527	\$65,978,058	\$1,103,905,585
New Hampshire	\$1,148,626,371	\$57,524,145	\$1,206,150,516
New Jersey	\$7,928,423,533	\$341,308,307	\$8,269,731,840
New Mexico	\$2,212,810,008	\$109,345,257	\$2,322,155,265
New York	\$40,978,466,799	\$1,305,482,048	\$42,283,948,847
North Carolina	\$7,945,585,983	\$367,458,622	\$8,313,044,605
North Dakota	\$479,677,381	\$21,794,791	\$501,472,172
Ohio	\$11,550,492,206	\$382,664,037	\$11,933,156,243
Oklahoma	\$2,500,517,344	\$149,002,294	\$2,649,519,638
Oregon	\$2,596,299,977	\$242,647,701	\$2,838,947,678
Pennsylvania	\$14,088,449,923	\$737,215,429	\$14,825,665,352
Rhode Island	\$1,646,343,632	\$81,640,747	\$1,727,984,379
South Carolina	\$3,848,423,641	\$141,733,356	\$3,990,156,997
South Dakota	\$561,562,642	\$18,294,671	\$579,857,313
Tennessee	\$7,029,807,190	\$545,895,059	\$7,575,702,249
Texas	\$16,077,695,030	\$695,157,913	\$16,772,852,943
Utah	\$1,235,552,901	\$80,130,021	\$1,315,682,922
Vermont	\$798,758,992	\$67,177,207	\$865,936,199
Virginia	\$3,825,216,022	\$245,400,541	\$4,070,616,563
Washington	\$5,243,560,705	\$502,872,691	\$5,746,433,396
West Virginia	\$1,937,298,997	\$94,256,418	\$2,031,555,415
Wisconsin	\$4,410,918,293	\$190,657,533	\$4,601,575,826
Wyoming	\$365,832,661	\$32,993,173	\$398,825,834

Source: CMS, CMS-64 Report, FY 2004.

Total SCHIP Enrollment, 2004*

State	Medicaid SCHIP Enrollment	Non-Medicaid SCHIP Enrollment	Total SCHIP Enrollment	Adults Enrolled in SCHIP Demonstrations
National Total	1,723,182	4,379,602	6,102,784	646,159
Alabama	-	79,407	79,407	-
Alaska	21,966	-	21,966	-
Arizona	-	87,681	87,681	113,490
Arkansas	-	799	799	-
California	152,041	883,711	1,035,752	-
Colorado**	-	57,244	57,244	NR
Connecticut	-	21,438	21,438	-
Delaware	181	10,069	10,250	-
District of Columbia	6,093	-	6,093	-
Florida	2,031	417,676	419,707	-
Georgia	-	280,083	280,083	-
Hawaii	19,237	-	19,237	-
Idaho	17,879	1,175	19,054	-
Illinois	95,522	138,505	234,027	120,152
Indiana	55,187	25,511	80,698	-
Iowa	14,996	26,640	41,636	-
Kansas	-	44,350	44,350	-
Kentucky	60,496	34,004	94,500	-
Louisiana	105,580	-	105,580	-
Maine	20,204	8,967	29,171	-
Maryland	101,664	9,824	111,488	-
Massachusetts	119,377	47,131	166,508	-
Michigan	31,427	56,136	87,563	132,590
Minnesota	110	4,674	4,784	39,571
Mississippi	-	82,900	82,900	-
Missouri	176,014	-	176,014	-
Montana	-	15,281	15,281	-
Nebraska	44,646	-	44,646	-
Nevada	-	38,519	38,519	-
New Hampshire	598	10,371	10,969	-
New Jersey	39,870	87,374	127,244	88,826
New Mexico	20,804	-	20,804	-
New York	74,895	690,135	765,030	-
North Carolina	-	174,434	174,434	-
North Dakota	1,845	3,292	5,137	-
Ohio	220,190	-	220,190	-
Oklahoma	100,761	-	100,761	-
Oregon	-	46,720	46,720	4,294
Pennsylvania	-	177,415	177,415	-
Rhode Island	24,089	1,484	25,573	23,327
South Carolina	75,597	-	75,597	-
South Dakota	10,338	3,059	13,397	-
Tennessee	-	-	-	-
Texas	-	650,856	650,856	-
Utah	-	38,693	38,693	-
Vermont	-	6,693	6,693	-
Virginia	41,651	57,918	99,569	-
Washington	-	17,002	17,002	-
West Virginia	-	36,906	36,906	-
Wisconsin	67,893	-	67,893	123,999
Wyoming	-	5,525	5,525	-

*The data displayed in this table were compiled from the CMS website at <http://www.cms.hhs.gov/NationalSCHIPPolicy/downloads/FY2004AnnualEnrollmentReport.zip>.
Column and row values do not always sum to totals.

** Colorado was only able to provide accurate data for 10.5 months for Fiscal Year 2004 due to a new system.

NR- State has not reported data via the Statistical Enrollment Data System (SEDS).

Source: CMS, SCHIP Annual Enrollment Report 2004 (Revised).

Total SCHIP Enrollment, 2005*

State	Medicaid SCHIP Enrollment	Non-Medicaid SCHIP Enrollment	Total SCHIP Enrollment	Adults Enrolled in SCHIP Demonstrations
National Total	1,701,073	4,412,945	6,114,018	638,789
Alabama		81,856	81,856	
Alaska	22,322		22,322	
Arizona		88,005	88,005	113,621
Arkansas		1,214	1,214	
California**	181,017	1,042,458	1,223,475	
Colorado		59,530	59,530	1,575
Connecticut		22,289	22,289	
Delaware	150	10,204	10,354	
District of Columbia	6,631		6,631	
Florida	1,942	382,859	384,801	
Georgia		306,733	306,733	
Hawaii	20,602		20,602	
Idaho	18,639	3,200	21,839	135
Illinois	120,582	160,850	281,432	175,994
Indiana	93,666	35,878	129,544	
Iowa	16,453	30,109	46,562	
Kansas		47,323	47,323	
Kentucky	41,180	22,548	63,728	
Louisiana	109,150		109,150	
Maine	21,806	8,848	30,654	
Maryland	106,471	13,845	120,316	
Massachusetts	119,268	43,411	162,679	
Michigan	33,965	55,292	89,257	101,283
Minnesota	107	4,969	5,076	35,011
Mississippi		79,352	79,352	
Missouri	115,355		115,355	
Montana		15,841	15,841	
Nebraska	44,706		44,706	
Nevada		39,316	39,316	
New Hampshire	707	11,185	11,892	
New Jersey	43,435	86,156	129,591	66,827
New Mexico	24,310		24,310	
New York	NR	618,973	618,973	
North Carolina		196,181	196,181	
North Dakota	1,936	3,789	5,725	
Ohio	216,495		216,495	
Oklahoma	108,100		108,100	
Oregon		52,722	52,722	11,366
Pennsylvania		179,807	179,807	
Rhode Island	25,609	1,535	27,144	24,169
South Carolina	80,646		80,646	
South Dakota	10,843	3,195	14,038	
Tennessee				
Texas		526,406	526,406	
Utah		43,931	43,931	
Vermont		6,614	6,614	
Virginia	57,815	66,240	124,055	
Washington		15,547	15,547	
West Virginia		38,614	38,614	
Wisconsin	57,165		57,165	108,808
Wyoming		6,120	6,120	

*The data displayed in this table were compiled from the CMS website at <http://www.cms.hhs.gov/NationalSCHIPPolicy/downloads/FY2004AnnualEnrollmentReport.zip>.
Column and row values do not always sum to totals.

** California reported aggregate enrollment for unborn children via email.

NR- State has not reported data via the Statistical Enrollment Data System (SEDS).

Source: CMS, SCHIP Annual Enrollment Report 2005.

Total SCHIP Expenditures, 2004

State	Medicaid SCHIP Expenditures	Non-Medicaid SCHIP Expenditures	Total SCHIP Expenditures
National Total	\$1,523,448,662	\$5,047,658,628	\$6,571,107,290
Alabama	\$8,274	\$91,557,433	\$91,565,707
Alaska	\$25,759,849	\$1,662,994	\$27,422,843
Arizona	\$0	\$335,838,557	\$335,838,557
Arkansas	\$31,529,205	\$3,503,245	\$35,032,450
California	\$202,211,600	\$846,614,181	\$1,048,825,781
Colorado	\$0	\$57,889,088	\$57,889,088
Connecticut	\$2,354	\$26,414,641	\$26,416,995
Delaware	\$353,726	\$7,762,812	\$8,116,538
District of Columbia	\$8,489,350	\$651,513	\$9,140,863
Florida	-\$175,841,068	\$420,895,100	\$245,054,032
Georgia	\$0	\$299,752,241	\$299,752,241
Hawaii	\$13,026,971	\$1,102,140	\$14,129,111
Idaho	\$16,793,792	\$1,870,193	\$18,179,869
Illinois	\$40,756,725	\$435,923,562	\$476,680,287
Indiana	\$64,827,843	\$24,054,022	\$88,881,865
Iowa	\$16,793,792	\$33,069,728	\$49,863,520
Kansas	\$0	\$54,569,894	\$54,569,894
Kentucky	\$60,370,692	\$30,017,862	\$90,388,554
Louisiana	\$109,884,719	\$7,955,941	\$117,840,660
Maine	\$19,799,713	\$13,304,250	\$33,103,963
Maryland	\$134,365,543	\$29,218,284	\$163,583,827
Massachusetts	\$131,069,887	\$53,108,759	\$184,178,646
Michigan	\$29,859,166	\$200,831,980	\$230,691,146
Minnesota	\$0	\$111,852,016	\$111,852,016
Mississippi	\$0	\$121,316,465	\$121,316,465
Missouri	\$106,800,123	\$3,051,643	\$109,851,766
Montana	\$0	\$17,682,790	\$17,682,790
Nebraska	\$47,903,003	\$1,158,365	\$49,061,368
Nevada	\$0	\$30,143,329	\$30,143,329
New Hampshire	\$330,824	\$7,852,982	\$8,183,806
New Jersey	\$43,900,322	\$297,517,275	\$341,417,597
New Mexico	\$22,977,777	\$198,612	\$23,176,389
New York	\$130,469,336	\$326,360,688	\$456,830,024
North Carolina	\$0	\$224,651,016	\$224,651,016
North Dakota	\$4,341,662	\$4,471,492	\$8,813,154
Ohio	\$227,413,800	\$6,449,054	\$233,862,854
Oklahoma	\$56,991,951	\$1,281,989	\$58,273,940
Oregon	\$0	\$34,817,954	\$34,817,954
Pennsylvania	\$0	\$185,300,733	\$185,300,733
Rhode Island	\$15,404,754	\$20,315,589	\$35,720,343
South Carolina	\$60,003,771	\$4,324,643	\$64,328,414
South Dakota	\$10,409,332	\$3,878,300	\$14,287,632
Tennessee	\$0	\$0	\$0
Texas	-\$36	\$391,515,248	\$391,515,212
Utah	\$0	\$34,957,127	\$34,957,127
Vermont	\$0	\$3,943,922	\$3,943,922
Virginia	\$31,957,811	\$64,896,516	\$96,854,327
Washington	\$0	\$26,219,988	\$26,219,988
West Virginia	\$0	\$37,301,505	\$37,301,505
Wisconsin	\$34,966,215	\$101,429,461	\$136,395,676
Wyoming	\$0	\$7,201,506	\$7,201,506

Source: CMS, CMS-64 Report, 2004.

Total Medicaid/Medicare Dual Eligibles by Dual Eligibility Type, 2003¹

State	All Eligibles	Not a Dual Eligible	QMB Only	QMB/ Medicaid	SLMB Only
National Total	55,157,775	43,691,570	461,966	4,366,245	400,733
Alabama	893,115	657,877	43,869	86,027	23,915
Alaska	126,587	104,251	1	8,042	153
Arizona	1,278,894	1,059,980	1,013	60,896	12,395
Arkansas	675,552	521,120	19,718	68,506	1,796
California	10,047,498	8,202,259	7,615	898,858	4,590
Colorado	473,880	383,628	6,822	28,429	4,054
Connecticut	502,265	381,460	7,509	44,900	4,143
Delaware	156,721	120,950	4,466	6,653	3,893
District of Columbia	157,101	133,860	86	12,809	980
Florida	2,841,305	2,209,859	34,411	311,149	43,576
Georgia	1,640,500	1,286,761	40,939	3,541	23,202
Hawaii	216,167	169,434	149	23,678	1,744
Idaho	208,748	175,305	3,067	10,730	0
Illinois	2,177,724	1,683,037	7,027	135,840	1,472
Indiana	945,267	747,107	8,874	64,019	6,606
Iowa	378,708	276,271	4,617	29,511	3,624
Kansas	325,177	237,418	5,306	27,894	2,857
Kentucky	810,159	571,027	29,222	74,909	9,468
Louisiana	1,054,455	838,305	27,423	108,037	14,857
Maine	378,346	281,467	1,133	28,392	4,788
Maryland	825,493	642,471	15,399	46,274	6,145
Massachusetts	1,193,533	832,028	219	93,055	15,500
Michigan	1,572,356	1,283,013	1,690	52,332	6,889
Minnesota	730,195	542,418	2,277	61,655	5,664
Mississippi	730,995	506,609	879	146,284	1,793
Missouri	1,157,231	949,246	6,875	66,280	4,803
Montana	110,549	81,830	440	10,891	535
Nebraska	269,331	207,998	0	23,148	2,333
Nevada	236,211	191,384	8,519	19,061	6,663
New Hampshire	129,685	99,922	1,806	5,276	1,674
New Jersey	974,601	735,350	0	131,539	21,176
New Mexico	492,830	447,116	11,301	29,429	0
New York	4,583,362	3,604,132	3,092	234,874	1,087
North Carolina	1,450,218	1,054,504	653	196,993	28,528
North Dakota	76,677	56,060	743	1,528	616
Ohio	1,938,785	1,603,587	22,678	141,477	13,567
Oklahoma	666,529	518,656	0	82,945	8,913
Oregon	625,704	466,240	10,523	30,848	5,854
Pennsylvania	1,787,059	1,387,044	748	213,160	22,544
Rhode Island	211,136	160,459	545	18,278	2,066
South Carolina	992,090	836,590	0	75,990	6,204
South Dakota	119,693	93,304	2,808	9,515	1,483
Tennessee	1,651,486	1,255,952	6,007	91,246	5,253
Texas	3,661,163	3,156,926	66,500	278,615	36,610
Utah	278,232	236,689	270	13,722	1,191
Vermont	159,701	122,355	161	9,815	499
Virginia	736,672	556,511	19,702	85,801	13,406
Washington	1,160,614	969,292	8,192	83,740	6,541
West Virginia	366,787	285,126	11,554	0	0
Wisconsin	903,902	704,531	3,532	76,816	4,365
Wyoming	76,786	62,851	1,586	2,838	718

¹Eligibles are defined as individuals who were on the Medicaid roles at least one month during the year.

QMB Only = Qualified Medicare Beneficiaries Without Other Medicaid

QMB/ Medicaid = QMBs With Full Medicaid

SLMB Only = Specified Low-Income Beneficiaries Without Other Medicaid

SLMB/Medicaid = SLMBs with full Medicaid

QDWI = Qualified Disabled and Working Individuals

QI 1 = Qualifying Individuals (1)

QI 2 = Qualifying Individuals (2)

Other = Other Dual Eligibles, Dual Category Unknown, and Dual Status Unknown

Source: CMS, MSIS Report, FY 2003.

Total Medicaid/Medicare Dual Eligibles by Dual Eligibility Type, 2003 (Con't)¹

State	SLMB/ Medicaid	QDWI	QI(1)	QI(2)	Other
National Total	201,679	79	199,744	32,300	3,869,573
Alabama	4,072	0	13,218	6,577	63,221
Alaska	0	0	0	0	11,359
Arizona	0	0	6,841	57	110,614
Arkansas	0	37	1,494	242	64,412
California	3,479	3	2,868	1,004	812,936
Colorado	3	1	1,989	588	23,446
Connecticut	6,205	0	6,569	0	34,331
Delaware	0	0	0	0	16,206
District of Columbia	1,121	0	416	142	4,619
Florida	13,872	0	24,442	0	176,372
Georgia	31	1	11,571	0	124,133
Hawaii	0	0	0	0	18,113
Idaho	0	0	0	0	11,456
Illinois	18,895	0	10,586	0	265,038
Indiana	16,229	3	4,125	1,774	68,924
Iowa	7,156	0	1,819	567	34,163
Kansas	746	0	1,222	0	33,739
Kentucky	4,530	0	4,927	1,188	90,311
Louisiana	89	0	7,840	3,975	65,715
Maine	2,136	9	2,523	751	3,283
Maryland	0	0	2,390	923	98,065
Massachusetts	0	0	3,405	2,752	138,800
Michigan	8,156	3	3,081	9	63,632
Minnesota	11,726	1	2,513	0	70,198
Mississippi	0	0	0	2,381	75,430
Missouri	10,144	0	310	443	37,263
Montana	379	0	0	0	10,276
Nebraska	0	1	0	0	23,559
Nevada	0	0	0	0	10,584
New Hampshire	1,028	2	668	0	6,240
New Jersey	0	0	8,828	0	71,866
New Mexico	0	0	0	0	0
New York	4,600	0	1,328	0	337,976
North Carolina	5,999	0	12,261	0	128,338
North Dakota	387	0	324	48	5,767
Ohio	18	0	6,766	2,680	86,350
Oklahoma	892	0	4,216	67	55,123
Oregon	5,801	0	3,296	0	82,065
Pennsylvania	16,255	0	13,111	3,494	87,753
Rhode Island	0	0	1,402	607	14,569
South Carolina	0	0	3,511	359	30,763
South Dakota	1,020	0	625	154	9,218
Tennessee	24,951	0	0	0	111,007
Texas	16,139	0	19,035	0	32,761
Utah	1,478	0	585	104	19,158
Vermont	944	0	0	0	19,742
Virginia	0	18	4,815	1,257	40,766
Washington	2,211	0	3,702	0	73,864
West Virginia	0	0	0	0	22,062
Wisconsin	7,545	0	743	63	68,650
Wyoming	3,442	0	379	94	5,337

¹Eligibles are defined as individuals who were on the Medicaid roles at least one month during the year.

QMB Only = Qualified Medicare Beneficiaries Without Other Medicaid

QMB/ Medicaid = QMBs With Full Medicaid

SLMB Only = Specified Low-Income Beneficiaries Without Other Medicaid

SLMB/Medicaid = SLMBs with full Medicaid

QDWI = Qualified Disabled and Working Individuals

QI 1 = Qualifying Individuals (1)

QI 2 = Qualifying Individuals (2)

Other = Other Dual Eligibles, Dual Category Unknown, and Dual Status Unknown

Source: CMS, MSIS Report, FY 2003.

Total Medicaid Medical Vendor Payments and Dual Eligibility Status, 2003¹

State	All Eligibles	Not a Dual Eligible	QMB Only	QMB/ Medicaid	SLMB Only
National Total	\$233,205,998,192	\$120,560,197,984	\$458,520,179	\$50,922,058,004	\$204,642,002
Alabama	\$3,471,319,724	\$1,423,773,689	\$33,309,752	\$903,719,891	\$1,500,379
Alaska	\$835,515,131	\$546,312,236	\$0	\$140,168,170	\$120,740
Arizona	\$3,285,364,385	\$2,245,437,866	\$1,368,755	\$462,888,742	\$190,792
Arkansas	\$2,211,952,987	\$1,153,902,158	\$40,811,031	\$874,491,192	\$710,396
California	\$25,812,495,569	\$14,402,004,461	\$20,424,778	\$6,827,704,634	\$11,659,138
Colorado	\$2,268,794,322	\$1,179,128,948	\$3,644,136	\$415,536,379	\$606,008
Connecticut	\$3,359,497,127	\$1,264,057,737	\$7,695,318	\$1,153,802,475	\$1,869,333
Delaware	\$750,252,370	\$434,235,365	\$5,469,497	\$112,732,697	\$1,400,301
District of Columbia	\$1,199,837,436	\$720,166,146	\$282,681	\$233,162,141	\$850,389
Florida	\$11,104,376,050	\$5,441,971,259	\$56,496,236	\$2,783,972,936	\$50,072,807
Georgia	\$5,357,550,658	\$3,001,263,891	\$36,320,080	\$2,948,170	\$4,011,534
Hawaii	\$753,463,428	\$419,984,916	\$229,563	\$206,360,890	\$444,113
Idaho	\$867,160,476	\$483,655,796	\$2,274,911	\$154,925,089	\$0
Illinois	\$9,391,357,857	\$4,379,484,165	\$5,465,682	\$1,624,424,753	\$577,947
Indiana	\$3,950,802,203	\$1,981,274,842	\$2,592,068	\$956,209,018	\$896,632
Iowa	\$1,996,207,221	\$908,533,109	\$4,409,756	\$546,756,998	\$955,711
Kansas	\$1,614,744,381	\$697,274,613	\$7,348,432	\$463,172,243	\$625,757
Kentucky	\$3,557,820,183	\$2,024,696,200	\$20,236,857	\$750,561,900	\$2,349,908
Louisiana	\$3,614,909,979	\$1,948,202,037	\$20,176,361	\$1,251,377,494	\$2,645,792
Maine	\$2,074,246,677	\$1,328,330,580	\$901,243	\$375,482,858	\$2,095,600
Maryland	\$4,398,301,341	\$2,624,973,944	\$53,790,841	\$653,924,260	\$8,980,222
Massachusetts	\$6,391,977,781	\$2,718,762,753	\$607,845	\$1,354,223,511	\$11,389,602
Michigan	\$6,479,029,763	\$3,162,059,746	\$3,211,569	\$595,460,762	\$4,815,695
Minnesota	\$4,701,612,364	\$2,187,010,640	\$2,423,799	\$1,330,095,950	\$1,820,971
Mississippi	\$2,569,776,154	\$1,253,209,613	\$632,077	\$1,158,919,687	\$839,685
Missouri	\$4,406,852,103	\$2,326,676,563	\$2,874,569	\$803,765,144	\$2,291,185
Montana	\$536,372,686	\$261,207,328	\$120,639	\$127,417,550	\$246
Nebraska	\$1,282,568,106	\$584,018,581	\$0	\$166,698,319	\$760,514
Nevada	\$881,323,024	\$515,879,527	\$6,419,566	\$230,857,410	\$1,669,026
New Hampshire	\$786,014,720	\$334,710,889	\$5,785,240	\$84,904,738	\$268,436
New Jersey	\$6,029,601,253	\$2,835,817,070	\$0	\$2,626,922,092	\$25,176,882
New Mexico	\$2,033,478,397	\$1,314,005,543	\$10,595,895	\$417,615,497	\$0
New York	\$35,206,760,472	\$17,213,816,644	\$453,440	\$5,134,406,440	\$160,056
North Carolina	\$6,521,288,060	\$3,432,181,634	\$353,260	\$2,028,959,394	\$12,299,584
North Dakota	\$444,803,367	\$155,528,111	\$311,419	\$12,535,975	\$65,117
Ohio	\$10,235,239,405	\$4,989,259,695	\$21,983,494	\$2,749,294,615	\$18,023,692
Oklahoma	\$2,128,524,455	\$1,111,863,089	\$0	\$891,727,617	\$1,402,796
Oregon	\$2,115,608,505	\$1,183,569,974	\$17,052,444	\$357,884,214	\$5,546,470
Pennsylvania	\$9,450,026,724	\$5,116,597,319	\$1,062,821	\$2,113,720,237	\$6,179,674
Rhode Island	\$1,338,212,632	\$644,332,600	\$59,878	\$205,337,954	\$827,901
South Carolina	\$3,641,714,949	\$1,782,098,595	\$0	\$664,985,591	\$1,134,781
South Dakota	\$541,910,489	\$268,093,954	\$3,083,784	\$153,745,138	\$344,272
Tennessee	\$5,459,293,763	\$3,131,874,594	\$3,876,681	\$936,106,192	\$2,773,247
Texas	\$12,524,526,333	\$7,954,322,503	\$15,444,765	\$2,712,997,507	\$3,352,181
Utah	\$1,200,789,487	\$568,969,497	\$246,194	\$169,839,494	\$392,427
Vermont	\$641,738,944	\$361,646,452	\$385,655	\$87,222,769	\$1,191,188
Virginia	\$3,180,990,089	\$1,653,808,099	\$17,246,154	\$948,419,021	\$3,082,006
Washington	\$4,524,032,645	\$2,028,408,909	\$7,184,927	\$884,250,550	\$2,492,428
West Virginia	\$1,829,967,627	\$893,522,701	\$8,258,757	\$0	\$0
Wisconsin	\$3,921,363,613	\$1,795,690,739	\$4,113,395	\$1,048,987,705	\$3,703,949
Wyoming	\$324,630,777	\$172,590,664	\$1,483,934	\$30,434,001	\$74,492

¹Eligibles are defined as individuals who were on the Medicaid roles at least one month during the year.

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Q1 1 = Qualifying Individuals (1)

Q1 2 = Qualifying Individuals (2)

Other = Other Dual Eligibles, Dual Category Unknown, and Dual Status Unknown

Source: CMS, MSIS Report, FY 2003.

Total Medicaid Medical Vendor Payments and Dual Eligibility Status, 2003 (Con't)¹

State	SLMB/ Medicaid	QDWI	QI (1)	QI (2)	Other
National Total	\$3,828,209,038	\$312,874	\$179,521,616	\$3,033,892	\$57,049,502,603
Alabama	\$116,558,070	\$0	\$2,284,465	\$109,537	\$990,063,941
Alaska	\$0	\$0	\$0	\$0	\$148,913,985
Arizona	\$0	\$0	-\$14,305	\$562	\$575,491,973
Arkansas	\$0	\$241,114	\$436,971	\$6,814	\$141,353,311
California	\$9,628,955	\$0	\$1,345,299	\$104,722	\$4,539,623,582
Colorado	\$0	\$0	\$251,724	\$6,703	\$669,620,424
Connecticut	\$205,416,491	\$0	\$544,863	\$0	\$726,110,910
Delaware	\$0	\$0	\$0	\$0	\$196,414,510
District of Columbia	\$17,854,838	\$0	\$748,709	\$110,128	\$226,662,404
Florida	\$321,002,065	\$0	\$32,549,965	\$0	\$2,418,310,782
Georgia	\$140,543	\$0	\$1,430,840	\$0	\$2,311,435,600
Hawaii	\$0	\$0	\$0	\$0	\$126,443,946
Idaho	\$0	\$0	\$0	\$0	\$226,304,680
Illinois	\$290,390,008	\$0	\$69,483,363	\$0	\$3,021,531,939
Indiana	\$257,797,179	\$0	\$459,916	\$85,576	\$751,486,972
Iowa	\$125,765,286	\$0	\$351,840	\$83,345	\$409,351,176
Kansas	\$4,488,726	\$0	\$284,568	\$0	\$441,550,042
Kentucky	\$110,012,182	\$0	\$1,086,481	\$70,013	\$648,806,642
Louisiana	\$1,108,693	\$0	\$807,791	\$160,694	\$390,431,117
Maine	\$33,758,981	\$35,066	\$2,417,650	\$248,303	\$330,976,396
Maryland	\$0	\$0	\$895,905	\$135,683	\$1,055,600,486
Massachusetts	\$0	\$0	\$759,013	\$231,415	\$2,306,003,642
Michigan	\$143,599,732	\$17,165	\$5,985,751	\$55,878	\$2,563,823,465
Minnesota	\$248,477,214	-\$503	\$960,986	\$0	\$930,823,307
Mississippi	\$0	\$0	\$0	\$27,123	\$156,147,969
Missouri	\$124,883,481	\$0	\$135,172	\$22,123	\$1,146,203,866
Montana	\$2,166,044	\$0	\$0	\$0	\$145,460,879
Nebraska	\$0	\$0	\$0	\$0	\$531,090,692
Nevada	\$0	\$0	\$0	\$0	\$126,497,495
New Hampshire	\$17,001,049	\$0	\$16,287	\$0	\$343,328,081
New Jersey	\$0	\$0	\$11,590,470	\$0	\$530,094,739
New Mexico	\$0	\$0	\$0	\$0	\$291,261,462
New York	\$156,502,326	\$0	\$20,760,072	\$0	\$12,680,661,494
North Carolina	\$152,835,842	\$0	\$4,197,157	\$0	\$890,461,189
North Dakota	\$2,572,020	\$0	\$14,485	\$12	\$273,776,228
Ohio	\$178,323	\$0	\$8,461,793	\$1,133,114	\$2,446,904,679
Oklahoma	\$11,058,735	\$0	\$461,115	\$6,487	\$112,004,616
Oregon	\$92,800,662	\$0	\$2,832,267	\$0	\$455,922,474
Pennsylvania	\$472,817,285	\$0	\$2,828,193	\$178,558	\$1,736,642,637
Rhode Island	\$0	\$0	\$299,945	\$13,980	\$487,340,374
South Carolina	\$0	\$0	\$983,129	\$15,035	\$1,192,497,818
South Dakota	\$25,241,554	\$0	\$98,733	\$9,232	\$91,293,822
Tennessee	\$212,394,768	\$0	\$0	\$0	\$1,172,268,281
Texas	\$364,528,415	\$0	\$1,432,283	\$0	\$1,472,448,679
Utah	\$29,404,164	\$0	\$153,139	\$1,829	\$431,782,743
Vermont	\$5,023,141	\$0	\$0	\$0	\$186,269,739
Virginia	\$0	\$20,032	\$1,189,539	\$216,886	\$557,008,352
Washington	\$11,523,621	\$0	\$891,633	\$0	\$1,589,280,577
West Virginia	\$0	\$0	\$0	\$0	\$928,186,169
Wisconsin	\$158,770,142	\$0	\$86,932	\$49	\$910,010,702
Wyoming	\$102,508,503	\$0	\$17,477	\$91	\$17,521,615

¹Eligibles are defined as individuals who were on the Medicaid rolls at least one month during the year.

QMB Only = Qualified Medicare Beneficiaries Without Other Medicaid

QMB/ Medicaid = QMBs With Full Medicaid

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QDWI = Qualified Disabled and Working Individuals

QI 1 = Qualifying Individuals (1)

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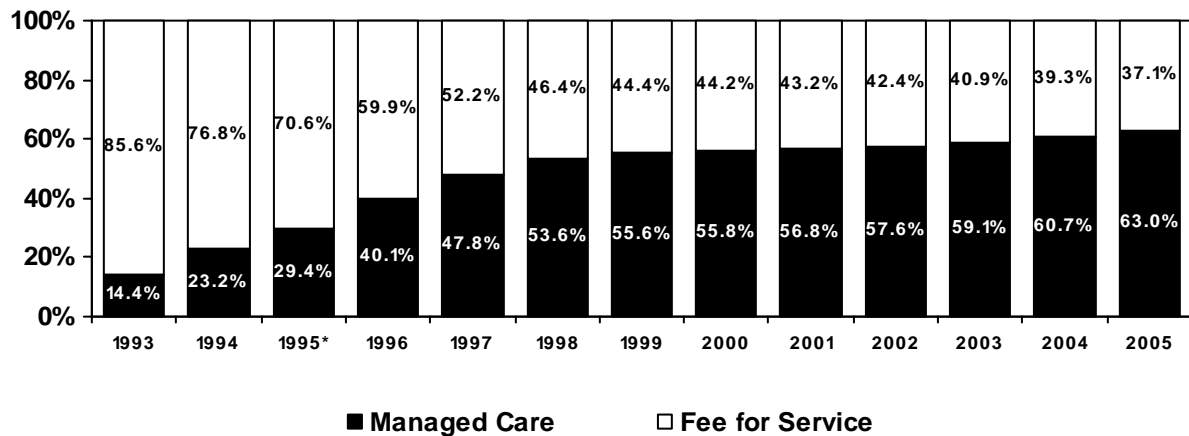
Other = Other Dual Eligibles, Dual Category Unknown, and Dual Status Unknown

Source: CMS, MSIS Report, FY 2003

MEDICAID MANAGED CARE ENROLLMENT

Since 1981, when Congress authorized States to implement Section 1915(b) and Section 1115 Medicaid waivers to increase access to managed care and test innovative health care financing and delivery options, enrollment in Medicaid managed care has grown considerably, although the trend appears to be leveling off. Since 1993, managed care enrollment has increased from 14.4% to 63.0% of total Medicaid enrollment. In 2005, 63.0% of all Medicaid beneficiaries were enrolled in some type of managed care program. As of June 30, 2005, all but two States (Alaska and Wyoming) were enrolling Medicaid beneficiaries in some type of managed care plan.

Figure 2-1: Managed Care Enrollment as a Percentage of Total Medicaid Enrollment



Source: Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 2005. DHHS, CMS, Center for Medicaid & State Operations. *Approximated numbers for 1995. Total Medicaid population was provided by the Office of the Actuary, which used CMS 2082 data to calculate average Medicaid enrollees over 1995. The managed care population differs from the 11,619,929 reported in the 1995 report as the number represented enrollment of some beneficiaries in more than one plan.

TYPES OF MEDICAID MANAGED CARE PLANS

Medicaid managed care beneficiaries can be enrolled in one of five basic Medicaid managed care plans:

- **Health Insuring Organization (HIO):** an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.
- **Commercial Managed Care Organization (Com-MCO):** a Com-MCO is a health maintenance organization with a contract under §1876 or a Medicare+Choice organization, a provider sponsored organization or any other private or public organization, which meets the requirements of §1902(w). They provide comprehensive services to commercial and/or Medicare enrollees, as well as Medicaid enrollees.

- **Medicaid-only Managed Care Organization (Mcaid-MCO):** an MCO that provides comprehensive services to Medicaid beneficiaries, but not commercial or Medicare enrollees.
- **Prepaid Inpatient Health Plan (PIHP):** an entity that provides less than comprehensive services on an at-risk basis or one that provides any benefit package on a non-risk or other than State reimbursement Plan basis; and provides, arranges for or otherwise has responsibility for the provision of any inpatient hospital or institutional services.
- **Prepaid Ambulatory Health Plan (PAHP):** a prepaid ambulatory health plan that provides less than comprehensive services on an at-risk or other than State Plan reimbursement basis, and does not provide, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services.
- **Primary Care Case Management (PCCM):** a provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse-midwives, or physician assistants) who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category includes those PIHPs that act as PCCMs.
- **Program for All-Inclusive Care for the Elderly (PACE):** a program that provides prepaid, capitated comprehensive health care services to the frail elderly.
- **“Other” Managed Care Arrangement:** An entity where the plan is not considered a PCCM, PIHP, PAHP, Comprehensive MCO, Medicaid-only MCO, HIO, or PACE.

The most utilized of these plans are Comprehensive MCOs and Prepaid Health Plans.

Table 2-1: Medicaid Managed Care Plans

	Number of Plans	Number of Enrollees
Health Insuring Organization (HIO)	5	500,780
Commercial Managed Care Organization (COM-MCO)	157	9,780,823
Medicaid-Only Managed Care Organization (Mcaid-MCO)	130	8,606,164
Primary Care Case Management (PCCM)	36	6,559,561
Prepaid Inpatient Health Plan (PIHP)	107	8,119,325
Prepaid Ambulatory Health Plan (PAHP)	43	4,986,161
Program of All-Inclusive Care for the Elderly (PACE)	33	11,824
Other	8	549,358
Total	519	39,113,996*

*This table provides duplicated figures by plan type. The total number of enrollees includes 10,538,411 individuals who were enrolled in more than one managed care plan. It also includes individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

Source: Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 2005. DHHS, CMS, Center for Medicaid & State Operations.

The following tables provide an overview of Medicaid managed care enrollment at the State level.

Medicaid Managed Care Enrollment, As of June 30, 2005

State	Medicaid Enrollment	Medicaid Managed Care Enrollment	Percent in Managed Care	Rank Based on Percent in Managed Care
National Total	45,392,325	28,575,585	62.95%	
Alabama	820,629	496,190	60.46%	39
Alaska	97,767	0	0.00%	51
Arizona	997,344	885,204	88.76%	13
Arkansas	624,155	505,942	81.06%	17
California	6,552,553	3,290,851	50.22%	41
Colorado	410,445	389,769	94.96%	6
Connecticut	403,437	302,427	74.96%	21
Delaware	140,202	106,783	76.16%	20
District of Columbia	140,843	91,217	64.77%	32
Florida	2,247,559	1,487,991	66.20%	30
Georgia	1,377,746	1,319,554	95.78%	5
Hawaii	200,534	160,130	79.85%	18
Idaho	172,097	142,512	82.81%	16
Illinois	1,827,200	175,000	9.58%	49
Indiana	810,744	555,642	68.53%	26
Iowa	297,943	274,094	92.00%	7
Kansas	275,580	154,184	55.95%	40
Kentucky	692,053	636,465	91.97%	8
Louisiana	964,106	761,468	78.98%	19
Maine	266,306	164,774	61.87%	34
Maryland	716,158	482,749	67.41%	28
Massachusetts	992,330	610,437	61.52%	35
Michigan	1,435,236	1,290,240	89.90%	12
Minnesota	573,218	377,912	65.93%	31
Mississippi	633,123	85,197	13.46%	47
Missouri	949,341	427,615	45.04%	45
Montana	84,282	57,475	68.19%	27
Nebraska	206,971	147,245	71.14%	22
Nevada	175,043	175,043	100.00%	1
New Hampshire	100,000	2,000	2.00%	50
New Jersey	802,060	553,461	69.00%	25
New Mexico	411,069	248,990	60.57%	38
New York	4,188,586	2,575,175	61.48%	36
North Carolina	1,137,506	806,634	70.91%	23
North Dakota	53,880	32,670	60.63%	37
Ohio	1,711,152	534,265	31.22%	46
Oklahoma	544,306	473,369	86.97%	14
Oregon	411,478	372,789	90.60%	10
Pennsylvania	1,697,693	1,534,331	90.38%	11
Puerto Rico	866,549	865,299	99.86%	3
Rhode Island	180,457	125,250	69.41%	24
South Carolina	833,027	81,964	9.84%	48
South Dakota	100,932	98,391	97.48%	4
Tennessee	1,349,591	1,349,591	100.00%	1
Texas	2,767,261	1,339,194	48.39%	42
Utah	203,016	184,829	91.04%	9
Vermont	130,208	87,061	66.86%	29
Virgin Islands	10,900	0	0.00%	51
Virginia	673,995	421,431	62.53%	33
Washington	963,057	816,576	84.79%	15
West Virginia	296,020	140,584	47.49%	43
Wisconsin	813,198	377,621	46.44%	44
Wyoming	61,439	0	0.00%	51

State Medicaid enrollment includes individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards. This table provides unduplicated figures for Medicaid Enrollment and Managed Care Enrollment by State for a single point in time. These values differ significantly (i.e., are lower than) unduplicated annual counts of enrollees over the entire year.

Source: Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 2005. DHHS, CMS, Center for Medicaid & State Operations.

Pharmaceutical Benefits Under Managed Care Plans

State	Where do managed care recipients receive pharmacy benefits? (State, Managed Care Plan, Both)	Special requirements for pharmacy benefits in managed care?
Alabama	N/A	N/A
Alaska	-	-
Arizona	-	-
Arkansas	State	-
California	Both	Statutes, regulations, guidelines, contractual
Colorado	Managed Care Plan	Statutes, regulations, contractual
Connecticut	Managed Care Plan	Statutes, regulations, contractual
Delaware	State	N/A
District of Columbia	Managed Care Plan	Regulations, contractual
Florida	Managed Care Plan	Statutes
Georgia	-	-
Hawaii	Managed Care Plan (Except dental and behavioral health)	Guidelines
Idaho	N/A	N/A
Illinois	State	-
Indiana	Managed Care Plan	Statutes
Iowa	State	None
Kansas	Managed Care Plan (Except hemophilia drugs)	Statutes, regulations, guidelines, contractual
Kentucky	Both	Contractual
Louisiana	N/A	N/A
Maine	State	N/A
Maryland	Both	Regulations
Massachusetts	Both	Contractual
Michigan	Managed Care Plan	Contractual, policy
Minnesota	Managed Care Plan	Statutes
Mississippi	State	-
Missouri	Managed Care Plan	Regulations, guidelines
Montana	State	None
Nebraska	State	-
Nevada	Managed Care Plan	None
New Hampshire	State	None
New Jersey	Both	Contractual
New Mexico	Managed Care Plan	Regulations, contractual
New York	State	N/A
North Carolina	State	-
North Dakota	State	None
Ohio	Managed Care Plan	Statutes
Oklahoma	State	-
Oregon	Both	Statutes, regulations, guidelines, contractual
Pennsylvania	Both	Statutes, regulations, guidelines, contractual
Rhode Island	Managed Care Plan	Regulations
South Carolina	Managed Care Plan	Guidelines, contractual
South Dakota	N/A	N/A
Tennessee	State	-
Texas	State	N/A
Utah	State	-
Vermont	State	None
Virginia	Managed Care Plan	Regulations, State Plan
Washington	Both	Contractual
West Virginia	State	N/A
Wisconsin	Managed Care Plan	Statutes, regulations, guidelines, contractual
Wyoming	-	-

“-” indicates Not Applicable, “N/A” indicates “No Answer” was received on the Survey.

Sources: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Medicaid Managed Care Enrollment Trends, 2000-2005

State	2000	2001	2002	2003	2004	2005
National Total	18,786,137	20,773,813	23,117,668	25,262,873	26,913,570	28,575,585
Alabama	325,059	350,485	405,090	404,797	439,832	496,190
Alaska	0	0	0	0	0	0
Arizona	442,254	527,674	697,171	808,506	806,193	885,204
Arkansas	222,261	257,662	336,111	374,067	386,395	505,942
California	2,525,406	2,870,514	3,191,168	3,258,787	3,258,787	3,290,851
Colorado	254,232	247,181	278,095	262,263	369,270	389,769
Connecticut	229,995	239,829	280,106	294,331	303,404	302,427
Delaware	75,535	83,422	87,465	86,709	99,598	106,783
District of Columbia	78,864	79,673	80,300	85,370	88,452	91,217
Florida	1,016,641	1,184,506	1,267,998	1,354,025	1,450,117	1,487,991
Georgia	806,009	878,140	1,043,154	1,212,639	1,273,133	1,319,554
Hawaii	121,581	127,779	132,787	141,399	145,580	160,130
Idaho	32,338	37,913	58,284	101,257	131,693	142,512
Illinois	137,622	136,497	130,988	137,682	158,869	175,000
Indiana	376,066	433,014	484,116	502,401	509,732	555,642
Iowa	182,251	206,751	227,495	243,954	262,487	274,094
Kansas	108,093	118,209	130,162	141,119	153,395	154,184
Kentucky	464,191	489,711	500,987	611,878	625,807	636,465
Louisiana	48,802	56,542	206,992	505,434	723,837	761,468
Maine	57,151	96,051	110,922	148,151	154,785	164,774
Maryland	385,687	421,355	451,307	466,688	469,998	482,749
Massachusetts	583,324	616,241	628,832	572,835	581,520	610,437
Michigan	1,063,557	1,023,264	1,208,803	1,314,810	1,255,067	1,290,240
Minnesota	291,365	322,640	368,186	362,349	361,381	377,912
Mississippi	218,431	297,916	0	0	73,445	85,197
Missouri	304,499	378,771	413,361	425,161	432,339	427,615
Montana	42,312	46,995	52,209	55,372	58,030	57,475
Nebraska	140,199	150,840	163,772	142,377	149,405	147,245
Nevada	37,945	47,518	60,823	74,923	89,846	175,043
New Hampshire	4,432	6,200	9,206	13,407	0	2,000
New Jersey	371,641	459,087	523,904	525,864	541,820	553,461
New Mexico	199,297	212,456	243,069	261,015	273,018	248,990
New York	691,422	728,709	1,099,900	1,914,794	2,341,733	2,575,175
North Carolina	598,852	674,133	722,089	749,152	788,943	806,634
North Dakota	23,962	25,540	30,808	35,515	33,065	32,670
Ohio	239,460	277,617	378,476	436,146	507,337	534,265
Oklahoma	279,205	299,272	338,819	338,859	354,110	473,369
Oregon	312,064	360,926	378,739	330,874	345,410	372,789
Pennsylvania	975,211	1,037,374	1,140,211	1,192,031	1,265,891	1,534,331
Puerto Rico	828,021	898,171	865,285	857,310	842,827	865,299
Rhode Island	104,041	111,624	117,024	119,257	124,921	125,250
South Carolina	32,149	41,716	64,272	71,195	69,791	81,964
South Dakota	67,835	79,641	85,868	90,733	95,577	98,391
Tennessee	1,323,319	1,426,622	1,430,966	1,304,794	1,345,131	1,349,591
Texas	606,238	753,613	839,798	1,065,945	1,150,773	1,339,194
Utah	119,200	128,898	154,784	162,364	167,338	184,829
Vermont	55,605	78,181	82,261	85,751	86,263	87,061
Virgin Islands	0	0	0	0	0	0
Virginia	280,978	291,767	323,863	262,961	398,871	421,431
Washington	800,481	766,366	829,625	854,861	834,883	816,576
West Virginia	90,631	122,230	144,911	151,515	156,468	140,584
Wisconsin	210,423	266,577	317,106	349,246	374,003	377,621
Wyoming	0	0	0	0	0	0

State Medicaid enrollment includes individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

Sources: Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 2000; 2001; 2002; 2003; 2004; 2005. DHHS, CMS, Center for Medicaid & State Operations.

Medicaid Managed Care Plan Type, As of June 30, 2005

State	Commercial		Medicaid-only		PCCM	PIHP	PAHP	PACE	Other
	HIO	MCO	MCO						
National Total	5	157	130		36	107	43	33	8
Alabama	0	0	0		1	2	0	0	0
Alaska	-	-	-		-	-	-	-	-
Arizona	0	0	26		0	1	0	0	0
Arkansas	0	0	0		1	0	1	0	0
California	5	22	1		0	0	11	4	1
Colorado	0	0	2		1	6	0	1	0
Connecticut	0	2	2		0	0	0	0	0
Delaware	0	0	1		0	0	0	0	1
District of Columbia	0	0	3		0	1	0	0	0
Florida	0	10	1		1	3	6	1	2
Georgia	0	0	0		1	1	1	0	0
Hawaii	0	2	1		0	2	0	0	1
Idaho	0	0	0		1	0	0	0	0
Illinois	0	3	2		0	0	0	0	0
Indiana	0	0	5		3	0	0	0	0
Iowa	0	1	0		1	1	0	0	0
Kansas	0	0	1		1	0	0	1	0
Kentucky	0	0	1		1	0	1	0	0
Louisiana	0	0	0		1	0	0	0	0
Maine	0	0	0		1	0	0	0	0
Maryland	0	0	7		0	0	0	1	0
Massachusetts	0	2	2		1	1	0	6	0
Michigan	0	6	9		0	18	0	1	0
Minnesota	0	6	3		0	0	0	0	0
Mississippi	0	0	0		0	0	1	0	0
Missouri	0	3	4		0	0	0	1	0
Montana	0	0	0		1	0	0	0	0
Nebraska	0	1	0		1	0	0	0	1
Nevada	0	2	0		0	0	1	0	0
New Hampshire	0	0	0		0	0	1	0	0
New Jersey	0	2	3		0	0	0	0	0
New Mexico	0	2	1		0	0	0	1	0
New York	0	13	22		4	12	1	4	1
North Carolina	0	1	0		2	2	0	0	0
North Dakota	0	1	0		1	0	0	0	0
Ohio	0	3	2		0	0	4	2	0
Oklahoma	0	0	0		1	0	2	0	0
Oregon	0	2	11		1	9	8	1	1
Pennsylvania	0	5	7		1	27	0	3	0
Puerto Rico	0	5	0		0	2	0	0	0
Rhode Island	0	3	0		0	0	0	0	0
South Carolina	0	0	2		1	0	1	1	0
South Dakota	0	0	0		1	0	1	0	0
Tennessee	0	4	3		0	2	0	1	0
Texas	0	9	2		2	1	0	2	0
Utah	0	0	0		1	12	1	0	0
Vermont	0	0	0		1	0	0	0	0
Virgin Islands	-	-	-		-	-	-	-	-
Virginia	0	6	1		1	0	0	0	0
Washington	0	5	2		1	1	2	1	0
West Virginia	0	3	0		1	0	0	0	0
Wisconsin	0	33	3		0	3	0	1	0
Wyoming	-	-	-		-	-	-	-	-

HIO=Health Insuring Organization; Commercial MCO=Commercial Managed Care Organization; Medicaid-only MCO=Medicaid-only Managed Care Organization; PCCM=Primary Care Case Management; PIHP=Prepaid Inpatient Health Plan; PAHP=Prepaid Ambulatory Health Plans; PACE=Program for All-Inclusive Care for the Elderly.

Source: Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 2005. DHHS, CMS, Center for Medicaid & State Operations.

Medicaid Managed Care Enrollment by Plan Type, As of June 30, 2005

State	HIO	Commercial MCO	Medicaid- only MCO	PCCM	PIHP	PAHP	PACE	Other
National Total	500,780	9,780,823	8,606,164	6,559,561	8,119,325	4,986,161	11,824	549,358
Alabama	-	-	-	409,234	496,657	-	-	-
Alaska	-	-	-	-	-	-	-	-
Arizona	-	-	885,204	-	79,931	-	-	-
Arkansas	-	-	-	499,029	-	422,127	-	-
California	500,780	2,647,834	835	-	-	365,205	1,778	3,465
Colorado	-	-	61,255	44,570	402,808	-	897	-
Connecticut	-	214,590	87,837	-	-	-	-	-
Delaware	-	-	94,099	-	-	-	-	12,684
District of Columbia	-	-	91,217	-	3,385	-	-	-
Florida	-	550,302	215,156	705,665	117,091	374,712	103	33
Georgia	-	-	-	872,146	2,519	1,319,554	-	-
Hawaii	-	107,683	50,468	-	1,526	-	-	2,135
Idaho	-	-	-	142,512	-	-	-	-
Illinois	-	84,500	90,500	-	-	-	-	-
Indiana	-	-	415,315	217,535	-	-	-	-
Iowa	-	5,291	-	134,953	274,094	-	-	-
Kansas	-	-	67,819	86,203	-	-	162	-
Kentucky	-	-	135,642	331,528	-	636,465	-	-
Louisiana	-	-	-	761,468	-	-	-	-
Maine	-	-	-	164,774	-	-	-	-
Maryland	-	-	482,601	-	-	-	148	-
Massachusetts	-	108,142	226,000	276,295	297,614	-	1,348	-
Michigan	-	333,487	570,752	-	1,290,053	-	187	-
Minnesota	-	351,410	26,502	-	-	-	-	-
Mississippi	-	-	-	-	-	85,197	-	-
Missouri	-	120,710	306,735	-	-	-	170	-
Montana	-	-	-	57,475	-	-	-	-
Nebraska	-	31,127	-	37,906	-	-	-	147,245
Nevada	-	81,861	-	-	-	175,043	-	-
New Hampshire	-	-	-	-	-	2,000	-	-
New Jersey	-	188,921	364,540	-	-	-	-	-
New Mexico	-	124,391	124,599	-	-	-	227	-
New York	-	795,053	1,729,198	20,002	11,268	6,510	2,137	11,007
North Carolina	-	9,083	-	797,551	64,587	-	-	-
North Dakota	-	749	-	31,921	-	-	-	-
Ohio	-	110,856	419,308	-	-	3,469	632	-
Oklahoma	-	-	-	6,798	-	838,553	-	-
Oregon	-	28,288	249,942	11,501	337,204	363,326	593	372,789
Pennsylvania	-	459,095	778,028	272,627	1,157,001	-	699	-
Puerto Rico	-	848,576	-	-	848,576	-	-	-
Rhode Island	-	125,250	-	-	-	-	-	-
South Carolina	-	-	59,391	10,892	-	11,276	405	-
South Dakota	-	-	-	76,640	-	98,391	-	-
Tennessee	-	895,590	454,001	-	1,349,591	-	281	-
Texas	-	490,196	366,358	347,101	306,794	-	902	-
Utah	-	-	-	48,220	252,132	161,284	-	-
Vermont	-	-	-	87,061	-	-	-	-
Virgin Islands	-	-	-	-	-	-	-	-
Virginia	-	249,161	86,253	86,017	-	-	-	-
Washington	-	450,203	45,545	4,106	816,576	123,049	237	-
West Virginia	-	122,753	-	17,831	-	-	-	-
Wisconsin	-	245,721	121,064	-	9,918	-	918	-
Wyoming	-	-	-	-	-	-	-	-

* This table provides **duplicated** figures that include enrollees receiving comprehensive and limited benefits. Total number of enrollees includes those who were enrolled in more than one managed care plan. Figures also include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

Source: Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 2005. DHHS, CMS, Center for Medicaid & State Operations.

Medicaid Managed Care Enrollment by Payment Arrangement, As of June 30, 2005

State	Fee-for-Service (FFS)	Capitated	Other
National Total	7,097,738	31,761,091	255,167
Alabama	409,234	477,450	19,207
Alaska			
Arizona		965,135	
Arkansas	499,029	422,127	
California		3,519,897	
Colorado	44,570	464,960	
Connecticut		302,427	
Delaware	12,684	94,099	
District of Columbia		94,602	
Florida	723,752	1,074,371	164,939
Georgia	872,146	1,322,073	
Hawaii		161,812	
Idaho	142,512		
Illinois		175,000	
Indiana	217,535	415,315	
Iowa	134,953	279,385	
Kansas	86,203	67,981	
Kentucky	331,528	772,107	
Louisiana	761,468		
Maine	164,774		
Maryland		482,749	
Massachusetts	276,295	633,104	
Michigan		2,194,479	
Minnesota		377,912	
Mississippi		85,197	
Missouri		427,615	
Montana	57,475		
Nebraska	185,151	31,127	
Nevada		256,904	
New Hampshire		2,000	
New Jersey		553,461	
New Mexico		249,217	
New York	7,374	2,567,801	
North Carolina	797,551	73,670	
North Dakota	31,921	749	
Ohio		534,265	
Oklahoma	6,798	838,553	
Oregon	384,290	979,353	
Pennsylvania	272,627	2,394,823	
Puerto Rico		1,697,152	
Rhode Island		125,250	
South Carolina	10,892	71,072	
South Dakota	76,640	98,391	
Tennessee		2,699,463	
Texas	347,101	1,164,250	
Utah	48,220	342,395	71,021
Vermont	87,061		
Virgin Islands			
Virginia	86,017	335,414	
Washington	4,106	1,435,610	
West Virginia	17,831	122,753	
Wisconsin		377,621	
Wyoming			

Individual State totals may not sum to total managed care enrollment (page 2-29) because State totals include individuals enrolled in more than one plan type including dental, mental, and long-term care.

Source: Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 2005. DHHS, CMS, Center for Medicaid & State Operation

MEDICAID MANAGED CARE WAIVERS

In 1981, Congress authorized States to implement Section 1915(b) and Section 1115 Medicaid waivers to increase access to managed care and test innovative health care financing and delivery options. The U.S. Department of Health and Human Services (DHHS) granted these waivers to allow States to “waive” certain Medicaid requirements in Sections 1902 and 1903 of the Social Security Act and “mandate” enrollment of Medicaid eligibles in managed care programs.

SECTION 1915(b) “FREEDOM OF CHOICE” WAIVERS

Section 1915(b) waivers are granted to give States the authority to conduct Medicaid programs outside of the scope of the Medicaid statute, allowing them to waive freedom of choice, statewide access to care, and comparability requirements under Section 1902 of the Social Security Act. With a 1915(b) waiver, a State can require mandatory enrollment of Medicaid recipients in managed care plans. Section 1915(b) waivers can also allow a State to create a “carveout” delivery system for specialty care, e.g., a Managed Behavioral Health Care Plan. Section 1915(b) waivers cannot negatively impact beneficiary access or quality of care of services, and must be cost-effective (i.e., cost must be less than the Medicaid program would cost without the waiver). Section 1915(b) waivers are typically limited to a targeted geographical area or population, are approved for an initial period of two years, and can be renewed on an ongoing basis if the State reapplies.

Four options for 1915(b) waivers exist; each is governed by a different subsection(s) of Section 1915(b);

- Paragraph (b)(1) - Case Management: States are allowed to implement case management systems which can be as simple as requiring each beneficiary to choose a primary care provider or as comprehensive as mandating enrollment in a prepaid health plan. The Balanced Budget Act of 1997 also gave States the option to enroll certain beneficiaries into managed care via a State Plan Amendment.
- Paragraph (b)(2) - Central Broker: Localities are allowed to act as a central broker in assisting Medicaid eligibles in selecting among competing health care plans, if such a restriction does not substantially impair access to medically necessary services of adequate quality.
- Paragraph (b)(3) - Shared Cost Saving: States are allowed to share (through provision of additional services) cost savings (resulting from use by the recipient of more cost-effective medical care) with recipients of medical assistance under the State Plan.
- Paragraph (b)(4) - Restrict Providers: States can limit the number of providers of certain services. These waivers are sometimes referred to as selective contracting waivers and are gaining in popularity. For example, some approved 1915(b)(4) waivers include programs to restrict the number of providers of transportation services, organ transplants, and inpatient obstetrical care.

Although Section 1915(b) waivers allow States to increase access to managed care plans, States are still limited under Federal regulations and cannot use them to serve beneficiaries beyond Medicaid State Plan Eligibility or change their benefits package. In order to expand their Medicaid programs even further than under Section 1915(b) waivers, States apply for Section 1115 research and demonstration waivers.

SECTION 1115 RESEARCH AND DEMONSTRATION WAIVERS

Section 1115 research and demonstration waivers release States from standard Medicaid requirements, allowing them the flexibility to test substantially new ideas of policy merit. Along with Section 1915(b) waivers, Section 1115 waivers allow States to waive freedom of choice, statewide access to care, and comparability requirements. However, a Section 1115 waiver also allows States to provide new and additional services, test new payment methods, offer benefits to new and expanded populations, and contract with managed care organizations that do not meet the necessary criteria of Section 1903 of the Social Security Act.

To receive approval of a Section 1115 waiver, States submit a proposal to CMS for discussion and review. Once operational, States allow formal evaluations of the research and public policy value of the programs and to demonstrate that their programs do not exceed costs, which would have otherwise occurred under traditional Medicaid programs (i.e., States must demonstrate budget neutrality). Section 1115 waivers are usually granted for a five-year period and each State must submit a request for continuation. For example, Arizona has operated its program under a Section 1115 waiver for over 20 years. The Benefits Improvement and Protection Act (BIPA) of 2000 streamlined the process for States to submit requests for and receive extensions of Section 1115 demonstration waivers.

PHARMACY PLUS DEMONSTRATIONS UNDER SECTION 1115 AUTHORITY

Section 1115 demonstration authority may be used to extend pharmacy coverage to certain low-income elderly and disabled individuals who are not otherwise eligible for Medicaid. This type of Section 1115 waiver program is commonly referred to as “Pharmacy Plus.” Its purpose is to provide a subsidized pharmacy benefit that is intended to assist individuals in maintaining their healthy status and avoid spending down to Medicaid income and asset eligibility levels. The waivers will test how provision of a pharmacy benefit to a non-Medicaid covered population will affect Medicaid costs, utilization and future eligibility trends.

Pharmacy Plus demonstrations have been largely discontinued since the implementation of Medicare Part D. Wisconsin is the only state continuing its waiver program, through summer 2007.

Section 1915(b) and 1115 Waivers

State	Official Program Name	Waiver Authority	Date Originally Approved
Alabama	Alabama Patient 1st 1915(b)	1915(b)	10/02/1996
Alabama	Alabama Family Planning 1115	1115	07/01/2000
Alabama	Alabama Hurricane Katrina Relief Program	1115 Katrina	09/22/2005
Alaska	Alaska Denali KidCare 1115	1115	09/24/2004
Alaska	Alaska Non Emergency Transportation 1915b	1915(b)	11/18/2005
Arizona	Arizona HIFA	1115 HIFA	12/12/2001
Arizona	Arizona Health Care Cost Containment System	1115	07/13/1982
Arizona	Arizona Hurricane Katrina Relief	1115 Katrina	03/06/2006
Arizona	Arizona Health Care Cost Containment System	1115	07/13/1982
Arkansas	Arkansas RX Senior Care 1115	1115	Pending
Arkansas	Arkansas ARKidsB 1115	1115	08/19/1997
Arkansas	Arkansas Primary Care Physician Program 1915(b)	1915(b)	06/11/1993
Arkansas	Arkansas Non Emergency Transportation Waiver 1915(b)	1915(b)	02/19/1998
Arkansas	Arkansas TEFRA-Like 1115 Demonstration	1115	10/17/02
Arkansas	Arkansas Independent Choices - Cash and Counseling	1115	10/9/98
Arkansas	Arkansas Hurricane Katrina Relief Program	1115 Katrina	09/28/2005
Arkansas	Arkansas Family Planning 1115	1115 Family Planning	06/18/1996
Arkansas	Arkansas HIFA 1115	1115	03/03/2006
California	California Parental Coverage Expansion	1115 HIFA	01/25/2002
California	California In Home Supportive Services Plus Demonstration	1115	06/30/2004
California	California Geographic Managed Care Sacramento	1915(b)	11/22/1996
California	California Two Plan Model	1915(b)	10/17/1998
California	California Medi-Cal Hospital Uninsured Care 1115 Waiver	1115	08/24/2005
California	California - ICF/DD-CN (Intermediate Care Facility/Developmentally Disabled..)	1915(b)	8/17/01
California	Specialty Mental Health Service Consolidation - Medi-Cal	1915(b)	11/16/00
California	Medicaid Demonstration Project for Los Angeles County	1115	04/15/1996

Source: CMS, Medicaid Waivers and Demonstrations List, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

Section 1915(b) and 1115 Waivers (Cont.)

State	Official Program Name	Waiver Authority	Date Originally Approved
California	California Family Planning, Access, Care and Treatment (PACT) 1115	1115	12/01/1999
California	California Health Insuring Organizations (HIOs)	1915(b)	07/10/2003
California	California Health Plan of San Mateo	1915(b)	12/30/1987
California	California CalOPTIMA	1915(b)	10/01/1995
California	California Fee For Service Managed Care Network	1915(b)	02/28/1997
California	California Health San Diego	1915(b)	10/07/1998
California	California Selective Provider Contracting 1915(b)	1915(b)	07/21/1982
California	California Solano Partnership Health Plan 1915(b)	1915(b)	05/01/1994
California	California Children's Services and Sacramento Dental Geographic Managed Care	1915(b)	08/13/2003
California	California Santa Barbara Health Initiative 1915(b)	1915(b)	01/01/1987
California	California Primary Care Case Management 1915(b)	1915(b)	12/20/1982
California	California Central Coast Alliance for Health	1915(b)	01/01/1996
California	California Hurricane Katrina Relief Program	1115 Katrina	12/07/2005
Colorado	Colorado Family Planning 1115	1115	withdrawn
Colorado	Community Mental Health Services Program	1915(b)	3/6/1998
Colorado	Consumer Directed Attendant Support Project	1115	8/10/01
Colorado	Colorado Adult Prenatal Coverage in CHP+ HIFA	HIFA 1115	09/27/2002
Connecticut	Connecticut Medicaid Transfer of Assets Reform	1115	pending
Connecticut	Connecticut ConnPACE Program Rx	1115	pending
Connecticut	Connecticut HUSKY Plan Part A	1915(b)	07/20/1995
Delaware	Delaware Pharmacy Assistance Program 1115	1115	Disapproved
Delaware	Delaware Healthy Adult Program HIFA	1115	Disapproved
Delaware	Delaware Diamond State Health Plan 1115	1115	05/17/1995
District of Columbia	District of Columbia 1115 for Childless Adults	1115	03/07/2002
District of Columbia	D.C. Program to Enhance Medicaid Access for Low-Income HIV-Infected Individuals	1115	1/19/01
District of Columbia	DC Coverage Initiative HIFA	1115	Pending
District of Columbia	District of Columbia Hurricane Katrina Relief Program	1115 Katrina	09/28/2005

Source: CMS, Medicaid Waivers and Demonstrations List, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

Section 1915(b) and 1115 Waivers (cont.)

State	Official Program Name	Waiver Authority	Date Originally Approved
Florida	Florida Coordinated Non Emergency Transportation 1915(b)	1915(b)	06/07/2001
Florida	Florida Managed Care Waiver (Medipass) 1915(b)	1915(b)	01/1990
Florida	Florida Family Planning 1115	1115	08/23/1998
Florida	Alzheimer's Medicaid Home and Community Based Waiver Program	1915(b)(c)	2/19/04
Florida	Comprehensive Adult Day Health Care Program	1915(b)(c)	3/18/03
Florida	Consumer Directed Care Plus	1115	10/9/1998
Florida	Statewide Inpatient Psychiatric Program (SIPP)	1915(b)	6/8/01
Florida	Florida Program for All Inclusive Care for Children 1115	1115	N/A
Florida	Florida Medicaid Reform 1115	1115	10/19/2005
Florida	Florida Eligibility Privatization 1115	1115	Pending
Florida	Florida Hurricane Katrina Relief Program	1115 Katrina	09/23/2005
Georgia	Georgia Better Health Care Program 1915(b)	1915(b)	07/14/1993
Georgia	HIV/AIDS	1115	N/A
Georgia	MH/MR Preadmission Screening and Resident Review (PASRR) Program	1915(b)	4/1/1994
Georgia	Georgia Non Emergency Transportation 1915(b)	1915(b)	09/08/1999
Georgia	Georgia Hurricane Katrina Relief Program	1115 Katrina	09/28/2005
Hawaii	Hawaii Prescription Plus 1115	1115	Disapproved
Hawaii	Hawaii QUEST 1115	1115	07/16/1993
Idaho	Idaho Access Card 1115 Waiver	1115	11/04/2004
Idaho	Idaho Healthy Connections 1915(b) Waiver	1915(b)	09/17/1993
Idaho	Idaho Hurricane Katrina Relief Program	1115 Katrina	09/27/2005
Illinois	Illinois KidCare Parent Coverage HIFA	1115 HIFA	10/13/2002
Illinois	Prescription Drug Benefit for Illinois' Low Income Seniors 1115	1115 Pharmacy	01/28/2002
Illinois	Illinois Family Planning 1115	1115 Family Planning	06/23/2003
Indiana	Indiana Hoosier Healthwise 1915(b)	1915(b)	09/13/1993
Indiana	Indiana Hurricane Katrina Relief Program	1115 Katrina	10/21/2005
Iowa	Iowa Family Planning	1115	01/10/2006
Iowa	IowaCare 1115	1115	06/30/2005

Source: CMS, Medicaid Waivers and Demonstrations List, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

Section 1915(b) and 1115 Waivers (cont.)

State	Official Program Name	Waiver Authority	Date Originally Approved
Iowa	Iowa Plan	1915(b)	12/9/1998
Kansas	Kansas Managed Care Program 1915(b)	1915(b)	06/24/1998
Kansas	Kansas Children & Family Services Behavioral and Rehabilitative Treatment Services Waiver	1915(b)	5/27/05
Kansas	Work Opportunities Reward Kansans (WORK)	1115	N/A
Kentucky	Kentucky Non Emergency Medical Transportation Program	1915(b)	02/01/1996
Kentucky	Kentucky Health Care Partnership 1115	1115	12/09/1993
Kentucky	Kentucky Health Choices 1115	1115	pending
Louisiana	Louisiana Community Care Statewide 1915(b)	1915(b)	06/29/1998
Louisiana	Louisiana Models of Excellence Waiver 1915(b)	1915(b)	11/11/2002
Louisiana	Louisiana HIFA	1115	withdrawn
Louisiana	Louisiana Hurricane Katrina Relief Program	1115 Katrina	11/10/2005
Louisiana	Louisiana Family Planning Waiver 1115	1115 Family Planning	June 6, 2006
Maine	MaineCare for Childless Adults HIFA 1115	1115	09/13/2002
Maine	Maine - HIV/AIDS	1115	2/24/00
Maryland	Maryland Health Choice 1115	1115	10/30/1996
Maryland	Maryland Funding for Pregnant Women 1115	1115	Pending
Maryland	Maryland CommunityChoice	1115	N/A
Maryland	Maryland Hurricane Katrina Relief Program	1115 Katrina	11/10/2005
Massachusetts	Massachusetts MassHealth Waiver 1115	1115	04/24/1995
Massachusetts	Massachusetts Family Planning	1115	Under Review
Michigan	Michigan EPIC Ex 1115	1115 Pharmacy	12/12/2005
Michigan	Michigan Comprehensive Health Care Program 1915 (b)	1915(b)	10/10/1996
Michigan	Michigan Adult Benefits Waiver HIFA	1115 HIFA	01/16/2004
Michigan	Michigan Specialty Services and Supports Waiver Program	1915(b)(c)	6/26/1998
Michigan	Michigan Modernizing Medicaid	1115	Pending
Michigan	Michigan Plan First! Family Planning Program 1115	1115 Family Planning	March 1, 2006
Minnesota	Minnesota Prepaid Medical Assistance Project Plus	1115	04/27/1995
Minnesota	Minnesota HIFA 1115	1115 HIFA	Inactive

Source: CMS, Medicaid Waivers and Demonstrations List, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

Section 1915(b) and 1115 Waivers (cont.)

State	Official Program Name	Waiver Authority	Date Originally Approved
Minnesota	Consolidated Chemical Dependency Treatment Fund (CCDTF)	1915(b)	1/1/1988
Minnesota	Minnesota Senior Care Project	1915(b)	6/30/05
Minnesota	Region 10 Quality Assurance Pilot Project (ICF/MR Quality)	1115	N/A
Minnesota	Minnesota Transfer of Assets	1115	N/A
Minnesota	Minnesota Katrina Relief	1115 Katrina	N/A
Minnesota	Minnesota Care SCHIP 1115	1115	06/13/2001
Minnesota	Minnesota Family Planning Project	1115	June 20, 2004
Mississippi	Mississippi Non Emergency Transportation 1915(b)	1915(b)	04/11/2003
Mississippi	Mississippi Family Planning 1115	1115	01/31/2003
Mississippi	Healthier Mississippi	1115	9/10/04
Mississippi	Mississippi Hurricane Katrina Relief Program	1115 Katrina	09/28/2005
Missouri	Missouri Managed Care Plus 1915(b)	1915(b)	10/01/1995
Missouri	Missouri Managed Care Plus (MC+) 1115	1115	04/29/1998
Montana	Montana Passport to Health 1915(b)	1915(b)	08/31/1993
Montana	Montana Basic Medicaid for Able Bodied Adults	1115	01/30/2004
Montana	Montana Katrina Relief Program	1115 Katrina	03/20/2006
Nebraska	Health Connection MH/SA Waiver	1915(b)	7/1/1995
Nevada	Nevada Non Emergency Transportation 1915(b)	1915(b)	06/22/2004
Nevada	Nevada Hurricane Katrina Relief Program	1115 Katrina	11/23/2005
New Hampshire	New Hampshire Disease Management 1915(b)	1915(b)	Pending
New Jersey	New Jersey Standardized Parent Service Package HIFA 1115	1115 HIFA	01/31/2003
New Jersey	New Jersey Kid Care SCHIP 1115	1115 SCHIP	01/18/2001
New Jersey	New Jersey Care 2000+	1915(b)	11/2/1999
New Jersey	Personal Preference Program (Cash/Counseling)	1115	10/9/1998
New Mexico	New Mexico 1115 HIFA	1115 HIFA	08/23/2002
New Mexico	New Mexico Family Planning	1115 Family Planning	08/01/1997
New Mexico	New Mexico SCHIP Waiver	1115 SCHIP	01/11/1999
New Mexico	New Mexico Salud 1915(b)	1915(b)	07/01/1997
New Mexico	NM Behavioral Health Waiver	1915(b)	6/24/05

Source: CMS, Medicaid Waivers and Demonstrations List, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

Section 1915(b) and 1115 Waivers (cont.)

State	Official Program Name	Waiver Authority	Date Originally Approved
New York	New York Partnership Plan	1115	07/15/1997
New York	New York Non Emergency Transportation Program 1915 b	1915(b)	01/17/1996
North Carolina	North Carolina ACCESS HealthCare Connection 1915(b)	1915 (b)	01/01/1991
North Carolina	North Carolina Family Planning 1115	1115 Family Planning	11/05/2004
North Carolina	North Carolina - Piedmont Behavioral Health Care	1915(b)(c)	10/06/04
North Carolina	North Carolina Katrina Waiver	1115 Katrina	02/17/2006
North Dakota	North Dakota Transfer of Assets	1115	N/A
Ohio	Ohio PremierCare 1915(b)	1915(b)	05/23/2001
Ohio	Ohio Hurricane Katrina Relief Program	1115 Katrina	12/07/2005
Oklahoma	Oklahoma Non Emergency Transportation 1915(b)	1915(b)	06/02/2004
Oklahoma	Oklahoma SoonerCare 1115	1115	10/12/1995
Oklahoma	Oklahoma SoonerCare Family Planning	1115 Family Planning	11/05/2004
Oregon	Oregon Non Emergency Transportation 1915(b)	1915(b)	09/01/1994
Oregon	Oregon Family Planning 1115	1115 Family Planning	10/01/1998
Oregon	Oregon Health Plan Demonstration 1115	1115	03/19/1993
Oregon	Oregon Health Plan 2 HIFA 1115	1115 HIFA	10/15/2002
Oregon	Independent Choices	1115	11/22/00
Oregon	Oregon Hurricane Katrina Relief Waiver	1115 Katrina	03/06/2006
Pennsylvania	Pennsylvania Access Plus 1915(b)	1915(b)	12/03/2004
Pennsylvania	Pennsylvania Health Choices 1915(b)	1915(b)	07/31/2002
Pennsylvania	Pennsylvania Lancaster County Health Plan 1915(b)	1915(b)	N/A
Rhode Island	Rhode Island RItCare 1115	1115	11/01/1993
Rhode Island	Rhode Island Rx + 1115	1115	pending
Rhode Island	Rhode Island Katrina Waiver	1115 Katrina	02/17/2006
South Carolina	Prescription Drug Benefit for South Carolina's Low Income Seniors	1115 Pharmacy	07/30/2002
South Carolina	South Carolina Health Connections 1115	1115	Pending
South Carolina	South Carolina Hurricane Katrina Relief Program	1115 Katrina	10/20/2005
South Carolina	South Carolina Family Planning Demonstration	FP 1115	N/A

Source: CMS, Medicaid Waivers and Demonstrations List, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

Section 1915(b) and 1115 Waivers (cont.)

State	Official Program Name	Waiver Authority	Date Originally Approved
South Dakota	South Dakota PRIME 1915(b)	1915 (b)	03/26/1996
Tennessee	Tennessee TennCare 1115	1115	05/30/2002
Tennessee	Tennessee TennCare for Medicaid Medicare Duals 1915(b)	1915(b)	06/28/2002
Tennessee	Tennessee Hurricane Katrina Relief Program	1115 Katrina	10/06/2005
Texas	Texas PsychMed 1115	1115	Inactive
Texas	Texas LoneStar Select I 1915(b)	1915(b)	07/01/1994
Texas	Texas Access Reform STAR MMC Consolidated 1915(b)	1915(b)	08/10/2001
Texas	LoneStar Select II Contracting Program 1915(b)	1915(b)	03/10/1995
Texas	Texas NorthStar Behavioral Health	1915(b)	09/07/1999
Texas	Texas Star+Plus	1915(b)	1/30/98
Texas	Texas Disease Management	1915(b)	8/9/05
Texas	Texas 3 Share HIFA Demonstration	1115 HIFA	PENDING
Texas	Texas 3 Share	1115 HIFA	pending
Texas	Texas Family Planning 1115	1115 Family Planning	pending
Texas	Tex Kat Program	1115 Katrina	09/15/2005
Texas	Texas SCHIP Cost Share 1115	1115	Pending
Utah	Utah Primary Care Network PCN 1115	1115	02/08/2002
Utah	Utah Non-Emergency Transportation Waiver 1915(b)	1915(b)	09/19/2000
Utah	Home Health Services for San Juan & Grand Counties	1915(b)	N/A
Utah	Utah - Prepaid Mental Health Plan	1915(b)	12/20/01
Utah	Utah Choice of Health Care Delivery Program 1915(b)	1915(b)	03/23/1982
Utah	Utah Katrina Relief Program	1115 Katrina	03/20/2006
Vermont	Vermont Health Access Plan 1115	1115	07/28/1995
Vermont	VT Long-Term Care Plan	1115	6/13/05
Vermont	Vermont Global Commitment to Healthcare	1115	09/27/2005
Virginia	Virginia Family Planning 1115	1115 Family Planning	07/22/2002
Virginia	Virginia Medallion I 1915(b)	1915(b)	12/23/1991
Virginia	Virginia Medallion II 1915(b)	1915(b)	09/28/1998

Source: CMS, Medicaid Waivers and Demonstrations List, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

Section 1915(b) and 1115 Waivers (cont.)

State	Official Program Name	Waiver Authority	Date Originally Approved
Virginia	Virginia Non Emergency Transportation Waiver 1915(b)	1915(b)	08/23/2005
Virginia	Virginia FAMIS MOMS	1115 HIFA	06/30/2005
Virginia	Virginia Katrina Relief Program	1115 Katrina	03/20/2006
Washington	Washington Healthy Options 1915(b)	1915(b)	10/01/1993
Washington	Washington Premium Proposal 1115	1115	02/13/2004
Washington	Washington Selective Hospital Contracting Program 1915(b)	1915(b)	04/01/1988
Washington	Washington Mental Health	1915(b)	3/1/02
Washington	Washington Disease Management	1915(b)	3/3/03
Washington	Washington Family Planning 1115	1115 Family Planning	03/06/2001
West Virginia	West Virginia Mountain Health Trust 1915(b)	1915(b)	04/29/1996
West Virginia	West Virginia Physician Assured Access System PAAS 1915(b)	1915(b)	06/01/1992
West Virginia	West Virginia Dental and Vision Waiver	1115	Pending
Wisconsin	Wisconsin Family Planning 1115	1115 Family Planning	06/14/2002
Wisconsin	Wisconsin Badger Care 1115	1115	01/22/1999
Wisconsin	Wisconsin Allied Services for Healthy Foster Children 1915(b)	1915(b)	07/01/2004
Wisconsin	Wisconsin Family Care Concurrent b/c Waiver	1915(b)(c)	6/1/01
Wisconsin	Wisconsin Hurricane Katrina Relief Program	1115 Katrina	03/24/2006
Wyoming	Wyoming Katrina Waiver	1115 Katrina	02/17/2006

Source: CMS, Medicaid Waivers and Demonstrations List, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

Section 3:

State Characteristics

STATE CHARACTERISTICS

Presented in Section 3 of the Compilation is State-by-State information on several topics. The Section begins with a series of tables showing select State demographic characteristics including age composition and racial/Hispanic status. Next, insurance coverage, poverty status, employment, and income data for each State are presented. The final group of tables show select components of each State's health care system including Medicare and Medicaid certified facilities (hospitals, SNFs, ICFs/MR, home health agencies, and rural health clinics), licensed pharmacies, and health manpower (physicians, Registered Nurses, and pharmacists).

The data in Section 3 have been compiled from a myriad of sources. These include:

- CMS
- The U.S. Bureau of the Census
- The Bureau of Labor Statistics (BLS)
- The Health Resources and Services Administration (HRSA)
- The National Association of Boards of Pharmacy

Because of the unevenness with which the various government agencies and other organizations have released updated information, we have carefully reviewed all possible information sources and made judgments on which data to present. In the final analysis, we have included those data that, in our opinion, best reflect the factors and characteristics on which we have reported. However, certain limitations in the different sources have resulted in some inconsistencies among the tables. The following examples illustrate this problem.

The table showing the age distribution of the population is derived from the 2005 American Community Survey conducted by the U.S. Bureau of the Census. Unfortunately, the approximately 5 million individuals residing in "group quarters" are not included in this survey. Hence, the total population figure (and the corresponding figures for each State) presented in this table is inconsistent with the population total in the table showing insurance status.

The data on insurance status was compiled from the Current Population Survey, 2005 Annual Social and Economic Supplement, a collaborative effort by the Census Bureau and BLS. Hence, the estimates on the number of Medicare and Medicaid beneficiaries differ slightly from those published by CMS. In addition, more detailed data on poverty, also compiled from the 2005 Annual Social and Economic Supplement to the Current Population Survey, have been included in this year's Compilation.

HRSA's Bureau of Health Professions, National Center for Health Workforce Analysis is responsible for compiling the Area Resource File (ARF), an important annual data file for researchers, planners, policymakers, and others seeking information on the health professions workforce, health care facilities, health care utilization and expenditures, etc. at a variety of geographic levels. Physician data come from the 2005 ARF, while nursing data come from HRSA's 2004 National Sample Survey of Registered Nurses.

Despite the limitations confronted while compiling these statistics, we believe that the data presented in Section 3 provide a useful and meaningful picture of State characteristics. Users of the Compilation are urged to carefully read the source information and notes at the bottom of each table in order to understand the limitations of the data contained therein.

Age Demographics, 2005*

State	Total Population	Percent Ages 19 and under	Percent Ages 20-44	Percent Ages 45-64	Percent Ages 65+
National Total	288,378,137	27.8%	31.8%	25.0%	12.1%
Alabama	4,442,558	26.9%	30.9%	25.8%	12.9%
Alaska	641,724	32.5%	31.6%	26.7%	6.6%
Arizona	5,829,839	29.5%	31.6%	22.8%	12.6%
Arkansas	2,701,431	27.6%	30.4%	25.1%	13.5%
California	35,278,768	30.0%	32.9%	23.3%	10.5%
Colorado	4,562,244	28.2%	34.1%	24.4%	9.7%
Connecticut	3,394,751	26.6%	30.4%	27.2%	13.0%
Delaware	818,587	26.0%	31.7%	25.7%	13.0%
District of Columbia	515,118	22.8%	34.6%	24.3%	12.1%
Florida	17,382,511	25.6%	29.6%	25.2%	16.6%
Georgia	8,821,142	29.2%	34.5%	23.5%	9.2%
Hawaii	1,238,158	26.4%	30.3%	26.8%	13.6%
Idaho	1,395,634	29.5%	31.3%	24.6%	11.2%
Illinois	12,440,351	28.4%	32.3%	24.4%	11.5%
Indiana	6,093,372	28.4%	31.1%	25.1%	11.9%
Iowa	2,862,541	25.7%	30.5%	26.4%	14.0%
Kansas	2,662,616	27.7%	31.4%	25.0%	12.4%
Kentucky	4,058,633	26.4%	31.7%	26.3%	12.2%
Louisiana	4,389,747	28.8%	31.4%	24.9%	11.4%
Maine	1,283,673	23.9%	29.8%	29.5%	14.1%
Maryland	5,461,318	28.0%	31.6%	26.1%	11.2%
Massachusetts	6,182,860	25.4%	32.4%	25.9%	12.9%
Michigan	9,865,583	27.9%	31.0%	25.8%	12.1%
Minnesota	4,989,848	27.1%	32.6%	25.4%	11.6%
Mississippi	2,824,156	29.0%	31.0%	24.4%	11.9%
Missouri	5,631,910	26.8%	31.2%	25.8%	12.8%
Montana	910,651	24.9%	29.7%	29.1%	13.3%
Nebraska	1,706,976	27.5%	31.1%	25.1%	12.8%
Nevada	2,381,281	28.4%	33.1%	23.8%	11.2%
New Hampshire	1,272,486	25.9%	31.1%	28.3%	11.9%
New Jersey	8,521,427	27.7%	31.2%	25.7%	12.5%
New Mexico	1,887,200	28.8%	30.1%	25.9%	12.1%
New York	18,655,275	26.5%	31.9%	25.5%	12.7%
North Carolina	8,411,041	27.6%	32.5%	24.7%	11.7%
North Dakota	609,645	24.5%	30.8%	26.8%	14.2%
Ohio	11,155,606	27.0%	30.8%	26.2%	12.8%
Oklahoma	3,433,496	27.4%	30.9%	25.4%	12.9%
Oregon	3,560,109	26.1%	31.6%	26.3%	12.6%
Pennsylvania	11,979,147	25.5%	29.7%	27.0%	14.6%
Rhode Island	1,032,662	25.3%	31.4%	26.0%	13.6%
South Carolina	4,113,961	27.1%	31.3%	25.9%	12.3%
South Dakota	746,033	27.6%	30.1%	25.4%	13.6%
Tennessee	5,810,590	26.2%	32.1%	26.1%	12.2%
Texas	22,270,165	30.9%	33.1%	22.7%	9.6%
Utah	2,427,350	33.4%	34.1%	19.1%	8.5%
Vermont	602,290	24.1%	30.2%	30.0%	12.8%
Virginia	7,332,608	27.0%	32.2%	26.3%	11.2%
Washington	6,146,338	26.6%	32.8%	26.1%	11.1%
West Virginia	1,771,750	23.6%	29.5%	28.7%	15.0%
Wisconsin	5,375,751	26.4%	31.5%	26.3%	12.5%
Wyoming	495,226	25.3%	30.3%	29.4%	12.0%

This information was taken from the 2005 American Community Survey conducted by the U.S. Bureau of The Census. The information provided is limited to the household population and excludes the population living in institutions, college dormitories, and other group quarters. This accounts for the difference in the estimates of the U.S. population from this source compared to other estimates presented by the Bureau of the Census. The data are based on a sample and are subject to sampling variability. Data based on twelve monthly samples during 2005.

*Sum of percentages may not equal 100 percent due to rounding.

Source: U.S. Department of Commerce, Bureau of the Census, 2005 American Community Survey.

Race Demographics, 2005*

State	Total Population	% White	% Black	% Asian	% American Indian and Alaska Native	% Native Hawaiian & Oth Pacif Islndr	% Some other race	% Indicated 2 or More Races
National Total	288,378,137	74.7%	12.1%	4.3%	0.8%	0.1%	6.0%	1.9%
Alabama	4,442,558	71.0%	25.8%	0.9%	0.5%	0.0%	0.8%	1.1%
Alaska	641,724	69.2%	3.4%	4.5%	14.2%	0.5%	1.3%	6.9%
Arizona	5,829,839	76.2%	3.1%	2.2%	4.7%	0.1%	11.3%	2.4%
Arkansas	2,701,431	79.0%	15.3%	0.9%	0.7%	0.2%	2.4%	1.4%
California	35,278,768	60.9%	6.1%	12.4%	0.7%	0.4%	16.4%	3.1%
Colorado	4,562,244	83.5%	3.6%	2.6%	0.9%	0.1%	6.7%	2.6%
Connecticut	3,394,751	81.2%	9.1%	3.2%	0.2%	0.0%	4.5%	1.7%
Delaware	818,587	73.6%	19.9%	2.7%	0.3%	0.0%	2.0%	1.5%
District of Columbia	515,118	32.4%	56.8%	3.0%	0.3%	0.0%	6.0%	1.5%
Florida	17,382,511	76.8%	15.0%	2.1%	0.3%	0.0%	4.1%	1.6%
Georgia	8,821,142	62.5%	29.2%	2.7%	0.2%	0.0%	3.9%	1.4%
Hawaii	1,238,158	24.9%	2.0%	42.0%	0.3%	8.5%	1.3%	21.0%
Idaho	1,395,634	91.8%	0.4%	1.1%	1.1%	0.1%	3.5%	2.0%
Illinois	12,440,351	72.2%	14.5%	4.1%	0.2%	0.0%	7.5%	1.5%
Indiana	6,093,372	86.1%	8.6%	1.2%	0.2%	0.0%	2.4%	1.5%
Iowa	2,862,541	93.5%	2.2%	1.5%	0.2%	0.0%	1.5%	1.1%
Kansas	2,662,616	85.2%	5.5%	2.0%	0.9%	0.0%	4.1%	2.2%
Kentucky	4,058,633	89.9%	7.2%	0.9%	0.2%	0.1%	0.7%	1.1%
Louisiana	4,389,747	63.7%	32.5%	1.3%	0.6%	0.0%	0.8%	1.1%
Maine	1,283,673	96.6%	0.7%	0.8%	0.5%	0.0%	0.4%	1.0%
Maryland	5,461,318	61.5%	28.7%	4.7%	0.3%	0.0%	3.1%	1.7%
Massachusetts	6,182,860	83.4%	5.9%	4.7%	0.2%	0.0%	4.4%	1.4%
Michigan	9,865,583	80.0%	14.0%	2.3%	0.6%	0.0%	1.5%	1.6%
Minnesota	4,989,848	88.0%	4.1%	3.6%	1.1%	0.0%	1.8%	1.5%
Mississippi	2,824,156	60.8%	36.5%	0.8%	0.4%	0.0%	0.7%	0.9%
Missouri	5,631,910	84.5%	11.2%	1.4%	0.4%	0.1%	1.0%	1.5%
Montana	910,651	90.6%	0.5%	0.6%	6.0%	0.1%	0.5%	1.7%
Nebraska	1,706,976	89.6%	4.0%	1.5%	0.8%	0.0%	2.6%	1.5%
Nevada	2,381,281	76.1%	7.2%	5.8%	1.2%	0.5%	6.2%	3.1%
New Hampshire	1,272,486	95.5%	0.8%	1.8%	0.4%	0.0%	0.6%	1.0%
New Jersey	8,521,427	69.9%	13.3%	7.3%	0.2%	0.0%	7.8%	1.5%
New Mexico	1,887,200	69.5%	1.9%	1.2%	9.6%	0.1%	14.5%	3.2%
New York	18,655,275	67.1%	15.3%	6.7%	0.4%	0.0%	9.0%	1.5%
North Carolina	8,411,041	71.4%	21.0%	1.7%	1.3%	0.0%	3.1%	1.5%
North Dakota	609,645	91.5%	0.8%	0.9%	4.9%	0.1%	0.6%	1.2%
Ohio	11,155,606	84.3%	11.5%	1.5%	0.2%	0.0%	1.0%	1.5%
Oklahoma	3,433,496	75.4%	7.1%	1.6%	7.4%	0.1%	2.7%	5.7%
Oregon	3,560,109	86.8%	1.6%	3.5%	1.3%	0.2%	3.5%	3.0%
Pennsylvania	11,979,147	84.6%	10.1%	2.2%	0.1%	0.0%	1.9%	1.1%
Rhode Island	1,032,662	82.9%	5.0%	2.6%	0.5%	0.1%	6.9%	1.9%
South Carolina	4,113,961	67.4%	28.5%	1.1%	0.3%	0.0%	1.5%	1.1%
South Dakota	746,033	88.0%	0.8%	0.6%	8.4%	0.0%	0.6%	1.5%
Tennessee	5,810,590	79.6%	16.4%	1.3%	0.3%	0.0%	1.2%	1.2%
Texas	22,270,165	71.9%	11.0%	3.3%	0.5%	0.1%	11.6%	1.7%
Utah	2,427,350	89.8%	0.8%	1.9%	1.2%	0.6%	4.2%	1.5%
Vermont	602,290	96.6%	0.5%	1.1%	0.2%	0.0%	0.2%	1.4%
Virginia	7,332,608	71.7%	19.1%	4.7%	0.3%	0.1%	2.3%	1.8%
Washington	6,146,338	81.2%	3.3%	6.6%	1.4%	0.5%	3.7%	3.3%
West Virginia	1,771,750	95.0%	3.1%	0.4%	0.1%	0.1%	0.2%	1.1%
Wisconsin	5,375,751	88.1%	5.7%	2.0%	0.8%	0.0%	2.2%	1.2%
Wyoming	495,226	92.4%	0.7%	0.6%	1.9%	0.0%	2.4%	1.9%

This information was taken from the 2005 American Community Survey conducted by the U.S. Bureau of The Census. The information provided is limited to the household population and excludes the population living in institutions, college dormitories, and other group quarters. This accounts for the difference in the estimates of the U.S. population from this source compared to other estimates presented by U.S. Census. The data are based on a sample and are subject to sampling variability. Data based on twelve monthly samples during 2005.

*Sum of percentages may not equal 100 percent due to rounding. Source: U.S. Department of Commerce, Bureau of the Census, 2005 American Community Survey.

Hispanic Demographics, 2005

State	Total Population	Hispanic Population	Percent Hispanic
National Total	288,378,137	41,870,703	14.5%
Alabama	4,442,558	99,040	2.2%
Alaska	641,724	30,843	4.8%
Arizona	5,829,839	1,668,524	28.6%
Arkansas	2,701,431	126,932	4.7%
California	35,278,768	12,523,379	35.5%
Colorado	4,562,244	891,614	19.5%
Connecticut	3,394,751	371,425	10.9%
Delaware	818,587	50,218	6.1%
District of Columbia	515,118	45,901	8.9%
Florida	17,382,511	3,414,414	19.6%
Georgia	8,821,142	625,028	7.1%
Hawaii	1,238,158	98,699	8.0%
Idaho	1,395,634	126,785	9.1%
Illinois	12,440,351	1,804,619	14.5%
Indiana	6,093,372	277,558	4.6%
Iowa	2,862,541	106,052	3.7%
Kansas	2,662,616	224,152	8.4%
Kentucky	4,058,633	69,702	1.7%
Louisiana	4,389,747	123,066	2.8%
Maine	1,283,673	12,059	0.9%
Maryland	5,461,318	316,257	5.8%
Massachusetts	6,182,860	490,839	7.9%
Michigan	9,865,583	371,627	3.8%
Minnesota	4,989,848	181,959	3.6%
Mississippi	2,824,156	43,275	1.5%
Missouri	5,631,910	148,994	2.6%
Montana	910,651	20,232	2.2%
Nebraska	1,706,976	122,518	7.2%
Nevada	2,381,281	563,999	23.7%
New Hampshire	1,272,486	27,933	2.2%
New Jersey	8,521,427	1,307,412	15.3%
New Mexico	1,887,200	822,224	43.6%
New York	18,655,275	3,028,658	16.2%
North Carolina	8,411,041	533,087	6.3%
North Dakota	609,645	8,553	1.4%
Ohio	11,155,606	253,889	2.3%
Oklahoma	3,433,496	227,767	6.6%
Oregon	3,560,109	353,433	9.9%
Pennsylvania	11,979,147	484,679	4.0%
Rhode Island	1,032,662	112,722	10.9%
South Carolina	4,113,961	135,041	3.3%
South Dakota	746,033	14,140	1.9%
Tennessee	5,810,590	172,704	3.0%
Texas	22,270,165	7,903,079	35.5%
Utah	2,427,350	264,084	10.9%
Vermont	602,290	5,214	0.9%
Virginia	7,332,608	438,789	6.0%
Washington	6,146,338	541,722	8.8%
West Virginia	1,771,750	10,139	0.6%
Wisconsin	5,375,751	242,287	4.5%
Wyoming	495,226	33,437	6.8%

This information was taken from the 2005 American Community Survey conducted by the U.S. Bureau of The Census. The information provided is limited to the household population and excludes the population living in institutions, college dormitories, and other group quarters. This accounts for the difference in the estimates of the U.S. population from this source compared to other estimates presented by the U.S. Census. The data are based on a sample and are subject to sampling variability. Data based on twelve monthly samples during 2005.

Source: U.S. Department of Commerce, Bureau of the Census, 2005 American Community Survey.

Insurance Status - Populations, 2005*

State	Total Population	Medicaid Population	Medicare Population	Military Insurance	Privately Insured	Not Insured
National Total	293,834,000	38,134,000	40,185,000	11,172,000	198,901,000	46,577,000
Alabama	4,524,000	730,000	718,000	236,000	2,956,000	696,000
Alaska	659,000	108,000	56,000	84,000	401,000	117,000
Arizona	6,047,000	976,000	826,000	225,000	3,576,000	1,219,000
Arkansas	2,760,000	396,000	421,000	165,000	1,717,000	494,000
California	35,940,000	5,692,000	4,141,000	1,043,000	22,307,000	6,961,000
Colorado	4,641,000	357,000	458,000	232,000	3,317,000	788,000
Connecticut	3,487,000	337,000	514,000	77,000	2,662,000	394,000
Delaware	844,000	94,000	131,000	34,000	602,000	110,000
District of Columbia	540,000	118,000	67,000	9,000	341,000	73,000
Florida	17,886,000	1,897,000	3,093,000	988,000	11,152,000	3,703,000
Georgia	9,045,000	1,206,000	1,007,000	476,000	5,612,000	1,709,000
Hawaii	1,279,000	131,000	189,000	136,000	940,000	116,000
Idaho	1,442,000	176,000	175,000	46,000	1,003,000	222,000
Illinois	12,608,000	1,361,000	1,656,000	275,000	9,069,000	1,802,000
Indiana	6,141,000	717,000	729,000	164,000	4,369,000	871,000
Iowa	2,909,000	327,000	419,000	111,000	2,323,000	251,000
Kansas	2,695,000	279,000	399,000	123,000	2,075,000	290,000
Kentucky	4,052,000	592,000	629,000	181,000	2,775,000	514,000
Louisiana	4,088,000	567,000	638,000	133,000	2,564,000	767,000
Maine	1,320,000	259,000	208,000	74,000	878,000	143,000
Maryland	5,569,000	527,000	722,000	287,000	4,054,000	788,000
Massachusetts	6,328,000	881,000	884,000	117,000	4,684,000	618,000
Michigan	9,982,000	1,359,000	1,313,000	228,000	7,435,000	1,133,000
Minnesota	5,129,000	485,000	704,000	104,000	4,139,000	431,000
Mississippi	2,854,000	601,000	458,000	142,000	1,610,000	495,000
Missouri	5,710,000	739,000	831,000	163,000	4,080,000	691,000
Montana	928,000	98,000	157,000	59,000	606,000	162,000
Nebraska	1,766,000	178,000	240,000	104,000	1,320,000	208,000
Nevada	2,448,000	188,000	339,000	137,000	1,686,000	425,000
New Hampshire	1,301,000	79,000	187,000	49,000	1,027,000	135,000
New Jersey	8,725,000	669,000	1,108,000	135,000	6,471,000	1,324,000
New Mexico	1,938,000	330,000	295,000	112,000	1,114,000	396,000
New York	19,022,000	3,503,000	2,786,000	219,000	12,822,000	2,559,000
North Carolina	8,561,000	1,136,000	1,236,000	428,000	5,652,000	1,371,000
North Dakota	626,000	48,000	92,000	35,000	483,000	76,000
Ohio	11,334,000	1,416,000	1,611,000	276,000	8,240,000	1,394,000
Oklahoma	3,505,000	483,000	546,000	252,000	2,189,000	647,000
Oregon	3,627,000	458,000	507,000	106,000	2,495,000	579,000
Pennsylvania	12,281,000	1,454,000	1,930,000	229,000	9,357,000	1,287,000
Rhode Island	1,054,000	181,000	147,000	32,000	753,000	125,000
South Carolina	4,181,000	584,000	654,000	178,000	2,657,000	741,000
South Dakota	768,000	81,000	119,000	50,000	563,000	95,000
Tennessee	5,867,000	960,000	890,000	350,000	3,734,000	836,000
Texas	22,819,000	2,821,000	2,778,000	1,015,000	13,354,000	5,516,000
Utah	2,524,000	270,000	222,000	88,000	1,798,000	420,000
Vermont	622,000	124,000	86,000	25,000	426,000	73,000
Virginia	7,454,000	563,000	906,000	739,000	5,387,000	1,011,000
Washington	6,250,000	618,000	768,000	459,000	4,462,000	866,000
West Virginia	1,799,000	258,000	341,000	88,000	1,127,000	322,000
Wisconsin	5,447,000	667,000	786,000	115,000	4,189,000	534,000
Wyoming	511,000	55,000	71,000	37,000	348,000	82,000

*The sum of rows may be greater than the total State population because individuals may have dual coverage and appear in more than one category.

Source: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, Annual Social and Economic Supplement.

Insurance Status - Percentages, 2005*

State	Total Population	% Covered by Medicaid	% Covered by Medicare	% Covered by Military Insurance	% Covered by Private Insurance	% Not Insured
National Total	293,834,000	13.0%	13.7%	3.8%	67.7%	15.9%
Alabama	4,524,000	16.1%	15.9%	5.2%	65.3%	15.4%
Alaska	659,000	16.4%	8.5%	12.7%	60.8%	17.8%
Arizona	6,047,000	16.1%	13.7%	3.7%	59.1%	20.2%
Arkansas	2,760,000	14.3%	15.3%	6.0%	62.2%	17.9%
California	35,940,000	15.8%	11.5%	2.9%	62.1%	19.4%
Colorado	4,641,000	7.7%	9.9%	5.0%	71.5%	17.0%
Connecticut	3,487,000	9.7%	14.7%	2.2%	76.3%	11.3%
Delaware	844,000	11.1%	15.5%	4.0%	71.3%	13.0%
District of Columbia	540,000	21.9%	12.4%	1.7%	63.1%	13.5%
Florida	17,886,000	10.6%	17.3%	5.5%	62.4%	20.7%
Georgia	9,045,000	13.3%	11.1%	5.3%	62.0%	18.9%
Hawaii	1,279,000	10.2%	14.8%	10.6%	73.5%	9.1%
Idaho	1,442,000	12.2%	12.1%	3.2%	69.6%	15.4%
Illinois	12,608,000	10.8%	13.1%	2.2%	71.9%	14.3%
Indiana	6,141,000	11.7%	11.9%	2.7%	71.1%	14.2%
Iowa	2,909,000	11.2%	14.4%	3.8%	79.9%	8.6%
Kansas	2,695,000	10.4%	14.8%	4.6%	77.0%	10.8%
Kentucky	4,052,000	14.6%	15.5%	4.5%	68.5%	12.7%
Louisiana	4,088,000	13.9%	15.6%	3.3%	62.7%	18.8%
Maine	1,320,000	19.6%	15.8%	5.6%	66.5%	10.8%
Maryland	5,569,000	9.5%	13.0%	5.2%	72.8%	14.1%
Massachusetts	6,328,000	13.9%	14.0%	1.8%	74.0%	9.8%
Michigan	9,982,000	13.6%	13.2%	2.3%	74.5%	11.4%
Minnesota	5,129,000	9.5%	13.7%	2.0%	80.7%	8.4%
Mississippi	2,854,000	21.1%	16.0%	5.0%	56.4%	17.3%
Missouri	5,710,000	12.9%	14.6%	2.9%	71.5%	12.1%
Montana	928,000	10.6%	16.9%	6.4%	65.3%	17.5%
Nebraska	1,766,000	10.1%	13.6%	5.9%	74.7%	11.8%
Nevada	2,448,000	7.7%	13.8%	5.6%	68.9%	17.4%
New Hampshire	1,301,000	6.1%	14.4%	3.8%	78.9%	10.4%
New Jersey	8,725,000	7.7%	12.7%	1.5%	74.2%	15.2%
New Mexico	1,938,000	17.0%	15.2%	5.8%	57.5%	20.4%
New York	19,022,000	18.4%	14.6%	1.2%	67.4%	13.5%
North Carolina	8,561,000	13.3%	14.4%	5.0%	66.0%	16.0%
North Dakota	626,000	7.7%	14.7%	5.6%	77.2%	12.1%
Ohio	11,334,000	12.5%	14.2%	2.4%	72.7%	12.3%
Oklahoma	3,505,000	13.8%	15.6%	7.2%	62.5%	18.5%
Oregon	3,627,000	12.6%	14.0%	2.9%	68.8%	16.0%
Pennsylvania	12,281,000	11.8%	15.7%	1.9%	76.2%	10.5%
Rhode Island	1,054,000	17.2%	13.9%	3.0%	71.4%	11.9%
South Carolina	4,181,000	14.0%	15.6%	4.3%	63.5%	17.7%
South Dakota	768,000	10.5%	15.5%	6.5%	73.3%	12.4%
Tennessee	5,867,000	16.4%	15.2%	6.0%	63.6%	14.2%
Texas	22,819,000	12.4%	12.2%	4.4%	58.5%	24.2%
Utah	2,524,000	10.7%	8.8%	3.5%	71.2%	16.6%
Vermont	622,000	19.9%	13.8%	4.0%	68.5%	11.7%
Virginia	7,454,000	7.6%	12.2%	9.9%	72.3%	13.6%
Washington	6,250,000	9.9%	12.3%	7.3%	71.4%	13.9%
West Virginia	1,799,000	14.3%	19.0%	4.9%	62.6%	17.9%
Wisconsin	5,447,000	12.2%	14.4%	2.1%	76.9%	9.8%
Wyoming	511,000	10.8%	13.9%	7.2%	68.1%	16.0%

*The sum of rows may be greater than the total State population because individuals may have dual coverage and appear in more than one category.

Source: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, Annual Social and Economic Supplement.

Poverty Status - Populations, 2005

State	Total Population	Population Below 100% FPL*	Population Below 135% FPL*	Population Below 150% FPL*	Population Below 200% FPL*
National Total	293,135,000	36,950,000	55,075,000	63,077,000	90,858,000
Alabama	4,501,000	750,000	1,073,000	1,217,000	1,645,000
Alaska	657,000	66,000	100,000	115,000	178,000
Arizona	6,025,000	917,000	1,373,000	1,540,000	2,262,000
Arkansas	2,756,000	382,000	615,000	702,000	1,064,000
California	35,840,000	4,716,000	7,106,000	8,253,000	11,694,000
Colorado	4,629,000	530,000	801,000	908,000	1,250,000
Connecticut	3,483,000	326,000	504,000	565,000	786,000
Delaware	842,000	78,000	119,000	134,000	206,000
District of Columbia	539,000	115,000	144,000	160,000	200,000
Florida	17,845,000	1,975,000	3,056,000	3,605,000	5,474,000
Georgia	9,014,000	1,298,000	1,805,000	2,064,000	2,887,000
Hawaii	1,274,000	110,000	170,000	193,000	282,000
Idaho	1,441,000	143,000	252,000	310,000	465,000
Illinois	12,571,000	1,441,000	2,115,000	2,352,000	3,498,000
Indiana	6,131,000	774,000	1,108,000	1,309,000	1,928,000
Iowa	2,902,000	327,000	479,000	554,000	786,000
Kansas	2,693,000	337,000	481,000	550,000	809,000
Kentucky	4,049,000	599,000	899,000	1,011,000	1,431,000
Louisiana	4,086,000	748,000	967,000	1,097,000	1,586,000
Maine	1,314,000	166,000	252,000	286,000	422,000
Maryland	5,560,000	542,000	775,000	934,000	1,291,000
Massachusetts	6,318,000	641,000	977,000	1,079,000	1,559,000
Michigan	9,964,000	1,196,000	1,790,000	1,991,000	2,805,000
Minnesota	5,113,000	412,000	621,000	709,000	1,085,000
Mississippi	2,843,000	571,000	814,000	883,000	1,229,000
Missouri	5,697,000	659,000	1,008,000	1,188,000	1,755,000
Montana	926,000	128,000	201,000	219,000	329,000
Nebraska	1,760,000	167,000	254,000	311,000	473,000
Nevada	2,447,000	260,000	453,000	519,000	753,000
New Hampshire	1,298,000	73,000	127,000	154,000	244,000
New Jersey	8,692,000	592,000	937,000	1,102,000	1,718,000
New Mexico	1,938,000	347,000	515,000	596,000	802,000
New York	18,995,000	2,760,000	3,878,000	4,371,000	6,159,000
North Carolina	8,538,000	1,115,000	1,753,000	1,992,000	2,899,000
North Dakota	625,000	70,000	114,000	130,000	185,000
Ohio	11,310,000	1,392,000	2,016,000	2,314,000	3,278,000
Oklahoma	3,486,000	543,000	813,000	938,000	1,342,000
Oregon	3,619,000	436,000	725,000	836,000	1,221,000
Pennsylvania	12,237,000	1,372,000	2,045,000	2,360,000	3,353,000
Rhode Island	1,052,000	127,000	174,000	202,000	271,000
South Carolina	4,164,000	626,000	885,000	1,000,000	1,465,000
South Dakota	765,000	90,000	143,000	162,000	230,000
Tennessee	5,853,000	872,000	1,302,000	1,508,000	2,118,000
Texas	22,777,000	3,681,000	5,569,000	6,290,000	8,811,000
Utah	2,521,000	232,000	354,000	426,000	714,000
Vermont	621,000	47,000	81,000	93,000	156,000
Virginia	7,442,000	684,000	1,008,000	1,219,000	1,867,000
Washington	6,237,000	636,000	938,000	1,031,000	1,627,000
West Virginia	1,795,000	276,000	416,000	473,000	643,000
Wisconsin	5,440,000	553,000	892,000	1,029,000	1,483,000
Wyoming	509,000	54,000	81,000	92,000	140,000

*FPL- Federal Poverty Level

Source: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, Annual Social and Economic Supplement.

Poverty Status - Percentages, 2005

State	Total Population	Percent Below 100% FPL*	Percent Below 135% FPL*	Percent Below 150% FPL*	Percent Below 200% FPL*
National Total	293,135,000	12.6%	18.8%	21.5%	31.0%
Alabama	4,501,000	16.7%	23.8%	27.0%	36.5%
Alaska	657,000	10.0%	15.2%	17.5%	27.1%
Arizona	6,025,000	15.2%	22.8%	25.6%	37.5%
Arkansas	2,756,000	13.8%	22.3%	25.5%	38.6%
California	35,840,000	13.2%	19.8%	23.0%	32.6%
Colorado	4,629,000	11.4%	17.3%	19.6%	27.0%
Connecticut	3,483,000	9.3%	14.5%	16.2%	22.6%
Delaware	842,000	9.2%	14.1%	15.9%	24.5%
District of Columbia	539,000	21.3%	26.7%	29.7%	37.2%
Florida	17,845,000	11.1%	17.1%	20.2%	30.7%
Georgia	9,014,000	14.4%	20.0%	22.9%	32.0%
Hawaii	1,274,000	8.6%	13.4%	15.2%	22.1%
Idaho	1,441,000	9.9%	17.5%	21.5%	32.2%
Illinois	12,571,000	11.5%	16.8%	18.7%	27.8%
Indiana	6,131,000	12.6%	18.1%	21.4%	31.4%
Iowa	2,902,000	11.3%	16.5%	19.1%	27.1%
Kansas	2,693,000	12.5%	17.8%	20.4%	30.0%
Kentucky	4,049,000	14.8%	22.2%	25.0%	35.4%
Louisiana	4,086,000	18.3%	23.7%	26.8%	38.8%
Maine	1,314,000	12.6%	19.1%	21.8%	32.1%
Maryland	5,560,000	9.7%	13.9%	16.8%	23.2%
Massachusetts	6,318,000	10.1%	15.5%	17.1%	24.7%
Michigan	9,964,000	12.0%	18.0%	20.0%	28.2%
Minnesota	5,113,000	8.1%	12.1%	13.9%	21.2%
Mississippi	2,843,000	20.1%	28.6%	31.1%	43.2%
Missouri	5,697,000	11.6%	17.7%	20.8%	30.8%
Montana	926,000	13.8%	21.7%	23.7%	35.6%
Nebraska	1,760,000	9.5%	14.4%	17.7%	26.9%
Nevada	2,447,000	10.6%	18.5%	21.2%	30.8%
New Hampshire	1,298,000	5.6%	9.8%	11.9%	18.8%
New Jersey	8,692,000	6.8%	10.8%	12.7%	19.8%
New Mexico	1,938,000	17.9%	26.6%	30.7%	41.4%
New York	18,995,000	14.5%	20.4%	23.0%	32.4%
North Carolina	8,538,000	13.1%	20.5%	23.3%	34.0%
North Dakota	625,000	11.2%	18.3%	20.8%	29.5%
Ohio	11,310,000	12.3%	17.8%	20.5%	29.0%
Oklahoma	3,486,000	15.6%	23.3%	26.9%	38.5%
Oregon	3,619,000	12.0%	20.0%	23.1%	33.7%
Pennsylvania	12,237,000	11.2%	16.7%	19.3%	27.4%
Rhode Island	1,052,000	12.1%	16.5%	19.2%	25.8%
South Carolina	4,164,000	15.0%	21.3%	24.0%	35.2%
South Dakota	765,000	11.8%	18.6%	21.2%	30.0%
Tennessee	5,853,000	14.9%	22.2%	25.8%	36.2%
Texas	22,777,000	16.2%	24.4%	27.6%	38.7%
Utah	2,521,000	9.2%	14.0%	16.9%	28.3%
Vermont	621,000	7.6%	13.1%	15.0%	25.2%
Virginia	7,442,000	9.2%	13.6%	16.4%	25.1%
Washington	6,237,000	10.2%	15.0%	16.5%	26.1%
West Virginia	1,795,000	15.4%	23.2%	26.4%	35.8%
Wisconsin	5,440,000	10.2%	16.4%	18.9%	27.3%
Wyoming	509,000	10.6%	15.9%	18.1%	27.4%

*FPL- Federal Poverty Level

Source: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, Annual Social and Economic Supplement.

Employment Status, 2005*

State	Total Population	Civilian Labor Force	Population Unemployed	Unemployment Rate
National Total	226,082,000	149,320,000	7,591,000	5.1%
Alabama	3,521,000	2,155,000	86,000	4.0%
Alaska	473,000	339,000	23,000	6.8%
Arizona	4,433,000	2,844,000	134,000	4.7%
Arkansas	2,132,000	1,362,000	67,000	4.9%
California	26,935,000	17,696,000	949,000	5.4%
Colorado	3,526,000	2,548,000	129,000	5.0%
Connecticut	2,714,000	1,817,000	89,000	4.9%
Delaware	655,000	438,000	18,000	4.2%
District of Columbia	437,000	296,000	19,000	6.5%
Florida	13,868,000	8,654,000	325,000	3.8%
Georgia	6,769,000	4,588,000	242,000	5.3%
Hawaii	958,000	635,000	18,000	2.8%
Idaho	1,073,000	739,000	28,000	3.8%
Illinois	9,700,000	6,469,000	369,000	5.7%
Indiana	4,760,000	3,209,000	174,000	5.4%
Iowa	2,329,000	1,660,000	76,000	4.6%
Kansas	2,089,000	1,476,000	75,000	5.1%
Kentucky	3,222,000	2,000,000	121,000	6.1%
Louisiana	3,344,000	2,071,000	148,000	7.1%
Maine	1,063,000	712,000	34,000	4.8%
Maryland	4,261,000	2,935,000	121,000	4.1%
Massachusetts	5,027,000	3,364,000	162,000	4.8%
Michigan	7,771,000	5,097,000	344,000	6.7%
Minnesota	3,985,000	2,947,000	119,000	4.0%
Mississippi	2,185,000	1,343,000	106,000	7.9%
Missouri	4,479,000	3,024,000	162,000	5.4%
Montana	741,000	493,000	20,000	4.0%
Nebraska	1,344,000	986,000	37,000	3.8%
Nevada	1,826,000	1,216,000	49,000	4.1%
New Hampshire	1,030,000	732,000	26,000	3.6%
New Jersey	6,687,000	4,430,000	194,000	4.4%
New Mexico	1,463,000	936,000	49,000	5.3%
New York	14,971,000	9,416,000	472,000	5.0%
North Carolina	6,567,000	4,333,000	227,000	5.2%
North Dakota	501,000	359,000	12,000	3.4%
Ohio	8,859,000	5,900,000	350,000	5.9%
Oklahoma	2,704,000	1,742,000	76,000	4.4%
Oregon	2,848,000	1,860,000	114,000	6.1%
Pennsylvania	9,747,000	6,292,000	312,000	5.0%
Rhode Island	843,000	569,000	29,000	5.0%
South Carolina	3,251,000	2,081,000	142,000	6.8%
South Dakota	593,000	432,000	17,000	3.9%
Tennessee	4,631,000	2,910,000	162,000	5.6%
Texas	16,736,000	11,226,000	596,000	5.3%
Utah	1,774,000	1,268,000	54,000	4.3%
Vermont	503,000	356,000	12,000	3.5%
Virginia	5,704,000	3,934,000	136,000	3.5%
Washington	4,862,000	3,292,000	182,000	5.5%
West Virginia	1,456,000	800,000	40,000	5.0%
Wisconsin	4,317,000	3,041,000	144,000	4.7%
Wyoming	400,000	285,000	10,000	3.6%

*This information was compiled from the U.S. Department of Labor, Bureau of Labor Statistics News Release on State and Regional Unemployment, 2005 Annual Averages, released on March 2, 2006. The table summarizes the employment status of the civilian noninstitutional population, 16 years of age and over, by state.

Source: U.S. Department of Labor, Bureau of Labor Statistics, March 2, 2006.

Medicaid/Medicare Certified Facilities, 2004/2006*

State	Hospitals	Skilled Nursing Facilities	ICF-MR Facilities	Home Health Agencies	Rural Health Clinics
National Total	6,0482	15,022	6,436	8,212	3,545
Alabama	126	226	6	142	66
Alaska	24	15		14	6
Arizona	91	133	12	77	12
Arkansas	105	209	41	170	71
California	432	1208	1127	587	241
Colorado	87	193	3	139	37
Connecticut	45	245	120	81	0
Delaware	10	38	2	16	16
District of Columbia	14	19	114	21	0
Florida	237	677	105	669	154
Georgia	178	353	11	96	93
Hawaii	27	43	18	14	1
Idaho	48	77	65	50	46
Illinois	220	698	311	376	209
Indiana	156	493	522	170	53
Iowa	120	412	134	178	131
Kansas	152	264	31	133	177
Kentucky	119	293	9	99	118
Louisiana	221	293	504	219	62
Maine	42	113	20	29	46
Maryland	65	226	4	48	0
Massachusetts	112	445	6	118	1
Michigan	175	397	1	293	158
Minnesota	147	385	219	208	73
Mississippi	111	169	13	56	141
Missouri	138	481	18	158	284
Montana	66	96	1	36	42
Nebraska	96	192	4	66	99
Nevada	43	45	11	58	6
New Hampshire	32	73	1	35	17
New Jersey	108	362	9	50	0
New Mexico	51	67	43	63	12
New York	245	654	599	186	9
North Carolina	138	420	332	165	103
North Dakota	50	83	68	26	62
Ohio	216	946	425	415	17
Oklahoma	152	285	80	197	40
Oregon	59	121	1	60	53
Pennsylvania	247	705	210	282	41
Rhode Island	15	90	5	22	1
South Carolina	77	176	105	67	95
South Dakota	66	92	1	38	55
Tennessee	153	299	83	137	41
Texas	517	1062	889	1597	327
Utah	48	85	15	51	14
Vermont	16	41	2	11	19
Virginia	109	254	32	168	56
Washington	101	236	14	59	111
West Virginia	68	121	63	61	68
Wisconsin	143	370	25	121	58
Wyoming	30	33	2	26	19

* Hospitals and rural health clinics data are from 2004; all others are from 2006.

Sources: OSCAR Report 10. Facility Counts: Active Providers. CMS, Center for Medicaid and State Operations, January 18, 2005 (hospitals and rural health clinics); http://www.cms.hhs.gov/HealthPlanRepFileData/05_Inst.asp (SNF and ICF-MR); <http://www.medicare.gov/Download/DownloadDB.asp> (Home Health Compare)

Licensed Pharmacies, As of June 30, 2005*

State	Total Pharmacies	Hospital/ Institutional Pharmacies	Independent Community Pharmacies	Chain Pharmacies (Four or More)	Out-of-State or Non-Resident Pharmacies
National Total	82,276	7,758	16,222	16,654	14,026
Alabama	1,902	163	708	636	395
Alaska	117	25(H)			257
Arizona	1,362	85	98	787	295
Arkansas	746	201			227
California	6,122	497			198
Colorado	1,270				353
Connecticut	642(D)	51(D)	182(D)	460(D)	358(D)
Delaware	245	18	63	182	517
District of Columbia	123	13	27	61	0
Florida	6841(F)	1,945	(V)	(V)	419
Georgia	3,689	205	(P)	(P)	
Hawaii	216				225
Idaho	692	59	347(A,E)		286
Illinois	3,077	234	2668(A)	(A)	296
Indiana	1,378				371
Iowa	1,280	127(F)	801(A,F)	(A)	331
Kansas	835	177	350	278	399
Kentucky	1495(X)	174	633	493	189
Louisiana	1,644	181	729	473	260
Maine	300	42			259
Maryland	1537(I)	65	289	713	352
Massachusetts	1048(J)	158	250	740	0
Michigan	2,547				150
Minnesota	1,586	144	476	610	374
Mississippi	962	130			220
Missouri	1604(K)	133	234	515	365
Montana	323	90	232		255
Nebraska	498				174(L)
Nevada	836				268
New Hampshire	282	33	41	185	324
New Jersey	1,981				
New Mexico	695	53	75		342
New York	4,763	488(Q)	2,061	2,124	273
North Carolina	2183(F)	173	578	1,073	311
North Dakota	620	47	155	33	324
Ohio	3014(N)	228	561	1,565	385
Oklahoma	1,507	168(D)	928(A)	(A)	411
Oregon	1,051	126	366	543	469
Pennsylvania	3,222				0
Rhode Island	206	21	38	5	363
South Carolina	1,169				403
South Dakota	577	45	125	87	320
Tennessee	1,999	454	550	874	83
Texas	6080(B)	597	1,750	3,448	367
Utah	686	132	412(A)	(A)	267
Vermont	137	17	154		151
Virginia	1,567				475
Washington	1,728	230(C)	341	769	293
West Virginia	555(J)				331
Wisconsin	3,165			0	
Wyoming	140(F)	29			341

*Figures reported reflect number of pharmacies licensed by state boards of pharmacy. Individual columns will not sum to total. Total includes other pharmacies not specified in the four practice settings. Blanks indicate that information was not available.

Source: 2006 National Association of Boards of Pharmacy, Survey of Pharmacy Law.

LEGEND

- A — Chains included in independent community pharmacies figure.
- B — Also licenses 790 nuclear, public health, clinic, ambulatory surgical center, and HMO pharmacies.
- C — Includes 121 hospital, 35 nursing home, 19 home infusion, 7 nuclear, 42 HMO, and 18 other pharmacies.
- D — Approximately.
- E — Plus 25 limited service and 66 parenteral admixture pharmacies.
- F — In-state.
- H — Drug rooms.
- I — Total includes other areas not listed: clinic, correctional, HMO, nursing home, IV, nuclear, research, and other. 105 pharmacies have waiver (specialty permits) Board issued 735 distributor permits.
- J — Total also includes home IV and mail-order pharmacies.
- K — Includes the following pharmacy categories: 9 long-term care, 3 home health, 10 radiopharmaceutical, 2 renal dialysis, 2 sterile pharmaceuticals, 2 consultant pharmacy, 0 medical gas, 0 shared services, and 357 with multiple classes.
- L — Nebraska licenses out-of-state pharmacies.
- N — Includes 275 nuclear, clinic, fluid therapy, mail-order, specialty, and pharmacies serving nursing homes only.
- P — 2,202 (2,165 independent and chain pharmacies, 14 nuclear pharmacies, 18 prison pharmacies, 5 clinic pharmacies, and 2 pharmacy schools).
- Q — 16 nuclear pharmacies.
- X — Includes 6 charitable pharmacies.

Physicians, 2004

State	Physicians (Non-Federal, Patient Care)	Physicians Per 1,000 Population	Office Based Physicians (Non-Federal, Patient Care)	Percent Office Based	Primary Care Physicians (Non-Federal, Patient Care, Office Based)*	Percent Office Based Physicians Primary Care
National Total	674,856	2.4	531,934	79%	278,630	52%
Alabama	8,638	2.0	7,071	82%	3,859	55%
Alaska	1,208	1.9	1,108	92%	791	71%
Arizona	10,481	1.9	8,949	85%	4,501	50%
Arkansas	5,081	1.9	4,209	83%	2,636	63%
California	80,401	2.3	67,356	84%	35,384	53%
Colorado	10,421	2.3	8,908	85%	4,966	56%
Connecticut	10,824	3.2	8,108	75%	3,598	44%
Delaware	1,817	2.3	1,453	80%	726	50%
District of Columbia	3,346	6.5	2,126	64%	862	41%
Florida	37,502	2.2	32,470	87%	15,332	47%
Georgia	17,077	2.0	14,309	84%	7,658	54%
Hawaii	3,319	2.7	2,821	85%	1,514	54%
Idaho	2,160	1.6	2,016	93%	1,288	64%
Illinois	30,265	2.4	22,621	75%	12,253	54%
Indiana	12,049	2.0	9,932	82%	5,731	58%
Iowa	4,841	1.7	3,855	80%	2,457	64%
Kansas	5,332	2.0	4,352	82%	2,607	60%
Kentucky	8,542	2.1	7,071	83%	3,898	55%
Louisiana	10,636	2.4	8,270	78%	4,103	50%
Maine	3,091	2.4	2,585	84%	1,538	59%
Maryland	17,785	3.3	13,580	76%	6,214	46%
Massachusetts	23,676	3.8	16,713	71%	7,327	44%
Michigan	21,311	2.2	15,607	73%	8,437	54%
Minnesota	12,699	2.6	10,015	79%	6,795	68%
Mississippi	4,669	1.7	3,871	83%	2,169	56%
Missouri	12,073	2.2	9,084	75%	4,456	49%
Montana	1,864	2.1	1,729	93%	1,042	60%
Nebraska	3,709	2.2	2,908	78%	1,898	65%
Nevada	3,875	1.7	3,484	90%	1,822	52%
New Hampshire	3,008	2.4	2,501	83%	1,415	57%
New Jersey	23,049	2.7	17,927	78%	8,034	45%
New Mexico	3,842	2.1	3,098	81%	1,877	61%
New York	62,789	3.4	41,677	66%	18,696	45%
North Carolina	18,701	2.3	15,107	81%	8,231	54%
North Dakota	1,360	2.2	1,129	83%	757	67%
Ohio	25,968	2.3	19,421	75%	10,373	53%
Oklahoma	5,330	1.6	4,432	83%	2,470	56%
Oregon	8,279	2.4	7,117	86%	4,084	57%
Pennsylvania	31,228	2.6	22,848	73%	10,915	48%
Rhode Island	3,242	3.1	2,390	74%	1,116	47%
South Carolina	8,567	2.1	6,955	81%	3,988	57%
South Dakota	1,481	2.0	1,288	87%	834	65%
Tennessee	13,530	2.4	11,165	83%	5,899	53%
Texas	41,186	1.9	33,438	81%	17,840	53%
Utah	4,437	1.9	3,615	81%	1,969	54%
Vermont	1,936	3.2	1,433	74%	913	64%
Virginia	17,148	2.4	13,814	81%	7,712	56%
Washington	14,116	2.3	12,034	85%	7,318	61%
West Virginia	3,581	2.0	2,768	77%	1,558	56%
Wisconsin	12,526	2.3	10,411	83%	6,240	60%
Wyoming	860	1.7	785	91%	529	67%

*Primary care physicians include General Practice, General Family Practice, General Internal Medicine, Ob-Gyn, and General Pediatrics.

Source: USDHHS, HRSA, Bureau of Health Professions, National Center for Health Workforce Information & Analysis, Area Resource File, February 2005.

Other Providers, 2004/2005

State	# FTE Registered Nurses*	# FTE Registered Nurses* per 1,000 population	Pharmacists** (Licensed by State)	Pharmacists** per 1,000 population
National Total	2,057,058	7.2	362,780	1.3
Alabama	31,736	7.2	7,633	1.7
Alaska	5,839	9.2	678	1.1
Arizona	35,036	6.2	7,232	1.3
Arkansas	18,318	6.8	3,862	1.4
California	175,292	5.0	29,676	0.8
Colorado	29,268	6.5	5,685	1.3
Connecticut	26,698	7.9	4,528	1.3
Delaware	7,194	8.9	1,385	1.7
District of Columbia	10,194	19.7	1,564	3.0
Florida	117,447	6.9	21,540	1.3
Georgia	58,910	6.9	10,474	1.2
Hawaii	7,978	6.5	1,666	1.4
Idaho	7,401	5.4	1,612	1.2
Illinois	95,490	7.7	14,458	1.2
Indiana	46,676	7.7	8,436	1.4
Iowa	27,450	9.6	5,012	1.8
Kansas	21,328	8.0	3,646	1.4
Kentucky	33,435	8.3	5,383	1.3
Louisiana	32,182	7.3	6,218	1.4
Maine	12,798	10.0	1,267	1.0
Maryland	39,725	7.3	7,391	1.4
Massachusetts	59,337	9.6	9,940	1.6
Michigan	70,630	7.2	11,322	1.1
Minnesota	40,454	8.2	6,357	1.3
Mississippi	21,768	7.8	3,483	1.2
Missouri	49,174	8.8	7,131	1.3
Montana	6,520	7.2	1,601	1.8
Nebraska	15,990	9.4	3,004	1.8
Nevada	12,733	5.5	8,475	3.7
New Hampshire	13,668	10.8	2,000	1.6
New Jersey	59,690	7.0	13,100	1.5
New Mexico	11,811	6.3	2,278	1.2
New York	148,653	8.0	18,990	1.0
North Carolina	68,030	8.2	10,136	1.2
North Dakota	6,390	10.5	2,188	3.6
Ohio	93,830	8.4	14,953	1.3
Oklahoma	21,651	6.3	4,838	1.4
Oregon	24,459	7.0	4,235	1.2
Pennsylvania	106,912	8.9	17,950	1.5
Rhode Island	9,133	8.8	1,810	1.7
South Carolina	26,920	6.6	5,256	1.3
South Dakota	7,856	10.6	1,485	2.0
Tennessee	48,252	8.4	7,588	1.3
Texas	129,442	5.9	22,233	1.0
Utah	13,056	5.6	2,207	0.9
Vermont	5,006	8.3	871	1.5
Virginia	47,904	6.6	8,869	1.2
Washington	38,740	6.4	7,361	1.2
West Virginia	14,124	8.0	2,975	1.7
Wisconsin	40,954	7.7	6,157	1.2
Wyoming	3,577	7.3	1,007	2.0

*FTE- Full-time equivalent employees as of 2004

**As of June 30, 2005

Source: USDHHS, HRSA, Bureau of Health Professions, National Center for Health Workforce Information & Analysis, 2004 National Sample Survey of Registered Nurses. 2006 National Association of Boards of Pharmacy, Survey of Pharmacy Law.

Section 4: Pharmacy Program Characteristics

THE MEDICAID DRUG PROGRAM

The Medicaid program defines prescribed drugs as simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, which are prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional practice (42 CFR 440.120). The drugs must be dispensed by licensed authorized practitioners on a written prescription that is recorded and maintained in the pharmacist's or the practitioner's records.

MEDICAID PRESCRIPTION DRUG REIMBURSEMENT

On July 31, 1987, CMS published a notice of the final rule for limits on payments for drugs in the Medicaid program. The regulations adopted in the rule became effective October 29, 1987 (52 FR 28648). In this final rule, CMS attempted to (1) respond to public comments on the NPRM (51 FR 2956); (2) provide maximum flexibility to the States in their administration of the Medicaid program; (3) provide responsible but not burdensome Federal oversight of the Medicaid program; and (4) take advantage of savings in the marketplace for multiple-source drugs.

To accomplish this, CMS adopted a Federal upper limit standard for certain multiple-source drugs, based on application of a specific formula. The upper limit for other drugs is similar, in that it retains the estimated acquisition cost (EAC) as the upper limit standard that State agencies must meet. However, this standard is applied on an aggregate basis rather than on a prescription-specific basis. State agencies are therefore encouraged to exercise maximum flexibility in establishing their own payment methods (see the *Federal Register*, Vol. 52, No. 147, Friday, July 31, 1987, page 28648).

Multiple-Source Drugs

A multiple-source drug is one that is marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or under a proprietary name and without such a name.

A specific upper limit for a multiple-source drug may be established if the following requirements are met:

- All of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the current edition of the publication, *Approved Drug Products with Therapeutically Equivalent Evaluations*; and
- At least three suppliers list the drug (which is classified by the FDA as Category A in its publication) in the current editions of published compendia of cost information for drugs available for sale nationally.

The upper limit for a multi-source drug for which a specific limit has been established does not apply if a physician certifies in his or her own handwriting that a specific brand is "medically necessary" for a particular recipient.

The handwritten phrase "brand necessary," "medically necessary," or "brand medically necessary" must appear on the face of the prescription. The rule specifically states that a check-off box on a prescription form is not acceptable, but it does not address the use of two-line prescription forms.

The formula to be used in calculating the aggregate upper limit of payment for certain multiple-source drugs will be 150% of the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules (or if the drug is not commonly available in quantities of 100, the package size commonly listed), or in the case of liquids, the commonly listed size, plus a reasonable dispensing fee.

Other Drugs

A drug described as an “other drug” is (1) a brand name drug certified as medically necessary by the physician, (2) a multiple-source drug not subject to the 150% formula; or (3) a single-source drug. Payments for these drugs must not exceed, in the aggregate, payment levels determined by applying the lower of:

- Estimated acquisition cost (EAC) plus reasonable dispensing fees; or
- The provider’s usual and customary charges to the general public.

States may continue to use their existing EAC program, or adopt another method, as long as their aggregate expenditures do not exceed what would have been paid under EAC principles.

Other Requirements

The rule requires States to submit a State plan that describes their payment methods for prescribed drugs. The rule does not prescribe a preferred payment method, as long as the State’s aggregate spending in each category is equal to or below the upper limit requirements. States are also required to submit assurances to CMS that the requirements are met.

The rule does not prescribe a preferred payment method for the States, but gives States the flexibility to determine how they will pay for prescription drugs under Medicaid. As long as the State’s aggregate spending is at or below the amount derived from the formula, the State is free to maintain its current payment program or adopt other methods. States can alter payment rates for individual drugs, balancing payment increases for certain products with payment decreases for other drugs so that, in the aggregate, the program does not exceed the established limit. With the establishment of upper limit payment maximums, some States may alter their current payment methods to comply with the established limits.

State programs vary, depending upon whether or not State maximum allowable cost (MAC) programs cover the same drugs listed by CMS. States with established MAC programs may be unaffected if their MAC rates are already low, or they may have to make certain adjustments in their MAC levels to meet the Federal aggregate expenditure limits. States without MAC programs may develop a new payment method to increase the use of lower cost generic drug products in order to stay within the upper payment limits, or may simply adopt CMS’ formula for listed drug products.

DRUG RECIPIENTS

Drug recipients are defined as individuals who received drugs, not as everyone eligible to receive drugs. Today, all 50 States and the District of Columbia cover drugs under the Medicaid program.

Drug Expenditures Trends, 2003-2004*

State	2003	2004	% Change 2003-2004
National Total	\$33,912,159,591	\$40,065,314,592	18.1%
Alabama	\$536,222,703	\$594,477,767	10.9%
Alaska	\$94,265,165	\$115,273,427	22.3%
Arizona	\$4,744,244	\$5,367,723	13.1%
Arkansas	\$310,709,182	\$380,446,105	22.4%
California	\$4,219,504,969	\$4,817,590,501	14.2%
Colorado	\$225,297,507	\$264,117,222	17.2%
Connecticut	\$403,802,170	\$448,164,399	11.0%
Delaware	\$109,844,743	\$122,552,631	11.6%
District of Columbia	\$81,762,504	\$106,453,411	30.2%
Florida	\$2,015,594,273	\$2,472,756,351	22.7%
Georgia	\$1,073,715,230	\$1,213,833,584	13.0%
Hawaii	\$97,386,406	\$117,149,907	20.3%
Idaho	\$132,143,091	\$153,351,334	16.0%
Illinois	\$1,469,190,682	\$1,751,647,987	19.2%
Indiana	\$627,575,345	\$703,941,201	12.2%
Iowa	\$331,222,324	\$371,927,390	12.3%
Kansas	\$228,920,787	\$274,203,278	19.8%
Kentucky	\$685,229,661	\$802,700,636	17.1%
Louisiana	\$827,713,132	\$944,175,123	14.1%
Maine	\$268,547,563	\$281,693,429	4.9%
Maryland	\$429,589,193	\$490,288,888	14.1%
Massachusetts	\$946,210,618	\$987,294,716	4.3%
Michigan	\$758,266,989	\$874,729,802	15.4%
Minnesota	\$363,365,473	\$394,600,158	8.6%
Mississippi	\$568,007,104	\$668,097,090	17.6%
Missouri	\$941,522,305	\$1,119,655,471	18.9%
Montana	\$79,771,831	\$99,334,048	24.5%
Nebraska	\$210,199,726	\$231,317,773	10.0%
Nevada	\$106,821,075	\$127,920,160	19.8%
New Hampshire	\$112,948,647	\$128,552,504	13.8%
New Jersey	\$766,995,569	\$1,016,646,964	32.5%
New Mexico	\$86,408,362	\$117,451,186	35.9%
New York	\$4,219,745,421	\$4,782,579,851	13.3%
North Carolina	\$1,291,263,155	\$1,575,005,070	22.0%
North Dakota	\$56,960,417	\$59,722,091	4.8%
Ohio	\$1,520,147,470	\$1,819,580,108	19.7%
Oklahoma	\$301,294,000	\$416,314,217	38.2%
Oregon	\$262,335,388	\$245,180,310	-6.5%
Pennsylvania	\$791,053,653	\$952,341,486	20.4%
Rhode Island	\$140,686,626	\$166,067,772	18.0%
South Carolina	\$565,890,228	\$673,035,838	18.9%
South Dakota	\$71,223,108	\$81,936,507	15.0%
Tennessee	\$1,280,129,986	\$2,196,066,176	71.6%
Texas	\$1,920,865,985	\$2,202,097,688	14.6%
Utah	\$163,217,885	\$192,093,154	17.7%
Vermont	\$127,763,857	\$160,039,523	25.3%
Virginia	\$506,414,352	\$582,093,270	14.9%
Washington	\$592,437,155	\$649,265,744	9.6%
West Virginia	\$345,831,214	\$376,426,405	8.8%
Wisconsin	\$592,295,000	\$684,912,153	15.6%
Wyoming	\$49,106,118	\$52,845,063	7.6%

*Rebates have not been subtracted from these figures.

Source: CMS, CMS-64 Report, FY 2003 and FY 2004.

Ranking Based on Drug Expenditures, 2003-2004*

State	2004 Payments	2004 Ranking	% of 2004 National Medicaid Drug Expenditures	2003 Payments	2003 Ranking
National Total	\$40,065,314,592			\$33,912,159,591	
California	\$4,817,590,501	1	12.0%	\$4,219,504,969	2
New York	\$4,782,579,851	2	11.9%	\$4,219,745,421	1
Florida	\$2,472,756,351	3	6.2%	\$2,015,594,273	3
Texas	\$2,202,097,688	4	5.5%	\$1,920,865,985	4
Tennessee	\$2,196,066,176	5	5.5%	\$1,280,129,986	8
Ohio	\$1,819,580,108	6	4.5%	\$1,520,147,470	5
Illinois	\$1,751,647,987	7	4.4%	\$1,469,190,682	6
North Carolina	\$1,575,005,070	8	3.9%	\$1,291,263,155	7
Georgia	\$1,213,833,584	9	3.0%	\$1,073,715,230	9
Missouri	\$1,119,655,471	10	2.8%	\$941,522,305	11
New Jersey	\$1,016,646,964	11	2.5%	\$766,995,569	14
Massachusetts	\$987,294,716	12	2.5%	\$946,210,618	10
Pennsylvania	\$952,341,486	13	2.4%	\$791,053,653	13
Louisiana	\$944,175,123	14	2.4%	\$827,713,132	12
Michigan	\$874,729,802	15	2.2%	\$758,266,989	15
Kentucky	\$802,700,636	16	2.0%	\$685,229,661	16
Indiana	\$703,941,201	17	1.8%	\$627,575,345	17
Wisconsin	\$684,912,153	18	1.7%	\$592,295,000	19
South Carolina	\$673,035,838	19	1.7%	\$565,890,228	21
Mississippi	\$668,097,090	20	1.7%	\$568,007,104	20
Washington	\$649,265,744	21	1.6%	\$592,437,155	18
Alabama	\$594,477,767	22	1.5%	\$536,222,703	22
Virginia	\$582,093,270	23	1.5%	\$506,414,352	23
Maryland	\$490,288,888	24	1.2%	\$429,589,193	24
Connecticut	\$448,164,399	25	1.1%	\$403,802,170	25
Oklahoma	\$416,314,217	26	1.0%	\$301,294,000	30
Minnesota	\$394,600,158	27	1.0%	\$363,365,473	26
Arkansas	\$380,446,105	28	0.9%	\$310,709,182	29
West Virginia	\$376,426,405	29	0.9%	\$345,831,214	27
Iowa	\$371,927,390	30	0.9%	\$331,222,324	28
Maine	\$281,693,429	31	0.7%	\$268,547,563	31
Kansas	\$274,203,278	32	0.7%	\$228,920,787	33
Colorado	\$264,117,222	33	0.7%	\$225,297,507	34
Oregon	\$245,180,310	34	0.6%	\$262,335,388	32
Nebraska	\$231,317,773	35	0.6%	\$210,199,726	35
Utah	\$192,093,154	36	0.5%	\$163,217,885	36
Rhode Island	\$166,067,772	37	0.4%	\$140,686,626	37
Vermont	\$160,039,523	38	0.4%	\$127,763,857	39
Idaho	\$153,351,334	39	0.4%	\$132,143,091	38
New Hampshire	\$128,552,504	40	0.3%	\$112,948,647	40
Nevada	\$127,920,160	41	0.3%	\$106,821,075	42
Delaware	\$122,552,631	42	0.3%	\$109,844,743	41
New Mexico	\$117,451,186	43	0.3%	\$86,408,362	45
Hawaii	\$117,149,907	44	0.3%	\$97,386,406	43
Alaska	\$115,273,427	45	0.3%	\$94,265,165	44
District of Columbia	\$106,453,411	46	0.3%	\$81,762,504	46
Montana	\$99,334,048	47	0.2%	\$79,771,831	47
South Dakota	\$81,936,507	48	0.2%	\$71,223,108	48
North Dakota	\$59,722,091	49	0.1%	\$56,960,417	49
Wyoming	\$52,845,063	50	0.1%	\$49,106,118	50
Arizona	\$5,367,723	51	0.0%	\$4,744,244	51

*Rebates have not been subtracted from these figures.

Source: CMS, HCFA-64 Report, FY 2003 and FY 2004.

Drugs as a Percentage of Total Net Expenditures, 2004

State	Total Medicaid Net Medical Assistance Expenditures	Total Drug Expenditures*	% of Total Net Expenditures
National Total	\$280,771,854,976	\$40,065,314,592	14.3%
Alabama	\$3,636,777,895	\$594,477,767	16.3%
Alaska	\$884,037,863	\$115,273,427	13.0%
Arizona	\$4,933,111,255	\$5,367,723	0.1%
Arkansas	\$2,585,068,063	\$380,446,105	14.7%
California	\$30,677,337,285	\$4,817,590,501	15.7%
Colorado	\$2,648,577,338	\$264,117,222	10.0%
Connecticut	\$3,875,748,955	\$448,164,399	11.6%
Delaware	\$792,028,808	\$122,552,631	15.5%
District of Columbia	\$1,116,037,028	\$106,453,411	9.5%
Florida	\$12,789,934,905	\$2,472,756,351	19.3%
Georgia	\$7,044,051,167	\$1,213,833,584	17.2%
Hawaii	\$907,974,098	\$117,149,907	12.9%
Idaho	\$938,680,696	\$153,351,334	16.3%
Illinois	\$9,991,310,983	\$1,751,647,987	17.5%
Indiana	\$4,889,329,727	\$703,941,201	14.4%
Iowa	\$2,239,281,593	\$371,927,390	16.6%
Kansas	\$1,782,435,217	\$274,203,278	15.4%
Kentucky	\$4,086,404,587	\$802,700,636	19.6%
Louisiana	\$4,933,031,400	\$944,175,123	19.1%
Maine	\$2,021,194,249	\$281,693,429	13.9%
Maryland	\$4,586,430,658	\$490,288,888	10.7%
Massachusetts	\$8,725,068,052	\$987,294,716	11.3%
Michigan	\$8,224,940,371	\$874,729,802	10.6%
Minnesota	\$5,550,210,439	\$394,600,158	7.1%
Mississippi	\$3,284,724,191	\$668,097,090	20.3%
Missouri	\$6,082,476,995	\$1,119,655,471	18.4%
Montana	\$666,602,722	\$99,334,048	14.9%
Nebraska	\$1,430,800,678	\$231,317,773	16.2%
Nevada	\$1,037,927,527	\$127,920,160	12.3%
New Hampshire	\$1,148,626,371	\$128,552,504	11.2%
New Jersey	\$7,928,423,533	\$1,016,646,964	12.8%
New Mexico	\$2,212,810,008	\$117,451,186	5.3%
New York	\$40,978,466,799	\$4,782,579,851	11.7%
North Carolina	\$7,945,585,983	\$1,575,005,070	19.8%
North Dakota	\$479,677,381	\$59,722,091	12.5%
Ohio	\$11,550,492,206	\$1,819,580,108	15.8%
Oklahoma	\$2,500,517,344	\$416,314,217	16.6%
Oregon	\$2,596,299,977	\$245,180,310	9.4%
Pennsylvania	\$14,088,449,923	\$952,341,486	6.8%
Rhode Island	\$1,646,343,632	\$166,067,772	10.1%
South Carolina	\$3,848,423,641	\$673,035,838	17.5%
South Dakota	\$561,562,642	\$81,936,507	14.6%
Tennessee	\$7,029,807,190	\$2,196,066,176	31.2%
Texas	\$16,077,695,030	\$2,202,097,688	13.7%
Utah	\$1,235,552,901	\$192,093,154	15.5%
Vermont	\$798,758,992	\$160,039,523	20.0%
Virginia	\$3,825,216,022	\$582,093,270	15.2%
Washington	\$5,243,560,705	\$649,265,744	12.4%
West Virginia	\$1,937,298,997	\$376,426,405	19.4%
Wisconsin	\$4,410,918,293	\$684,912,153	15.5%
Wyoming	\$365,832,661	\$52,845,063	14.4%

*Rebates have not been subtracted from these figures.

Source: CMS, CMS-64 Report, FY 2004.

Drugs as a Percentage of Total Net Expenditures, 2002-2004*

State	2002	2003	2004
National Total	11.9%	13.0%	14.3%
Alabama	14.6%	15.4%	16.3%
Alaska	10.3%	11.4%	13.0%
Arizona	0.1%	0.1%	0.1%
Arkansas	12.2%	13.3%	14.7%
California	13.4%	14.0%	15.7%
Colorado	8.2%	8.8%	10.0%
Connecticut	10.4%	11.5%	11.6%
Delaware	15.4%	15.3%	15.5%
District of Columbia	6.5%	7.6%	9.5%
Florida	17.4%	18.4%	19.3%
Georgia	14.0%	17.0%	17.2%
Hawaii	11.9%	12.7%	12.9%
Idaho	15.4%	16.3%	16.3%
Illinois	14.7%	15.9%	17.5%
Indiana	14.2%	14.7%	14.4%
Iowa	11.1%	15.5%	16.6%
Kansas	11.6%	13.0%	15.4%
Kentucky	17.3%	18.5%	19.6%
Louisiana	14.6%	18.7%	19.1%
Maine	15.4%	15.1%	13.9%
Maryland	8.2%	9.9%	10.7%
Massachusetts	11.9%	12.3%	11.3%
Michigan	8.9%	9.5%	10.6%
Minnesota	7.0%	7.5%	7.1%
Mississippi	19.7%	19.9%	20.3%
Missouri	14.8%	17.0%	18.4%
Montana	14.6%	15.6%	14.9%
Nebraska	15.5%	15.9%	16.2%
Nevada	10.8%	10.5%	12.3%
New Hampshire	9.8%	12.3%	11.2%
New Jersey	9.0%	9.8%	12.8%
New Mexico	4.2%	4.3%	5.3%
New York	10.1%	10.6%	11.7%
North Carolina	16.4%	18.3%	19.8%
North Dakota	11.4%	12.2%	12.5%
Ohio	13.8%	14.9%	15.8%
Oklahoma	12.6%	13.0%	16.6%
Oregon	10.9%	9.8%	9.4%
Pennsylvania	5.9%	6.2%	6.8%
Rhode Island	9.2%	9.8%	10.1%
South Carolina	13.7%	16.0%	17.5%
South Dakota	11.3%	13.3%	14.6%
Tennessee	15.6%	20.1%	31.2%
Texas	11.8%	12.5%	13.7%
Utah	14.3%	14.9%	15.5%
Vermont	17.3%	18.1%	20.0%
Virginia	12.0%	14.4%	15.2%
Washington	10.5%	11.9%	12.4%
West Virginia	17.5%	18.6%	19.4%
Wisconsin	10.6%	12.4%	15.5%
Wyoming	14.2%	14.6%	14.4%

*Percentages are based on figures that have not had rebates subtracted from them.

Source: CMS, HCFA-64 Report, FY 2002 - FY 2004.

Drug Expenditures by Category, 2003

State	Central Nervous System Agents	Psychotherapeutic Agents	Cardiovascular Agents	Antihyperlipidemic Agents	Anti-Infective Agents
National Total	\$5,762,143,729	\$8,010,094,504	\$2,687,050,094	\$1,515,024,141	\$3,489,893,662
Alabama	\$89,206,249	\$120,312,068	\$51,151,620	\$21,077,222	\$52,245,396
Alaska	\$19,834,449	\$24,684,984	\$5,858,849	\$2,651,426	\$7,969,848
Arizona*					
Arkansas	\$55,029,484	\$81,352,253	\$25,849,259	\$9,179,551	\$33,841,691
California	\$615,836,581	\$851,363,719	\$361,581,514	\$246,766,235	\$365,064,860
Colorado	\$53,257,819	\$63,159,662	\$16,254,885	\$8,615,091	\$17,362,264
Connecticut	\$76,920,638	\$111,585,681	\$29,202,261	\$17,776,600	\$34,850,532
Delaware	\$15,996,615	\$22,207,869	\$6,333,704	\$4,129,440	\$15,666,181
District of Columbia	\$8,106,180	\$15,677,968	\$8,060,441	\$3,639,932	\$21,667,109
Florida	\$328,306,949	\$425,483,812	\$158,494,045	\$84,477,396	\$312,239,536
Georgia	\$168,751,781	\$216,815,193	\$80,592,868	\$33,734,412	\$125,153,122
Hawaii	\$20,298,105	\$21,855,247	\$10,620,819	\$6,840,867	\$8,349,974
Idaho	\$20,574,498	\$30,885,947	\$6,441,443	\$3,029,752	\$8,487,004
Illinois	\$236,569,960	\$326,976,273	\$153,890,122	\$87,583,331	\$153,075,703
Indiana	\$123,417,777	\$184,916,181	\$39,893,898	\$22,992,384	\$50,865,551
Iowa	\$61,377,066	\$105,817,906	\$22,313,370	\$10,604,569	\$26,618,622
Kansas	\$48,448,046	\$70,059,922	\$15,224,948	\$7,157,039	\$16,917,811
Kentucky	\$119,421,472	\$164,474,019	\$55,842,165	\$28,061,091	\$59,427,835
Louisiana	\$119,371,519	\$147,009,041	\$63,236,637	\$23,718,196	\$87,238,985
Maine	\$53,674,066	\$71,591,288	\$13,559,528	\$13,817,284	\$18,836,439
Maryland	\$67,234,066	\$146,823,857	\$36,052,150	\$19,402,585	\$37,961,662
Massachusetts	\$174,084,269	\$277,903,706	\$56,062,496	\$42,422,891	\$97,276,136
Michigan	\$143,320,466	\$238,638,352	\$53,635,607	\$29,702,869	\$40,029,589
Minnesota	\$73,928,517	\$119,682,619	\$14,663,210	\$10,214,865	\$21,416,417
Mississippi	\$89,013,346	\$107,148,817	\$67,044,805	\$23,238,445	\$60,234,476
Missouri	\$198,914,546	\$245,405,977	\$78,113,852	\$35,410,440	\$85,477,110
Montana	\$18,601,857	\$25,076,839	\$5,383,777	\$2,385,676	\$6,098,504
Nebraska	\$38,533,497	\$58,824,017	\$13,258,251	\$6,943,699	\$18,177,047
Nevada	\$25,603,111	\$26,056,853	\$8,050,855	\$4,154,233	\$10,989,450
New Hampshire	\$22,270,094	\$38,347,714	\$5,650,138	\$4,049,858	\$6,623,676
New Jersey	\$131,209,196	\$176,152,689	\$72,870,658	\$34,249,472	\$87,181,935
New Mexico	\$17,253,128	\$19,728,815	\$7,230,563	\$3,939,071	\$7,203,730
New York	\$525,074,752	\$851,594,698	\$307,759,037	\$185,455,874	\$653,500,040
North Carolina	\$223,394,899	\$268,362,383	\$107,747,480	\$55,280,609	\$121,945,537
North Dakota	\$11,096,738	\$16,419,419	\$3,912,413	\$1,617,909	\$3,918,217
Ohio	\$299,250,096	\$406,522,932	\$104,092,090	\$66,857,268	\$127,514,613
Oklahoma	\$52,045,102	\$77,476,668	\$22,461,686	\$10,696,854	\$26,504,255
Oregon	\$45,591,983	\$102,980,121	\$10,314,420	\$5,058,229	\$12,879,567
Pennsylvania	\$151,905,727	\$188,658,335	\$63,986,962	\$30,125,808	\$48,817,097
Rhode Island	\$26,234,164	\$40,882,565	\$12,067,874	\$7,159,090	\$10,888,542
South Carolina	\$102,080,394	\$123,245,910	\$64,213,404	\$30,535,629	\$63,117,087
South Dakota	\$14,246,858	\$19,297,848	\$4,411,560	\$1,606,900	\$6,684,555
Tennessee	\$304,887,110	\$401,527,060	\$132,395,840	\$95,539,785	\$111,354,279
Texas	\$315,064,029	\$390,645,935	\$138,746,408	\$71,197,048	\$239,499,170
Utah	\$33,535,139	\$46,904,324	\$7,367,868	\$4,150,263	\$13,780,617
Vermont	\$5,605,238	\$7,981,557	\$2,073,339	\$2,380,658	\$2,476,099
Virginia	\$94,782,459	\$115,418,060	\$46,842,635	\$22,555,155	\$38,252,254
Washington	\$129,616,208	\$154,355,538	\$39,301,131	\$23,220,564	\$45,440,361
West Virginia	\$60,994,414	\$80,474,917	\$26,048,030	\$18,353,401	\$29,398,135
Wisconsin	\$124,342,524	\$169,892,326	\$48,724,182	\$30,417,645	\$35,233,076
Wyoming	\$8,030,548	\$11,434,620	\$2,164,997	\$849,533	\$4,141,966

* Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2003.

Drug Expenditures by Category, 2003 (Con't.)

State	Gastrointestinal Agents	Hormones	Respiratory Agents	Topical Agents	Coagulation Modifiers
National Average	\$2,440,407,945	\$2,933,149,913	\$2,380,132,257	\$1,554,423,942	\$1,186,541,597
Alabama	\$26,904,579	\$52,136,799	\$49,915,651	\$31,831,839	\$20,407,859
Alaska	\$7,861,942	\$6,167,811	\$5,849,264	\$3,378,844	\$5,215,342
Arizona*					
Arkansas	\$14,672,617	\$29,251,336	\$28,318,618	\$14,799,621	\$17,809,376
California	\$321,700,290	\$451,953,190	\$213,370,029	\$124,333,434	\$205,282,817
Colorado	\$13,135,332	\$19,422,447	\$15,685,535	\$8,945,596	\$7,780,270
Connecticut	\$32,689,172	\$26,541,306	\$17,293,981	\$14,011,746	\$8,721,576
Delaware	\$6,513,820	\$8,296,794	\$9,360,632	\$4,998,062	\$3,385,585
District of Columbia	\$2,152,537	\$5,047,860	\$3,913,666	\$3,671,587	\$1,965,142
Florida	\$157,391,088	\$162,104,447	\$134,860,676	\$98,874,216	\$94,148,394
Georgia	\$43,480,476	\$88,308,593	\$104,468,421	\$67,935,961	\$34,848,715
Hawaii	\$3,638,153	\$11,341,567	\$4,838,531	\$3,865,684	\$5,252,785
Idaho	\$4,352,093	\$9,136,651	\$7,469,042	\$3,366,092	\$2,232,004
Illinois	\$125,391,665	\$141,389,817	\$109,731,615	\$70,620,759	\$73,843,754
Indiana	\$37,362,205	\$57,532,911	\$46,019,825	\$26,240,867	\$34,684,206
Iowa	\$20,375,089	\$27,574,504	\$22,376,718	\$12,948,824	\$7,931,378
Kansas	\$17,765,417	\$19,068,152	\$15,731,823	\$7,173,168	\$4,521,034
Kentucky	\$38,186,306	\$61,355,310	\$72,904,446	\$30,861,920	\$22,571,246
Louisiana	\$54,967,838	\$63,549,736	\$76,262,359	\$50,368,620	\$23,842,364
Maine	\$24,437,708	\$22,162,882	\$18,027,421	\$8,932,041	\$7,939,769
Maryland	\$30,327,136	\$28,521,395	\$16,326,285	\$12,809,322	\$13,712,488
Massachusetts	\$62,677,457	\$67,991,396	\$45,400,021	\$36,282,294	\$30,180,899
Michigan	\$44,960,322	\$54,737,841	\$37,739,098	\$23,362,063	\$28,402,671
Minnesota	\$24,706,096	\$23,477,891	\$15,781,692	\$10,357,964	\$10,834,456
Mississippi	\$32,026,366	\$53,184,012	\$40,707,555	\$26,910,049	\$19,706,188
Missouri	\$37,786,487	\$79,839,931	\$71,258,801	\$35,468,117	\$31,913,439
Montana	\$6,574,786	\$6,950,404	\$6,460,016	\$2,780,665	\$2,263,672
Nebraska	\$9,003,521	\$17,011,585	\$15,577,235	\$10,046,893	\$5,305,903
Nevada	\$4,257,995	\$8,415,114	\$8,446,551	\$4,280,771	\$5,260,210
New Hampshire	\$7,584,827	\$8,140,340	\$8,104,118	\$4,271,871	\$1,692,128
New Jersey	\$64,252,931	\$56,887,112	\$42,218,431	\$41,904,585	\$29,482,482
New Mexico	\$9,394,373	\$11,310,922	\$6,322,099	\$4,040,861	\$2,838,330
New York	\$286,994,499	\$338,181,151	\$243,954,853	\$267,600,208	\$74,581,211
North Carolina	\$133,877,338	\$106,697,344	\$110,810,458	\$59,679,833	\$47,083,343
North Dakota	\$3,613,804	\$4,606,174	\$3,432,911	\$2,122,204	\$1,310,922
Ohio	\$123,944,077	\$125,543,399	\$133,393,117	\$72,413,665	\$47,908,852
Oklahoma	\$17,472,455	\$24,915,130	\$17,317,055	\$11,709,721	\$13,232,717
Oregon	\$7,920,313	\$14,251,229	\$8,905,679	\$3,003,993	\$6,140,247
Pennsylvania	\$73,436,603	\$62,159,086	\$48,905,433	\$32,251,361	\$29,788,845
Rhode Island	\$12,010,316	\$10,411,712	\$8,402,147	\$5,448,639	\$2,655,854
South Carolina	\$27,438,509	\$61,517,452	\$54,488,007	\$28,368,051	\$16,848,877
South Dakota	\$6,434,004	\$5,829,742	\$6,144,790	\$3,228,491	\$2,508,125
Tennessee	\$151,264,116	\$123,931,063	\$101,777,345	\$48,478,371	\$39,256,644
Texas	\$118,554,973	\$185,502,936	\$214,015,212	\$132,502,858	\$75,621,572
Utah	\$12,233,613	\$12,055,077	\$10,922,033	\$5,869,867	\$1,683,209
Vermont	\$1,186,487	\$2,892,343	\$2,469,594	\$1,148,211	\$1,138,687
Virginia	\$53,796,553	\$40,100,972	\$39,823,787	\$21,619,163	\$20,956,376
Washington	\$46,504,643	\$50,104,337	\$31,133,249	\$20,526,031	\$15,627,920
West Virginia	\$22,824,379	\$31,671,964	\$34,242,934	\$14,608,355	\$7,202,961
Wisconsin	\$51,723,684	\$50,499,608	\$35,291,061	\$22,456,384	\$17,465,468
Wyoming	\$2,646,956	\$3,469,137	\$3,962,438	\$1,714,203	\$1,553,286

* Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2003.

Drug Expenditures by Category, 2003 (Con't.)

State	Immunologic Agents	Biologicals	Antineoplastics	Miscellaneous Agents	Unclassified
National Average	\$761,102,956	\$468,144,619	\$460,215,397	\$1,077,200,699	\$53,639,314
Alabama	\$16,344,009	\$3,364,183	\$10,158,199	\$18,211,875	\$1,460,964
Alaska	\$2,563,588	\$1,235,492	\$1,329,240	\$2,934,183	\$24,943
Arizona*					
Arkansas	\$6,600,885	\$2,447,662	\$6,238,877	\$8,531,517	\$552,665
California	\$49,766,015	\$91,948,251	\$60,863,999	\$108,506,036	\$4,558,663
Colorado	\$7,305,677	\$1,071,280	\$1,926,090	\$9,098,728	\$287,315
Connecticut	\$6,237,025	\$6,589,638	\$4,699,566	\$11,868,556	\$295,774
Delaware	\$2,451,330	\$675,019	\$1,093,486	\$2,808,940	\$45,181
District of Columbia	\$1,034,626	\$2,269,089	\$918,624	\$2,546,344	\$24,363
Florida	\$72,969,380	\$19,201,620	\$25,801,687	\$58,796,192	\$2,777,269
Georgia	\$39,127,492	\$10,868,126	\$18,883,730	\$28,824,601	\$1,984,927
Hawaii	\$1,739,332	\$1,115,985	\$2,125,354	\$3,354,470	\$154,344
Idaho	\$3,538,039	\$409,275	\$709,679	\$3,000,687	\$47,328
Illinois	\$35,511,890	\$15,394,410	\$20,773,467	\$55,697,957	\$4,392,110
Indiana	\$16,754,796	\$7,413,314	\$17,723,214	\$25,432,259	\$1,407,788
Iowa	\$8,614,277	\$1,114,373	\$2,300,204	\$12,263,264	\$517,574
Kansas	\$5,467,871	\$2,094,604	\$4,298,657	\$8,098,178	\$184,179
Kentucky	\$14,151,130	\$6,974,487	\$10,752,054	\$22,313,397	\$1,310,338
Louisiana	\$35,035,984	\$10,859,132	\$9,951,900	\$30,610,795	\$1,324,179
Maine	\$5,037,038	\$1,951,037	\$2,165,666	\$7,956,572	\$180,257
Maryland	\$5,717,103	\$7,576,815	\$4,993,372	\$12,142,553	\$270,041
Massachusetts	\$20,188,474	\$8,335,867	\$10,283,715	\$25,157,149	\$880,802
Michigan	\$15,480,621	\$7,595,111	\$13,643,744	\$27,611,207	\$783,408
Minnesota	\$10,359,385	\$2,238,290	\$3,928,553	\$13,288,042	\$593,426
Mississippi	\$12,592,766	\$5,828,738	\$7,129,387	\$19,059,505	\$798,978
Missouri	\$19,678,119	\$11,747,059	\$14,415,499	\$33,964,843	\$1,304,107
Montana	\$2,376,979	\$372,100	\$557,540	\$4,108,422	\$84,954
Nebraska	\$2,666,342	\$880,877	\$1,242,260	\$6,892,073	\$527,763
Nevada	\$3,880,550	\$749,061	\$928,659	\$3,358,377	\$154,695
New Hampshire	\$1,743,400	\$1,027,214	\$1,078,785	\$3,821,421	\$255,829
New Jersey	\$14,229,019	\$22,394,372	\$11,770,374	\$26,343,270	\$970,502
New Mexico	\$2,074,743	\$970,623	\$951,488	\$4,393,973	\$239,713
New York	\$107,618,351	\$114,837,240	\$53,307,879	\$120,987,782	\$7,382,678
North Carolina	\$33,738,315	\$11,930,925	\$23,244,355	\$40,247,786	\$1,069,085
North Dakota	\$767,457	\$290,722	\$320,330	\$2,133,873	\$99,506
Ohio	\$31,472,490	\$7,704,455	\$11,595,594	\$55,565,977	\$2,696,944
Oklahoma	\$6,432,552	\$1,587,921	\$4,207,707	\$9,447,876	\$232,294
Oregon	\$4,175,627	\$1,383,733	\$2,625,328	\$6,522,952	\$155,831
Pennsylvania	\$17,653,014	\$17,435,183	\$13,275,198	\$26,321,657	\$763,809
Rhode Island	\$3,001,846	\$1,883,517	\$1,163,597	\$3,503,017	\$106,975
South Carolina	\$17,864,233	\$6,709,294	\$11,800,092	\$18,508,462	\$1,112,287
South Dakota	\$1,602,216	\$384,149	\$950,181	\$2,458,708	\$49,117
Tennessee	\$27,730,539	\$9,185,555	\$11,912,300	\$42,198,154	\$2,248,650
Texas	\$20,919,960	\$22,057,429	\$26,626,616	\$68,320,489	\$7,044,656
Utah	\$3,333,412	\$408,039	\$968,278	\$4,794,311	\$162,033
Vermont	\$1,700,930	\$389,721	\$769,627	\$1,483,449	\$30,962
Virginia	\$11,305,520	\$5,279,073	\$5,903,649	\$17,093,077	\$529,907
Washington	\$9,807,538	\$4,146,697	\$6,740,880	\$22,175,979	\$566,563
West Virginia	\$5,902,858	\$1,931,790	\$3,262,153	\$9,305,197	\$288,844
Wisconsin	\$13,566,985	\$3,606,689	\$7,519,451	\$23,457,370	\$641,646
Wyoming	\$1,271,226	\$279,384	\$385,111	\$1,679,194	\$63,152

* Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2003.

Prescriptions Processed by Category, 2003

State	Central Nervous System Agents	Psychotherapeutic Agents	Cardiovascular Agents	Antihyperlipidemic Agents	Anti-Infective Agents
National Average	100,478,651	89,569,295	88,165,723	16,278,359	48,792,546
Alabama	1,982,571	1,505,006	1,777,795	243,680	1,124,246
Alaska	293,575	300,917	217,411	38,623	121,100
Arizona*					
Arkansas	937,524	947,633	911,202	106,997	761,383
California	8,986,957	6,798,248	7,723,067	1,950,492	4,090,584
Colorado	967,844	830,368	696,376	112,066	426,988
Connecticut	1,022,360	1,224,643	970,018	193,025	260,347
Delaware	261,485	264,285	187,242	43,097	162,442
District of Columbia	160,993	129,144	242,756	38,814	85,547
Florida	5,225,497	4,958,626	5,329,159	973,759	2,811,685
Georgia	3,341,694	2,576,209	2,762,997	383,413	2,471,136
Hawaii	325,915	212,712	299,466	80,552	91,341
Idaho	319,283	364,116	222,638	37,579	176,126
Illinois	5,264,601	4,038,501	6,220,257	1,035,375	2,565,164
Indiana	2,413,541	2,121,034	1,596,140	267,060	990,599
Iowa	1,151,255	1,221,081	871,841	133,595	573,202
Kansas	804,312	753,624	650,936	89,965	346,664
Kentucky	2,521,358	2,044,396	2,051,931	368,818	1,297,868
Louisiana	2,225,083	1,786,427	1,931,030	267,700	1,681,047
Maine	964,050	1,069,371	696,550	176,623	356,465
Maryland	1,042,671	1,611,546	1,149,468	226,871	312,707
Massachusetts	2,828,452	3,429,835	2,380,581	506,290	1,040,207
Michigan	2,691,733	3,010,661	2,263,284	399,773	740,207
Minnesota	1,053,417	1,180,197	604,770	121,296	310,394
Mississippi	1,644,545	1,193,616	1,939,182	254,361	1,123,679
Missouri	2,937,736	2,753,507	2,516,222	420,461	1,192,630
Montana	317,936	294,091	204,844	31,302	129,357
Nebraska	724,093	650,962	514,598	79,850	390,004
Nevada	363,488	294,141	266,472	50,057	149,762
New Hampshire	406,659	435,107	239,170	46,662	133,033
New Jersey	1,872,940	1,877,878	2,037,756	360,502	627,615
New Mexico	379,022	264,098	315,532	49,995	133,949
New York	9,303,787	7,915,401	8,684,547	1,995,540	5,162,403
North Carolina	3,627,411	3,161,222	3,728,416	605,870	2,015,124
North Dakota	178,990	203,296	176,805	22,756	91,661
Ohio	5,773,204	4,975,768	4,183,761	778,976	2,337,368
Oklahoma	796,928	724,039	668,283	83,130	508,652
Oregon	827,178	1,278,681	518,002	77,242	221,552
Pennsylvania	2,287,176	2,298,954	2,309,312	336,211	834,099
Rhode Island	389,106	483,542	299,048	82,031	116,198
South Carolina	1,650,111	1,510,891	2,104,413	351,608	1,038,431
South Dakota	203,768	224,851	185,629	20,925	157,269
Tennessee	5,854,588	5,695,664	5,051,900	1,044,005	1,825,678
Texas	6,062,215	3,700,540	3,383,618	529,831	4,814,871
Utah	630,686	556,461	263,223	50,590	296,803
Vermont	81,663	98,420	74,900	20,607	41,768
Virginia	1,694,217	1,382,067	1,571,755	259,307	599,511
Washington	2,305,765	1,878,426	1,603,852	302,679	699,767
West Virginia	1,221,803	1,151,765	968,763	199,618	658,735
Wisconsin	2,026,945	2,058,327	2,520,630	419,726	598,205
Wyoming	130,520	129,000	78,175	9,054	96,973

*Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2003.

Prescriptions Processed by Category, 2003 (Con't)

State	Gastrointestinal Agents	Hormones	Respiratory Agents	Topical Agents	Coagulation Modifiers
National Average	37,355,276	55,113,842	53,798,350	38,224,567	10,196,402
Alabama	608,175	1,006,022	1,379,727	765,735	182,767
Alaska	105,690	138,822	101,415	74,500	21,829
Arizona*					
Arkansas	290,484	582,528	661,837	374,445	114,557
California	3,390,247	5,686,183	4,274,933	3,131,759	724,579
Colorado	278,377	527,113	393,343	287,569	100,659
Connecticut	387,852	542,196	320,310	292,848	140,536
Delaware	88,275	151,152	200,824	117,804	20,806
District of Columbia	37,497	92,500	71,308	66,888	16,792
Florida	1,890,636	3,018,191	2,694,816	2,249,704	739,057
Georgia	917,021	1,848,850	2,693,583	1,642,132	285,990
Hawaii	149,641	191,418	121,316	107,158	32,257
Idaho	85,745	191,403	156,463	92,922	27,195
Illinois	2,297,239	3,280,718	2,647,419	2,303,529	709,602
Indiana	972,129	1,071,667	1,128,190	732,037	217,556
Iowa	341,880	606,186	505,771	343,963	102,870
Kansas	256,782	431,510	326,453	209,542	80,864
Kentucky	1,063,095	1,264,627	1,746,985	829,796	245,659
Louisiana	681,964	1,200,237	1,788,454	1,141,120	218,454
Maine	320,535	544,234	366,861	249,120	67,593
Maryland	394,304	605,574	337,485	294,750	149,295
Massachusetts	945,852	1,543,203	930,251	916,496	266,627
Michigan	827,824	1,260,588	756,651	665,386	285,219
Minnesota	479,144	452,351	326,497	283,564	71,883
Mississippi	493,979	980,800	982,807	635,803	219,379
Missouri	880,126	1,539,837	1,498,936	762,542	316,050
Montana	101,941	165,556	131,537	72,677	24,583
Nebraska	329,511	366,007	427,082	276,964	64,502
Nevada	84,765	178,222	178,138	94,882	37,401
New Hampshire	166,310	171,873	161,369	119,536	26,420
New Jersey	778,289	1,038,122	780,626	825,437	279,251
New Mexico	157,528	285,958	166,002	120,515	33,776
New York	4,227,217	5,531,023	5,316,985	5,994,570	723,738
North Carolina	1,434,812	2,215,916	2,416,685	1,312,589	400,445
North Dakota	57,032	117,721	75,660	57,445	21,850
Ohio	2,599,005	2,773,710	3,072,752	1,971,639	542,714
Oklahoma	271,472	430,827	289,357	277,684	79,947
Oregon	229,811	380,968	220,517	104,687	56,960
Pennsylvania	966,971	1,314,530	978,817	843,682	451,642
Rhode Island	172,458	185,693	168,373	129,131	41,906
South Carolina	514,359	1,266,973	1,216,766	638,023	212,234
South Dakota	82,662	128,653	124,768	81,394	27,456
Tennessee	2,110,433	2,834,231	2,439,794	1,100,887	510,559
Texas	1,836,733	2,629,378	5,708,133	3,298,066	490,017
Utah	177,488	280,868	262,720	161,940	33,860
Vermont	24,331	51,455	47,086	31,881	7,161
Virginia	829,923	838,490	866,781	528,079	180,591
Washington	862,890	1,180,941	807,599	596,210	159,386
West Virginia	387,130	646,200	721,502	359,944	102,858
Wisconsin	725,860	1,274,925	716,218	610,839	316,824
Wyoming	41,852	67,692	90,448	44,754	12,246

*Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2003.

Prescriptions Processed by Category, 2003 (Con't)

State	Immunologic Agents	Biologicals	Antineoplastics	Miscellaneous Agents	Unclassified
National Average	1,062,643	895,829	2,931,816	30,874,425	4,493,386
Alabama	20,667	3,925	112,610	621,134	67,018
Alaska	4,053	1,225	7,166	72,445	1,245
Arizona*					
Arkansas	9,342	2,801	61,340	253,387	37,916
California	72,782	423,520	459,163	2,178,543	390,940
Colorado	15,117	1,779	16,990	220,975	11,985
Connecticut	9,506	11,516	23,513	256,808	14,322
Delaware	3,199	687	8,848	63,149	3,507
District of Columbia	1,754	1,511	4,475	68,158	1,192
Florida	90,901	15,729	165,078	1,536,909	139,647
Georgia	39,380	15,040	100,632	890,910	107,225
Hawaii	2,776	2,174	10,073	100,252	15,991
Idaho	5,389	614	5,132	78,619	2,262
Illinois	47,150	21,875	167,936	2,167,857	337,683
Indiana	26,221	12,147	63,213	949,918	127,578
Iowa	11,031	1,486	20,262	297,225	32,503
Kansas	8,484	4,883	25,596	210,596	14,926
Kentucky	16,839	10,189	66,868	827,718	104,418
Louisiana	36,234	10,645	82,475	845,358	53,685
Maine	9,531	2,225	19,612	187,257	14,005
Maryland	10,022	13,256	33,621	322,586	10,899
Massachusetts	33,821	8,676	69,215	610,556	34,452
Michigan	25,849	12,367	66,742	860,659	64,893
Minnesota	18,885	3,510	24,082	322,880	49,901
Mississippi	15,609	4,514	48,816	495,604	43,138
Missouri	28,378	33,355	76,149	794,526	63,610
Montana	4,344	471	4,887	80,374	4,653
Nebraska	3,823	857	9,980	254,888	74,942
Nevada	4,337	1,030	7,413	85,892	6,289
New Hampshire	2,618	1,894	7,817	137,901	20,726
New Jersey	18,378	32,366	61,812	723,377	35,809
New Mexico	4,185	1,382	8,425	150,851	22,990
New York	156,270	101,887	230,523	3,421,285	1,402,731
North Carolina	42,087	14,182	147,716	1,046,094	49,980
North Dakota	1,371	376	3,351	57,235	4,344
Ohio	44,371	10,083	88,753	2,187,033	240,377
Oklahoma	8,159	1,689	27,520	191,975	8,361
Oregon	8,127	2,276	16,404	247,319	15,215
Pennsylvania	24,771	30,076	69,327	773,153	50,284
Rhode Island	4,860	2,528	8,812	108,314	8,743
South Carolina	22,836	9,744	81,761	532,614	38,950
South Dakota	2,578	691	7,756	61,802	2,218
Tennessee	46,543	11,381	116,298	1,483,140	156,667
Texas	25,963	28,564	116,482	1,934,760	443,296
Utah	6,336	697	7,434	158,020	8,973
Vermont	1,591	439	2,273	30,372	2,480
Virginia	16,304	8,736	36,258	627,119	40,303
Washington	16,042	5,973	46,782	538,690	45,233
West Virginia	8,756	2,343	26,219	258,372	14,106
Wisconsin	23,450	6,218	55,434	511,271	46,715
Wyoming	1,623	297	2,772	38,545	4,060

*Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2003.

Medicaid Average Cost Per Prescription, 2003*

State	Drug Payments	Prescriptions Processed	Average Prescription Cost
<i>National Average</i>	<i>\$34,779,164,768</i>	<i>578,231,110</i>	<i>\$60.15</i>
Alabama	\$564,728,512	11,401,078	\$49.53
Alaska	\$97,560,204	1,500,016	\$65.04
Arizona**			
Arkansas	\$334,475,412	6,053,376	\$55.25
California	\$4,072,895,633	50,281,997	\$81.00
Colorado	\$243,307,992	4,887,549	\$49.78
Connecticut	\$399,284,051	5,669,800	\$70.42
Delaware	\$103,962,657	1,576,802	\$65.93
District of Columbia	\$80,695,467	1,019,329	\$79.17
Florida	\$2,135,926,708	31,839,394	\$67.08
Georgia	\$1,063,778,419	20,076,212	\$52.99
Hawaii	\$105,391,217	1,743,042	\$60.46
Idaho	\$103,679,534	1,765,486	\$58.73
Illinois	\$1,610,842,834	33,104,906	\$48.66
Indiana	\$692,657,178	12,689,030	\$54.59
Iowa	\$342,747,739	6,214,151	\$55.16
Kansas	\$242,210,850	4,215,137	\$57.46
Kentucky	\$708,607,216	14,460,565	\$49.00
Louisiana	\$797,347,285	13,949,913	\$57.16
Maine	\$270,268,995	5,044,032	\$53.58
Maryland	\$439,870,831	6,515,055	\$67.52
Massachusetts	\$955,127,572	15,544,514	\$61.44
Michigan	\$759,642,968	13,931,836	\$54.53
Minnesota	\$355,471,421	5,302,771	\$67.04
Mississippi	\$564,623,433	10,075,832	\$56.04
Missouri	\$980,698,325	15,814,065	\$62.01
Montana	\$90,076,191	1,568,553	\$57.43
Nebraska	\$204,890,963	4,168,063	\$49.16
Nevada	\$114,586,487	1,802,289	\$63.58
New Hampshire	\$114,661,414	2,077,095	\$55.20
New Jersey	\$812,117,027	11,350,158	\$71.55
New Mexico	\$97,892,434	2,094,208	\$46.74
New York	\$4,138,830,252	60,167,907	\$68.79
North Carolina	\$1,345,109,690	22,218,549	\$60.54
North Dakota	\$55,662,600	1,069,893	\$52.03
Ohio	\$1,616,475,569	31,579,514	\$51.19
Oklahoma	\$295,739,993	4,368,023	\$67.71
Oregon	\$231,909,252	4,204,939	\$55.15
Pennsylvania	\$805,484,117	13,569,005	\$59.36
Rhode Island	\$145,819,853	2,200,743	\$66.26
South Carolina	\$627,847,688	11,189,714	\$56.11
South Dakota	\$75,837,242	1,312,420	\$57.78
Tennessee	\$1,603,686,811	30,281,768	\$52.96
Texas	\$2,026,319,289	35,002,467	\$57.89
Utah	\$158,168,082	2,896,099	\$54.61
Vermont	\$33,726,900	516,427	\$65.31
Virginia	\$534,258,639	9,479,441	\$56.36
Washington	\$599,267,639	11,050,235	\$54.23
West Virginia	\$346,510,331	6,728,114	\$51.50
Wisconsin	\$634,838,101	11,911,587	\$53.30
Wyoming	\$43,645,749	748,011	\$58.35

*Rebates have not been subtracted from these figures.

**Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2003.

Drug Expenditures by Category, 2004

State	Central Nervous System Agents	Psychotherapeutic Agents	Cardiovascular Agents	Antihyperlipidemic Agents	Anti-Infective Agents
National Total	\$6,494,875,373	\$9,076,916,231	\$2,876,167,915	\$1,900,484,637	\$3,778,059,617
Alabama	\$98,930,687	\$129,888,007	\$49,903,458	\$25,183,659	\$52,776,577
Alaska	\$22,665,436	\$29,203,091	\$6,393,403	\$3,537,945	\$8,387,389
Arizona*					
Arkansas	\$53,323,802	\$75,832,986	\$22,140,611	\$8,767,920	\$26,952,994
California	\$658,600,750	\$994,587,796	\$377,493,881	\$269,696,615	\$420,654,110
Colorado	\$59,846,655	\$73,988,149	\$18,020,197	\$11,304,442	\$19,490,250
Connecticut	\$89,750,091	\$123,688,563	\$31,940,687	\$22,449,472	\$38,107,386
Delaware	\$18,189,044	\$25,592,935	\$7,094,231	\$5,195,936	\$16,765,103
District of Columbia	\$8,302,337	\$17,364,320	\$8,165,389	\$4,339,872	\$24,687,745
Florida	\$356,862,149	\$460,474,597	\$177,618,614	\$109,301,894	\$339,690,298
Georgia	\$188,102,973	\$253,468,857	\$83,036,571	\$42,671,640	\$125,010,301
Hawaii	\$22,252,767	\$24,851,048	\$10,783,395	\$8,095,352	\$8,552,289
Idaho	\$28,295,473	\$47,207,424	\$7,576,741	\$4,819,115	\$10,024,377
Illinois	\$263,509,762	\$356,405,594	\$181,070,405	\$115,222,710	\$163,427,189
Indiana	\$140,887,698	\$214,002,702	\$40,214,720	\$29,889,845	\$51,851,532
Iowa	\$70,577,408	\$122,151,533	\$22,566,001	\$13,175,785	\$27,007,592
Kansas	\$56,375,729	\$84,228,750	\$16,457,973	\$9,197,916	\$18,253,860
Kentucky	\$142,079,251	\$185,780,391	\$58,701,598	\$36,956,707	\$65,123,626
Louisiana	\$139,529,066	\$177,507,162	\$69,696,629	\$31,572,796	\$88,394,185
Maine	\$51,450,734	\$75,816,274	\$12,482,245	\$17,019,136	\$18,907,065
Maryland	\$70,543,471	\$159,385,840	\$36,109,574	\$24,344,761	\$39,308,426
Massachusetts	\$177,356,998	\$284,057,393	\$50,650,834	\$48,495,993	\$98,575,417
Michigan	\$177,913,194	\$315,090,822	\$50,718,384	\$37,277,268	\$45,343,908
Minnesota	\$82,149,999	\$134,444,658	\$14,193,512	\$12,427,098	\$22,609,636
Mississippi	\$107,104,852	\$126,676,215	\$76,690,225	\$30,919,282	\$62,015,502
Missouri	\$232,989,170	\$283,129,529	\$84,574,662	\$43,285,110	\$94,671,260
Montana	\$18,553,446	\$26,305,511	\$4,599,543	\$2,568,889	\$5,085,800
Nebraska	\$44,065,916	\$69,320,985	\$14,836,424	\$8,762,690	\$18,271,987
Nevada	\$28,466,732	\$27,945,391	\$7,159,205	\$5,036,652	\$9,137,802
New Hampshire	\$26,034,001	\$42,556,697	\$6,034,779	\$4,714,393	\$6,844,982
New Jersey	\$165,698,457	\$206,294,587	\$86,033,050	\$47,602,343	\$108,100,796
New Mexico	\$20,456,333	\$22,705,556	\$7,957,944	\$5,156,758	\$7,032,763
New York	\$600,706,123	\$975,241,587	\$341,875,998	\$234,635,843	\$720,201,323
North Carolina	\$272,848,659	\$324,269,413	\$118,277,850	\$70,580,283	\$127,894,314
North Dakota	\$12,518,678	\$18,461,431	\$4,134,795	\$2,046,902	\$3,647,754
Ohio	\$256,344,308	\$354,437,661	\$85,091,454	\$63,583,053	\$107,150,882
Oklahoma	\$73,679,094	\$111,788,452	\$24,946,025	\$15,310,949	\$36,826,516
Oregon	\$40,339,656	\$110,329,007	\$9,877,484	\$5,989,846	\$10,932,647
Pennsylvania	\$183,878,776	\$218,425,839	\$68,778,062	\$38,032,129	\$55,116,329
Rhode Island	\$22,315,829	\$34,038,674	\$9,805,005	\$6,707,575	\$8,438,803
South Carolina	\$114,196,694	\$140,642,849	\$65,237,257	\$38,589,238	\$63,874,855
South Dakota	\$15,997,053	\$22,358,778	\$4,591,281	\$2,017,320	\$6,354,874
Tennessee	\$403,511,147	\$474,243,522	\$172,873,978	\$163,917,125	\$175,510,419
Texas	\$360,730,364	\$454,989,813	\$150,473,558	\$93,239,282	\$244,456,814
Utah	\$38,911,079	\$56,923,157	\$8,522,454	\$5,646,562	\$14,043,951
Vermont	\$6,697,241	\$8,646,859	\$2,012,535	\$1,776,290	\$2,367,386
Virginia	\$103,936,203	\$129,834,132	\$45,512,066	\$31,116,942	\$41,370,915
Washington	\$134,761,941	\$175,260,204	\$38,487,095	\$26,009,168	\$47,506,621
West Virginia	\$70,078,911	\$87,636,633	\$26,458,706	\$21,812,041	\$28,185,675
Wisconsin	\$153,378,824	\$195,722,633	\$56,278,913	\$39,500,196	\$39,303,120
Wyoming	\$9,180,412	\$13,712,224	\$2,018,516	\$983,899	\$3,814,271

* Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2004.

Drug Expenditures by Category, 2004 (Con't.)

State	Gastrointestinal Agents	Hormones	Respiratory Agents	Topical Agents	Coagulation Modifiers
National Average	\$2,675,839,774	\$3,267,549,142	\$2,516,573,974	\$1,852,167,753	\$1,325,800,334
Alabama	\$34,775,755	\$54,417,017	\$49,311,472	\$34,383,133	\$23,627,720
Alaska	\$8,507,307	\$7,340,974	\$6,795,549	\$4,040,634	\$4,714,508
Arizona*					
Arkansas	\$14,848,435	\$28,029,906	\$24,921,608	\$14,844,108	\$14,551,027
California	\$355,895,298	\$453,213,998	\$202,073,600	\$139,683,594	\$155,699,415
Colorado	\$12,476,952	\$23,118,032	\$18,689,039	\$11,261,501	\$6,858,450
Connecticut	\$35,126,996	\$30,408,822	\$18,669,721	\$16,124,116	\$10,002,785
Delaware	\$3,276,979	\$9,321,395	\$10,265,292	\$5,740,499	\$3,976,854
District of Columbia	\$2,422,484	\$4,960,931	\$4,072,546	\$3,846,110	\$1,878,491
Florida	\$186,631,817	\$181,527,447	\$152,494,777	\$115,841,000	\$109,882,879
Georgia	\$49,308,280	\$98,608,362	\$109,749,303	\$79,531,213	\$41,010,970
Hawaii	\$3,433,339	\$12,681,741	\$5,454,224	\$4,134,601	\$5,769,826
Idaho	\$8,513,524	\$12,876,178	\$10,612,964	\$4,700,750	\$2,729,621
Illinois	\$141,564,815	\$162,744,895	\$108,660,330	\$82,183,790	\$87,122,642
Indiana	\$35,757,525	\$61,679,953	\$45,147,760	\$27,729,871	\$44,786,268
Iowa	\$22,327,641	\$30,810,347	\$24,873,997	\$14,820,722	\$9,309,289
Kansas	\$20,686,986	\$21,132,455	\$15,656,417	\$8,683,450	\$6,877,741
Kentucky	\$42,556,722	\$71,477,568	\$81,602,323	\$40,995,266	\$26,731,800
Louisiana	\$64,420,069	\$71,132,057	\$85,074,732	\$61,405,223	\$32,624,691
Maine	\$27,816,868	\$22,383,148	\$17,976,574	\$9,279,723	\$9,474,551
Maryland	\$32,356,852	\$30,064,623	\$16,174,000	\$13,637,425	\$18,410,086
Massachusetts	\$71,431,218	\$70,208,602	\$42,386,921	\$35,497,727	\$29,311,792
Michigan	\$45,212,426	\$63,580,552	\$38,037,856	\$27,344,454	\$41,965,199
Minnesota	\$26,626,921	\$25,213,714	\$16,130,919	\$10,899,010	\$13,329,096
Mississippi	\$35,889,234	\$61,861,294	\$47,801,254	\$33,458,460	\$24,206,912
Missouri	\$33,535,609	\$91,449,475	\$79,781,047	\$41,676,610	\$39,676,990
Montana	\$4,372,373	\$6,483,082	\$5,635,492	\$2,581,030	\$2,267,252
Nebraska	\$8,439,402	\$19,661,746	\$17,142,830	\$11,624,034	\$7,624,875
Nevada	\$3,697,336	\$8,672,263	\$8,902,783	\$4,600,403	\$8,864,944
New Hampshire	\$7,892,360	\$9,291,727	\$8,708,908	\$4,742,405	\$1,679,311
New Jersey	\$77,371,626	\$71,550,142	\$55,463,763	\$55,104,850	\$36,530,320
New Mexico	\$10,205,228	\$13,123,032	\$6,853,093	\$4,551,487	\$3,480,618
New York	\$331,336,777	\$379,009,842	\$260,434,172	\$331,194,595	\$94,578,918
North Carolina	\$151,709,118	\$123,952,404	\$124,907,450	\$74,059,781	\$54,804,376
North Dakota	\$2,741,837	\$4,931,463	\$3,332,840	\$2,271,035	\$1,145,717
Ohio	\$90,318,632	\$106,968,721	\$108,245,243	\$65,071,259	\$45,269,652
Oklahoma	\$20,317,345	\$35,993,066	\$28,880,798	\$18,945,368	\$20,118,459
Oregon	\$7,836,466	\$14,334,216	\$9,030,155	\$2,826,766	\$6,693,537
Pennsylvania	\$81,751,987	\$71,299,623	\$54,972,900	\$38,576,275	\$36,350,324
Rhode Island	\$9,808,939	\$8,627,125	\$6,589,354	\$4,539,007	\$2,422,392
South Carolina	\$28,008,473	\$69,008,309	\$57,028,170	\$32,671,654	\$20,462,100
South Dakota	\$7,062,722	\$6,737,003	\$6,818,239	\$3,725,916	\$2,874,786
Tennessee	\$215,153,930	\$194,292,857	\$155,018,670	\$95,327,098	\$63,673,403
Texas	\$125,911,632	\$208,643,434	\$206,282,267	\$157,631,998	\$73,485,658
Utah	\$14,236,343	\$14,128,828	\$10,627,578	\$6,868,557	\$2,128,763
Vermont	\$1,830,824	\$3,011,517	\$2,143,218	\$1,130,435	\$914,821
Virginia	\$49,637,161	\$44,719,549	\$36,947,284	\$24,002,802	\$22,264,160
Washington	\$44,629,905	\$54,586,510	\$32,241,550	\$22,795,863	\$19,250,201
West Virginia	\$23,128,697	\$32,854,041	\$35,197,181	\$16,838,702	\$8,589,417
Wisconsin	\$40,881,316	\$61,542,622	\$38,342,301	\$26,855,411	\$24,832,271
Wyoming	\$2,159,292	\$3,882,536	\$4,413,510	\$1,888,031	\$964,457

* Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2004.

Drug Expenditures by Category, 2004 (Con't.)

State	Immunologic Agents	Biologicals	Antineoplastics	Miscellaneous Agents	Unclassified
National Average	\$953,917,208	\$555,512,789	\$538,637,901	\$1,258,409,870	\$76,492,499
Alabama	\$17,898,990	\$5,451,546	\$10,486,204	\$20,441,903	\$1,769,109
Alaska	\$3,706,267	\$1,385,112	\$1,517,242	\$3,784,047	\$83,842
Arizona*					
Arkansas	\$8,690,065	\$1,873,248	\$6,238,909	\$8,175,151	\$581,531
California	\$75,134,626	\$91,666,185	\$74,303,681	\$130,600,643	\$8,531,057
Colorado	\$10,367,936	\$1,448,959	\$2,496,432	\$10,626,358	\$553,931
Connecticut	\$8,387,304	\$9,120,261	\$4,941,212	\$14,462,251	\$443,725
Delaware	\$3,325,109	\$1,083,644	\$1,395,882	\$3,625,382	\$66,215
District of Columbia	\$1,216,392	\$2,100,976	\$837,643	\$2,740,603	\$49,736
Florida	\$76,642,076	\$21,071,949	\$30,976,849	\$70,589,887	\$4,390,245
Georgia	\$48,501,912	\$13,863,654	\$22,184,661	\$33,544,746	\$2,078,991
Hawaii	\$1,726,692	\$1,366,328	\$2,403,827	\$3,810,574	\$218,948
Idaho	\$4,337,297	\$1,031,535	\$1,536,989	\$4,700,484	\$140,719
Illinois	\$40,655,215	\$20,231,932	\$24,578,537	\$65,643,820	\$5,897,758
Indiana	\$21,895,541	\$15,998,074	\$16,850,374	\$27,978,004	\$1,544,693
Iowa	\$10,126,386	\$1,210,703	\$2,658,245	\$14,380,702	\$817,538
Kansas	\$6,564,605	\$2,763,076	\$4,482,000	\$9,067,973	\$348,104
Kentucky	\$18,600,062	\$9,608,847	\$13,212,726	\$28,354,099	\$2,011,291
Louisiana	\$43,358,628	\$13,770,977	\$11,763,271	\$34,981,368	\$1,549,435
Maine	\$6,133,557	\$2,019,515	\$2,533,582	\$8,453,153	\$268,341
Maryland	\$5,807,655	\$8,749,291	\$5,953,929	\$13,218,592	\$370,502
Massachusetts	\$22,457,689	\$8,623,495	\$10,957,074	\$27,303,575	\$1,680,217
Michigan	\$19,874,928	\$11,381,694	\$13,253,931	\$32,787,294	\$1,243,925
Minnesota	\$12,308,138	\$3,147,306	\$5,090,936	\$14,348,133	\$912,454
Mississippi	\$16,061,483	\$7,320,652	\$8,859,338	\$22,302,965	\$973,798
Missouri	\$28,299,709	\$14,810,419	\$20,640,854	\$42,316,128	\$2,049,872
Montana	\$2,373,646	\$330,273	\$492,620	\$4,365,975	\$89,916
Nebraska	\$2,907,240	\$718,854	\$1,381,274	\$8,076,900	\$753,003
Nevada	\$4,234,650	\$583,829	\$1,179,791	\$4,464,441	\$143,209
New Hampshire	\$1,988,570	\$850,812	\$1,154,881	\$4,234,316	\$177,145
New Jersey	\$20,666,208	\$28,133,548	\$13,442,009	\$33,111,390	\$1,801,330
New Mexico	\$2,875,130	\$1,015,037	\$1,211,478	\$5,405,947	\$350,212
New York	\$125,585,644	\$129,888,421	\$69,560,833	\$142,484,104	\$10,216,829
North Carolina	\$40,574,988	\$13,740,410	\$23,007,025	\$49,030,060	\$2,086,271
North Dakota	\$986,033	\$352,059	\$380,101	\$2,585,235	\$72,435
Ohio	\$34,317,164	\$6,296,069	\$9,430,572	\$50,780,240	\$2,506,747
Oklahoma	\$11,688,033	\$2,837,438	\$4,977,629	\$13,021,217	\$649,691
Oregon	\$3,348,158	\$2,049,708	\$2,264,316	\$6,340,654	\$219,618
Pennsylvania	\$22,635,630	\$25,510,631	\$16,794,437	\$30,744,595	\$1,269,568
Rhode Island	\$2,010,079	\$1,689,324	\$1,045,522	\$3,090,438	\$190,035
South Carolina	\$16,108,090	\$7,677,681	\$12,282,902	\$22,506,133	\$1,405,307
South Dakota	\$2,128,228	\$417,268	\$1,144,606	\$2,784,765	\$138,997
Tennessee	\$62,353,036	\$16,306,641	\$19,193,692	\$64,334,678	\$3,962,275
Texas	\$24,831,916	\$24,228,536	\$26,770,330	\$69,815,524	\$8,025,912
Utah	\$4,003,001	\$540,036	\$1,174,249	\$5,317,578	\$269,160
Vermont	\$1,763,165	\$418,362	\$858,692	\$1,263,118	\$52,255
Virginia	\$14,421,158	\$7,917,052	\$8,121,718	\$20,962,305	\$880,637
Washington	\$12,988,213	\$5,839,605	\$8,865,576	\$24,150,589	\$965,184
West Virginia	\$7,104,068	\$1,930,979	\$3,570,963	\$10,563,976	\$472,225
Wisconsin	\$18,246,867	\$4,865,042	\$9,816,728	\$28,790,422	\$1,148,830
Wyoming	\$1,700,032	\$275,797	\$361,628	\$1,947,434	\$69,734

* Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2004.

Prescriptions Processed by Category, 2004

State	Central Nervous System Agents	Psychotherapeutic Agents	Cardiovascular Agents	Antihyperlipidemic Agents	Anti-Infective Agents
National Average	106,530,718	94,948,548	92,936,548	19,696,558	48,031,829
Alabama	2,064,091	1,532,941	1,808,319	258,012	1,073,759
Alaska	301,018	317,343	235,969	50,173	114,403
Arizona*					
Arkansas	820,187	819,606	733,023	97,796	569,699
California	9,570,360	7,391,189	7,939,008	2,142,821	4,054,643
Colorado	1,087,474	953,705	756,543	144,351	462,129
Connecticut	1,063,547	1,255,672	1,021,780	233,398	265,276
Delaware	298,343	280,367	198,943	53,988	167,840
District of Columbia	154,673	122,878	236,617	44,091	84,442
Florida	5,491,699	5,233,809	5,791,048	1,240,246	2,747,857
Georgia	3,523,710	2,783,180	2,844,542	466,416	2,363,713
Hawaii	325,032	215,016	302,115	91,105	87,970
Idaho	415,634	488,359	248,782	58,038	198,337
Illinois	5,428,861	4,194,099	6,792,900	1,309,226	2,421,556
Indiana	2,492,639	2,243,465	1,688,695	328,991	906,740
Iowa	1,220,513	1,338,915	921,856	163,980	568,786
Kansas	852,762	824,429	686,273	110,637	351,049
Kentucky	2,765,193	2,265,605	2,170,725	455,255	1,350,940
Louisiana	2,367,872	1,965,521	2,021,386	327,621	1,575,088
Maine	990,817	1,147,399	732,577	209,418	346,092
Maryland	1,057,269	1,668,405	1,212,446	274,596	299,176
Massachusetts	2,819,363	3,402,825	2,408,840	576,477	970,786
Michigan	3,069,174	3,873,137	2,437,214	506,207	774,512
Minnesota	1,066,672	1,245,881	641,330	153,003	304,608
Mississippi	1,794,652	1,322,588	2,081,734	321,747	1,055,562
Missouri	3,283,533	3,031,583	2,768,440	536,885	1,254,656
Montana	291,721	274,382	178,278	32,768	101,420
Nebraska	764,128	709,881	542,997	97,301	374,460
Nevada	363,941	296,480	256,706	57,434	123,960
New Hampshire	450,237	469,047	257,802	54,431	142,026
New Jersey	2,162,759	2,163,592	2,367,928	494,473	700,473
New Mexico	392,831	278,506	333,633	60,427	128,624
New York	9,378,512	8,114,903	9,049,680	2,371,254	4,937,817
North Carolina	3,936,008	3,497,609	3,945,406	743,986	1,915,004
North Dakota	185,339	215,284	182,972	27,298	83,156
Ohio	4,622,324	4,041,995	3,330,976	714,509	1,823,290
Oklahoma	1,237,906	1,064,524	865,123	116,486	751,956
Oregon	763,253	1,290,747	487,630	87,813	193,818
Pennsylvania	2,473,320	2,445,738	2,386,971	407,539	853,933
Rhode Island	305,549	375,316	235,670	75,344	84,438
South Carolina	1,710,380	1,587,297	2,147,660	424,092	943,840
South Dakota	211,609	241,988	190,489	25,679	141,644
Tennessee	8,203,751	6,235,427	6,437,115	1,609,224	2,789,087
Texas	6,221,102	4,023,435	3,509,690	608,940	4,660,083
Utah	688,803	625,825	293,492	66,319	292,618
Vermont	89,831	95,574	71,453	16,819	35,623
Virginia	1,720,534	1,431,753	1,589,770	308,610	584,068
Washington	2,365,671	1,988,143	1,702,865	370,568	660,181
West Virginia	1,273,314	1,184,648	964,308	219,676	601,973
Wisconsin	2,263,455	2,244,326	2,852,285	541,145	656,209
Wyoming	129,352	134,211	74,544	9,945	82,509

*Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2004.

Prescriptions Processed by Category, 2004 (Con't)

State	Gastrointestinal Agents	Hormones	Respiratory Agents	Topical Agents	Coagulation Modifiers
National Average	40,239,328	57,793,846	54,680,483	40,396,783	11,151,606
Alabama	674,076	1,013,879	1,343,028	744,980	177,097
Alaska	113,183	148,658	108,904	76,078	24,714
Arizona*					
Arkansas	251,236	514,637	522,564	324,785	91,870
California	3,863,355	5,694,059	4,232,004	3,373,639	794,416
Colorado	294,402	588,421	432,508	340,877	114,591
Connecticut	414,178	570,787	314,737	313,837	156,290
Delaware	79,663	159,019	207,313	130,586	26,633
District of Columbia	37,352	87,174	66,763	62,884	17,075
Florida	2,105,305	3,106,122	2,819,044	2,366,644	826,802
Georgia	982,731	1,953,521	2,654,751	1,726,404	306,440
Hawaii	154,776	193,068	119,918	105,183	33,898
Idaho	127,759	236,314	204,105	113,272	34,454
Illinois	2,429,709	3,482,943	2,651,909	2,334,281	809,603
Indiana	986,957	1,106,158	1,050,205	725,712	241,247
Iowa	372,059	639,143	519,290	360,534	110,818
Kansas	281,894	457,255	339,666	226,749	88,178
Kentucky	1,166,934	1,348,508	1,886,699	919,827	278,149
Louisiana	748,853	1,241,206	1,801,287	1,224,731	236,170
Maine	355,574	551,651	365,587	246,514	73,377
Maryland	406,353	642,099	322,500	293,645	173,336
Massachusetts	1,002,318	1,536,862	854,868	884,101	281,082
Michigan	884,441	1,374,520	801,282	699,848	325,464
Minnesota	488,971	478,080	315,732	275,163	77,056
Mississippi	550,480	1,038,678	1,029,633	685,147	245,111
Missouri	956,507	1,672,758	1,600,201	820,387	354,080
Montana	90,808	142,941	108,944	60,590	23,109
Nebraska	344,186	387,796	441,193	292,509	70,613
Nevada	88,146	169,144	167,346	92,278	37,436
New Hampshire	184,335	188,451	179,733	128,510	28,599
New Jersey	912,213	1,227,317	910,604	954,309	322,727
New Mexico	164,478	301,478	163,327	126,927	36,709
New York	4,506,063	5,706,563	5,272,760	6,257,378	809,505
North Carolina	1,576,306	2,324,484	2,423,033	1,431,801	446,358
North Dakota	57,574	117,365	68,134	55,744	23,007
Ohio	2,076,718	2,203,542	2,459,357	1,532,480	453,693
Oklahoma	369,515	594,416	528,946	418,658	93,740
Oregon	233,329	349,054	194,050	93,114	57,662
Pennsylvania	1,020,606	1,388,120	1,013,928	891,058	488,011
Rhode Island	136,686	145,736	123,283	98,309	34,705
South Carolina	519,983	1,305,131	1,132,573	628,611	233,722
South Dakota	88,701	133,658	123,800	82,620	27,847
Tennessee	2,982,119	4,008,964	3,654,954	1,866,149	678,501
Texas	1,942,486	2,717,915	5,699,192	3,587,863	475,754
Utah	199,419	301,253	254,256	166,886	37,645
Vermont	26,860	51,517	40,445	28,574	7,184
Virginia	841,647	867,571	806,358	531,965	190,926
Washington	920,527	1,199,986	798,282	615,041	176,329
West Virginia	406,192	626,723	722,436	362,853	111,778
Wisconsin	778,505	1,435,223	743,634	672,793	375,237
Wyoming	42,860	63,978	85,417	43,955	12,858

*Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2004.

Prescriptions Processed by Category, 2004 (Con't)

State	Immunologic Agents	Biologicals	Antineoplastics	Miscellaneous Agents	Unclassified
National Average	1,209,655	1,003,504	2,987,584	32,537,686	5,414,079
Alabama	22,217	5,658	116,209	639,602	71,418
Alaska	4,883	1,130	6,076	78,365	2,764
Arizona*					
Arkansas	9,994	2,426	58,433	206,273	31,658
California	90,369	457,972	460,307	2,569,960	588,579
Colorado	17,667	2,090	17,321	237,471	17,628
Connecticut	10,763	14,454	23,307	286,836	19,855
Delaware	4,116	1,117	10,211	74,460	3,859
District of Columbia	1,662	1,365	3,819	66,333	1,706
Florida	103,217	18,080	162,529	1,636,998	195,205
Georgia	47,572	25,681	122,812	930,474	102,176
Hawaii	2,506	2,066	9,498	103,111	16,050
Idaho	6,219	2,349	8,258	102,357	5,058
Illinois	51,424	27,369	168,306	2,247,128	401,176
Indiana	29,455	18,362	57,781	949,247	112,510
Iowa	12,153	1,658	19,819	315,470	37,500
Kansas	9,419	5,907	23,949	223,645	22,644
Kentucky	20,055	13,874	67,945	877,032	142,280
Louisiana	42,174	13,089	84,254	884,383	59,268
Maine	10,750	2,267	21,356	194,946	15,615
Maryland	9,281	15,708	33,081	337,644	14,235
Massachusetts	35,974	7,917	64,392	640,112	62,818
Michigan	31,355	15,886	63,071	924,227	88,044
Minnesota	20,668	3,831	24,454	335,064	59,929
Mississippi	18,023	5,342	53,819	492,201	46,006
Missouri	36,938	32,154	86,527	915,820	107,163
Montana	3,724	416	3,644	73,906	4,381
Nebraska	3,863	649	9,793	271,604	88,830
Nevada	4,426	1,005	6,648	86,868	8,065
New Hampshire	2,969	1,632	8,075	155,021	11,804
New Jersey	24,733	37,857	65,642	850,977	56,746
New Mexico	4,690	1,543	9,357	162,348	27,339
New York	157,171	106,749	238,578	3,616,963	1,538,508
North Carolina	47,861	15,984	124,876	1,169,010	78,227
North Dakota	1,519	455	3,435	58,758	5,046
Ohio	42,363	7,759	64,818	1,703,703	188,217
Oklahoma	11,979	2,441	31,953	250,176	27,821
Oregon	5,882	2,311	11,880	238,690	16,441
Pennsylvania	27,850	37,840	70,611	814,674	60,744
Rhode Island	3,334	1,973	6,521	85,329	8,816
South Carolina	20,022	9,948	90,572	602,038	43,962
South Dakota	3,267	869	8,251	62,109	3,051
Tennessee	81,252	16,779	163,539	2,020,010	287,120
Texas	29,961	28,042	113,184	1,711,038	499,219
Utah	7,066	776	7,710	158,199	13,960
Vermont	1,587	512	4,719	27,353	2,241
Virginia	18,065	11,276	39,427	697,720	54,132
Washington	19,143	7,458	45,040	572,008	70,395
West Virginia	9,330	2,328	25,424	261,199	22,196
Wisconsin	26,843	8,871	64,097	581,350	67,418
Wyoming	1,901	279	2,256	37,476	4,256

*Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2004.

Medicaid Average Cost Per Prescription, 2004*

State	Drug Payments	Prescriptions Processed	Average Prescription Cost
<i>National Average</i>	<i>\$39,147,405,017</i>	<i>609,558,755</i>	<i>\$64.22</i>
Alabama	\$609,245,237	11,545,286	\$52.77
Alaska	\$112,062,744	1,583,661	\$70.76
Arizona**			
Arkansas	\$309,772,304	5,054,187	\$61.29
California	\$4,407,835,251	53,222,681	\$82.82
Colorado	\$280,547,282	5,467,178	\$51.31
Connecticut	\$453,623,392	5,964,717	\$76.05
Delaware	\$114,914,500	1,696,458	\$67.74
District of Columbia	\$86,985,575	988,834	\$87.97
Florida	\$2,393,996,477	33,844,605	\$70.73
Georgia	\$1,190,672,433	20,834,123	\$57.15
Hawaii	\$115,534,952	1,761,312	\$65.60
Idaho	\$149,103,190	2,249,295	\$66.29
Illinois	\$1,818,919,395	34,750,490	\$52.34
Indiana	\$776,214,559	12,938,164	\$59.99
Iowa	\$386,813,890	6,602,494	\$58.59
Kansas	\$280,777,034	4,504,456	\$62.33
Kentucky	\$823,792,276	15,729,021	\$52.37
Louisiana	\$926,780,287	14,592,903	\$63.51
Maine	\$282,014,465	5,263,940	\$53.57
Maryland	\$474,435,028	6,759,774	\$70.19
Massachusetts	\$978,994,946	15,548,735	\$62.96
Michigan	\$921,025,835	15,868,382	\$58.04
Minnesota	\$393,831,529	5,490,442	\$71.73
Mississippi	\$662,141,466	10,740,723	\$61.65
Missouri	\$1,132,886,445	17,457,632	\$64.89
Montana	\$86,104,849	1,391,032	\$61.90
Nebraska	\$233,588,159	4,399,803	\$53.09
Nevada	\$123,089,431	1,759,883	\$69.94
New Hampshire	\$126,905,286	2,262,672	\$56.09
New Jersey	\$1,006,904,420	13,252,350	\$75.98
New Mexico	\$112,380,615	2,192,217	\$51.26
New York	\$4,746,951,009	62,062,404	\$76.49
North Carolina	\$1,571,742,402	23,675,953	\$66.39
North Dakota	\$59,608,314	1,085,086	\$54.93
Ohio	\$1,385,811,657	25,265,744	\$54.85
Oklahoma	\$419,980,079	6,365,640	\$65.98
Oregon	\$232,412,232	4,025,674	\$57.73
Pennsylvania	\$944,137,106	14,380,943	\$65.65
Rhode Island	\$121,318,101	1,721,009	\$70.49
South Carolina	\$689,699,712	11,399,831	\$60.50
South Dakota	\$85,151,836	1,345,582	\$63.28
Tennessee	\$2,279,672,472	41,033,991	\$55.56
Texas	\$2,229,517,038	35,827,904	\$62.23
Utah	\$183,341,296	3,114,227	\$58.87
Vermont	\$34,886,717	500,292	\$69.73
Virginia	\$581,644,083	9,693,822	\$60.00
Washington	\$648,338,225	11,511,637	\$56.32
West Virginia	\$374,422,215	6,794,378	\$55.11
Wisconsin	\$739,505,495	13,311,391	\$55.55
Wyoming	\$47,371,774	725,797	\$65.27

*Rebates have not been subtracted from these figures.

**Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2004.

Drug Expenditures by Category, 2005

State	Central Nervous System Agents	Psychotherapeutic Agents	Cardiovascular Agents	Antihyperlipidemic Agents	Anti-Infective Agents
National Total	\$6,118,983,826	\$9,258,518,882	\$2,875,834,651	\$2,101,815,166	\$3,821,617,487
Alabama	\$97,386,944	\$135,739,650	\$50,199,115	\$29,366,725	\$48,712,633
Alaska	\$23,644,319	\$33,715,102	\$7,857,322	\$4,994,518	\$9,283,408
Arizona*					
Arkansas	\$58,188,604	\$86,381,281	\$24,873,405	\$11,664,605	\$31,335,698
California	\$578,039,457	\$1,052,733,595	\$381,217,080	\$309,999,069	\$426,072,050
Colorado	\$61,961,583	\$84,693,101	\$19,477,045	\$14,112,738	\$21,320,046
Connecticut	\$88,239,077	\$136,314,077	\$34,495,146	\$27,191,610	\$40,486,785
Delaware	\$11,164,198	\$17,863,689	\$4,614,303	\$4,099,520	\$13,320,876
District of Columbia	\$11,655,546	\$23,263,275	\$10,461,022	\$5,804,380	\$11,093,157
Florida	\$327,218,995	\$442,474,632	\$182,403,885	\$128,057,956	\$350,125,678
Georgia	\$180,343,202	\$261,590,757	\$85,080,027	\$49,698,035	\$132,825,325
Hawaii	\$21,042,882	\$27,258,191	\$11,412,566	\$8,830,775	\$8,929,402
Idaho	\$25,722,829	\$49,371,993	\$7,150,676	\$5,464,067	\$10,634,814
Illinois	\$267,244,299	\$379,533,644	\$191,068,324	\$143,745,706	\$186,204,454
Indiana	\$137,601,001	\$212,940,262	\$40,594,117	\$35,870,404	\$46,164,469
Iowa	\$74,804,708	\$138,242,478	\$23,172,385	\$16,991,974	\$29,693,663
Kansas	\$58,943,392	\$91,868,296	\$18,689,146	\$12,076,720	\$19,218,822
Kentucky	\$129,083,525	\$170,074,663	\$51,935,081	\$40,760,291	\$61,461,767
Louisiana	\$141,764,188	\$191,591,460	\$75,395,339	\$36,435,938	\$96,980,639
Maine	\$53,245,693	\$77,669,830	\$13,535,342	\$20,359,275	\$19,979,887
Maryland	\$74,493,143	\$172,518,836	\$39,340,672	\$28,858,117	\$45,435,200
Massachusetts	\$175,606,015	\$288,194,574	\$50,247,287	\$56,868,893	\$105,570,821
Michigan	\$172,678,263	\$319,373,166	\$53,197,912	\$45,271,979	\$53,732,607
Minnesota	\$83,972,529	\$151,617,828	\$15,620,499	\$17,209,925	\$24,781,276
Mississippi	\$94,500,343	\$123,127,211	\$70,326,488	\$30,945,420	\$59,982,989
Missouri	\$242,991,697	\$310,240,484	\$93,947,304	\$58,858,631	\$100,921,081
Montana	\$19,196,047	\$29,171,022	\$4,649,383	\$3,597,647	\$5,602,332
Nebraska	\$45,618,161	\$76,691,357	\$17,586,432	\$10,762,039	\$18,889,392
Nevada	\$30,145,755	\$29,833,078	\$7,825,523	\$6,068,254	\$9,485,296
New Hampshire	\$25,568,675	\$41,896,908	\$5,618,821	\$6,007,835	\$6,416,081
New Jersey	\$172,389,296	\$229,108,470	\$96,310,726	\$59,374,752	\$119,579,900
New Mexico	\$7,414,805	\$9,096,173	\$2,214,130	\$1,134,984	\$2,858,041
New York	\$604,667,278	\$1,056,596,642	\$376,093,874	\$280,081,778	\$780,952,742
North Carolina	\$292,761,735	\$366,845,391	\$131,112,690	\$86,575,477	\$141,861,535
North Dakota	\$10,286,522	\$16,018,950	\$3,906,930	\$1,875,526	\$3,234,824
Ohio	\$371,287,454	\$495,199,050	\$118,703,987	\$102,773,463	\$140,333,467
Oklahoma	\$77,633,411	\$120,287,908	\$29,198,188	\$19,825,996	\$40,367,214
Oregon	\$41,984,812	\$122,196,057	\$10,286,557	\$6,625,307	\$10,207,997
Pennsylvania	\$185,687,766	\$226,342,220	\$69,920,214	\$44,672,340	\$54,919,173
Rhode Island	\$31,227,996	\$49,504,930	\$14,615,513	\$10,503,791	\$12,252,266
South Carolina	\$114,666,393	\$153,873,171	\$67,396,987	\$47,259,961	\$71,131,114
South Dakota	\$15,666,338	\$24,374,450	\$4,903,349	\$2,419,820	\$6,565,614
Tennessee					
Texas	\$359,518,293	\$507,379,095	\$167,590,697	\$113,049,570	\$259,342,443
Utah	\$44,717,675	\$66,673,208	\$9,866,889	\$7,342,184	\$16,566,047
Vermont	\$8,595,812	\$12,799,447	\$3,058,107	\$3,032,261	\$3,614,129
Virginia	\$107,358,444	\$142,296,450	\$46,881,373	\$38,673,289	\$40,159,746
Washington	\$124,515,092	\$189,567,408	\$40,338,115	\$32,348,057	\$49,681,684
West Virginia	\$80,439,218	\$97,137,389	\$28,432,749	\$26,393,388	\$30,770,162
Wisconsin	\$147,689,289	\$202,850,812	\$61,268,422	\$46,531,131	\$38,905,415
Wyoming	\$8,411,127	\$14,387,223	\$1,743,508	\$1,352,048	\$3,653,326

* Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2005.

Drug Expenditures by Category, 2005 (Con't.)

State	Gastrointestinal Agents	Hormones	Respiratory Agents	Topical Agents	Coagulation Modifiers
National Average	\$2,655,476,687	\$3,401,293,979	\$2,527,957,069	\$1,961,652,559	\$1,436,206,157
Alabama	\$41,519,457	\$53,436,178	\$49,825,177	\$30,509,312	\$30,330,654
Alaska	\$10,314,097	\$8,858,807	\$7,967,020	\$4,596,472	\$8,043,781
Arizona*					
Arkansas	\$20,229,678	\$30,628,270	\$27,660,427	\$16,989,016	\$16,811,794
California	\$374,873,946	\$455,512,527	\$195,036,412	\$142,466,108	\$179,412,383
Colorado	\$13,432,308	\$26,803,582	\$20,774,444	\$12,655,824	\$7,785,123
Connecticut	\$38,116,294	\$34,478,361	\$21,757,217	\$18,580,803	\$11,737,735
Delaware	\$2,414,053	\$7,387,671	\$7,666,296	\$4,084,292	\$2,560,021
District of Columbia	\$3,241,772	\$6,997,428	\$5,248,485	\$5,091,721	\$2,862,749
Florida	\$203,273,227	\$207,596,181	\$161,220,023	\$130,553,598	\$114,763,554
Georgia	\$63,040,959	\$109,858,836	\$102,306,083	\$83,713,498	\$47,597,055
Hawaii	\$3,322,097	\$14,371,534	\$6,025,515	\$4,575,562	\$6,652,459
Idaho	\$8,654,635	\$13,390,420	\$10,801,677	\$5,235,314	\$2,767,840
Illinois	\$101,183,955	\$184,990,731	\$122,903,917	\$87,016,151	\$93,113,637
Indiana	\$40,736,941	\$61,096,861	\$39,101,264	\$25,897,653	\$49,830,961
Iowa	\$21,385,290	\$35,000,581	\$28,068,769	\$15,237,924	\$11,216,315
Kansas	\$24,184,637	\$23,451,435	\$17,041,269	\$9,702,891	\$8,180,717
Kentucky	\$38,106,320	\$70,746,405	\$83,340,424	\$44,646,092	\$29,426,480
Louisiana	\$69,623,780	\$78,072,879	\$87,719,927	\$64,394,524	\$31,534,442
Maine	\$32,030,969	\$25,472,958	\$20,555,005	\$10,014,583	\$9,716,372
Maryland	\$34,066,330	\$34,514,661	\$19,066,641	\$16,626,063	\$18,846,069
Massachusetts	\$78,470,728	\$76,408,041	\$46,952,804	\$36,009,011	\$36,791,961
Michigan	\$60,045,681	\$70,721,797	\$43,116,723	\$30,755,417	\$43,489,969
Minnesota	\$29,605,698	\$28,057,620	\$18,548,399	\$12,046,526	\$16,773,062
Mississippi	\$23,849,622	\$60,776,492	\$42,423,134	\$27,508,376	\$29,558,569
Missouri	\$39,996,469	\$105,928,286	\$92,235,877	\$48,410,997	\$44,358,037
Montana	\$4,342,166	\$7,429,044	\$6,560,245	\$2,657,052	\$2,637,760
Nebraska	\$8,421,606	\$21,837,025	\$19,324,960	\$12,548,051	\$8,019,676
Nevada	\$3,783,532	\$9,494,643	\$9,173,935	\$5,358,548	\$7,969,081
New Hampshire	\$7,586,132	\$9,622,200	\$7,824,636	\$4,849,416	\$1,946,606
New Jersey	\$86,537,557	\$84,135,921	\$64,257,777	\$65,272,772	\$40,223,153
New Mexico	\$2,889,004	\$5,825,482	\$2,615,034	\$1,690,293	\$2,057,125
New York	\$342,197,711	\$428,533,739	\$290,458,211	\$384,986,884	\$109,370,066
North Carolina	\$164,450,878	\$143,025,866	\$144,148,396	\$84,489,202	\$64,664,587
North Dakota	\$1,863,795	\$4,474,551	\$2,797,636	\$1,913,247	\$1,096,851
Ohio	\$169,586,257	\$159,605,654	\$131,907,897	\$98,343,027	\$59,677,287
Oklahoma	\$28,675,078	\$42,216,325	\$37,193,648	\$22,971,069	\$24,104,183
Oregon	\$7,776,925	\$14,237,564	\$9,532,590	\$3,056,463	\$7,594,415
Pennsylvania	\$54,568,100	\$75,782,758	\$54,106,336	\$42,042,745	\$36,799,867
Rhode Island	\$13,847,208	\$12,692,085	\$9,725,245	\$6,766,118	\$3,757,805
South Carolina	\$31,627,035	\$76,420,961	\$54,153,008	\$36,700,274	\$23,277,869
South Dakota	\$7,331,458	\$7,528,144	\$7,599,187	\$3,901,119	\$2,197,337
Tennessee					
Texas	\$149,571,159	\$234,905,198	\$218,307,317	\$183,224,918	\$96,762,750
Utah	\$15,765,591	\$16,759,560	\$12,695,241	\$7,874,308	\$2,391,996
Vermont	\$3,756,098	\$3,991,212	\$3,175,367	\$1,565,542	\$1,187,729
Virginia	\$53,027,434	\$49,665,200	\$41,750,915	\$27,927,180	\$24,342,915
Washington	\$43,966,656	\$59,484,738	\$38,847,823	\$25,542,092	\$25,231,704
West Virginia	\$36,844,174	\$37,352,287	\$37,121,601	\$19,292,271	\$9,888,983
Wisconsin	\$38,903,218	\$67,802,603	\$42,906,944	\$29,446,988	\$25,990,665
Wyoming	\$2,438,973	\$3,912,678	\$4,410,192	\$1,915,252	\$854,008

* Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2005.

Drug Expenditures by Category, 2005 (Con't.)

State	Immunologic Agents	Biologicals	Antineoplastics	Miscellaneous Agents	Unclassified
National Average	\$975,182,122	\$642,515,518	\$568,363,488	\$1,340,773,264	\$112,256,972
Alabama	\$19,183,624	\$5,667,287	\$12,354,745	\$21,843,494	\$4,088,185
Alaska	\$4,731,209	\$1,947,016	\$1,909,232	\$4,572,831	\$140,570
Arizona*					
Arkansas	\$8,052,720	\$2,384,911	\$6,987,665	\$8,697,773	\$797,293
California	\$73,740,505	\$101,073,410	\$66,035,855	\$139,665,146	\$10,335,702
Colorado	\$11,556,828	\$1,542,364	\$2,599,586	\$12,905,877	\$680,800
Connecticut	\$8,855,196	\$10,933,603	\$5,179,917	\$17,308,158	\$1,046,952
Delaware	\$2,691,811	\$908,154	\$1,052,565	\$2,711,587	\$61,239
District of Columbia	\$1,839,314	\$2,153,770	\$1,230,086	\$4,087,992	\$82,816
Florida	\$73,003,478	\$30,304,141	\$42,588,828	\$74,985,406	\$5,651,947
Georgia	\$51,152,382	\$14,434,562	\$23,544,300	\$39,513,495	\$3,856,843
Hawaii	\$2,271,042	\$1,644,363	\$2,455,035	\$4,825,921	\$417,756
Idaho	\$4,543,973	\$1,351,783	\$1,577,057	\$5,359,931	\$281,503
Illinois	\$47,736,721	\$27,715,123	\$30,354,428	\$78,455,819	\$5,762,860
Indiana	\$25,120,296	\$25,785,245	\$16,219,242	\$29,214,035	\$1,642,130
Iowa	\$11,702,485	\$1,299,664	\$3,235,891	\$16,138,890	\$858,160
Kansas	\$7,536,051	\$3,126,291	\$4,163,973	\$10,091,602	\$560,876
Kentucky	\$19,919,071	\$10,278,407	\$12,969,859	\$27,114,958	\$3,265,860
Louisiana	\$47,196,835	\$16,668,015	\$12,031,601	\$36,115,002	\$4,371,669
Maine	\$7,572,922	\$1,988,353	\$3,217,037	\$9,703,992	\$334,246
Maryland	\$6,879,652	\$10,990,952	\$6,458,568	\$15,352,756	\$559,857
Massachusetts	\$22,885,736	\$10,252,339	\$12,422,178	\$31,083,241	\$2,134,520
Michigan	\$23,884,405	\$11,798,734	\$14,872,369	\$35,891,505	\$1,561,032
Minnesota	\$13,844,986	\$4,126,840	\$5,593,475	\$17,120,149	\$1,241,918
Mississippi	\$17,661,242	\$6,455,632	\$9,081,889	\$21,699,843	\$1,915,076
Missouri	\$32,706,109	\$19,057,972	\$21,702,972	\$50,677,676	\$3,207,509
Montana	\$2,355,601	\$292,157	\$667,469	\$5,091,356	\$122,695
Nebraska	\$2,871,438	\$551,031	\$1,719,698	\$9,355,190	\$920,175
Nevada	\$4,337,950	\$899,598	\$1,684,650	\$5,771,968	\$228,669
New Hampshire	\$2,109,366	\$1,268,781	\$1,014,161	\$4,451,632	\$235,664
New Jersey	\$22,576,407	\$33,038,257	\$15,992,682	\$40,254,230	\$3,493,163
New Mexico	\$1,269,477	\$706,932	\$689,971	\$1,785,863	\$244,019
New York	\$134,875,436	\$141,133,712	\$76,055,662	\$143,581,782	\$12,235,840
North Carolina	\$43,140,109	\$16,070,461	\$24,617,203	\$56,127,734	\$3,833,908
North Dakota	\$980,798	\$264,209	\$381,671	\$2,140,222	\$104,219
Ohio	\$47,367,713	\$10,826,943	\$15,688,720	\$79,273,249	\$4,537,417
Oklahoma	\$12,662,998	\$3,817,926	\$5,652,385	\$15,714,805	\$1,211,201
Oregon	\$3,284,914	\$2,570,339	\$2,557,056	\$7,033,556	\$388,621
Pennsylvania	\$25,147,808	\$32,463,090	\$19,134,823	\$33,770,442	\$1,655,614
Rhode Island	\$2,832,196	\$2,576,275	\$1,577,486	\$4,991,211	\$720,566
South Carolina	\$21,725,200	\$12,478,315	\$14,343,382	\$28,592,295	\$2,494,537
South Dakota	\$2,160,656	\$410,698	\$1,161,303	\$3,045,168	\$371,175
Tennessee					
Texas	\$31,798,422	\$29,625,609	\$28,691,545	\$80,722,575	\$18,645,285
Utah	\$4,396,388	\$557,758	\$1,481,622	\$6,035,789	\$531,814
Vermont	\$2,257,501	\$524,029	\$1,052,647	\$1,801,352	\$102,174
Virginia	\$17,198,769	\$11,053,242	\$9,175,666	\$25,131,488	\$1,362,217
Washington	\$14,032,938	\$6,754,793	\$9,186,096	\$25,652,193	\$1,367,458
West Virginia	\$8,009,475	\$2,266,932	\$4,599,968	\$12,921,247	\$1,121,783
Wisconsin	\$19,971,027	\$8,253,960	\$11,015,969	\$30,465,172	\$1,373,927
Wyoming	\$1,550,944	\$221,542	\$383,296	\$1,925,663	\$97,514

* Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2005.

Prescriptions Processed by Category, 2005

State	Central Nervous System Agents	Psychotherapeutic Agents	Cardiovascular Agents	Antihyperlipidemic Agents	Anti-Infective Agents
<i>National Average</i>	<i>100,952,937</i>	<i>92,071,182</i>	<i>91,653,798</i>	<i>21,257,754</i>	<i>47,418,416</i>
Alabama	2,011,180	1,530,485	1,781,485	283,218	1,071,490
Alaska	326,344	357,819	281,854	65,939	130,078
Arizona*					
Arkansas	858,447	856,117	769,471	112,905	656,040
California	8,768,285	7,140,588	7,982,950	2,559,945	3,793,629
Colorado	1,132,755	997,070	782,447	170,392	506,707
Connecticut	1,071,274	1,311,150	1,065,779	275,690	274,677
Delaware	215,891	209,583	135,712	42,423	129,148
District of Columbia	198,897	162,032	288,448	57,089	66,814
Florida	5,428,989	5,258,391	5,999,274	1,387,263	2,817,840
Georgia	3,556,311	2,871,400	2,901,883	506,610	2,536,693
Hawaii	326,569	218,203	310,600	100,706	89,483
Idaho	406,608	489,068	253,169	61,873	216,113
Illinois	5,892,828	4,479,054	7,442,912	1,618,102	2,823,278
Indiana	2,368,099	2,112,292	1,687,827	378,825	771,483
Iowa	1,278,704	1,421,957	970,968	200,642	622,035
Kansas	892,641	881,656	703,392	132,154	368,118
Kentucky	2,720,390	2,180,699	2,073,122	480,088	1,336,685
Louisiana	2,375,598	2,008,860	2,052,045	367,259	1,677,399
Maine	1,013,052	1,170,849	756,278	238,011	364,938
Maryland	1,156,062	1,795,702	1,331,308	314,411	334,827
Massachusetts	2,799,569	3,366,749	2,410,935	643,615	957,399
Michigan	3,133,053	3,747,191	2,495,521	588,010	823,322
Minnesota	1,097,034	1,309,606	666,391	178,025	324,818
Mississippi	1,651,634	1,242,452	1,898,172	315,353	1,035,391
Missouri	3,470,638	3,230,365	2,981,953	668,082	1,298,914
Montana	288,741	285,084	182,775	37,473	106,393
Nebraska	792,497	734,968	562,519	114,532	396,197
Nevada	390,605	311,201	285,433	67,429	122,194
New Hampshire	447,478	454,214	253,760	61,927	140,670
New Jersey	2,134,228	2,198,656	2,424,285	590,475	728,722
New Mexico	146,001	109,068	104,457	13,884	65,527
New York	9,478,209	8,402,579	9,477,684	2,713,254	5,119,377
North Carolina	4,090,645	3,707,466	4,093,654	877,889	2,030,107
North Dakota	154,331	179,182	654,723	24,165	76,952
Ohio	6,500,565	5,594,381	4,632,048	1,143,516	2,363,223
Oklahoma	1,363,274	1,160,898	915,331	146,521	836,504
Oregon	710,287	1,301,655	450,764	89,303	182,268
Pennsylvania	2,579,627	2,560,034	2,501,294	488,039	884,557
Rhode Island	433,888	525,031	1,125,304	122,647	117,041
South Carolina	1,795,927	1,644,274	2,182,187	496,061	994,939
South Dakota	213,239	248,603	193,016	29,716	154,673
Tennessee					
Texas	6,387,197	4,151,294	3,670,978	688,321	4,973,121
Utah	752,131	686,528	324,313	83,561	334,043
Vermont	126,040	145,496	109,823	27,536	53,923
Virginia	1,809,024	1,532,960	1,672,532	358,042	595,257
Washington	2,389,037	2,079,218	1,787,519	438,776	697,275
West Virginia	1,400,205	1,278,509	1,030,502	256,470	638,530
Wisconsin	2,293,170	2,295,942	2,921,904	629,448	693,182
Wyoming	125,739	134,603	73,097	12,139	86,422

*Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2005.

Prescriptions Processed by Category, 2005 (Con't)

State	Gastrointestinal Agents	Hormones	Respiratory Agents	Topical Agents	Coagulation Modifiers
National Average	38,739,730	56,925,032	52,877,112	39,893,777	11,218,791
Alabama	695,910	1,003,061	1,349,623	676,329	170,314
Alaska	131,280	173,529	122,300	81,347	29,762
Arizona*					
Arkansas	283,842	520,254	540,817	344,045	95,940
California	3,663,760	5,669,778	3,900,645	2,957,043	821,305
Colorado	307,512	626,926	449,911	344,396	117,236
Connecticut	442,113	609,622	333,936	326,251	159,839
Delaware	54,474	118,742	153,489	94,392	18,131
District of Columbia	48,505	112,732	83,416	79,798	23,175
Florida	2,213,414	3,389,737	2,855,390	2,478,674	864,955
Georgia	1,076,962	2,028,819	2,636,608	1,800,099	319,606
Hawaii	158,106	204,954	124,838	108,206	35,542
Idaho	129,947	230,252	201,939	121,270	34,543
Illinois	2,250,788	3,891,526	3,014,354	2,457,245	901,263
Indiana	985,931	1,072,492	924,746	651,851	244,344
Iowa	415,461	679,397	574,632	379,037	116,058
Kansas	292,959	477,080	358,264	232,892	91,418
Kentucky	1,141,076	1,308,246	1,925,091	933,906	275,768
Louisiana	767,560	1,288,242	1,777,049	1,205,972	238,924
Maine	376,978	574,951	384,726	252,974	81,143
Maryland	436,614	715,356	368,529	332,822	185,571
Massachusetts	1,028,622	1,540,721	849,940	871,177	280,373
Michigan	965,972	1,433,657	850,389	746,414	339,688
Minnesota	502,737	499,791	338,797	281,717	78,555
Mississippi	486,596	992,965	957,862	571,998	229,181
Missouri	1,089,534	1,816,141	1,757,885	880,329	381,315
Montana	98,901	148,465	117,117	59,372	22,120
Nebraska	370,273	402,981	468,908	302,631	75,436
Nevada	97,272	180,096	166,027	96,950	44,847
New Hampshire	181,812	187,434	155,214	117,873	29,778
New Jersey	966,575	1,303,285	970,228	999,816	315,243
New Mexico	58,177	138,832	71,458	52,968	15,339
New York	4,437,736	6,116,547	5,557,779	6,655,896	877,939
North Carolina	1,663,909	2,468,446	2,585,654	1,510,132	461,082
North Dakota	46,403	100,079	56,550	43,621	17,730
Ohio	2,868,938	3,065,966	3,185,099	2,099,044	643,286
Oklahoma	436,180	655,504	633,212	467,499	103,552
Oregon	236,631	317,568	189,051	94,695	55,554
Pennsylvania	1,010,590	1,478,216	1,005,395	939,911	515,301
Rhode Island	188,571	206,075	173,642	140,085	57,516
South Carolina	567,924	1,368,740	1,106,235	669,820	242,441
South Dakota	92,981	140,339	132,404	84,011	28,213
Tennessee					
Texas	2,041,719	2,828,224	5,759,205	3,806,909	635,043
Utah	218,667	332,315	291,800	179,814	39,100
Vermont	49,673	68,100	56,516	38,292	11,188
Virginia	881,785	943,947	866,330	574,052	183,839
Washington	971,685	1,235,036	860,090	638,462	185,891
West Virginia	461,667	686,512	764,237	381,462	121,427
Wisconsin	798,250	1,509,198	784,040	688,632	390,922
Wyoming	46,758	64,156	85,745	41,646	12,055

*Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2005.

Prescriptions Processed by Category, 2005 (Con't)

State	Immunologic Agents	Biologicals	Antineoplastics	Miscellaneous Agents	Unclassified
National Average	1,186,861	1,066,894	2,691,819	30,550,061	6,900,438
Alabama	22,183	5,259	113,546	609,645	142,982
Alaska	5,894	1,590	6,797	90,784	6,557
Arizona*					
Arkansas	9,603	3,035	54,829	204,341	38,529
California	88,840	452,894	435,583	2,424,832	650,419
Colorado	17,491	2,183	16,633	238,555	26,706
Connecticut	11,124	18,120	22,567	296,977	32,490
Delaware	3,320	1,131	7,847	54,878	3,322
District of Columbia	2,369	1,363	4,996	84,277	3,859
Florida	89,570	35,466	162,642	1,621,407	255,220
Georgia	51,975	28,673	140,905	990,065	202,995
Hawaii	3,355	2,040	8,401	105,444	25,136
Idaho	6,018	3,366	8,711	105,843	7,617
Illinois	59,191	35,538	181,416	2,443,778	496,998
Indiana	30,790	24,432	45,187	878,232	113,135
Iowa	14,111	1,778	19,803	332,959	50,994
Kansas	10,232	3,404	22,889	225,148	33,213
Kentucky	21,537	12,819	54,566	853,148	219,894
Louisiana	44,114	15,401	76,619	866,611	178,190
Maine	11,732	2,303	21,002	215,073	21,178
Maryland	10,220	21,338	31,909	371,307	29,869
Massachusetts	36,009	9,485	58,779	656,621	98,636
Michigan	34,131	13,347	59,896	949,698	113,864
Minnesota	21,723	3,983	23,440	365,421	78,255
Mississippi	18,399	4,366	47,293	454,007	85,223
Missouri	40,029	42,135	85,078	1,021,945	159,793
Montana	3,503	393	4,032	76,902	5,816
Nebraska	3,981	481	9,771	281,112	109,719
Nevada	4,973	1,296	7,971	98,821	12,820
New Hampshire	2,862	2,047	6,615	143,705	13,866
New Jersey	26,445	42,995	66,215	880,114	78,728
New Mexico	1,455	760	4,086	72,366	13,128
New York	170,464	113,214	232,904	2,471,514	1,423,497
North Carolina	48,377	14,730	98,618	1,199,070	145,320
North Dakota	1,447	260	2,657	47,416	5,253
Ohio	57,108	12,287	85,612	2,383,098	330,137
Oklahoma	12,764	2,985	33,772	267,786	49,580
Oregon	6,105	2,352	10,649	239,166	25,311
Pennsylvania	30,100	44,022	71,518	859,109	90,433
Rhode Island	4,325	3,286	8,631	125,962	21,177
South Carolina	22,596	14,355	44,851	659,041	93,363
South Dakota	3,339	960	7,685	63,732	6,313
Tennessee					
Texas	33,717	26,523	108,946	1,773,682	1,028,241
Utah	7,828	844	7,903	165,620	20,438
Vermont	1,796	574	4,136	41,305	4,870
Virginia	19,832	14,058	39,386	732,248	87,122
Washington	19,399	9,174	43,111	607,583	111,635
West Virginia	10,280	2,434	27,381	281,440	54,258
Wisconsin	28,326	11,201	51,903	581,146	89,240
Wyoming	1,879	214	2,132	37,127	5,099

*Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2005.

Medicaid Average Cost Per Prescription, 2005*

State	Drug Payments	Prescriptions Processed	Average Prescription Cost
<i>National Average</i>	<i>\$39,798,447,825</i>	<i>595,404,602</i>	<i>\$66.84</i>
Alabama	\$630,163,181	11,466,710	\$54.96
Alaska	\$132,575,703	1,811,874	\$73.17
Arizona**			
Arkansas	\$351,683,139	5,348,215	\$65.76
California	\$4,486,213,246	51,310,496	\$87.43
Colorado	\$312,301,251	5,736,920	\$54.44
Connecticut	\$494,720,932	6,251,609	\$79.13
Delaware	\$82,600,276	1,242,483	\$66.48
District of Columbia	\$95,113,512	1,217,770	\$78.10
Florida	\$2,474,221,529	34,858,232	\$70.98
Georgia	\$1,248,552,361	21,649,604	\$57.67
Hawaii	\$124,035,101	1,821,583	\$68.09
Idaho	\$152,308,512	2,276,337	\$66.91
Illinois	\$1,947,029,768	37,988,271	\$51.25
Indiana	\$787,814,880	12,289,666	\$64.10
Iowa	\$427,049,177	7,078,536	\$60.33
Kansas	\$308,836,119	4,725,460	\$65.36
Kentucky	\$793,129,204	15,537,035	\$51.05
Louisiana	\$989,896,238	14,939,843	\$66.26
Maine	\$305,396,463	5,485,188	\$55.68
Maryland	\$524,007,517	7,435,845	\$70.47
Massachusetts	\$1,029,898,149	15,608,630	\$65.98
Michigan	\$980,391,558	16,294,153	\$60.17
Minnesota	\$440,160,729	5,770,293	\$76.28
Mississippi	\$619,812,325	9,990,892	\$62.04
Missouri	\$1,265,241,101	18,924,136	\$66.86
Montana	\$94,371,976	1,437,087	\$65.67
Nebraska	\$255,116,231	4,626,006	\$55.15
Nevada	\$132,060,479	1,887,935	\$69.95
New Hampshire	\$126,416,912	2,199,255	\$57.48
New Jersey	\$1,132,545,063	13,726,010	\$82.51
New Mexico	\$42,491,334	867,506	\$48.98
New York	\$5,161,821,355	63,248,593	\$81.61
North Carolina	\$1,763,725,172	24,995,099	\$70.56
North Dakota	\$51,339,948	1,410,769	\$36.39
Ohio	\$2,005,111,585	34,964,308	\$57.35
Oklahoma	\$481,532,335	7,085,362	\$67.96
Oregon	\$249,333,173	3,911,359	\$63.75
Pennsylvania	\$957,013,296	15,058,146	\$63.55
Rhode Island	\$177,590,690	3,253,181	\$54.59
South Carolina	\$756,140,501	11,902,754	\$63.53
South Dakota	\$89,635,816	1,399,224	\$64.06
Tennessee			
Texas	\$2,479,134,876	37,913,120	\$65.39
Utah	\$213,656,070	3,444,905	\$62.02
Vermont	\$50,513,407	739,268	\$68.33
Virginia	\$636,004,327	10,310,414	\$61.69
Washington	\$686,516,847	12,073,891	\$56.86
West Virginia	\$432,591,627	7,395,314	\$58.50
Wisconsin	\$773,375,542	13,766,504	\$56.18
Wyoming	\$47,257,293	728,811	\$64.84

*Rebates have not been subtracted from these figures.

**Data not reported for Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, State Drug Utilization Data, FY 2005.

MEDICAID DRUG REBATES

In 1990, Congress considered a number of proposals designed to reduce and control Federal and State expenditures for prescription drug products provided to Medicaid patients (S.2605, the Pharmaceutical Access and Prudent Purchasing Act; S.3029, the Medicaid Anti-Discriminatory Drug Act, sponsored by Senator David Pryor; and H.R.5589, the Medicaid Prescription Drug Fair Access and Pricing Act, sponsored by Representatives Ron Wyden and Jim Cooper). A vigorous Congressional debate ensued over which of these approaches to pursue. Several pharmaceutical manufacturers voluntarily offered rebates to the States in exchange for open access for their products, while the Pharmaceutical Manufacturers Association proposed a set rebate amount in exchange for open formularies. Numerous public interest groups offered opinions on the proposals and in some cases proposals of their own.

The Congressional debate ended in both the House and Senate offering somewhat similar proposals. During the ensuing Conference between the House and Senate, the Office of Management and Budget (OMB) argued for the inclusion of several proposals into the provisions in budget bill, the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). The resulting Public Law 101-508, enacted November 5, 1990, required a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of DHHS for States to receive Federal funding for outpatient drugs dispensed to Medicaid patients. (For a detailed account of the debate and genesis of various provisions see Robert Betz's analysis of the Medicaid Best Price Law and its effect on pharmaceutical manufacturers' pricing policies.*)

The requirement for rebate agreements does not apply to the dispensing of a single-source or innovator multiple-source drug if the State has determined that the drug is essential, rated 1-A by the FDA, and prior authorization is obtained for the exception. Existing rebate agreements qualify under the law if the State agrees to report all rebates to DHHS and the agreement provides for a minimum aggregate rebate of 10% of the State's expenditures for the manufacturer's products.

OBRA '90 was amended by the Veterans Health Care Act of 1992 which also required a drug manufacturer to enter into discount pricing agreements with the Department of Veterans Affairs and with covered entities funded by the Public Health Service in order to have its drugs covered by Medicaid. The Medicaid rebate law, as amended, is included as Appendix C.

The drug rebate program is administered by CMS' Center for Medicaid and State Operations (CMSO). Currently, the rebate for covered outpatient drugs is as follows:

- For all innovator products, reimbursement requires: (1) a rebate that is the greater of 15.1 percent of the average manufacturer's price (AMP) or the difference between the AMP and the manufacturer's "best price," and (2) an additional rebate for any price increase for a product that exceeds the increase in the Consumer Price Index (CPI-U) for all items since the fall of 1990. AMP is the average price paid by wholesalers for products distributed to the retail class of trade. The best price is the lowest price offered to any other customer, excluding Federal Supply Schedule prices, prices to State pharmaceutical assistance programs, and prices that are nominal in amount, and includes all discounts and rebates.
- For generic drugs (non-innovator drugs), reimbursement requires: a rebate of 11 percent of each product's AMP.

* Robert Betz, "The Medicaid Best Price Law and Its Effect on Pharmaceutical Manufacturer's Pricing Policies and Behavior for Name Brand, Outpatient Pharmaceutical Products," unpubl. Ph.D. dissertation, The George Washington University, May 21, 2000.

Medicaid Drug Rebates, 2004

State	Allocation of Drug Rebate Monies ¹	Total Rebates ²	Federal Share ²
National Total		\$9,652,191,744	\$5,763,901,810
Alabama	Medicaid General	\$127,283,554	\$92,779,126
Alaska	Medicaid Expenditure Offset	\$29,188,871	\$17,638,089
Arizona*	-	-	\$0
Arkansas	Medicaid Drug Budget	\$82,286,907	\$63,281,808
California	Medicaid Drug Budget	\$1,611,941,832	\$850,479,653
Colorado	Medicaid Drug Budget	\$60,264,706	\$31,687,462
Connecticut	General Fund	\$96,617,771	\$50,247,010
Delaware	Medicaid General	\$25,068,377	\$13,364,209
District of Columbia	Medicaid General	\$20,512,606	\$14,861,020
Florida	Medicaid Drug Budget	\$670,836,774	\$410,212,259
Georgia	General Fund	\$256,980,634	\$158,522,685
Hawaii	General Fund	\$27,794,342	\$17,036,914
Idaho	Medicaid General	\$30,041,654	\$21,907,786
Illinois	Drug Rebate Fund	\$469,399,409	\$247,979,360
Indiana	General Fund	\$177,387,116	\$115,380,660
Iowa	Medicaid Drug Budget	\$84,729,745	\$56,401,736
Kansas	Medicaid Drug Budget	\$65,409,297	\$41,329,870
Kentucky	General Fund	\$169,285,080	\$122,287,836
Louisiana	Medicaid Drug Budget	\$220,068,423	\$163,133,338
Maine	Medicaid Drug Budget	\$80,173,931	\$54,833,065
Maryland	Medicaid General	\$90,642,415	\$47,705,420
Massachusetts	Medicaid General	\$277,112,233	\$144,666,136
Michigan	Medicaid Drug Budget	\$246,698,471	\$143,199,397
Minnesota	General Fund	\$92,188,275	\$48,104,129
Mississippi	Medicaid General	\$125,406,134	\$99,500,015
Missouri	Medicaid Drug Budget	\$220,602,904	\$140,843,510
Montana	Medicaid General	\$20,783,447	\$15,634,346
Nebraska	Medicaid General	\$46,634,148	\$29,265,740
Nevada	General Fund	\$28,947,187	\$16,665,102
New Hampshire	General Fund	\$33,253,239	\$17,526,295
New Jersey	Medicaid Drug Budget	\$197,451,860	\$102,980,846
New Mexico	General Fund	\$24,519,599	\$18,877,870
New York	General Fund	\$962,452,836	\$500,977,344
North Carolina	Medicaid General	\$324,686,591	\$211,994,785
North Dakota	Medicaid Drug Budget	\$14,069,176	\$9,947,956
Ohio	Medicaid General	\$447,436,396	\$275,166,196
Oklahoma	Medicaid General	\$74,198,766	\$53,927,443
Oregon	General Fund	\$53,842,614	\$34,003,993
Pennsylvania	Medical Assistance Outpatient Fund	\$196,449,883	\$115,235,816
Rhode Island	General Fund	\$38,067,294	\$22,145,659
South Carolina	Medicaid Drug Budget	\$163,587,518	\$118,093,982
South Dakota	Medicaid Drug Budget	\$17,559,898	\$11,944,814
Tennessee	Medicaid General	\$492,767,285	\$327,221,523
Texas	Medicaid Drug Budget	\$507,363,520	\$316,738,622
Utah	General Fund	\$45,818,326	\$33,998,176
Vermont	Health Access Trust Fund	\$35,983,462	\$23,139,169
Virginia	General Fund	\$137,924,722	\$72,366,356
Washington	General Fund	\$148,998,346	\$77,663,624
West Virginia	Medicaid General	\$107,509,922	\$83,448,860
Wisconsin	Medicaid General	\$162,034,977	\$100,028,842
Wyoming	Medicaid Drug Budget	\$11,929,271	\$7,525,958

*Does not apply for Arizona. Arizona has a 1115 waiver for which special rules apply.

Sources: ¹As reported by State drug program administrators in the 2005/2006 NPC Survey; ²CMS, CMS-64 Report, FY 2004, includes reported state supplemental rebates for CA, FL, IL, LA, MI, VT, and WV.

Medicaid Drug Rebate Trends, 2000-2004

State	2000	2001	2002**	2003**	2004**
National Total	\$3,980,646,518	\$4,948,222,331	\$5,917,504,760	\$7,008,382,303	\$9,652,191,744
Alabama	\$60,984,826	\$76,624,463	\$84,994,286	\$102,784,110	\$127,283,554
Alaska	\$8,594,014	\$11,337,883	\$14,347,654	\$15,060,446	\$29,188,871
Arizona*	-	-	-	-	-
Arkansas	\$40,814,931	\$45,744,406	\$56,688,398	\$58,097,761	\$82,286,907
California	\$600,895,711	\$786,113,991	\$946,651,118	\$1,207,800,866	\$1,611,941,832
Colorado	\$28,832,989	\$34,264,574	\$39,054,140	\$32,446,928	\$60,264,706
Connecticut	\$49,164,014	\$61,916,192	\$62,627,160	\$81,550,711	\$96,617,771
Delaware	\$13,780,359	\$17,042,045	\$16,990,455	\$28,352,506	\$25,068,377
District of Columbia	\$9,215,651	\$10,446,499	\$11,445,790	\$15,120,780	\$20,512,606
Florida	\$248,637,014	\$297,362,792	\$353,649,807	\$464,880,949	\$670,836,774
Georgia	\$91,886,605	\$110,087,285	\$205,469,531	\$219,238,104	\$256,980,634
Hawaii	\$10,947,632	\$14,363,603	\$15,267,796	\$19,212,047	\$27,794,342
Idaho	\$13,984,004	\$18,841,154	\$22,939,130	\$31,430,642	\$30,041,654
Illinois	\$143,590,170	\$170,733,612	\$190,316,986	\$292,630,625	\$469,399,409
Indiana	\$84,453,135	\$103,148,144	\$126,512,101	\$131,850,261	\$177,387,116
Iowa	\$36,040,216	\$42,602,101	\$50,092,788	\$62,173,583	\$84,729,745
Kansas	\$31,022,023	\$39,731,568	\$29,755,595	\$59,849,370	\$65,409,297
Kentucky	\$93,688,165	\$104,759,238	\$133,330,557	\$124,919,867	\$169,285,080
Louisiana	\$84,800,897	\$115,254,842	\$113,729,749	\$165,904,174	\$220,068,423
Maine	\$31,598,262	\$41,847,632	\$47,395,300	\$68,331,107	\$80,173,931
Maryland	\$42,081,781	\$34,263,429	\$54,261,949	\$77,934,401	\$90,642,415
Massachusetts	\$146,225,538	\$180,517,139	\$191,118,385	\$208,146,240	\$277,112,233
Michigan	\$75,687,945	\$111,716,756	\$172,522,597	\$179,774,542	\$246,698,471
Minnesota	\$43,228,324	\$54,548,714	\$62,655,474	\$54,081,115	\$92,188,275
Mississippi	\$61,260,326	\$88,481,567	\$115,221,421	\$114,233,479	\$125,406,134
Missouri	\$110,025,619	\$133,927,028	\$147,281,505	\$178,620,625	\$220,602,904
Montana	\$10,985,923	\$13,359,968	\$15,955,235	\$17,172,113	\$20,783,447
Nebraska	\$31,004,940	\$30,219,685	\$47,855,128	\$42,766,762	\$46,634,148
Nevada	\$4,863,879	\$16,330,579	\$13,547,604	\$21,078,909	\$28,947,187
New Hampshire	\$15,073,211	\$13,934,765	\$20,888,707	\$27,628,562	\$33,253,239
New Jersey	\$105,535,091	\$124,127,231	\$127,373,014	\$149,040,244	\$197,451,860
New Mexico	\$8,901,456	\$12,110,896	\$13,274,387	\$19,585,223	\$24,519,599
New York	\$470,317,992	\$543,984,948	\$663,973,100	\$598,407,083	\$962,452,836
North Carolina	\$140,047,825	\$207,551,841	\$207,064,443	\$260,487,290	\$324,686,591
North Dakota	\$6,503,601	\$8,780,182	\$11,651,682	\$11,369,358	\$14,069,176
Ohio	\$171,685,793	\$217,702,350	\$263,267,258	\$325,329,459	\$447,436,396
Oklahoma	\$37,135,809	\$40,177,945	\$51,471,649	\$59,205,487	\$74,198,766
Oregon	\$32,056,386	\$34,991,037	\$54,474,938	\$65,706,778	\$53,842,614
Pennsylvania	\$118,989,849	\$129,265,110	\$154,338,235	\$149,563,463	\$196,449,883
Rhode Island	\$19,223,034	\$21,467,002	\$26,213,636	\$30,477,726	\$38,067,294
South Carolina	\$73,052,676	\$95,438,155	\$98,272,773	\$119,101,600	\$163,587,518
South Dakota	\$7,198,848	\$9,405,933	\$12,056,925	\$14,808,661	\$17,559,898
Tennessee	\$41,302,450	\$102,644,077	\$180,613,885	\$224,072,761	\$492,767,285
Texas	\$222,314,531	\$268,557,241	\$305,110,523	\$392,292,711	\$507,363,520
Utah	\$21,889,639	\$21,949,963	\$36,756,960	\$25,931,043	\$45,818,326
Vermont	\$17,869,053	\$22,045,277	\$24,488,863	\$28,595,852	\$35,983,462
Virginia	\$75,630,717	\$79,484,868	\$76,776,155	\$112,854,618	\$137,924,722
Washington	\$69,782,396	\$91,250,830	\$100,874,789	\$123,683,508	\$148,998,346
West Virginia	\$46,762,149	\$52,402,218	\$48,976,536	\$69,568,029	\$107,509,922
Wisconsin	\$66,358,433	\$79,554,207	\$89,226,751	\$118,267,026	\$162,034,977
Wyoming	\$4,720,686	\$5,809,366	\$8,681,912	\$6,962,798	\$11,929,271

*Does not apply for Arizona. Arizona has a 1115 waiver for which special rules apply.

**Includes reported State supplemental rebates.

Source: CMS, CMS-64 Report, FY 2000-FY 2004.

Medicaid Drug Rebate Trends

Annual Percent Change, 1999-2004

State	% Change 99-00	% Change 00-01	% Change 01-02	% Change 02-03	% Change 03-04
National Total	19.2%	24.3%	19.6%	18.4%	37.7%
Alabama	22.5%	25.6%	10.9%	20.9%	23.8%
Alaska	21.9%	31.9%	26.5%	5.0%	93.8%
Arizona*	-	-	-	-	-
Arkansas	7.6%	12.1%	23.9%	2.5%	41.6%
California	11.3%	30.8%	20.4%	27.6%	33.5%
Colorado	14.6%	18.8%	14.0%	-16.9%	85.7%
Connecticut	27.2%	25.9%	1.1%	30.2%	18.5%
Delaware	40.8%	23.7%	-0.3%	66.9%	-11.6%
District of Columbia	10.0%	13.4%	9.6%	32.1%	35.7%
Florida	27.2%	19.6%	18.9%	31.5%	44.3%
Georgia	-3.5%	19.8%	86.6%	6.7%	17.2%
Hawaii	30.7%	31.2%	6.3%	25.8%	44.7%
Idaho	17.5%	34.7%	21.8%	37.0%	-4.4%
Illinois	18.1%	18.9%	11.5%	53.8%	60.4%
Indiana	34.7%	22.1%	22.7%	4.2%	34.5%
Iowa	11.3%	18.2%	17.6%	24.1%	36.3%
Kansas	15.4%	28.1%	-25.1%	101.1%	9.3%
Kentucky	28.9%	11.8%	27.3%	-6.3%	35.5%
Louisiana	11.4%	35.9%	-1.3%	45.9%	32.6%
Maine	5.2%	32.4%	13.3%	44.2%	17.3%
Maryland	30.2%	-18.6%	58.4%	43.6%	16.3%
Massachusetts	4.4%	23.5%	5.9%	8.9%	33.1%
Michigan	0.0%	47.6%	54.4%	4.2%	37.2%
Minnesota	15.6%	26.2%	14.9%	-13.7%	70.5%
Mississippi	24.2%	44.4%	30.2%	-0.9%	9.8%
Missouri	30.0%	21.7%	10.0%	21.3%	23.5%
Montana	18.2%	21.6%	19.4%	7.6%	21.0%
Nebraska	43.5%	-2.5%	58.4%	-10.6%	9.0%
Nevada	-37.1%	235.8%	-17.0%	55.6%	37.3%
New Hampshire	16.3%	-7.6%	49.9%	32.3%	20.4%
New Jersey	16.6%	17.6%	2.6%	17.0%	32.5%
New Mexico	11.7%	36.1%	9.6%	47.5%	25.2%
New York	32.1%	15.7%	22.1%	-9.9%	60.8%
North Carolina	25.8%	48.2%	-0.2%	25.8%	24.6%
North Dakota	9.2%	35.0%	32.7%	-2.4%	23.7%
Ohio	15.6%	26.8%	20.9%	23.6%	37.5%
Oklahoma	16.1%	8.2%	28.1%	15.0%	25.3%
Oregon	50.1%	9.2%	55.7%	20.6%	-18.1%
Pennsylvania	-0.3%	8.6%	19.4%	-3.1%	31.3%
Rhode Island	33.1%	11.7%	22.1%	16.3%	24.9%
South Carolina	30.5%	30.6%	3.0%	21.2%	37.4%
South Dakota	20.6%	30.7%	28.2%	22.8%	18.6%
Tennessee	84.1%	148.5%	76.0%	24.1%	119.9%
Texas	19.7%	20.8%	13.6%	28.6%	29.3%
Utah	44.5%	0.3%	67.5%	-29.5%	76.7%
Vermont	68.9%	23.4%	11.1%	16.8%	25.8%
Virginia	11.7%	5.1%	-3.4%	47.0%	22.2%
Washington	28.4%	30.8%	10.5%	22.6%	20.5%
West Virginia	30.1%	12.1%	-6.5%	42.0%	54.5%
Wisconsin	27.9%	19.9%	12.2%	32.5%	37.0%
Wyoming	8.2%	23.1%	49.4%	-19.8%	71.3%

*Does not apply to Arizona. Arizona has a 1115 waiver for which special rules apply.

Source: CMS, CMS-64 Report, FY 1999 – FY 2004.

Rebates as a Percent of Drug Expenditures, 2004

State	Drug Expenditures	Rebates**	Rebates as % Drug Expenditure
National Total	\$40,065,314,592	\$9,652,191,744	24.1%
Alabama	\$594,477,767	\$127,283,554	21.4%
Alaska	\$115,273,427	\$29,188,871	25.3%
Arizona*	\$5,367,723	-	-
Arkansas	\$380,446,105	\$82,286,907	21.6%
California	\$4,817,590,501	\$1,611,941,832	33.5%
Colorado	\$264,117,222	\$60,264,706	22.8%
Connecticut	\$448,164,399	\$96,617,771	21.6%
Delaware	\$122,552,631	\$25,068,377	20.5%
District of Columbia	\$106,453,411	\$20,512,606	19.3%
Florida	\$2,472,756,351	\$670,836,774	27.1%
Georgia	\$1,213,833,584	\$256,980,634	21.2%
Hawaii	\$117,149,907	\$27,794,342	23.7%
Idaho	\$153,351,334	\$30,041,654	19.6%
Illinois	\$1,751,647,987	\$469,399,409	26.8%
Indiana	\$703,941,201	\$177,387,116	25.2%
Iowa	\$371,927,390	\$84,729,745	22.8%
Kansas	\$274,203,278	\$65,409,297	23.9%
Kentucky	\$802,700,636	\$169,285,080	21.1%
Louisiana	\$944,175,123	\$220,068,423	23.3%
Maine	\$281,693,429	\$80,173,931	28.5%
Maryland	\$490,288,888	\$90,642,415	18.5%
Massachusetts	\$987,294,716	\$277,112,233	28.1%
Michigan	\$874,729,802	\$246,698,471	28.2%
Minnesota	\$394,600,158	\$92,188,275	23.4%
Mississippi	\$668,097,090	\$125,406,134	18.8%
Missouri	\$1,119,655,471	\$220,602,904	19.7%
Montana	\$99,334,048	\$20,783,447	20.9%
Nebraska	\$231,317,773	\$46,634,148	20.2%
Nevada	\$127,920,160	\$28,947,187	22.6%
New Hampshire	\$128,552,504	\$33,253,239	25.9%
New Jersey	\$1,016,646,964	\$197,451,860	19.4%
New Mexico	\$117,451,186	\$24,519,599	20.9%
New York	\$4,782,579,851	\$962,452,836	20.1%
North Carolina	\$1,575,005,070	\$324,686,591	20.6%
North Dakota	\$59,722,091	\$14,069,176	23.6%
Ohio	\$1,819,580,108	\$447,436,396	24.6%
Oklahoma	\$416,314,217	\$74,198,766	17.8%
Oregon	\$245,180,310	\$53,842,614	22.0%
Pennsylvania	\$952,341,486	\$196,449,883	20.6%
Rhode Island	\$166,067,772	\$38,067,294	22.9%
South Carolina	\$673,035,838	\$163,587,518	24.3%
South Dakota	\$81,936,507	\$17,559,898	21.4%
Tennessee	\$2,196,066,176	\$492,767,285	22.4%
Texas	\$2,202,097,688	\$507,363,520	23.0%
Utah	\$192,093,154	\$45,818,326	23.9%
Vermont	\$160,039,523	\$35,983,462	22.5%
Virginia	\$582,093,270	\$137,924,722	23.7%
Washington	\$649,265,744	\$148,998,346	22.9%
West Virginia	\$376,426,405	\$107,509,922	28.6%
Wisconsin	\$684,912,153	\$162,034,977	23.7%
Wyoming	\$52,845,063	\$11,929,271	22.6%

*Does not apply to Arizona. Arizona has a 1115 waiver for which special rules apply.

**Includes reported State supplemental rebates.

Source: CMS, CMS-64 Report, FY 2004.

MEDICAID DRUG COVERAGE

In general, all prescription products sold by a manufacturer that has signed a drug rebate agreement are covered outpatient drugs reimbursable by Medicaid. A State Medicaid program may require prior approval before dispensing of any drug product and may design and implement a formulary intended to limit coverage for specific drugs. Drug formularies and prior authorization programs must meet specific requirements established in Medicaid law.

A State Medicaid program can restrict coverage for a drug product through a formulary, if based on official labeling or information in designated official medical compendia, “the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcome of such treatment” over other drug products, and there is a written explanation (available to the public) of the basis for the exclusion. However, drug products excluded from the formulary under these conditions, nevertheless, must be available through prior authorization.

Drugs in certain specific classes may be restricted or excluded from coverage without regard to the formulary conditions and need not be available through prior authorization. These classes include:

- Drugs used for anorexia, weight gain, fertility, hair growth, cosmetic effect, symptomatic relief of cough or colds, or for cessation of smoking.
- Vitamins and minerals (except prenatal prescription vitamins and fluoride preparations) or non-prescription drugs.
- Drugs that require tests or monitoring services to be purchased exclusively from the manufacturer or his designee.
- Barbiturates or benzodiazepines.

PRIOR AUTHORIZATION

Whether or not a drug product is on a formulary, States may require physicians to request and receive official permission before a particular product can be dispensed. This procedure is called Prior Authorization or Prior Approval.

States may not operate prior authorization plans unless the State provides for a response within 24 hours of a request and provides for a 72-hour emergency supply of the medication.

The Congressional intent for the prior authorization provision was not to encourage the use of such programs, but rather to make them available to the States for the purpose of controlling utilization of products that have very narrow indications or high abuse potential.

The majority of States report the establishment of prior authorization programs and have plans to apply prior authorization to a select number of drugs. Some States will do so only after their Drug Utilization Review (DUR) program has identified areas of therapeutic concern.

DRUG UTILIZATION REVIEW

DUR Program. Each State must establish a Drug Utilization Review (DUR) Program in order to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. A DUR Program consists of prospective and retrospective components as well as components to educate physicians and pharmacists on common drug therapy problems.

Specifically, the program educates physicians and pharmacists how to identify and reduce fraud, abuse, gross overuse, or inappropriate or medically unnecessary care; potential and actual severe adverse reactions to drugs, including education on therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse or misuse.

The two primary objectives of DUR systems are (1) to improve quality of care; and (2) to assist in containing health care costs. While there is a general belief that DUR is cost beneficial, it is difficult to isolate concrete evidence that supports this view. The primary issue facing Medicaid DUR programs is whether or not the systems currently in place (or envisioned) meet the two objectives outlined above.

Prospective DUR. Prospective DUR is to be conducted at the point of sale (POS) before delivery of a medication by the pharmacist to the Medicaid recipient or caregiver. The State is to establish standards for counseling patients and will require the pharmacist to offer to discuss matters, which, in the exercise of the pharmacist's professional judgment are deemed significant, including the following:

- Name and description of the medication;
- The route of administration, dosage form, dosage, and duration of therapy;
- Special directions and precautions for preparation, administration and use by the patient;
- Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
- Techniques for self-monitoring prescription therapy;
- Proper storage;
- Prescription refill information; and
- Action to be taken in the event of a missed dose.

State law must also require pharmacists to make a reasonable effort to obtain, record, and maintain at least the following information for each Medicaid recipient:

- Name, address, telephone number, date of birth (or age) and gender;
- Individual history where significant, including a disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices; and
- Pharmacist comments relevant to the individual's pharmaceutical therapy.

Retrospective DUR. This activity continuously assesses data on drug use against established standards, preferably using automated claims processing and information retrieval techniques to monitor for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, clinical abuse/misuse and, as necessary, introduce remedial strategies in order to improve the quality of care and to conserve program funds or personal expenditures. This activity is also intended to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients, or with respect to specific drugs or groups of drugs.

State Drug Use Review Board. Each State must provide for the establishment of a DUR board of health practitioners (one-third to one-half physicians and at least one-third pharmacists) to help implement the DUR program. Each State must require its DUR board to make annual reports to DHHS on its activities and on cost savings resulting from the DUR program.

Pharmacy Advisory Committees

State	Pharmacy Advisory Committee	Meetings	Preferred Product Introduction Process
Alabama	Pharmacy Advisory Committee	Quarterly	Introductory letter
Alaska	None	-	Introductory letter
Arizona*	-	-	Inform health plans directly
Arkansas	None	-	Introductory letter
California	Medi-Cal Contract Drug Advisory Comm.	Ad Hoc	Petition with specific content requirements
Colorado	None	-	Introductory letter
Connecticut	DUR Board and P & T Committee advise	Quarterly	Introductory letter
Delaware	DUR Board	Bi-Monthly	Introductory letter
District of Columbia	None	-	Introductory letter
Florida	None	-	Introductory letter
Georgia	None	-	Intro. letter to Express Scripts & Medicaid
Hawaii	DUR Board	Quarterly	Formulary kit
Idaho	None	-	Introductory letter
Illinois	None	-	Contact First DataBank
Indiana	DUR Board	Monthly	Electronic form
Iowa	DUR Board	8 per year	Introductory letter
Kansas	None	-	Introductory letter
Kentucky	Pharmacy & Therapeutics Committee	Bi-Monthly	Introductory letter, Package insert
Louisiana	Pharmacy Advisory Committee	Semiannually	Intro. ltr., Package insert, & FDA approval ltr.
Maine	DUR Committee	Monthly	Introductory letter
Maryland	MD Medical Advisory Committee	Monthly	Introductory letter
Massachusetts	DUR Board	Quarterly	Introductory letter
Michigan	Pharmacy & Therapeutics Committee	Quarterly	FDB files
Minnesota	None	-	Introductory letter, Contact M.C. Woheltz
Mississippi	None	-	Introductory letter
Missouri	Pharmacy Advisory Group	Quarterly	AMPC format dossier
Montana	DUR Board	Monthly	Introductory letter, Electronic submission
Nebraska	DUR Board	Bi-Monthly	Introductory letter
Nevada	DUR Board	Quarterly	Introductory letter
New Hampshire	None	-	Introductory letter, Information packet
New Jersey	None	-	Introductory letter
New Mexico	None	-	Contact First DataBank
New York	Pharmacy Advisory Committee	Quarterly	Introductory letter
North Carolina	Pharmacy Advisory Committee	Monthly	Introductory letter
North Dakota	None	-	Contact First DataBank
Ohio	Pharmacy & Therapeutics Committee	Quarterly	Introductory letter
Oklahoma	DUR Board	Monthly	E-mail to medicaidrx@okhca.org
Oregon	None	-	Introductory letter
Pennsylvania	Pharmacy & Therapeutics Committee	Quarterly	Introductory letter/e-mail to State agency
Rhode Island	None	-	Introductory letter
South Carolina	Medical Care Advisory Committee	Quarterly	Introductory letter
South Dakota	Pharmacy & Therapeutics Committee	-	Product profile information
Tennessee*	TennCare Pharmacy Advisory Comm.	Quarterly	Introductory letter
Texas	None	-	State form
Utah	Policy & Operations Committee	Bi-monthly	Introductory letter
Vermont	DUR Board	10 per year	Introductory letter
Virginia	Pharmacy Liaison Committee	Quarterly	Introductory letter
Washington	Drug Evaluation Matrix Team	Weekly	AMCP format dossier
West Virginia	Medical Services Fund Advisory Council	Quarterly	Introductory letter
Wisconsin	None	-	Notification
Wyoming	DUR Board	Bi-Monthly	Introductory letter

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Pharmacy Benefit Design - Coverage

State	Cosmetics	Fertility Drugs	Experimental Drugs
Alabama	Not Covered	Not Covered	Not Covered
Alaska	Covered with Restrictions	Not Covered	Not Covered
Arizona*	-	-	-
Arkansas	Not Covered	Not Covered	Not Covered
California	Not Covered	Not Covered	Not Covered
Colorado	Not Covered	Not Covered	Not Covered
Connecticut	Not Covered	Not Covered	Not Covered
Delaware	Not Covered	Not Covered	Not Covered
District of Columbia	Covered with Restrictions	Not Covered	Not Covered
Florida	Not Covered	Not Covered	Not Covered
Georgia	Not Covered	Not Covered	Not Covered
Hawaii	Not Covered	Not Covered	Not Covered
Idaho	Not Covered	Not Covered	Not Covered
Illinois	Not Covered	Not Covered	Not Covered
Indiana	Not Covered	Not Covered	Not Covered
Iowa	Not Covered	Not Covered	Not Covered
Kansas	Not Covered	Not Covered	Not Covered
Kentucky	Not Covered	Not Covered	Not Covered
Louisiana	Not Covered	Not Covered	Not Covered
Maine	Not Covered	Not Covered	Not Covered
Maryland	Not Covered	Not Covered	Not Covered
Massachusetts	Not Covered	Not Covered	Not Covered
Michigan	Not Covered	Not Covered	Not Covered
Minnesota	Not Covered	Not Covered	Not Covered
Mississippi	Not Covered	Not Covered	Not Covered
Missouri	Not Covered	Not Covered	Not Covered
Montana	Not Covered	Not Covered	Not Covered
Nebraska	Not Covered	Not Covered	Not Covered
Nevada	Not Covered	Not Covered	Not Covered
New Hampshire	Not Covered	Not Covered	Not Covered
New Jersey	Not Covered	Not Covered	Not Covered
New Mexico	Not Covered	Not Covered	Not Covered
New York	Not Covered	Not Covered	Not Covered
North Carolina	Not Covered	Not Covered	Not Covered
North Dakota	Not Covered	Not Covered	Not Covered
Ohio	Not Covered	Not Covered	Not Covered
Oklahoma	Not Covered	Not Covered	Not Covered
Oregon**	Not Covered	Not Covered	Not Covered
Pennsylvania	Not Covered	Not Covered	Not Covered
Rhode Island	Not Covered	Not Covered	Not Covered
South Carolina	Not Covered	Not Covered	Not Covered
South Dakota	Not Covered	Not Covered	Not Covered
Tennessee	Not Covered	Not Covered	Not Covered
Texas	Not Covered	Not Covered	Not Covered
Utah	Not Covered	Not Covered	Not Covered
Vermont	Not Covered	Not Covered	Not Covered
Virginia	Not Covered	Not Covered	Not Covered
Washington	Not Covered	Not Covered	Not Covered
West Virginia	Not Covered	Not Covered	Not Covered
Wisconsin	Not Covered	Not Covered	Not Covered
Wyoming	Not Covered	Not Covered	Not Covered

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

**Subject to the restrictions of the Oregon Health Plan.

PA = Prior Authorization, DME = Durable Medical Equipment

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Pharmacy Benefit Design - Coverage (Con't)

State	Prescribed Insulin	Disposable Needles for Insulin Use	Syringe Combinations for Insulin Use	Blood Glucose Test Strips
Alabama	Covered with Restrictions	Covered	Covered	Covered as DME
Alaska	Covered	Covered as DME	Covered as DME	Covered as DME
Arizona*	-	-	-	-
Arkansas	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Not Covered
California	Covered	Covered	Covered	Covered
Colorado	Covered	DME	DME	DME
Connecticut	Covered	Covered	Covered	Covered
Delaware	Covered	Covered	Covered	Covered
District of Columbia	Covered	Covered	Covered	Covered
Florida	Covered	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Georgia	Covered with Restrictions	Covered	Covered	Covered with Restrictions
Hawaii	Covered	Covered as DME	Covered as DME	Covered as DME
Idaho	Covered	Covered as DME	Covered as DME	Covered as DME
Illinois	Covered with Restrictions	Covered	Covered	Covered with Restrictions
Indiana	Covered	Covered	Covered	Covered
Iowa	Covered	Not Covered	Not Covered	Not Covered
Kansas	Covered	Covered with PA as DME	Covered with PA as DME	Covered as DME
Kentucky	Covered	Not Covered	Covered	Not Covered
Louisiana	Covered	Covered	Covered	Covered
Maine	Covered	Covered	Covered with Restrictions	Covered
Maryland	Covered	Covered	Covered	Covered as DME
Massachusetts	Covered	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Michigan	Covered	Covered	Covered as DME	Covered as DME
Minnesota	Covered	Covered	Covered	Covered
Mississippi	Covered	Not Covered	Not Covered	Not Covered
Missouri	Covered	Covered	Covered	Covered
Montana	Covered	Not Covered	Not Covered	Not Covered
Nebraska	Covered, PA Required	Covered as DME	Covered as DME	Covered as DME
Nevada	Covered	Covered	Covered	Covered
New Hampshire	Covered	Covered	Covered	Covered
New Jersey	Covered	Covered	Covered	Covered
New Mexico	Covered	Covered	Covered	Covered
New York	Covered	Covered	Covered	Covered
North Carolina	Covered	Covered	Covered	Covered
North Dakota	Covered	Covered	Covered	Covered
Ohio	Covered	Covered as DME	Covered as DME	Covered as DME
Oklahoma	Covered	Covered as DME	Covered as DME	Covered as DME
Oregon**	Covered	Covered as DME	Covered as DME	Covered as DME
Pennsylvania	Covered	Covered	Covered	Covered
Rhode Island	Covered	Covered	Covered	Covered as DME
South Carolina	Covered	Covered	Covered	Covered as DME
South Dakota	Covered	Covered	Covered	Covered
Tennessee	Covered	Covered	Covered	Covered
Texas	Covered	Covered	Not Covered	Not Covered
Utah	Covered	Covered	Covered	Covered
Vermont	Covered	Covered	Covered	Covered
Virginia	Covered	Covered as DME	Covered as DME	Covered as DME
Washington	Covered	Covered	Covered	Covered
West Virginia	Covered with Restrictions	Covered with Limitations	Covered with Limitations	Covered
Wisconsin	Covered	Covered	Covered	Covered
Wyoming	Covered	Covered	Covered	Covered

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

**Subject to the restrictions of the Oregon Health Plan.

PA = Prior Authorization, DME = Durable Medical Equipment

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Pharmacy Benefit Design - Coverage (Con't)

State	Urine Ketone Test Strips	Total Parenteral Nutrition	Interdialytic Parenteral Nutrition
Alabama	Covered as DME	Covered with Restrictions	Covered with Restrictions
Alaska	Covered as DME	Covered as DME	Covered as DME
Arizona*	-	-	-
Arkansas	Not Covered	Not Covered	Not Covered
California	Covered	Covered, PA Required	Not Covered
Colorado	Covered as DME	Covered	Covered
Connecticut	Covered	Not Covered	Not Covered
Delaware	Covered	Covered	Covered
District of Columbia	Covered	Not Covered	Not Covered
Florida	Covered with Restrictions	Covered	Covered
Georgia	Covered	Covered, PA Required	Covered, PA Required
Hawaii	Covered as DME	Covered, PA Required	Covered, PA Required
Idaho	Covered as DME	Covered as DME	Covered as DME
Illinois	Covered	Covered	Covered
Indiana	Covered	Covered	Covered
Iowa	Not Covered	Covered	Covered
Kansas	Covered as DME	Covered with PA as DME	Covered with PA as DME
Kentucky	Not Covered	Covered, PA Required	Covered, PA Required
Louisiana	Covered	Covered as DME	Covered as DME
Maine	Covered	Not Covered	Not Covered
Maryland	Covered as DME	Covered	Covered with Restrictions
Massachusetts	Covered with Restrictions	Covered with Restrictions	Not Covered
Michigan	Covered as DME	Covered, PA required	Covered, PA required
Minnesota	Covered	Covered	Covered
Mississippi	Not Covered	Covered	Not Covered
Missouri	Covered	Covered	Covered
Montana	Not Covered	Covered, PA Required	Covered, PA Required
Nebraska	Covered as DME	Covered as DME	Covered as DME
Nevada	Covered	Covered as DME	Covered as DME
New Hampshire	Covered	Covered	Covered
New Jersey	Covered	Covered	Covered
New Mexico	Covered	Covered	Covered
New York	Covered	Covered	Covered
North Carolina	Covered	Covered	Covered
North Dakota	Not Covered	Covered	Not Covered
Ohio	Covered as DME	Covered as DME, PA Required	Covered as DME, PA Required
Oklahoma	Covered as DME	Covered with Restrictions	N/A
Oregon**	Covered as DME	Covered, PA Required	Covered, PA Required
Pennsylvania	Covered	Not Covered	Not Covered
Rhode Island	Covered	Covered as DME, PA Required	Covered as DME, PA Required
South Carolina	Covered as DME	Covered as DME	Covered as DME
South Dakota	Covered	Covered, PA Required	Covered, PA Required
Tennessee	Covered	Covered	Covered
Texas	Not Covered	Not Covered	Not Covered
Utah	Covered	Covered as DME	Covered
Vermont	Not Covered	Covered as DME	Not Covered
Virginia	Covered	Covered	Covered
Washington	Covered	Covered	Covered
West Virginia	Covered	Covered under DME	Covered under DME
Wisconsin	Covered	Covered	Covered
Wyoming	Covered	Covered as DME	Covered as DME

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

**Subject to the restrictions of the Oregon Health Plan.

PA= Prior Authorization, DME = Durable Medical Equipment

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Coverage of Injectables

Reimbursement for Non Self-Administered Medicines via the Prescription Drug Program (PDP) or Physician Payment (PP)

State	Physicians Office	Home Health Care	Extended Care Facility
Alabama	PP	PP	PDP
Alaska	PP	PDP	PDP
Arizona*	-	-	-
Arkansas	PP	PDP	PDP
California	PDP and PP	PDP	PDP
Colorado	PP	PDP	PDP
Connecticut	PP	PP	PP
Delaware	PDP and PP	-	PDP
District of Columbia	PP	PDP	PP
Florida	PDP and PP	PDP	PDP
Georgia	PP	PDP	PDP
Hawaii	PDP	PDP	PDP
Idaho	PP	PP	PP
Illinois	PP	PP	PP
Indiana	PDP and PP	PDP and PP	PDP and PP
Iowa	PDP and PP	PDP and PP	PDP and PP
Kansas	PP	PDP	PDP
Kentucky	PDP and PP	PDP	PDP
Louisiana	PDP and PP	-	-
Maine	PP	PDP	PDP
Maryland	PDP and PP	PDP	PDP
Massachusetts	PDP and PP	PDP	PDP
Michigan	PP	PDP	PDP or PP
Minnesota	PP	PP	PP
Mississippi	PP	PDP	PDP
Missouri	PDP	PDP	PDP
Montana	PP	PP	PP
Nebraska	PP	PDP	PDP
Nevada	PP	PDP	PDP
New Hampshire	PP	PDP	PDP
New Jersey	PDP and PP	PDP and PP	PDP and PP
New Mexico	PDP and PP	PDP and PP	PDP and PP
New York	PP	PDP	Included in facility rate
North Carolina	PP	PDP	PDP
North Dakota	PDP and PP	PDP	PDP
Ohio	PP	PDP	PDP
Oklahoma	PP	PDP and PP	PDP and PP
Oregon	PP	PP	PDP
Pennsylvania	PDP	PDP	PDP
Rhode Island	PDP	PDP	PDP
South Carolina	PP	PDP	PDP
South Dakota	PDP and PP	PDP and PP	PDP and PP
Tennessee	PP	PDP	PDP
Texas	PP	PP	PP
Utah	PP	PDP	PDP
Vermont	PP	PP	PP
Virginia	PP	PDP	PDP
Washington	PP	PDP	PDP
West Virginia	PP	PDP	PDP
Wisconsin	PDP and PP	PDP	PDP
Wyoming	PP	PP	PP

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Coverage of Vaccines and Unit Dose

State	Method for Vaccine Reimbursement ^	Reimbursement for Unit Dose
Alabama	EPSDT	Yes
Alaska	EPSDT, VCP	Yes
Arizona*	-	-
Arkansas	EPSDT, CHIP, VCP	Yes
California	VCP	No
Colorado	EPSDT	Yes
Connecticut	CHIP	No
Delaware	CHIP, VCP	No
District of Columbia	EPSDT, CHIP	No
Florida	VCP	Yes
Georgia	EPSDT, CHIP, VCP	Yes
Hawaii	EPSDT, CHIP	Yes
Idaho	VCP	Yes
Illinois	EPSDT, VCP	No
Indiana	VCP	Yes
Iowa	VCP	Yes
Kansas	VCP	No
Kentucky	EPSDT, CHIP, VCP, Pharmacy Program	Yes
Louisiana	EPSDT, VCP	No
Maine	EPSDT	Yes
Maryland	VCP	No
Massachusetts	EPSDT, Department of Public Health	No
Michigan	CHIP, VCP	Yes
Minnesota	CHIP	Yes
Mississippi	VCP	Yes
Missouri	VCP	Yes
Montana	EPSDT, CHIP, VCP	Yes
Nebraska	VCP	No
Nevada	EPSDT	Yes
New Hampshire	EPSDT, CHIP, VCP	Yes
New Jersey	VCP	Yes
New Mexico	EPSDT, CHIP, VCP, Dept. of Health	Yes – for commercially unit dose packaged drugs
New York	EPSDT, CHIP, VCP	No
North Carolina	VCP	No
North Dakota	EPSDT	No
Ohio	VCP	No
Oklahoma	EPSDT, VCP	No
Oregon	VCP	No
Pennsylvania	EPSDT, VCP	No
Rhode Island	VCP	No
South Carolina	VCP	Yes
South Dakota	EPSDT, CHIP, VCP	Yes
Tennessee	EPSDT, VCP	No
Texas	EPSDT	No
Utah	VCP	Yes
Vermont	Health Dept. provides vaccines to physician offices	Yes
Virginia	VCP	Yes
Washington	EPSDT	Yes
West Virginia	EPSDT, CHIP, VCP, Physician Payment Program	Yes
Wisconsin	VCP	Yes
Wyoming	EPSDT, CHIP, VCP	No

^ Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Children Health Insurance Program (CHIP), Vaccines for Children Program (VCP), or other.

LTC = Long Term Care

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Coverage of Over-the-Counter Medications

State	Allergy, Asthma, and Sinus	Analgesics	Cough and Cold	Smoking Deterrents
Alabama	Covered	Covered	Covered	Not Covered
Alaska	Not Covered	Not Covered	Not Covered	Covered
Arizona*	-	-	-	-
Arkansas	Limited Coverage	Limited Coverage	Limited Coverage	Covered with Restrictions
California	Partial Coverage, PA Req.	Partial Coverage, PA Req.	Partial Coverage, PA Req.	Partial Coverage, PA Req.
Colorado	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Connecticut	Covered	Not Covered	Covered with Restrictions	Not Covered
Delaware	Covered	Covered	Covered	Covered with Restrictions
District of Columbia	Not Covered	Covered	Not Covered	Not Covered
Florida	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Georgia	Limited Coverage	Covered with Restrictions	Not Covered	Not Covered
Hawaii	Covered	Covered	Limited Coverage	Covered with Restrictions
Idaho	Limited Coverage	Not Covered	Not Covered	Not Covered
Illinois	Covered with Restrictions	Covered with Restrictions	Limited Coverage	Covered
Indiana	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Iowa	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Not Covered
Kansas	Covered	Covered	Covered with Restrictions	Covered with Restrictions
Kentucky	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Not Covered
Louisiana	Covered with Restrictions	Not Covered	Not Covered	Not Covered
Maine	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Maryland	Covered with Restrictions	Limited Coverage	Not Covered	Not Covered
Massachusetts	Limited Coverage	Limited Coverage	Limited Coverage	Not Covered
Michigan	Limited Coverage	Limited Coverage	Not Covered	Covered
Minnesota	Covered	Covered	Covered	Covered
Mississippi	Limited Coverage	Limited Coverage	Limited Coverage	Limited Coverage
Missouri	Limited Coverage	Limited Coverage	Limited Coverage	Not Covered
Montana	Covered with Restrictions	Covered with Restrictions	Not Covered	PA Required
Nebraska	Covered	Covered	Covered	Not Covered
Nevada	Covered	Covered	Covered	Covered
New Hampshire	Covered	Covered	Covered	Covered
New Jersey	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered
New Mexico	Covered	Covered	Covered	Covered
New York	Covered	Covered	Covered	Limited Coverage
North Carolina	Limited Coverage	Not Covered	Not Covered	Covered
North Dakota	Covered with Restrictions	Covered	Not Covered	Covered with Restrictions
Ohio	Selective Coverage	Selective Coverage	Selective Coverage	Selective Coverage
Oklahoma	Covered with Restrictions	Not Covered	Not Covered	Covered with Restrictions
Oregon	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Pennsylvania	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered
Rhode Island	Covered	Covered	Covered	Not Covered
South Carolina	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
South Dakota	Limited Coverage	Not Covered	Not Covered	Not Covered
Tennessee	Covered	Covered	Not Covered	Not Covered
Texas	Covered	Covered	Covered	Covered
Utah	Limited Coverage	Limited Coverage	Limited Coverage	Separate program
Vermont	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Virginia	Covered	Covered	Covered	Covered
Washington	Limited Coverage	Limited Coverage	Limited Coverage	Not Covered
West Virginia	Limited Coverage	Limited Coverage	Limited Coverage	PA Required
Wisconsin	Covered with Restrictions	Covered	Covered with Restrictions	Not Covered
Wyoming	Covered	Covered	Covered	Not Covered

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

PA= Prior Authorization

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Coverage of Over-the-Counter Medications (Con't)

State	Digestive Products (non- H2 antagonists)	H2 Antagonists	Feminine Products	Topical Products
Alabama	Covered	Covered	Covered	Covered
Alaska	Not Covered	Not Covered	Limited Coverage	Limited Coverage
Arizona*	-	-	-	-
Arkansas	Limited Coverage	Limited Coverage	Limited Coverage	Limited Coverage
California	Partial Coverage, PA Req.	Partial Coverage, PA Req.	Partial Coverage, PA Req.	Partial Coverage, PA Req.
Colorado	Limited Coverage	Not Covered	Not Covered	Not Covered
Connecticut	Covered with Restrictions	Covered with Restrictions	Not Covered	Covered
Delaware	Covered	Covered	Covered with Restrictions	Covered
District of Columbia	Not Covered	Not Covered	Not Covered	Not Covered
Florida	Covered with Restrictions	Not Covered	Covered with Restrictions	Not Covered
Georgia	Not Covered	Not Covered	Not Covered	Covered with Restrictions
Hawaii	Covered	Limited Coverage	N/A	Limited Coverage
Idaho	Covered with Restrictions	Not Covered	Not Covered	Limited Coverage
Illinois	Covered with Restrictions	Not Covered	Not Covered	Covered with Restrictions
Indiana	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Iowa	Not Covered	Not Covered	Not Covered	Covered with Restrictions
Kansas	Covered	Covered	Covered with Restrictions	Covered
Kentucky	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Louisiana	Not Covered	Not Covered	Not Covered	Not Covered
Maine	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Maryland	Not Covered	Covered with Restrictions	Not Covered	Not Covered
Massachusetts	Limited Coverage	Limited Coverage	Limited Coverage	Limited Coverage
Michigan	Limited Coverage	Limited Coverage	Limited Coverage	Limited Coverage
Minnesota	PA Required	PA Required	Covered	Covered
Mississippi	Limited Coverage	Not Covered	Limited Coverage	Limited Coverage
Missouri	Limited Coverage	Limited Coverage	Not Covered	Limited Coverage
Montana	Covered	Covered	Not Covered	Not Covered
Nebraska	Covered	Covered	Covered	Covered
Nevada	Covered	Covered	Not Covered	Covered with Restrictions
New Hampshire	Covered	Covered	Covered	Covered
New Jersey	Not Covered	Not Covered	Not Covered	Covered with Restrictions
New Mexico	Covered	Covered	Not Covered	Covered with Restrictions
New York	Covered	Covered	Covered	Covered
North Carolina	Limited Coverage	Not Covered	Not Covered	Not Covered
North Dakota	Covered	Covered	Not Covered	Covered with Restrictions
Ohio	Selective Coverage	Selective Coverage	Selective Coverage	Selective Coverage
Oklahoma	Covered with Restrictions	Not Covered	Not Covered	Not Covered
Oregon	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Pennsylvania	Covered with Restrictions	Covered	Covered	Covered
Rhode Island	Not Covered	Not Covered	Covered	Covered
South Carolina	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
South Dakota	Limited Coverage	Not Covered	Not Covered	Not Covered
Tennessee	Covered	Covered	Not Covered	Covered
Texas	Covered	Covered	Not Covered	Covered
Utah	Not Covered	Limited Coverage	Limited Coverage	Limited Coverage
Vermont	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions	Covered with Restrictions
Virginia	Covered	Covered	Not Covered	Covered
Washington	Limited Coverage	Limited Coverage	Limited Coverage	Limited Coverage
West Virginia	Covered	Not Covered	Covered	Covered
Wisconsin	Covered with Restrictions	Covered	Covered	Covered with Restrictions
Wyoming	Covered with Restrictions	Covered	Covered with Restrictions	Covered

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

PA= Prior Authorization

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Prior Authorization Process and Procedures

State	PA Procedure	Prior Authorization Committee	Members	Meetings
Alabama	Yes	Pharmacy and Therapeutics Committee	10	Quarterly
Alaska	Yes	No	-	-
Arizona*	-	-	-	-
Arkansas	Yes	DUR Board	9	Quarterly
California	Yes	No	-	-
Colorado	Yes	No	-	-
Connecticut	Yes	Pharmaceutical and Therapeutics Committee	14	Quarterly
Delaware	Yes	No	-	-
District of Columbia	Yes	No	-	-
Florida	Yes	No	-	-
Georgia	Yes	No	-	-
Hawaii	Yes	No	-	-
Idaho	Yes	PA Review Committee	5	Twice Weekly
Illinois	Yes	Drugs and Therapeutics Committee	12	Atleast quarterly
Indiana	Yes	No	-	-
Iowa	Yes	DUR Board	9	8 per year
Kansas	Yes	DUR Board	9	Bi-monthly
Kentucky	Yes	Pharmacy and Therapeutics Advisory Committee	14	Bi-monthly
Louisiana	Yes	Pharmaceutical and Therapeutics Committee	21	Semi-annually
Maine	Yes	No	-	-
Maryland	Yes	No	-	-
Massachusetts	Yes	No	-	-
Michigan	Yes	Pharmacy and Therapeutics Committee	11	Quarterly
Minnesota	Yes	None	-	-
Mississippi	Yes	Pharmacy and Therapeutics Committee	12	Quarterly
Missouri	Yes	Prior Authorization Committee	9	Quarterly
Montana	Yes	DUR Board	10	Monthly
Nebraska	Yes	DUR Board	14	Bi-Monthly
Nevada	Yes	No	-	-
New Hampshire	Yes	Pharmacy and Therapeutics Advisory Committee	13	Quarterly
New Jersey	Yes	No	-	-
New Mexico	Yes	No	-	-
New York	Yes	Pharmacy and Therapeutics Committee	11	Quarterly
North Carolina	Yes	No	-	-
North Dakota	Yes	DUR Board	14	Quarterly
Ohio	Yes	No	8	Quarterly
Oklahoma	Yes	No	-	-
Oregon	Yes	DUR Board	12	Quarterly
Pennsylvania	Yes	Pharmacy and Therapeutics Committee	Varies	Quarterly
Rhode Island	Yes	DUR Board	6	Quarterly
South Carolina	Yes	Pharmacy and Therapeutics Committee	12	Quarterly
South Dakota	No	No	-	-
Tennessee	Yes	No	-	-
Texas	Yes	No	-	-
Utah	Yes	Prior Approval Committee	3	Monthly
Vermont	Yes	No	-	-
Virginia	Yes	Pharmacy and Therapeutics Committee	12	Quarterly
Washington	Yes	DUR Team and Drug Eval. Matrix Team	8	Daily, weekly
West Virginia	Yes	Pharmaceutical and Therapeutics Committee	11	Semi-annually
Wisconsin	Yes	Pharmacy Prior Authorization Advisory Comm.	9	As needed
Wyoming	Yes	DUR Board	12	Bi-monthly

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Prior Authorization Process and Procedures (Con't)

State	Initiated By:	Annual Requests	% Approved
Alabama	M.D., R.Ph.	350,000	N/A
Alaska	M.D.	3,600	96%
Arizona*	-	-	-
Arkansas	M.D.	260,000	77%
California	M.D., R.Ph.	2,900,000	82%
Colorado	M.D., M.D.'s Agent	14,400	90%
Connecticut	M.D., R.Ph.	88,000	99%
Delaware	M.D., R.Ph.	34,000	92%
District of Columbia	M.D., R.Ph.	4,800	65%
Florida	M.D.	440,000	78%
Georgia	M.D., R.Ph., Pharm. Tech.	172,000	65%
Hawaii	M.D., R.Ph., Pharm. Tech.	N/A	99%
Idaho	M.D., R.Ph., N.P., P.A.	37,000	60%
Illinois	M.D., R.Ph.	216,000	75%
Indiana	M.D., Other Providers	N/A	N/A
Iowa	M.D.	60,000	95%
Kansas	M.D., R.Ph.	4,700	81%
Kentucky	M.D., R.Ph.	285,000	58%
Louisiana	M.D.	121,000	N/A
Maine	M.D.	65,000	82%
Maryland	M.D., R.Ph.	77,500	95%
Massachusetts	M.D., Other Licensed Prescriber	137,000	67%
Michigan	M.D., R.Ph.	120,000	95%
Minnesota	M.D., R.Ph.	17,000	87%
Mississippi	M.D.	394,000	23%
Missouri	M.D., R.Ph., Other Authorized Prescriber	129,000	63%
Montana	M.D., R.Ph., Pharm. Tech.	19,000	66%
Nebraska	M.D., R.Ph.	12,000	60%
Nevada	M.D.	N/A	N/A
New Hampshire	M.D.	11,700	79%
New Jersey	M.D., R.Ph.	715,000	95%
New Mexico	M.D.	1,300	N/A
New York	M.D./Ordering Provider	158,000	100%
North Carolina	M.D., R.Ph. (LTC)	25,000	90%
North Dakota	M.D., R.Ph., Pharm. Tech.	2,000	60%
Ohio	M.D.	240,000	Most
Oklahoma	M.D., R.Ph.	180,000	52%
Oregon	M.D.	21,400	90%
Pennsylvania	M.D.	55,760	44%
Rhode Island	M.D.	N/A	N/A
South Carolina	M.D., R.Ph.	121,000	68%
South Dakota	M.D., R.Ph.	28	100%
Tennessee	M.D.	180,000	74%
Texas	M.D.	N/A	95%
Utah	R.Ph., DUR Board has veto power	70	90%
Vermont	M.D., Prescribing Agent	42,400	85%
Virginia	M.D.	52,700	86%
Washington	R.Ph., Pharm. Tech.	N/A	N/A
West Virginia	M.D., R.Ph., Other Prescribers	120,000	73%
Wisconsin	M.D., R.Ph.	182,000	97%
Wyoming	M.D., R.Ph., Pharm. Tech., Nurse Pract.	8,000	77%

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Prior Authorization Process and Procedures (Con't)

State	Reviewer	Review Time	Response Vehicle
Alabama	R.N., R.Ph., Pharm. Tech.	<8 hours	Fax, mail
Alaska	R.Ph., Pharm. Tech.	2 hours	Phone, fax
Arizona*	-	-	-
Arkansas	M.D., R.Ph.	1-3 minutes	Voice response system, mail
California	R.Ph.	One business day	Phone, fax
Colorado	M.D., R.Ph.	24 hours	Phone, fax
Connecticut	R.Ph., Pharm. Tech.	2 hours	Phone, fax, mail
Delaware	M.D., R.Ph., R.N., Pharm. Tech.	< 1 working day	Phone, mail, e-mail
District of Columbia	R.Ph., Pharm. Tech.	48 hours	Phone
Florida	R.Ph., Pharm. Tech.	24 hours	Phone, fax, e-mail
Georgia	PBM, R.Ph.	10 minutes	Phone, fax, mail
Hawaii	R.Ph., Pharm. Tech.	24 hours	Phone, fax, mail
Idaho	R.Ph., Pharm. Tech.	24 hours	Phone
Illinois	M.D., R.Ph.	24 hours or less	Phone, mail
Indiana	Medicaid Director or designee	10 days	Phone, letter
Iowa	R.Ph.	4 hours	Fax
Kansas	R.N.	15-30 minutes	Mail
Kentucky	R.N., R.Ph.	4-24 hours	Phone, fax
Louisiana	R.Ph.	3-5 minutes	Phone, fax
Maine	M.D.	4 hours	Fax
Maryland	R.Ph.	24 hours or less	Phone, fax
Massachusetts	R.Ph.	<24 hours	Phone, fax, mail
Michigan	M.D., R.Ph., Pharm. Tech.	24 hours	Phone, fax
Minnesota	R.N.	Within minutes	Phone
Mississippi	R.N., R.Ph., Pharm. Tech.	6 hours	Phone, fax, mail
Missouri	M.D., R.Ph., R.N., Medicaid Tech.	< 5 minutes	Phone, fax
Montana	R.Ph., Pharm. Tech.	1-2 minutes	Phone, fax, mail
Nebraska	R.Ph., Pharm. Tech.	1 business day	Phone, fax, mail
Nevada	R.Ph., Pharm. Tech.	24 hours	Phone
New Hampshire	R.Ph., Pharm. Tech.	24 hours	Phone, fax with written follow-up of denials
New Jersey	R.N., R.Ph.	3 minutes	Phone, fax, mail
New Mexico	R.Ph.	24 hours	Phone, fax
New York	Voice interactive system	Processed during call	PA issued to prescriber by phone
North Carolina	R.Ph., Pharm. Tech.	24 hours or less	Phone, fax
North Dakota	R.Ph.	4 hours	Fax, mail
Ohio	R.Ph., Pharm. Tech.	Immediate	Phone, fax
Oklahoma	R.Ph., Pharm. Tech, Pharm. Intern	24 hours or less	Fax, secure provider e-mail
Oregon	R.Ph., Pharm. Tech.	24 hours or less	Phone, mail
Pennsylvania	M.D., R.Ph., Pharm. Tech.	24 hours	Phone
Rhode Island	Contractor	Immediately to 24 hours	Phone
South Carolina	R.Ph.	Minutes to 24 hours	Phone, fax, mail
South Dakota	R.Ph.	24 hours	Phone, fax, mail, e-mail
Tennessee	R.Ph.	Same day	Fax
Texas	R.Ph., Pharm. Tech.	24 hours	Phone, fax, e-mail
Utah	Nurse & DUR Board	1 working day	Phone, mail
Vermont	R.Ph., Pharm. Tech, Medical Dir.	24 hours	Phone, fax, mail
Virginia	R.Ph., Pharm. Tech.	Less than 3 minutes	Phone, fax
Washington	M.D., R.Ph.	24 hours	Phone, fax
West Virginia	R.Ph.	5 min-2 hours	Phone, fax
Wisconsin	R.Ph., Done electronically	Immediate	Online, phone, fax, mail
Wyoming	R.Ph., Pharm. Tech.	8-10 hours	Phone, fax, mail

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Prior Authorization

State	Anabolic Steroids	Analgesics, Antipyretics, NSAIDs	Anorectics
Alabama	Not Covered	Covered, PA Required	Not Covered
Alaska	Covered	Covered, PA Required	Not Covered
Arizona*	-	-	-
Arkansas	Covered	Covered, PA Required	Not Covered
California	Partial Coverage, PA Required	Partial Coverage, PA Required	Partial Coverage, PA Required
Colorado	Covered, PA Required	Partial Coverage	Not Covered
Connecticut	Covered	Covered	Not Covered
Delaware	Covered	Partial Coverage, PA Required	Partial Coverage, PA Required
District of Columbia	Not Covered	Partial Coverage, PA Required	Partial Coverage, PA Required
Florida	Covered	Covered	Not Covered
Georgia	Covered, PA Required	Partial Coverage, PA Required	Not covered
Hawaii	Covered, PA Required	Covered	Covered, PA Required
Idaho	Not Covered	Covered, PA Required	Not Covered
Illinois	Covered, PA Required	Covered, PA Required	Not Covered
Indiana**	N/A	N/A	Not Covered
Iowa	Covered	Covered, PA Required	Not Covered
Kansas	Covered	Partial Coverage	Partial Coverage
Kentucky	Covered, PA Required	Covered, PA Required	Covered, PA Required
Louisiana	Covered	Covered, PA Required	Partial Coverage
Maine	Covered, PA Required	Covered, PA Required	Covered, PA Required
Maryland***	Covered	Covered	Not Covered
Massachusetts	Covered	Partial Coverage, PA Required	Not Covered
Michigan	Not Covered	Covered	Not Covered
Minnesota	Covered	Covered, PA Required	Not Covered
Mississippi	Covered	Covered	Not Covered
Missouri	Partial Coverage, PA Required	Covered	Not Covered
Montana	Covered	Covered, PA Required	Not Covered
Nebraska	Covered	Partial Coverage, PA Required	Not Covered
Nevada	Partial Coverage	Covered	Not Covered
New Hampshire	Covered	Covered, PA Required	Covered, PA Required
New Jersey	Covered	Covered	Covered
New Mexico	Covered	Covered	Covered, PA Required
New York	Covered	Covered	Not Covered
North Carolina	Covered	Covered, PA Required	Not Covered
North Dakota	Covered	Covered	Partial Coverage, PA Required
Ohio	Covered, PA Required	Covered	Not Covered
Oklahoma	Not Covered	Covered, PA Required	Partial Coverage, PA Required
Oregon****	Partial Coverage	Partial Coverage	Partial Coverage
Pennsylvania	Covered	Covered, PA Required	Not Covered
Rhode Island	Covered	Covered, PA Required	Covered, PA Required
South Carolina	Covered	Covered	Not Covered
South Dakota	Covered	Covered	Covered
Tennessee	Covered	Covered, PA Required	Not Covered
Texas	Covered	Covered	Partial Coverage, PA Required
Utah	Partial Coverage, PA Required	Covered, PA Required	Covered, PA Required
Vermont	Covered, PA Required	Covered, PA Required	Not Covered
Virginia	Covered	Covered, PA Required	Covered, PA Required
Washington	Covered, PA Required	Covered, PA Required	Not Covered
West Virginia	Covered	Covered, PA Required	Not Covered
Wisconsin	Covered	Covered, PA Required	Covered, PA Required
Wyoming	Not Covered	Covered, Some require PA	Not Covered

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

** All coverage in accordance with OBRA'90 and OBRA'93.

***PA required for all drugs not on the preferred drug list.

****Subject to the restrictions of the Oregon Health Plan.

PA = Prior Authorization

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Prior Authorization (Con't)

State	Antihistamines	Anxiolytics, Sedatives, and Hypnotics	Prescribed Cold Medications
Alabama	Covered, PA Required	Covered, PA Required	Covered
Alaska	Covered	Covered	Not Covered
Arizona*	-	-	-
Arkansas	Covered	Covered	Partial Coverage
California	Partial Coverage, PA Required	Partial Coverage, PA Required	Partial Coverage, PA Required
Colorado	Covered	Covered	Covered, PA Required
Connecticut	Covered	Covered	Covered
Delaware	Covered	Partial Coverage, PA Required	Partial Coverage, PA Required
District of Columbia	Covered	Covered	Covered
Florida	Covered	Covered	Partial Coverage
Georgia	Covered, PA Required	Partial Coverage, PA Required	Partial Coverage
Hawaii	Partial Coverage, PA Required	Covered	Covered, PA Required
Idaho	Covered, PA Required	Covered, PA Required	Covered
Illinois	Covered, PA Required	Covered, PA Required	Covered, PA Required
Indiana**	N/A	N/A	N/A
Iowa	Covered, PA Required	Covered, PA Required	Covered, PA Required
Kansas	Covered	Covered	Partial Coverage
Kentucky	Covered, PA Required	Covered, PA Required	Covered, PA Required
Louisiana	Covered, PA Required	Covered, PA Required	Partial Coverage
Maine	Covered, PA Required	Covered, PA Required	Covered, PA Required
Maryland***	Covered	Covered	Covered
Massachusetts	Partial Coverage, PA Required	Partial Coverage, PA Required	Partial Coverage
Michigan	Covered	Covered	Partial Coverage
Minnesota	Covered, PA Required	Covered	Covered
Mississippi	Covered	Covered	Partial Coverage
Missouri	Covered	Covered, PA Required	Covered, PA Required
Montana	Covered, PA Required	Covered, PA Required	Covered, PA Required
Nebraska	Partial Coverage, PA Required	Partial Coverage	Covered
Nevada	Covered	Covered	Covered
New Hampshire	Covered, PA Required	Covered, PA Required	Covered
New Jersey	Covered	Covered	Covered
New Mexico	Covered	Not Covered	Covered
New York	Covered, PA Required	Covered	Partial Coverage
North Carolina	Covered	Covered	Covered
North Dakota	Covered, PA Required	Covered	Covered
Ohio	Covered, PA Required	Covered	Covered, PA Required
Oklahoma	Partial Coverage, PA Required	Covered, PA Required	Not Covered
Oregon***	Partial Coverage, PA Required	Partial Coverage, PA Required	Partial Coverage
Pennsylvania	Covered, PA Required	Covered, PA Required	Covered, PA Required
Rhode Island	Covered, PA Required	Covered	Covered
South Carolina	Covered	Covered	Covered
South Dakota	Covered	Covered	Covered
Tennessee	Covered, PA Required	Covered	Not Covered
Texas	Covered	Covered	Covered
Utah	Covered	Covered	Covered
Vermont	Covered, PA Required	Covered, PA Required	Covered, PA Required
Virginia	Covered, PA Required	Covered, PA Required	Covered
Washington	Covered	Covered, PA Required	Covered, PA Required
West Virginia	Covered, PA Required	Covered, PA Required	Partial Coverage
Wisconsin	Covered	Covered	Covered
Wyoming	Covered	Covered	Covered

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

**All coverage in accordance with OBRA '90 and OBRA '93.

***PA required for all drugs not on the preferred drug list.

****Subject to the restrictions of the Oregon Health Plan.

PA = Prior Authorization

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Prior Authorization (Con't)

State	Growth Hormones	Miscellaneous GI Products	Prescribed Smoking Deterrents
Alabama	Covered, PA Required	Covered, PA Required	Not Covered
Alaska	Covered, PA Required	Covered, PA Required	Covered, PA Required
Arizona*	-	-	-
Arkansas	Covered	Covered, PA Required	Partial Coverage, PA Required
California	Partial Coverage, PA Required	Partial Coverage, PA Required	Partial Coverage, PA Required
Colorado	Covered, PA Required	Covered	Covered, PA Required
Connecticut	Covered	Covered	Not Covered
Delaware	Partial Coverage, PA Required	Covered	Partial Coverage, PA Required
District of Columbia	Partial Coverage, PA Required	Partial Coverage, PA Required	Not Covered
Florida	Covered, PA Required	Covered	Covered
Georgia	Covered, PA Required	Covered, PA Required	Partial Coverage
Hawaii	Covered, PA Required	Covered	Covered, PA Required
Idaho	Covered, PA Required	Covered, PA Required	Not Covered
Illinois	Covered, PA Required	Covered, PA Required	Covered
Indiana**	Covered, PA Required	N/A	N/A
Iowa	Covered, PA Required	Covered, PA Required	Partial Coverage
Kansas	Covered, PA Required	Covered	Partial Coverage
Kentucky	Covered, PA Required	Covered, PA Required	Not Covered
Louisiana	Covered, PA Required	Covered, PA Required	Covered
Maine	Covered, PA Required	Covered, PA Required	Covered
Maryland***	Partial Coverage, PA Required	Covered	Partial Coverage
Massachusetts	Covered, PA Required	Partial Coverage, PA Required	Not Covered
Michigan	Covered, PA Required	Covered	Covered
Minnesota	Covered, PA Required	Covered, PA Required	Covered
Mississippi	Covered	Covered	Covered
Missouri	Covered, PA Required	Covered, PA Required	Not Covered
Montana	Covered, PA Required	Covered, PA Required	Covered, PA Required
Nebraska	Partial Coverage, PA Required	Partial Coverage, PA Required	Not Covered
Nevada	Partial Coverage, PA Required	Covered	Covered
New Hampshire	Covered	Covered, PA Required	Covered
New Jersey	Covered	Covered	Covered
New Mexico	Covered	Covered	Covered
New York	Covered, PA Required	Partial Coverage, PA Required	Covered
North Carolina	Covered, PA Required	Covered	Covered
North Dakota	Covered	Covered, PA Required	Partial Coverage
Ohio	Covered, PA Required	Covered, PA Required	Covered, PA Required
Oklahoma	Covered, PA Required	Covered, PA Required	Partial Coverage, PA Required
Oregon****	Partial Coverage, PA Required	Partial Coverage, PA Required	Covered
Pennsylvania	Covered, PA Required	Covered, PA Required	Covered
Rhode Island	Covered, PA Required	Covered	Partial Coverage
South Carolina	Covered, PA Required	Covered	Covered
South Dakota	Covered, PA Required	Covered	Partial Coverage
Tennessee	Covered	Covered	Not Covered
Texas	Covered, PA Required	Covered	Covered
Utah	Covered	Covered	Partial Coverage
Vermont	Covered, PA Required	Covered, PA Required	Covered, PA Required
Virginia	Covered	Covered, PA Required	Covered
Washington	Covered, PA Required	Covered, PA Required	Limited Coverage
West Virginia	Covered, PA Required	Covered, PA Required	Partial Coverage, PA Required
Wisconsin	Covered, PA Required	Covered, PA Required	Covered
Wyoming	Partial Coverage	Covered, PA Required on PPIs	Not Covered

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

**All coverage in accordance with OBRA '90 and OBRA '93.

***PA required for all drugs not on the preferred drug list.

****Subject to the restrictions of the Oregon Health Plan.

PA = Prior Authorization

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Drug Utilization Review

State	State Contact	Telephone	In-House or Contracted	PRODUR Implemented
Alabama	Tiffany Minnifield	334-353-4596	Contracted	Jul-96
Alaska	Dave Campana, R.Ph.	907-334-2425	In-House	Jun-95
Arizona*	-	-	-	-
Arkansas	Pamela Ford, P.D.	501-683-4120	Contracted	Mar-97
California	J. Kevin Gorospe, Pharm.D.	916-552-9500	Both	Aug-95
Colorado	Kimberly Eggert	303-866-3176	Contracted	Dec-98
Connecticut	James Zakszewski, R.Ph.	860-424-5150	Contracted	Sep-96
Delaware	Cynthia R. Denemark, R.Ph.	302-453-8453	Contracted	Feb-94
District of Columbia	Carolyn Rachel-Price	202-442-9078	Contracted	Sep-96
Florida	Linda Barnes, R.Ph.	850-487-4441	Contracted	Jul-93
Georgia	Patricia Z. Jeter, R.Ph., M.P.A.	404-656-4044	Contracted	Oct-00
Hawaii	Kathleen Kang-Kaulupali	808-692-8065	In-House	1997
Idaho	Tamara Eide, P.D., B.C.P.S., FASHP	208-364-1821	Contracted	Jan-98
Illinois	Sinead Madigan	217-524-7478	In-House	Jan-93
Indiana	DUR Board Secretary	317-232-4307	Contracted	Mar-96
Iowa	Johnna Neary, R.Ph.	515-725-1295	Contracted	Jul-97
Kansas	Anne S. Ferguson, R.Ph.	785-296-3981	In-House	Nov-96
Kentucky	Debra Bahr, R.Ph.	502-564-7940	In-House	1987
Louisiana	Mary J. Terrebonne, Pharm.D.	225-342-9768	Contracted	Apr-66
Maine	Kim Rackleff	207-622-7153	Contracted	Dec-95
Maryland	Phil Cogan	410-767-5878	Contracted	Jan-93
Massachusetts	Paul L. Jeffrey	617-210-5319	Contracted	Oct-95
Michigan	Debra Eggleston, M.D.	517-335-5181	Contracted	Jul-00
Minnesota	Mary Beth Reinke, Pharm.D., M.S.A.	651-431-2505	In-House	Feb-96
Mississippi	Susan Brown	601-359-5253	Contracted	Oct-93
Missouri	Tisha A. Honse	573-751-6961	Contracted	Feb-93
Montana	Mark Eichler, R.Ph., FASCP	406-457-5818	Contracted	Sep-94
Nebraska	Marcia Mueiting	402-420-1500	Contracted	Apr-95
Nevada	Dionne Coston, R.N.	702-684-3775	Contracted	2004
New Hampshire	Robert Coppola	603-220-2083	Contracted	Jul-95
New Jersey	Kaye S. Morrow	609-631-2396	In-House	Oct-96
New Mexico	Neal Solomon, M.P.H., R.Ph.	505-827-3174	In-House	Oct-93
New York	Lydia Kosinski, R.Ph.	518-474-6866	In-House	Mar-95
North Carolina	Leah Terrel, R.Ph., Pharm.D.	919-855-4300	In-House	Oct-96
North Dakota	Brendan K. Joyce, Pharm.D., R. Ph.	701-328-4023	In-House	Jul-96
Ohio	Margaret Scott, R.Ph.	614-466-9689	Both	Feb-00
Oklahoma	Ronald Graham, D.Ph.	405-271-6614	Contracted	2000
Oregon	Kathy L. Ketchum, R.Ph., M.P.A	503-947-5220	Contracted	Mar-94
Pennsylvania	Terri Cathers	717-346-8156	Contracted	Jun-93
Rhode Island	Paula Avarista, R.Ph., M.B.A.	401-4642-6390	Contracted	Dec-94
South Carolina	Caroline Sojourner, R.Ph.	803-898-2876	In-House	Nov-00
South Dakota	Teddi Martell	605-773-3653	In-House	1996
Tennessee	Jeffrey G. Stockard, D.Ph.	615-507-6496	Contracted	Jul-01
Texas	Don Valdes, R.Ph.	512-491-1157	In-House	Feb-95
Utah	Tim Morley	801-538-6293	In-House	1994
Vermont	David Calabrese	508-421-8932	Contracted	Nov-93
Virginia	Rachel E. Cain, Pharm.D.	804-225-2873	Contracted	Jul-94
Washington	Nicole Nguyen, Pharm.D.	360-725-1757	In-House	Mar-96
West Virginia	Vicki M. Cunningham, R.Ph.	304-588-1700	Contracted	Mar-95
Wisconsin	Michael Mergener, R.Ph., Ph.D.	608-258-3348	Contracted	2001
Wyoming	Debra Devereux, R.Ph.	307-766-6750	Contracted	Oct-95

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

PRODUR = Prospective Drug Utilization Review System

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Prescribing/Dispensing Limits

Limits on		
State	Rx	Limits on Number, Quantity, and Refills of Prescriptions
Alabama	Yes	5 refills per Rx, 34 day supply per Rx, 4 brand limit per month
Alaska	Yes	30 day supply per Rx, maximum number units for 50 classes and 40 narcotics
Arizona*	-	-
Arkansas	Yes	31 day supply per Rx; 3 Rx per month (extension to 6); 5 refills per Rx within 6 months
California	Yes	6 Rx per month, maximum 100 day supply for most medications, 3 claims per drug within 75 days
Colorado	Yes	30 day quantity supply per Rx; 100 days maint. meds. Other limits may apply
Connecticut	Yes	240 units or 30 day supply, 5 refills per Rx except 12 month limit on oral contraceptives
Delaware	Yes	34 day supply or 100 unit doses per Rx (whichever is greater) or by therapeutic category
District of Columbia	Yes	30 day supply per Rx, 3 refills per Rx within 4 mos. Max/min quantities for certain meds
Florida	Yes	Vary according to the drug
Georgia	Yes	34 day supply per Rx; 5 (adult)/6 (child) Rx per month; Per Rx limit: \$2999.99 (potential override)
Hawaii	Yes	30 day supply or 100 unit doses per Rx, maximum quantities for some drugs
Idaho	Yes	34 day supply per Rx (with exceptions); 3 cycles of birth control; limits on refills/early refills
Illinois	Yes	Medically appropriate monthly quantity, 3 brand scripts per month, 11 refills per script
Indiana	No	-
Iowa	Yes	Maximum 30 day supply except oral contraceptives (90 days)
Kansas	Yes	31 day supply per Rx, 5 Rx per month, other limitations specific to certain medications
Kentucky	Yes	32 day supply, max. 5 refills in 6 months; 92 days/100 units for maintenance medication, 4 scripts/mo.
Louisiana	Yes	Greater of 30 day supply or 100 unit doses; 5 refills per Rx within 6 mos., max. 8 scripts/mo./recipient
Maine	Yes	34 day supply (brand), 90 day supply (generic); Max. 11 refills per Rx, 5 brand scripts per month
Maryland	Yes	34 day supply per Rx; maximum 11 refills per Rx, refills may not exceed 360 day supply
Massachusetts	Yes	30 day supply, per month limits on some drugs, maximum 5 refills per prescription
Michigan	Yes	100 day supply, quantity limits for selected drugs (e.g., sedative hypnotics)
Minnesota	Yes	34 day supply, quantity limits for selected drugs (triptans, antiemetics, sedatives)
Mississippi	Yes	31 day supply or 100 unit doses (whichever is greater); 5 Rx per month (no more than 2 brand); 11 refills maximum
Missouri	No	-
Montana	Yes	34 day supply
Nebraska	Yes	90 day/100 unit doses, 5 refills per Rx 6 mos. for controlled substances, 31 days for injectibles
Nevada	Yes	34 day supply per Rx; 100 day supply for maintenance medications. 5 refills within 6 months.
New Hampshire	Yes	34 day supply, 90 day supply on maintenance medications
New Jersey	Yes	34 day supply or 100 unit doses per Rx, 5 refills within 6 months
New Mexico	No	34 day supply, except contraceptives (100 days) and maintenance drugs (90 days)
New York	Yes	5 refills per Rx; annual limit on number of Rx and OTC drugs avail. (potential override)
North Carolina	Yes	34 day supply per Rx, with exceptions; 8 Rx per month with exceptions
North Dakota	Yes	34 day supply per Rx
Ohio	Yes	34 day supply; 102 day supply for maintenance medications; 5 refills per Rx
Oklahoma	Yes	6 Rx (incl. 3 brands) per month (21+; under 21 unlimited), 34 day supply or 100 unit doses per Rx
Oregon	Yes	34 day supply (100 days for mail order and maintenance drugs)
Pennsylvania	Yes	34 day supply or 100 unit doses per Rx (whichever is greater); 5 refills within 6 mos., 6 Rx per month
Rhode Island	Yes	30 day supply per Rx (non-maintenance); 5 refills per Rx
South Carolina	Yes	34 day supply w/ unlimited Rx (children); quantity limits on some drugs, 4 Rx per month (adult)
South Dakota	Yes	Varies by drug
Tennessee	Yes	Varies by basis of eligibility
Texas	Yes	3 Rx per month (unlimited Rx's for nursing home recipients or those < 21), max 5 refills or 6 months
Utah	Yes	31 day supply per Rx, max 5 refills, cumulative limit on specific drugs
Vermont	Yes	34 days (102 days for maintenance medications), 5 refills per Rx
Virginia	Yes	34 day supply per Rx
Washington	Yes	34 day supply per Rx; 2 scripts per month; except antibiotics and schedule drugs, 4 brand cap
West Virginia	Yes	34 day supply except antibiotics (14 days and 1 refill)
Wisconsin	Yes	34 day supply per Rx with exceptions, 5 refills for Schedule III, IV, & V drugs, max. 11 refills during 12-month period for non-schedule drugs
Wyoming	Yes	Quantity limits on some medications as deemed clinically appropriate.

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

PHARMACY PAYMENT AND PATIENT COST SHARING

Medicaid Payment for Outpatient Prescription Drugs. Federal Medicaid regulations prescribe the principles that apply to State Medicaid programs when they pay a pharmacy for outpatient drugs. These regulations don't just indicate the FFP cannot be based on amounts that exceed drug costs as determined under the federal formula; they indicate the actual method for paying for prescription drugs.

Medicaid Managed Care Organizations (MCOs). If the recipient is enrolled in a Medicaid managed care organization, payment is made to the MCO in accordance with its contract with the State Medicaid agency to the extent the contract covers outpatient prescribed drugs.

Medicaid Payment to Pharmacies. Each State's Medicaid State Plan must comprehensively describe its payment for prescription drugs. Its aggregate Medicaid expenditures for "multiple-source drugs" must not exceed the Federal Upper Limits published by CMS (see Appendix D) and its payment level for other drugs must not exceed, in the aggregate, the lower of (1) EAC plus a reasonable dispensing fee, or (2) providers' charges to the general public.

PATIENT COST SHARING

States are permitted to require certain recipients to share some of the costs of Medicaid by imposing on them such payments as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost-sharing charges (42 CFR 447.50). For States that impose cost-sharing payments, the regulations specify the standards and conditions under which States may impose cost-sharing, set forth minimum amounts and the methods for determining maximum amounts, and describe limitations on availability that relate to cost-sharing requirements.

With the passage of the Social Security Amendments of 1972, States were empowered to impose "nominal" cost-sharing requirements on optional Medicaid services for cash assistance recipients, and on any services for the medically needy. Section 131 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 introduced major changes to Medicaid cost-sharing requirements. Under this act, States may impose a nominal deductible, coinsurance, copayment, or similar charge on both categorically needy and medically needy persons for any service offered under the State Plan. Public Law 97-248, TEFRA, has been in effect since October 1982; it prohibits imposition of cost-sharing on the following:

- Services furnished to individuals under 18 years of age (or up to 21 at State option);
- Pregnancy-related services (or, at State option, any service provided to pregnant women);
- Services provided to certain institutionalized individuals, who are required to spend all of their income for medical care except for a personal needs allowance;
- Emergency services;
- Family planning services and supplies;
- Services furnished to categorically needy HMO enrollees (or, at State option, services provided to both categorically needy and medically needy HMO enrollees).

In addition, the law prohibits imposing more than one type of charge on any service.

While emergency services are excluded from cost sharing, States may apply for waivers of nominal amounts for non-emergency services furnished in hospital emergency rooms. Such a waiver allows States to impose a copayment amount up to twice the current maximum for such services. Approval of a waiver request by CMS is based partly on the State's assurance that recipients will have access to alternative sources of care.

Pharmacy Payment and Patient Cost Sharing

State	Dispensing Fee	Ingredient Reimbursement Basis	Copayment
Alabama	\$5.40	AWP- 10%; WAC+9.2%	\$0.50 - \$3.00
Alaska	\$3.45-\$11.46	AWP-5%	\$2.00
Arizona*	-	-	-
Arkansas	\$5.51 (\$7.51 non-MAC generics)	B: AWP-14%, G: AWP-20%	\$0.50 - \$5.00
California	\$7.25 (\$8.00 for LTC)	AWP-17%	\$1.00
Colorado	\$4.00; \$1.89 Inst. & dispensing physicians >25 miles from participating pharmacy	AWP-13.5% or direct pricing +18%; AWP-35% (for generics)	B: \$3.00, G: \$1.00
Connecticut	\$3.15	AWP-14%	None
Delaware	\$3.65	AWP-14%, AWP-16% (LTC)	\$0.50 - \$3.00
District of Columbia	\$4.50	AWP-10%	\$1.00
Florida	\$4.23	AWP-15.4%; WAC+5.75%	None
Georgia	\$4.63 (for profit), \$4.33 (non-profit)	AWP-11%	G/P: \$0.50, B/NP: \$0.50 - \$3.00
Hawaii	\$4.67	AWP-10.5%	None
Idaho	\$4.94 (\$5.54 for unit dose)	AWP-12%	None
Illinois	G: \$4.60, B: \$3.40	B: AWP-12%	B: \$3.00
Indiana	\$4.90	B: AWP-13.5%, G: AWP-20%	\$3.00
Iowa	\$4.39	AWP-12%	\$0.50-\$3.00
Kansas	\$3.40	B: AWP-13%, G: AWP-27%, IV AWP-50%, blood AWP-30%	\$3.00
Kentucky	\$4.51	AWP-12%	\$1.00 - \$3.00
Louisiana	\$4.59 (avg.) to \$5.77	AWP-13.5% (AWP-15% for chains)	\$0.50 - \$3.00
Maine	\$3.35	AWP-15%	\$2.00, Max \$25/rec/pharm/mo
Maryland	\$2.69-\$4.69	Lowest of :WAC+8%, direct+8%, AWP-12%	\$3.00 Brand not on PDL, \$1.00 Brand on PDL & generics
Massachusetts	\$3.50 - \$5.00	WAC+5%	B: \$3.00, G and OTC: \$1.00
Michigan	\$2.50 (\$2.75 - LTC)	AWP-13.5% (1-4 stores), AWP-15.1% (5+stores)	B: \$3.00, G: \$1.00, ABW: \$1.00
Minnesota	\$3.65	AWP-12%	B: \$3.00, G: \$1.00
Mississippi	\$3.91 sole source, \$4.91 multisource	AWP-12% or WAC+9%	\$3.00
Missouri	\$4.09 - \$8.19	AWP-10.43%, WAC+10%	\$0.50 - \$2.00, \$5.00 for some 1115 waiver pop.
Montana	\$2.00 - \$4.70, \$3.50 out-of-state	AWP-15%	\$1.00 - \$5.00
Nebraska	\$3.27 - \$5.00	AWP-11%	\$2.00
Nevada	\$4.76	AWP-15%	B: \$3.00, G: \$1.00, (dual eligibles)
New Hampshire	\$1.75	AWP-16%	B: \$2.00, G: \$1.00
New Jersey	\$3.70 - \$4.07	AWP-12.75%	None
New Mexico	\$3.65	AWP-14%	None (except \$5.00 for CHIP and working disabled)
New York	B: \$3.50, G: \$4.50	B: AWP-12. 75%:, G: AWP-16.50%	B: \$3.00, G: \$1.00, OTC: \$0.50
North Carolina	B: \$4.00, G: \$5.60	AWP-10%	\$3.00
North Dakota	B: \$4.60, G: \$5.60	Lowest of AWP-10%, EAC+12.5% or MAC	\$3.00 (Brand)
Ohio	\$3.70	WAC +7%	B: \$3.00, PA: \$3.00
Oklahoma	\$4.15	AWP-12.0%	\$1.00 - \$2.00
Oregon	Retail: \$3.50, Inst./NF: \$3.91	AWP-15% (retail), AWP-11% (inst.)	B: \$3.00, G: \$2.00
Pennsylvania	\$4.00 (\$5.00 for compounds)	AWP-10%, WAC+7%	B: \$3.00, G: \$1.00
Rhode Island	\$3.40 (LTC: \$2.85)	WAC+10%	None
South Carolina	\$4.05	AWP-10%	\$3.00
South Dakota	\$4.75 (\$5.55 for unit dose)	AWP-10.5%	B: \$3.00, G: no copay
Tennessee	\$2.50	AWP-13%	Varies by eligibility status
Texas	\$5.14	AWP-15% or WAC+12%, whichever is lowest	None
Utah	\$3.90 (urban), \$4.40 (rural), \$1.00 OTC	AWP-15%	\$3.00
Vermont	\$4.75	AWP-11.9%	\$1.00 - \$3.00 dep. on Rx Cost
Virginia	\$4.00	AWP-10.25%	B: \$3.00, G: \$1.00
Washington	\$4.24-\$5.25 (based on annual # of Rx)	AWP-14%, AWP-50% (>5 labelers)	None
West Virginia	\$3.90 (+ extra \$1.00 for compounding)	AWP-12%	\$0.50 - \$3.00
Wisconsin	\$4.88 (to a maximum \$40.11)	AWP-13%	\$1.00-\$3.00, max \$12/rec/pharm/mo
Wyoming	\$5.00	AWP-11%	G: \$1.00, PB: \$2.00, NP: \$3.00

WAC = Wholesalers Acquisition Cost; AWP = Average Wholesale Price; EAC = Estimated Acquisition Cost; AAC= Actual Acquisition Cost;

G = Generic; B = Brand Name; OP = Outpatient; LTC = Long Term Care; P = Preferred; NP = Non-Preferred; PDL= Preferred Drug List; PB = Preferred Brand

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Maximum Allowable Cost (MAC) Programs

State	Federal Upper Limits	State-Specific Upper Limits	MAC Override Provisions
Alabama	Yes	Yes	Dispense as written, brand medically necessary
Alaska	Yes	No	Brand medically necessary and reason
Arizona*	-	-	-
Arkansas	Yes	Yes	Brand medically necessary MedWatch indicating why generics cannot be dispensed
California	Yes	Yes	Medically necessary and product unavailable at MAC rate
Colorado	Yes	Yes	Medically necessary
Connecticut	Yes	Yes	No physician MAC override
Delaware	Yes	Yes	MedWatch form for prior authorization
District of Columbia	No	No	-
Florida	Yes	Yes	MedWatch form and prior authorization request
Georgia	Yes	Yes	Brand medically necessary and MedWatch form
Hawaii	Yes	Yes	Brand medically necessary or do not substitute on script
Idaho	Yes	Yes	Medically necessary with appropriate documentation
Illinois	Yes	Yes	Prior authorization request by M.D. justifying need for brand
Indiana	Yes	Yes	Brand medically necessary, prior authorization
Iowa	Yes	Yes	Brand medically necessary
Kansas	Yes	Yes	Prior authorization and MedWatch form
Kentucky	Yes	Yes	Brand necessary, brand medically necessary, plus PA on some drugs
Louisiana	Yes	Yes	Brand necessary, brand medically necessary
Maine	Yes	Yes	Brand medically necessary and prior authorization
Maryland	No	Yes	Brand medically necessary and MedWatch form
Massachusetts	Yes	Yes	Dispense as written, brand medically necessary, plus prior authorization
Michigan	Yes	Yes	Prior authorization with appropriate documentation
Minnesota	Yes	Yes	Dispense as written, brand medically necessary, must meet PA criteria
Mississippi	Yes	No	Dispense as written or prior authorization for brand multi-source
Missouri	Yes	Yes	Brand medically necessary, prior authorization and MedWatch form
Montana	Yes	No	Dispense as written, medically necessary
Nebraska	Yes	Yes	State-specific form
Nevada	Yes	Yes	Brand medically necessary
New Hampshire	Yes	Yes	Brand medically necessary, dispense as written
New Jersey	Yes	No	Dispense as written, medically necessary
New Mexico	Yes	Yes	Brand necessary, brand medically necessary
New York	Yes	No	Prior authorization
North Carolina	Yes	Yes	Brand medically necessary in writing on prescription
North Dakota	Yes	Yes	Dispense as written
Ohio	Yes	Yes	Prior authorization
Oklahoma	Yes	Yes	Brand medically necessary
Oregon	Yes	Yes	Dispense as written, medically necessary
Pennsylvania	Yes	Yes	Prior authorization and documentation of generic intolerance
Rhode Island	No	No	Dispense as written with justification
South Carolina	Yes	Yes	Brand medically necessary w/cert. by prescriber and prior authorization
South Dakota	Yes	Yes	Brand necessary, brand medically necessary
Tennessee	Yes	Yes	Dispense as written
Texas	Yes	Yes	Brand necessary, brand medically necessary
Utah	Yes	Yes	Prior approval plus documentation of generic failure
Vermont	Yes	Yes	Dispense as written, medically necessary, brand necessary, brand medically necessary or DAW 8 (generic not available)
Virginia	Yes	Yes	Medically necessary in physician's own handwriting
Washington	Yes	Yes	Brand medically necessary
West Virginia	Yes	Yes	Brand medically necessary
Wisconsin	No	Yes	Brand medically necessary plus prior authorization
Wyoming	Yes	Yes	Brand medically necessary

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Mandatory Substitution

State	Incentive Fee for Generic Substitution	Dispensing of Generic Multi-Source Required	Dispensing of Lowest Cost Multi-Source Required
Alabama	No	No	No
Alaska	No	Yes	No
Arizona*	-	-	-
Arkansas	\$2.00	Yes	Yes
California	No	No	Yes
Colorado	No	Yes	No
Connecticut	No	Yes	No
Delaware	No	Yes	No
District of Columbia	No	Yes	No
Florida	No	Yes	No
Georgia	No	Yes	Yes
Hawaii	No	Yes	No
Idaho	No	Yes	No
Illinois	No	No	No
Indiana	No	Yes	Yes
Iowa	No	Yes	Yes
Kansas	No	Yes	No
Kentucky	No	Yes	Yes
Louisiana	No	No	No
Maine	No	No	Yes
Maryland	No	No	No
Massachusetts	No	Yes	No
Michigan	No	No	No
Minnesota	No	Yes	No
Mississippi	No	Yes	No
Missouri	No	Yes	Yes
Montana	No	Yes	No
Nebraska	No	No	No
Nevada	No	Yes	No
New Hampshire	No	Yes	No
New Jersey	No	Yes	No
New Mexico	No	No	No
New York	\$1.00	Yes	No
North Carolina	\$1.60	Yes	Yes
North Dakota	No	Yes	No
Ohio	No	No	No
Oklahoma	No	Yes	No
Oregon	No	Yes, if 2+AB-rated generics	No
Pennsylvania	No	Yes	No
Rhode Island	No	Yes	No
South Carolina	No	Yes	Yes
South Dakota	No	No	No
Tennessee	No	Yes	Yes
Texas	\$0.50 if supplemental rebate	Yes	No
Utah	No	Yes	Yes
Vermont	No	Yes	No
Virginia	No	Yes	No
Washington	No	No	Yes
West Virginia	No	Yes	No
Wisconsin	No	Yes	No
Wyoming	No	Yes	No

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

Counseling Requirements and Payment for Cognitive Services

State	Medicaid Patient Counseling Required ¹	Medicaid Payment for Cognitive Services ²
Alabama	Yes	No
Alaska	Yes	No
Arizona	Yes	-
Arkansas	Yes	No
California	When patient present in pharmacy	No
Colorado	Yes	No
Connecticut	Yes	No
Delaware	Yes	No
District of Columbia	Yes	No
Florida	Only an offer to counsel is required	No
Georgia	Yes	No
Hawaii	Yes	Yes (emergency contraception)
Idaho	Yes	No
Illinois	Only an offer to counsel is required	No
Indiana	Only an offer to counsel is required	No
Iowa	Yes	Yes (pharm. case management)
Kansas	Yes	No
Kentucky	Yes	No
Louisiana	Yes	No
Maine	Yes	No
Maryland	Yes	No
Massachusetts	Only an offer to counsel is required	No
Michigan	Yes	No
Minnesota	Yes	Yes (pat. w/ 4 or more meds or > 2 disease states)
Mississippi	Yes	Yes (diabetes, asthma, coagulation, and lipids)
Missouri	Yes	Yes (diabetes, asthma, heart failure, and depression education)
Montana	Yes	No
Nebraska	Yes	No
Nevada	Yes	No
New Hampshire	Yes	No
New Jersey	Yes	No
New Mexico	Yes	No
New York	Yes	No
North Carolina	Yes	No
North Dakota	Yes	No
Ohio	Only an offer to counsel is required	No
Oklahoma	When applicable/appropriate	No
Oregon	Yes	No
Pennsylvania	Yes	No
Rhode Island	Only an offer to counsel is required	No
South Carolina	Yes	No
South Dakota	Yes	No
Tennessee	Yes	No
Texas	Yes	No
Utah	Yes	No
Vermont	Yes	No
Virginia	Yes	No
Washington	Yes	Yes (emerg. contraceptive counseling, clozaril case management)
West Virginia	Only an offer to counsel is required	No
Wisconsin	Yes	Yes
Wyoming	Only an offer to counsel is required	No

Sources: ¹2006 National Association of Boards of Pharmacy Law, Survey of Pharmacy Law; ²As reported by State drug program administrators in the 2005/2006 NPC Survey

Prescription Price Updating

State	Contact	Telephone	Updated
Alabama	Stephanie Frawley	334-353-4592	Biweekly
Alaska	Dave Campana, R.Ph.	907-334-2425	Weekly
Arizona*	-	-	-
Arkansas	First DataBank	650-588-5454	Weekly
California	EDS Federal Corp.	916-636-1000	Monthly
Colorado	Cathy Traugott	303-866-2468	Weekly
Connecticut	Melissa Johnson	860-832-5896	Weekly
Delaware	Cynthia R. Denemark, R.Ph.	302-453-8453	Weekly
District of Columbia	Christine Quinn	202-906-8344	Monthly
Florida	First DataBank	650-588-5454	Weekly
Georgia	Express Scripts	770-552-3793	Daily
Hawaii	ACS State Healthcare	800-358-2381	Weekly
Idaho	Mary Wheatley, R.Ph.	208-364-1832	Weekly
Illinois	First DataBank	650-588-5454	Weekly
Indiana	First DataBank	650-588-5454	Weekly
Iowa	Sandy Pranger, R.Ph.	515-725-1272	Weekly
Kansas	Mary H. Lesperance	785-296-3981	Weekly
Kentucky	Bernice Shelton	502-209-3176	Weekly
Louisiana	Maggie Vick, Unisys Corp.	225-216-6251	Weekly
Maine	Marcia Pykare	207-622-7153	Weekly
Maryland	First DataBank	650-588-5454	Weekly
Massachusetts	First DataBank	650-588-5454	Weekly
Michigan	First Health Service Corp.	877-864-9014	Weekly
Minnesota	First DataBank	650-588-5454	Weekly
Mississippi	Terri R. Kirby, R.Ph.	601-359-5253	Weekly
Missouri	First DataBank	650-588-5454	Weekly
Montana	First DataBank	650-588-5454	Weekly
Nebraska	Barbara Mart	402-471-9301	Weekly
Nevada	First DataBank	650-588-5454	Monthly
New Hampshire	First Health Services Corp.	800-884-2822	Weekly
New Jersey	First DataBank	650-588-5454	Weekly
New Mexico	First DataBank	800-633-3453	Weekly
New York	Carl Cioppa, Pharm.D.	518-474-9219	Monthly
North Carolina	Tom D'Andrea, R.Ph., M.B.A.	919-855-4300	Weekly
North Dakota	Brendan K. Joyce, Pharm.D., R.Ph.	701-328-4023	Biweekly
Ohio	First DataBank	650-588-5454	Monthly
Oklahoma	First DataBank	800-633-3453	Weekly
Oregon	First Health Service Corp.	503-391-1980	Biweekly
Pennsylvania	Janet Solomon	717-346-8164	Monthly
Rhode Island	Paula Avarista, R.Ph., M.B.A.	401-462-6390	Biweekly
South Carolina	First DataBank	650-588-5454	Weekly
South Dakota	Mark Petersen, R.Ph.	605-773-3498	Biweekly
Tennessee	First DataBank	650-588-5454	Weekly
Texas	Betty Wasko	512-491-1155	Weekly
Utah	RaeDell Ashley, R.Ph.	801-538-6495	Biweekly
Vermont	Ann Bennett	802-879-5900	Monthly
Virginia	Keith T. Hayashi	804-225-2773	Weekly
Washington	Johnna Ziegler	360-725-1841	Weekly
West Virginia	Eric N. Sears, R.Ph.	304-348-3316	Weekly
Wisconsin	First DataBank	800-633-3453	Biweekly
Wyoming	First DataBank	800-633-3453	Weekly

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2005/2006 NPC Survey.

**Section 5:
State Pharmacy Program
Profiles**

Profiles of State Medicaid Drug Programs

In the following State profiles, we present a general overview of the characteristics of State programs together with detailed information on the pharmaceutical benefits provided. Specifically, the following information is provided for each State:

- A. Benefits Provided and Groups Eligible
- B. Expenditures for Drugs
- C. Administration
- D. Provisions Relating to Drugs, including:
 - Drug Benefit Product Coverage
 - Over-the-Counter Product Coverage
 - Therapeutic Category Coverage
 - Coverage of Injectables, Vaccines, and Unit Dosing
 - Formulary/Prior Authorization
 - Prescribing or Dispensing Limitations
 - Drug Utilization Review
 - Dispensing Fee
 - Ingredient Reimbursement Basis
 - Prescription Charge Formula
 - Maximum Allowable Cost
 - Incentive Fee
 - Patient Cost Sharing
 - Cognitive Services
- E. Use of Managed Care
- F. State Contacts

ALABAMA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2004		2005	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$593,790,733	539,061	\$622,777,164	\$544,400
RECEIVING CASH ASSISTANCE TOTAL	\$396,277,544	193,686	\$410,969,308	191,182
Aged	\$37,902,460	19,203	\$39,915,708	17,699
Blind/Disabled	\$336,903,013	138,283	\$353,786,496	138,297
Child	\$4,443,212	12,541	\$3,692,129	10,537
Adult	\$17,028,858	23,659	\$17,574,973	24,649
MEDICALLY NEEDY, TOTAL	\$0	0	\$0	0
Aged	\$0	0	\$0	0
Blind/Disabled	\$0	0	\$0	0
Child	\$0	0	\$0	0
Adult	\$0	0	\$0	0
POVERTY RELATED, TOTAL	\$85,990,954	269,353	\$88,675,021	272,673
Aged/Blind/Disabled	\$3,725,703	3,019	\$4,521,741	3,022
Child	\$79,440,211	250,945	\$81,519,379	254,291
Adult	\$2,825,039	15,389	\$2,633,900	15,360
BCCA Women	\$0	0	\$0	0
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$111,522,233	76,022	\$123,132,834	80,545

*Total other expenditures/recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

Source: Alabama Medicaid Statistical Information System, 2004 and 2005.

C. ADMINISTRATION

Alabama Medicaid Agency.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: disposable needles and syringe combinations used for insulin. Products covered with restrictions: prescribed insulin (on PDL and max units apply); total parenteral nutrition (cert. of med. necessity on script); and interdialytic parenteral nutrition (cert. of med. necessity on script). Products covered as DME: blood glucose test strips; urine ketone test strips. Products not covered: cosmetics; fertility drugs; experimental drugs; drugs for anorexia or weight gain; hair growth products; and DESI drugs.

Over-the-Counter Product Coverage: Products covered if prescribed by a physician: allergy, asthma and sinus products; analgesics; cough and cold preparations (generics only); digestive products; feminine products; topical products; prenatal vitamins; and hemorrhoidal products. Products not covered: smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories covered: anticoagulants; anticonvulsants; anti-psychotics; chemotherapy agents; prescribed cold medications; contraceptives; and thyroid agents. Prior authorization required for: analgesics; antipyretics, and NSAIDs; antibiotics; antidepressants; antidiabetic agents; antihistamines; antilipemic agents; anxiolytics, sedatives, and hypnotics; cardiac drugs; ENT anti-inflammatory agents; estrogens; growth hormones; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); skeletal muscle relaxants; skin and mucous membrane agents; triptan agents; respiratory agents; PPIs; platelet aggregation inhibitors; Alzheimer's Disease agents; ADHD agents; anti-infective agents; EENT anti-allergic agents; H2 antagonists; intranasal corticosteroids; narcotic agents; nutritional supplements; Retina A; Dipyrindamole; and Synagis. Therapeutic categories not covered: anabolic steroids; anoretics; prescribed smoking deterrents; and OBRA 90 excludables.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in extended care facilities, and through physician payment when used in physicians' offices and home health care.

Vaccines: Vaccines reimbursable as part of the EPSDT service.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list. Formulary managed through restrictions on use, prior authorization, preferred products, and physician profiling. Prior authorization required for non-preferred drugs. Anti-psychotics and HIV/AIDs drugs are exempted from the prior authorization requirements. (For additional information see: www.medicaid.alabama.gov)

Prior Authorization: State currently has a formal prior authorization procedure. Prior authorization decisions may be appealed by physician submitting written notice along with medical documentation (i.e., peer reviewed literature and medical records) to the administrative services contractor for physician review. The request is forwarded to the Medicaid agency's Medical Director for review.

Prescribing or Dispensing Limitations

Prescription Refill Limit: maximum of five refills for controlled substance, 11 for non-controlled.

Monthly Quantity Limit: 34-day supply.

Monthly Prescription Limit: four brand limit.

Drug Utilization Review

PRODUR system implemented in July 1996. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$5.40 (additional reimbursement for compounding).

Ingredient Reimbursement Basis: AWP-10%, WAC + 9.2%.

Prescription Charge Formula: Medicaid pays for prescribed legend and non-legend drugs authorized under the program based upon and shall not exceed the lowest of:

1. The Federal Upper Limit or Maximum Allowable Cost (MAC) of the drug plus a dispensing fee,
2. The Estimated Acquisition Cost (EAC) of the drug plus a dispensing fee, or
3. The provider's usual and customary charge to the public for the drug.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Dispense as Written" or "Brand Medically Necessary" in the physician's own handwriting. Approximately 13,000 drugs on State-specific MAC list.

Incentive Fee: None.

Patient Cost Sharing: Tiered copayment.

<u>Drug Ingredient Cost</u>	<u>Copayment</u>
\$0.00 to \$10.00	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00

Exemptions: No copayment amount is to be collected by the pharmacy or paid by the recipient for recipients under age 18, pregnant, or living in nursing facilities.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Does not use MCOs to deliver services to Medicaid recipients.

F. STATE CONTACTS

State Drug Program Administrator

Kelli D. Littlejohn, R.Ph.
Director of Pharmacy
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Prior Authorization Contact

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DUR Contact

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Medicaid DUR Board

John Searcy, M.D.
Jimmy Jackson, R.Ph.
Darin Elliot, Pharm.D.
J. Kevin Royal, M.D.
W. Kevin Green, M.D.
Bernie Olin, Pharm.D.
Kelli D. Littlejohn, R.Ph.
Paula Thompson, Pharm.D.
B. Jerome Harrison, M.D.
Steven Rostand, M.D.
Rhonda Harden, Pharm.D.
Rob Colburn, R.Ph. (Chair)
Clemice Hurst, R.Ph.

New Brand Name Products Contact

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Prescription Price Updating

Stephanie Frawley
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Medicaid Drug Rebate Contact

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Claims Submission Contact

Cyndi Crocket, Supervisor
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301 Technacenter Dr.
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Medicaid Managed Care Contact

Mary Timmerman
Associate Director Medical Services
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P.O. Box 5624
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334/242-5014

Mail Order Pharmacy Program

None

Disease Management/Patient Education Programs

Disease/Medical State: Diabetes
Program Name: Diabetes In Home Monitoring
Program Manager: Paige Clark, Medical Services
Program Sponsor: Univ. of South Alabama/Alabama
Dept. of Public Health.

Disease Management Program/Initiative Contact

Kathy Hall
Deputy Commissioner Program Administration
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Alabama Medicaid Agency Officials

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Title XIX Medical Care Advisory Committee

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John Searcy, M.D.
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Karin Scott
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Donald Williamson, M.D.
Helen Wilson

Pharmacy and Therapeutics Committee

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Richard Freeman, M.D.
Ben Main, R.Ph.
Lucy Culpepper, M.D.
W. Thomas Geary, Jr., M.D.
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Mary McIntyre, M.D.
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Health Advocacy Plus

Vickie Little, R.Ph.
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Alison Wingate
Alabama Retail Association

Steve Frawley, R.Ph.
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Kenny Sanders, R.Ph.
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Bob Hager, R.Ph.
American Pharmacy Cooperative, Inc.

Sharon Taylor
Alabama Independent Drug Store Association

Norman Davis, R.Ph.
Alabama Independent Drug Store Association

Cary Kuhlmann
Medical Association of Alabama

**Executive Officers of State Medical and
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ALASKA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. DRUG PAYMENTS AND RECIPIENTS

	2004		2005	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$104,722,128	72,748	\$127,792,222	76,557
RECEIVING CASH ASSISTANCE TOTAL	\$79,671,127	34,108	\$97,510,121	35,046
Aged	\$14,457,796	5,105	\$17,960,921	5,267
Blind/Disabled	\$52,834,213	10,188	\$65,660,858	10,895
Child	\$2,525,455	9,009	\$2,796,568	8,937
Adult	\$9,853,663	9,806	\$11,091,774	9,947
MEDICALLY NEEDY, TOTAL	\$13,029,036	32,700	\$14,966,546	35,337
Aged	\$16,177	12	\$36,526	8
Blind/Disabled	\$11,481	6	\$29,360	6
Child	\$11,842,695	29,153	\$13,283,959	31,237
Adult	\$1,158,683	3,529	\$1,616,701	4,086
POVERTY RELATED, TOTAL	\$10,616,384	4,744	\$13,385,244	4,647
Aged	\$3,576,720	735	\$4,323,747	787
Blind/Disabled	\$4,885,800	906	\$6,018,580	963
Child	\$1,365,215	2,137	\$2,119,077	1,908
Adult	\$788,649	966	\$923,840	989
BCCA Women	\$0	0	\$0	0
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$1,405,581	1,196	\$1,930,311	1,527

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

Source: Alaska Medicaid Management Information System, FY 2004 and 2005.

C. ADMINISTRATION

Department of Health and Social Services, Division of Health Care Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: cosmetics (covered with restrictions- non hair growth products); prescribed insulin. Covered under DME: disposable needles and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition; and interdialytic parenteral nutrition. Prior authorization required for: Clozaril; Lupron Depot; ADC infant vitamins; some DME; Synagis; Panretin; Botox; Byetta; Clozapine; Revatio; Carisoprodol; and Actig Naltrexone. Products not covered: fertility drugs and experimental drugs.

Over-the Counter Product Coverage: Products covered: Smoking deterrent products. Products covered with restrictions: feminine products (spermicides and vaginal miconazole and clotrimazole); topical products (Bacitracin ointment only). Products not covered: allergy, asthma, and sinus products; analgesics; cough and cold preparations; and digestive products.

Therapeutic Category Coverage: Categories covered: anabolic steroids; antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: analgesics, antipyretics, and NSAIDs; growth hormones; misc. GI drugs; and prescribed smoking deterrents. Categories not covered: anoretics; prescribed cold medications; amphetamines (except for narcolepsy and hyperactivity); cough suppressants; DESI drugs; vitamins (except prenatal); and vitamins with fluoride.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment when used in physicians' offices.

Vaccines: Vaccines reimbursable at cost as part of EPSDT services and the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list (PDL). PDL managed by exclusion of products based on contracting issues and preferred products.

Prior Authorization: State currently has a formal prior authorization procedure. Request for fair hearing required for appealing coverage of an excluded product and PA decision. Medical necessity form required.

Prescribing or Dispensing Limitations

Monthly Quantity Limit: Prescriptions are limited to 30-day supplies (except family planning drugs). Dispensing of generic multi-source product is required. Maximum number of units for about 50 therapeutic classes and 40 narcotic analgesics.

Drug Utilization Review

PRODUR system implemented in June 1995. State currently has a 5-member DUR Board that meets six times per year.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.45 - \$11.46

- 1) \$23,192 added to the number resulting from multiplying total prescriptions filled by that pharmacy in the previous calendar year by 5.070;
- 2) to 1), add the result of multiplying total Medicaid prescriptions filled in the previous calendar year by 12.44;
- 3) from 2), subtract the result of multiplying the total floor space volume of the pharmacy in sq. ft. by 2.103;
- 4) divide 3) by total prescriptions filled by that pharmacy
- 5) add \$0.73 to 4)

Extra fee for compounding:

Long-term care pharmacies receive highest dispensing fee once per month per NDC.

Ingredient Reimbursement Basis: EAC = AWP-5%.

Maximum Allowable Cost: State imposes Federal Upper Limits on generic drugs. Override requires "Brand Medically Necessary" and the reason of necessity.

Incentive Fee: None.

Cognitive Services: Does not pay for cognitive services.

Patient Cost Sharing: \$2.00 copayment for branded and generic products.

E. USE OF MANAGED CARE

Does not use MCOs to deliver services to Medicaid recipients.

F. STATE CONTACTS

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DUR Contact

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New Brand Name Products Contact

Dave Campana, R.Ph.
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Prescription Price Updating

Dave Campana, R.Ph.
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Medicaid Drug Rebate Contact

Dave Campana, R.Ph.
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Claims Submission Contact

First Health Services Corporation
4300 Cox Road
Glen Allen, VA 23060
800/965-7400

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Mail Order Pharmacy Benefit

Yes, for all Medicaid recipients residing in rural areas.

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ARIZONA

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS - PRONOUNCED "ACCESS")

AHCCCS FEATURES

The Arizona Health Care Cost-Containment System (AHCCCS), Arizona's Medicaid program, is a Title XIX (Medicaid) 1115 Research and Demonstration Waiver project, jointly funded by the federal government and the State of Arizona. AHCCCS was created to defray the cost of indigent health care. Implemented in October 1982, it serves as a model for providing medical services to the indigent in a managed care system rather than through fee-for-service arrangements. Typically, Medicaid programs have incorporated the traditional hallmarks of the U.S. health care system: namely, independent providers and fee-for-service reimbursement. In contrast, organized health plans and capitation mark the AHCCCS model. This capitated model, although new to Medicaid in 1982, was patterned on the way many consumers paid for private healthcare insurance.

AHCCCS is a partnership between the State and private and public managed care health plans, opening up the private physician network to Medicaid recipients and allowing AHCCCS members to choose a primary care provider who acts as a gatekeeper and case manager. In traditional Medicaid programs, the States assume responsibility for contracting with individual pharmacies and reimbursing them. In the AHCCCS model however, the State contracts, instead, with pre-paid health plans, HMOs and HMO-like entities. These plans are paid on a capitation basis and are responsible for providing all of the services covered by the program.

Thus, with the exception of behavioral health drugs which are carved out of managed care, the delivery of pharmacy services is the responsibility of each prepaid plan.

GENERAL INFORMATION

The Arizona Health Care Cost Containment System (AHCCCS), developed in Senate Bill 1001, was passed by the Legislature and signed by the Governor in November 1981. It contained six major mechanisms for restraining health care costs at the same time ensuring that appropriate levels of quality health care services are provided to eligible persons in a dignified fashion. The goal of these 6 items was to contribute to the establishment of health care

financing that is less expensive than conventional fee-for-service systems. The six mechanisms were:

- Primary Care Physicians Acting as Gatekeepers
- Prepaid Capitated Financing
- Competitive Bidding Process
- Cost Sharing
- Limitations on Freedom-of-Choice
- Capitation of the State by the Federal Government.

Primary Care Physicians as Gatekeepers

AHCCCS legislation provided that all members must be under the care and supervision of a primary care physician who assumed the role of gatekeeper. A statewide network of primary care physicians was established to perform the gatekeeping function for the system and manage all aspects of a member's medical care.

Prepaid Capitated Financing

It was the intent of the AHCCCS legislation that health plans and their providers offer all covered services to groups of members within a geographical area for a fixed price, for a definite period. The law allowed for the establishment of a statewide bidding process to accomplish this. Services are provided on a county-by-county basis, by prepaid health plans. Providers may bid on a prepaid capitated basis for covered services to be provided within a particular county. The law allows for expansion and contraction of bids to achieve the best possible system. In the event there are insufficient bids for a given area, the legislation permits capped fee-for-service arrangements. It is intended, however, that capped fee-for-service will be authorized as a last resort only.

In essence, AHCCCS prepaid health plans (PHPs), health maintenance organizations (HMOs), and other types of organized health delivery systems charge a fixed fee per individual enrolled (i.e., a capitation rate) and assume responsibility for providing a broad array of health care services to members. The plan or contractor is then "at risk" to deliver the necessary services within the capitated amount. AHCCCS receives Federal, State, and county funds to operate, plus some monies from Arizona's tobacco tax.

Competitive Bidding Process

The statewide competitive aspect of the bid process for selecting providers and offering prepaid capitated services is the most unique feature of the AHCCCS model. A competition of this magnitude had never been attempted in any other State. The AHCCCS administration believes competitive bidding for health care service contracts, as opposed to conventional negotiation processes, provides accessible cost-effective delivery of health care without sacrificing quality performance.

The AHCCCS administration issues an invitation to qualified health plans once every five years. Qualified health plans may bid to offer the full range of AHCCCS services in one or more counties.

Cost Sharing

The fourth major device for containing costs in the AHCCCS model is a provision for cost sharing by users. A statewide copayment schedule was developed for this purpose, and the medically needy participate in coinsurance cost sharing. It is expected that the imposition of nominal copayments will ensure optimal effectiveness in the area of service utilization. The copayment schedule accomplishes three objectives: curtailment of over-utilization; enhancement of patient dignity; and service utilization by members for truly needed health care. There is no copayment for drugs and medication, prenatal care including all obstetrical visits, members in long care facilities and for visits scheduled by the primary care physician or practitioner, and not at the request of the member.

Limitations On Freedom-of-Choice

The fifth major item for containing costs is a restriction on provider/physician selection by AHCCCS members. Unlike conventional delivery models, Arizona does not rely on fee-for-service arrangements. The goal is to have the State completely blanketed with prepaid capitated arrangements. Members are linked to selected or assigned plans for definite durations of time. Freedom-of-choice is permitted to the extent practicable for members to select the particular group with which to enroll, as well as the primary care physician within the selected group. Capped fee-for-service health service arrangements are used as a last resort, and only in areas not covered by prepaid capitated plans.

CAPITATION BY THE FEDERAL GOVERNMENT

The State of Arizona will itself be capitated by the Federal government and therefore will be at financial risk for containing health care costs. Capitation rates will be established according to sound actuarial principles, and will represent no more than 95 percent of the estimated cost of services delivered in Arizona under conventional fee-for-service arrangements. Capitation provides a key incentive for the State to monitor health care costs on a careful and continuous basis.

IMPLEMENTATION OF AHCCCS

AHCCCS is based on plans that have been tested, in part, on smaller scales in different areas of the country. By combining a number of key mechanisms on a statewide basis, AHCCCS represents a novel health care model. The purpose of this section is to present a discussion of how the key concepts embodied in the AHCCCS legislation will be implemented and rendered operational.

Provider Participation

Providers may participate in AHCCCS in 2 different ways. First, they may contract with prepaid capitated plans as either full or partial benefit providers.

The second mode of participation is on a capped fee-for-service basis. Here, providers agree to accept capped fee payments as payments in full for services provided on a FFS basis.

Functions of the AHCCCS Administration

The Arizona Health Care Containment System Administration (AHCCCSA) contracts with full benefit capitated health plans to serve AHCCCS members through a network of providers.

Contracting Health Plans

Under the Contracting Health Plan arrangement, plans are defined in terms of explicit groups of providers organized as entities that are more formal. These consortia, or formal entities, are capable of providing the full range of AHCCCS benefits within a defined service area for all AHCCCS members who elect to join the plans, up to a predetermined capacity. This is the dominant mode of operation within AHCCCS -- with two or more competing plans wherever possible.

The Contracting Health Plans are delivery systems, not simply insurance plans, but they need not be Health Maintenance Organizations by any legal or conventional definition of the term. The AHCCCS legislation provides for the creation of provider consortia for the purpose of participation in the program. The Contracting Health Plan may be a loosely organized system, but it must be capable of providing the full range of AHCCCS benefits to a defined population at a capitation rate.

The Organizational Role of AHCCCS Administration

The AHCCCS Administration has been charged with the general implementation and monitoring of the AHCCCS program.

The AHCCCS Administration develops the Rules and Regulations; manages the health plan bidding processes; awards the contracts; provides technical assistance to providers for the purpose of forming consortia to contract with AHCCCS; and monitors the overall operation of the program. The State also provides regulatory oversight, including operational and financial oversight of the plans and contract monitoring to ensure quality of care.

The Operational Role of the AHCCCS Administration

Organizationally, the AHCCCS Administration assumes responsibility for the oversight of every day operations.

The AHCCCS Administration has overall responsibility for the following activity areas:

- Eligibility Oversight
- Procurement of Health Plans
- Quality Management
- Health Plan Oversight
- Provider, Member Call Center
- Grievances and Complaints
- Fee-for-Service for IHS

AHCCCS became effective December 1, 1981, and services commenced October 1, 1982. Services include: inpatient, outpatient, laboratory, long-term care, x-ray, prescription drugs, medical supplies, prosthetic devices, emergency dental care including extractions and dentures, treatment of eye conditions and EPSDT.

Though AHCCCS was a three-year experiment that was to end in October 1985, the Federal government continues to extend funding for the program. In 1988, AHCCCS received a five-year extension from

the Federal government and in 1993, it received an additional one-year extension. In 1994, AHCCCS received a three-year extension and in 1998, it received a one-year extension. Since then, AHCCCS has received additional extensions. Currently, AHCCCS is operating under a five year waiver extension that will expire on September 30, 2006. Some 20 years after it first began, AHCCCS has grown in numbers from the first wave of 180,000 enrollees to over 1 million beneficiaries, representing 18 percent of Arizona's population. AHCCCS has evolved into a mature, well-respected health care system and has become a model as managed care is increasingly being implemented in other States' Medicaid programs.

(Additional information about AHCCCS can be found on the agency's website at www.ahcccs.state.az.us)

MEDICAL PLANS AND ADMINISTRATORS

AHCCCS Contracted Health Plans

Arizona Physicians IPA (APIPA)
3141 North 3rd Avenue
Phoenix, AZ 85013
800/445-1683

Care1st Health Plan of Arizona, Inc.
2355 E. Camelback Rd.
Suite 300
Phoenix, AZ 85016
T: 866/560-4042
F: 602/778-1863

Health Choice Arizona
Suite 260
1600 West Broadway
Tempe, AZ 85282
T: 800/322-8670
F: 800/784-2933

Maricopa Health Plan
2502 East University Drive
Suite 125
Phoenix, AZ 85034
800/582-8686

Mercy Care Plan
Suite 400
2800 North Central
Phoenix, AZ 85004
800/624-3879

Phoenix Health Plan/Community Connection
7878 North 16th Street, Suite 105
Phoenix, AZ 85020
800/747-7997

Pima Health System
Suite A-200
5055 East Broadway
Tucson, AZ 85711
800/423-3801

University Family Care
575 East River Road
Tucson, AZ 85704
888/708-2930

Phoenix Area Indian Health Services (IHS)
Two Renaissance Square
40 N. Central Avenue
Phoenix, AZ 85004-5036
602/364-5039

Tucson Area Indian Health Services (IHS)
7900 South J. Stock Road
Tucson, AZ 85746
520/295-2405

Navajo Area Indian Health Services (IHS)
P.O. Box 9020
Window Rock, AZ 86515-9020
928/871-5811

Long-Term Care Contractor List

Cochise Health Systems
Cochise County Health & Social Services
1415 West Melody Lane, Building A
P.O. Box 4249
Bisbee, AZ 85603-4249
800/285-7485

DES/DDD
1789 West Jefferson, 4th Floor
Phoenix, AZ 85007
866/229-5553

Evercare Select
314 N. 3rd Avenue, Suite 100
Phoenix, AZ 85013
800/293-0039

Mercy Care Plan
Suite 400
2800 North Central
Phoenix, AZ 85004
800/624-3879

Pima Long Term Care
Pima Health System
5055 East Broadway
Suite A-200
Tucson, AZ 85711
800/423-3801

Pinal/Gila LTC
P.O. Box 2140
971 N. Jason Lopez Circle
Building D
Florence, AZ 85232
T: 800/831-4213
F: 520/866-6720

Yavapai County LTC
Yavapai County Department of Medical Assistance
6717 East Second Street, Suite D
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ARKANSAS

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2003		2004	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$325,295,608	398,819	\$393,948,896	422,424
RECEIVING CASH ASSISTANCE, TOTAL	\$178,457,300	120,706	\$210,757,332	120,252
Aged	\$16,740,556	11,538	\$17,902,594	10,591
Blind/Disabled	\$148,620,681	73,243	\$177,381,172	75,271
Child	\$6,158,213	22,945	\$6,721,539	20,653
Adult	\$6,937,850	12,980	\$8,752,027	13,737
MEDICALLY NEEDY, TOTAL	\$5,491,687	7,673	\$6,902,864	7,885
Aged	\$128,939	260	\$163,862	287
Blind/Disabled	\$3,010,610	2,508	\$3,665,426	2,627
Child	\$534,266	1,562	\$528,868	1,386
Adult	\$1,817,872	3,343	\$2,544,708	3,585
POVERTY RELATED, TOTAL	\$46,906,430	167,697	\$62,141,754	184,557
Aged	\$1,918,203	2,513	\$4,253,583	3,247
Blind/Disabled	\$1,215,050	895	\$1,524,348	971
Child	\$42,456,630	155,252	\$54,878,958	171,130
Adult	\$1,316,547	9,037	\$1,484,865	9,209
BCCA Women	\$0	0	\$0	0
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$94,440,191	102,743	\$114,146,946	109,730

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

Source: Arkansas Medicaid Statistical Information System, FY 2003 and FY 2004.

C. ADMINISTRATION

Department of Human Services, Division of Medical Services, Pharmacy Program.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered with restrictions: prescribed insulin; disposable needles and syringe combinations used for insulin. Products not covered: blood glucose test strips; urine ketone test strips; total parenteral nutrition, interdialytic parenteral nutrition; cosmetics; fertility drugs; experimental drugs; and vitamins (other than prenatal vitamins for pregnant women). Prior authorization required for: nitroglycerin patches; agents for impotence; Synagis; Respigam; Xenical-hyper lipidemia; Remicade; Regranex; Kineret; Enbrel; Xolair; Humira, and Xopenex. Some self-administered injectables may also require prior authorization.

Over-the-Counter Product Coverage: Limited coverage for: allergy, asthma and sinus products; analgesics; cough and cold preparations (under 21 years and long-term care limited needs); digestive products; feminine products; and topical products. Products covered with restriction: smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamines; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; growth hormones; hypotensive agents; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: analgesics, antipyretics, NSAIDs; misc. GI drugs. Partial coverage and prior authorization for: prescribed cold medications and prescribed smoking deterrents. Therapeutic categories not covered: prescription drugs for cosmetic use and vitamin products (other than prenatal).

Coverage of Injectables: Injectable medicines are reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment when used in physicians offices (if reimbursed through the physician's office). Some products may require prior authorization.

Vaccines: Vaccines reimbursable as part of EPSDT services, the Children's Health Insurance Program, and the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: State has a preferred drug list (PDL). Covers outpatient drugs whose manufacturers have signed a rebate agreement with CMS. General exclusions include:

1. Agents used for hair growth.
2. Vitamin products except prescription prenatal vitamins.
3. Drugs determined by the FDA to be ineffective (DESI drugs).
4. Sedatives and hypnotics in the benzodiazepine category (partial coverage).
5. Compounded prescriptions (mixtures of two or more ingredients). States are not allowed to have state codes such as 99999-9999-99. All drugs reimbursed by the State must be traced by NDC code and appear on the utilization report.

Drug utilization managed by preferred products, physician profiling, restrictions on use, and prior authorization (requires a Federal MedWatch form to document why a generic can not be dispensed rather than a brand-name product).

Prior Authorization: State currently has a prior authorization procedure. Beneficiaries have a right to appeal prior authorization decisions. Physician must submit letter and accredited literature explaining medical necessity leading to the request for the medication. For off-label use, the appeal must document all failed treatments leading to the request for the medication.

Prescribing or Dispensing Limitations

Prescription Refill Limit: 5 refills within 6 months are allowed. New Rx required every 6 months.

Monthly Quantity Limit: 31-day supply.

Monthly Prescription Limit: Three prescriptions per month per recipient, except unlimited for certified LTC recipients and recipients under 21 years old. Others can receive extension of three more per month.

Drug Utilization Review

PRODUR system implemented in March 1997. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$5.51 effective 3/1/02. Non-MAC generics receive an additional \$2.00 dispensing fee. LTC pharmacies generally receive one dispensing fee per NDC per month.

Ingredient Reimbursement Basis: EAC = AWP-14% (Brand), AWP-20% (Generic).

Prescription Charge Formula: Legend drugs: lower of the EAC plus a dispensing fee or CFA/state upper limit plus a dispensing fee. Total charge may not exceed provider's charge to the self-paying public.

Maximum Allowable Costs: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. State-specific MAC list contains 800 drugs (see www.medicaid.ar.us). Override requires "Brand Medically Necessary" plus physician documentation on MedWatch form as to why the generic cannot be dispensed.

Incentive Fee: \$2.00 additional dispensing fee on non-MAC generics.

Patient Cost Sharing: Effective 9/1/92, for each prescription reimbursed, the Medicaid recipient is responsible for paying a copayment based on the following:

<u>State Payment</u>	<u>Copay</u>
\$10.00 or less	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00
ArKids	\$5.00

Services to individuals under 18, pregnant women, nursing home residents, emergency services, family planning services, and services provided by an HMO to its enrollees are excluded from the Medicaid copay policy.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

An estimated 322,000 Medicaid recipients were enrolled with Primary Care Physicians at the end of 2005. Pharmaceutical benefits are provided through the State.

F. STATE CONTACTS**Medicaid Drug Program Administrator**

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Michael N. Moody, M.D.
Laurence Miller, M.D.
P. Justin Boyd, Pharm.D.

New Brand Name Products Contact

Suzette Bridges, Pharm.D.
501/683-4120

Prescription Price Updating

First DataBank
1111 Bay Hill Drive
San Bruno, CA 94066
T: 650/588-5454
F: 650/588-4003

Medicaid Drug Rebate Contacts

Audits: Suzette Bridges, Pharm.D.
501/683-4120

Dispute Resolution: Shirley Harrell
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E-mail: kellie.phillips@medicaid.state.ar.us

Disease Management/Patient Education Programs

Disease/Medical State: Diabetes
Program Name: Arkansas Medicaid Diabetes Project
Program Manager: Coalition of Dept. of Health and Medicaid
Sponsor: Eli Lilly and Company

Disease/Medical State: Behavioral Health
Program Name: Arkansas Behavioral Health Project
Program Manager: Medicaid

Sponsor: Comprehensive NeuroScience /Eli Lilly and Company

Disease Management/ Patient Education Contact

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Mail Order Pharmacy Benefit

None

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CALIFORNIA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

Note: Certain classifications of aliens in the above categories are eligible only for emergency and pregnancy-related benefits.

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$3,402,508,001	2,651,229	\$4,019,645,375	2,868,468
RECEIVING ASSISTANCE, TOTAL	\$2,552,720,446	1,379,776		
Aged	\$582,176,474	278,543		
Blind/Disabled	\$1,826,731,055	593,945		
Children	\$49,316,799	304,963		
Adult	\$94,496,118	202,325		
MEDICALLY NEEDY, TOTAL	\$499,284,360	281,471		
Aged	\$248,136,400	130,533		
Blind/Disabled	\$223,302,948	58,736		
Children	\$10,574,655	55,277		
Adults	\$17,270,357	36,925		
POVERTY RELATED, TOTAL	\$126,084,007	135,070		
Aged	\$40,135,036	27,679		
Disabled	\$75,923,867	22,313		
Children	\$5,580,840	51,160		
Adults	\$2,671,613	32,398		
BCCA Women	\$1,772,651	1,520		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$224,419,188	854,912		

*Total Other Expenditures/ Recipients include foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and CMS FY 2003.

C. ADMINISTRATION

Under the Health and Human Services Agency with direct administration by the Department of Health Services.

The Department of Health Services Pharmaceutical Unit of the Medi-Cal Policy Division monitors the full scope and quality of pharmaceutical benefits covered under the provisions of the California Medical Assistance Program.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: The Medi-Cal pharmacy benefit covers practically all FDA-approved drugs, including both legend and over-the-counter products. There are very few drugs or classes of drugs that are non-benefits. Non-benefits include common household remedies; non-legend analgesics and cough/cold medications, except when specifically listed; multivitamin preparations, except certain pre-natal and pediatric products; cosmetics; fertility drugs; experimental drugs, and interdialytic parenteral nutrition. Most other products are potential benefits.

In general, products that are listed on the Medi-Cal List of Contract Drugs do not require prior authorization. Those not on the List of Contract Drugs do require prior authorization.

Physician-administered drugs: The Medi-Cal List of Contract Drugs applies to drugs dispensed from pharmacies to patients. Drugs administered directly in a physician's, dentist's, or podiatrist's office are not bound by the List of Contract Drugs.

Coverage of Injectables: Injectable medicines are reimbursable through the Prescription Drug Program when used in extended care facilities, through physician payment when used in physician offices, and through both the prescription drug program and physician payment when used in home health care.

Vaccines: Vaccines are reimbursable by schedule as part of the Vaccines for Children Program. Vaccines for adults are covered through the prescription drug program or as administered in a physician's office.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: The Medi-Cal List of Contract Drugs is a preferred drug list. It contains over 600 drugs, in differing strengths and dosage forms, listed generically. The PDL is managed through performed products, exclusion of products based on contracting issues, restrictions on use, and prior authorization. Patients can get prior authorization for unlisted drugs or for listed drugs that are restricted to specific use(s), if medically justified. Manufacturers frequently petition Medi-Cal to add drugs to the List of Contract Drugs. Based on Medi-Cal's five criteria (safety, efficacy, misuse potential, essential need, and cost), a drug may be added to the list by contractual agreement with the manufacturer to provide the State a negotiated rebate. The Medi-Cal website at: <http://www.dhs.ca.gov/mcs/mcpd/MBB/contracting/html/faqpage.htm> has details of how the drug contracting process works.

Examples of general limitations and exclusions (other uses require prior authorization):

1. CNS stimulants, e.g., amphetamines and methylphenidate, are restricted to attention deficit disorder in individuals between 4 and 16 years of age.
2. Diazepam is restricted to use in cerebral palsy, athetoid states, and spinal cord degeneration.
3. Most non-steroidal anti-inflammatory agents are restricted to use for arthritis.
4. Some antibiotics have diagnostic and/or age restrictions.
5. Acyclovir capsules are restricted to herpes genitalis, immunocompromised, and herpes zoster (shingles) patients.
6. Codeine Combinations: payment to a pharmacy for ASA or APAP with codeine 30 mg is limited to a maximum dispensing quantity of 45 tablets or capsules and a maximum of 3 claims for the same beneficiary in any 75-day period.
7. Enteral nutritional supplements or replacements are covered, subject to prior authorization, if used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular foodstuffs.
8. Cancer, AIDS, and DESI Drugs: Any antineoplastic drug approved by FDA for the treatment of cancer and any drug approved by FDA for the treatment of AIDS or AIDS-related condition is covered through the Medi-Cal List of Contract Drugs; most DESI drugs rated less-than-effective by FDA are not covered.

Prior Authorization: Nearly all drugs not included on the Medi-Cal list of Contract Drugs require prior authorization. State currently has a formal prior authorization procedure to appeal prior authorization decisions.

The patient's physician or pharmacist may request prior authorization from the field office Medi-Cal consultant for approval of unlisted drugs or for listed drugs that are restricted to specific use(s). This is done by completing a *Treatment Authorization Request (TAR)* form. Providers may appeal prior authorization decisions within 60 days of notification to the local field office and then to field services headquarters if necessary. Beneficiaries also have the ability to request a hearing to review the denial and must do so within 90 days of notification.

TARs may be approved for: covered items or services not included on the Medi-Cal List of Contract Drugs (including special circumstance such as the need to override multiple source drug price ceilings or minimum quantity/ frequency of billing limitations); and for patients exceeding the 6 Rx per month limit. Statewide mail and fax requests are accepted in the Stockton and Los Angeles Medi-Cal Field Offices. Requests must include adequate information and justification. Authorization may only be given for the lowest cost item or service that meets the patient's medical needs.

Beneficiary or Prescriber Prior Authorization: On a case by case basis, the Dept. of Health Services restricts, through the requirements of prior authorization, the availability of designated prescription drugs to certain beneficiaries or prescribers found by the Department to abuse those benefits.

Prescribing or Dispensing Limitations

Prescription Refill Limit: A prescription refill can be dispensed as authorized by prescriber. An exception is allowed for refill of a reasonable quantity when prescriber is unavailable (pursuant to California law). Fee is to be pro-rated so that total fee (for partial quantity and balance of the prescription after prescriber is contacted) does not exceed the fee for the same prescription when refilled as a routine service. Many drugs are limited to 3 claims in a 75 day period.

Monthly Quantity Limit: This is flexible, but should be consistent with the medical needs of the patient. Limited to 100 days' supply on most drugs. Many maintenance drugs are subject to minimum quantity or maximum frequency of billing controls.

Monthly Prescription Limit: Limited to 6 per month without prior authorization. The limit does not apply to family planning drugs, patients in nursing facilities, or to AIDS or cancer drugs.

Hospital Discharge Medications: Quantities furnished as discharge medications are limited to no more than a 10-day supply. Charges are incorporated in the hospital's claims for inpatient services.

Drug Utilization Review

Prospective DUR system implemented in August 1995. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$7.25 (\$8.00 LTC), effective 9/1/04.

Ingredient Reimbursement Basis: EAC = AWP-17%

Prescription Charge Formula: Reimbursement is based on the lowest of:

1. Estimated Acquisition Cost (EAC) plus current professional fees
2. Federal Upper Limit (FUL) plus current professional fees
3. State Maximum Allowable Ingredient Cost (MAIC) plus current professional fees
4. Pharmacy's usual price to general public.

State law requires that reimbursement for blood factors be by NDC and not exceed 120 percent of the average selling price during the preceding quarter or the provider's usual and customary charge.

Maximum Allowable Cost: State imposes a combination of Federal and State-specific limits on generic drugs. Maximum Allowable Ingredient Costs (MAICs) are established for about 50 multi-source items. Override requires "Medically Necessary" or unavailability of drug products at or below MAC. List is periodically revised and price limits changed to reflect current market conditions.

Incentive Fee: None.

Patient Cost Sharing: \$1.00 copayment for branded and generic products.

Cognitive Services: Does not pay for cognitive services, but this is under consideration.

E. USE OF MANAGED CARE

Approximately 3.3 million Medicaid recipients were enrolled in MCOs in FY 2005. Recipients receive pharmaceutical benefits through the State and managed care plans. Certain psychiatric drugs (antipsychotics, lithium, MAO inhibitors) some anti-Parkinson drugs, and many HIV drugs are carved out of managed care.

AIDS Healthcare Foundation
Positive HealthCare
6255 W. Sunset Blvd., 21st Floor
Los Angeles, CA 90028
323/860-5231

Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502
510/747-4500

Altamed Senior BuenaCare
5425 East Pomona Boulevard
Los Angeles, CA 90022
323/728-0411

Blue Cross of California
P.O. Box 9054
Oxnard, CA 93031
800/407-4627

Care 1st Health Plan
800 Howe Avenue, Suite 420
Sacramento, CA 95825
800/605-2556

Center for Elders Independence
1955 San Pablo Avenue
Oakland, CA 94612
510/433-1150

Community Health Group
740 Bay Blvd.
Chula Vista, CA 91910
619/498-6457

Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, CA 94553
925/313-6008

Health Net of California
State Health Programs
11971 Foundation Place, GPD1
Rancho Cordova, CA 95670
800/675-6110

Health Plan of San Joaquin
1550 W. Fremont Street, Suite 200
Stockton, CA 95203-2643
800/932-7526

Inland Empire Health Plan
303 East Vauderbilt Way, Suite 400
San Bernardino, CA 92408
909/890-2000

Kaiser Foundation Health Plan, Inc.
393 E. Walnut Street
Pasadena, CA 91188
800/390-3510

Kern Health Systems
Kern Family Health Care
1600 Norris Road
Bakersfield, CA 93308
661/391-4036

LA Care Health Plan
555 W. Fifth Street, 20th Floor
Los Angeles, CA 90013
213/694-1250

Molina Healthcare of California
One Golden Shore Drive
Long Beach, CA 90802
562/432-3666

On Lok Senior Health Services-Alameda
159 Washington Boulevard
Fremont, CA 94539
415/292-8888

On Lok Senior Health Services-SF
1333 Bush Street
San Francisco, CA 94109
415/292-8888

Orange County Organized Health System
CalOPTIMA
1120 West La Veta Ave.
Orange, CA 92868
714/246-8400

San Francisco Health Authority
San Francisco Health Plan
568 Howard Street, Fifth Floor
San Francisco, CA 94105
415/547-7800

San Francisco City & County Public Health
Family Mosaic Project
1309 Evans Avenue
San Francisco, CA 94124
415/206-7600

San Mateo Health Commission
Health Plan of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
650/616-0050

Santa Barbara Regional Health Authority
Santa Barbara Health Initiative
110 Castilian Drive
Goleta, CA 93117
805/685-9525 (Northern CA)
800/421-2560 (Southern CA)

Santa Clara Family Health Plan
210 E Hacienda Ave
Campbell, CA 95008
408/376-2000

Santa Cruz -Monterey
Managed Care Commission
Central Coast Alliance for Health
375 Encinal Street, Suite A
Santa Cruz, CA 95060
800/700-3874

Scan Health Plan
Senior Care Action Network
3780 Kilroy Airport Way, Suite 600
Long Beach, CA 90801
562/989-5100

Solano-Napa County Commission on Medical Care
Partnership Health Plan of California
360 Campus Lane, Suite 100
Fairfield, CA 94534
707/863-4100

Sutter Senior Care
1234 U Street
Sacramento, CA 95818
916/446-3100

Universal Care
1600 E. Signal Hill Street
Signal Hill, CA 90806
800/635-6668

Western Health Advantage
1331 Garden Highway Suite 100
Sacramento, CA 95833
916/563-3189

F. STATE CONTACTS

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Prior Authorization Contact

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Mail Order Drug Benefit

State currently has a mail order pharmacy capability in the Medi-Cal program. All fee-for-service beneficiaries are entitled to participate.

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COLORADO

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$202,286,461	153,520	\$251,367,181	197,128
RECEIVING CASH ASSISTANCE, TOTAL	\$131,455,323	81,187		
Aged	\$42,740,055	18,549		
Blind/Disabled	\$78,779,997	26,398		
Child	\$3,365,340	18,079		
Adult	\$6,568,168	18,160		
Unknown	\$1,763	1		
MEDICALLY NEEDY, TOTAL	\$0	0		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$6,751,922	40,538		
Aged	\$127,100	128		
Blind/Disabled	\$226,817	129		
Child	\$4,875,966	29,415		
Adult	\$1,515,915	10,854		
BCCA Women	6,124	12		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$64,079,216	31,795		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Colorado Department of Health Care Policy and Financing administers the drug program. Eligibility is determined by 63 County Departments of Social Services and the Department.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; total parenteral nutrition; and interdialytic parenteral nutrition. Products not covered: cosmetics; DESI drugs; fertility drugs; prescribed vitamins (except prenatal); and experimental drugs. Disposable needles and syringe combinations used for insulin; blood glucose test strips; and urine ketone test strips are considered DME and do not fall under the State's drug benefit.

Over-the-Counter Product Coverage: Products covered with restrictions: allergy, asthma, and sinus products (must be medically necessary); analgesics (aspirin only without PA); cough and cold preparations (for chronic respiratory conditions); non-H2 antagonists (must be medically necessary); and smoking deterrent products (prior authorization, once in a lifetime benefit, 90-day supply in conjunction with smoking cessation program). Products not covered: H2 antagonists; feminine products, and topical products.

Therapeutic Category Coverage: Therapeutic categories covered: analgesics, antipyretics, and NSAIDs (partial coverage); antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamines; antilipemic agents; anxiolytics, sedatives and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: anabolic steroids; anti-psychotics (partial coverage); prescribed cough and cold medications; growth hormones; PPIs; Leukotrienes; Epoetin; cox-2 inhibitors; Bactroban; brand name drugs; acne products, Revia; Xenical; and prescribed smoking deterrents. Products not covered: anoretics; erectile dysfunction drugs.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment when used in physician offices. Prior authorization is required for self-administration at home.

Vaccines: Vaccines reimbursable as part of the EPSDT Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary. Managed through restrictions on use and prior authorization.

Prior Authorization: State currently has a formal prior authorization procedure. There is an appeal process and re-review when appealing coverage of an excluded product and prior authorization decisions.

Prescribing or Dispensing Limitations

Monthly Quantity Limit: New prescriptions for chronic or acute conditions are prescribed at the discretion of the physician. Normal quantity limit is a 30-day supply. Maintenance medications can receive up to a 100 day supply.

Other Limits: Additional quantity limits may be applied to certain drugs. Oxycontin: 2 tablet (any strength) per day limit without prior authorization.

Drug Utilization Review

PRODUR system implemented in December 1998. DUR Board meets quarterly.

Lock-In Review Procedures: The Department receives computer processed printouts designed to discover over-utilization of drugs prescribed by physicians, dispensed by vendors, and received by eligible recipients.

Pharmacy Payment and Patient Cost Sharing

Dispensing fee: \$4.00 as of July 1, 2001. Institutional pharmacies receive a dispensing fee equal to \$1.89. Dispensing physicians shall not receive a dispensing fee unless their offices or sites of practice are located more than 25 miles from the nearest participating pharmacy. In the latter case, physicians receive a fee equal to \$1.89.

Ingredient Reimbursement Basis: EAC = AWP-13.5%, State MAC, or direct pricing plus 18%.

Prescription Charge Formula: Benefit drugs shall be reimbursed at the lesser of the Medicaid allowable reimbursement charge, or the provider's usual and customary charge or whatever is accepted from any third party, discounts, rebates, etc.

The Medicaid allowable reimbursement charge is the sum of the ingredient cost of the drug dispensed and the provider's dispensing fee.

Ingredient cost for retail pharmacies (estimated acquisition cost) is the price of the drug actually dispensed as defined below or the MAC or the high volume EAC, whichever is less.

The ingredient cost for institutional and government pharmacies is defined as the actual cost of acquisition for the drug dispensed or the MAC, or the high volume EAC, whichever is less.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Medically Necessary."

The State MAC is the maximum ingredient cost allowed by the Department for certain multiple-source drugs. The establishment of a MAC is subject, but not limited to, the following considerations:

- (1) Multiple manufacturers;
- (2) Broad wholesale price span;
- (3) Availability of drugs to retailers at the selected cost;
- (4) High volume of Medicaid recipient utilization;
- (5) Bioequivalence or interchangeability.

When Federal MAC limits for multiple source drugs are announced, they will be adopted if they are less than State MACs or if no State MACs exist.

The ingredient cost of any drug subject to MAC shall be limited to MAC or wholesale price as determined by the Department, whichever is less. Exceptions that will allow reimbursement greater than MAC for a drug entity are obtained through a prior authorization mechanism. An exception will be granted if the patient's response to the generic drug is not therapeutic, an allergic reaction is involved, or any similar situation exists.

If a recipient requests a brand name for a prescription that is subject to MAC, then he/she may pay the ingredient cost difference between the MAC and brand name drug. The recipient must sign the

prescription stating that he/she is willing to pay the difference in ingredient cost to the pharmacy. The pharmacy will be paid MAC plus a dispensing fee or reimbursement charges, whichever is lower.

High volume Estimated Acquisition Cost (EAC): Reimbursement for single source drugs or certain multiple source drugs which are most frequently prescribed will be based upon average wholesale prices (AWP) minus 13.5%, or direct manufacturers' prices for package sizes containing quantities greater than 100 dosage units or less if not available in 100's.

Basis for inclusion in the high volume estimated acquisition cost list includes but is not limited to:

- (1) Single source manufacturers;
- (2) High volume Medicaid recipient utilization;
- (3) Interchangeability problems with multiple source drugs;
- (4) Package sizes in excess of 100.

Drug Pricing: The Department will maintain a drug-pricing file that will be updated at least monthly. The average wholesale price of a drug as determined by the Department, MAC, and high volume EAC, will be the basis for setting the prices in the drug pricing file.

The Department will determine the average wholesale price that will be placed in the drug-pricing file as follows:

- (1) The average wholesale price as it appears in the Red Book, its supplements, and Medi-Span will be the first source. However, if there is a difference between the two published average wholesale prices, the Department will set the price as the published amount which is the closest to the lowest average price charged by two drug wholesalers doing business in Colorado.
- (2) If there is a price change which does not appear immediately in the Red Book, its supplements, or in Medi-Span, then the Department will set the average wholesale price by averaging the wholesale prices of three drug wholesalers doing business in Colorado, until the price is published in the Red Book, its supplements, or in Medi-Span.
- (3) If the prices or changes do not appear in the publications or the wholesalers' records, then the distributors' or manufacturers' prices will be adjusted to the wholesale pricing level and used in the drug pricing file as the price of the drug.

If the difference between the pharmacist's invoice purchase price and the average wholesale price which appears in the Red Book, its supplements, or Medi-Span exceeds 18%, then the Department may adopt a lower price after a survey is conducted to determine the validity of the published prices. The price from the distributor or manufacturer will be adjusted the same as in 3 above.

Special Note: The Maximum Allowable Cost shall be determined by the Division of Medical Assistance, based upon professional determination of a quality product available at the least expense possible.

Exceptions to the above are:

- Shelf package size oral liquid medications, in pint size only, or smaller package size when not packaged in pint size.
- Shelf package size oral tablet and capsule medications in quantities of 100 only or smaller when not available in package size of 100.
- Prescriptions for less than minimum amounts will be denied reimbursement of the professional fee unless the physician notified the Department in writing of the medical need for amounts less than a 30-day supply. Medical consultation determines the decision.

Incentive Fee: None.

Patient Cost Sharing: Brand: \$3.00; Generic: \$1.00

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 70,000 Medicaid recipients were enrolled in MCOS in FY 2005. Recipients receive pharmaceutical benefits through the Managed Care Organization. Beneficiaries enrolled in behavioral health organizations receive drugs through the FFS program or other Medicaid HMOs.

Managed Care Organizations

Total Long-Term Care
303 East 17th Avenue, Suite 650
Denver, CO 80203
303/896-4664
Kaiser Permanente
10350 East Dakota Avenue
Denver, CO 80905
303/344-7250

Rocky Mountain HMO
2775 Crossroads Boulevard
Grand Junction, CO 81506
800/843-0719

Colorado Access
600 South Cherry Street, Suite 800
Denver, CO 80222
303/355-6707

Community Health Plan of the Rockies
400 South Colorado Boulevard, Suite 300
Denver, CO 80222
303/355-3220

United Healthcare
6251 Greenwood Plaza Boulevard, Suite 200
Englewood, CO 80111-4910
303/267/3594

F. STATE CONTACTS

Medicaid Drug Program Administrator

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Pharmacy Supervisor
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Internet Address:
www.hcph.state.us/hcpf/pharmacy/pharmindex.asp

DUR Contact

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Department of Health Care Policy and Financing
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F: 303/866-2573
E-mail: kimberly.eggert@state.co.us

DUR Board

James R. Kant, R.Ph.
James R. Regan, M.D., F.A.C.P.
Lucy Williams Loomis, M.D., M.S.P.H.
Robert D. McCartney, M.D., F.A.C.P.
Mary Newell, R.Ph.
Robert Lee Page, II, Pharm.D., F.A.S.C.P., B.C.P.S.
Terrie A. Sajbel, Pharm.D.
Edra B. Weiss, M.D., F.A.A.P.
Robert Horst

New Brand Names Products Contact

Catherine Traugott
303/866-2468

Prescription Price Updating

Catherine Traugott
303/866-2468

Medicaid Drug Rebate Contacts

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Drug Rebate Manager
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203
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Claims Submission Contact

Susan Pfau
ACS, State Healthcare
600 17th Street
Suite 600 North
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F: 303/534-0439

Medicaid Managed Care Contact

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Managed Care Manager
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Disease Management/Patient Education Programs

Disease/Medical State: Asthma
Program Name: Asthma Management Program
Program Manager: Christy Hunter
Program Sponsor: National Jewish Medical and Research Center

Disease/Medical State: Diabetes
Program Name: Diabetes Disease Management Program
Program Manager: Christy Hunter
Program Sponsor: McKesson Health Solutions, Inc.

Disease Management/Patient Education Contact

Christy Hunter
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818
T: 303/866-2993
F: 303/866-2573

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Internet address: www.chcpf.state.co.us

Mail Order Pharmacy Program

None

Health Care Policy & Financing Department Officials

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Department of Healthcare Policy and Financing
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303/866-3058

Medical Services Board

Jeffrey Cain, M.D.
Julie Reiskin
Richard Markley
Joan M. Johnson (Vice President)
Wendell Phillips
Joe Rall (President)
Maguerite Salazar
Rulon Stacey
Mathew Dunn, M.D.
Sally Schaefer
David Bolin

Executive Officers of State Medical and Pharmaceutical Societies

Colorado Medical Society
Alfred Gilchrist
Executive Director
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Colorado Pharmacists Society

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Denver, CO 80224-1662
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Colorado Society of Osteopathic Medicine

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650 South Cherry Street, Suite 510
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Colorado State Board of Pharmacy

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Colorado Health and Hospital Association

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Internet address: www.cha.com

CONNECTICUT

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$356,980,484	123,704	\$402,380,645	119,698
RECEIVING CASH ASSISTANCE, TOTAL	\$86,045,876	26,172		
Aged	\$16,590,546	5,940		
Blind/Disabled	\$68,770,620	15,311		
Child	\$183,663	2,686		
Adult	\$501,047	2,235		
MEDICALLY NEEDY, TOTAL	\$107,981,037	31,035		
Aged	\$25,232,717	10,618		
Blind/Disabled	\$82,442,392	19,884		
Child	\$171,259	332		
Adult	\$134,669	201		
POVERTY RELATED, TOTAL	\$3,928,268	5,859		
Aged	\$665,123	577		
Blind/Disabled	\$2,090,017	1,002		
Child	\$1,002,861	3,228		
Adult	\$69,818	981		
BCCA Women	\$100,449	71		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$159,025,303	60,638		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

State of Connecticut Department of Social Services through three regional offices and twelve sub-offices.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin, disposable needles and syringe combinations for insulin; blood glucose test strips; urine ketone test strips. Products not covered: cosmetics; fertility drugs; experimental drugs; total parenteral nutrition; interdialytic parenteral nutrition; and weight loss products.

Over-the-Counter Product Coverage: Products covered: allergy, asthma, and sinus products; topical products. Products covered with restrictions: cough and cold preparations (children < 19 years); digestive products (non H2 antagonists) – liquid generics only (legend drugs not covered); digestive products (H2 antagonists) – after first 60 days, diagnosis required on the prescription for continued use; birth control products; antihistamines; and decongestants. Products not covered: smoking deterrent products; analgesics; feminine products; iron; calcium; and some trace elements. For nursing home patients, the department will not pay for OTC drugs used in nursing facilities (such drugs are covered in the per diem rate). Some drugs require diagnosis for reimbursement such as CNS stimulants for ADD and narcolepsy.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; analgesics, antipyretics, NSAIDs; antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamine drugs; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); thyroid agents; and growth hormones. Therapeutic categories not covered: anorectics and prescribed smoking deterrents. Prior authorization required for: Brand Medically Necessary prescriptions; early refills; prescriptions costing more than \$500, and drugs not on the preferred drug list (PDL). A complete listing of the drugs on the PDL can be found at www.ctmedicalprogram.com.

Coverage of Injectables: Injectable medicines reimbursable through physician payment when used in home health care, extended care facilities, and in physicians offices.

Vaccines: Vaccines reimbursable as part of the Children Health Insurance Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with PDL. Managed through prior authorization and preferred products. However, the following products are excluded from Medicaid prescription coverage: experimental drugs, cosmetics, fertility drugs; smoking cessation products; DESI drugs, and drugs available free from the Department of Health Services.

Prior Authorization: State currently has a prior authorization procedure. Clients can request an administrative hearing to appeal prior authorization decisions.

Prescribing or Dispensing Limitations

Prescription Refill Limit: 5 refills per prescription except for oral contraceptives, which have a 12-month limit.

Monthly Quantity Limit: Maximum 240 tablets or capsules/30-day supply. Oral contraceptives: 3 months supply may be dispensed at one time.

Physicians are encouraged to prescribe drugs generically, when possible.

Drug Utilization Review

Pro-DUR system implemented September 1996. Retro-DUR since September 1991; the State currently has a 9 member DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.15, effective 7/1/04.

Ingredient Reimbursement Basis: EAC = AWP-14%. Special rules for Factor VIII (AAC + 8%).

Prescription Charge Formula: Federal MAC or EAC plus dispensing fee; or usual and customary if lower. Special rules for blood factor VIII.

Maximum Allowable Cost: State imposes a combination of Federal and State-specific Upper Limits on generic drugs. Effective 1/1/2003, the Department implemented a state MAC to include additional multi-source generic products that are not on the FUL list. The State MAC reimbursement is AWP-40%.

Patient Cost Sharing: None.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Connecticut had approximately 310,000 Medicaid recipients enrolled in managed care in 2005. Beneficiaries receive pharmaceutical services through managed care plans.

Managed Care Organizations

Anthem Blue Cross/Blue Shield of CT
Blue Care Family Plan
Paula Smyth, Director
Medicaid Managed Care
370 Bassett Road
North Haven, CT 06473-4201
T: 203/654-3506
F: 203/234-5310

Community Health Network of CT
Sylvia Kelly, CEO
11 Fairfield Boulevard
Wallingford, CT 06492
T: 203/237-4000
F: 203/634-8411

Health Net
Janice Perkins, Vice President
One Far Mill Crossing, Box 904
Shelton, CT 06484-0944
T: 203/225-8630
F: 203/225-4175

First Choice of CT, Preferred One
David Smith, Chief Operating Officer
23 Maiden Lane
North Haven, CT 06473
T: 203/239-7444
F: 203/239-3381

F. STATE CONTACTS

Medicaid Drug Program Administrator

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Medical Operations Unit #4
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Department of Social Services Officials

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Connecticut DUR Board

Kenneth Fisher, R.Ph. (Chair)
Brooks Pharmacy

Arturo Morales, M.D.
St. Francis Hospital

Lori Jane Duntz Lord, R.Ph.
Greenville Drug

Dennis J. Chapron, M.S., R.Ph.
Pharmokinetics Lab

Keith Lyke, R.Ph. (Vice Chair)
Pelton's Pharmacy

Frederick N. Rowland, M.D., Ph.D.
St. Francis Hospital and Medical Center

Richard Gannon, Pharm.D.
Hartford Hospital

Bhupesh Mangla, M.D., M.P.H.
Community Health Services

Michael Moore, R.Ph.
Hebrew Home Hospital

Prescription Price Updating

Melissa Johnson
Staff Pharmacist
EDS
1000 Stanley Street
New Britain, CT 06053
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Steve Marchan, R.Ph.
Vernon, CT

Peggy Memoli, R.Ph.
Stratford, CT

Joseph Misiak, M.D.
Windsor, CT

Carl Sherter, M.D.
Southbury, CT

Medicaid Drug Rebate Contacts

Evelyn A. Dudley
860-424-5654

Melissa Johnson (Rebates & Disputes)
860/832-5896

Lawrence Sobel, R.Ph.
West Hartford, CT

Robert Zavoski, M.D.
West Simsbury, CT

Claims Submission Contact

Melissa Johnson
860/832-5896

Executive Officers of State Medical and Pharmaceutical Societies

Connecticut State Medical Society
Timothy B. Norbeck, Executive Director
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New Haven, CT 06511-2390
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Medicaid Managed Care Contact

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Connecticut Pharmacists Association
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Rocky Hill, CT 06067-3161
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E-mail: mguiliano@ctpharmacists.org
Internet address: www.ctpharmacists.org

Mail Order Pharmacy Program

None

Disease Management Contact

David Parrella
Director, Medical Care Administration
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Connecticut Osteopathic Medical Society
Donald Halpin, Executive Director
P.O. Box 487
Winchester, MA 01800-0487
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F: 781/721-4400
E-mail: nocdos@shore.net

Elderly Drug Coverage Program Contact

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860/424-5654

Pharmaceutical and Therapeutics Committee

Holly Bessoni-Lutz, R.N.
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Stella Cretella
West Haven, CT

Richard Carbray, Jr., R.Ph.
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Connecticut Hospital Association, Inc.

Jennifer Jackson

President and CEO

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DELAWARE

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$100,112,623	125,461	\$110,942,313	99,634
RECEIVING CASH ASSISTANCE, TOTAL	\$48,342,702	47,053		
Aged	\$6,124,532	2,456		
Blind/Disabled	\$28,909,766	10,035		
Child	\$5,126,585	22,562		
Adult	\$18,181,819	12,000		
MEDICALLY NEEDY, TOTAL	\$0	0		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$1,583,883	4,248		
Aged	\$176,789	141		
Blind/Disabled	\$636,901	337		
Child	\$688,345	3,473		
Adults	\$53,731	278		
BCCA Women	\$28,117	19		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$50,186,038	74,160		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Division of Social Services, Department of Health and Social Services, through three county offices of the State agency.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition; and interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; experimental drugs; and quality of life medications.

Over-the-Counter Product Coverage: Products covered: allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; and topical products. Products covered with restrictions: smoking deterrent products (prior authorization and quantity limits); feminine products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamine drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); and thyroid agents. Partial coverage and prior authorization required for: analgesics, antipyretics, and NSAIDs; anoretics; antibiotics; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; prescribed cold medications; growth hormones; prescribed smoking deterrents; Regranex; Zyvox; Soma Accutane Cipro; Cholinesterase inhibitors; Modafanil; and Epoetin.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in extended care facilities, and through both the prescription drug program and physician payment when used in physicians' offices.

Vaccines: Vaccines reimbursable under the CHIP Program and Vaccines for Children program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list. PDL managed through preferred products and prior authorization.

Prior Authorization: State currently has a formal prior authorization procedure. Standard procedures for clients to request a fair hearing to appeal prior authorization decisions.

Prescribing or Dispensing Limitations

Monthly Limit on Scripts: 15 medications per 30 days.

Prescription Refills: Prescription blank has space for physician to authorize renewals.

Monthly Quantity Limit: Greater of 34-day supply or 100 dosing units. May vary depending on therapeutic category.

Monthly Dollar Limits: None.

Drug Utilization Review

PRODUR system implemented in August 1994. State has a DUR Board that meets bimonthly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.65.

Ingredient Reimbursement Basis: EAC = AWP-14.0%. (AWP-16% for LTC)

Prescription Charge Formula: Payment is based on AWP-14.0% or maximum allowable cost (MAC) plus a dispensing fee, or the usual and customary cost to the general public, whichever is lower.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires completion of an FDA MedWatch form. Over 1,000 drugs on State MAC list.

Incentive Fee: None.

Patient Cost Sharing: \$0.50-\$3.00 (based on the cost of the prescription).

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 90,000 Medicaid recipients were enrolled in MCOs in FY 2005. Recipients receive pharmaceutical benefits through the State.

Managed Care Organizations

Diamond State Partners
P.O. Box 907
Manor Branch
New Castle, DE 19720
800/390-6093

F. STATE CONTACTS**State Drug Program Administrator**

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DUR Contact

Cynthia R. Denemark, R.Ph.
302/453-8453

DUR Board

Calvin Freedman, R.Ph. (Chair)
Scott Harrison, D.O.
Phillip Anderson, R.Ph.
Susan Fullerton, A.P.N.
Mark Borer, M.D.
Nadia Helenga, Pharm.D.
Joseph Peoples, R.Ph.
Frank Falco, M.D. (Vice Chair)
Sebastion Hamilton, R.Ph.
Albert Rizzo, M.D.
Michael Marcus, M.D.

New Brand Name Products Contact

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T: 302/453-8453
F: 302/454-0224
E-mail: joli.martini@eds.com

Prescription Price Updating

Cynthia R. Denemark, R.Ph.
302/453-8453

Medicaid Drug Rebate Contacts

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Claims Submission Contact

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Medicaid Managed Care Contact

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Division of Social Services
Herman Holloway Campus
Lewis Building
1901 North DuPont Highway
New Castle, DE 19720
T: 302/255-9548
F: 302/255-4481
E-mail: mary.marinari@state.de.us

Mail Order Pharmacy Benefit

None

Health and Social Services Department Officials

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Secretary
Dept. of Health & Social Services
1901 North DuPont Highway-Main Bldg.
New Castle, DE 19720
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E-mail: vmeconi@state.de.us
Internet address: www.state.de.us/dhhs

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1901 North DuPont Highway – Lewis Building
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F: 302/555-4454

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Pharmaceutical and Therapeutics Committee

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Valerie Green, M.D.
Pat Klishevich, R.Ph.
James Lafferty
Brian Levine, M.D.
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M. Diana Metzger, M.D.
Tamara J. Newell, A.P.N.
Obi Onyewu, M.D.
James A. Owen, R.Ph.
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Jose Quinones
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Executive Officers of State Medical and Pharmaceutical Societies

Medical Society of Delaware
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F: 302/658-9669
E-mail: mama@medsocdel.org
Internet address: www.msddhub.com

Delaware Pharmacists Society
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T: 800/782-3716
F: 302/659-3089
E-mail: questions@depharmacy.net
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Talleyville, DE 19803-8177
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F: 302/764-1322
E-mail: info@deosteopathic.org
Internet address: www.deosteopathic.org

Delaware State Board of Pharmacy
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T: 302/744-4526
F: 302/739-2711
E-mail: debop@state.de.us
Internet address: www.dpr.delaware.gov

Delaware Healthcare Association
Joseph M. Letnaunchyn
President and CEO
1280 South Governors Avenue
Dover, DE 19904-4802
T: 302/674-2853
F: 302/734-2731
E-mail: joelet@deha.org
Internet address: www.deha.org

DISTRICT OF COLUMBIA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disable	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$68,050,981	45,216	\$82,817,543	34,424
RECEIVING CASH ASSISTANCE TOTAL	\$45,487,560	28,198		
Aged	\$4,038,389	3,279		
Blind/Disabled	\$39,946,424	21,040		
Child	\$282,114	1,256		
Adult	\$1,220,633	2,623		
MEDICALLY NEEDY, TOTAL	\$9,287,462	5,984		
Aged	\$1,685,420	1,132		
Blind/Disabled	\$6,992,364	3,355		
Child	\$115,789	666		
Adult	\$493,889	831		
POVERTY RELATED, TOTAL	\$9,410,167	6,432		
Aged	\$3,096,675	2,294		
Blind/Disabled	\$6,096,888	2,657		
Child	\$164,442	1,330		
Adult	\$52,162	151		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURE/RECIPIENTS*	\$3,865,792	4,602		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

The District of Columbia Department of Health (DOH), Medical Assistance Administration.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; and urine ketone test strips. Products covered with restrictions: cosmetics (<25 years of age only). Prior authorization required for: all self-administered injectable drugs except insulin; anorexic drugs for treatment of narcolepsy and minimal brain dysfunction in children; acute anti-ulcer drugs, and brand NSAIDs. Products not covered: fertility drugs; experimental drugs; total parenteral nutrition; interdialytic parenteral nutrition; anesthetics; infant formulas; cold tar preparations; reusable needles/syringes (non-insulin); and all other non-legend items.

Over-the-Counter Product Coverage: Products covered: oral analgesics. Products covered with restrictions: contraceptive foams and jellies; prenatal, pediatric and geriatric vitamins; and bowel preparation kits. Products not covered: allergy, asthma, and sinus products; cough and cold preparations; digestive products; feminine products; topical products; and smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories covered: antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents; anti-psychotics; anxiolytics; sedatives; and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; sympathomimetics (adrenergic); and thyroid agents. Partial coverage and prior authorization required for: analgesics, antipyretics, and NSAIDs; anoretics; growth hormones; misc. GI drugs; erectile dysfunction products; Brand Medically Necessary drugs; immunosuppressants; amphetamines; Stadol; Levocamitine; Hepatitis C medications; and Synagis. Therapeutic categories not covered: anabolic steroids and prescribed smoking deterrents.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and through physician payment when used in physicians' offices and extended care facilities.

Vaccines: Vaccines reimbursable at cost as part of the EPSDT service and The Children's Health Insurance Program.

Unit Dose: Unit dose packaging not reimbursable

Formulary/Prior Authorization

Formulary: Open formulary managed through restrictions on use and prior authorization. Appeals for coverage of an excluded product can be made by submission of medically relevant information to the Medical Director for review.

Prescribing or Dispensing Limitations

Monthly Quantity Limit: In general, amounts dispensed are to be limited to quantities sufficient to treat an episode of illness. Maintenance drugs such as thyroid, digitalis, etc. may be dispensed in amounts up to a 30-day supply with 3 refills that must be dispensed within 4 months. Antibiotic medications used in treatment of acute infections are not to be dispensed in excess of a 10-day supply. Birth control tablets may be dispensed in 3-cycle units with a maximum of 3 refills within one year. Other limits on specific products.

Monthly Dollar Limits: \$1,500 limit. Physicians are to request prior authorization for prescriptions that exceed this amount.

Drug Utilization Review

PRODUR system implemented in September 1996. The District currently has a DUR Board that meets monthly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.50.

Ingredient Reimbursement Basis: AWP-10%.

Prescription Charge Formula: The lesser of: FUL or the AWP-10% plus the dispensing fee or usual and customary to the public.

Maximum Allowable Cost: The District does not impose MAC limits on generic drugs.

Incentive Fee: None.

Patient Cost Sharing: \$1.00 copay by recipient. Does not apply to recipients under 18, prescriptions for family planning, nursing home patients, or pregnancy related.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 94,000 Medicaid recipients were enrolled in managed care in 2005. Recipients enrolled in managed care receive pharmaceutical benefits through managed care plans.

Managed Care Organizations

D.C. Chartered Health Plan
1025 15th Street, N.W.
Washington, DC 20005
202/408-4720

Amerigroup
750 First Street, NE, Suite 1120
Washington, DC 20002
800/600-4441

Health Right, Inc.
1101 14th Street, NW, Suite 900
Washington, DC 20005
202/418-0380

F. STATE CONTACTS

State Drug Program Administrator

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DUR Contact

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District of Columbia DUR Board

Christopher Keeyes, Pharm.D. (Chair)
Martin Dillard, M.D. (Vice Chair)
Howard Robinson, R.Ph.
Dr. Kim Bullock
Dr. Stephen Steury

Prior Authorization Contacts

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New Brand Name Products Contact

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Prescription Price Updating Contact

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Office of Quality Management
Department of Health
Medical Assistance Administration
825 North Capitol Street, NE, 5th Floor
Washington, DC 20002
T: 202/442-9076
F: 202/535-1216
E-mail: charlene.fairfax@dc.gov

Mail Order Pharmacy Program

None

Department of Human Services Officials

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Department of Health
825 North Capitol Street, NE
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Internet Address: www.dchealth.dc.gov

Executive Officers of District Medical and Pharmaceutical Societies

Medical Society of the District of Columbia
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E-mail: shanbacker@msdc.org
Internet address: www.msdc.org

Washington D.C. Pharmacy Association
Herbert Kwash, R.Ph., President
6406 Georgia Avenue, N.W.
Washington, DC 20012-2960
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F: 202/829-1515

Osteopathic Association of the District of Columbia
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Arlington, VA 22207
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DC Board of Pharmacy
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E-mail: graphelia.ramseur@dc.gov
Internet address: www.dchealth.dc.gov

District of Columbia Hospital Association
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E-mail: rmalson@dcha.org
Internet address: www.dcha.org

FLORIDA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$1,736,991,594	1,245,841	\$2,422,440,384	1,292,241
RECEIVING CASH ASSISTANCE TOTAL	\$1,003,983,709	559,948	\$1,371,908,887	593,679
Aged	\$170,559,577	80,626	\$238,260,026	82,337
Blind/Disabled	\$745,290,114	236,377	\$994,536,618	243,728
Child	\$38,098,660	152,574	\$61,235,847	170,765
Adult	\$50,035,358	90,371	\$77,786,396	96,849
MEDICALLY NEEDY, TOTAL	\$79,151,203	26,944	\$234,190,202	45,851
Aged	\$6,303	7	\$31,015,312	6,050
Blind/Disabled	\$62,557,905	9,963	\$169,380,236	19,159
Child	\$2,228,296	3,206	\$4,379,348	2,856
Adult	\$14,358,699	13,768	\$29,414,779	17,785
Other			\$527	1
POVERTY RELATED, TOTAL	\$392,630,319	400,492	\$486,460,426	454,297
Aged	\$140,952,724	74,911	\$173,981,996	65,907
Blind/Disabled	\$182,755,926	46,604	\$203,471,205	45,142
Child	\$63,888,019	249,619	\$94,203,449	258,882
Adult	\$5,033,650	29,358	\$14,803,776	84,366
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURE/RECIPIENTS	\$261,226,363	258,457	\$329,880,869	198,414

*Total other Expenditures/Recipients include foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data provided by the Florida Agency for Health Care Administration.

Source: CMS, MSIS Report, FY 2002 and Florida Medicaid Statistical Information System, FY 2003

C. ADMINISTRATION

Agency for Health Care Administration. Claims processing and payment by contract with fiscal agent.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; total parenteral nutrition; and interdialytic parenteral nutrition. Products covered with restrictions: non-PDL products require prior authorization. Products not covered: cosmetics; fertility drugs; experimental drugs; disposable needles and syringe combinations used for insulin; blood glucose test strips; and urine ketone test strips.

Over-the-Counter Product Coverage: Products covered with restrictions: allergy, asthma, and sinus products; analgesics (selected aspirin and Tylenol products); cough and cold preparations (select products); digestive products (non-H2 antagonists); feminine products; and smoking deterrent products. Products not covered: digestive products (H2 antagonists); topical products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; analgesics, antipyretics, and NSAIDs; antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents; antipsychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs; prescribed smoking deterrents; sympathomimetics (adrenergic); and thyroid agents. Partial coverage for: prescribed cold medications. Prior authorization required for: growth hormones; mental health drugs; drugs not included on the Medicaid preferred drug list; and brand name prescriptions beyond the four brand cap unless exempted. Therapeutic categories not covered: anoretics; anti-retrovirals for HIV.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through both the Prescription Drug Program and physician payment when used in physicians' offices.

Vaccines: Vaccines reimbursable as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Preferred Drug List (PDL) with mandatory limits and exclusions. All covered drugs are available through the preferred drug process. PDL managed by excluding products based on contracting issues, restrictions on use, prior authorization, therapeutic substitution, preferred products, physician profiling and supplemental rebates. Specific limits and exclusions include:

1. Vitamins and phosphate binders only for dialysis patients.
2. Prostheses; appliances; devices; and personal care items.
3. Non-legend drugs (except for prescribed insulin, pancreatic enzymes, buffered and enteric coated aspirin when prescribed as an anti-inflammatory agent only, and single entity hematinics).
4. Anorexants unless the drug is prescribed for an indication other than obesity (i.e., narcolepsy, hyperkinesia).
5. Drugs with questionable efficacy as rated by FDA (DESI).
6. Investigational and experimental items.
7. Oral vitamins with exception of fluorinated pediatric vitamins prescribed for pediatric patients, vitamins for dialysis patients, prenatal vitamins.
8. Nursing home floor stock drugs.

Prior Authorization: State currently has a formal prior authorization procedure. Direct appeal to AHCA and/or formal request for administrative hearing required to appeal prior authorization decisions.

Prescribing or Dispensing Limitation

Prescription Refill Limit:

1. Variable quantity limits per prescription according to the drug.
2. Drugs not included in the Preferred Drug list (PDL) require PA.
3. Maintenance medication should be dispensed and billed for at least a one-month supply.
4. Refills must be authorized by the prescriber and can be made for up to one year, except that controlled substances can be refilled only in accordance with Federal and State regulations.
5. Nutritional supplements are covered with prior authorization when the patient is otherwise at risk of hospitalization.
6. Other third parties, including Medicare, must be billed first.

Drug Utilization Review

PRODUR system implemented in July 1993. State currently has a DUR board with a quarterly review. Retrospective Drug Utilization Review has been in place since 1982. The State Medicaid agency and the Florida Pharmacy Association, which performs the reviews, share the administration of the program.

Heritage Information Systems contracts to provide DUR and prescriber pattern profiling and clinical review assistance.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.23, effective 3/11/86.

Ingredient Reimbursement Basis: AWP-15.40 % or WAC+5.75%. (effective 7/1/04)

Prescription Charge Formula: Lower of:

1. FUL (Federal Upper Limits or State MAC) plus dispensing fee.
2. EAC plus dispensing fee.
3. Usual and customary charge.
4. In-house unit dose diff. + 0.015/dose.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. MAC override by physicians requires completed MedWatch form and prior authorization.

Incentive Fee: No incentive fee.

Patient Cost Sharing: No copayment

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 786,000 Medicaid recipients received pharmaceutical benefits through managed care plans (inclusion of such benefits is mandated under State law) in FY 2005.

Managed Care Organizations

Amerigroup Florida, Inc.
(FKA Physicians Health Care Plans, Inc.)
4200 W. Cypress Street, Suite 900
Tampa, FL 33607-4173
T: 813/830-6900
F: 813/314-2045

Buena Vista Medicaid
Vista Health Plan, Inc.
(FKA Beacon and Discovery)
300 South Park Road
Hollywood, FL 33021
866/847-8235

Citrus Health Care, Inc.
5420 Bay Center Drive, Suite 250
Tampa, FL 33609
T: 877/624-8787
F: 813/490-8907

Healthcase of Florida, Inc.
8735 Henderson Road, Ren 2
Tampa, FL 33634
T: 800/278-0656
F: 813/290-6332

Humana Family
c/o Humana Medical Plan, Inc.
3501 SW 160th Street
Miramar, FL 33027
T: 800/488-6262
F: 305/626-5086

Jackson Memorial Health Plan
1801 NW 9th Ave., Suite 700
Miami, FL 33136
T: 800/721-2993
F: 305/545-5212

Personal Health Plan
324 Datura Street, Suite 401
West Palm Beach, FL 33401
T: 866/930-0035
F: 561/833-9786

Preferred Medical Plan, Inc.
4950 SW 8th Street
Coral Gables, FL 33134
T: 305/447-8373
F: 305/447-4959

StayWell Health Plan of Florida, Inc.
8735 Henderson Road, Ren 2
Tampa, FL 33634
T: 813/935-5227
F: 813/290-6332

United Healthcare of Florida, Inc.
13621 N.W. 12th Street
Sunrise, FL 33323
T: 800/910-3145

Universal HealthCare, Inc.
150 Second Avenue North
Suite 800
St. Petersburg, FL 33701
T: 866/690-4842
F: 727-823-3840

Vista South Florida
(FKA Foundation Health Plan)
300 South Park Road
Hollywood, FL 33021
T: 800/441-5501
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F. State Contacts

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DUR Contact

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Medicaid DUR Board

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Lois Adams, R.Ph.
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David Levine, DPM, D.O.
Ft. Lauderdale, FL

Earlene Lipowski, Ph.D., R.Ph.
Gainesville, FL

Larry Mattingly, D.O.
Orange Park, FL

Jeane McCarthy, M.D., Ph.D.
St. Petersburg, FL

Richard Roberts, Pharm.D.
Jacksonville, FL

Peggyann Zaenger, Pharm.D.
Jacksonville, FL

Prescribing Pattern Review Panel

Stephen Clark, M.D.
Walter Flesner, D.O.
Cynthia Griffin, Pharm.D.
Dennis Penzell, D.O.
John Steele, M.D.
George Thomas, M.D.

Pharmaceutical and Therapeutics Committee

Carl Brueggemeyer, M.D.
Ponte Verda Beach, FL

Lisa Cosgrove, M.D. (Chair)
Cocoa Beach, FL

Leanne Lai, Ph.D.
Ft. Lauderdale, FL

Martin Lazoritz, M.D.
Gainesville, FL

John Lelekis, R.Ph., M.B.A. (Vice Chair)
Belleair, FL

Shawn Myers, R.Ph., M.B.A.
Largo, FL

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New Brand Name Products Contact

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Prescription Price Updating

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Mail Order Pharmacy Program

State has a mail order pharmacy benefit under its diabetes demonstration waiver.

Disease Management/Patient Education Programs

Disease/ Medical State: AIDS/HIV
Program Manager: Gene Bundrock
Program Sponsor: AIDS Healthcare Foundation

Disease/ Medical State: Asthma
Program Manager: Rachel Lacroix
Program Sponsor: AHCA

Disease/ Medical State: Cardiovascular Disease
Program Manager: Rachel Lacroix/Joyce Stickles
Program Sponsor: AHCA/Life Masters Supported Selfcare, Inc.

Disease/ Medical State: Diabetes
Program Manager: Rachel Lacroix/Diana Schmidt
Program Sponsor: AHCA

Disease Management Program/Initiative Contact

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GEORGIA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	
Physician Services	◆	◆	◆	◆	◆	◆	◆	
Dental Services	◆	◆	◆	◆	◆	◆	◆	

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$749,552,199	1,076,904	\$1,003,853,892	1,222,323
RECEIVING CASH ASSISTANCE, TOTAL	\$448,422,546	383,966		
Aged	\$49,087,789	30,164		
Blind/Disabled	\$337,070,842	155,825		
Child	\$28,579,385	123,343		
Adults	\$33,684,530	74,634		
MEDICALLY NEEDY, TOTAL	\$16,602,873	9,145		
Aged	\$5,773,374	3,893		
Blind/Disabled	\$10,829,303	5,248		
Child	\$196	4		
Adults	\$0	0		
POVERTY RELATED, TOTAL	\$79,977,136	351,470		
Aged	\$3,873,063	2,310		
Blind/Disabled	\$3,943,280	2,328		
Child	\$60,781,933	277,697		
Adults	\$10,358,627	68,181		
BCCA Women	\$1,020,233	954		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$204,549,644	332,323		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Department of Community Health, Division of Medical Assistance.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: Most Federal Legend products with CMS rebates except as otherwise noted. Selected OTC products are also covered with prescriptions. Products covered with restrictions: human insulins (Novo Nordisk human insulins and disposable needles and syringe combinations used for insulin administration are preferred); blood glucose test strips (Roche products only); and urine ketone test strips. Products requiring prior authorization: total parenteral nutrition and interdialytic parenteral nutrition. See PDL for a comprehensive list of covered products (www.dch.state.ga.us-providers-pharmacy-PDL). Products not covered: cosmetics; fertility drugs; experimental drugs; prescription vitamins and minerals (except for prenatal and fluorides not in combination with other vitamins); barbituates (except Seconal, Secobarbital, and Mebaral); DESI drugs; and smoking cessation products.

Over-the-Counter Product Coverage (with a prescription): Products covered: diphenhydramine; OTC iron and multivitamins; and meclizine. Products covered with restrictions: allergy, asthma, and sinus products (generic loratadine products – up to 6 Rx per year for adults, unlimited for children); analgesics (ibuprofen suspension for < 21 yrs. + enteric coated aspirin); and topical products (Klout and permethrin lotcon 1%) Products not covered: digestive products; feminine products; cough and cold preparations; and smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories covered: Most therapeutic categories are covered, including but not limited to the following and their exceptions: anticoagulants; anticonvulsants; chemotherapy agents; prescribed cold medications (partial coverage); contraceptives; estrogens; and thyroid agents. Prior authorization required for: anabolic steroids; analgesics, antipyretics, NSAIDS (partial coverage); antibiotics; antidepressants; antidiabetic agents; antihistamines; hyperlipidemic agents; antipsychotics; anxiolytics, sedatives, and hypnotics (partial coverage); cardiac drugs; ENT anti-inflammatory agents; growth hormones; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); immunoglobulins; COX-II's; Quinolones; Cephalosporins; Atypical Antipsychotics; ADHD/Ophthalmic Prostaglandin

Agents/ Beta Adrenergic Neb/Inhaled Corticosteroids; Bone Ossification; COX-II's/ CCB's/ Nasal Steroids; ARBs/ Serotonin Receptor Agonists; Topical Immunomodulators; Urinary Tract Antispasmodics/Immunomodulators; ophthalmic mastcell stabilizers; COPD agents; and fibric acid derivatives. Therapeutic categories not covered: anoretics; prescribed smoking deterrents; fertility drugs; Alprazolam-XR; Klonopin Wafer; Niravam; and Doral.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment when used in physicians offices.

Vaccines: Vaccines reimbursable as part of the EPSDT service, the CHIP program, and the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list. PDL managed through restrictions on use (quantity level limits), PA, and preferred products.

Prior Authorization: State currently has a formal prior authorization procedure with right of appeal. Clients may write to the Medicaid Medical Director and the Pharmacy Services Unit to appeal coverage and prior authorization decisions.

Prescribing or Dispensing Limitations:

Prescription Refill Limit: Maximum of five refills for adults, six for children. May be overridden at POS by the pharmacist for certain maintenance drugs.

Monthly Quantity Limit: 34-day supply maximum.

Monthly Dollar Limit: \$2,999.99 requires an override; >\$9,999.99 requires paper claim and a copy of the prescription.

Drug Utilization Review

On-line PRODUR system implemented in October 2000. State has a 20 member DUR Board (4-6 meetings per year).

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.63 (for profit), \$4.33 (non-profit)
– eff. 7/1/2005

Ingredient Reimbursement Basis: EAC = AWP - 11%, MFN price or GMAC.

Prescription Charge Formula: Lower of average wholesale price (AWP) minus 11% plus dispensing fee, MAC plus fee, or usual and customary.

Maximum Allowable Cost: State imposes a combination of Federal Upper Limits as well as State-specific Limits on generic drugs. Override requires Brand Medically Necessary and MedWatch form. Approximately 1,440 drugs on the State-specific MAC list.

Incentive Fee: None

Patient Cost Sharing: \$0.50 per prescription for generics or preferred drugs. \$0.50-\$3.00 for non-preferred and brand drugs, dependent on the cost of the drug.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Does not use MCOs to deliver services to Medicaid recipients.

F. STATE CONTACTS**State Drug Program Administrator**

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Stacy Michael Dickens, R.Ph., CDM
Gregory Allen Foster, M.D.
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Marilavinia Jones, M.D.
James Russell Lee, Jr., R.Ph., CGP
Robyn Loris, Pharm.D.
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Vanessa D. Mickles, Pharm.D.

Mathew Perri, III, R.Ph., Ph.D. (Chair)
Raymond Rossenberg, M.D.
Richard S. Singer, D.D.S.
Cynthia Allen Wainscott
Gary M. Williams, M.D. (Vice Chair)

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Disease Management/Patient Education Programs*Diseases/Medical States:*

AIDS/HIV
Asthma
Cardiovascular Disease
Depression
Diabetes
Hemophilia
Schizophrenia

Program Name: GA Enhanced Care Program

Program Manager: APS and United Healthcare

Program Sponsor: Georgia Medicaid

Disease Management Program/Initiative Contact

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Mail Order Pharmacy Benefits

None

Medical Assistance Advisory Committee

Representatives from each of the following groups:

Medical Association of Georgia
Georgia Pharmaceutical Association
Atlanta Medical Association
Georgia Health Care Association
Georgia Hospital Association
Georgia Dental Association
Georgia Osteopathic Medical Association
National Pharmaceutical Association

Executive Officers of State Medical and Pharmaceutical Societies

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HAWAII

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002*		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$81,453,811	39,320	\$96,404,644	41,748
RECEIVING CASH ASSISTANCE TOTAL	\$46,778,608	20,066		
Aged	\$12,383,241	7,063		
Blind/Disabled	\$34,312,136	12,263		
Child	\$27,304	361		
Adult	\$55,927	379		
MEDICALLY NEEDY, TOTAL	\$3,666,738	1,958		
Aged	\$2,392,598	1,527		
Blind/Disabled	\$1,274,140	431		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$25,699,618	12,272		
Aged	\$10,230,442	6,724		
Blind/Disabled	\$15,354,226	5,215		
Child	\$114,950	333		
Adult	\$0	0		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$5,308,847	5,024		

*Total Other Expenditures/Recipients include foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Hawaii Department of Human Services through its Med-Quest Division and four county branch offices.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin. Products covered as DME: disposable needles and syringe combinations used for insulin; blood glucose test strips; and urine ketone test strips. Products requiring prior authorization: total parenteral nutrition (for home infusion); interdialytic parenteral nutrition (for home infusion); Clozaril; brand products on FUL price list; Betaseron; Oxycontin; and non-preferred PDL drugs. Products not covered: cosmetics; fertility drugs; and experimental drugs.

Over-the-Counter Product Coverage: Products covered: allergy, asthma, and sinus products; analgesics; and digestive products (non-H2 antagonists). Products covered with restrictions: cough and cold preparations (select products, others require prior authorization); digestive products (H2 antagonists-cimetidine and ranitidine, others require prior authorization); topical products (for non-cosmetic purposes only); and smoking deterrent products (Xyban only, others require prior authorization).

Therapeutic Category Coverage: Products covered: analgesics, antipyretics, and NSAIDs; antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antilipemic agents; anxiolytics; sedatives; and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; estrogens; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: anabolic steroids; anorectics; non-sedating antihistamine drugs; atypical anti-psychotics; prescribed cold medications; proton pump inhibitors; growth hormones; and prescribed smoking deterrents.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care, extended care facilities and physicians' offices.

Vaccines: Vaccines reimbursable as part of EPSDT service and CHIP.

Unit Dose: Unit dose packaging reimbursable

Formulary/Prior Authorization

Formulary: Open formulary managed through preferred products and prior authorization. Preferred drug list implemented in 2004.

Prior Authorization: State currently has a formal prior authorization procedure. A fair hearing may be requested for appeal of prior authorization decisions.

Prescribing or Dispensing Limitations

Monthly Quantity Limit: Physicians are encouraged to prescribe a 30-day supply or 100 units. State has implemented maximum doses for certain drugs, including Epogen, Liptor, Zofran, and Zomig.

Drug Utilization Review

PRODUR system implemented in September 1997. State currently has a DUR board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.67, effective May 9, 1990.

Ingredient Reimbursement Basis: EAC = AWP-10.5%.

Prescription Charge Formula: Payment for prescription and OTC drugs listed in the formulary is limited to the State or Federally established MAC price, or Estimated Acquisition Cost (EAC) or AWP-10.5% when equal to average selling price plus dispensing fee, or billed amount, whichever is lowest.

Maximum Allowable Cost: State imposes Federal Upper Limits and State-specific limits on generically available drugs. Override requires "Brand Medically Necessary" or "Do Not Substitute" written on the prescription.

Incentive Fee: None.

Patient Cost Sharing: No copayment.

Cognitive Services: Emergency Contraception (eff. 2005).

E. USE OF MANAGED CARE

Approximately 140,000 Medicaid recipients were enrolled in MCOs in FY 2004. Recipients receive most of their pharmaceutical benefits through managed care plans. State has specific guidelines for the pharmacy benefit for Medicaid recipients enrolled in managed care plans. Behavioral health drugs and

drugs prescribed by dentists are “carved out” of managed care and provided through the State.

Managed Care Organizations

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James Lumeng, M.D. (Medicine/Pathology)
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Brian Matsuura (Medical Services Rep.)
Kapolei, HI

Joy Higa, R.Ph. (Long Term Care) (Chair)
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Jerry Smead, R.Ph. (Ambulatory Care)
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Mail Order Pharmacy Benefit

None

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Emerick Orimoto, Pharm.D.
Stephen Wallach, M.D.
Rio Banner, M.D.
Josh Green, M.D.
Sonny Borja-Barton, Pharm.D.
Stuart Rusnak, M.D.
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IDAHO

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$121,780,793	125,537	\$137,360,436	133,592
RECEIVING CASH ASSISTANCE, TOTAL	\$72,269,410	23,218		
Aged	\$5,418,059	2,078		
Blind/Disabled	\$66,398,243	20,077		
Child	\$270,352	842		
Adult	\$182,756	221		
MEDICALLY NEEDY, TOTAL	\$0	0		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$12,870,890	63,429		
Aged	\$326,033	147		
Blind/Disabled	\$384,836	178		
Child	\$11,104,429	56,523		
Adult	\$1,055,592	6,581		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$36,640,493	38,890		

*Total Other Expenditures/Recipients include foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Division of Medicaid, Idaho Department of Health & Welfare

By the State Department of Health and Welfare through seven regional offices, each serves five or more of the State's 44 counties.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin. Products covered through DME: disposable needles and syringe combinations used for insulin; blood glucose test strips; urine keton test strips; total parenteral nutrition; and interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; experimental drugs.

OTC Coverage: Products covered: loratadine OTC; permethrin; Prilosec OTC; oral iron salts; insulin and insulin syringes. Products not covered: allergy, asthma, and sinus products; analgesics, cough and cold preparations; digestive products; feminine products; topical products; and smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories covered: antidepressants; anti-psychotics; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; and thyroid agents. Prior authorization required for: analgesics; antipyretics, and NSAIDs; antibiotics; anticoagulants; anticonvulsants; antidiabetic agents; antihistamines; antilipemic agents; anxiolytics, sedatives, and hypnotics; cardiac drugs; growth hormones; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); Alzheimer's agents; PPIs; Cox II; Triptans; long acting opioids; urinary incontinence products; select prenatal vitamins; stimulants; antiemetics; retinoids; topical antiacne products; Provigil; Aldara; Synagis; Regranex; Androgel; Prolastin; Klonopin Wafers; Marinol; Nascobal; Xenical; Penlac; Prozac Weekly; Remeron Sol. Tabs; Restasis; Strattera; Taladine; Thalomid; Triostat; Triptans; Zetia; Xanax XR; Xolair; Vytarin; and brand names of FUL and SMAC drugs. Therapeutic categories not covered: anabolic steroids; anorectics; and prescribed smoking deterrents.

Coverage of Injectables: Injectable medicines reimbursable through the Physician Payment when used in home health care, extended care facilities, and physicians offices.

Vaccines: Vaccines reimbursable as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable when used in unit dose systems.

Formulary Authorization

Formulary: None. State maintains a preferred drug list. Pharmacy program is managed through an enhanced prior authorization program (Smart PA), restrictions on use, preferred products, and generic substitution for multi-source products.

Prior Authorization: State currently has a formal prior authorization procedure and a prior authorization committee. Patient only may appeal a prior authorization decision. Written "notice of appeal" required for fair hearing within 30 days of receiving the denial.

Prescribing or Dispensing Limitations

Monthly Quantity Limit: Prescription drugs are limited to a 34-day supply. Limits on the number of refills per script and early refills. The following drugs are limited to a 100-day supply: cardiac glycosides, thyroids, prenatal vitamins, nitroglycerin, fluoride, fluoride and vitamin combinations, non-legend oral iron salts and 3 cycles of birth control.

Drug Utilization Review

Contracted DUR through Idaho State University. PRODUR system implemented January 1998. State currently has a DUR board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.94 (\$5.54 for unit dose), effective March 1999.

Ingredient Reimbursement Basis: Discounted AWP = AWP-12% as determined by First DataBank Data File Service or manufacturer direct price for selected manufacturers.

Prescription Charge Formula: Lower of FUL, SMAC or Discounted AWP plus a dispensing fee or provider's usual and customary price to the general public.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Medically Necessary" and submission of appropriate documentation through the prior authorization process.

Incentive Fee: None.

Patient Cost Sharing: No copayment.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Does not use MCOs to deliver services to Medicaid recipients.

F. STATE CONTACTS

Medicaid Drug Program Administrator

Paul Leary, Chief
Bureau of Medical Care
Department of Health and Welfare
Division of Medicaid
3232 Elder
Boise, ID 83705
T: 208/364-1831
F: 208/364-1864
E-mail: learyp@idhw.state.id.us
Internet address: www.healthandwelfare.idaho.gov

Prior Authorization Contact

Tamara Eide, Pharm.D., BCPS, FASHP
Pharmacy Services Supervisor
Department of Health and Welfare
Division of Medicaid
3232 Elder
Boise, ID 83705
T: 208/364-1821
F: 208/364-1864
E-mail: eidet@idhw.state.id.us

Pharmacy and Therapeutics Committee

Bob Comstock, R.Ph.
Catherine Gundlach, Pharm.D.
Stan Eisele, M.D.
William Woodhouse, M.D.
Phil Peterson, M.D.
Richard J. Pines, D.O.
Rick Sutton, R.Ph.
Thomas Rau, M.D.
Richard Markuson, R.Ph.
Donald Norris, M.D.
Stephen Montamat, M.D. (Chair)
Tamara Eide, Pharm.D.

DUR Contact

Tamara Eide, Pharm.D., BCPS, FASHP
208/364-1821

Medicaid DUR Board

Board Members:

Wayne Baures, R.Ph.
Suzette Cooper, R.Ph.
Joseph Steiner, Pharm. D.
Nancy Mann, M.D.
Gregory Kadlec, M.D.
Myrna Olsan-Fisher, F.N.P.

DUR Program Coordinator:

Tamara Eide, Pharm. D.

Staff:

Vaughn Culbertson, Pharm.D., Project Dir.

New Brand Name Products Contact

Mary Wheatley, R.Ph.
Pharmacy Services Specialist
Department of Health and Welfare
Division of Medicaid
3232 Elder
Boise, ID 83705
T: 208/364-1832
F: 208/364-1864
E-mail: wheatlem@idw.state.id.us

Prescription Price Updating

Mary Wheatley, R.Ph.
208/364-1832

Medicaid Drug Rebate Contact

Larry Tisdale
Program Supervisor
3rd Party Recovery Unit
Department of Health and Welfare
3232 Elder Street
Boise, ID 83705
208/287-1141
E-mail: tisdale@idhw.state.id.us

Claims Submission Contact

Electronic Data Systems (EDS)
P.O. Box 23
Boise, ID 83707
T: 208/395-2000
F: 208/395-2030

Medicaid Managed Care Contact

State currently has no managed care program.

Mail Order Pharmacy Program

State currently has no mail order pharmacy program.

Health and Welfare Department Officials

Richard Armstrong
Department of Health & Welfare
450 West State Street
Boise, ID 83720-0036
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Leslie Clement, Administrator
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Title XIX Medical Care Advisory Committee

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Idaho Medical Association

Jim Baugh
CO-AD - Comprehensive Advocacy

Leslie Clement
Idaho Medical Program

Senator Richard Compton
Idaho Senate

Greg Dickerson
Mental Health Provider's Association

Bill Foxcroft
Idaho Primary Care Association

Elizabeth Henry
American Indian Tribes

Kristyn Herbert
Individual

Deedra Hunt
Aged Community

Toni Lawson
Idaho Hospital Association

Mark Leeper
Disabled Community

Marla Lewis
Kootenai County Welfare Department

Cathy McDougall
AARP

Representative John Rusche, M.D.
Idaho House of Representatives/Board Certified
Physician

Dick Schultz
Division of Health

Elke Stava
Hospice

Robert VandeMerwe
Idaho Health Care Association

Mike Wilson
Living Independently Forever, Inc.

Teresa Wolf
Nez Perce County

Executive Officers of State Medical and Pharmaceutical Societies

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P.O. Box 2668
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F: 208/344-7903
E-mail: mail@idmed.org
Internet address: www.idmed.org

Idaho State Pharmacy Association
JoAn Condie
Executive Director
P.O. Box 140117
Boise, ID 83714-0117
T: 208/424-1107
F: 208/376-3131
E-mail: condie@velocitus.net
Internet address: www.idahopharmacy.org

Idaho State Board of Pharmacy
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3380 Americana Terrace, Suite 320
P.O. Box 83720
Boise, ID 83706
T: 208/334-2356
F: 208/334-3536
E-mail: rmarkuson@bop.state.id.us
Internet address: www.accessidaho.org/bop

Idaho Hospital Association
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Internet address: www.teamiha.org

ILLINOIS

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$1,222,947,241	1,199,933	\$1,258,646,834	1,227,361
RECEIVING CASH ASSISTANCE TOTAL	\$428,095,975	211,001		
Aged	\$50,859,185	20,248		
Blind/Disabled	\$361,528,367	126,826		
Child	\$8,870,084	48,180		
Adult	\$6,838,339	15,747		
MEDICALLY NEEDY, TOTAL	\$489,678,297	314,648		
Aged	\$138,597,747	55,634		
Blind/Disabled	\$270,370,434	85,271		
Child	\$542,742	839		
Adult	\$80,167,374	172,904		
POVERTY RELATED, TOTAL	\$123,171,941	495,926		
Aged	\$4,663,774	2,288		
Blind/Disabled	\$15,624,787	5,122		
Child	\$98,238,455	455,846		
Adult	\$4,305,676	32,478		
BCCA Women	\$339,249	192		
OTHER EXPENDITURES/RECIPIENTS*	\$182,001,028	178,358		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Illinois Department of Healthcare and Family Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: disposable needles and syringe combinations used for insulin; total parenteral nutrition; interdialytic parenteral nutrition; and urine ketone test strips. Products covered with restrictions: (PDL applies): prescribed insulin; blood glucose test strips; and self-administered injectables. Products not covered: cosmetics; DESI-ineffectives; fertility drugs; and experimental drugs.

OTC Coverage: Products covered: smoking deterrent products. Products covered with restrictions: allergy, asthma, and sinus products (children <18); analgesics (children <18); cough and cold preparations (limited products); digestive products (non-H2 antagonist) (PDL applies); and topical products (PDL applies). Products not covered: digestive products (H2 antagonists) and feminine products.

Therapeutic Category Coverage: Categories covered: anticoagulants; anticonvulsants; chemotherapy agents; contraceptives; prescribed smoking deterrents; and thyroid agents. Prior authorization required for: anabolic steroids; analgesics, antipyretics, and NSAIDs, antibiotics; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents; anti-psychotics; anxiolytics, sedatives and hypnotics; cardiac drugs; ENT anti-inflammatory agents; prescribed cold medications; estrogens; growth hormones; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); and Cox II's.

Coverage of Injectables: Injectable medicines reimbursable through physician payment when used in home health care, extended care facilities, and physician offices. PDL rules apply.

Vaccines: Vaccines are reimbursable as part of the EPSDT service and the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list (PDL). State PDL is managed through restrictions on use, prior authorization, and preferred products.

Prior Authorization: State currently has a formal prior authorization procedure and a Drugs and Therapeutics Committee. Manufacturers can appeal a decision to place products on non-preferred status to the Drug and Therapeutics Committee. Recipients can appeal prior authorization decisions through the Department's Bureau of Administrative Hearings.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Maximum of eleven refills.

Monthly Quantity Limit: 3 brand name scripts per month.

Quantity Limit per Script: varies by drug.

Drug Utilization Review

PRODUR system implemented in January 1993.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.40 for branded drugs; \$4.60 for generics.

Ingredient Reimbursement Basis: EAC: AWP-12%.

Prescription Charge Formula: Lowest of 1) usual and customary, 2) Department's MAC plus fee.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires prior authorization (i.e., letter from physician justifying medical need for the brand drugs).

Incentive Fee: None.

Patient Cost Sharing: \$3.00 for branded drugs. No copay for generics.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 146,000 Medicaid recipients are voluntarily enrolled in MCOs in 2006. Recipients receive pharmaceutical benefits through the State.

Managed Care Organizations

Amerigroup Illinois
211 Wacker Drive
Suite 1350
Chicago, IL 60606-3101
T: 312/214-0400
F: 312/214-0424

Harmony Health Plan of Illinois
125 South Wacker Drive
Suite 2600
Chicago, IL 60606
T: 312/630-2025
F: 312/368-1784

Family Health Network
910 West Van Buren
6th Floor
Chicago, IL 60607
T: 312/491-1956
F: 312/491-1175

F. STATE CONTACTS**State Drug Program Administrator**

Sinead Madigan, Chief
Bureau of Pharmacy Services
Illinois Department of Healthcare and Family
Services
201 S. Grand Avenue East
Springfield, IL 62763
T: 217/524-7478
F: 217/558-1531
E-mail: sinead.madigan@illinois.gov
Internet address: www.hfs.illinois.gov

Prior Authorization Contact

Pharmacy Unit Staff
217/524-2570

DUR Contact

Sinead Madigan
217/524-7478

New Brand Name Products Contact

Lisa Voils
Special Assistant to Medicaid Deputy Administrator
Illinois Department of Healthcare and Family
Services
201 S. Grand Avenue East
Springfield, IL 62763
T: 217/782-2570
F: 217/782-5672
E-mail: lisa.voils@illinois.gov

Prescription Price Updating

First DataBank
111 Bayhill Dr.
San Bruno, CA 94066
T: 650/588-5454
F: 650/588-4003

Medicaid Drug Rebate Contact

Bradley Wallner, Chief
Bureau of Budget and Cash Management
Illinois Department of Healthcare and Family
Services
2200 Churchill Road, Bldg A-1
Springfield, IL 62702
T: 217/524-7161
F: 217/785-4174
E-mail: bradley.wallner@illinois.gov

Claims Submission Contact

Illinois Department of Healthcare and Family
Services
201 S. Grand Avenue East
Springfield, IL 62763
T: 217/782-2570
F: 217/782-5672

Medicaid Managed Care Contact

Kelly Carter, Chief
Bureau of Contract Management
Illinois Department of Healthcare and Family
Services
201 S. Grand Avenue East
Springfield, IL 62763
T: 217/524-7478
F: 217/524-7535
E-mail: kelly.carter@illinois.gov

Mail Order Pharmacy Benefit

State has a mail order pharmacy benefit. Any
Medicaid beneficiary can choose to receive pharmacy
services from a Medicaid enrolled mail order
pharmacy.

Illinois Medicaid Agency Officials

Barry Maram, Director
Illinois Department of Healthcare and Family
Services
201 South Grand Avenue, East, Third Floor
Springfield, IL 62763
T: 217/782-1200
F: 217/524-7120
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Dr. Anne Marie Murphy, Administrator
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Title XIX Medical Care Advisory Committee

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Springfield, IL 62704-2526
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Illinois Osteopathic Medical Society
Elizabeth Forkins Harano
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142 East Ontario Avenue, Suite 1023
Chicago, IL 60611-2854
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E-mail: ioms@ioms.org
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Illinois State Board of Pharmacy
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320 West Washington Street
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T: 217/782-8556
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Illinois Hospital Association
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1151 East Warrenville Road
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Internet address: www.ihatoday.org

INDIANA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$636,357,519	490,386	\$655,689,109	459,938
RECEIVING CASH ASSISTANCE, TOTAL	\$315,484,522	200,489		
Aged	\$52,184,587	16,691		
Blind/Disabled	\$217,167,920	59,727		
Child	\$17,736,334	70,416		
Adult	\$28,395,681	53,655		
MEDICALLY NEEDY, TOTAL	\$0	0		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$56,010,936	156,012		
Aged	\$400,906	482		
Blind/Disabled	\$1,018,867	777		
Child	\$53,085,594	145,439		
Adult	\$1,391,683	9,198		
BCCA Women	\$113,886	116		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$264,862,061	133,885		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

The State of Indiana did not respond to the 2005/2006 NPC Survey. Using information from the State's website and other source material, we have, to the extent possible, updated the Profile and the tables in other Sections of the Compilation. Users should contact the Indiana Medicaid program to assess the accuracy and currency of the information included.

C. ADMINISTRATION

Indiana Family and Social Services Administration,
Office of Medicaid Policy and Planning

***NOTE WELL—All requests for information by, or on behalf of, drug manufacturers must be made ONLY to: PDL@FSSA.state.in.us**

Phone requests will not be accepted.

D. PROVISIONS RELATING TO DRUGS**Benefit Design**

Drug Benefit Product Coverage: Products covered: All FDA-approved legend drugs from rebating labelers, excluding those products specifically non-covered by State law (e.g., cosmetics; fertility enhancement drugs; products to promote weight loss; DESI drugs; and experimental drugs). For more detailed coverage information see www.indianamedicaid.com or www.indianapbm.com.

Over-the-Counter Product Coverage: Indiana has a Medicaid OTC drug formulary. Listed drugs are reimbursed based on State MAC. For more detailed information, see www.indianapbm.com.

Therapeutic Category Coverage: All coverage in accordance with OBRA '90 & '93.

Coverage of Injectables: Covered.

Vaccines: Covered, under the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Preferred Drug List (see www.indianapbm.com-pharmacyservices)

Prior Authorization: State has a prior authorization program with formal appeal process. Prior authorization determined solely on the basis of medical necessity. For additional information see www.indianapbm.com

Prescribing or Dispensing Limitations

Monthly Quantity Limit: None.

Drug Utilization Review

PRODUR system implemented in March 1996. State currently has a DUR Board with a monthly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.90, effective 05/30/02.

Ingredient Reimbursement Basis:

EAC = Brand: AWP-13.5%
Generic: AWP-20%

Legend Drug Reimbursement Methodology:

Lower/Lowest of:

1. Federal MAC, if applicable, plus a dispensing fee.
2. State MAC, if applicable, plus a dispensing fee.
3. EAC plus a dispensing fee.
4. Pharmacy's usual and customary charge to the general public.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Brand Medically Necessary" plus prior authorization (as of September 2001).

Incentive Fee: None.

Patient Cost Sharing: \$3.00. Exemptions include institutionalized beneficiaries, pregnant women, children <18 years old, and family planning-related services.

Cognitive Services: None.

E. USE OF MANAGED CARE

Approximately 294,000 Medicaid recipients were enrolled in MCOs in FY 2004. Recipients receive pharmaceutical benefits through managed care plans.

Managed Care Organizations

Harmony Health Plan of Indiana
504 Broadway, Suite 200
Gary, IN 46204
800/504-2766

Managed Health Services
1099 N. Meridian Street, Suite 400
Indianapolis, IN 46204
800/944-9661

MDwise
1099 N. Meridian Street, Suite 320
Indianapolis, IN 46204
317/630-2828

AmeriChoice
333 N. Alabama
Suite 350
Indianapolis, IN 46204
317/263-0355

CareSource
Market Square Center
151 N. Delaware Street, Suite 1840
Indianapolis, IN 46204
866/930-0017

Molina Healthcare of Indiana
8001 Broadway, Suite 400
Merrillville, IN 46410
219/736-9101

Health Care Excel
P.O. Box 53380
Indianapolis, IN 46253
317/347-4500

F. STATE CONTACTS

State Drug Program*

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Pharmacist
Family and Social Services Administration
Office of Medicaid Policy and Planning
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Indiana State Government Center South
402 W. Washington Street
Indianapolis, IN 46204-2739
T: 317/232-4343
F: 317/232-7382
E-mail: marc.shirley@fssa.in.gov
Internet address: www.indianamedicaid.com

***NOTE WELL—All requests for information by,
or on behalf of, drug manufacturers must
be made ONLY to: PDL@FSSA.state.in.us**

Phone requests will not be accepted.

DUR Contact

DUR Board Secretary
Office of Medicaid Policy & Planning
Room W382, Indiana State Government Center South
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T: 317/232-4307
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Medicaid DUR Board

Physicians

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John J. Wernert, M.D.
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Pharmacists

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Citizens' Representatives (3)

Vacant

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Senator Jim Merritt

Indiana State House of Representatives (2)

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Katy Howard (ex-officio)

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IOWA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$277,753,942	245,711	\$325,270,012	258,417
RECEIVING CASH ASSISTANCE TOTAL	\$134,268,348	112,725		
Aged	\$16,496,475	6,468		
Blind/Disabled	\$93,745,177	32,850		
Child	\$9,755,348	42,757		
Adult	\$14,271,348	30,650		
MEDICALLY NEEDY, TOTAL	\$12,771,499	5,887		
Aged	\$3,985,026	2,020		
Blind/Disabled	\$7,050,585	1,716		
Child	\$112,460	300		
Adult	\$1,623,428	1,851		
POVERTY RELATED, TOTAL	\$12,521,471	58,277		
Aged	\$420,755	677		
Blind/Disabled	\$738,034	672		
Child	\$9,796,078	48,440		
Adult	\$1,566,604	8,488		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$118,192,624	68,822		

*Total Other Expenditures/Recipients include foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

State Department of Human Services, Bureau of Long Term Care.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; total parenteral nutrition; and interdialytic parenteral nutrition. Products covered requiring prior authorization: PPIs; dipyridamole; epoetin; filgrastim; vitamins and minerals; ergotamine derivatives; narcotic agonist-antagonist nasal sprays; isotretinoin; oral antifungals; non-parenteral vasopressin derivatives; and Serotonin 5-HT₁ receptor agonists. Products not covered: fertility drugs; experimental drugs; cosmetics; disposable needles and syringe combinations for insulin; blood glucose test strips; urine ketone test strips; and DESI drugs. For additional information on drug product coverage, see www.iowamedicaidpdl.com.

Over-the-Counter Product Coverage: Products covered with restriction (selected products): allergy, asthma, and sinus products; analgesics; cough and cold preparations; and topical products. Products not covered: digestive products (non-H₂ antagonists and H₂ antagonists); feminine products; and smoking deterrent products.

The Iowa Department of Human Services adopted an administrative rule that permits coverage for certain non-prescription drugs. A list of covered OTC products, may be found at www.iowamedicaidpdl.com.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antilipemic agents; anti-psychotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: analgesics, antipyretics, NSAIDs; amphetamines; antihistamines; anxiolytics, sedatives, and hypnotics; prescribed cold medications; growth hormones; and misc. GI drugs. Partial coverage for: prescribed smoking deterrents. Therapeutic categories not covered: anorectics; drugs for strictly cosmetic purposes and hair growth; fertility drugs; and drugs without signed Medicaid rebate agreements.

Additional information on product coverage and preferred drug lists may be found at: www.iowamedicaidpdl.com

Coverage of Injectables: Injectable medicines reimbursable through both the Prescription Drug Program and through physician payment when used in home health care, extended care facilities, and physicians' offices.

Vaccines: Vaccines reimbursable as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: No formulary. Preferred drug list managed through prior authorization.

Prior Authorization: State currently has a formal prior authorization procedure. State appeals and a fair hearing procedure required for appeal of prior authorization decisions and coverage of an excluded product.

Prescribing and Dispensing Limitations:

Prescribing or Dispensing Limitations: Maximum 30 day supply except 90 days for oral contraceptives.

Drug Utilization Review

PRODUR system implemented in July 1997. State currently has a DUR Board that meets 8 times per year.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.39, effective 7/1/05.

Ingredient Reimbursement Basis: EAC = AWP-12%.

Prescription Charge Formula: Payment will be based on the pharmacist's usual, customary and reasonable charge, but payment may not exceed EAC plus a dispensing fee.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Brand Medically Necessary."

Incentive Fee: None.

Patient Cost Sharing: Copayment of \$0.50-\$3.00 for brand products, depending on the cost of the drug.

Cognitive Services: State pays for pharmaceutical case management.

E. USE OF MANAGED CARE

Approximately 280,000 Medicaid beneficiaries were enrolled in managed care organizations in 2004. This includes both medical managed care organizations and the behavioral care carve-out program. Iowa Medicaid recipients enrolled in managed care receive pharmaceutical benefits through the State fee-for-service payment program.

Managed Care Organizations

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515/225-1234

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Mail Order Pharmacy Program

State currently has a mail order pharmacy program. Participating pharmacies must be enrolled as an Iowa Medicaid provider.

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Title XIX Medical Assistance Advisory Council

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Iowa Senate
Senator James Seymour
Senator Jack Hatch

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KANSAS

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$220,800,602	157,618	\$235,117,999	165,599
RECEIVING CASH ASSISTANCE TOTAL	\$99,282,654	61,641		
Aged	\$9,283,080	4,097		
Blind/Disabled	\$82,468,988	30,470		
Child	\$2,944,174	15,227		
Adult	\$4,586,412	11,847		
MEDICALLY NEEDY, TOTAL	\$14,150,472	10,958		
Aged	\$2,617,843	1,251		
Blind/Disabled	\$9,464,393	2,729		
Child	\$802,606	3,799		
Adult	\$1,265,630	3,179		
POVERTY RELATED, TOTAL	\$9,866,701	45,961		
Aged	\$232,385	170		
Blind/Disabled	\$506,336	266		
Child	\$8,430,609	39,595		
Adult	\$697,371	5,930		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$97,500,775	39,058		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

State Department of Social and Rehabilitation Services, Health Care Policy Division.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin. Products covered under DME: disposable needles and syringe combinations used for insulin used for insulin (prior authorization required); blood glucose test strips; urine ketone test strips; total parenteral nutrition (prior authorization required); and interdialytic parenteral nutrition (prior authorization required). Products not covered: cosmetics; fertility drugs; erectile dysfunction drugs; experimental drugs; DESI drugs; and drugs not rebated by the manufacturer.

Over-the-Counter Product Coverage: Products covered: allergy, asthma, and sinus products; analgesics; digestive products; and topical products. Products covered with restrictions: cough and cold preparations (for children only); feminine products (some covered); and smoking deterrent products (zyban and patches covered for limited time period). Products not covered: OTC nutritional supplements.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamine drugs; anti-psychotics; antilipemic agents; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); growth hormones (PA required); and thyroid agents. Partial coverage for: analgesics, antipyretics, and NSAIDs (PA required on some); anoretics; prescribed cold medications (children only); and prescribed smoking deterrents. Prior authorization required for: triptans; nasal steroids; PPIs, statins; Cox-II inhibitors; wound products; brand name drugs with bioequivalent generics; and all non-preferred drugs.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment program when used in physician offices.

Vaccines: Vaccines reimbursed as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: State currently maintains an open formulary along with a Preferred Drug List (PDL) (see www.da.ks.gov/hpf). The formulary/ PDL is managed through restrictions on use, preferred products, and clinical equivalency determined by the PDL Committee. Prior authorization required for non-PDL products.

Prior Authorization: State currently has a formal prior authorization procedure. The individual appealing may request an administrative hearing to appeal a prior authorization decision by sending a request in writing to:

Administrative Hearing Office
1020 S. Kansas
Topeka, KS 66612

Prescribing or Dispensing Limitations

Monthly Prescription Limit: 5 single source scripts/month.

Prescription Refill Limit: As authorized by the prescriber and allowed by statute up to a one-year period from the date of issuance of the prescription for non-controlled drugs. No early refills (<80% Rx utilized).

Monthly Quantity Limit: 31-day supply.

Other: Narcotics, Ketorolac, Toradol Relpex and triptans have specific limits.

Drug Utilization Review

PRODUR system implemented in November 1996. State currently has a DUR Board that meets every two months.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.40, effective 7/1/03.

Ingredient Reimbursement Basis: EAC Brand, = AWP-13%. Generics, AWP-27%. IV fluids, AWP-50%. Blood fraction products, AWP-30%.

Prescription Charge Formula: Pharmacies are reimbursed the lesser of usual and customary, MAC, FUL, or acquisition cost (EAC) plus a dispensing fee.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific maximum allowable cost (MAC) limits on generic drugs.

Override requires prior authorization and MedWatch form.

Incentive Fee: None.

Patient Cost Sharing: A recipient copay charge of \$3.00 (effective 7/02) applies to each new and refill prescription not specifically exempted under Federal regulations.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 102,000 Medicaid Recipients were enrolled in MCOs in FY 2005. Recipients receive most pharmaceutical benefits through managed care plans. However, hemophilia drugs and certain other specific compounds are carved out of managed care.

Managed Care Organizations

First Guard Health Plans
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KENTUCKY¹

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$661,409,737	489,416	\$693,988,604	512,351
RECEIVING CASH ASSISTANCE, TOTAL	\$466,733,445	245,159		
Aged	\$37,620,114	15,676		
Blind / Disabled	\$388,598,724	140,619		
Child	\$16,398,100	55,943		
Adult	\$24,116,507	32,921		
MEDICALLY NEEDY, TOTAL	\$21,156,198	20,816		
Aged	\$5,714,524	2,250		
Blind / Disabled	\$4,820,219	1,765		
Child	\$2,774,925	8,607		
Adult	\$7,846,530	8,194		
POVERTY RELATED, TOTAL	\$47,434,056	155,883		
Aged	\$595,876	627		
Blind / Disabled	\$1,664,425	981		
Child	\$41,796,311	136,285		
Adult	\$3,377,444	17,990		
BCCA Woman	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$126,086,038	67,558		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

¹ The State of Kentucky did not respond to the 2005/2006 NPC Survey. Using information from the State's website and other source materials, we have, to the extent possible, updated the Profile and the tables in the other sections of the Compilation. Users should contact the Kentucky Medicaid program to assess the accuracy and currency of the information included.

C. ADMINISTRATION

Department for Medicaid Services, within the Cabinet for Health and Family Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: Most legend drugs including prescribed insulin and syringe combinations used for insulin. Products covered with restrictions (i.e., require prior authorization): total parenteral nutrition; and interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; experimental drugs; disposable needles used for insulin; blood glucose test strips; urine ketone test strips; hair growth products; drugs for weight loss or weight gain; vitamins (except prenatal and fluoride preparations); and DESI drugs.

Over-the-Counter Product Coverage: Products covered with restrictions (i.e., prior authorization and prescription required): allergy, asthma, and sinus products; analgesics; digestive products (H2 and non-H2 antagonists); feminine products; topical products; and other OTCs with signed rebate agreements. Products not covered: smoking deterrent products; most supplies; and non-rebatable items except covered vitamins and vaccines.

Therapeutic Category Coverage: Therapeutic categories covered: antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; and thyroid agents. Prior authorization required for: anabolic steroids; analgesics, antipyretics, NSAIDs; anoretics; antihistamine drugs; antileptic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; prescribed cold medications; growth hormones; hypotensive agents; misc. GI drugs; topical steroids; erectile dysfunction products; Leukotriene inhibitors; Synagis; Respigam; Zetia; CNS stimulants for ADHD and other disorders; Avodart; Proscar; anti-fungals for nails; Serotonin 5HT1 Receptor Agonists; GCSF products; Recombinant Human Erythropoietin agents; and Xolair. Therapeutic categories not covered: prescribed smoking deterrents; agents for cosmetic purposes or hair growth and agents to promote fertility.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through both the Prescription Drug

Program and physician payment when used in physician offices. Reimbursement is limited to antineoplastic drugs with "J" codes in physician offices, several antibiotics, Depo-Provera for birth control.

Vaccines: Vaccines reimbursable in the cost of the physician visit as part of EPSDT service, Children's Health Insurance Program, Vaccines for Children Program and through the Pharmacy Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Closed Formulary. The Kentucky Medicaid Program maintains a closed formulary and covers all rebated products. The State manages the formulary through a variety of techniques including the exclusion of products based on contracting issues, restrictions on use, prior authorization, algorithms, and preferred products. Prior authorization required for many brand name products with generic equivalents.

Prior Authorization: State currently has a prior authorization procedure. A formal appeals process is available if a request is denied.

Prescribing or Dispensing Limitations

Monthly Limit on Scripts: 4 scripts per month with exceptions (children <19, nursing home residents, insulin) and override criteria. Override possible for specific medical conditions and with prior authorization.

Monthly Dollar Limit: None.

Quantity Limit per Script: 32 day supply except maintenance drugs (93 days or 100 units, whichever is greater).

Prescription Refill Limit: Up to 5 refills within a 6 month period.

Drug Utilization Review

PRODUR system implemented in 1987. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.51, effective 1/16/01.

Ingredient Reimbursement Basis: EAC = AWP-12%.

Prescription Charge Formula: Reimbursement consists of the lowest of: (1) the usual and customary charge; (2) the FUL, if any, plus a dispensing fee; or (3) the EAC plus a dispensing fee, or (4), SMAC if any, plus a dispensing fee.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Brand Necessary," "Brand Medically Necessary," or Prior Authorization.

Incentive Fee: None.

Patient Cost Sharing: \$1.00 - \$3.00 except pregnant women, children <19, and institutionalized beneficiaries.

- \$1.00 – Generic
- \$2.00 – Preferred brand
- \$3.00 – Non-preferred brand

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 141,000 Medicaid recipients were enrolled in MCOs in FY 2005. Recipients receive pharmaceutical benefits through both the State and managed care plans. Medications prescribed by a board certified psychiatrist are carved out of managed care.

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Mail Order Pharmacy Program

State currently has a mail order pharmacy program. Mail order pharmacy program is open to all Medicaid recipients. Must use a pharmacy that participates in the Kentucky Medicaid Program.

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LOUISIANA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$682,557,080	689,973	\$783,761,071	758,388
RECEIVING CASH ASSISTANCE, TOTAL	\$417,471,680	265,688		
Aged	\$102,349,922	40,066		
Blind/Disabled	\$273,812,613	117,247		
Child	\$18,906,266	65,315		
Adult	\$22,402,879	43,060		
MEDICALLY NEEDY, TOTAL	\$9,814,798	6,976		
Aged	\$3,765,950	1,276		
Blind/Disabled	\$3,341,251	1,654		
Child	\$80,023	313		
Adult	\$2,627,574	3,733		
POVERTY RELATED, TOTAL	\$103,843,466	327,000		
Aged	\$2,384,492	1,455		
Blind/Disabled	\$2,321,558	1,603		
Child	\$93,885,845	295,607		
Adult	\$5,251,571	28,335		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$151,427,136	90,309		

*Total Other Expenditures/Recipients include foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Department of Health and Hospitals.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; and urine ketone test strips. Products covered as DME: total parenteral nutrition and interdialytic parenteral nutrition. Products not covered: cosmetics; DESI drugs; fertility drugs; experimental drugs; and cough and cold preparation.

Over-the-Counter Product Coverage: Products covered with restrictions: allergy, asthma, and sinus products. Products not covered (with limited exceptions): analgesics; cough and cold preparations; digestive products; feminine products; topical products; and smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories/products covered: all except cosmetics; cough and cold preparations; DESI drugs; and experimental drugs. Prior authorization required for: analgesics, antipyretics, and NSAIDs; antibiotics; anticoagulants; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents; anxiolytics, sedatives, and hypnotics; cardiac drugs; contraceptives; ENT anti-inflammatory agents; estrogens; growth hormones; hypotensive agents; misc. GI drugs; and sympathomimetics (adrenergic). Partial coverage for: anoretics; prescribed cold medications.

Coverage of Injectables: Injectable medicines reimbursable under the Prescription Drug Program and through physician payment when used in physician offices.

Vaccines: Vaccines reimbursable at cost as part of EPSDT service and the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list (PDL). General management techniques include restrictions on use, prior authorization, and preferred products.

Prior Authorization: State currently has a formal prior authorization procedure. Request in writing required to appeal a prior authorization decision.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Permitted as indicated by physician within 6 months and not to exceed 5 refills.

Monthly Quantity Limits: New prescription must be issued for drugs given on a continuing basis, after 5 refills or after 6 months. Maximum quantity for prescriptions shall be either 30-day supply or 100 unit doses, whichever is greater. Monthly limit of 8 prescriptions per recipient.

Other: Viagra and other drugs to treat impotence are limited to a quantity of 6 pills per month.

Drug Utilization Review

PRODUR system implemented in April 1996. State has a DUR Board that meets quarterly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.59 on average, to \$5.77 maximum, effective 7/1/94.

Ingredient Reimbursement Basis: EAC = AWP-13.5% for Independent Pharmacies. AWP-15% for chain pharmacies. (Chain pharmacies are defined as ownership of more than fifteen (15) Medicaid enrolled pharmacies under common ownership.)

Prescription Charge Formula: Medicaid reimbursement for pharmacy services will be based on the lower of:

1. AWP minus 13.5% for independent pharmacies and AWP minus 15% for chain pharmacies plus a dispensing fee for single source products or multiple source products with no maximum allowable cost limitations or when physician authorizes "Brand Medically Necessary" for a brand name product which has a State MAC or FUL.
2. Louisiana Maximum Allowable Costs (LMAC) or the Federal Upper Limit plus the dispensing fee.
3. AWP for multi-source drugs when lower than FUL or LMAC.
4. The provider's usual and customary charge to other payors.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Approximately 800 drugs are listed on the State-specific MAC list. Override requires “Brand Necessary” or “Brand Medically Necessary.”

Incentive Fee: None.

Patient Cost Sharing: \$ 0.50 - \$3.00 copayment depending of the cost of the prescription, effective 7/13/95.

Cognitive Services: Does not pay for cognitive services

E. USE OF MANAGED CARE

Does not use MCOs to deliver services to Medicaid recipients.

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State has a voluntary mail order pharmacy program open to all Medicaid recipients.

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MAINE

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$250,331,526	224,664	\$278,812,700	245,562
RECEIVING CASH ASSISTANCE, TOTAL	\$108,471,190	60,793		
Aged	\$11,438,641	4,719		
Blind/Disabled	\$82,399,461	28,595		
Child	\$2,552,699	10,124		
Adults	\$12,080,389	17,355		
MEDICALLY NEEDY, TOTAL	\$6,010,987	2,105		
Aged	\$4,459,097	1,633		
Blind/Disabled	\$1,488,866	372		
Child	\$19,514	40		
Adults	\$43,510	60		
POVERTY RELATED, TOTAL	\$54,374,249	60,765		
Aged	\$14,428,282	8,407		
Blind/Disabled	\$27,044,560	9,424		
Child	\$12,399,263	41,078		
Adult	\$502,144	1,856		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$81,475,100	101,001		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report FY 2002 and FY 2003.

C. ADMINISTRATION

State Department of Health and Human Services,
Office of MaineCare Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin (not covered for nursing home patients); blood glucose test strips (with HbA1c values); urine ketone test strips. Products not covered: cosmetics; fertility drugs; experimental drugs; total parenteral nutrition; interdialytic parenteral nutrition (part of procedure); vitamins and vitamin preparations (except pregnancy); and injectables when oral medication is available for equally effective treatment.

Over-the-Counter Product Coverage: Products covered with restrictions: allergy, asthma, and sinus products; analgesics; cough and cold preparations; digestive products; feminine products; topical products. Products covered with restrictions: H2 antagonists (limited coverage after 1/1/01); smoking deterrent products (by Rx only).

Therapeutic Category Coverage: Therapeutic categories covered: anti-psychotics; prescribed smoking deterrents. Prior authorization required for: anabolic steroids; analgesics, antipyretics, and NSAIDs; anoretics; antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamine drugs; antilipemic agents; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; growth hormones; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); thyroid agents; injectable arthritis medications; acute migraine medications; Synvisc; antifungals; EPO; Synagis, and erectile dysfunction products.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment when used in physician offices.

Vaccines: Vaccines reimbursable based at cost as part of the EPSDT service (admin. fees).

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list (PDL). PDL managed through exclusion of products based on contracting issues; restrictions on use; prior authorization; therapeutic substitution; and preferred products. (The Maine Care Preferred Drug List can be seen at www.ghsinc.com.)

Prior Authorization: State currently has a formal prior authorization procedure. Prior authorization may be obtained in the case of necessary exceptions. Fair hearing appeal of denials through the Office of Administrative Hearings. State has no formal prior authorization committee.

Prescribing or Dispensing Limitations

Monthly Prescription Limit: 5 brand name scripts per month.

Monthly Quantity Limit: 34-day for brand name drugs and 90 days for generic drugs.

Prescription Refill Limit: maximum of 11 refills per prescription.

Drug Utilization Review

PRODUR system implemented in 1995. State currently has a DUR Board that meets monthly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.35.

Ingredient Reimbursement Basis: EAC = AWP-15%.

Prescription Charge Formula: Lowest of usual and customary, FUL, AWP-15%, or Maine MAC. Maine MAC includes 1,232 drug products in addition to FUL products.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Brand Medically Necessary" and prior authorization.

Incentive Fee: None.

Patient Cost Sharing: \$2.00 per script up to a maximum of \$25.00 per month.

Cognitive Services: State does not pay for cognitive services.

E. USE OF MANAGED CARE

State does not use managed care organizations to provide service services to Maine Medicaid beneficiaries. Approximately 155,000 Medicaid recipients were enrolled in primary care case management in 2004. Medicaid recipients enrolled in primary care case management receive pharmaceutical benefits through the State.

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Robert Weiss, M.D. (Co Chair)
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Mail Order Pharmacy Program

State has a mail order Medical Assistance pharmacy program. All MaineCare (Medicaid), Maine Rx, and Drugs for the elderly (SPAP) enrollees may participate.

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MARYLAND

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$320,313,995	181,101	\$380,007,833	204,994
RECEIVING CASH ASSISTANCE, TOTAL	\$177,261,021	84,026		
Aged	\$36,606,581	16,294		
Blind / Disabled	\$134,096,117	51,811		
Child	\$3,025,652	7,317		
Adult	\$3,484,807	8,561		
Unknown	\$47,864	43		
MEDICALLY NEEDY, TOTAL	\$79,642,289	36,286		
Aged	\$51,496,176	18,001		
Blind / Disabled	\$22,625,834	11,248		
Child	\$3,390,163	2,816		
Adult	\$2,130,116	4,221		
POVERTY RELATED, TOTAL	\$43,538,946	47,229		
Aged	\$14,076,445	8,115		
Blind / Disabled	\$17,110,997	5,620		
Child	\$11,615,154	26,700		
Adult	\$736,350	6,794		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$19,871,739	13,560		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

State Department of Health and Mental Hygiene,
Division of Health Care Financing, Office of
Operations, Eligibility and Pharmacy.

D. PROVISIONS RELATING TO DRUGS**Benefit Design**

Drug Benefit Product Coverage: Products covered: legend drugs; prescribed insulin; and disposable needles and syringe combinations used for insulin; total parenteral nutrition: Products covered under DME: blood glucose test strips; urine ketone test strips. Products covered with restrictions: interdialytic parenteral nutrition (according to Medicare criteria). Products not covered: cosmetics; fertility drugs; experimental drugs; DESI drugs; prescriptions and injections for central nervous system stimulants; food supplements or infant formulas; products for which Federal financial participation is not allowed, i.e., "less than effective" drugs and products whose manufacturers have not signed rebate agreements; and certain other items as specified in the State's Medicaid Plan.

Over-the-Counter Product Coverage: Products covered: contraceptives; oral ferrous sulfate. Products covered with restrictions: allergy, asthma, and sinus products (specific preferred products); analgesics (enteric coated aspirin only); non H2 antagonists (specific preferred products). Products not covered: cough and cold preparations; H2 antagonists; feminine products (except contraceptives); topical products; and smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories covered*: anabolic steroids; analgesics, antipyretics, NSAIDs; antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamine drugs; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); and thyroid agents. Partial coverage for: prescribed legend smoking deterrents. Prior authorization required for: growth hormones; synagis; and nutritional supplements for tube-fed recipients. Therapeutic categories not covered: anorectics.

*Prior authorization required for all drugs not on the preferred drug list.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through both the Prescription Drug Program and physician payment when used in physician offices.

Vaccines: Vaccines reimbursable as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with a preferred drug list (PDL) managed through preferred products and prior authorization. Prior authorization required for all non-PDL products.

Prior Authorization: State currently has a prior authorization procedure. A general appeals procedure is available when a physician can provide additional information to justify the medical necessity of a particular product.

Preauthorization is needed for any prescription with a usual and customary charge exceeding \$400. Prior authorization is also needed for early refills, nutritional supplements, brand medically necessary and excessive quantities.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Maximum of eleven refills. The original prescription and its refills may not exceed a 360-day supply.

Monthly Quantity Limit: The amount of medication to be dispensed on a prescription at one time is limited to a less than 34-day supply except for specific maintenance drugs for chronic conditions, where up to a 100-day supply may be dispensed at one time.

Drug Utilization Review

PRODUR system implemented January 1993. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$2.69 - \$4.69 as of July 2004.
\$2.69 - non-PDL Brand.
\$3.69 - PDL Generic
\$3.69-Nursing Home non-PDL Brand
\$4.69 - Nursing Home PDL or Generic

Ingredient Reimbursement Basis: Estimated Acquisition Cost (EAC) equals/lowest of:

1. Wholesale Acquisition Cost (WAC) plus 8%.
2. Direct cost plus 8%.
3. Distributor's price plus 8%.
4. Average Wholesale Price (AWP) minus 12%.

Prescription Charge Formula: Reimbursement will be the lower of: (1) the calculated ingredient cost plus a dispensing fee; (2) the usual and customary fee.

Maximum Allowable Cost: State imposes State-specific limits on generic drugs. Approximately 1,000 drugs are listed on the State-specific MAC list. Override requires "Brand Medically Necessary" and a MedWatch form documenting the reason for the request.

Incentive Fee: None

Patient Cost Sharing: Copayment = \$3.00 for Brands not on the PDL; \$1.00 for generics and drugs on the PDL. Does not apply to managed care, family planning, nursing home residents, recipients under 21 years old.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 488,600 Medicaid recipients were enrolled in MCOs in FY 2005. Recipients receive pharmaceutical benefits through the State and managed care plans. (Mental health drugs are "carved out" of managed care.)

Managed Care Organizations

United Healthcare
Lyndwood Executive Center
6095 Marshalee Drive
Elkridge, MD 21075
800/487-7391

Helix Family Choice, Inc.
8094 Sandpiper Circle
Baltimore, MD 21236
410/933-3021

Jai Medical Systems, Inc.
5010 York Road
Baltimore, MD 21212
410/433-2200

Maryland Physicians Care MCO
509 Progress Drive
Lithicum, MD 21090
410/401-9400

Diamond Plan
Coventry Health Care of Delaware, Inc.
Ambassador Center D
7125 Ambassador Road
Suite 100
Woodlawn, MD 21244
866/212-5305

Priority Partners MCO
Baymeadow Industrial Park
6704 Curtis Court
Glen Burnie, MD 21060
410/424-4400

AmeriGroup Maryland, Inc.
857 Elkridge Landing Road, #300
Lithicum, MD 21090
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Vincent Ferrari, R.Ph. (Chair)
Steve A. Anifowshe, R.Ph.
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Prescription Price Updating

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Mail Order Pharmacy Benefit

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MASSACHUSETTS

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$952,790,939	659,626	\$938,275,647	640,437
RECEIVING CASH ASSISTANCE TOTAL	\$464,206,888	225,282		
Aged	\$50,116,594	26,400		
Blind/Disabled	\$381,221,991	126,509		
Child	\$9,530,411	43,726		
Adult	\$23,337,892	28,647		
MEDICALLY NEEDY, TOTAL	\$38,451,280	16,745		
Aged	\$16,299,026	8,974		
Blind/Disabled	\$22,152,254	7,771		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$272,625,841	220,501		
Aged	\$67,368,453	29,267		
Blind/Disabled	\$165,887,679	49,900		
Child	\$36,950,055	136,765		
Adult	\$2,419,654	4,569		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$177,506,930	197,098		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Executive Offices of Health and Human Services,
Division of Medical Assistance, Office of
Medicaid.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin. Products covered (except in LTC facilities): disposable needles and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips. Products covered with restrictions: total parenteral nutrition (prior authorization required). Products not covered: cosmetics; fertility drugs; experimental drugs; interdialytic parenteral nutrition; DESI drugs; legend vitamins not on Drug List, non-legend drugs not on Drug List; propoxyphene-containing products and products rated by the FDA as less-than-effective.

Over-the-Counter Product Coverage: Products covered with restrictions (limited OTC list-generics only- not covered in LTC facilities): allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; feminine products and topical products. Products not covered: smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; antibiotics; anticoagulants; chemotherapy agents; contraceptives; estrogens, and thyroid agents. Prior authorization required for: growth hormones; Erythropoietin; and selected biotech drugs. Partial coverage for: prescribed cold medications. Partial coverage with prior authorization required for: analgesic, antipyretics, and NSAIDs; anticonvulsants; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; ENT anti-inflammatory agents; hypotensive agents; misc. GI drugs; and sympathomimetics (adrenergic). Therapeutic categories not covered: anoretics; prescribed smoking deterrents; weight loss or gain medications; medications to treat sexual dysfunction; experimental or investigational drugs; and less than effective drugs.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities and through both the Prescription Drug Program and physician payment when used in physician offices.

Vaccines: Vaccines reimbursable as part of the EPSDT service if not provided by the Department of Public Health.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary managed through restrictions on use, prior authorization, and physician profiling.

Prior Authorization: State currently has a prior authorization procedure. A recipient may file a request for a fair hearing to appeal a prior authorization decision.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Prescription may be refilled, as authorized, with a limit of up to 5 refills from the filling of the original prescription

Monthly Quantity Limit: Schedule II and III drugs are generally limited to a 30-day supply. Limits on units per month on some medications.

Monthly Dollar Limits: None.

Drug Utilization Review

PRODUR system implemented in October 1995. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.00 (basic) plus \$1.00-\$2.00 additional for compounded Rx's, effective 1/1/2004.

Ingredient Reimbursement Basis: $EAC = WAC + 5\%$.

Prescription Charge Formula: Payment shall be for the lowest of:

1. EAC plus dispensing fee;
2. The usual and customary charge defined as the lowest price charged or accepted by a provider for any payor;
3. FULP plus a dispensing fee; or
4. MULP plus a dispensing fee.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires “Dispense as Written,” and/or “Brand Medically Necessary” plus prior authorization.

Patient Cost Sharing: Copayment = \$3.00 (Brands) and \$1.00 (Generics and OTC products), effective 2/1/2004. Exceptions include:

- Institutionalized patients
- Children under age 19
- Pregnant and postpartum women
- Hospice care
- Family planning items

Incentive Fee: None.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 277,000 Medicaid recipients were enrolled in MCOs in FY 2004 with another 325,000 enrolled in pre-paid health plans (PHPs) and 304,000 in PCCM. Recipients receive pharmaceutical benefits through managed care plans. Enrollees in the PCCM program receive pharmaceutical benefits from the State.

Managed Care Organization

Primary Care Clinician Plan
Boston Medical Center HealthNet Plan
Fallon Community Health Plan
Neighborhood Health Plan
Network Health

F. STATE CONTACTS

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DUR Contact

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Prescription Price Updating

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Mail Order Pharmacy Benefit

None

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Massachusetts Osteopathic Society, Inc.
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Massachusetts Board of Registration in Pharmacy
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Massachusetts Society of Health-Systems Pharmacists
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Massachusetts Extended Care Federation
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2310 Washington Street
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Internet address: www.mecf.org

MICHIGAN

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2003**		2004**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$753,841,353	610,641	\$874,729,802	

RECEIVING CASH ASSISTANCE TOTAL

Aged
Blind/Disabled
Child
Adult

MEDICALLY NEEDY, TOTAL

Aged
Blind/Disabled
Child
Adult

POVERTY RELATED, TOTAL

Aged
Blind/Disabled
Child
Adult
BCCA Women

TOTAL OTHER EXPENDITURES/RECIPIENTS*

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 and 2004 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2003 and Michigan Medicaid Statistical Information System, FY 2004.

C. ADMINISTRATION

Michigan Department of Community Health,
Medical Services Administration.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles used for insulin; and interdialytic parenteral nutrition. Products covered under DME: syringe combinations used for insulin; blood glucose test strips; and urine ketone test strips. Prior authorization required for: total parenteral nutrition; some self-administered injectables; brand name products equivalent to MACs; Accutane & Retin-A; Dexedrine and Adderall; Persantine; Lactulose (Cephulac); Methylphenidate (selected ages); selected benzodiazepines; Epogen administered in the home setting; dietary formulas; and drugs not listed on the formulary. Products not covered: cosmetics; fertility drugs; experimental drugs; vitamins for general health and well-being; products to treat impotence; and other categories specified by CMS as excluded. For additional information on the scope of Michigan Medicaid drug coverage, see www.michigan.fhsc.com.

Over-the-Counter Product Coverage: Products covered: smoking deterrent products (tablets, patches, and gum quantity limits per beneficiary per year). Products covered with restrictions (prescription required and selected products only in each category): allergy, asthma and sinus products (antihistamines); analgesics (payment limits, considered part of nursing home per diem reimbursement); non-H2 antagonists (payment limits, considered part of nursing home per diem reimbursement); H2 antagonist (payment limits); feminine products (payment limits); topical products;. Products not covered: cough and cold preparations.

Therapeutic Category Coverage: Therapeutic categories covered: analgesics, antipyretics, NSAIDs; antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamine drugs; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs; prescribed smoking deterrents; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: growth hormones. Partial coverage for: prescribed cold medications. Therapeutic

categories not covered: anabolic steroids; and anoretics.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and through physician payment when used in physician offices. In extended care facilities, reimbursement is either through the Prescription Drug Program or physician payment, depending on the prescription. Some self-administered injectables require prior authorization.

Vaccines: Vaccines reimbursable at cost plus a fee/or vaccine replacement as part of the Children Health Insurance Program and the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Closed formulary and a preferred drug list (PDL). (See www.michigan.fhsc.com for listing of drugs on the PDL.) Formulary managed through restrictions on use, prior authorization requirements, preferred products, differential copayments, and MAC pricing.

Prior Authorization: State currently has a formal prior authorization procedure. Beneficiaries receive written notice of denial and have a right to appeal prior authorization decisions on the basis of medical necessity. Informal review of additional information can be conducted at any time. Beneficiaries also have fair hearing rights to appeal denial of coverage for an excluded product. (See the Pharmacy Chapter of the Medicaid Provider Manual at www.michigan.gov/mdch for additional information.)

Prescribing or Dispensing Limitations

Prescription Refill Limit: None

Monthly Quantity Limit: Prescribed quantities should be limited to an amount necessary to keep the recipient supplied during the therapy regimen. Quantity limits for selected pharmaceuticals (e.g., sedative hypnotics). In certain cases and conditions, more than a month's supply will be appropriate. However, in no instance may more than 100-days supply be dispensed per prescription. (See the Pharmacy Chapter of the Medicaid Provider Manual at www.michigan.gov/mdch for additional information.)

Drug Utilization Review

PRODUR system implemented in July 2000. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$2.50, (\$2.75 for long-term care) effective Nov. 1, 2004. Additional dispensing fee for compounding.

Ingredient Reimbursement Basis: 1-4 stores = AWP-13.5%, 5 or more stores = AWP-15.1%. Special rules for potassium supplements, oral contraceptives, and anti-hemophilia factors.

Prescription Charge Formula: Reimbursement for legend drugs is limited to the lower of:

1. AWP-13.5% for 1 to 4 stores & AWP-15.1% for 5 or more stores or LTC, plus dispensing fee minus patient copay, or
2. The MAC rate, plus dispensing fee, or
3. The provider's usual and customary charge to the general public.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires beneficiary-specific prior authorization with appropriate documentation/clinical information in support of the request.

Incentive Fee: None.

Patient Cost Sharing: Effective Jan. 1, 2005, ambulatory recipients age 21 and older are required to pay a \$3.00 copayment for brand name drugs and a \$1.00 copayment for generic drugs. Effective March 1, 2005, Adult Benefit Waiver (ABW) beneficiaries are required to pay a \$1.00 copayment for each prescription drug dispensed. If the recipient is unable to pay a required copayment on the date of service, the pharmacy cannot refuse to render the service. However, the pharmacy may bill the recipient for the copayment amount, and he/she is responsible for paying it. If the recipient fails to pay a copayment, the pharmacy could, in the future, refuse to serve the recipient as a Medicaid recipient.

Drugs not requiring a co-payment include pregnancy-related and family planning products.

Recipients are not required to make a copayment if:

- They are under age 21, or

- They reside in a long-term care facility (nursing home, hospital long-term care facility, or medical care facility), or
- Health Maintenance Organization (HMO), or a capitated Clinic Plan.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 850,000 Medicaid recipients were enrolled in MCOs in FY 2003. Recipients receive pharmaceutical benefits through managed care plans. Psychotropics, antidepressants, anti-mania, central nervous system stimulants, HIV antiretrovirals and other select classes of drugs are administered by managed care organizations but paid for by the State.

Managed Care Organizations

Cape Health Plan
26711 Northwestern Highway, Suite 300
Southfield, MI 48034
T: 248/386-3000
T: 888/354-2273
Internet address: www.capehealth.com

Community Choice Michigan
2369 Woodlake Drive
Okemos, MI 48864
T: 517/349-9922
T: 800/390-7102
Internet address: www.ccmhmo.org

Great Lakes Health Plan, Inc.
17117 W. Nine Mile, Suite 1600
Southfield, MI 48075
T: 248/559-5656
T: 800/903-5253
Internet address: www.glhp.com

Health Plan of Michigan, Inc.
17515 W. Nine Mile, Suite 650
Southfield, MI 48075
T: 248/557-3700
T: 888/437-0606
Internet address: www.hpmich.com

HealthPlus Partners, Inc.
2050 S. Linden Road
P.O. Box 1700
Flint, MI 48501-1700
T: 810/230-2132
T: 800/322-9161
Internet address: www.healthplus.com

M-Caid
2301 Commonwealth Blvd.
Ann Arbor, MI 48105-1573
T: 800/527-5549
Internet address: www.mcare.org

McLaren Health Plan
G 3245 Beacher Road, Suite 200
Flint, MI 48532
T: 888/327-0671
Internet address: www.mclarenhealthplan.org

Midwest Health Plan
5050 Schaefer Road
Dearborn, MI 48126
T: 313/581-3700
T: 888/654-2200
Internet address: www.midwesthealthplan.com

Molina Healthcare of Michigan
100 W. Big Beaver Road, Suite 600
Troy, MI 48084
T: 248/925-1700
T: 888/898-7969
Internet address: www.molinahealthcare.com

OmniCare Health Plan, Inc.
1333 Gratiot, Suite 400
Detroit, MI 48207
T: 313/465-1564
T: 866/728-8507
Internet address: www.omnicarehealthplan.com

PHP- MM Family Care
P.O. Box 30377
Lansing, MI 48909-7877
T: 517/364-8400
T: 800/661-8299
Internet address: www.phpmm.org

PHP of Southwest Michigan, Inc.
106 Farmers Alley, Suite 300
Kalamazoo, MI 49007
T: 269/341-7200
T: 800/261-0084
Internet address: www.ibahealthplans.com

Priority Health, Government Programs, Inc.
1231 E. Beltline, NE
Grand Rapids, MI 49525-4501
T: 616/942-0954
T: 888/975-8102
Internet address: www.priority-health.com

ProCare
3956 Mt. Elliot
Detroit, MI 48207
T: 313/925-4607
T: 866/776-0891

Total Health Care
3011 W. Grand Blvd., Suite 1600
Detroit, MI 48202
T: 313/871-2000
T: 800/826-2862
Internet address: www.totalhealthcareonline.com

Upper Peninsula Health Plan
228 W. Washington Street
Marquette, MI 49855
T: 906/225-7500
T: 800/835-2556
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F. STATE CONTACTS

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F: 517/241-8135
E-mail: perrig@michigan.gov
Internet address: www.michigan.gov/mdch

New Brand Names Products Contact

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Prior Authorization Contact

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Glen Allen, VA 23060
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Mail Order Pharmacy Program

None

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MINNESOTA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$294,838,630	190,577	\$336,444,933	201,366
RECEIVING CASH ASSISTANCE, TOTAL	\$161,712,804	84,306		
Aged	\$6,759,656	4,182		
Blind / Disabled	\$147,337,336	50,623		
Child	\$2,746,917	15,191		
Adult	\$4,868,895	14,310		
MEDICALLY NEEDY, TOTAL	\$56,712,355	27,809		
Aged	\$19,826,418	13,434		
Blind / Disabled	\$35,344,455	9,576		
Child	\$328,726	1,389		
Adult	\$1,212,756	3,410		
POVERTY RELATED, TOTAL	\$1,833,878	9,033		
Aged	\$170,597	285		
Blind / Disabled	\$451,718	302		
Child	\$996,671	6,704		
Adult	\$211,724	1,732		
BCCA Women	\$3,168	10		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$74,579,593	69,429		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Minnesota Department of Human Services, Health Care Management Division, Medical Assistance Program.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products not covered: drugs used for cosmetic purposes; drugs used for hair growth; fertility drugs; appetite suppressants; and experimental drugs. Products covered with limitations: amphetamines; atomoxetine; rapidly disintegrating tablet formulations. Prior authorization required for: H2 receptor antagonists; PPIs; ACE inhibitors; statins; antidiabetic agents; urinary incontinence products; antiemetics; botulinum toxin; triptans; interferon; and various ophthalmic products. (For a complete list of products requiring prior authorization, contact the Pharmacy Program at The Minnesota Department of Human Services, Health Care Management Division, Medical Assistance Program at <http://www.dhs.state.mn.us/provider/pharm/>.)

Over-the-Counter Product Coverage: Products covered: allergy, products; antalgics; cough and cold preparations; and smoking deterrent products. Products covered with limitations: vitamins; ocular lubricants; pediculocides; and activated charcoal and ipecac.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; anti-infectives; anticoagulants; anticonvulsants; antidiabetic agents; antidepressants; anti-psychotics; anxiolytics; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; prescribed smoking deterrents; and thyroid agents. Prior authorization required for: analgesics, antipyretics, and NSAIDs; antibiotics; antidiabetic agents; antihistamines; antileptic agents; growth hormones, sedatives and hypnotics; cardiac drugs; hypotensive agents; misc. GI drugs; and sympathomimetics (adrenergic). Therapeutic categories not covered: anoretics; DESI drugs.

Coverage of Injectables: Injectable medicines reimbursable through the pharmacy benefit when dispensed by a pharmacy and through physician payment when used in physician offices, home health care, and extended care facilities.

Vaccines: Vaccines reimbursable when billed as part of the Children's Health Insurance Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/ Prior Authorization

Formulary: Open formulary with preferred drug list. General exclusions include restrictions, prior authorization, and preferred products.

Prior Authorization: State currently has a prior authorization procedure and a Drug Formulary Committee. Recipient has the right to appeal prior authorization decisions and coverage of an excluded product by appeals referee followed by an appeal in court.

Prescribing or Dispensing Limitations

Monthly Quantity Limit: Minimum 34-days for maintenance drugs. Contraceptives may be filled to provide a 3-month supply. Quantity limits on some drug products including triptans, antiemetics, lyrica, and sedatives.

Drug Utilization Review

PRODUR system implemented in February 1996. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.65, effective 7/1/99. Pharmacies that dispense drugs that they package into unit packaging receive an additional \$0.30 per prescription.

Ingredient Reimbursement Basis: $EAC = AWP - 12\%$.

Prescription Charge Formula: Reimbursement is based on the lesser of submitted AWP minus 12% plus a dispensing fee, MAC plus a dispensing fee, or usual and customary. Special rules for IV admixtures.

Maximum Allowable Cost: State imposes a combination of Federal Upper Limits and State-specific MAC on generic drugs. Override requires "dispense as written or "brand medically necessary." Prescriber must also obtain prior authorization.

Incentive Fee: None.

Patient Cost Sharing: Brand: \$3.00
Generic: \$1.00

Cognitive Services: State pays for medication therapy management to enrolled MTM Pharmacist for patients with 4 or more medications or more than 2 disease states.

E. USE OF MANAGED CARE

Approximately 450,000 Medicaid recipients were enrolled in MCOs in FY 2006. Recipients receive pharmaceutical benefits through managed care plans.

Managed Care Organizations

Itasca Medical Care
Itasca Resource Center
1209 SE 2nd Ave.
Grand Rapids, MN 55744-3983
T: 800/843-9536
F: 218/327-5545

Blue Plus
P.O. Box 64179
St. Paul, MN 55164-0179
651/662-5200

First Plan Blue
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T: 800/635-4159
F: 218/724-9176

HealthPartners
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P.O. Box 1309
Minneapolis, MN 55414-1309
T: 952/967-6633

Medica
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Metropolitan Health Plan
822 South 3rd Street, Suite 140
Minneapolis, MN 55415
T: 612/347-6308
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PrimeWest Health System
305 8th Avenue West
Alexandria, MN
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UCare Minnesota
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MISSISSIPPI

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Skilled Nursing Home Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$568,084,274	526,923	\$568,265,605	547,268
RECEIVING CASH ASSISTANCE TOTAL	\$297,248,432	240,302		
Aged	\$39,630,817	20,265		
Blind/Disabled	\$219,218,827	105,764		
Child	\$17,536,770	72,324		
Adult	\$20,862,018	41,949		
MEDICALLY NEEDY, TOTAL	\$0	0		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$206,384,484	265,482		
Aged	\$66,656,881	31,322		
Blind/Disabled	\$88,036,351	30,492		
Child	\$47,118,247	179,454		
Adult	\$4,573,005	24,214		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$64,451,358	21,139		

**Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Division of Medicaid, Office of the Governor.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; and total parenteral nutrition. Prior authorization required for: brand name multisource products; Sandimmune; oral erectile dysfunction agents; enteral feeding products; nutritional products; immunosuppressant agents; Clozaril (must be prescribed by Board Certified or Board Eligible Psychiatrist); * Xenical, Benzodiazepines, NSAD, Protoprin and Humatrope; * all Antihemophilic Factors including VIII and IX; * Synagis; Enbrel; Brand SR opioid agonists; Neurontin; and all Home IV drug therapies. Products not covered: cosmetics; fertility drugs; experimental drugs; disposable needles and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips; and interdialytic parenteral nutrition.

* These products are covered only for children ages 0-21 years through the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

Over-the-Counter Product Coverage: Products covered with restrictions (i.e., must be on limited formulary, requires a prescription, and counts against monthly service limits): allergy, asthma, and sinus products (Benadryl); analgesics (ASA, generic Tylenol); cough and cold preparations (generic Robitussin); digestive products (non-H2 antagonist); feminine products; topical products; smoking deterrent products; certain vitamins (prenatal and dialysis). Products not covered: H2 antagonists.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; analgesics, antipyretics, and NSAIDs; antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamines; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; growth hormones; hypotensive agents; misc.; GI drugs; prescribed smoking deterrents, antilipemic agents; sympathomimetics (adrenergic); and thyroid agents. Partial coverage for: prescribed cold medications. Products not covered: anoretics; weight loss drugs; fertility drugs; vitamins and minerals (except prenatal); and DESI drugs.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment when used in physicians' offices.

Unit Dose: Unit dose packaging is reimbursable.

Vaccines: Vaccines reimbursable as part of the Vaccine for Children Program. LTC reimbursed in cost reports. POS only for adult non-LTC beneficiaries. Counts against monthly Rx limits.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list (PDL). General exclusions include:

1. Drugs used for anorexia or weight gain.
2. Drugs when used for the symptomatic relief of cough and colds (except quafenesin syrup 100 mg/5 ml, iodinated glycerol tablets 30 mg, which are covered).
3. Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are covered).
4. Covered outpatient drugs for which the manufacturer requires (as a condition of sale) that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
5. Barbiturates (except amobarbital, butabarbital, mephobarbital, pentobarbital, phenobarbital, secobarbital, which are covered).
6. Benzodiazepines (except Klonopin, Lorazepam, Diazepam and Temazepam which are covered).
7. DESI drugs (those drugs that are designated less than effective by the FDA).

Additional techniques to manage the PDL include restrictions on use, prior authorization, and preferred products. Additional information about the PDL can be found at www.dom.ms.us

Prior Authorization: State currently has a prior authorization procedure. A written request (including medical justification for beneficiaries under age 21) must be made within 30 days of denial to appeal a prior authorization decision. Review and determination made by clinical specialists within 3 days of receipt. All parties notified in writing within 24 hours of decision.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Limited to 11 scripts per year.

Monthly Quantities Limit: 31-day supply or 100 units or doses, whichever is greater. Birth control pills may be supplied in 3-month quantities.

Monthly Prescription Limit: Maximum of 5 scripts per month with no more than 2 branded. Two additional prescriptions per month may be allowed with prior authorization. Beneficiaries under age 21 years old or in long term care facilities are exempt from monthly prescription limits.

Drug Utilization Review

PRODUR system implemented in 1993. State has a 12 member DUR Board that meets quarterly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.91 sole source, \$4.91 multisource (eff. 7/1/05). IV mixtures can receive up to a \$30 per liter dispensing fee.

Ingredient Reimbursement Basis: EAC = lower of AWP-12% or WAC + 9%.

Prescription Charge Formula: Reimbursement for legend drugs will be at the lessor of AWP-12% or WAC+9% plus a dispensing fee or usual and customary charge. OTC drugs will be paid at lessor of AWP plus a dispensing fee, usual and customary price, or estimated shelf price plus a dispense fee.

Maximum Allowable Cost: State imposes Federal Upper Limits on generic drugs. Override requires "Dispense as Written" or prior authorization (e.g., brand name multi-source prior authorization form showing allergic Rx, ADR, or failure to respond) for brand multi-source drugs.

Incentive Fee: None.

Patient Cost Sharing: \$3.00

Cognitive Services: Pays for disease management services for diabetes, hyperlipidemia, asthma, and coagulatory disorders (effective 8/1/98). Pays \$20 for average 30-minute encounter.

E. USE OF MANAGED CARE

No Medicaid recipients receive health benefits through MCOs.

F. STATE CONTACTS**State Drug Program Administrator**

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Disease Management/Patient Education Programs

Disease/Medical State: Asthma
Program Name: Asthma Disease Management (eff. 2/03)

Program Manager: Mckesson

Disease/Medical State: Diabetes
Program Name: Diabetes Disease Management (eff. 2/03)

Program Manager: Mckesson

Disease/Medical State: Hypertension
Program Name: Hypertension Disease Management (eff. 2/03)

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Mail Order Pharmacy Program

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MISSOURI

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$799,910,014	493,230	\$953,324,877	526,991
RECEIVING CASH ASSISTANCE TOTAL	\$356,695,975	275,059		
Aged	\$51,673,954	18,903		
Blind/Disabled	\$225,953,649	66,602		
Child	\$35,102,211	110,002		
Adult	\$43,966,161	79,552		
MEDICALLY NEEDY, TOTAL	\$0	0		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$35,427,693	47,905		
Aged	\$7,218,295	4,168		
Blind/Disabled	\$16,527,657	4,142		
Child	\$9,869,502	27,036		
Adult	\$1,812,239	12,559		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$407,786,346	170,266		

**Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Division of Medical Services, Missouri Department of Social Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Categories or drugs that are covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition; and interdialytic parenteral nutrition. Limited coverage (limited to OTC formulary) for: allergy, asthma, and sinus products; analgesics; cough and cold preparations; digestive products; and topical products. Prior authorization required for: amphetamines; barbiturates; Isotretinoin; Orlistat; and Retinoic Acid. Products not covered: cosmetics; fertility drugs; experimental drugs; smoking deterrent products; feminine products; hair growth products; Halazepam; Prazepam; Estazolam; Quazepam; and non-legend products.

Therapeutic Category Coverage: Therapeutic categories covered: analgesics, antipyretics, and NSAIDs; antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents; anti-psychotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: anxiolytics, sedatives, and hypnotics; prescribed cold medications; growth hormones; and Misc. GI drugs. Partial coverage for: anabolic steroids (PA required). Categories not covered: anoretics; prescribed smoking deterrents.

(For additional information on products and/or category coverage, see the pharmacy provider bulletin at www.medicaid.state.mo.us.)

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in physician offices, home health care settings, and extended care facilities.

Vaccines: Vaccines reimbursable as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list. PDL managed through exclusions and restrictions, including preferred products, physician profiling, prior authorization, therapeutic substitution, clinical edits, and step therapy.

Prior Authorization: State currently has a prior authorization procedure and a Drug Prior Authorization Committee composed of 9 members who meet quarterly. Fair hearing process to appeal prior authorization decisions.

Prescribing or Dispensing Limitations

Prescription Refill Limit: None

Monthly Quantity Limit: Physician encouraged to prescribe 34-day or 100 dose supply but may, at own discretion, prescribe up to a maximum 90-day supply.

Dose Limit: Prescriptions for the following must be dispensed for at least 200 units per prescriptions: Acetaminophen 5 gr. Prenatal vitamins must be dispensed in a quantity of at least 30.

Drug Utilization Review

PRODUR system implemented in 1993. State currently has a 13 member DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.09 (out-of-state), \$8.04 (in-state), \$8.19 (long-term care pharmacies).

Ingredient Reimbursement Rate: EAC = AWP-10.43% or WAC+10%.

Prescription Charge Formula:

1. Method of reimbursement payment is based on acquisition cost plus a dispensing fee per prescription filled. Acquisition may vary depending whether it is based on AWP and Federal or Missouri MAC.
2. Any drug that is not a Federal or Missouri MAC drug will be based on the AWP-10.43% or the WAC+10%. The majority of drugs listed are based on AWP. The method of pricing will be taken from the NDC number.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. 1,221 drugs are listed on the State-specific MAC list. Override requires "Brand Medically Necessary," prior authorization and a MedWatch form.

Incentive Fee: None.

Patient Cost Sharing: Variable tiered copayment:

<u>Drug Ingredient Cost</u>	<u>Copayment</u>
\$0.00 to \$10.00	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 or more	\$2.00
(\$5.00 copayment for certain 1115 waiver populations (see Pharmacy Bulletin).)	

Copayment retained by pharmacist.

Cognitive Services: Payment for cognitive services is provided to qualified pharmacies who enroll to provide asthma, diabetes, heart failure, and depression education.

E. USE OF MANAGED CARE

Approximately 450,000 Medicaid recipients were enrolled in managed care organizations in 2005. All receive pharmacy services through managed care. Protease inhibitors are carved out of managed care.

Managed Care Organizations

Healthcare USA
10 South Broadway, Suite 1200
St. Louis, MO 63102
314/444-7226

Blue Cross and Blue Shield of Kansas City
Blue-Advantage Plus of Kansas City, Inc.
P.O. Box 419169
2301 Main St., 3rd Floor
Kansas City, MO 64108
816/395-2128

Mercy Health Plan
14528 S. Outer 40 Road, Suite 300
Chesterfield, MO 63017
314/214-8245

Community Care Plus Health Plan
10123 Corporate Square Drive
St. Louis, MO 63132
314/432-9300

FirstGuard Health Plan
4001 Blue Parkway, Suite 300
Kansas City, MO 64130
816/922-7289

Family Health Partners Health Plan
215 W. Pershing Road, 6th Floor
P.O. Box 411806
Kansas City, MO 64108
816/855-1885

Missouri Care Health Plan
2404 Forum Boulevard
Columbia, MO 65203
573/441-2100

F. STATE CONTACTS

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DUR Board

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Stacy Mangum, Pharm.D.
David C. Campbell, M.D., M.Ed.
Joy S. Gronstedt, D.O.
Joseph M. Yasso, D.O.
Randy Beckner, Pharm.D.
Karla Dwyer, R.Ph.
Susan Abdel-Rahman, Pharm.D.
Peggy Wanner-Barjenbrunch, M.D.
Sandra Bollinger, Pharm.D.
Stephen Calloway, R.Ph.
Robert Dale Potter, R.N.
Sharad Parikh, M.D.

Drug Prior Authorization Committee

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Joseph Parks, M.D.
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Gene Forrester, R.Ph.
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Henry Petry, D.O.
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Jay R. Bryant-Wimp, R.Ph.
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Lorraine C. Brown, D.O.
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Prescription Price Updating

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Medicaid Drug Rebate Contact

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Jefferson City, MO 65109
573/635-2434

Medicaid Managed Care Contact

Michael Ditmore, M.D., Director
Division of Medicaid Services
573/751-3425

Mail Order Pharmacy Program

None

Disease Management/ Patient Education Programs

Disease Medical States: Asthma
Cardiovascular Disease
Depression
Diabetes
Hypertension-COPD
Hyperlipidemia-GERD

Program Manager: Jennifer Cornelious
Program Sponsor: State of Missouri

Disease Management Initiatives Contact

George Oestreich, Pharm.D., M.P.A.
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Pharmacy Subcommittee Roster

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Philip A. Bangert, R.Ph.
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Tom Beetem, R.Ph., Chairman
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MONTANA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2004		2005**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$94,037,747	70,165	\$104,900,517	71,077

RECEIVING CASH ASSISTANCE, TOTAL

Aged
Blind / Disabled
Child
Adult

MEDICALLY NEEDY, TOTAL

Aged
Blind / Disabled
Child
Adult

POVERTY RELATED, TOTAL

Aged
Blind / Disabled
Child
Adult
BCCA Women

TOTAL OTHER EXPENDITURES/RECIPIENTS*

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2004 and 2005 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: Montana Department of Public Health and Human Services, Health Resources Division.

C. ADMINISTRATION

Department of Public Health and Human Services,
Health Resources Division, Medicaid Services
Bureau

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: legend drugs, prescribed insulin; certain prescribed over-the-counter products, vaccines except children 18 and under and clients with Medicare Part B coverage; compounded prescriptions; contraceptive supplies and devices. Products not covered: fertility drugs; syringe combinations used for insulin; cosmetics; fertility drugs; experimental drugs; disposable needles and syringe combinations used for insulin, blood glucose test strips; and urine ketone test strips. Prior authorization required for: total parenteral nutrition; interdialytic parenteral nutrition; non-steroidal anti-inflammatory drugs; all single source NSAIDs; Celebrex, Vioxx; disease-modifying anti-rheumatic drugs (Arava, Enbrel, Remicade); growth hormones; single-source benzodiazepines; gastro-intestinal drugs (including H2 antagonists, proton pump inhibitors, Carafate and Cytotec); migraine headache drugs for certain monthly quantities on Imitrex, Maxalt, Zomig, Migranal, Amerge; weight reduction drugs (Fastin, Ionamin, Meridia, Xenical); smoking-cessation drugs; Toradol; Dipyridamole; Aggrenox; Trental, Pletal; Ambien and Sonata; Viagra; Thalomid; Zyvox; Tretinoin; Zolof; Hismanal; Bextra; Kineret; Stadol; Isoetharine; and Isoproterenol.

Over-the-Counter Product Coverage: Products covered (i.e., when prescribed): analgesics (aspirin only); allergy, asthma, and sinus products; (loratadine, diphenhydramine); insulin; laxatives; head lice treatments; digestive products; GI products; bronchosaline; and smoking deterrent products (prior authorization required). Products not covered: cold and cough preparations; feminine products; and topical products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; anticoagulants; anticonvulsants; anti-psychotics; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: antibiotics; antihistamines; analgesics, antipyretics, and NSAIDs; antidepressants; antidiabetic agents; antilipemic agents; anxiolytics, sedatives, and

hypnotics; cardiac drugs; prescribed cold medications; misc. GI products; prescribed smoking deterrents; and growth hormones. Therapeutic categories not covered: anoretics.

Coverage of Injectables: Injectable medicines reimbursable through the physician payment when used in home health care and extended care facilities, and physician offices.

Vaccines: Vaccines reimbursable as part of the EPSDT service, the Children Health Insurance Program, and the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with a preferred drug list. Formulary managed through exclusion of products based on contracting issues, restrictions on use, prior authorization preferred products, and physician profiling. Drugs classified as less-than-effective (LTE) by the FDA are not covered. Drugs with no manufacturer rebate are not covered.

Prior Authorization: State has a formal prior authorization procedure. Expedited administrative review and a formal appeal procedure through the Department possible for PA decisions. Prescriber letter documenting evidence for use of prescribed medication in treatment of disease is reviewed by DUR Board for appeal of excluded product.

Prescribing or Dispensing Limitations

Prescription Refill Limit: None

Monthly Quantity Limit: 34-day supply. May have quantity limits on certain medications selected by the DUR Board.

Drug Utilization Review

PRODUR system implemented in September 1994. State DUR Board meets monthly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$2.00-\$4.70; effective 7/1/02. Pharmacies submit documentation showing their costs. Dispensing fee is based on their cost up to a maximum of \$4.70. Pharmacies that do not submit documentation receive a dispensing fee of \$2.00. Out-of-State pharmacies receive \$3.50.

Ingredient Reimbursement Basis: EAC = AWP-15%.

Prescription Charge Formula: The lower of EAC, the Federal MAC (plus a dispensing fee), or the provider usual and customary charge.

Maximum Allowable Cost: State imposes Federal Upper Limits on generic drugs. Override requires "Dispense as Written" or "Medically Necessary" on the prescription.

Incentive Fee: None.

Patient Cost Sharing: Copayment of \$1.00 - \$5.00. Recipient pays 5% of Medicaid allowable cost between \$1.00 and \$5.00. \$5.00 copayment cap per prescription. \$25.00 copayment cap per month.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Does not use MCO's to provide services to Medicaid recipients.

F. STATE CONTACTS

State Drug Program Administrator

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Jim Crichton, M.D.
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Mail Order Pharmacy Benefit

None

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NEBRASKA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$196,526,107	194,889	\$197,518,471	197,704
RECEIVING CASH ASSISTANCE TOTAL	\$69,279,614	48,501		
Aged	\$9,843,626	3,983		
Blind/Disabled	\$49,388,569	15,517		
Child	\$4,534,213	19,350		
Adult	\$5,513,206	9,651		
MEDICALLY NEEDY, TOTAL	\$48,643,279	33,380		
Aged	\$29,632,049	9,808		
Blind/Disabled	\$6,684,567	1,527		
Child	\$2,260,713	6,761		
Adult	\$10,065,950	15,284		
POVERTY RELATED, TOTAL	\$65,092,537	90,997		
Aged	\$15,871,572	6,505		
Blind/Disabled	\$29,727,730	8,077		
Child	\$18,756,687	71,241		
Adult	\$694,614	5,144		
BCCA Women	\$41,934	30		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$13,510,677	22,011		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data provided by the Nebraska Department of Health and Human Services, Finance and Support, Medicaid Division.

Source: CMS, MSIS Report, FY 2002 and Nebraska Medicaid Statistical Information System, FY 2003

Note: Nebraska estimates 2004 drug expenditures to be approximately \$216.5 million and the number of Medicaid drug recipients to be 192,000.

C. ADMINISTRATION

State Department of Health and Human Services,
Finance and Support, Medicaid Division.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: legend drugs, compound prescriptions, prescribed insulin with prior approval (i.e., must be medically necessary pre-filled syringes). Products covered under the supplier program: disposable needles used for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition; and interdialytic parenteral nutrition. Products not covered: DESI drugs, drugs for weight control; cosmetics; fertility drugs; and experimental drugs. Prior authorization required for: methadone; IV infusions; and protein replacement supplements.

Over-the-Counter Product Coverage: Products covered: (must be prescribed and subject to rebate) allergy, asthma, and sinus products; analgesics; topical products; vitamin/mineral supplements; eye/ear products; cough and cold preparations; digestive products; and feminine products. Products not covered: smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; anticoagulants; anticonvulsants; antilipemic agents; anti-psychotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; sympathomimetics (adrenergic); antibiotics; anti-depressants; and thyroid agents. Prior authorization required for: anxiolytics, sedatives, and hypnotics; sunscreens; Erythropoietin (e.g., Epogen, Procrit); modified versions of FUL or SMAC drugs; convenience packaged drugs (e.g., Refresh Ophthalmic 0.3 ml and Novalin penfil insulin); drugs to prevent or treat Respiratory Syncytial Virus Immune Globulin (e.g., Palivizumab, RSV-IG); and drugs for sexual dysfunction (e.g., Sildenafil, Alprostadil). Partial coverage (PA required) for: analgesics, antipyretics, NSAIDs; antidiabetic agents; antihistamines; growth hormones; and misc. GI drugs. Therapeutic categories not covered: anorectics; and prescribed smoking deterrents.

Coverage of Injectables: Injectables reimbursable through the Pharmacy program when used in home health care and extended care facilities, and through physician payment when used in physician offices.

Vaccines: Vaccines reimbursable by Medicaid for individuals under 21 years of age through the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary managed through restrictions on use and prior authorization. General exclusions include:

1. More than a three-month supply of birth control tablets;
2. Experimental drugs or non-FDA approved drugs;
3. Drugs or items when the prescribed use is not for a medically accepted indication;
4. Liquors (any alcoholic beverages);
5. DESI drugs and all identical, related, or similar drugs;
6. Personal care items (e.g., non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentrifices, eye washes, and contact solutions);
7. Medical supplies and certain drugs for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) patients;
8. Over-the-counter (OTC) drugs not listed on the Department's Drug Name/License Number Listing microfiche;
9. Baby foods or metabolic agents (Lofenalac, etc.) normally supplied by the Nebraska Department of Health;
10. Drugs distributed or manufactured by certain drug manufacturers or labelers that have not agreed to participate in the drug rebate program.

Drugs, items, or manufacturers that are identifiable as non-covered are so designated on the NE-POP system, and on the Department's Drug Name/License Number Listing microfiche or website.

Prior Authorization: State currently has a formal prior authorization procedure. Prescriber must submit a letter of medical necessity with documentation to the Pharmacy Consultant. The Department requires that authorization be granted prior to payment for certain products. Prior authorization can be verified through the NE-POP System, or by contacting the Department. (or its designated contractor) if authorization is not verified through the NE-POP System.

Prescribing or Dispensing Limitations

Prescription Refill Limit: As authorized by the prescribing physician. For controlled substances, maximum 5 refills every 6 months.

Monthly Quantity Limit: In general, 90-day supply or 100 dosage units, whichever is greater. 31-days for injectables. Quantity limits per day or per month for certain drugs.

Drug Utilization Review

PRODUR system implemented in April 1995. State currently has a DUR Board that meets 6 times each year.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.27 - \$5.00. The Nebraska Department of Health and Human Services assigns a dispensing fee to each individual pharmacy based on location, services, volume, and other third-party participation. The fee is calculated from information obtained through the Department's Prescription Survey.

Ingredient Reimbursement Basis: EAC = AWP - 11%.

Prescription Charge Formula: Lower of:

1. Product cost (EAC, SMAC, or FUL) plus a dispensing fee, or
2. The usual and customary price to the general public.

Listed OTCs are reimbursed at the lower of:

1. Product cost (EAC, SMAC, or FUL) plus a dispensing fee,
2. The usual and customary shelf price to the general public, or
3. Product cost (EAC, SMAC, or FUL) plus a 50% mark-up.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires a State-specific form signed by the physician.

Incentive Fee: None.

Patient Cost Sharing: Copayment = \$2.00.

Additional Pharmacy Payments: Additional payments for tablet splitting (effective 2000)

E. USE OF MANAGED CARE

Approximately 147,000 unduplicated Medicaid recipients were enrolled in managed care in 2005. Recipient enrolled in MCOs receive pharmaceutical services through the State.

Managed Care Organizations

Share Advantage
United Healthcare of the Midland
2717 North 118th Circle
Omaha, NE 68164

Primary Care +
Blue Cross/Blue Shield of Nebraska
P.O. Box 241739
Omaha, NE 68124

Magellan Behavioral Health
P.O. Box 82047
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Mail Order Pharmacy Program

None

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NEVADA¹**A. BENEFITS PROVIDED AND GROUPS ELIGIBLE**

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$90,134,969	71,950	\$110,070,582	76,745
RECEIVING CASH ASSISTANCE TOTAL	\$64,869,022	34,682		
Aged	\$13,073,373	6,228		
Blind/Disabled	\$49,568,652	17,472		
Child	\$953,980	6,473		
Adult	\$1,273,017	4,509		
MEDICALLY NEEDY, TOTAL	\$0	0		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$2,687,912	11,667		
Aged	\$163,078	204		
Blind/Disabled	\$423,871	329		
Child	\$834,644	5,694		
Adult	\$1,266,319	5,440		
BCC Women	\$0	\$0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$22,578,035	25,601		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report FY 2002 and FY 2003

¹ The State of Nevada did not respond to the 2005/2006 NPC Survey. Using information from the State's website and other source materials, we have, to the extent possible, updated the profile and the tables in other sections of the Compilation. Users should contact the Nevada Medicaid Program to assess the accuracy and currency of the information included.

C. ADMINISTRATION

Division of Health Care Financing and Policy of the Department of Health and Human Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: Most legend drugs from companies with rebate agreements and drugs on the Nevada Preferred Drug List including prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; and urine ketone test strips. Products covered under DME: total parental nutrition; interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; experimental drugs; hair growth products; weight loss products; and DESI drugs.

Over-the-Counter Product Coverage: Products covered: allergy, asthma, and sinus products; analgesics; cough and cold preparations; digestive products; and smoking deterrent products. Products covered with restrictions: topical products. OTC drugs are reimbursed at EAC+\$4.76 or the usual and customary amount, whichever is less, and require prior authorization. Products not covered: feminine products.

Therapeutic Category Coverage: Therapeutic categories covered: analgesics, antipyretics, and NSAIDs; antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamine drugs; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; hypotensive agents; misc. GI products; prescribed smoking deterrents; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: CNS stimulants; antifungals; Hemapopoietic; PPIs; Cox2 inhibitors; duragisic patches; HCG; Gonadotropin, Gonadotropin releasing hormone analog; Erythropoietin; Interferon; IV antibiotic; Methylphenidate, Peomoline; vitamins; and Remicade. Partial coverage for: growth hormones (prior authorization required); estrogens; and anabolic steroids. Therapeutic categories not covered: anorectics; amphetamine combinations; erectile dysfunction medications; radiopaque and radiographic products; DESI drugs; yohimbine; and drugs not participating in the drug rebate program.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment when used in physicians' offices.

Vaccines: Vaccines reimbursable at cost plus an administration fee (\$3.83) as part of the EPSDT service.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list. General exclusions include:

1. Agents used for cosmetic purposes or hair growth.
2. Yohimbine (e.g., Yocon).
3. Radiopaque agents (e.g., Telepaque, Hypaque, Barium Sulfate).
4. Radiographic adjuncts (e.g., Perchloracap).
5. Pharmaceuticals designed "ineffective," or "less than effective" (including identical, related, or similar drugs) by the FDA.
6. Non-rebated medications.

Prior Authorization: State currently has a prior authorization procedure with appeals process. Prior authorization procedure screening for individual drugs. Drugs requiring PA include:

1. Amphetamine (e.g., Dexedrine)
2. Chorionic Gonadotropin (HCG)
3. Dipyridamole (e.g., Persantine)
4. Erythropoietin (e.g., Epogen, Procrit)
5. Gonadotropin releasing hormone analog (e.g., Lupron, Zoladex)
6. Growth hormone (e.g., Protropin, Nutropin)
7. Interferon (all combinations manufactured by recombinant DNA technology)
8. Intravenous antibiotic therapy
9. Methylphenidate (e.g., Ritalin)
10. Non-legend pharmaceuticals
11. Nutritional supplements or replacements
12. Pemoline (e.g., Cylert)
13. Pulmozyme
14. Vitamins, vitamin/mineral combinations or hematinics
15. Non-preferred drugs in listed classes

Prescribing or Dispensing Limitations

Monthly Limit on Number of Scripts: None. PA required if more than 2 OTC prescriptions per class within a 30 day period.

Monthly Quantity Limit: The maximum dispensable quantity is limited to a 34-day supply. Maintenance medications limited to a 100-day supply.

Refill Limits: 5 refills within 6 months for controlled drugs. Up to 11 refills for non-controlled drugs.

Drug Utilization Review

State currently has a DUR Board with a quarterly review by a PRODUR contractor. PRODUR system implemented in 2003.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.76, effective 10/1/98. IV dispensing fee is \$16.80 for first ingredient; \$5.60 for other ingredients.

Ingredient Reimbursement Basis: EAC = AWP-15%.

Prescription Charge Formula: The lowest of (1) AWP-15% plus a dispensing fee, (2) specific upper limit (SUL) plus a dispensing fee, (3) estimated acquisition cost (EAC) plus a dispensing fee, or (4) the pharmacy's usual charge to the general public.

Maximum Allowable Cost: State imposes Federal Upper Limits plus State-specific limits on generic drugs. Override requires "Brand Medically Necessary."

Incentive Fee: None.

Patient Cost Sharing: None for general Medicaid population. \$1.00 (generics) and \$3.00 (brand) for dual eligibles.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 90,000 Medicaid recipients are enrolled in MCOs in 2004; all receive pharmacy benefits through their managed care plan.

Managed Care Organizations

Health Plan of Nevada
P.O. Box 15645
Las Vegas, NV 89114
800/962-8074

NevadaCare, Inc.
10600 W. Charleston Blvd.
P.O. Box 379020
Las Vegas, NV 89137
T: 702/304-5500
F: 702/474-7592
E-mail: NevadaCare@Imxinc.com

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775/684-3775

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Steven W. Parker, M.D.
David England, R.Ph., Pharm.D. (Chair)
Lori Winchell, R.N.P.
Keith W. MacDonald, Pharm.D.
Amy H. Schwartz
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First DataBank
1111 Bayhill Drive, Suite 350
San Bruno, CA 94066
T: 650/588-5454
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Policy: Dionne Coston, R.N., 775/684-3755
Rebate: Anita Sheard, 775/684-3749

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Glen Allen, VA 23060
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775/684-3697
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Mail Order Pharmacy Program

None

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Mr. Paul Boyar (LTC Administrator)
Patricia Craddock, D.D.S.
Ms. Jessie Harris
Mr. Keith MacDonald, Pharm.D.
Mr. Ken Richardson (Administrator, Health Care Clinic)
Ms. Linda Sheldon (Advocate for Children)
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NEW HAMPSHIRE¹

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$98,836,636	78,861	\$117,004,510	85,787
RECEIVING CASH ASSISTANCE, TOTAL	\$27,161,385	19,253		
Aged	\$3,424,175	1,431		
Blind/Disabled	\$19,092,652	5,671		
Child	\$1,763,556	7,911		
Adult	\$2,881,002	4,240		
MEDICALLY NEEDY, TOTAL	\$24,082,471	9,223		
Aged	\$10,981,139	4,380		
Blind/Disabled	\$10,425,563	2,472		
Child	\$463,065	935		
Adult	\$2,212,704	1,436		
POVERTY RELATED, TOTAL	\$8,422,399	30,040		
Aged	\$441,811	287		
Blind/Disabled	\$600,362	327		
Child	\$7,006,717	27,509		
Adult	\$373,509	1,917		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/ RECIPIENTS*	\$39,170,381	20,345		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

¹ The State of New Hampshire did not respond to the 2005/2006 NPC Survey. Using information from the State's website and other source materials, we have, to the extent possible, updated the profile and the tables in other Sections of the Compilation. Users should contact the New Hampshire Medicaid program to assess the accuracy and currency of the information.

C. ADMINISTRATION

Office of Medicaid, Business and Policy;
Department of Health and Human Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition; interdialytic parenteral nutrition; and drugs covered by rebate agreements. Products not covered: cosmetics; fertility drugs; DESI drugs; and experimental drugs.

Over-the-Counter Product Coverage: Products covered: allergy, asthma, and sinus products; analgesics; cough and cold preparations; digestive products (including H2 antagonists); feminine products smoking deterrents; and topical products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; anticoagulants; anticonvulsants; chemotherapy agents; prescribed cold medications; contraceptives; estrogens; growth hormones; thyroid agents; and prescribed smoking deterrents. Therapeutic categories/products requiring prior authorization: analgesics, antipyretics; and NSAIDs*; anorectics; antibiotics; antidepressants; antidiabetic agents; antihistamines; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; ENT anti-inflammatory agents; hypotensive agents; misc. GI drugs*; sympathomimetics (adrenergic); erectile dysfunction products; PPIs; Cox II; CNS stimulants; anti-fungals for nail fungus; leukotrine modifiers; glaucoma agents; triptans; anti-emetics; anti-obesity drugs; Alzheimer's agents; and rheumatoid arthritis agents.

*Brand approval override required for NSAIDs, controlled substances, and GI drugs for which there are therapeutically equivalent (A-rated) generics available.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home healthcare and extended care facilities, and through physician payment when used in physicians' offices.

Vaccines: Vaccines reimbursable as part of the EPSDT, CHIP, and VCP service. Childhood immunization vaccine is provided to all children through the Division of Public Health Services. The Medicaid program does not reimburse

providers for routine vaccines, although an administration fee is allowed.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: States maintain a formulary with a preferred drug list. General exclusions include cosmetic agents for hair growth, experimental and fertility drugs. Management of formulary includes prior authorization and quantity limits on certain products (e.g., anti-emetics, anti-migraine agents, etc.).

Prior Authorization: State currently has a formal prior authorization procedure with an associated grievance and appeal procedure. Prior authorization requests must be initiated by the prescriber.

Prescribing or Dispensing Limitations

Monthly Quantity Limit: Limited to 34-day supply
Maintenance Medications: Limited to 90-day Supply

Prescription Refill Limits: Up to 5 refills within 6 months.

Monthly Dollar Limits: None.

Drug Utilization Review

PRODUR system implemented in July 1995. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$1.75, effective 1/24/2004.

Ingredient Reimbursement Basis: EAC = AWP-16%.

Prescription Charge Formula: Lesser of usual and customary charge or AWP-16%, Federal Upper Limit; State MAC; or DOJ pricing, plus a dispensing fee. Special rules for Blood Factor products on the DOJ price list.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Brand Medically Necessary" or "Dispense as Written" with an explanation as to why the generic cannot be used.

Incentive Fee: None.

Patient Cost Sharing: Copayment – Generics: \$1.00; Brand: \$2.00, effective 3/1/04. Copayments apply to all recipients except nursing home patients in SNF or ICF facilities; home and community based care waived recipients holding form 949; pregnant women; children under 18 years; and prescriptions for family planning drugs.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

None as of June 2004.

F. STATE CONTACTS

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800/884-2822

Medicaid Managed Care Contact

Pharmacy Administrator
603/271-4210

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None

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NEW JERSEY

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	
Physician Services	◆	◆	◆	◆	◆	◆	◆	
Dental Services	◆	◆	◆	◆	◆	◆	◆	

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$686,301,522	296,059	\$757,754,210	297,997
RECEIVING CASH ASSISTANCE, TOTAL	\$363,069,902	139,560		
Aged	\$72,311,029	28,986		
Blind / Disabled	\$285,795,677	85,000		
Child	\$2,049,951	14,902		
Adult	\$2,913,245	10,672		
MEDICALLY NEEDY, TOTAL	\$10,351,402	3,657		
Aged	\$9,122,951	3,389		
Blind / Disabled	\$1,223,455	254		
Child	\$4,996	14		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$111,545,421	57,258		
Aged	\$34,813,603	13,901		
Blind / Disabled	\$73,422,788	16,669		
Child	\$2,790,853	21,063		
Adult	\$469,454	5,587		
BCCA Women	\$48,723	38		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$201,334,797	95,584		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Division of Medical Assistance and Health Services, Department of Human Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: All FDA-approved drugs with Federal Medicaid Drug Rebate agreements; needles and syringes. Products not covered: cosmetics; fertility drugs; ED drugs; experimental drugs; and DESI drugs. Prior authorization required for: methadone; protein replacement supplements; and drugs subject to DUR.

Over-the-Counter Product Coverage: Adults: PPIs; smoking deterrent products; family planning products. Products covered with restrictions (for children under age 21 only): allergy; asthma; sinus products; analgesics; topical products; and cough and cold preparations.

Therapeutic Category Coverage: All covered except erectile dysfunction; cosmetic; and fertility drugs.

Coverage of Injectables: Both physician-administered and self-administered injectables are covered.

Vaccines: Vaccines covered by Vaccine for Children Program provided at no State cost; \$11.50 administrations fee. Non-VFC vaccines reimbursable at AWP less 12.5%.

Unit Dose: Unit dose packaging reimbursable in long-term care facilities only, not in retail settings (unless unit dose is only way item is packaged).

Formulary/Prior Authorization

Formulary: Open.

Prior Authorization: State currently has a formal prior authorization procedure. Prior authorization is based on medical necessity using DUR standards. Fair hearing for appealing prior authorization decisions.

Prescribing or Dispensing Limitations

Prescription Refill Limit: 5 times within a 6-month period.

Monthly Quantity Limit: Original, 34-day supply. Refills, 34 days or 100 units, whichever is more.

Drug Utilization Review

PRODUR system implemented in October 1996. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.73. Additional add-ons per Rx shall be given to pharmacy providers who provide the following:

1. 24-hr. Emergency Service: add \$0.11
2. Patient Consultation: add \$0.08
3. Impact Area Location: add \$0.15 (provider shall have a combined NJ FamilyCare/Medicaid and PAAD prescription volume equal to or greater than 50% of total prescription volume).

Ingredient Reimbursement Basis: EAC = AWP-12.5%.

Prescription Charge Formula: "Maximum Allowable Cost," or Average Wholesale Price-12.5% (reduction from AWP is pharmacy specific) plus a dispensing fee or the provider's usual and customary charge, whichever is lower.

Maximum Allowable Cost: State imposes Federal Upper Limits on generic drugs. Override requires "Dispense as Written" or "Medically Necessary."

Incentive Fee: None.

Patient Cost Sharing: None.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 646,000 Medicaid recipients received pharmacy benefits through managed care in 2004. Approximately 53,550 aged, blind, and disabled (ABD) beneficiaries receive their drug benefit through FFS. Also, atypical antipsychotic drugs are carved out of managed care for enrolled clients and are paid through FFS program.

Managed Care Organizations

AMERIGROUP New Jersey, Inc
399 Thornall Street, 9th Floor
Edison, NJ 08837
800/600-4441

Health Net of New Jersey, Inc.
90 Matawan Road
Matawan, NJ 07747
800/555-2604

AmeriChoice of New Jersey, Inc.
Two Gateway Center, 13th Floor
Newark, NJ 07102
800/941-4647

Horizon NJ Health
210 Silvia Street
Trenton, NJ 08628
800/765-4325

University Health Plans, Inc.
550 Broad Street, 17th Floor
Newark, NJ 07102
800/564-6847

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New Brand Name Products Contact

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Medicaid Drug Rebate Contacts

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Mail Order Benefit Program

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Elderly Expanded Drug Coverage Contact

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NEW MEXICO

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003*	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$92,674,018	122,098	\$108,079,641	99,931
RECEIVING CASH ASSISTANCE TOTAL	\$11,574,166	24,286		
Aged	\$2,231,875	5,200		
Blind/Disabled	\$8,861,075	12,384		
Child	\$167,821	3,257		
Adult	\$313,385	3,445		
MEDICALLY NEEDY, TOTAL	\$0	0		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
MEDICALLY NEEDY, TOTAL	\$667,225	8,009		
Aged	\$41,483	132		
Blind/Disabled	\$165,963	254		
Child	\$430,430	7,110		
Adult	\$29,349	513		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$80,432,627	89,803		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Human Services Department (HSD), Medical Assistance Division.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Approximately three-fourths of New Mexico Medicaid recipients with full benefits are enrolled in the SALUD! Medicaid managed care program via three Managed Care Organizations (MCO): Lovelace Community Health Plan, Presbyterian Healthcare Services and Molina Healthcare. As a waiver program, the MCOs are allowed to maintain closed formularies, with required exception and appeals processes. Medicare-Medicaid dual eligibles are not enrolled in managed care. Those not in SALUD! Managed care (i.e., fee-for-service) receive pharmacy benefits through either the NMRx Preferred Drug List (PDL) program administered by Presbyterian, or the non-PDL pharmacy benefit administered directly by the State via its fiscal agent, ACS. The NMRx program provides pharmacy coverage for Native Americans who have not opted into managed care, and Medicare-Medicaid dual eligibles for Part D excluded drug coverage. The state directly administers the pharmacy benefit for Medicaid recipients residing in nursing homes and ICF/MR facilities, those transitioning into managed care during the election period, and for pharmacy claims from Indian Health Service (IHS) and tribally operated pharmacies. New Mexico has single Statewide Entity for behavioral health services, ValueOptions of New Mexico. With the exception of HIS/tribal pharmacies and state operated facilities, prescriptions written by behavioral health providers are covered by the Statewide Entity. New Mexico Medicaid does not cover Medicare Part D copays for dual eligibles. Part D excluded drug coverage is provided by the applicable plan, NMRx, non-PDL fee-for-service or ValueOptions of New Mexico, in the same manner and to the same extent as non-dual eligibles. Products covered: Most FDA-approved prescription drugs; prescribed insulin; disposable needle and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition. Prior authorization required for: CNS stimulants for ADD (adults only); anorexiant; nutritional supplements; disposable diapers. Products not covered: drugs for treatment of tuberculosis; cosmetics; experimental drugs; fertility drugs; drugs and immunizations available from any other source; medications supplied by the New Mexico State Hospital to clients on convalescent leave from hospital; drugs classified by FDA as “ineffective;” hypnotic drugs

(barbiturates); and drugs without Medicaid rebate participation agreement.

Over-the-Counter Product Coverage: OTC products covered when a) they may be the drug of choice for common medical conditions or b) when they are an appropriate economic and therapeutic alternative to prescription drugs. Products covered: personal care items (i.e., over-the-counter shampoo and soap); feminine products.

Therapeutic Category Coverage: Products Covered: anabolic steroids; analgesics, antipyretics, and NSAIDs, antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents, antihistamines; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; growth hormones; hypotensive agents; misc. GI drugs; prescribed smoking deterrents; and thyroid agents. Prior authorization required: anoretics; sympathomimetics (adrenergic); and drugs used to treat impotence. *Coverage of Injectables:* Injectable medicines reimbursable through both the Prescription Drug Program and physician payment when used in physician offices, home health care, and extended care facilities.

Vaccines: Vaccines reimbursable as part of the EPSDT service, the Children’s Health Insurance Program, the Vaccine for Children Program, and various Department of Health Programs.

Unit Dose: Does not reimburse for unit dose packaging or for prefilling syringes. The Medical Assistance Division does reimburse for commercial unit dose packaged drugs.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list (PDL). PDL managed through restrictions on use, prior authorization, and therapeutic “step” requirements.

Prior Authorization: State currently has a formal prior authorization procedure screening for drug classes with right of fair hearing to appeal a prior authorization decision.

Prescribing or Dispensing Limitations

Monthly Quantity Limit: 34-day supply maximum, excluding birth control pills (1 year) and maintain drugs (90 days). Number of refills must conform to applicable State and Federal laws.

Drug Utilization Review

PRODUR system implemented in October 1993.
State currently has a DUR Board that meets at
between 1-4 times per year.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.65, effective 6/12/02.
Ingredient Reimbursement Basis: EAC = AWP-
14%.

Prescription Charge Formula: Prescriptions
reimbursed at the lesser of the following:

1. Cost (EAC or MAC) dispensed plus a
dispensing fee or,
2. The usual and customary charge by the
pharmacy to the general public.

Maximum Allowable Cost: State imposes Federal
Upper Limits as well as State-specific limits on
generic drugs. Override "Brand Necessary" or
"Brand Medically Necessary." Also prescriber is
not prohibited from generic substitution and, if due
to drug shortage, requesting reimbursement at the
brand level.

Incentive Fee: None.

Patient Cost Sharing: No copayment, except \$5.00
for CHIP clients and working disabled clients.

Cognitive Services: Does not pay for cognitive
services.

E. USE OF MANAGED CARE

Approximately 273,000 Medicaid recipients
enrolled in are MCOs in FY 2004. Recipients
receive pharmaceutical benefits through managed
care plans.

Managed Care Organizations

Molina Healthcare of New Mexico
P.O. Box 3887
Albuquerque, NM 87110
800/377-9594

Lovelace Community Health Plan
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111 Bayhill Drive, Suite 350
San Bruno, CA 94066
800/633-3453

Claims Submission

ACS State Healthcare
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Mail Order Pharmacy Program

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NEW YORK

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2004		2005	
	Expenditures	Recipients	Expenditures	Recipients
TOTAL	\$4,547,959,447	2,664,195	\$5,032,941,827	2,770,487
RECEIVING CASH ASSISTANCE, TOTAL	\$2,653,521,366	832,090	\$2,919,829,296	836,347
Aged	\$478,740,071	140,775	\$532,163,745	140,344
Blind/Disabled	\$2,053,182,159	458,170	\$2,256,381,019	467,521
Child	\$48,812,631	168,900	\$52,566,932	161,935
Adult	\$72,786,305	64,254	\$78,717,600	66,547
MEDICALLY NEEDY, TOTAL	\$1,184,351,896	1,065,031	\$1,337,392,683	1,110,744
Aged	\$308,134,181	119,174	\$345,750,536	124,339
Blind/Disabled	\$539,575,457	117,857	\$599,928,503	121,821
Child	\$160,498,703	560,930	\$177,721,423	568,844
Adult	\$176,143,555	267,070	\$213,992,221	295,740
POVERTY RELATED, TOTAL	\$676,250,865	721,561	\$742,131,590	778,509
Aged	\$504	16	\$35,745	450
Blind/Disabled	\$0	0	\$0	0
Child	\$95,471,976	355,094	\$117,926,573	399,573
Adult	\$580,778,385	366,451	\$624,169,272	378,486
BCCA Women	\$0	0	\$0	0
TOTAL OTHER EXPENDITURES/ RECIPIENTS*	\$33,835,321	45,513	\$33,588,258	44,887

* Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

Source: New York State Medicaid Statistical Information System, 2004 and 2005.

C. ADMINISTRATION

State Department of Health, Office of Medicaid Management.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition; and interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; and experimental drugs.

Over-the-Counter Product Coverage: Products covered: allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; feminine products; smoking deterrent products (max. 2 courses of treatment/year); and topical products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; analgesics, antipyretics, NSAIDs; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamine drugs; antileptic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; prescribed smoking deterrents; sympathomimetics (adrenergic); and thyroid agents. Therapeutic categories partially covered: prescribed cold medication and misc. GI drugs. Therapeutic categories requiring prior authorization: antibiotics (zyvox only); second generation antihistamines; growth hormones (serostim); medical/surgical supplies; proton pump inhibitors; brand name products if A-rated generic is available; orthopedic shoes; compression stockings; and some DME items. Therapeutic categories not covered: anorectics; agents used for hair growth; and erectile dysfunction products.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care facilities and through physician payment when used in physician offices. In extended care facilities reimbursement for non-self administered injectable medicines is included in the facility rate. No special coverage policies exist for self-administered injectable medicines.

Vaccines: Vaccines are reimbursable under the EPSDT service, CHIP, and the Vaccines for Children program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary. Utilization managed through restrictions on use, prior authorization, and quantity limits. General exclusions: New York State follows OBRA '90 guidelines in the reimbursement of prescription drugs.

Prior Authorization: The State uses an automated voice activation system and has a Pharmacy and Therapeutics Committee that meets quarterly. Prior authorization is required for: all brand name drugs with A-rated generics, Zyvox, Serostim, second generation antihistamines, and proton pump inhibitors.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Maximum of 5 refills within 6 months. Also, annual limits on number of prescriptions and prescription and nonprescription drugs without an override.

Monthly Dollar Limits: None.

Drug Utilization Review

PRODUR system implemented in March 1995. State currently has a DUR Board which meets bimonthly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.50 for brand name drugs, \$4.50 for generic drugs. Effective 8/1/98.

Ingredient Reimbursement Basis: EAC = AWP-12.75% for brand name drugs and AWP-16.5% for generics (effective 10/1/04).

Prescription Charge Formula:

1. Payment for multiple source drugs must not exceed the aggregate of the specified upper limit set by the Federal Centers for Medicare and Medicaid Services (CMS), plus a dispensing fee, for a particular drug; and
2. Payment for brand name drugs and other multiple source drugs not covered by clause (1) will be the lower of: EAC plus a dispensing fee; or
3. The billing pharmacy's usual and customary price charged to the general public.

Maximum Allowable Cost: State imposes Federal Upper Limits on generic drugs. Must get prior authorization for most brand name products. (see www.health.state.ny.us/nysdoh/medicaid/ptcommittee/mandatorggen.htm)

Incentive Fee: \$1.00 for dispensing a lower cost multi-source product.

Patient Cost Sharing: Copayment is \$3.00 for brand name drugs, \$1.00 for generic and \$0.50 for OTC drugs. Exceptions include psychotropic drugs as well as drugs FDA approved for the treatment of tuberculosis and family planning drugs.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 3.1 million Medicaid recipients were enrolled in MCOs in FY 2005. Recipients receive pharmaceutical benefits through the State.

Health Maintenance Organizations

- Affinity Health Plan
- AmeriChoice of New York
- Broome MAX
- Capitol District Physicians' Health Plan
- CarePlus, LLC
- Center Care/Manhattan PHSP
- Community Choice HP of Westchester
- Community Premier Plus
- Excellus Health Plan
- Fidelis/NYS Catholic Health Plan
- GHI HMO Select
- HealthFirst PHPS
- Health Insurance Plan of Greater New York
- HealthPlus PHPS
- HealthNow/BCBS-WNY/Community Blue
- HealthNow/Blue Shield of NENY
- Hudson Health Plan
- Independent Health Association
- Managed Health Inc./A+ Health Plan
- MetroPlus Health Plan
- MVP Health Plan
- Neighborhood Health Providers
- NYPS Select Health
- NYP Community Health Plan
- NYS Catholic Health Plan
- PCMP
- Preferred Care
- SCHC Total Care/Syracuse PHSP
- Southern Tier
- St. Barnabas/Partners in Health

- Suffolk Health Plan
- United Healthcare Plan of NY, Inc.
- Univera Community Health
- VidaCare, Inc.
- Wellcare of New York

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John Gotowko, R.Ph., M.S., M.B.A.
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Disease Management/Patient Education Programs

Disease/Medical State: AIDS/HIV
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Program Manager: Guthrie Birkhead
Program Sponser: AIDS Institute, NYSDOH

Disease/Medical State: Asthma
Program Name: NYS Asthma Grant
Program Manager: Patricia Waniewski
Program Sponser: Division of Family Health, NYSDOH

Disease/Medical State: Diabetes
Program Name: Diabetes Prevention and Control Program
Program Manager: Maureen Spence
Program Sponser: Bureau of Chronic Disease Services, NYSDOH

Disease/Medical State: Smoking Cessation
Program Name: Smokers' Quit Line (866/697-8487)
Program Manager: QuitSite@Roswellpark.org
Program Sponsor: Roswell Park and NYSDOH

Disease/Medical State: Cardiovascular Disease
Program Name: Healthy Heart Program
Program Manager: hhp@health.state.ny.us
Program Sponser: NYSDOH

Check the NYSDOH website for further information about disease management demonstrations. Several county demonstrations will phase in during 2006.

Disease Management Program/Initiative Contacts

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Mail Order Pharmacy Program

None

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David Cerniglia, D.C.
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Elena Padilla, Ph.D.
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NORTH CAROLINA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$1,069,140,895	949,795	\$1,263,258,395	1,015,932
RECEIVING CASH ASSISTANCE TOTAL	\$603,557,480	450,000		
Aged	\$158,697,938	63,887		
Blind/Disabled	\$340,911,000	130,730		
Child	\$32,488,999	132,601		
Adult	\$71,459,543	122,782		
MEDICALLY NEEDY, TOTAL	\$69,821,479	28,176		
Aged	\$47,950,356	16,850		
Blind/Disabled	\$18,071,505	6,202		
Child	\$276,567	789		
Adult	\$3,523,051	4,335		
POVERTY RELATED, TOTAL	\$370,773,038	421,345		
Aged	\$148,954,057	61,023		
Blind/Disabled	\$147,615,329	53,941		
Child	\$68,217,052	272,181		
Adult	\$5,986,600	34,200		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS	\$24,988,898	50,274		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Division of Medical Assistance, Department of Health and Human Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition; and interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; experimental drugs; OTC drugs not listed on the selected coverage list; and those products/categories mentioned below under "Therapeutic Category Coverage" section.

Over-the-Counter Product Coverage: North Carolina covers a select list of OTC products. (See www.dhhs.state.nc.us/dma/mp/mpindex.htm for a complete list of covered OTC products.)

Therapeutic Category Coverage: North Carolina provides coverage for all therapeutic categories except anoretics; products used for cosmetic purposes; fertility drugs; weight gain; erectile dysfunction; diaphragms; IV fluids (Dextrose 500ml or greater) and irrigations fluids used in an inpatient facility; drugs on the DESI list; any drug manufactured by a company who has not signed the Federal rebate agreement; and experimental drugs. Prior authorization required for: analgesics, antipyretics, and NSAIDs; drugs used to treat ADHD; Procrit/Epogen; Neupogen; Aransep; OxyContin; Growth Hormones; Provigil; Rebetrone; Vioxx; Celebrex; Bextra; Botox; Mybloc; Zyban, Nicotrol, Nicotine Patch; Synagis; and RespiGam. (See www.ncmedicaidpbm.com for additional information.)

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facility, and through physician payment when used in physician offices.

Vaccines: Vaccines reimbursable as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary.

Prior Authorization: Formal prior authorization process can be found at: www.ncmedicaidpbm.com. A prescriber's written justification is required to appeal a prior authorization decision.

Prescribing or Dispensing Limitations

Monthly Quantity Limit: 34-day supply maximum. Except birth control tablets and hormonal replacement therapy dial packs: 3 months; maintenance non-controlled medications, tied with the FUL and/or SMAC after a prior successful fill may receive a 3 month supply upon the prescriber's discretion.

Monthly Prescription Limit: Six prescriptions per month per recipient. (Effective June 2006: 8 scripts per month with possible additional 3 prescriptions. If over 11, "locked in" and requires a MTMS program.)

Prescription Dollar Limits: None.

Drug Utilization Review

PRODUR system implemented in May 1996. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: B: \$4.00; G: \$5.60, effective 2002.

Ingredient Reimbursement Basis: EAC = AWP-10%.

Prescription Charge Formula: The lowest price of AWP minus 10%, State MAC or Federal MAC plus a dispensing fee or usual and customary, whichever is lowest. The pharmacist filling the original prescription will not be reimbursed for refills for the same drug within a calendar month.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific maximum allowable cost (MAC) limits generic drugs. 457 drugs are listed on the State-specific MAC list. Override requires "Brand Medically Necessary" written on the face of the prescription by the prescriber.

Incentive Fee: \$1.60 to dispense a lower cost multisource product.

Patient Cost Sharing: \$3.00 copayment/Rx.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 9,100 Medicaid recipients were enrolled in MCOs in FY 2005. Recipients receive pharmaceutical benefits through the State.

Managed Care Organizations

SouthCare/Coventry
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F. STATE CONTACTS**State Drug Program Administrator**

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NORTH DAKOTA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2004**		2005**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$59,423,283		\$61,559,915	

RECEIVING CASH ASSISTANCE, TOTAL

Aged
Blind/Disabled
Child
Adult

MEDICALLY NEEDY, TOTAL

Aged
Blind/Disabled
AFDC-Child
AFDC-Adult

POVERTY RELATED, TOTAL

Aged
Blind/Disabled
AFDC-Child
AFDC-Adult
BCCA Women

TOTAL OTHER EXPENDITURES/RECIPIENTS*

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2004 and 2005 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: North Dakota Department of Human Services, 2006.

C. ADMINISTRATION

North Dakota Department of Human Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; and total parenteral nutrition. Products not covered: cosmetics; fertility drugs; urine ketone test strips; interdialytic parenteral nutrition; drugs used for hair growth; prescription vitamins (except prenatal vitamins); experimental drugs; and DESI drugs. Prior authorization required for: nutritional supplements; and orlistat.

Over-the-Counter Product Coverage: Products covered: antacids; analgesics; iron supplements; digestive products; and anti-ulcer medications. Products covered with restriction: allergy, asthma, and sinus products (loratadine only); and topical products (artificial tears only); smoking deterrent products (lifetime limits). Products not covered: cough and cold preparations; feminine products.

Therapeutic Category Coverage: Categories covered: anabolic steroids; analgesics, antipyretics, and NSAIDs; antibiotics; anticoagulants; anticouvolants; anti-depressants; antidiabetic agents; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; growth hormones; hypotensive agents, sympathomimetics (adrenergic); thyroid agents; and prescribed smoking deterrents (partial coverage). Prior authorization required for: brand name NSAIDs, anoretics (orlistat); antihistamines; and PPIs.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care, and extended care facilities, and through both the Prescription Drug Program and physician payment when used in physician offices.

Vaccines: Vaccines reimbursable as part of the EPSDT service.

Unit Dose: Unit dose packaging not reimbursable.

Additional information on benefit design may be found at www.hidndmedicaid.com.

Formulary/Prior Authorization

Formulary: Open formulary

Prior Authorization: State currently has a formal prior authorization procedure. Beneficiary can request a fair hearing to appeal a prior authorization decision.

Prescribing or Dispensing Limitations

Prescription Refill Limit: None.

Monthly Quantity Limit: 34-day supply.

Monthly Dollar Limits: None.

Drug Utilization Review

PRODUR system implemented in July 1996. State has a DUR Board that meets quarterly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$5.60 for generic, \$4.60 for brand effective 8/1/03.

Ingredient Reimbursement Basis: EAC = lesser of AWP-10%, LAC+12.5%, or MAC.

Prescription Charge Formula: Acquisition Cost plus a dispensing fee per prescription or the usual and customary retail charge, whichever is lower. Acquisition Cost = AWP-10%, LAC+12.5%, or MAC.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on drugs. Override requires "Dispense As Written."

Incentive Fee: None.

Patient Cost Sharing: \$3.00 (brand-name drugs)

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 817 Medicaid recipients were enrolled in managed care organizations in 2003. Recipients enrolled in MCO's receive pharmacy benefits through the State.

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Prescription Price Updating

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Disease Management Program/Initiative Contact

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Mail Order Pharmacy Benefit Program

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OHIO

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$1,330,569,382	997,246	\$1,569,067,697	1,054,737
RECEIVING CASH ASSISTANCE, TOTAL	\$636,705,938	287,972		
Aged	\$98,218,659	33,902		
Blind/Disabled	\$510,976,291	171,277		
Child	\$13,850,390	59,837		
Adult	\$13,660,598	22,956		
MEDICALLY NEEDED, TOTAL	\$0	0		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$47,855,411	164,830		
Aged	\$2,277,564	1,878		
Blind/Disabled	\$5,780,069	3,194		
Child	\$36,005,788	138,564		
Adult	\$3,791,990	21,194		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$646,008,033	544,444		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Ohio Department of Job and Family Services, Bureau of Health Plan Policy.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: most drugs including prescribed insulin. Products not covered: cosmetics; fertility drugs; obesity drugs; experimental drugs. Prior authorization required for some drugs including these examples: Ceredase; Cerebyx; Cerezyme; Clorazepates; Depo-Provera; Enbrel; immunoglobulins; Lioresal Intrathecal; Lodosyn; Nascobal; Orgaran; Oxandrin Panretin; Periostat; Priftin; Prolastin; Proleukin; Provigil; Psoralens; Remicade; Rituxan; Stimote; Synagis; and Targretin. Products covered under DME: disposable needles and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition (PA required); and interdialytic parenteral nutrition (PA required).

OTC Coverage: Selective coverage for: allergy, asthma, and sinus products; analgesics; feminine products; smoking deterrent products; cough and cold preparations; digestive products; topical products; laxatives; antacids; and vitamins and minerals.

Therapeutic Category Coverage: Therapeutic categories covered: analgesics, antipyretics, and NSAIDS; antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: anabolic steroids; antihistamines; cardiac drugs; prescribed cold medications; growth hormones; hypotensive agents; misc. GI drugs; and prescribed smoking deterrents. Therapeutic categories not covered: anorectics; innovator multi-source drugs; selected high-risk drugs (e.g., Accutane); and drugs used in special settings (e.g., outpatient hospital).

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment when used in physicians offices.

Vaccines: Vaccines reimbursable as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Approved Drug List (ADL)/Prior Authorization

ADL: Closed ADL of preferred products with approximately 28,000 NDC-specific trade and generic drugs. Products excluded include obesity, fertility, and experimental drugs. ADL managed by excluding products based on contracting issues, restrictions on use, and prior authorization.

Prior Authorization: State currently has a formal prior authorization procedure. Prior authorization is needed for certain individual drugs (see examples above) A beneficiary may appeal a prior authorization decision and be granted an administrative hearing. Manufacturers may also request reconsideration for an excluded product.

Prescribing or Dispensing Limitations

Monthly Dollar Limits: None

Monthly Quantity Limits: None

Quantity Limit per Prescription: 34-day supply. 102-day supply for chronic maintenance medications.

Prescription Refill Limit: 5 refills per script.

Drug Utilization Review

PRODUR system implemented through POS in Feb 2000. State currently has a DUR Board with quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.70, effective 7/1/98. (\$0.50 fee for flu vaccine.)

Ingredient Reimbursement Basis: EAC = WAC+7% (eff. 10/1/05).

Prescription Reimbursement Formula:

Reimbursement for legend drugs and selected OTC products based on the lowest of:

1. Provider's submitted charge, which should reflect usual and customary charge to the general public;
2. WAC+7% plus a dispensing fee.
3. Federal- or state-established Maximum Allowable Cost (MAC), for specifically designated generically equivalent drugs plus a dispensing fee.

Non-legend drugs - reimbursement is based on WAC + 7% plus a dispensing fee, or MAC if applicable. Special reimbursement for Blood Factors 8 and 9.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires prior authorization.

Incentive Fee: None.

Patient Cost Sharing: \$2.00 for brand name drugs; \$3.00 (for prior authorized drugs).

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 507,000 Medicaid recipients were enrolled in managed care in 2004. All received pharmacy services through managed care plans. Significant growth in managed care enrollment anticipated for 2006.

Managed Care Organizations

Buckeye Community Health Plan
U.S. Bank Building
175 South Third Street, Suite 1200
Columbus, OH 43215
866/246-4356

CareSource
One South Main Street, Suite 900
Dayton, OH 45402
937/224-3300

MediPlan Corporation
P.O. Box 6907
Canton, OH 44706
330/451-0934

Paramount Advantage
P.O. Box 928
Toledo, OH 43697-0928
419/887-2550

QualChoice Select, Inc.
6000 Parkland Boulevard
Cleveland, OH 44124
440/460-0093

AMERICGROUP Community Care
10123 Alliance Road
Suite 140
Cincinnati, OH 45242
513/733-2300

Gateway Health Plan of Ohio, Inc.
U.S. Steel Tower - Floor 41
600 Grant Street
Pittsburgh, PA 15219
412/255-1303

Molina Healthcare of Ohio, Inc.
8101 N. High Street, Suite 210
Columbus, OH 43235
614/781-4303

Unison Health Plan of Ohio, Inc.
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Prior Authorization Contacts

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DUR Board

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Jill Orn, R.Ph.
Donald Sullivan, Ph.D., R.Ph.

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Medicaid Drug Rebate Contacts

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(Transitioning to ACS on 7/1/06)

Medicaid Managed Care Contact

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Mail Order Pharmacy Benefit

State has mail order providers. Recipients free to select mail order pharmacy of their choosing.

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OKLAHOMA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$267,549,002	276,111	\$290,182,401	302,424
RECEIVING CASH ASSISTANCE, TOTAL	\$93,374,439	64,654		
Aged	\$26,963,385	22,887		
Blind/Disabled	\$64,994,426	37,378		
Child	\$791,061	3,079		
Adult	\$625,567	1,310		
MEDICALLY NEEDY, TOTAL	\$386,198	607		
Aged	\$16,944	40		
Blind/Disabled	\$195,575	148		
Child	\$104,496	220		
Adult	\$69,183	199		
POVERTY RELATED, TOTAL	\$35,945,183	148,226		
Aged	\$124,949	217		
Blind/Disabled	\$195,087	211		
Child	\$33,687,481	132,437		
Adult	\$1,937,666	15,361		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$137,843,182	62,624		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Oklahoma Health Care Authority.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin. Products covered (DME benefit): disposable needles and syringe combinations for insulin; blood glucose test strips; and urine ketone test strips. Products covered with restrictions: total parenteral nutrition (reimburse single most costly ingredient, not reimbursed through pharmacy program). Products not covered: cosmetics; fertility drugs; and experimental drugs.

Over-the-Counter Product Coverage: Products covered: birth control products. Products covered with restrictions: allergy, asthma, and sinus products (Claritin OTC only for children < 21 years. PA required for adults. Rx required for all ages.); digestive products (non-H2 antagonists-Prilosec OTC only, Rx required); smoking deterrent products (PA and Rx required). Products not covered: analgesics; cough and cold preparations; H2 antagonists; feminine products; topical products.

Therapeutic Category Coverage: Therapeutic categories covered: antibiotics; anticoagulants; anticonvulsants; antidiabetic agents; antilipemic agents; anti-psychotics; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: anoretics (partial coverage); analgesics, antipyretics, NSAIDs; antidepressants; antihistamine drugs (partial coverage); anxiolytics, sedatives, and hypnotics; cardiac drugs; growth hormones; hypotensive agents; misc. GI drugs; prescribed smoking deterrents (partial coverage) stimulants for ADHD; clopidigrel; and montelukast. Therapeutic categories not covered: anabolic steroids; and prescribed cold medications. OBRA '90 drugs identified as "coverage optional."

Coverage of Injectables: Injectable medicines reimbursable through both the Prescription Drug Program and physician payment when used in home health care and extended care facilities, and through physician payment when used in physician offices.

Vaccines: Vaccines reimbursable as part of EPSDT services and the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with the preferred drug list (PDL). PDL managed through restrictions on use, prior authorization, therapeutic substitution, use of preferred products, and step therapy.

Prior Authorization: State currently has a formal prior authorization procedure. Grievance process exists for appeal of prior authorization decisions or coverage of an excluded product to the agency's Administrative Law Judge. Recipient must present compelling reason to obtain coverage.

Prescription or Dispensing Limitations

Prescription Refills: In accord with State law.

Monthly Quantity Limits: Six prescriptions per month/recipient, including a maximum of three brand name scripts. ICF-MR, Medicaid children, and nursing home recipients are allowed unlimited orders. Clients on Home and Community Based Waivers and DDSD Waivers are also allowed an unlimited number of prescriptions each month.

Quantity Limit per Prescription: Greater of 34-day supply or 100 units or as approved by DUR Board for individual drugs.

Drug Utilization Review

PRODUR system implemented in 2000. State currently has a DUR Board with a monthly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.15, effective 10/95.

Ingredient Reimbursement Basis: EAC = AWP-12.0%. Multisource branded drugs subject to State MAC limits.

Prescription Charge Formula: Estimated Acquisition Cost (EAC) plus dispensing fee, or usual and customary charge, whichever is lower. In no event shall charges to the Welfare Department exceed charges made to the general public for the same prescription or item. Special rules for hemophilia factor products and other injectable drugs on the "DOJ" list.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Brand Medically Necessary". Currently, 1,110 drugs on MAC list.

Incentive Fee: None.

Patient Cost Sharing: Copayment is \$1.00 for prescriptions up to \$29.99, \$2.00 for prescriptions over \$30.00.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Does not use MCOs to deliver drug services to Medicaid recipients.

F. STATE CONTACTS

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Medicare Managed Care Contact

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Mail Order Pharmacy Program

Oklahoma has a mail order pharmacy option.
Pharmacy must be a contracted provider.

Disease Management/ Patient Education Programs

Disease/ Medical State: Diabetes
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Disease Management Program/Initiative Contact

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OREGON

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆		
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆		
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆		
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆		
Nursing Facility Services	◆	◆	◆	◆	◆	◆		
Physician Services	◆	◆	◆	◆	◆	◆		
Dental Services	◆	◆	◆	◆	◆	◆		

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$269,936,847	242,865	\$251,539,420	240,228
RECEIVING CASH ASSISTANCE TOTAL	\$101,222,484	67,680		
Aged	\$12,149,831	8,646		
Blind/Disabled	\$80,475,039	33,840		
Child	\$1,687,922	12,138		
Adult	\$6,909,692	13,056		
MEDICALLY NEEDY, TOTAL	\$39,179,280	8,559		
Aged	\$6,131,229	2,149		
Blind/Disabled	\$33,048,051	6,410		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$6,445,727	38,728		
Aged	\$491,212	402		
Blind/Disabled	\$1,097,160	576		
Child	\$4,123,226	32,729		
Adult	\$734,129	5,021		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$123,089,356	127,898		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

** 2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Office of Medical Assistance Programs (OMAP),
Department of Human Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Drug coverage in Oregon depends on whether the product is being prescribed for a condition covered by the Oregon Health Plan (OHP). Oregon prioritizes health conditions and covers the “highest prioritized” conditions given available resources. Additional information about OHP, including drug coverage, can be found at www.oregon.gov/DHS/healthplan. Products covered: prescribed insulin. Products covered under DME: disposable needles and syringe combinations used for insulin; blood glucose test strips; and urine ketone test strips. Prior authorization required for: isotretinoin; acute anti-ulcer drugs; total parenteral nutrition; interdialytic parenteral nutrition; retinoic acid; nasal inhalers; coal tar preparations; and topical testosterone. Products not covered: cosmetics; fertility drugs; experimental drugs.

Over-the-Counter Product Coverage: Products covered if prescribed for a condition covered by OHP: asthma and sinus products; analgesics; cough and cold preparations; digestive products; feminine products; and topical products. Products not covered: topical products (cosmetics, acne medications, and psoriasis products); and allergy products.

Therapeutic Category Coverage: Therapeutic categories covered for medical conditions covered by OHP: analgesics, antipyretics, and NSAIDs; antibiotics; anticoagulants; anti-depressants; antidiabetic drugs; antilipemic agents; antipsychotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; estrogens; hypotensive agents; prescribed smoking deterrents; sympathomimetics (adrenergic); and thyroid agents. Therapeutic categories requiring prior authorization for covered diagnoses or for medically appropriate use: oral and topical antifungals; antihistamines; topical antivirals; growth hormones; leukotriene receptor antagonists; nasal inhalers; narcotics; sedatives; stimulants; oral nutritionals; triptans; PPIs; legend laxatives; anti-emetics; weight loss drugs; and brand name products for which a generic is available.

Coverage of Injectables: Injectable medicines reimbursable through physician payment when used in physician offices and home health care, and through the Prescription Drug Program when used in extended care facilities.

Vaccines: Vaccines reimbursable by Medicaid as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging is reimbursable, but no additional reimbursement for unit dose or modified unit dose packaging.

Formulary/Prior Authorization

Formulary: Open formulary with a “Plan Drug List (PDL).” The PDL consists of prescription drugs in selected classes that DHS, in consultation with the Health Resources Commission, has determined represent effective drugs available at the best possible price. The PDL is managed through physician education and outreach efforts by the Oregon State College of Pharmacy and through prior authorization. Prior authorization is required to (1) ensure that the drug is being prescribed for a condition that is covered by OHP or (2) for clinical reasons (i.e., medical appropriateness) as recommended by the DUR Board and adopted by OMAP. A copy of the current PDL is available on the OHP website at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/.

Prior Authorization: State currently has a formal prior authorization procedure. Client may request an administrative hearing to appeal a prior authorization decision or to appeal the coverage of excluded products.

Prescribing or Dispensing Limitations

34-day supply with the exception of 100-day supply for mail order and maintenance drugs.

Drug Utilization Review

PRODUR system implemented in March 1994. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: effective 2/1/03.

- 1) \$3.50 (retail);
- 2) \$3.91 (institutional/SNF: providers operating a True or Modified Dose Delivery System);
- 3) \$7.50 (compound prescriptions).

Ingredient Reimbursement Basis: EAC = AWP-15% (Retail), AWP-11% (Institutional)

Prescription Charge Formula: Estimated acquisition cost (EAC) defined as the lesser of: (1) AWP-15% (AWP-11% for institutional pharmacies), (2) Federal Upper Limits for multiple source drugs, (3) State MAC, or (4) the usual and customary charge plus a dispensing fee.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific maximum allowable cost (MAC) limits on generic drugs. Override requires "Dispense as written" or "Medically Necessary." DAW 1 also authorizes override.

Incentive Fee: None.

Patient Cost Sharing: \$2.00 (generic); \$3.00 (brand) for OHP Plus population. Family planning medications and mail order drugs exempt from copay.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 282,000 Medicaid Recipients were enrolled in MCOs in FY 2005. Recipients enrolled in MCOs receive most pharmaceutical benefits through managed care plans. However, mental health drugs are carved out of managed care and paid for by the fee-for-service system.

Care Oregon, Inc
522 SW Fifth Avenue, Suite 200
Portland, OR 97204
800/224-4840

Cascade Comprehensive Care, Inc.
2909 Daggett Avenue, Suite 200
Klamath Falls, OR 97601
541/883-2947

Central Oregon Individual Health Services, Inc.
2650 NE Courtney Drive
P.O. Box 5729
Bend, OR 97708-5729
800/431-4135

Doctors of The Oregon Coast South (DOCS)
750 Central, Suite 202
P.O. Box 1096
Coos Bay, OR 97420
541/269-7400

Douglas County IPA
1813 W. Harvard, Suite 206
Roseburg, OR 97470
800/676-7735

Family Care, Inc
2121 SW Broadway, Suite 300
Portland, OR 97201
800/335-3205

Intercommunity Health Network, Inc
3600 NW Samaritan Drive
Corvallis, OR 97330
800/757-5114

Lane Individual Practice Association, Inc. (LIPA)
1800 Millrace
Eugene, OR 97403
877/600-5472

Marion Polk Community Health Plan
198 Commercial Street, SE, Suite 240
Salem, OR 97301
866/318-5375

Mid Rogue Independent Physician Association, Inc.
820 NE 7th Street
Grants Pass, OR 97526
888/460-0185

ODS Community Health, Inc.
601 S.W. Second Avenue
Portland, OR 97204
503/228-6554

Oregon Health Management Services
109 NE Manzanita
Grants Pass, OR 97526
800/471-0304

Providence Health Assurance
P.O. Box 4327
Portland, OR 97208
800/878-4445

Tuality Health Alliance
335 SE 8th Avenue
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Hillsboro, OR 97123
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F. STATE CONTACTS**State Drug Program Administrator**

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Disease Management/Patient Education Programs

Disease States/Medical Conditions: asthma, cardiovascular disease (CAD and CHF), diabetes, COPD

Program Name: Care Enhance

Program Manager: Chris Barber

Mail Order Pharmacy Program

State has a mail order pharmacy program. All non-institutionalized beneficiaries are entitled to participate.

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PENNSYLVANIA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$719,243,402	464,848	\$769,962,791	404,586
RECEIVING CASH ASSISTANCE, TOTAL	\$289,159,044	163,053		
Aged	\$63,502,096	25,125		
Blind / Disabled	\$204,581,556	76,620		
Child	\$8,207,666	37,962		
Adult	\$12,867,726	23,346		
MEDICALLY NEEDY, TOTAL	\$78,820,915	36,294		
Aged	\$69,435,876	23,554		
Blind / Disabled	\$5,799,806	1,375		
Child	\$2,269,641	6,755		
Adult	\$1,315,592	4,610		
POVERTY RELATED, TOTAL	\$150,197,883	158,264		
Aged	\$47,969,716	19,213		
Blind / Disabled	\$80,402,609	36,860		
Child	\$19,935,060	92,408		
Adult	\$1,410,384	9,614		
BCCA Women	\$480,114	169		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$201,065,560	107,237		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Office of Medical Assistance Programs, Department of Public Welfare.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; and urine ketone test strips; Products not covered: cosmetics; fertility drugs; and experimental drugs; total parenteral nutrition; and interdialytic parenteral nutrition.

Over-the-Counter Product Coverage: Products covered: feminine products; topical products; digestive products (H2 antagonists); and smoking products. Products covered with restrictions: allergy, asthma, and sinus products (subject to PDL requirements); analgesics (subject to PDL and prior authorization requirements); cough and cold preparations (for recipients < 21 years old); and digestive products (not including H2 antagonists) (subject to PDL requirements). Products not covered: emollients.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; anticoagulants; chemotherapy agents; contraceptives; estrogens; hypotensive agents; sympathomimetics (adrenergic); and prescribed smoking deterrent products. Partial coverage for: prescribed cold medications. Prior authorization required for: analgesics, antipyretics, and NSAIDs; antibiotics; anticonvulsants; antidepressants; antidiabetic agents; antihistamines; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; ENT anti-inflammatory agents; growth hormones; misc. GI drugs; thyroid agents; Cox-2s; erectile dysfunction products; and Oxycodone/ Oxycontin; Lyrice, Topomax; Spiriva; Byetta; Symlin; Comtan; and Brand Medically Necessary drugs. Therapeutic categories not covered: anorectics (unless for treatment of hyperkinesia or narcolepsy); hair restoration products; drugs prescribed for obesity; appetite control products; vitamins (with some exceptions); and products from companies not participating in the rebate program.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in physician offices, home health care, and extended care facilities.

Vaccines: Vaccines reimbursable at AWP-10% as part of the Vaccines for Children Program and the EPSDT Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list. PDL managed through preferred products and prior authorization.

Prior Authorization: State currently has a prior authorization procedure screening for drug classes and individual drugs. Products that require PA include BMN brand name drugs that have A-rated generics, H2 antagonists used >90 days, and drugs for erectile dysfunction. Also, Oxycontin prescriptions with doses in excess of 3 tablets per day, or being on more than 2 different strengths concurrently and COX-2 drugs if the patient is taking another NSAID, the prescribed dose is higher than the FDA recommended dose, or the patient is under 70 years of age and is not taking an anticoagulant. State hearing and appeals process available to appeal a prior authorization decision.

Prescribing or Dispensing Limitations

Quantity Limit: 34-day supply or 100 units, whichever is greater.

Refill Limit: Up to 5 within 6 months.

Monthly Prescription Limit: 6

Daily Limit: Doses per day based on FDA approved dosing guidelines and dose optimization.

Drug Utilization Review

PRODUR system implemented in June 1993. Pharmacy and Therapeutics Committee performs drug utilization review. Meets quarterly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.00 (\$5.00 for compounds), effective 10/1/95.

Ingredient Reimbursement Basis: EAC = AWP-10% or WAC+7%.

Prescription Charge Formula:

1. Payment for single source drugs and those multisource brand name drugs certified as medically necessary will be the lower of the EAC plus dispensing fee or the pharmacy's usual and customary charge.
2. State MAC for the drug plus dispensing fee or the pharmacy's usual and customary charge.

3. For compound prescriptions, an additional fee of \$1.00 is allowed to a pharmacy, bringing the total dispensing fee to \$5.00.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. 1,075 drugs are listed on the State-specific MAC list. Override requires prior authorization with evidence to show that recipient is allergic to the inactive ingredients in the generic product.

Incentive Fee: None.

Patient Cost Sharing: Brand: \$3.00; Generic: \$1.00

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 1.8 million unduplicated Medicaid recipients were enrolled in managed care in 2005. Beneficiaries receive pharmacy services, depending on their category of assistance, through both managed care and the State's fee-for-fee service system.

Managed Care Organizations

AmeriHealth HMO/Mercy Health Plan
200 Stevens Drive
Philadelphia, PA 19113
215/937-8200

Keystone Mercy Healthplan
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Philadelphia, PA 19113-1570
215/937-8200

Americhoice of PA
The Wanamaker Building
100 Penn Square East, Suite 900
Philadelphia, PA 19107
215/835-4602

Health Partners of Philadelphia
901 Market Street, Suite 500
Philadelphia, PA 19107
215/991-4044

Unison Health Plan/MedPlus+
300 Oxford Drive
Monroeville, PA 15146
412/858-4000

UPMC Health Plan, Inc.
One Chatham Center
112 Washington Place, Suite 800
Pittsburgh, PA 15219
412/454-7640

Gateway Health Plan
U.S. Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219
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James Hardy
Deputy Secretary for Medical Assistance Programs
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David Haverstick, M.D.
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Andrew Maiorini, Pharm.D.
Steven Miller, M.S., D.Ph.
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Stephen Ruenroeng, Pharm.D.
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Medicaid Drug Rebate Contacts

Terri Cathers
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Claims Submission Contact

EDS
275 Grandview Avenue
Camp Hill, PA 17011
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(All contacts with contractor must be made through State agency.)

Medicaid Managed Care Contact

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Disease Management / Patient Education Programs

Disease/Medical States: AIDS/HIV
Asthma
Cardiovascular Disease
Diabetes
Program Name: AccessPlus

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Mail Order Pharmacy Program

None

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Melanie Zimmerman

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RHODE ISLAND¹

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expended</u>	<u>Recipients</u>	<u>Expended</u>	<u>Recipients</u>
TOTAL	\$126,331,040	53,729	\$141,126,655	57,605
RECEIVING CASH ASSISTANCE TOTAL	\$75,903,018	29,656		
Aged	\$8,594,928	4,365		
Blind/Disabled	\$67,160,656	24,010		
Child	\$34,974	516		
Adult	\$112,460	765		
MEDICALLY NEEDY, TOTAL	\$10,071,564	3,728		
Aged	\$6,921,415	3,002		
Blind/Disabled	\$3,149,477	723		
Child	\$0	0		
Adult	\$672	3		
POVERTY RELATED, TOTAL	\$614,107	1,266		
Aged	\$134,738	107		
Blind/Disabled	\$291,154	138		
Child	\$40,337	662		
Adult	\$34,272	228		
BCCA Women	\$113,606	131		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$39,742,351	19,079		

*Total Other Expenditures/Recipients include foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable. Source: CMS, MSIS Report, FY 2002 and FY 2003.

¹ The State of Rhode Island did not respond to the 2005/2006 NPC Survey. Using information from the State's website and other source materials, we have, to the extent possible, updated the Profile and tables in other sections of the Compilation. Users should contact the Rhode Island Medicaid program to assess the accuracy and currency of the information included.

C. ADMINISTRATION

Rhode Island Department Human Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; urine ketone test strips. Products covered under DME: blood glucose test strips; total parenteral nutrition (prior authorization required); and interdialytic parenteral nutrition (prior authorization required). Products not covered: cosmetics; fertility drugs; experimental drugs; DESI drugs.

Over-the-Counter Product Coverage: Products covered: allergy, asthma, and sinus products; analgesics (acetaminophen); cough and cold preparations (guaifenesin, diphenhydramine, chlorpheniramine); feminine products; topical products; (antibiotics only); antacids; and laxatives. Products not covered: digestive products; smoking deterrent products.

Therapeutic Category Coverage: Products covered: anabolic steroids; antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents, antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents, prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: analgesics, antipyretics, and NSAIDs; anoretics; antihistamines; growth hormones; PPIs; Provigil; CNS stimulants; Tracleer; Remodulin; Flolan; Xolair; erectile dysfunction products; and Cox 2 inhibitors. Partial coverage for: prescribed smoking deterrents. Therapeutic categories not covered: products for hair growth.

Coverage of Injectables: Injectable medicines reimbursable under the Prescription Drug Program when used in home health care, extended care facilities, and physician offices.

Vaccines: Limited coverage under the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: No formulary. Prior authorization is required for specific procedures, services, and equipment as identified by the Rhode Island Medical Assistance Program.

Prior Authorization: A review process is available to appeal prior authorization decisions and exclusion of specific products. The review process must be initiated by the provider by submitting a prior authorization request form to EDS. Upon review, the provider will be notified in writing of the approval or denial of the request. Administrative and/or consultative staff may determine that certain services which have been provided in the past without benefit of a written PA request can be approved if the services were medically necessary, would have been approved if reviewed, and payment does not represent a substantial amount.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Refills to a maximum of 5 are allowed.

Monthly Quantity Limit: One month's supply for non-maintenance drugs. One inhaler per fill. 8 tablets per month for erectile dysfunctions medication.

Maintenance Medication: The attending physician may prescribe certain maintenance drugs of 100 tablets, capsules or pint of liquid or a 30-day supply of these drugs - whichever is greater.

Monthly Dollar Limits: None

Drug Utilization Review

PRODUR system implemented in December 1994. State has a DUR Board that meets quarterly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.40 (ambulatory) and \$2.85 (long-term care), effective 1987.

Ingredient Reimbursement Basis: EAC = WAC+10%.

Prescription Charge Formula:

1. In accordance with Federal regulation the upper limit for payment for prescribed drugs will be based upon the amount allowed by the Medical Assistance Program or the usual and customary charge to the general public, whichever is lower.
2. Payment for over-the-counter drugs (non-legend drugs) will be based upon the lower of either the allowable cost of the drug plus 5 percent, the usual and customary charge to the general public, or the allowable cost plus the professional fee for service.

Maximum Allowable Cost: State does not impose Upper Limits on generic drugs. "Dispense as Written" with justification required to substitute a brand name drug where a generic is available.

Incentive Fee: None.

Patient Cost Sharing: No copayment.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximated 135,000 Medicaid recipients were enrolled in managed care in 2005. Managed care recipients receive pharmaceutical benefits through managed care plans.

Managed Care Organizations

- United Healthcare of New England
- Coordinated Health Partners/Blue CHIP
- Neighborhood Health Plan of Rhode Island

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www.healthri.org/hsr/professions/pharmacy.php

SOUTH CAROLINA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2003		2004	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$559,908,608	614,417	\$651,239,970	611,557
RECEIVING CASH ASSISTANCE, TOTAL	\$257,211,722	214,686	\$291,520,922	215,005
Aged	\$53,002,997	26,729	\$55,480,625	24,529
Blind/Disabled	\$157,058,050	75,189	\$182,398,242	77,315
Child	\$16,940,364	59,446	\$19,347,201	59,277
Adult	\$30,210,311	53,322	\$34,294,854	53,884
MEDICALLY NEEDY, TOTAL	\$0	0	\$0	0
Aged	\$0	0	\$0	0
Blind/Disabled	\$0	0	\$0	0
Child	\$0	0	\$0	0
Adult	\$0	0	\$0	0
POVERTY RELATED, TOTAL	\$177,810,401	280,587	\$203,724,048	273,496
Aged	\$47,343,063	24,873	\$53,551,230	24,825
Blind/Disabled	\$66,611,073	25,448	\$81,398,126	27,466
Child	\$59,918,718	210,210	\$64,602,789	201,120
Adult	\$3,937,547	20,056	\$4,171,903	20,085
BCCA Women	N/A	N/A	N/A	N/A
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$124,886,485	119,144	\$155,995,000	123,056

*Total Other Expenditures/ Recipients include foster care children, 1115 demonstration participants, other recipients, and unknown.

Source: South Carolina Medicaid Statistical Information System, FY 2003 and FY 2004.

C. ADMINISTRATION

South Carolina Department of Health & Human Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: most rebated legend generic drugs; prescribed insulin; and disposable needles and syringe combinations used for insulin. Products covered as DME: blood glucose test strips; urine ketone test strips; total parenteral nutrition; and interdialytic nutrition. Products not covered: pharmaceuticals for cosmetics purposes or hair growth; fertility drugs; DESI drugs; and experimental drugs.

Over-the-Counter Product Coverage: Within program guidelines and limitations, the Medicaid program covers all rebated OTC medications and their generic equivalents. Products not covered: brand name products for which equivalent generics are available.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; analgesics, antipyretics, NSAIDs; antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamine drugs; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; growth hormones; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); thyroid agents; and prescribed smoking deterrents. For categories/products not covered or requiring prior authorization, see "Formulary/Prior Authorization," below.

Coverage of Injectables: Injectable medicines are reimbursable through the Medicaid Physician Services Program when used in physicians' offices. Injectables are reimbursable through the Pharmacy Services Program when used at home, through home health care, or in long-term care facilities.

Vaccines: Vaccines are reimbursable based on CDC price as part of the Vaccines for Children Program (age under 21).

Unit Dose: Unit dose packaging is reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary; certain drug classifications excluded. Formulary managed through restrictions on use, prior authorization, preferred products, and physician profiling.

General Exclusions:

1. Weight control products. (except for lipase inhibitors)
2. Investigational pharmaceuticals or products.
3. Immunizing agents. (except for influenza, pneumococcal, and hepatitis-B vaccines where certain criteria are met)
4. Pharmaceuticals determined by the FDA to be less than effective and identical, related, or similar drugs (Referred to as "DESI" drugs).
5. Injectable pharmaceuticals administered by the practitioner in the office, in a clinic, or in a mental health center.
6. Products used as flushes to maintain potency of indwelling peripheral or central venipuncture devices.
7. Devices and supplies (e.g., diabetic supplies, infusion supplies, etc.)
8. Fertility products.
9. Pharmaceuticals which are not rebated.
10. Nutritional supplements
11. Oral hydration therapies for adults.
12. Pharmaceuticals used for cosmetic purposes or hair growth.
13. Anti-hemophilia factor.

Prior Authorization: State currently has a prior authorization program. A preferred drug list (PDL) was implemented in calendar year 2004. Consideration of additional therapeutic classes is ongoing. Beneficiaries can request a fair hearing and exception to policy in order to appeal a prior authorization decision. The prescriber must obtain prior authorization for Medicaid coverage of the following products:

1. Non-preferred drugs.
2. Brand name products (excluding certain narrow, therapeutic index drugs) for which there are A-rated, therapeutically equivalent, less costly generics available.
3. COX-2 inhibitors for patients < age 60.
4. Erectile dysfunction products.
5. OxyContin® (when maximum quantity limitation is exceeded).
6. Panretin®.
7. Proton pump inhibitors (patients age 12 and younger may receive Prevacid without PA).
8. Growth hormone products
9. Targretin®.
10. Xenical®.

Prescribing or Dispensing Limitations

Prescription Refill Limit: The prescriber authorizes the number of refills.

Monthly Quantity Limit: Children (birth to age 21) are allowed unlimited prescriptions per month. Beneficiaries over the age of 21 are limited to a maximum of four prescriptions per month; however, pharmacists may override the monthly prescription limit for adult Medicaid beneficiaries if the prescription meets certain specified override criteria.

Quantity Limit per Prescription: 34-day supply per prescription. Maximum quantity limitations have been established for certain pharmaceuticals. (See <http://southcarolina.fhsc.com/Downloads/provider/QuantityLimits-SCpharmacy.pdf>.)

Monthly Dollar Limit: None.

Drug Utilization Review

PRODUR system implemented November 2000. State currently has a DUR Panel with 10 monthly meetings per year.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.05, effective 7/1/89.

Ingredient Reimbursement Basis: EAC = AWP-10%.

Prescription Charge Formula: Medicaid reimbursement for pharmacy services will be based on the lowest of: the Estimated Acquisition Cost (EAC); Federal or State maximum allowable cost (MAC); or the provider's submitted usual and customary charge.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific maximum allowable costs (MAC) on additional drugs. Approximately 2,000 drugs listed on State MAC list. Override requires "Brand Medically Necessary," handwritten certification by the prescriber and prior authorization.

Incentive Fee: None.

Patient Cost Sharing: \$3.00 co-payment per prescription for most adult beneficiaries, unless otherwise excepted.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 82,400 Medicaid recipients were enrolled in MCOs in FY 2005. Recipients receive pharmaceutical benefits through managed care plans.

Managed Care Organizations

Select Health of South Carolina, Inc.
P.O. Box 40849
Charleston, SC 29423

Unison Health Plan of SC
100 Executive Center Drive, Suite 1-A
Columbia, SC 29210

Upstate Carolina Best Care
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Columbia, SC 28211

PhyTrust of South Carolina
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Mail Order Drug Program

Yes. Mail order pharmacies which have obtained a SC special mail order permit may enroll as SC Medicaid providers.

Disease Management/Patient Education Programs

Disease/Medical State: Diabetes Chronic Care Management

Program Manager: Joyce Eaker

Sponsor: S.C. Department of Health & Human Services

Disease Management Program/Initiative Contact

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SOUTH DAKOTA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$63,654,623	64,948	\$72,883,705	68,361
RECEIVING CASH ASSISTANCE, TOTAL	\$32,400,063	22,529		
Aged	\$3,687,941	1,793		
Blind/Disabled	\$24,972,780	8,898		
Child	\$1,514,094	7,211		
Adult	\$2,225,248	4,627		
MEDICALLY NEEDY, TOTAL	\$0	0		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$6,304,155	25,351		
Aged	\$38,283	62		
Blind/Disabled	\$110,665	99		
Child	\$5,678,563	22,699		
Adult	\$464,812	2,481		
BCCA Women	\$11,832	10		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$24,950,405	17,068		

*Total Other Expenditures/recipients include foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Department of Social Services, Office of Medical Services.

D. PROVISIONS RELATING TO DRUGS**Benefit Design**

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; and urine ketone test strips. Prior authorization required for: total parenteral nutrition and interdialytic parenteral nutrition. Products not covered: cosmetics; DESI drugs; fertility drugs; weight control products; hair growth products; experimental drugs; and drugs for impotence.

Over-the-Counter Product Coverage: Products covered with restrictions: allergy, asthma, and sinus products (OTC loratadine only) and digestive products (non-H2 antagonists-OTC omeprazole only). Products not covered: analgesics; cough and cold preparations; digestive products; (H2 antagonists); feminine products; topical products; and smoking deterrents.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; analgesics, antipyretics, NSAIDs; anoretics; antibiotics; anticoagulants; anticonvulsants; antidepressants; antidiabetic agents; antihistamine drugs; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); prescribed cold medications and thyroid agents. Prior authorization required for: growth hormones. Partial coverage for: prescribed smoking deterrents. Therapeutic categories not covered: nutritional supplements; clozapine.

Coverage of Injectables: Injectable medicines reimbursable through both the Prescription Drug Program and physician payment when used in physician offices, home health care, and extended care facilities.

Vaccines: Vaccines reimbursable with HCPC code as part of EPSDT services, The Children's Health Insurance Program, and the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary.

Prior Authorization: State currently has no formal prior authorization procedure.

Prescribing or Dispensing Limitations

Prescription Dollar Limit: None.

Refill Limit: None

Monthly Quantity Limit: Varies by drug.

Monthly Prescription Limit: None

Drug Utilization Review

PRODUR system implemented in 1996.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.75 to \$5.55 (with unit dose fee applied), effective 7/1/1991

Ingredient Reimbursement Basis: EAC = AWP-10.5%.

Prescription Charge Formula: Payment is the lower of:

1. FUL, State MAC plus a dispensing fee, or
2. EAC plus a dispensing fee, or usual and customary charge to the general public.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Approximately 1,000 drugs are listed on the State-specific MAC list. Override requires "Brand Necessary" or "Brand Medically Necessary."

Incentive Fee: None

Patient Cost Sharing: Copayment is B: \$3.00; G: no copay.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Does not use MCOs to deliver pharmacy services to Medicaid recipients.

F. STATE CONTACTS**State Drug Program Administrator**

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TENNESSEE – TennCare¹

On January 1, 1994, Tennessee began an innovative new health care reform program called TennCare. TennCare is a government-operated health insurance program designed for low income individuals and others whose health or employment status makes it difficult for them to access private insurance. The “core” population consists of individuals eligible for Medicaid. In addition, TennCare extends coverage to uninsured and uninsurable persons who are not eligible for Medicaid. This new program essentially replaced the traditional Medicaid program in Tennessee with a managed care model.

The TennCare program was implemented as a five-year demonstration under Section 1115 waiver authority issued by the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS). Administered by the Bureau of TennCare within the Tennessee Department of Finance and Administration, the program has received several extensions of its waiver. In July 2002, the most recent five-year extension was approved.

With an annual budget of \$8 billion, TennCare provides health care services to approximately 1.35 million beneficiaries, approximately 23 percent of the State’s population, through a network of managed care organizations. TennCare receives about 60 percent of its annual budget from the Federal government. The remaining 40 percent consists of State funds, drug rebate revenues, and premiums.

TennCare services are offered through managed care organizations (MCOs) and behavioral health organizations (BHOs) under contract to the State. TennCare services, as determined medically necessary by the managed care entity, cover inpatient and outpatient hospital care, physician services, lab and x-ray services, medical supplies, home health care, hospice care, and ambulance services. Each enrollee has an MCO for primary care and medical/surgical services, a behavioral health organization BHO for mental health and substance abuse treatment services, and a pharmacy Benefits Manager (PBM) for pharmacy services. Children under 21 years of age are also eligible for dental services. Enrollees are allowed to choose

their MCO from among those available in their area of residence.

In addition to the TennCare managed care programs, the Bureau of TennCare administers certain long-term care services. These include care in nursing facilities and intermediate care facilities for the mentally retarded, and several home and community-based services (HCBS) waiver programs which serve as alternatives to long-term care. The Bureau also handles Medicare cost sharing payments for eligible individuals.

ELIGIBILITY FOR TENNCARE COVERAGE

The current TennCare program is really two programs: TennCare Medicaid, which is for persons Medicaid eligible, and TennCare Standard, which is for persons who are not Medicaid eligible but who have been determined by the State’s criteria as being either uninsured or uninsurable. TennCare Medicaid is a continuation of the basic Medicaid program. It is based on Federally established criteria and regulations and is comprised of individuals who qualify for Medicaid by virtue of having low incomes and falling into one of the standard categories (i.e., children, pregnant women, families receiving public assistance, people with chronic medical conditions or disabilities, certain residents of nursing facilities, and women with cervical or breast cancer). In addition to the Medicaid population, TennCare also serves a sizable expansion population under the Section 1115 waiver, including previously uninsured and uninsurable individuals, through TennCare Standard. TennCare Standard enrollees with family incomes at or above the poverty level are required to pay premiums and copays. The more than 1.1 million TennCare beneficiaries eligible for Medicaid are enrolled in TennCare Medicaid. The other 250,000 are enrolled in TennCare Standard. Both groups of beneficiaries receive the same services.

¹ The State of Tennessee did not respond to the 2005/2006 NPC Survey. Using information from the State’s website and other source materials, we have, to the extent possible, updated the Profile and the tables in other Sections of the Compilation. Users should contact the Tennessee Medicaid program to assess the accuracy and currency of the information included.

TENNCARE PROGRAM REFORMS

TennCare MCOs originally operated under a fully capitated risk arrangement with the State to provide medical services to TennCare enrollees. However, because of instability among some of the MCOs participating in TennCare, the “at risk” concept was replaced in 2002 with an “Administrative Services Only” (ASO) stabilization arrangement which lasted for several years. Under the ASO arrangement, an MCO submitted invoices to TennCare for payment of medical services delivered and received a fixed administrative fee. The State also added its own MCO, TennCare Select, to serve as a backup if other plans failed or there was inadequate MCO capacity in any area of the State. TennCare Select is administered by Blue Cross/Blue Shield of Tennessee. In July 2005, the MCO network was returned to a risk-based status.

Over time, other changes have been made to the structure and operations of TennCare. For example, in 1996, behavioral health services were “carved out” from MCO responsibilities and new behavioral health entities were brought into the managed care system to deliver mental health and substance abuse services. In 2002, dental services were carved out and offered by a separate dental benefits manager. Also, between 1998 and the end of 2003, all pharmaceuticals were carved out and remain so. Currently, a separate PBM, First Health Services Corporation, manages the TennCare drug program. Therefore, as of 2005, each TennCare enrollee interacts with four managed care contractors (an MCO, a BHO, the DBM, and the PBM) to receive their needed health care services. Long-term care services and certain other services for children in State custody continue to be provided outside the managed care structure.

In 2004, despite the success of extending health insurance to hundreds of thousands of non-Medicaid eligible beneficiaries through TennCare, Tennessee faced a fiscal crisis resulting from the rapid growth of TennCare expenditures. An independent analysis concluded that, if left unchecked, TennCare would consume 91 percent of all new revenue growth by 2008, preventing the State from funding other departments and priorities. Because growth of TennCare threatened to bankrupt the State, the Governor and the TennCare bureau developed a reform plan to address the crisis. The plan was designed to preserve full enrollment, place certain service limits on some enrollees, and return the benefits package to one the State could afford to fund in the coming years. However, despite near unanimous support in the General Assembly, opponents blocked the initial reform plan.

New reforms to TennCare were finally approved by CMS in 2005. The reforms were implemented in two phases. Phase 1 included provisions for closing certain eligibility categories (e.g., the optional populations -- adult uninsured, adult medically eligible, adult non-pregnant medically needy) and for disenrolling persons in these categories. Phase 2 included provisions for limiting pharmacy benefits for most adults and, in some cases, eliminating them altogether. It also included proposals for eliminating certain benefits for adults.

A. ADMINISTRATION

Tennessee Department of Finance and Administration, Bureau of TennCare

B. PROVISIONS RELATING TO DRUGS

Benefit Design

Originally, all TennCare pharmacy services were provided by the MCOs. Within Federal and State guidelines, each MCO made its own formulary/drug coverage decisions. However, beginning in 1998, pharmacy services began to be carved out of the managed care plans and offered directly by the State. In 2000, drugs for dual eligibles were carved out. Finally, in 2003, all remaining drugs were carved out. TennCare contracts with First Health Services Corporation to manage the drug program. Pharmacy services are to be covered as medically necessary, excluding DESI, less than effective and IRS drugs and some drugs for which TennCare does not mandate coverage (e.g., drugs for infertility, weight reduction, cosmetic purposes, hair growth products, products for symptomatic relief of cough and colds, experimental drugs, smoking cessation products, and OTCs).

As a result of the reforms implemented in 2005, several significant changes have occurred in the TennCare drug benefit for enrollees age 21 and over. Prescription drug coverage has been eliminated for adults 21 years of age and older in the expansion population. With the exception of prenatal vitamins, over-the-counter medications are no longer covered for individuals over 21. Prescription drug coverage for Medicaid-eligible adults who are not institutionalized is limited to no more than 5 prescriptions per calendar month, only two of which can be brand name drug products. Pharmacy copayments have been implemented for all Medicaid-eligible adults age 21 and older and TennCare Standard enrollees under age 21 with incomes at or above the Federal poverty level.

However, no copayments are charged for generic drugs within the monthly limit, birth control products, drugs for pregnant women, drugs given in a medical emergency, or drugs for enrollees in hospice care. Finally, a "pharmacy short list" of certain drugs and supplies has been created for enrollees who continue to be eligible for a pharmacy benefit, listing those specific products that do not count against prescription limits and that continue to be available even after the prescription limits have been reached.

2005 also represents the first full year of operation of the preferred drug list (PDL). A Pharmacy Advisory Committee meets regularly to reassess the status of drugs in the categories already included in the PDL and to consider expanding the number of categories included in the PDL.

Formulary/Prior Authorization

Formulary: Preferred Drug List (PDL). The PDL is managed through preferred products and prior authorization. Pharmacies are encouraged to ensure that patients are using cost-effective preferred drugs. A bonus payment of \$0.10 per claim is available to pharmacies that achieve 90 percent or greater PDL compliance.

Prior Authorization: State currently has a formal prior authorization procedure. Recipient may appeal coverage and prior authorization decisions to TennCare.

Pharmacy Payment and Patient Cost Sharing

All Children Under 21: Prescriptions as medically necessary. No copayments.

Medicaid Adults: 5 prescriptions (only 2 brand name drugs) per month. \$3.00 copayment for each brand name drug. No copayments for generic drugs, birth control medications, meds received in hospice care, medical emergency meds, or meds for pregnancy problems.

Institutionalized Medicaid Adult: Prescriptions as medically necessary. No copayments.

Medically Needy Adult: Prescriptions as medically necessary. State has asked for permission to institute a 5 script, 2 brand name drug limit per month.

Institutionalized Medically Needy Adult: Prescriptions as medically necessary. No copayments.

TennCare Standard Adult: No prescription drug coverage.

TennCare Standard Child at or above 100% FPL: Prescriptions as medically necessary. \$3.00 copayment for each brand name drug. No copayments for generic drugs, birth control medications, meds received in hospice care, medical emergency meds, or meds for pregnancy problems.

Additional information on the Pharmacy Short List (i.e., the list of drugs that don't count against the monthly limit) and the PDL can be found at:

- tennessee.fhsc.com,
- www.tennessee.gov/tenncare/pharminfo.htm,
- or by calling the Family Assistance Center at 1-866-311-4287.

C. USE OF MANAGED CARE

1.3 million Medicaid recipients and the uninsured/uninsurable are enrolled in MCOs through the TennCare program. All receive pharmacy benefits through the State.

Managed Care Organizations

Unison Health Plan
890 Willow Tree Circle
Cordova, TN 38018
T: 800/600-9007
F: 901/737-1420

BlueCare
801 Pine Street
Chattanooga, TN 37402-2555
T: 800/468-9736
F: 423-752-6790

John Deere Health Plan
Executive Tower I, Suite 400
408 N. Cedar Bluff Road
Knoxville, TN 37923
T: 800/832-1539
F: 865/690-1941

TLC Family Care
1407 Union Avenue, Suite 200
Memphis, TN 38104
T: 800/473-6523
F: 901/725-2846

UAHC (OmniCare) Health Plan, Inc.
1769 Paragon Drive, Suite 100
Memphis, TN 38132
T: 800/346-0034
F: 901/348-2212

Preferred Health Partnership (PHP)
1420 Centerpoint Boulevard
Knoxville, TN 37932
T: 800/705-5248
F: 865-470-7404

TennCare Select
801 Pine Street
Chattanooga, TN 37402-2555
T: 800/276-1978
F: 423/752-6790

Windsor Health Plan of Tennessee
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T: 615/782-7878
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Mail Order Pharmacy Program

Tennessee has a mail order pharmacy option in its Medical Assistance Program. All beneficiaries are entitled to participate.

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TEXAS

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆			◆	◆
Inpatient Hospital Care	◆	◆	◆	◆			◆	◆
Outpatient Hospital Care	◆	◆	◆	◆			◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆			◆	◆
Nursing Facility Services	◆	◆	◆	◆			◆	◆
Physician Services	◆	◆	◆	◆			◆	◆
Dental Services	◆	◆	◆	◆			◆	◆

B. EXPENDITURES FOR DRUGS

	2003**		2004	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$1,921,877,468	2,475,742		2,679,025
RECEIVING CASH ASSISTANCE, TOTAL				686,339
Aged				156,934
Blind / Disabled				294,691
Child				162,411
Adult				72,303
MEDICALLY NEEDY, TOTAL				56,957
Aged				0
Blind / Disabled				0
Child				191
Adult				56,766
POVERTY RELATED, TOTAL				1,531,107
Aged				949
Blind / Disabled				1,219
Child				1,338,382
Adult				190,557
BCCA Women				0
TOTAL OTHER EXPENDITURES/RECIPIENTS*				404,622

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients and 2004 data on expenditures by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2003 and Texas Medicaid Statistical Information System, 2004.

C. ADMINISTRATION

Texas Health and Human Services Commission
Vendor Drug Program.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles (pen needles only) used for insulin. Products not covered: cosmetics; fertility drugs; experimental drugs; syringe combinations used for insulin; total parenteral nutrition; and interdialytic parenteral nutrition; blood glucose test strips; urine ketone test strips.

Over-the-Counter Product Coverage: Products covered: topical products; allergy, asthma, and sinus products; analgesics; cough and cold preparations; digestive products; smoking deterrent products. Products not covered: feminine products. Certain OTC drugs are covered on a prescription basis except as otherwise provided in the reimbursement formula and vendor payment to hospitals, nursing homes and institutions.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; antibiotics; analgesics; antipyretics, NSAIDs; anticoagulants; anticonvulsants; anti-depressants; antidiabetic drugs; antihistamine drugs; antilipemic agents; antipsychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; contraceptives; prescribed cold medications; ENT anti-inflammatory agents; estrogens; hypotensive agents; misc. GI drugs; thyroid agents; prescribed smoking deterrents; and sympathomimetics (adrenergic). Prior authorization required for: anoretics; growth hormones; dextroamphetamines (>21 years of age); xenical (hyperlipidemia only); Revatio; oral antifungals; and drugs not included on the preferred drug list. Therapeutic categories not covered: anti-obesity agents; vitamins (except prenatal); children's vitamins with fluoride; and DESI drugs.

Coverage of Injectables: Injectable medicines reimbursable through Physician Payment when used in home health care, extended care facilities, and physicians' offices.

Vaccines: Vaccines reimbursable as part of the EPSDT service.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary; however, products must be listed in the Texas Drug Code Index. Formulary managed through restrictions on use, prior authorization and preferred products. General exclusions (diseases, drug categories, etc.) include: amphetamines, appliances, durable medical equipment (bedpans, etc. - either rental or purchase), elastic stockings, first aid supplies, medical supplies, oxygen, supports and suspensories, and trusses.

Prior Authorization: State currently has a prior authorization procedure screening for drug classes and individual drugs. The prescriber can request reconsideration and the beneficiary can request a hearing through the fair hearings process to appeal a prior authorization decision.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Five refills, but total amount may not exceed 6-month supply.

Monthly Quantity Limit: Prescribed quantity cannot exceed 6-month supply.

Monthly Prescription Limit: Limited to 3 per month except for recipients under age 21 and recipients in institutions or nursing home.

Other Limit: Recipients in managed care pilots (i.e., community based waiver programs) receive unlimited prescription coverage.

Drug Utilization Review

PRODUR system implemented in February 1995. State currently has a DUR board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$5.14. The dispensing fee, including all costs of filling a prescription, was established by cost accounting and service evaluation of the expenses involved in dispensing a prescription.

Ingredient Reimbursement Basis: EAC = AWP-15% or WAC+12%, whichever is lower, AAC for hospitals and public health providers.

Prescription Charge Formula: Average dispensing expense (ADE) formula for payment:

1. (EAC+5.14) divided by 0.9805 = amount paid + \$0.15 delivery service.
2. DEAC only for Wyeth-Ayerst and Abbott.

Insulin and approved non-legend drugs on prescription: pharmacists and dispensing physicians will be reimbursed on the basis of usual charges to the general public or cost plus 50% of cost, whichever is lower; 50% of cost not to exceed assigned variable dispensing fee.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Over 3,000 drugs are listed on the State-specific MAC list. Override requires "Brand Necessary" or "Brand Medically Necessary."

Incentive Fee: \$0.50 for generic products for which there is a supplemental rebate.

Cognitive Services: Does not pay for cognitive services.

Patient Cost Sharing: No copayment.

E. USE OF MANAGED CARE

Approximately \$1.4 million Medicaid recipients were enrolled in MCOs in 2005 (all of whom are AFDC/AFDC-related). Recipients in managed care receive pharmaceutical benefits through the State. (Pharmacy program is "carved out.")

Managed Care Organizations

AMERIGROUP, Inc.
1200 East Copeland Road, Suite 200
Arlington, TX 76011
800/600-4441

Community First Health Plan
4801 NW Loop 410, Suite 1000
San Antonio, TX 78229
800/434-2347

El Paso First Health Plans
2501 North Mesa
El Paso, TX 79902
877/532-3778

Texas Children's Health Plan
1919 Braeswood
Houston, TX 77230
800/990-8247

Superior Health Plan
2100 S. IH35, Suite 202
Austin, TX 78704
800/302-6688

Community Health Choice
2636 South Loop, Suite 700
Houston, TX 77054
800/760-2600

Texas Health Network
12375-B Riata Trace Parkway
Austin, TX 78727
800/925-9126

First Care Health Plan
12940 N. Highway 183
Austin, TX 78750
800/431-7798

Parkland Health First
2777 N. Stemmons Freeway, Suite 300
Dallas, TX 75207
888/672-2277

F. STATE CONTACTS

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First Health Services Corp.
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Glen Allen, VA 23060
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Mail Order Pharmacy Program

None

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Donna Burkett, M.S., R.Ph. (Vice Chair)
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J.C. Jackson, R.Ph.
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UTAH

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$140,520,420	152,268	\$160,833,586	199,234
RECEIVING CASH ASSISTANCE TOTAL	\$65,104,788	58,926	\$71,038,782	73,150
Aged	\$5,882,916	2,943	\$6,277,365	3,125
Blind/Disabled	\$42,629,889	12,766	\$45,681,680	13,942
Child	\$5,115,660	26,318	\$6,337,127	33,275
Adult	\$11,476,323	16,899	\$12,742,610	22,808
MEDICALLY NEEDY, TOTAL	\$6,058,454	2,530	\$6,720,897	5,475
Aged	\$1,270,722	493	\$1,577,810	1,561
Blind/Disabled	\$4,063,939	939	\$4,535,970	2,650
Child	\$110,743	403	\$77,482	494
Adult	\$613,050	695	\$529,635	770
POVERTY RELATED, TOTAL	\$29,475,262	52,714	\$34,233,657	69,852
Aged	\$4,823,173	2,263	\$5,161,498	2,656
Blind/Disabled	\$16,876,649	4,770	\$19,228,073	6,399
Child	\$5,162,177	33,086	\$6,506,524	44,553
Adult	\$2,526,754	12,511	\$3,337,562	16,244
BCCA Women	\$86,509	84	N/A	N/A
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$39,881,916	38,098	\$48,840,250	50,757

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data provided by the Utah Department of Health Division of Health Care Financing.

Source: CMS, MSIS Report, FY 2002 and Utah Medicaid Statistical Information System, FY 2003.

Note: Utah estimates 2004 drug expenditures to be approximately \$177.5 million and the number of Medicaid drug recipients to be 212,000.

C. ADMINISTRATION

Division of Health Care Financing, State
Department of Health.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips; interdialytic parenteral nutrition. Prior authorization required for: amphetamines; Ritalin/methylphenidate; darvocet; darvon; enbrel; relenza; human growth hormones; lactulose syrup, lufyllin, oxandrin; panretin topical gel; prolactin; regranex retin-a-gel; tamiflu; zofran; aggrenox; cerezyme; adagen; xenical; lovenox; prilosec; prevacid; aciphex; protonix, normiflo; fragmin; kytril; anzemet; and self-administered injectables. Products covered under DME: total parenteral nutrition. Products not covered: cosmetics; fertility drugs; experimental drugs; and hair growth products.

Over-the-Counter Product Coverage: OTC products that are covered require a written prescription just like legend drugs in order for the pharmacy to fill them. Clients must present a Medicaid card and a prescription. Products covered:

- Acetone tests (e.g., Acetest, Chemstrip-K, Ketostix)
- Allergy, asthma and sinus products (specific products covered by special programs only)
- Analgesics (generics only)
- Contraceptives
- Cough and cold preparations (generics only)
- Digestive products (non H2 antagonists)
- DSS, caps liquid and syrup
- DSS concentrate drops 5%
- Feminine products
- Ferrous fumarate, All dosage forms
- Ferrous gluconate, All dosage forms
- Ferrous sulfate, All dosage forms
- Glucose blood tests (e.g., Chemstrip, BG, Dextrostix, Visidex)
- Glucose urine tests (e.g., Clinitest, Clinistix, Diatrix, Tes Tape, Chemstrip G)
- Insulin
- Insulin syringes/needles/disposable (100/month)
- Kaolin w/pectin suspension (e.g., Kaopectate)
- Lactobacillus acidophilus (e.g., Bacid, Lactinex)
- Nutrients (all nutrients require prior approval)
- Pedialyte liquid
- Prophylactics male

- Psyllium muciloid powder
- Quinine, 5 gr.

Products not covered: vitamins (except for expectant mothers and children to age 5); smoking deterrent products (special program for expectant mothers); and digestive products (H2 antagonists).

For additional information or to obtain a list of covered over-the-counter products, contact the Utah Medicaid program at
<http://health.utah.gov/medicaid/pdfs/otclist.pdf>

Therapeutic Category Coverage: Products covered: antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications; contraceptives; ENT anti-inflammatory agents; estrogens; growth hormones; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); and thyroid agents. Prior authorization required for: analgesics, antipyretics, and NSAIDs; synergis; anoretics; PPIs; and anticholinergic. Partial coverage for: anabolic steroids (PA required) and prescribed smoking deterrents. Products not covered: fertility drugs; diet medications.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment when used in physician offices.

Vaccines: Vaccines reimbursable at AWP minus 15% plus a fee as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary. No preferred drug list. Prior authorization required for some products.

Prior Authorization: State has a prior authorization procedure screening for individual drugs with fair hearing appeal process to DUR board.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Limited to five.

Monthly Quantity Limit: In general, the quantity of medication shall be limited to a supply not to exceed 31 days. Cumulative limits on specific drugs. Review patients with more than 7 scripts per month.

Drug Utilization Review

PRODUR system implemented in 1994. State has a DUR Board that meets monthly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.90 for urban, \$4.40 for rural; \$1.00 for OTC; \$1.00 for insulin, birth control, and special Utah MAC, effective 1998.

Ingredient Reimbursement Basis: EAC = Lesser of AWP-15% or Federal/State MAC.

Prescription Charge Formula: Lowest of:

1. EAC/MAC plus a dispensing fee, or
2. Usual and customary charges to the private sector for legend and generic legend drugs.

Formula for OTCs is AWP minus 15% plus dispensing fee.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires prior approval and chart documentation that generic(s) have been tried and failed. Approximately 100 drugs on State MAC list.

Incentive Fee: None.

Patient Cost Sharing: Copayment = \$3.00

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 100,000 Medicaid recipients are enrolled in managed care in 2005. Pharmacy benefits are through the State.

Managed Care Organizations

Molina
2120 South 13th East #303
Salt Lake City, UT 84106
888/483-0760

Healthy U
35 W. Broadway
Salt Lake City, VT 84101
888/271-5870

IHC Access
P.O. Box 116670
Salt Lake City, UT 84147
800/442-9023

Med Utah Healthwise
P.O. Box 30804
Salt Lake City, UT 84130-0804
800/624-6519

United Medchoice
7910 South 3500 East
Salt Lake City, UT 84121
800/401-0660

F. STATE CONTACTS**State Drug Program Administrator**

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Division of Health Care Financing
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Salt Lake City, UT 84116
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F: 801/538-6099
E-mail: rashley@utah.gov
Internet address: www.health.utah.gov/medicaid

New Brand Name Products Contact

RaeDell E. Ashley, R.Ph.
801/538-6495

DUR Contact

Tim Morley
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Mail Order Pharmacy Program

State has a mail order pharmacy program. Utah Medicaid beneficiaries may choose to obtain prescription drugs through mail order.

Department of Health Officials

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VERMONT

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$115,623,970	112,227	\$129,301,879	115,381
RECEIVING CASH ASSISTANCE TOTAL	\$40,886,714	24,609		
Aged	\$3,730,992	1,680		
Blind/Disabled	\$31,655,468	10,964		
Child	\$2,387,467	7,760		
Adult	\$3,112,787	4,205		
MEDICALLY NEEDY, TOTAL	\$19,598,384	10,415		
Aged	\$6,923,615	2,889		
Blind/Disabled	\$9,935,004	2,730		
Child	\$521,190	1,542		
Adult	\$2,218,575	3,254		
POVERTY RELATED, TOTAL	\$6,798,032	29,107		
Aged	\$0	0		
Blind/Disabled	\$0	0		
Child	\$6,475,960	27,574		
Adult	\$312,886	1,523		
BCCA Women	\$0	0		
Unknown	\$9,186	10		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$48,340,840	48,096		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Agency of Human Services, Office of Vermont Health Access.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips. Products covered as DME: total parenteral nutrition. Products not covered: cosmetics; fertility drugs; experimental drugs; urine ketone test strips; interdialytic parenteral nutrition (covered by Medicare); and erectile dysfunction drugs (as of 7/1/06). Prior authorization may be required for certain self-administered injectables.

Over-the-Counter Product Coverage: Products covered with a prescription and manufacturer's signed rebate agreement: allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; single source/multisource vitamins pending condition; lice shampoos; and topical products. Products covered with restrictions: feminine products (for bladder control only) and smoking deterrent products (maximum of 2 scripts for up to 90-day supply each year).

Therapeutic Category Coverage: Therapeutic categories covered: contraceptives; ENT anti-inflammatory agents; and estrogens. Prior authorization* required for: anabolic steroids; analgesics, antipyretics, and NSAIDs; antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamines; antipileptic agents; anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications; growth hormones (must meet clinical criteria); hypotensive agents; misc. GI drugs; prescribed smoking deterrents; sympathomimetics (adrenergic); thyroid agents; erectile dysfunction products; and antiobesity drugs. Therapeutic categories not covered: anoretics.

*In most therapeutic categories, there are both preferred (not needing PA) and non-preferred (needing PA) choices. Additional information about the preferred drug list may be found at http://www.ovha.state.vt/Preferred_drugs.cfm.

Coverage of Injectables: Injectable medicines reimbursable through physician payment when used in physician offices, home health care, and extended care facilities.

Vaccines: The Vermont Department of Health provides vaccines to physician offices.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list (PDL). PDL managed through exclusion of products based on contracting issues, restrictions on use, prior authorization, therapeutic substitution; preferred products; and step therapy. General exclusions include cosmetics and experimental drugs.

Prior Authorization: State has formal prior authorization procedure and a method for appealing coverage of an excluded product and prior authorization decisions. To appeal coverage of an excluded product or a prior authorization decision, a provider may contact MedMetric's Clinical Call Center by telephone (800/918-7549) or fax (866/767-2649) and request reconsideration. If the prescriber is unsatisfied with a MedMetrics decision, the prescriber may ask for reconsideration by a MedMetrics clinical pharmacist. If still unsatisfied with the MedMetrics decision, the prescriber may contact the Office of Vermont Health Access Medical Director for a second reconsideration. Prior authorization required for drugs not listed on the PDL.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Up to 5 may be authorized by a physician.

Monthly Quantity Limit: Max. 34 day supply (102 days for maintenance drugs).

Drug Utilization Review

PRODUR system implemented in November 1993. State currently has a DUR Board that meets 10 times per year.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.75 (Effective 1/1/06, Pharmacists will receive an additional \$5.25 for compounded scripts.)

Ingredient Reimbursement Basis: EAC = AWP-11.9%.

Prescription Charge Formula: Pharmacies bill their usual and customary charge. Medicaid pays the lower of:

1. Usual and customary charge;
2. EAC plus a dispensing fee; or
3. Maximum allowable cost plus a dispensing fee.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Dispense as Written", "Medically Necessary," "Brand Necessary," or DAW 8 (generic not available).

Incentive Fee: None.

Patient Cost Sharing: State uses a system of tiered copayments (\$1.00 - \$3.00):

- \$1.00 – for scripts < \$30.00
- \$2.00 – for Scripts \$30.00 - \$49.99
- \$3.00 – for Scripts \$50.00 and above.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Does not use use MCOs to deliver services to Medicaid beneficiaries.

F. STATE CONTACTS

State Drug Program Administrator

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Agency of Human Services
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Agency of Human Services Officials

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Joshua Slen
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Office of Vermont Health Access
312 Hurricane Lane, Suite 201
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Prior Authorization Contact

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Worcester, MA 01606
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DUR Contact

David Calabrese
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DUR Board

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Cheryl A. Gibson, M.D.
Stuart Graves, M.D.
Rich Harvie, R.Ph.
Virginia L. Hood, M.D.
Frank J. Landry, M.D.
John R. Low, R.Ph.
Andrew C. Miller, R.Ph.
Michael Scovner, M.D.
Lloyd (Tim) L. Thompson, M.D.
Norman S. Ward, M.D.

New Brand Name Products Contact

David Calabrese
508/421-8932

Prescription Price Updating

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802/879-5900

Medicaid Drug Rebate Contacts

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Claims Submission Contact

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Mail Order Pharmacy Benefit

None

Medicaid Advisory Board

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Dave Reynolds
Bi-State Primary Care Association

Michael Sirotkin
Community of Vermont Elders

Donna Sutton Fay
Health Care Ombudsman

Jacqueline Majoros
LTC Ombudsman

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VT Assembly of Home Health Agencies

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VT Association of Hospitals and Health Systems

Lila Richardson
VT Coalition for Disability Rights

Peter Taylor
VT Dental Society

Mary Shriver
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Paul Harrington
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Margaret Joyal
VT Council of Community Mental Health Services

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Dartmouth Hitchcock Medical Center

Julie Arel
Parent to Parent

Garry Schaedel
Department of Health

Edna Fairbanks-Williams

Sarah Littlefeather

Nancy Osborne

Michelle Parent

Linda Bassick

Dale Hackett

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E-mail: vtpa@sover.net
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Vermont State Association of Osteopathic Physicians & Surgeons, Inc.
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Executive Director
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Vermont State Board of Pharmacy
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Board Administrator
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F: 802/828-2465
E-mail: patkins@sec.state.vt.us
Internet address: www.vtprofessionals.org

Vermont Association of Hospitals and Healthcare Systems
Marie Beatrice Grause
President and CEO
148 Main Street
Montpelier, VT 05602
T: 802/223-3461
F: 802/223-0364
E-mail: bea@vahhs.org
Internet address: www.vahhs.org

VIRGINIA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	All eligible recipients under age 21							

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$453,663,058	319,196	\$506,529,241	325,047
RECEIVING CASH ASSISTANCE TOTAL	\$260,853,039	98,159		
Aged	\$81,793,724	33,845		
Blind/Disabled	\$178,998,190	64,149		
Child	\$17,496	90		
Adult	\$43,629	75		
MEDICALLY NEEDY, TOTAL	\$13,371,925	5,595		
Aged	\$5,782,597	2,811		
Blind/Disabled	\$7,565,189	2,617		
Child	\$19,393	141		
Adult	\$4,746	26		
POVERTY RELATED, TOTAL	\$54,484,185	137,210		
Aged	\$12,378,967	7,008		
Blind/Disabled	\$15,064,557	6,389		
Child	\$24,558,740	106,379		
Adult	\$2,33,400	17,324		
BCCA Women	\$148,521	110		
TOTAL OTHER EXPENDITURES/RECIPIENTS	\$124,953,909	78,232		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Department of Medical Assistance Services.
Eligibility determination by the Department of Social Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; urine ketone test strips total parenteral nutrition; and interdialytic parenteral nutrition. Products covered under DME: disposable needles and syringes combinations used for insulin; blood glucose test strips. Products not covered: cosmetics; fertility drugs; hair growth products; designated DESI drugs; experimental drugs; non-legend drugs; and expired drugs.

Over-the-Counter Drug Coverage: A majority of OTC drugs reimbursable when used in nursing homes and certain classes in outpatient populations. These include: allergy, asthma, and sinus products; analgesics; cough and cold preparations; digestive products; topical products; and smoking deterrent products. Products not covered: feminine products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; anticoagulants; anticonvulsants; anti-depressants; anti-psychotics; chemotherapy agents; prescribed cold medications; contraceptives; estrogens; growth hormones; prescribed smoking deterrents; and thyroid agents. Prior authorization required for: analgesics; antipyretics, and NSAIDs; anoretics; antibiotics; antidiabetic agents; antihistamines; antilipemic agents; anxiolytics, sedatives, and hypnotics; cardiac drugs; ENT anti-inflammatory agents; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); weight loss drugs and non-preferred drugs.

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care, and extended care facilities, and through physician payment when used in physician offices.

Vaccines: Vaccines reimbursable as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable in nursing homes.

Formulary/Prior Authorization

Formulary: Open Formulary with preferred drug list (PDL). Managed through exclusion of products based on contracting issues, prior authorization, and preferred products.

Prior Authorization: State currently has a formal prior authorization process with right to appeal prior authorization decisions (see www.dmas.virginia.gov under pharmacy initiatives for appropriate process). Prior authorization procedure screening for individual drugs for weight loss.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Physicians may authorize refills according to legal requirements.

Monthly Quantity Limit: 34-day supply.

Drug Utilization Review

PRODUR (online) system implemented in July 1994. RetroDUR Program also implemented in 1994. State currently has a DUR Board with quarterly meetings.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.00, effective 5/1/06.

Ingredient Reimbursement Basis: EAC = AWP-10.25% (Hemophilia drugs: AWP – 25%).

Prescription Charge Formula: Based upon the lower of VMAC or EAC plus a fee, or the usual and customary charge minus a copayment of \$1.00 for generics and \$3.00 for brand-name products, where appropriate.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires “Brand Medically Necessary” in physician’s own handwriting. Approximately 500 drugs on State MAC list.

Incentive Fee: None.

Patient Cost Sharing: Copayment is \$1.00/Rx for generics and \$3.00/Rx on brand-name products. Exclusions include less than 21 years old, pregnancy related, family planning, and nursing home patients.

Cognitive Services: Does not pay for cognitive services at present.

E. USE OF MANAGED CARE

Approximately 370,000 beneficiaries enrolled in HMOs in 2005. Recipients enrolled in managed care organizations receive pharmaceutical benefits through managed care plans.

Managed Care Organizations

AMERIGROUP Virginia
4425 Corporation Lane
Virginia Beach, VA 23462
800/600-4441

Anthem Healthkeepers Plus
(Healthkeepers, Inc.)
(Priority HealthCare, Inc.)
2220 Edward Holland Drive
Richmond, VA 23230
800/901-0020

Anthem Healthkeepers Plus
(Peninsula Health Care, Inc.)
277 Bendix Road, Suite 100
Virginia Beach, VA 23452
800/901-0020

CareNet/Southern Health Services
9881 Maryland Drive
Richmond, VA 23233
804/747-3700

Optima Family Care
4417 Corporation Lane
Virginia Beach, VA 23462
800-SENTRA

UniCare Health Plan of Virginia
241 South Van Dorn Street
888/229-3872

Virginia Premier Health Plan
600 E. Broad Street, Suite 400
Richmond, VA 23219
804/819-5151

F. STATE CONTACTS**State Drug Program Administrator**

Acting Pharmacy Manager
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
T: 804/783-2196
F: 804/786-0973
Internet address: www.dmas.virginia.gov

Prior Authorization Contact

Debra Moody
Clinical Manager
First Health Services Corporation
4300 Cox Road
Glen Allen, VA 23060
T: 804/956-7431
F: 804/273-6961
E-mail: moodyde@fhsc.com

DUR Contact

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DUR Board

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Jason Lyman, M.D.
Renita Warren, Pharm.D.
Elaine Ferrary, R.N./C.F.N.P.
Jane Settle, N.P.
Geneva Briggs, Pharm.D. (Chair)
Sandra Dawson, R.Ph.
Kelly Goode, Pharm.D.
Jonathan Evans, M.D., M.P.H.
Bill Rock, Pharm.D.
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Prescription Price Updating

Keith T. Hayashi
804/225-2773

Medicaid Drug Rebate Contacts

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804/225-2773

Disputes: John Cox
Rebate Pharmacist
First Health Services Corporation
4300 Cox Road
Glen Allen, VA 23060
T: 804/965-6791
F: 804/217-7911

Disease Management/Patient Education Programs

Diseases/Medical States: asthma, cardiovascular diseases, diabetes

Program Manager: Adrienne Fegans

Program Sponsor: HMG, Inc.

Disease Management/Patient Education Initiatives Contact

Adrienne Fegans
Department of Medical Assistance Services
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Richmond, VA 23219
804/786-4112
E-mail: Adrienne.Fegans@dmass.virginia.gov

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4300 Cox Road
Glen Allen, VA 23060
804/965-7400

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Managed Care Unit Manager
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
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F: 804/786-5799
E-mail: Mary.Mitchell@dmass.virginia.gov

Mail Order Pharmacy Program

None

Department of Medical Assistance Services Officials

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Department of Medical Assistance Services
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Richmond, VA 23219
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F: 804/225-4512
E-mail: pfinnert@dmass.state.va.us

Pharmacy and Therapeutics Committee

Randy Axelrod, M.D. (Chair)
Mark Szalwinski, R.Ph. (Vice Chair)
Avtar Dhillon, M.D.
James Reinhard, M.D.
Gill Abernathy, M.S., R.Ph.
Renita Warren, Pharm.D.
Mark Oley, R.Ph.
Mariann Johnson, M.D.
Roy Beveridge, M.D.
Rachel M. Selby-Penczak, M.D.
Sue Cantrell, M.D.
Arther Garson, M.D.

Virginia Medicaid Pharmacy Liaison Committee

Bill Hancock, R.Ph.
Long Term Care Pharmacy Coalition

Alexander Maculey, R.Ph.
Community Pharmacy

Michael Ayotte, R.Ph.
Virginia Association of Chain Drug Stores

Rebecca Snead, R.Ph.
Virginia Pharmacists Association

Jan Burrus
PhRMA

Ann Leigh Kerr
Troutman Sanders LLP

Richard Grossman
Vectre Corporation

**Executive Officers of State Medical and
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Internet address: www.dhp.state.va.us/pharmacy

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F: 804/784-2231
E-mail: voma@erols.com
Internet address: www.voma-net.org

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F: 804/965-0475
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Internet address: www.vhha.com

WASHINGTON

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2003		2004	
	<u>Expenditures</u>	<u>Recipients**</u>	<u>Expenditures</u>	<u>Recipients**</u>
TOTAL	\$587,309,730	198,434	\$663,613,603	202,586
RECEIVING CASH ASSISTANCE, TOTAL	\$47,473,695	19,410	\$57,001,415	20,774
Aged	\$1,854,999	475	\$6,045,302	1,935
Blind / Disabled	\$33,827,916	8,347	\$39,079,826	8,996
Child	\$3,048,163	4,655	\$3,113,060	4,242
Adult	\$8,742,617	5,933	\$8,763,227	5,601
MEDICALLY NEEDY, TOTAL	\$60,205,074	12,503	\$68,864,955	13,076
Aged	\$15,107,863	4,969	\$16,365,734	5,089
Blind / Disabled	\$45,081,200	7,519	\$52,440,849	7,952
Child	\$11,008	9	\$48,269	24
Adult	\$5,003	6	\$10,103	11
POVERTY RELATED, TOTAL	\$452,498,702	150,181	\$503,957,877	150,718
Aged	\$131,104,610	43,085	\$140,908,625	42,503
Blind / Disabled	\$292,866,409	69,765	\$334,058,450	72,329
Child	\$13,662,906	19,783	\$13,517,240	18,148
Adult	\$14,864,777	17,548	\$15,473,563	17,738
BCCA Women	\$0	0	\$0	0
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$27,132,259	16,340	\$33,789,356	18,018

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**Recipients are average monthly recipients, not an unduplicated annual account over the entire fiscal year.

Source: Washington State Medicaid Statistical Information System, FY 2003 and FY 2004.

C. ADMINISTRATION

Health Recovery and Services Administration,
Department of Social and Health Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition; and interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; DESI drugs; and experimental drugs.

Over-the-Counter Product Coverage: Products covered with restrictions: allergy, asthma and sinus products (selected items); analgesics (ASA and acetaminophen); cough and cold preparations (selected items); digestive products (selected items); feminine products (selected items); and topical products (selected items). Products not covered: smoking deterrent products. (Note: Zyban only covered for pregnant women in smoking cessation program).

Therapeutic Category Coverage: Therapeutic categories covered: antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents; cardiac drugs; chemotherapy agents; contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; sympathomimetics (adrenergic); and thyroid agents. Therapeutic categories requiring prior authorization: anabolic steroids; analgesics, antipyretics, and NSAIDs; anti-psychotics; anxiolytics, sedatives, and hypnotics; prescribed cold medications; estrogens; growth hormones; misc. GI drugs; and non-preferred drugs*. Therapeutic categories not covered: anoretics; prescribed smoking deterrents (except Zyban for pregnant women enrolled in a smoking cessation program); weight loss drugs; products for hair growth; drugs for infertility, frigidity, impotency, or sexual dysfunction.

*Drugs considered for prior authorization are drugs with high risk/benefit ratio, high potential for abuse/misuse, narrow therapeutic indication, and high cost. A complete list of drugs requiring prior authorization may be found on the Health Recovery and Services Administration's web site:

<http://maa.dshs.wa.gov/pharmacy>

Coverage of Injectables: Injectable medicines reimbursable through the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment when used in physician offices.

Vaccines: Vaccines reimbursable at EAC as part of EPSDT services.

Unit Dose: Unit dose packaging is reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list (PDL). Managed through excluding products based on contracting issues; restrictions on use, prior authorization, therapeutic substitution; preferred products, and physician profiling.

Prior Authorization: State currently has a prior authorization program and a Drug Utilization Review Team and a Drug Evaluation Matrix Team. Recipients can request a fair hearing and exception to policy to appeal an excluded product or prior authorization decision.

Prescribing or Dispensing Limitations

Prescription Refill Limit: Two (2) refills in 30-day period except for antibiotics and schedule drugs.

Monthly Prescription Limit: Review of client drug profile by a clinical pharmacist when request for 5th brand name prescription in any one-month period.

Monthly Quantity Limit: Maximum 34-day supply (90 days on select items).

Drug Utilization Review

PRODUR system implemented in March 1996. State currently has a P&T Committee/DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.24 to \$5.25, effective 7/1/05.

- \$4.24 - Retail pharmacies, filling over 35,000 Rx's annually.
- \$4.55 - Retail pharmacies, filling 15,001-35,000 Rx's annually.
- \$5.25 - Retail pharmacies, filling 15,000 or less Rx's annually.
- \$5.25 - Unit dose systems (nursing home Rx's).

Ingredient Reimbursement Basis: EAC = AWP-14%, except drugs on the MAC list with 5 or more labelers/manufacturers are reimbursed at AWP-50%.

Prescription Charge Formula: The amount shall not exceed the usual and customary charge to the public or EAC plus a dispensing fee. Any drug with more than 3 labelers will be reimbursed according to the Maximum Allowable Cost.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Brand Medically Necessary."

Incentive Fee: None.

Patient Cost Sharing: No copayment.

Cognitive Services: State pays for emergency contraceptive counseling and clozaril case management.

E. USE OF MANAGED CARE

Approximately 505,000 Medicaid recipients were enrolled in MCOs as of May, 2006. Recipients receive pharmaceutical benefits through both the State and managed care plans. Anti-retrovirals, mental health drugs, and family planning products are carved out of managed care.

Managed Care Organizations

Asuris Northwest Health Plan
P.O. Box 91130
Mail Stop BR 325
Seattle, WA 98111
866/240-9560

Columbia United Providers
19120 SE 34th Street, Suite 201
Vancouver, WA 98683
800/315-7862

Community Health Plan of Washington
720 Olive Way, Suite 300
Seattle, WA 98101
800/440-1561

Group Health Cooperative
521 Wall Street
Seattle, WA 98121
888/901-4636

Kaiser Foundation Health
Plan
500 NE Multnomah, Suite 100
Portland, OR 97232-2099
800/813-2000

Molina Healthcare of Washington, Inc.
P.O. Box 1469
Bothell, WA 98041
800/669-7165

Regence Blue Shield
P.O. Box 21267
Mail Stop BR 390
Seattle, WA 98111-3267
800/669-8791

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Mail Order Pharmacy Program

State has mail order pharmacy program for fee-for-service clients.

Disease Management/Patient Education Programs

Disease/Medical State: Asthma
Program Manager: McKesson

Disease/Medical State: Congestive Heart Failure
Program Manager: McKesson

Disease/Medical State: Diabetes
Program Manager: McKesson

Disease/Medical State: Renal Disease
Program Manager: Renaissance

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WEST VIRGINIA

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Service	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2001		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$274,613,136	276,338	\$339,816,022	366,987
RECEIVING CASH ASSISTANCE, TOTAL	\$205,990,651	114,996	\$253,457,293	129,958
Aged	\$49,146,107	20,959	\$59,294,089	23,842
Blind/Disabled	\$141,883,170	63,432	\$177,696,813	70,138
Child	\$83,757	445	-\$1,108,621***	491
Adult	\$14,877,617	30,160	\$17,575,011	35,487
MEDICALLY NEEDY, TOTAL	\$6,336,007	4,365	\$9,030,712	6,862
Aged	\$497,245	423	\$722,820	745
Blind/Disabled	\$4,630,102	2,566	\$6,657,321	3,816
Child	\$2,694	13	\$3,253	20
Adult	\$1,205,966	1,363	\$1,647,318	2,281
POVERTY RELATED, TOTAL	\$36,870,384	133,411	\$47,758,201	203,737
Aged	\$581,879	342	\$569,126	5,909
Blind/Disabled	\$4,337,649	1,794	\$5,010,476	6,095
Child	\$29,971,587	123,471	\$39,356,061	179,714
Adult	\$1,979,269	7,804	\$2,822,538	12,019
BCCA Women	\$0	0	N/A	N/A
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$25,416,094	23,566	\$29,569,816	26,430

*Total other expenditures/recipients includes foster care children, 1115 demonstration participants, other recipients and unknown.

**2003 data provided by the West Virginia Department of Health and Human Resources, Bureau for Medical Services.

***Represents a prior year adjustment.

Source: CMS, MSIS Report, FY 2002 and West Virginia Medicaid Statistical Information System, FY 2003.

Note: West Virginia estimates 2004 drug expenditures to be approximately \$360 million and the number of Medicaid drug recipients to be 364,000.

C. ADMINISTRATION

Bureau for Medical Services, Department of Health & Human Resources.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin (PDL restrictions); disposable needles and syringe combinations used for insulin (with limitations); blood glucose test strips; and urine ketone test strips. Products covered under DME: total parenteral nutrition and interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; experimental drugs; and DESI drugs.

Over-the-Counter Product Coverage: Products covered: feminine products; topical products; and digestive products (non- H2 antagonists). Products covered with restrictions (i.e., limited formulary/prescription required/age limitations, etc.): allergy, asthma, and sinus products; analgesics; cough and cold preparations; multivitamins; and prenatal vitamins. Prior authorization for: smoking deterrent products. Products not covered: digestive products (H2 antagonists).

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; anticoagulants; anticonvulsants; chemotherapy agents; contraceptives; estrogens; and thyroid agents. Partial coverage for: prescribed cold medications and prescribed smoking deterrents (PA required). Therapeutic categories requiring prior authorization: analgesics, antipyretics, and NSAID's; antibiotics; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents; antipsychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; ENT anti-inflammatory agents; growth hormones; hypotensive agents; misc. GI drugs; sympathomimetics (adrenergic); most injectables; and all stimulants except strattera (for beneficiaries > 18 yrs. of age). Therapeutic categories not covered: anorectics; agents for cosmetic use; weight loss products; and erectile dysfunction drugs.

Coverage of Injectables: Injectable medicines reimbursable under the Prescription Drug Program when used in home health care and extended care facilities, and through physician payment in physician offices. All injectable medications dispensed through outpatient pharmacies require prior authorization.

Vaccines: Vaccines reimbursable as part of EPSDT services, CHIP and the Vaccines for Children Program and through physician payment.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Preferred Drug List (as of 1/17/03) Restrictions include non-preferred products and prior authorization through the Rational Drug Therapy Program. General exclusions include: legend agents used for cosmetics purposes or hair growth; DESI drugs; fertility drugs; and products used for anorexia or weight gain.

Prior Authorization: State currently has a prior authorization screening procedure for drug classes and home health care. Written appeal to the Medical Director by the prescriber required to appeal a prior authorization decision. P&T Committee and DUR Board make prior authorization recommendations.

Prescribing or Dispensing Limitations

All covered outpatient drugs are reimbursed up to a 34-day supply and eleven refills.

Exceptions for antibiotics, which are covered for a 14-day supply and one refill.

Drug Utilization Review

PRODUR system implemented in March 1995. State currently has a DUR Board with a quarterly review.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$3.90, effective 1/1/96. For a compounded prescription, an additional \$1.00 will be added to the dispensing fee. A compound prescription is defined as any legend medication requiring a combination of any two or more substances to exclude normal reconstitution operations.

Ingredient Reimbursement Basis: EAC = AWP-12%.

Prescription Charge Formula: Reimbursement based on the lowest of:

1. The estimated acquisition cost (EAC) plus a dispensing fee.
2. The maximum allowable cost (MAC) plus a dispensing fee.
3. The usual and customary price charged by the pharmacy to the general public including any sale price that may be in effect on the date of service.

Maximum Allowable Cost: State imposes a combination of Federal Upper Limits and State-specific limits on generic drugs. Override will require physician certification of "Brand Medically Necessary."

Incentive Fee: None.

Patient Cost Sharing: Copayment varies - \$0.50 to \$3.00 based on ingredient costs. Exclusions include:

1. Family planning services and supplies.
2. Prescriptions originating with the Early and Periodic Screening, Diagnosis and Treatment Program.
3. Nursing home residents.
4. Children under the age of 18 years.

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Approximately 133,000 unduplicated Medicaid recipients were enrolled in MCOs in 2005. Beneficiaries in managed care receive pharmacy services through the State.

Managed Care Organizations

Carelink Health Plans
500 Virginia Street East, Suite 400
Charleston, WV 25301
T: 304/348-2900
T: 800/348-2922
F: 304/348-3948
Internet address: www.chccarelink.com

The Health Plan of the Upper Ohio Valley
52160 National Road, East
St. Clairsville, OH 43950
T: 740/695-3585
T: 888/613-8385
F: 740/695-5297
Internet address: www.healthplan.org

Wellpoint – Unicare
5151-A Camino Ruiz
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Mail Order Pharmacy Program

None

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Program Manager: Bonnie Barlow
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WISCONSIN¹

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆	◆	◆	◆	◆
Inpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Outpatient Hospital Care	◆	◆	◆	◆	◆	◆	◆	◆
Laboratory & X-ray Service	◆	◆	◆	◆	◆	◆	◆	◆
Nursing Facility Services	◆	◆	◆	◆	◆	◆	◆	◆
Physician Services	◆	◆	◆	◆	◆	◆	◆	◆
Dental Services	◆	◆	◆	◆	◆	◆	◆	◆

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$455,720,622	309,795	\$610,280,050	361,969
RECEIVING CASH ASSISTANCE TOTAL	\$220,578,511	116,396		
Aged	\$22,398,037	11,614		
Blind/Disabled	\$191,378,131	74,550		
Child	\$2,277,339	15,043		
Adult	\$4,525,004	15,189		
MEDICALLY NEEDY, TOTAL	\$31,711,402	16,672		
Aged	\$13,143,083	6,424		
Blind/Disabled	\$18,053,101	5,070		
Child	\$399,451	4,243		
Adult	\$115,767	935		
POVERTY RELATED, TOTAL	\$14,239,112	26,101		
Aged	\$315,971	521		
Blind/Disabled	\$10,747,774	3,584		
Child	\$2,632,959	17,837		
Adult	\$476,387	4,096		
BCCA Women	\$66,021	63		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$189,191,597	150,626		

*Total Other Expenditures/Recipients include foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

¹ The State of Wisconsin did not respond to the 2005/2006 NPC Survey. Using information from the State's website and other source materials, we have, to the extent possible, updated the Profile and the tables in other sections of the Compilation. Users should contact the Wisconsin Medicaid program to assess the accuracy and currency of the information included.

C. ADMINISTRATION

State Department of Health and Family Services,
Division of Health Care Financing.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin; disposable needles and syringe combinations used for insulin; blood glucose test strips; urine ketone test strips; total parenteral nutrition; and interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; experimental drugs; progesterone for PMS; topical minoxidil, legend prenatal vitamins; and impotence treatment drugs.

Over-The-Counter Product Coverage: Products covered: analgesics; digestive products (H2 antagonists) feminine products; and ophthalmic lubricants. Products covered with restrictions: allergy, asthma, and sinus products (loratadine, diphenhydramine, pseudoephedrine); cough and cold preparations (cough syrups containing expectorant with or without dextromethorphan only); non-H2 antagonists (Prilosec OTC only); topical products (antibiotics, antifungal agents; capsaicin, hydrocortisone). Products not covered: smoking deterrent products.

Therapeutic Category Coverage: Therapeutic categories covered: anabolic steroids; antibiotics; anticoagulants; anticonvulsants; antihistamines; antilipemic agents; anti-psychotics; chemotherapy agents; prescribed cold medications; contraceptives, ENT-anti-inflammatory agents; estrogens; prescribed smoking deterrents; sympathomimetics (adrenergic); and thyroid products. Prior authorization required for: analgesics; antipyretics, and (brand name) NSAIDs; anoretics; antidepressants; antidiabetic; agents; cardiac drugs; antilipemic agents; human growth hormone; hypotensive agents; misc. GI drugs; schedule III and IV stimulants; enteral nutrition products; Cerezyme; Mupirocin; fertility enhancing drugs; anti-obesity drugs; alitretinoin gel; brand name ACE inhibitors; brand name statins; brand name PPIs, stimulants and anti-obesity drugs; and medically necessary drugs with no rebate agreement.

Coverage of Injectables: Injectable medicines reimbursable through the prescription drug program when used in home health care and in extended care facilities, and through both the prescription drug program and physician payment when in physicians' offices.

Vaccines: Vaccines provided plus reimbursement for administrative fee as part of the Vaccines for Children Program.

Unit Dose: Unit dose packaging reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list. PDL managed through restrictions on use, prior authorization, therapeutic substitution, preferred products, and physician profiling.

Prior Authorization: State currently has formal prior authorization procedure and a Medicaid Pharmacy Prior Authorization Committee. Beneficiaries can request an administrative hearing to appeal prior authorization decisions or coverage for an excluded product.

Prescribing or Dispensing Limitations:

Quantity of Medication: Pharmacists may not dispense more than 34-day supply of a legend drug. Certain exceptions for some maintenance drugs (100 day supply limit).

Refills: 5 refills within 6 months for Schedule III, IV, and V drugs. Maximum of 11 refills during a 12-month period for non-scheduled medications.

Dollar Limits: None.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$4.88 to a maximum of \$40.11, effective 7/1/98. Incremental increases based on pharmaceutical care services being provided. Maximum of two dispensing fees per month, per prescription.

Ingredient Reimbursement Basis: EAC = AWP-13.0% (effective 7/1/04.)

Prescription Charge Formula: Reimbursement at the lowest of:

AWP-13.0% plus dispensing fee; Maximum Allowable Cost (MAC) plus dispensing fee; or providers usual and customary.

Maximum Allowable Cost: State imposes State-specific limits on generic drugs. Override requires hand written "Brand Medically Necessary" by the prescriber plus prior authorization.

Incentive Fee: None.

Cognitive Services: Provides an expanded dispensing fee for cognitive services.

Patient Cost Sharing: State uses tiered system of copayments. All generic legend drugs are subject to a \$1.00 copay, brand legend drugs are subject to a \$3.00 copay, limited to \$12.00 per month maximum per pharmacy. OTCs are subject to a \$0.50 copay. Disposable medical supplies are subject to a sliding scale copayment system. Residents of Skilled Nursing Facilities (SNF) or Intermediate Care Facilities (ICF), subsidized adoption recipients, children under age 18 and HMO enrollees are exempt from the copayment.

E. USE OF MANAGED CARE

Approximately 375,000 Medicaid recipients were enrolled in MCOs in FY 2005. Recipients receive pharmaceutical benefits through managed care plans. (Some mental health plans carve out pharmaceutical benefits.)

Managed Care Organizations

Abri Health Plan, Inc.
216 Green Bay Road, Suite 109
Thiensville, WI 53092
262/834-1139

Children's Community Health Plan
800/482-8010

CompCare Health Plan
(formerly Atrium Health Plan)
4222 Bagley Parkway
Madison, WI 53705
888/203-7771

Dean Health Plan, Inc.
1277 Denning Way
Madison, WI 53717
800/279-1301

Group Health Cooperative of Eau Claire
2503 N. Hillcrest Parkway
Eau Claire, WI 54702
888/203-7770

Group Health of
South Central Wisconsin
1265 John Q. Hammons Drive
Madison, WI 53717
608/251-4156

Health Tradition Health Plan
800 East Main Street
Onalaska, WI 54650
800/545-8499

Managed Health Services Insurance Corp.
1205 S. 70th Street, Suite 500
West Allis, WI 53214
888/713-6180

MercyCare Insurance Company
3430 Palmer Drive
Janesville, WI 53546
800/752-3431

Network Health Plan
1570 Midway Place
Menasha, WI 54952
888/713-6180

Security Health Plan of Wisconsin, Inc.
1515 St. Joseph Avenue
Marshfield, WI 54449
800/791-3044

United Healthcare of Wisconsin
10701 W. Research Drive
Milwaukee, WI 53226
800/504-9600

Unity Health Plans Insurance Corporation
840 Carolina Street
Sauk City, WI 53583-1374
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Medicaid Managed Care Contact

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Mail Order Pharmacy Program

None

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Wisconsin Pharmacy Examining Board

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Wisconsin Health and Hospital Association

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WYOMING

A. BENEFITS PROVIDED AND GROUPS ELIGIBLE

Type of Benefit	Categorically Needy				Medically Needy (MN)			
	Aged	Blind/ Disabled	Child	Adult	Aged	Blind/ Disabled	Child	Adult
Prescribed Drugs	◆	◆	◆	◆				
Inpatient Hospital Care	◆	◆	◆	◆				
Outpatient Hospital Care	◆	◆	◆	◆				
Laboratory & X-ray Service	◆	◆	◆	◆				
Nursing Facility Services	◆	◆	◆	◆				
Physician Services	◆	◆	◆	◆				
Dental Services	◆	◆	◆	◆				

B. EXPENDITURES FOR DRUGS

	2002		2003**	
	<u>Expenditures</u>	<u>Recipients</u>	<u>Expenditures</u>	<u>Recipients</u>
TOTAL	\$38,008,542	42,652	\$42,551,196	46,947
RECEIVING CASH ASSISTANCE, TOTAL	\$14,500,432	12,414		
Aged	\$1,506,985	721		
Blind / Disabled	\$9,963,809	3,834		
Child	\$1,031,505	4,484		
Adult	\$1,998,133	3,375		
MEDICALLY NEEDY, TOTAL	\$0	0		
Aged	\$0	0		
Blind / Disabled	\$0	0		
Child	\$0	0		
Adult	\$0	0		
POVERTY RELATED, TOTAL	\$4,496,942	20,111		
Aged	\$23,845	20		
Blind / Disabled	\$87,312	53		
Child	\$3,852,812	17,310		
Adult	\$532,973	2,728		
BCCA Women	\$0	0		
TOTAL OTHER EXPENDITURES/RECIPIENTS*	\$19,011,168	10,127		

*Total Other Expenditures/Recipients includes foster care children, 1115 demonstration participants, other recipients, and unknown.

**2003 data on expenditures and number of recipients by maintenance assistance status and basis of eligibility are unavailable.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

C. ADMINISTRATION

Department of Health, Office of Pharmacy Services.

D. PROVISIONS RELATING TO DRUGS

Benefit Design

Drug Benefit Product Coverage: Products covered: prescribed insulin, syringe combinations and disposable needles used for insulin; blood glucose test strips; and urine ketone test strips. Products covered under DME: total parenteral nutrition; and interdialytic parenteral nutrition. Products not covered: cosmetics; fertility drugs; tobacco cessation products; weight loss products; hair growth products; DESI drugs; experimental drugs; and erectile dysfunction drugs.

Over-the-Counter Product Coverage: Products covered (must be ordered by a licensed prescribing practitioner, furnished to a client who is not residing in a nursing facility, is listed in State's system, and filed with First DataBank): allergy, asthma, and sinus products; analgesics; cough and cold products; digestive products (including H2 antagonists); topical agents; food thickeners; nutrition products; pediatric and prenatal vitamins; artificial tears; and feminine products (vaginal anti-infective agents and contraceptives). Products not covered: smoking deterrent products.

Therapeutic Category Coverage: Products covered: analgesics, antipyretics, and NSAIDs (prior authorization for long-lasting opioids and NSAIDs); antibiotics; anticoagulants; anticonvulsants; anti-depressants; antidiabetic agents; antihistamines; antilipemic agents (prior authorization for statins); anti-psychotics; anxiolytics, sedatives, and hypnotics; cardiac drugs; chemotherapy agents; prescribed cold medications (PA for 2nd generation antihistamines); contraceptives; ENT anti-inflammatory agents; estrogens; hypotensive agents; (prior authorization for ACE Inhibitors and calcium channel blockers); GI drugs (prior authorization for PPIs); sympathomimetics (adrenergic); thyroid agents; antifungals; antiparasitic products; and bronchodilators. Prior authorization required for: Zogran; Xolair; doses of Oxycontin greater than twice per day or 2 different strengths for non-cancer pain; and brand name drugs with multisource generics. Partial coverage for: growth hormones. Products not covered; anabolic steroids; anoretics; and prescribed smoking deterrents.

Coverage of Injectables: Injectable medicines reimbursable through physician payment when used in home health care, extended care facilities, and physician offices.

Vaccines: Vaccines reimbursable at AWP plus a \$7.00 injection fee as part of the EPSDT services, the Children's Health Insurance Program and the Vaccines for Children Program.

Unit Dose: Unit dose packaging not reimbursable.

Formulary/Prior Authorization

Formulary: Open formulary with preferred drug list (PDL). PDL managed through preferred products and prior authorization. General exclusions include anorexants, except amphetamines and derivatives which are used for narcolepsy and hyperkinetic states; products to stimulate hair growth. Prior authorization implemented 10/1/02. Approximately 1,200 drugs listed on the PDL.

Prior Authorization: State currently has a formal prior authorization procedure with review/appeal process to the Department of Health, Office of Pharmacy Services Appeals Unit.

Prescribing or Dispensing Limitations

Monthly Quantity Limits: Quantity limits on some medications as deemed clinically appropriate.

Drug Utilization Review

PRODUR system implemented in October 1995. State currently has a DUR Board with 12 members that meet bimonthly.

Pharmacy Payment and Patient Cost Sharing

Dispensing Fee: \$5.00 (eff. 8/1/2005).

Ingredient Reimbursement Basis: EAC = AWP-11%.

Prescription Charge Formula: Payments shall be the lowest of:

1. The Estimated Acquisition Cost (AWP-11%) of the ingredient, plus a dispensing fee.
2. Usual and customary charge.
3. The upper limit established by CMS for multiple source drugs or State MAC.

Maximum Allowable Cost: State imposes Federal Upper Limits as well as State-specific limits on generic drugs. Override requires "Brand Medically Necessary." Currently, 1,226 drugs are included on the State's MAC list.

Incentive Fee: None.

Patient Cost Sharing: State uses a system of tiered copayments:

\$3.00 – Non-preferred brand

\$2.00 – Preferred brand

\$1.00 – Generics

The following recipients or products are exempt from the copayment:

- Pregnant women
- Eligible recipients under age 21
- Patients residing in nursing homes
- Family planning products

Cognitive Services: Does not pay for cognitive services.

E. USE OF MANAGED CARE

Does not use MCOs to deliver services to Medicaid recipients.

F. STATE CONTACTS

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Northridge Center 1, Suite 400
365 Northridge Road
Atlanta, GA 30350
T: 866/322-5960
F: 888/335-8459

Mail Order Pharmacy Program

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**Disease Management Program/Initiative
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Section 6:
State Pharmacy Assistance
Programs

State Pharmacy Assistance Programs

The role of SPAPs has evolved with the implementation of Medicare Part D. The following pages provide profiles of the SPAPs that responded to our survey. Wisconsin is not profiled due to non-response. Surveys to California's Genetically Handicapped Persons Program, Florida's Comprehensive Health Association and Washington's State Health Insurance programs are pending. The SPAP landscape is subject to change; good sources for updated information on SPAPs include CMS' SPAP page (www.cms.hhs.gov/States/07_SPAPs.asp) and NCSL's SPAP page (www.ncsl.org/programs/health/drugaid.htm).

State Pharmacy Assistance Programs

State	Program Name
Alaska	SeniorCare
California	Genetically Handicapped Persons Program
Connecticut	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled
Delaware	Delaware Prescription Assistance Program
Florida	Florida Comprehensive Health Association
Hawaii	Hawaii Smooth Transitions State Pharmacy Assistance Program
Illinois	Illinois Cares Rx
Indiana	Hoosier Rx
Maine	Low Cost Drugs for the Elderly and Disabled Program
Maryland	Maryland Senior Prescription Drug Assistance Program
Massachusetts	Prescription Advantage
Missouri	Missouri Rx Plan
Montana	Big Sky Rx Program
Nevada	Nevada Senior Rx
New Jersey	Pharmaceutical Assistance for the Aged and Disabled (PAAD); Senior Gold Prescription Discount Program
New York	Elderly Pharmaceutical Insurance Coverage (EPIC)
Pennsylvania	Pharmaceutical Assistance Contract for the Elderly (PACE); PACE Needs Enhancement Tier (PACENET)
Rhode Island	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)
South Carolina	Gap Assistance Prescription Program for Seniors (GAPS)
Texas	Kidney Health Care Program (KHC)
Vermont	VPharm (VHAP-Pharmacy, VScript; VScript Expanded)
Washington	Washington State High Risk Pool Prescription Drug Assistance (WSHIP)
Wisconsin*	SeniorCare Rx

* SPAP did not respond to our survey.

ALASKA SENIOR CARE

Number of enrollees: 107

ELIGIBILITY CRITERIA

Demographic groups:	65+
Medicare enrollment:	Not required
Income limits:	135% to 175% FPL (\$20,910 to \$28,053)
Asset limits:	\$50,000 individual / \$100,000 married
Duals eligibles enrolled?	No
Other eligibility notes:	Enrollees are required to apply for Part D LIS if eligible. No non-Medicare enrollees in the program currently. The SPAP will pay \$34.66/mo toward the premium of a commercial drug plan and up to \$250 toward that plan's deductible; however, no drug-only plans exist.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	No
For Medicare enrollees?	No
Are Part D excluded drugs covered?	No

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No
What are the copays?	n/a
Is there a benefit cap?	n/a
Enhanced benefit after catastrophic limit?	n/a
For Medicare enrollees –	
Premium subsidies?	Yes, up to \$34.66/mo.
Coverage for deductibles?	Yes, 100% up to \$250
Coverage for copays?	No
Coverage during doughnut hole?	No
Benefit cap?	Yes
Enhanced benefit after catastrophic threshold?	n/a

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$56,000
Budget FY06:	Unknown (SPAP part of global department budget)

PROGRAM CONTACT

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**CONNECTICUT
PHARMACEUTICAL ASSISTANCE TO THE ELDERLY AND DISABLED (PACE)**

Number of enrollees: 50,000

ELIGIBILITY CRITERIA

Demographic groups:	65 or older or 18 and older and disabled.
Medicare enrollment:	Both Medicare and non-Medicare beneficiaries may enroll
Income limits:	\$22,300 single / \$30,100 married
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	A \$30 annual registration fee is required. If eligible, enrollees are required to apply for Part D LIS and enroll in a PDP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	Yes
For Medicare enrollees?	No
Are Part D excluded drugs covered?	Yes, OTCs, Benzodiazepines, barbiturates

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No
What are the copays?	\$16.25
Is there a benefit cap?	No
Enhanced benefit after catastrophic limit?	No
For Medicare enrollees –	
Premium subsidies?	Yes. Up to the cost of any PDP's actual premium (giving the enrollee a choice of all plans)
Coverage for deductibles?	Yes, anything greater than the current \$16.25
Coverage for copays?	Yes, anything greater than the current \$16.25
Coverage during doughnut hole?	Yes, will provide coverage during the donut hole beyond current \$16.25 copayment
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$60,517,110
Budget FY06:	\$50,089,246

PROGRAM CONTACT

Evelyn Dudley Manager, Pharmacy Programs CT Dept. of Social Services, 25 Sigourney Street Hartford, CT 06106	Phone: 860-424-5654 Fax: 860-951-9544 Email: evelyn.dudley@po.state.ct.us
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DELAWARE PRESCRIPTION ASSISTANCE PROGRAM

Number of enrollees: 9,684

ELIGIBILITY CRITERIA

Demographic groups:	65+ or qualify for SSDI benefits.
Medicare enrollment:	Both Medicare and non-Medicare beneficiaries may enroll
Income limits:	200% FPL. Couples are counted as two individuals. Individuals with income over 200% FPL can qualify if they have prescription drug costs exceeding 30% of their income.
Asset limits:	None
Duals eligibles enrolled?	No, except Medicare Savings Program (QMB, SLMB, QI) currently enrolled.
Other eligibility notes:	If eligible, enrollees are required to apply for Part D LIS. Also, if Medicare-eligible, enrollee must enroll in a PDP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	Yes, same as Medicaid PDL
For Medicare enrollees?	Yes, same as Medicaid PDL
Are Part D excluded drugs covered?	Yes. OTCs, Benzodiazepines, Barbiturates

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No
What are the copays?	\$5 or 25% cost of drug, whichever is greater
Is there a benefit cap?	Yes, \$3,000 per year.
Enhanced benefit after catastrophic limit?	No
For Medicare enrollees –	
Premium subsidies?	Yes, up to the full premium amount for basic plans only.
Coverage for deductibles?	Yes, minus standard DPAP copays of \$5 or 25%
Coverage for copays?	No
Coverage during doughnut hole?	Yes, cost of drug minus standard copays of \$5 or 25%
Benefit cap?	Yes, \$3,000 per year.
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$6.2 million
Budget FY06:	\$7.8 million

PROGRAM CONTACT

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HAWAII SMOOTH TRANSITIONS

Number of enrollees: TBD

ELIGIBILITY CRITERIA

Demographic groups:	Aged, blind, disabled dual eligibles or low income Medicare enrollees
Medicare enrollment:	Must be Medicare enrolled; non-Medicare may not enroll in SPAP
Income limits:	135% FPL for non-dual Medicare beneficiaries (the state plans to raise this limit to 150% FPL in December, 2006)
Asset limits:	No
Duals eligibles enrolled?	Yes
Other eligibility notes:	Not required to apply for LIS or enroll in PDP. SPAP is currently not certified as qualified; payments do not count toward enrollee TrOOP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	n/a
For Medicare enrollees?	No
Are Part D excluded drugs covered?	No

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	n/a
What are the copays?	n/a
Is there a benefit cap?	n/a
Enhanced benefit after catastrophic limit?	n/a
For Medicare enrollees –	
Premium subsidies?	No
Coverage for deductibles?	No
Coverage for copays?	\$1 generic, \$3 brand for duals and Medicare enrollees under 100% FPL. \$2 generic, \$5 brand for Medicare enrollees over 100% FPL and not dual eligible
Coverage during doughnut hole?	No
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	n/a
Budget FY06:	\$600,000

PROGRAM CONTACT

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Medical Director	Fax: 808-692-8131
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Kapolei, HI 96709-0190	

ILLINOIS CARES Rx

Number of enrollees: 239,665 (includes 6,000 non-Medicare enrollees remaining in Medicaid waiver program and 3,000 non-Medicare disabled)

ELIGIBILITY CRITERIA

Demographic groups:	Group 1: Over 65, citizen or qualifying non-citizen Group 2: Over 65 and disabled; no citizenship required
Medicare enrollment:	Both Medicare and non-Medicare beneficiaries may enroll
Income limits:	Group 1: Less than \$19,600 single/\$26,400 couple (@ 200% FPL) Group 2: Less than \$21,219 single/\$28,480 couple (@215% FPL)
Asset limits:	None
Duals eligibles enrolled?	No. The state permits applications to come through from duals. The dual will only receive benefits from the SPAP if they lose Medicaid coverage during the year.
Other eligibility notes:	If eligible, enrollees are required to apply for Part D LIS and enroll in a PDP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	Yes, Medicaid Preferred Drug List
For Medicare enrollees?	Yes, two main benefit levels: Group 1 covers all diseases; group 2 covers only 10 disease states. The Medicare Part D plan formulary is used for both groups.
Are Part D excluded drugs covered?	Yes: OTCs, Benzodiazepines, Barbiturates

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No
What are the copays?	\$2 generic and \$5 for brand name drugs
Is there a benefit cap?	Yes; after the state pays \$1750, the individual begins to pay 20% of the cost of the drug plus any applicable copay.
Enhanced benefit after catastrophic limit?	No
For Medicare enrollees –	
Premium subsidies?	Yes, up to the LIS maximum (giving the enrollees only a choice of low cost plans); up to the full premium for those in MA-PDs (but not for those in PDPs). Also, can enroll in non-contracted plans and get premium assistance either up to the LIS amount or up to \$25.
Coverage for deductibles?	Yes - SPAP plays all Part D plan deductible
Coverage for copays?	Yes. \$2 for generic/multi-source drugs, \$5 for brand, and \$15 for non-preferred/specialty drugs. In subsequent years, copay amounts coincide with the LIS copays.
Coverage during doughnut hole?	Yes, 80% (less enrollee copay) from \$2250 to \$5100

Benefit cap?

Yes. Once member has reached the \$2250 threshold, member must pay 20% of the cost of each script plus applicable copay. After total drug costs of \$5100, the member cost share is 5% and the state is no longer contributing toward drug costs.

Enhanced benefit after catastrophic threshold?

No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:

\$349.5m

Budget FY06:

\$282.3m

PROGRAM CONTACT

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**INDIANA
HOOSIER Rx**

Number of enrollees: 1,402

ELIGIBILITY CRITERIA

Demographic groups:	65+
Medicare enrollment:	Must be enrolled in Medicare; no benefits for non-Medicare beneficiaries
Income limits:	\$14,940 individual/\$20,040 married
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	HoosierRx can assist those that get partial extra help from Medicare and those denied for Medicare's extra help due to resources. If eligible, enrollees are required to apply for Part D LIS. Also, if Medicare-eligible, enrollee must enroll in a PDP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	n/a
For Medicare enrollees?	No
Are Part D excluded drugs covered?	No

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	n/a
What are the copays?	n/a
Is there a benefit cap?	n/a
Enhanced benefit after catastrophic limit?	n/a
For Medicare enrollees –	
Premium subsidies?	Yes, up to the cost of any PDP's actual premium.
Coverage for deductibles?	No
Coverage for copays?	Yes, \$250 per calendar year but only for persons with enrollment dates prior to July 1, 2006.
Coverage during doughnut hole?	No
Benefit cap?	Yes, \$250 per calendar year for persons with enrollment dates prior to July 1, 2006 (n/a for persons with later enrollment dates.
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$16 million
Budget FY06:	\$8 million

PROGRAM CONTACT

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MAINE DRUGS FOR THE ELDERLY PROGRAM

Number of enrollees: 87,241 (50,000 are duals and 37,241 are non-duals)

ELIGIBILITY CRITERIA

Demographic groups:	Residents age 62 and older or persons with disabilities age 19-61
Medicare enrollment:	May be eligible for Medicaid; both Medicare and non-Medicare may enroll
Income limits:	Annual income less than \$17,712. If persons spends 40% of yearly income on prescription drugs, income limit is 15% higher or \$22,150
Asset limits:	None
Duals eligibles enrolled?	Yes
Other eligibility notes:	Medicare eligibles must enroll in a Part D plan

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	Yes, PDL separate from Medicaid - only covers brand drugs for 13 conditions
For Medicare enrollees?	No, defer to Part D plan formulary
Are Part D excluded drugs covered?	Yes

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No
What are the copays?	20% plus \$2 for brand name drugs for 13 conditions; no copay for any generic drugs
Is there a benefit cap?	No
Enhanced benefit after catastrophic limit?	No, but do allow higher income eligibility for persons who pay more than 40% of income on prescription drugs
For Medicare enrollees –	
Premium subsidies?	Yes, up to the LIS maximum
Coverage for deductibles?	Yes. \$125 (half of the deductible)
Coverage for copays?	Yes, up to \$2 of generic copays; 50% of brand up to \$10/Rx.
Coverage during doughnut hole?	Yes, 80% of any Medicaid covered drug
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	No, but do allow higher income eligibility for persons who pay more than 40% of income on prescription drugs

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$20 million
Budget FY06:	n/a

PROGRAM CONTACT

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MARYLAND SENIOR PRESCRIPTION DRUG PROGRAM

Number of enrollees:

ELIGIBILITY CRITERIA

Demographic groups:	
Medicare enrollment:	Only Medicare eligibles may enroll; full LIS recipients are ineligible
Income limits:	300% FPL
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	New applicants are required to apply for LIS and enroll in a PDP

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	n/a
For Medicare enrollees?	n/a
Are Part D excluded drugs covered?	No, however state Medicaid program does cover non-Part D drugs for duals

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	n/a
What are the copays?	n/a
Is there a benefit cap?	n/a
Enhanced benefit after catastrophic limit?	n/a
For Medicare enrollees –	
Premium subsidies?	Yes, up to \$25 or actual premium or actual LIS 25/50/75% copay benchmark premium
Coverage for deductibles?	No
Coverage for copays?	No
Coverage during doughnut hole?	No
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	n/a

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$23,942,000
Budget FY06:	\$27,264,749

PROGRAM CONTACT

Richard Popper Executive Director 201 E. Baltimore Street, Suite 630 Baltimore, MD 21202	Phone: 410-576-2055 Fax: 410-625-9202 Email: rpopper@mhip-spdap.com
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MASSACHUSETTS PRESCRIPTION ADVANTAGE

Number of enrollees: 71,003

ELIGIBILITY CRITERIA

Demographic groups:

Medicare enrollment:

Does not need to be Medicare eligible to enroll, but if Medicare eligible must be in a Part D plan and apply for LIS if eligible.

Income limits:

None for non-Medicare seniors; <500% FPL for Medicare seniors

Asset limits:

None

Duals eligibles enrolled?

No, but will continue enrollment of Medicare Savings Program enrollees/partial duals if they were already in the SPAP and want to stay.

Other eligibility notes:

Persons with disabilities under age 65 must have incomes below 188% FPL and not more than 40 work hours per month. Includes coverage during 2 year waiting period for federal Medicare eligibility. If eligible, enrollees are required to apply for Part D LIS. Also, if Medicare-eligible, enrollee must enroll in a PDP.

DRUG COVERAGE

Formulary

For non-Medicare enrollees?

Yes

For Medicare enrollees?

No

Are Part D excluded drugs covered?

Yes, Benzodiazepines

BENEFITS

For non-Medicare enrollees –

Is there a deductible?

Yes, \$0 to \$350 per quarter based on income

What are the copays?

< 188% FPL: \$7 / \$18 / \$40

>188% FPL: \$12 / \$30 / \$50

Is there a benefit cap?

No

Enhanced benefit after catastrophic limit?

Yes. No copay after reaching threshold of 10% of income or \$2,000 whichever is less.

For Medicare enrollees –

Premium subsidies?

Yes. Prescription Advantage bases premium subsidy amounts on the LIS maximum (regional benchmark and the basic plan portion of individual premiums). For members with incomes up to 188% FPL, members receive a subsidy of the premium up to the LIS maximum. For members with incomes of 188-225% FPL, members are responsible for the first \$20 of the premium and receive a subsidy for the difference up to the LIS maximum. No premium subsidy is provided for members with incomes of 225% or above. Members are not restricted to low-cost plans, but are responsible for any premium amount above the LIS maximum.

Coverage for deductibles?

Yes, up to SPAP copays.

Coverage for copays?

Yes, up to SPAP copays.

Coverage during doughnut hole?

Yes, up to SPAP copays

Benefit cap?

No

Enhanced benefit after catastrophic threshold?

Yes (varied by income: \$1,300 out-of-pocket per year for members with partial LIS; \$1440 if under 188% FPL; \$1800 if 188%-225% FPL; \$2150 if 225-300%FPL; \$2870 if income 300-500% FPL)

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:

\$102.1 million

Budget FY06:

\$96.0 million

PROGRAM CONTACT

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MISSOURI Rx PLAN

Number of enrollees: 160,000

ELIGIBILITY CRITERIA

Demographic groups:	65+
Medicare enrollment:	Must be Medicare eligible and enrolled in Part D plan.
Income limits:	Up to 200% FPL
Asset limits:	None
Duals eligibles enrolled?	Yes
Other eligibility notes:	SPAP is currently not open to new enrollment. Hope to re-open August 2006. Only previously enrolled SPAP members are currently enrolled. Medicare-eligible enrollees must enroll in a PDP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	n/a
For Medicare enrollees?	No. Defer to SPAP formulary, but require preferred PDPs to add or cover all Medicaid PDL drugs.
Are Part D excluded drugs covered?	No. For SPAP enrollees that are duals, non-Part D will be paid by Medicaid and will cover OTCs, Benzodiazepines, Barbiturates and Vitamins.

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	n/a
What are the copays?	n/a
Is there a benefit cap?	n/a
Enhanced benefit after catastrophic limit?	n/a
For Medicare enrollees –	
Premium subsidies?	No
Coverage for deductibles?	Yes, 50% of deductible cost.
Coverage for copays?	Yes, 50% of copay cost during initial benefit period, gap and catastrophic
Coverage during doughnut hole?	Yes, 50% of cost.
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	n/a

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$18,038,219
Budget FY06:	\$19.6 million (with flexibility to increase budget with rebate revenue collected)

PROGRAM CONTACT

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MONTANA BIG SKY Rx PROGRAM

Number of enrollees: 2,434

ELIGIBILITY CRITERIA

Demographic groups:	Montana resident
Medicare enrollment:	Must be Medicare eligible
Income limits:	200% FPL
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	If eligible, enrollees are required to apply for Part D LIS and enroll in a PDP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	n/a
For Medicare enrollees?	n/a
Are Part D excluded drugs covered?	No

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	n/a
What are the copays?	n/a
Is there a benefit cap?	n/a
Enhanced benefit after catastrophic limit?	n/a
For Medicare enrollees –	
Premium subsidies?	Yes. Up to \$33.11 per month - the LIS benchmark. May be used toward non-LIS benchmark plans. For partial LIS, Big Sky pays only the difference of LIS percent up to \$33.11
Coverage for deductibles?	No
Coverage for copays?	No
Coverage during doughnut hole?	No
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	n/a

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	n/a
Budget FY06:	\$7 million

PROGRAM CONTACT

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NEVADA SENIOR Rx

**Number of enrollees: 7,300 in both programs.
Disability Rx = 147, Senior Rx = 7153.**

ELIGIBILITY CRITERIA

Demographic groups:	>62 and disabled 18-61
Medicare enrollment:	Medicare eligibility not required, but if in Medicare Part D and LIS mandated; if full LIS, not eligible for the program/disenrolled.
Income limits:	Single \$24,118 / Couple \$31,396 (@240% FPL)
Asset limits:	None
Duals eligibles enrolled?	SPAP pays Medicaid for Part D copays, but not enrolling duals in SPAP
Other eligibility notes:	If eligible, enrollees are required to apply for Part D LIS. Also, if Medicare-eligible, enrollee must enroll in a PDP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	Yes, PBM defines formulary (fairly broad)
For Medicare enrollees?	No, follow Part D plan formulary
Are Part D excluded drugs covered?	Yes, OTCs, benzodiazepines, barbiturates, vitamins

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No
What are the copays?	\$10/\$25 for preferred brands/discount for non-preferred.
Is there a benefit cap?	Yes, \$5,100
Enhanced benefit after catastrophic limit?	No
For Medicare enrollees –	
Premium subsidies?	Yes, up to the LIS maximum (giving the enrollees only a choice of low cost plans)
Coverage for deductibles?	No
Coverage for copays?	No
Coverage during doughnut hole?	Yes, 100% of any costs not paid by the plan.
Benefit cap?	Yes. \$2,850
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$8,553,223 (including \$7,683,628 for drugs and \$869,595 for admin fees to PBM)
Budget FY06:	\$8,089,518

PROGRAM CONTACT

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**NEW JERSEY
PHARMACEUTICAL ASSISTANCE FOR THE AGED AND DISABLED (PAAD)**

Number of enrollees: 183,834

ELIGIBILITY CRITERIA

Demographic groups:	65 or older or disabled receiving SSDI
Medicare enrollment:	Both Medicare and non-Medicare beneficiaries may enroll
Income limits:	Income up to \$20,988 (@ 219% FPL)
Asset limits:	None
Duals eligibles enrolled?	No. PAAD does not cover full duals, but does have some partial duals (i.e., in Medicare Savings Programs) among its enrollees
Other eligibility notes:	If eligible, enrollees are required to apply for Part D LIS. Also, if Medicare-eligible, enrollee must enroll in a PDP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	No
For Medicare enrollees?	No. Open formulary covers all drugs for which the state has a rebate agreement.
Are Part D excluded drugs covered?	Yes. Benzodiazepines, Barbiturates, hair loss with PA, fertility, birth control, vitamins, weight loss with PA

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No
What are the copays?	\$5
Is there a benefit cap?	No
Enhanced benefit after catastrophic limit?	No
For Medicare enrollees –	
Premium subsidies?	Yes, up to the LIS maximum (giving the enrollees only a choice of low cost plans)
Coverage for deductibles?	Yes, up to the current copay of \$5
Coverage for copays?	Yes, up to the PAAD \$5 copayment
Coverage during doughnut hole?	Yes, up to the current PAAD \$5 copayment
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$403 million
Budget FY06:	\$384,176,000

PROGRAM CONTACT

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Trenton, NJ 08625-0715	

**NEW JERSEY
SENIOR GOLD PRESCRIPTION DISCOUNT PROGRAM**

Number of enrollees: 31,467

ELIGIBILITY CRITERIA

Demographic groups:	Age 65 or older or disabled receiving SSDI benefits
Medicare enrollment:	
Income limits:	Income between \$20,989 and \$30,989 annually (324% FPL in 2005). Single \$25,735 / Married \$35,735
Asset limits:	
Duals eligibles enrolled?	No
Other eligibility notes:	

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	No
For Medicare enrollees?	No
Are Part D excluded drugs covered?	Yes, Benzodiazepines, Barbiturates, cosmetic drugs with PA, Fertility, birth control, vitamins, weight loss with PA

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No
What are the copays?	50% of drug plus \$15
Is there a benefit cap?	No
Enhanced benefit after catastrophic limit?	Copay only \$15 after reaching \$2000 single / \$3,000 married
For Medicare enrollees –	
Premium subsidies?	No
Coverage for deductibles?	Yes, up to Senior Gold cost share
Coverage for copays?	Yes, up to Senior Gold cost share
Coverage during doughnut hole?	Yes, up to Senior Gold cost share
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$17,886,805
Budget FY06:	\$19,473,246

PROGRAM CONTACT

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NEW YORK
ELDERLY PHARMACEUTICAL INSURANCE COVERAGE
FEE PLAN AND DEDUCTIBLE PLAN

Number of enrollees: 374147

ELIGIBILITY CRITERIA

Demographic groups:	65+
Medicare enrollment:	Both Medicare and non-Medicare beneficiaries may enroll
Income limits:	Fee Plan = below \$20,000 single/\$26,000 married Deductible Plan = \$20,000 to \$35,000 single / \$26,000 to \$50,000 married
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	If eligible, enrollees are required to apply for Part D LIS, but PDP enrollment not required. Low income plan has an enrollment fee of \$8 - \$300 based on income.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	No
For Medicare enrollees?	No
Are Part D excluded drugs covered?	Yes, but prescription only including Benzodiazepines, Barbiturates, Cosmetic drugs, Hair loss, Fertility, Birth control, Vitamins and Weight loss

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	Yes, in the Deductible Plan ranging from \$530 to \$1,715 based on income. In the Fee Plan, enrollee pays a monthly fee of \$8 - \$300 based on income. There is no distinction between Medicare and non-Medicare enrollees. Medicare enrollees that do not enroll in Part D plans and non-Medicare enrollees qualify for the same benefit
What are the copays?	\$3/\$7/\$15/\$10 based on price of drug in both programs.
Is there a benefit cap?	No
Enhanced benefit after catastrophic limit?	Yes, threshold based on income \$291 - \$2,000 per year in both programs. No copays after threshold.
For Medicare enrollees –	
Premium subsidies?	No
Coverage for deductibles?	Yes, all but EPIC copay and deductible
Coverage for copays?	Yes, all but EPIC copay
Coverage during doughnut hole?	Yes, all but EPIC copay
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	Yes, threshold based on 6 to 9% of income, no copays after threshold

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:

Approximately \$850 million

Budget FY06:

\$847 million

PROGRAM CONTACT

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PENNSYLVANIA
PHARMACEUTICAL ASSISTANCE CONTRACT FOR THE ELDERLY (PACE)

Number of enrollees: 184,049

ELIGIBILITY CRITERIA

Demographic groups:	65+
Medicare enrollment:	Not mandated
Income limits:	Annual income up to \$14,500 single and \$17,700 for couples. Moratorium in new law protects existing enrollees from being disenrolled from PACE and PACENET due to income exceeding limits as a result of social security cost of living increases.
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	No requirement for Medicare eligibles to apply for LIS or enroll in PDP

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	No
For Medicare enrollees?	No
Are Part D excluded drugs covered?	Yes, Benzodiazepines, barbiturates, vitamins and weight loss.

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No
What are the copays?	\$6 generic/ \$9 brand
Is there a benefit cap?	No
Enhanced benefit after catastrophic limit?	No
For Medicare enrollees –	
Premium subsidies?	Yes, up to LIS maximum starting September 1, 2006 for PACE retroactive to July 1, 2006.
Coverage for deductibles?	Yes, up to the current copayment
Coverage for copays?	Yes, up to the current copayment
Coverage during doughnut hole?	Yes, up to the current copayment
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	~ \$296.7 million net of rebates plus \$14.4 million in admin costs for both PACE and PACENET.
Budget FY06:	\$138 million net of rebates excluding admin

PROGRAM CONTACT

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**PENNSYLVANIA
PHARMACEUTICAL ASSISTANCE CONTRACT FOR THE ELDERLY
NEEDS ENHANCEMENT TIER (PACENET)**

Number of enrollees: 127,881

ELIGIBILITY CRITERIA

Demographic groups:	65 +
Medicare enrollment:	Both Medicare and non-Medicare beneficiaries may enroll
Income limits:	Annual income up to \$23,500 single and \$31,500 for couples. Moratorium in new law protects existing enrollees from being disenrolled from PACE and PACENET due to income exceeding limits as a result of social security cost of living increases.
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	No requirement for Medicare eligibles to apply for LIS or enroll in PDP

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	No
For Medicare enrollees?	No
Are Part D excluded drugs covered?	Yes, Benzodiazepines, barbiturates, vitamins and weight loss.

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	PACENET members not enrolled in Part D plans must pay deductible of \$32.54 equal to benchmark premium.
What are the copays?	\$8 generic /\$15 brand
Is there a benefit cap?	No
Enhanced benefit after catastrophic limit?	No
For Medicare enrollees –	
Premium subsidies?	No
Coverage for deductibles?	Yes, up to the current copayment
Coverage for copays?	Yes, up to the current copayment
Coverage during doughnut hole?	Yes, up to the current copayment
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$144 million net of rebates excluding admin
Budget FY06:	\$94.3 million net of rebates excluding admin

PROGRAM CONTACT

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**RHODE ISLAND
PHARMACEUTICAL ASSISTANCE FOR THE ELDERLY (RIPAE)**

Number of enrollees: 16,800

ELIGIBILITY CRITERIA

Demographic groups:	65+ (Also 55+ with SSDI qualify for 15% discount)
Medicare enrollment:	Both Medicare and non-Medicare beneficiaries may enroll
Income limits:	Slide scale benefit for 65+ by three income categories: 60% discount: <\$17,987 single/<22,486 married 30% discount: <\$22,580 single/<\$28,226 married 15% discount: <39,516 single/<45,161 married
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	If eligible, enrollees are required to apply for Part D LIS. Also, if Medicare-eligible, enrollee must enroll in a PDP. Enrollees who are not LIS-eligible are not required to enroll in a PDP, but the state is strongly recommending that they apply because RIPAE is not creditable coverage.

DRUG COVERAGE

Formulary

For non-Medicare enrollees?	Yes. The benefit is limited to drugs for 20 conditions and the state has a PDL of preferred/non-preferred drugs in these classes.
For Medicare enrollees?	Yes. The benefit is limited to drugs for 20 conditions and the state has a PDL of preferred/non-preferred drugs in these classes.
Are Part D excluded drugs covered?	No

BENEFITS

For non-Medicare enrollees –

Is there a deductible?	No
What are the copays?	Yes, sliding scale by income - 40%, 70% or 85%
Is there a benefit cap?	No
Enhanced benefit after catastrophic limit?	Yes, threshold for the lowest income group only (1,500 out-of-pocket) after which state pays full drug cost with no copayment

For Medicare enrollees –

Premium subsidies?	No
Coverage for deductibles?	Yes. For RIPAE covered drugs, state will pay up to the current RIPAE cost-share (40%, 70% or 85% depending on income)
Coverage for copays?	No
Coverage during doughnut hole?	Yes. For RIPAE covered drugs, state will pay up to the current RIPAE cost-share (40%, 70% or 85% depending on income)
Benefit cap?	No

Enhanced benefit after catastrophic threshold? Yes, threshold for the lowest income group only (1,500 out-of-pocket) after which state pays full drug cost with no copayment

FUNDING AND REIMBURSEMENT

Actual expenditures FY05: \$9 million
Budget FY06: \$9 million

PROGRAM CONTACT

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**SOUTH CAROLINA
GAP ASSISTANCE PRESCRIPTION PROGRAM FOR SENIORS**

Number of enrollees: 10,000

ELIGIBILITY CRITERIA

Demographic groups:	65+
Medicare enrollment:	Yes, must be on Medicare
Income limits:	>200% FPL/ \$19,596
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	If Medicare-eligible, enrollees must enroll in a PDP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	n/a
For Medicare enrollees?	No
Are Part D excluded drugs covered?	No

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	n/a
What are the copays?	n/a
Is there a benefit cap?	n/a
Enhanced benefit after catastrophic limit?	n/a
For Medicare enrollees –	
Premium subsidies?	No
Coverage for deductibles?	No
Coverage for copays?	No
Coverage during doughnut hole?	Yes. Will cover 95% of drug costs during doughnut hole and enrollee pays 5%.
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	n/a

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	\$52.3 million
Budget FY06:	\$6 million for half the program year

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**TEXAS
KIDNEY HEALTH CARE PROGRAM**

Number of enrollees: 18,260

ELIGIBILITY CRITERIA

Demographic groups:	Residents of Texas with a diagnosis of ESRD, receiving regular renal dialysis or having received a kidney transplant
Medicare enrollment:	May have Medicare, but cannot have other insurance coverage for drugs.
Income limits:	Gross income less than \$60,000 a year
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	If eligible, enrollees are required to apply for Part D LIS. Also, if Medicare-eligible, enrollee must enroll in a PDP.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	Yes, medications related to ESRD and comorbid conditions
For Medicare enrollees?	Yes, medications related to ESRD and comorbid conditions
Are Part D excluded drugs covered?	Yes, OTCs and Vitamins

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No
What are the copays?	\$6 per Rx
Is there a benefit cap?	Yes (4 drug limit per month)
Enhanced benefit after catastrophic limit?	No
For Medicare enrollees –	
Premium subsidies?	Yes, up to a maximum allowable of \$35 per month.
Coverage for deductibles?	Yes, up to a 4 drug limit per month.
Coverage for copays?	Yes, up to SPAP copay of \$6
Coverage during doughnut hole?	Yes, up to SPAP copay of \$6
Benefit cap?	Yes (4 drug limit per month)
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	Unknown
Budget FY06:	Unknown

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**VERMONT
VPHARM**

Number of enrollees: 13,232

ELIGIBILITY CRITERIA

Demographic groups:	Residents on Medicare or SSDI
Medicare enrollment:	Both Medicare and non-Medicare beneficiaries may enroll
Income limits:	Annual income up to 225% FPL
Asset limits:	None
Duals eligibles enrolled?	No
Other eligibility notes:	If eligible, enrollees are required to apply for Part D LIS. Also, if Medicare-eligible, enrollee must enroll in a PDP. Must pay premium for enrollment; see below.

DRUG COVERAGE

Formulary	
For non-Medicare enrollees?	Yes, Medicaid Preferred Drug List
For Medicare enrollees?	Yes, for Part D excluded drugs only; otherwise, defer to PDP formulary
Are Part D excluded drugs covered?	Yes, to the extent that they are currently covered (OTCs, Benzodiazepines, Barbiturates, Vitamins, and Weight loss)

BENEFITS

For non-Medicare enrollees –	
Is there a deductible?	No, but does pay premium of \$15/mo for VHAP; \$20/mo. for VScript; and \$42/mo. for VScript Expanded.
What are the copays?	None
Is there a benefit cap?	No
Enhanced benefit after catastrophic limit?	No
For Medicare enrollees –	
Premium subsidies?	Yes, state pays PDP premium. Requires enrollees to pay a state premium for VPharm coverage on sliding scale by income (\$15, \$20, \$42 effective July, 2006)
Coverage for deductibles?	Yes. 100% below 150% FPL. 150-225% FPL, 100% all for maintenance drugs only.
Coverage for copays?	Yes. 100% below 150% FPL. 150-225% FPL, 100% all for maintenance drugs only.
Coverage during doughnut hole?	Yes. 100% below 150% FPL. 150-225% FPL, 100% all for maintenance drugs only.
Benefit cap?	No
Enhanced benefit after catastrophic threshold?	No

FUNDING AND REIMBURSEMENT

Actual expenditures FY05:	TBD
Budget FY06:	TBD

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CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

REGIONAL OFFICES

ASSOCIATE REGIONAL ADMINISTRATORS - MEDICAID

Region I Boston Regional Office	Charolotte Yeh John F. Kennedy Federal Bldg. Government Center, Room 2325 Boston, MA 02203-0003 617/565-1188	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Region II New York Regional Office	Jim Kerr 26 Federal Plaza, 38 th Floor New York, NY 10278 212/616-2205	New Jersey, New York, Puerto Rico, Virgin Islands
Region III Philadelphia Regional Office	Nancy O'Connor The Public Ledger Building, Suite 216 150 S. Independence Mall West Philadelphia, PA 19106 215/861-4140	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Region IV Atlanta Regional Office	Roger Perez Atlanta Federal Center 61 Forsyth Street, SW, Suite 4T20 Atlanta, GA 30303-8909 404/562-7500	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
Region V Chicago Regional Office	Jackie Garner 233 North Michigan Avenue Suite 600 Chicago, IL 60601-5519 312/886-6432	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Region VI Dallas Regional Office	Randy Farris 1301 Young Street, Room 714 Dallas, TX 75202 214/767-6423	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Region VII Kansas City Regional Office	Tom Lenz Richard Bolling Federal Building 601 East 12 th Street, Room 235 Kansas City, MO 64106-2808 816/426-5233	Iowa, Kansas, Missouri, Nebraska
Region VIII Denver Regional Office	Alex Trujillo Colorado State Bank Building 1600 Broadway, Suite 700 Denver, CO 80202-4367 303/844-2111	Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
Region IX San Francisco Regional Office	Jeff Flick 75 Hawthorne Street, Suite 408 San Francisco, CA 94105-3901 415/744-3501	Arizona, California, Hawaii, Guam Nevada, and Pacific Islands
Region X Seattle Regional Office	RJ Ruff 2201 6th Avenue, MS-40 Seattle, WA 98121-2500 206/615-2306	Alaska, Idaho, Oregon, Washington

Source: CMS, Central Office, Centers for Medicaid and State Operations, as of September 2006.

***Appendix B:
Medicaid Program Statistics -
CMS MSIS Tables***

Medicaid Program Statistics -- MSIS Report

The CMS MSIS Report is an annual report designed to collect State-reported statistical summary data on eligibles, recipients, services, and expenditures during a Federal fiscal year (i.e., October 1 through September 30). The data reported for a given year represent recipients of service and the amount of payments for claims adjudicated during the year. The data reflect bills adjudicated during the year rather than the services used during the year.

Historically, States summarized and reported the data processed through their Medicaid claims processing and payment operations unless they opted to participate in the Medicaid Statistical Information System (MSIS) project. Prior to Federal fiscal year 1999, MSIS was a voluntary program and those States participating in the MSIS project provide data tapes from their claims processing systems to HCFA in lieu of HCFA-2082 tables. However, in accordance with the Balanced Budget Act of 1997, all claims processed on or after January 1, 1999, must be submitted electronically in the MSIS format.

The MSIS Report is the primary CMS source on recipients' use of services and the associated payments for these services. However, the new reporting requirements have resulted in a lag in the timely release of MSIS summary tables. The most recent MSIS service utilization information available from CMS is for FY 2003. In addition, Puerto Rico and the U.S. territories have been excluded from the tables and the National totals.

In an effort to provide more recent recipient information as well as to maintain continuity with previous version of the Compilation, we have compiled ten tables from the MSIS data system for inclusion in this Appendix. The first two tables provide national level summary information on total expenditures and total number of recipients by type of service for FY 2002 and FY 2003. The remaining tables present State-by-State and national level data, including some trend information, on total Medicaid recipients, total Medicaid payments, number of prescription drug recipients, and Medicaid prescription drug payments.

Total U.S. Medical Assistance Recipients By Type of Service

Service	FY 2002	Percent of Total*	FY 2003	Percent of Total*	Percent Change 2002-2003
Capitated Payment Services	25,863,748	52.0%	27,574,367	16.7%	6.6%
Pharmaceuticals	24,424,493	49.1%	26,075,011	15.8%	6.8%
Physicians	22,102,682	44.4%	22,857,218	13.9%	3.4%
Hospital Outpatient	14,861,211	29.9%	15,510,542	9.4%	4.4%
Lab/X-ray	14,067,422	28.3%	14,687,064	8.9%	4.4%
Other Care	11,195,848	22.5%	11,741,797	7.1%	4.9%
Clinic	9,498,844	19.1%	10,162,022	6.2%	7.0%
Dental	7,885,538	15.8%	8,509,824	5.2%	7.9%
PCCM Services	7,177,583	14.4%	7,541,745	4.6%	5.1%
Personal Support Services	5,688,386	11.4%	6,022,040	3.7%	5.9%
Other Practitioners	5,570,691	11.2%	5,746,278	3.5%	3.2%
Hospital Inpatient	5,051,356	10.2%	5,217,106	3.2%	3.3%
Nursing Facility	1,765,700	3.5%	1,690,846	1.0%	-4.2%
Home Health Care	1,065,050	2.1%	1,183,764	0.7%	11.1%
ICF-Mentally Retarded	117,497	0.2%	113,984	0.1%	-3.0%
Mental Health Facility	99,403	0.2%	104,529	0.1%	5.2%
Total Unduplicated Recipients*	49,754,619		51,971,173		4.5%

*Sum of percentages will exceed 100% due to recipients' use of multiple services. Puerto Rico and the U.S. Territories are not included in these national totals.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

Total U.S. Medical Assistance Payments By Type of Service

Service	FY 2002	Percent of Total*	FY 2003	Percent of Total*	Percent Change 2002-2003
Nursing Facility	\$39,282,167,886	18.4%	\$40,381,022,223	17.3%	2.8%
Capitated Payment Services	\$33,634,458,789	15.8%	\$37,405,402,095	16.0%	11.2%
Hospital Inpatient	\$29,127,066,408	13.6%	\$31,549,248,411	13.5%	8.3%
Pharmaceuticals	\$28,408,181,719	13.3%	\$33,714,314,456	14.5%	18.7%
Other Care	\$20,042,516,439	9.4%	\$21,809,259,794	9.4%	8.8%
Personal Support Services	\$15,363,088,322	7.2%	\$17,245,382,598	7.4%	12.3%
ICF-Mentally Retarded	\$10,681,301,264	5.0%	\$10,861,243,599	4.7%	1.7%
Hospital Outpatient	\$8,470,604,661	4.0%	\$9,251,889,428	4.0%	9.2%
Physicians	\$8,354,616,947	3.9%	\$9,209,880,046	3.9%	10.2%
Clinic	\$6,693,856,507	3.1%	\$7,312,110,849	3.1%	9.2%
Home Health Care	\$3,924,725,800	1.8%	\$4,403,905,141	1.9%	12.2%
Dental	\$2,308,811,686	1.1%	\$2,594,893,174	1.1%	12.4%
Lab/X-Ray	\$2,157,359,177	1.0%	\$2,365,005,639	1.0%	9.6%
Mental Health Facility	\$2,122,406,677	1.0%	\$2,143,131,041	0.9%	1.0%
Unknown	\$1,878,534,734	0.9%	\$1,702,298,783	0.7%	-9.4%
Other Practitioners	\$841,952,557	0.4%	\$882,313,595	0.4%	4.8%
PCCM Services	\$199,663,705	0.1%	\$208,303,118	0.1%	4.3%
Total Payments	\$213,491,313,278		\$233,205,998,192		9.2%

*Sum of percentages will exceed 100% due to recipients' use of multiple services. Puerto Rico and the U.S. Territories are not included in these national totals.

Source: CMS, MSIS Report, FY 2002 and FY 2003.

2003 Baseline Data

State	Total Payments	Drug Payments	Total Recipients	Drug Recipients	Drug \$ as a % of Total \$
National Total	\$233,205,998,192	\$33,714,314,456	51,971,173	26,075,011	14.5%
Alabama	\$3,471,319,724	\$537,070,779	780,617	527,855	15.5%
Alaska	\$835,515,131	\$99,756,988	116,211	75,501	11.9%
Arizona	\$3,285,364,385	\$4,139,726	1,014,813	7,616	0.1%
Arkansas	\$2,211,952,987	\$325,829,229	702,064	432,556	14.7%
California	\$25,812,495,569	\$4,019,645,375	9,319,148	2,868,468	15.6%
Colorado	\$2,268,794,322	\$251,367,181	459,207	197,128	11.1%
Connecticut	\$3,359,497,127	\$402,380,645	496,680	119,698	12.0%
Delaware	\$750,252,370	\$110,942,313	149,864	99,634	14.8%
District of Columbia	\$1,199,837,436	\$82,817,543	158,179	34,424	6.9%
Florida	\$11,104,376,050	\$2,062,349,922	2,743,368	1,309,456	18.6%
Georgia	\$5,357,550,658	\$1,003,853,892	1,732,120	1,222,323	18.7%
Hawaii	\$753,463,428	\$96,404,644	208,985	41,748	12.8%
Idaho	\$867,160,476	\$137,360,436	193,302	133,592	15.8%
Illinois	\$9,391,357,857	\$1,258,646,834	1,830,233	1,227,361	13.4%
Indiana	\$3,950,802,203	\$655,689,109	895,973	459,938	16.6%
Iowa	\$1,996,207,221	\$325,270,012	361,760	258,417	16.3%
Kansas	\$1,614,744,381	\$235,117,999	316,411	165,599	14.6%
Kentucky	\$3,557,820,183	\$693,988,604	847,943	512,351	19.5%
Louisiana	\$3,614,909,979	\$783,761,071	995,362	758,388	21.7%
Maine	\$2,074,246,677	\$278,812,700	307,279	245,562	13.4%
Maryland	\$4,398,301,341	\$380,007,833	725,820	204,994	8.6%
Massachusetts	\$6,391,977,781	\$938,275,647	1,042,123	640,437	14.7%
Michigan	\$6,479,029,763	\$753,841,353	1,589,501	610,641	11.6%
Minnesota	\$4,701,612,364	\$336,444,933	667,500	201,366	7.2%
Mississippi	\$2,569,776,154	\$568,265,605	717,435	547,268	22.1%
Missouri	\$4,406,852,103	\$953,324,877	1,081,496	526,991	21.6%
Montana	\$536,372,686	\$86,637,045	110,403	74,400	16.2%
Nebraska	\$1,282,568,106	\$197,698,309	253,728	196,184	15.4%
Nevada	\$881,323,024	\$110,070,582	220,417	76,745	12.5%
New Hampshire	\$786,014,720	\$117,004,510	112,044	85,787	14.9%
New Jersey	\$6,029,601,253	\$757,754,210	949,741	297,997	12.6%
New Mexico	\$2,033,478,397	\$108,079,641	452,120	99,931	5.3%
New York	\$35,206,760,472	\$4,000,289,361	4,449,939	2,623,805	11.4%
North Carolina	\$6,521,288,060	\$1,263,258,395	1,416,912	1,015,932	19.4%
North Dakota	\$444,803,367	\$56,433,414	76,754	47,738	12.7%
Ohio	\$10,235,239,405	\$1,569,067,697	1,778,325	1,054,737	15.3%
Oklahoma	\$2,128,524,455	\$290,182,401	625,875	302,424	13.6%
Oregon	\$2,115,608,505	\$251,539,420	598,110	240,228	11.9%
Pennsylvania	\$9,450,026,724	\$769,962,791	1,721,707	404,586	8.1%
Rhode Island	\$1,338,212,632	\$141,126,655	201,875	57,605	10.5%
South Carolina	\$3,641,714,949	\$559,908,608	861,216	614,417	15.4%
South Dakota	\$541,910,489	\$72,883,705	123,590	68,361	13.4%
Tennessee	\$5,459,293,763	\$1,772,766,619	1,729,589	1,175,224	32.5%
Texas	\$12,524,526,333	\$1,921,877,468	3,339,796	2,475,742	15.3%
Utah	\$1,200,789,487	\$146,490,144	285,370	160,312	12.2%
Vermont	\$641,738,944	\$129,301,879	154,664	115,381	20.1%
Virginia	\$3,180,990,089	\$506,529,241	709,488	325,047	15.9%
Washington	\$4,524,032,645	\$597,415,127	1,077,070	438,618	13.2%
West Virginia	\$1,829,967,627	\$339,840,738	373,154	285,582	18.6%
Wisconsin	\$3,921,363,613	\$610,280,050	829,287	361,969	15.6%
Wyoming	\$324,630,777	\$42,551,196	66,605	46,947	13.1%

Source: CMS, MSIS Report, FY 2003.

Medicaid Payments and Recipients, 2003

State	Total Payments	Total Recipients	Payments Per Recipient
National Total	\$233,205,998,192	51,971,173	\$4,487
Alabama	\$3,471,319,724	780,617	\$4,447
Alaska	\$835,515,131	116,211	\$7,190
Arizona	\$3,285,364,385	1,014,813	\$3,237
Arkansas	\$2,211,952,987	702,064	\$3,151
California	\$25,812,495,569	9,319,148	\$2,770
Colorado	\$2,268,794,322	459,207	\$4,941
Connecticut	\$3,359,497,127	496,680	\$6,764
Delaware	\$750,252,370	149,864	\$5,006
District of Columbia	\$1,199,837,436	158,179	\$7,585
Florida	\$11,104,376,050	2,743,368	\$4,048
Georgia	\$5,357,550,658	1,732,120	\$3,093
Hawaii	\$753,463,428	208,985	\$3,605
Idaho	\$867,160,476	193,302	\$4,486
Illinois	\$9,391,357,857	1,830,233	\$5,131
Indiana	\$3,950,802,203	895,973	\$4,410
Iowa	\$1,996,207,221	361,760	\$5,518
Kansas	\$1,614,744,381	316,411	\$5,103
Kentucky	\$3,557,820,183	847,943	\$4,196
Louisiana	\$3,614,909,979	995,362	\$3,632
Maine	\$2,074,246,677	307,279	\$6,750
Maryland	\$4,398,301,341	725,820	\$6,060
Massachusetts	\$6,391,977,781	1,042,123	\$6,134
Michigan	\$6,479,029,763	1,589,501	\$4,076
Minnesota	\$4,701,612,364	667,500	\$7,044
Mississippi	\$2,569,776,154	717,435	\$3,582
Missouri	\$4,406,852,103	1,081,496	\$4,075
Montana	\$536,372,686	110,403	\$4,858
Nebraska	\$1,282,568,106	253,728	\$5,055
Nevada	\$881,323,024	220,417	\$3,998
New Hampshire	\$786,014,720	112,044	\$7,015
New Jersey	\$6,029,601,253	949,741	\$6,349
New Mexico	\$2,033,478,397	452,120	\$4,498
New York	\$35,206,760,472	4,449,939	\$7,912
North Carolina	\$6,521,288,060	1,416,912	\$4,602
North Dakota	\$444,803,367	76,754	\$5,795
Ohio	\$10,235,239,405	1,778,325	\$5,756
Oklahoma	\$2,128,524,455	625,875	\$3,401
Oregon	\$2,115,608,505	598,110	\$3,537
Pennsylvania	\$9,450,026,724	1,721,707	\$5,489
Rhode Island	\$1,338,212,632	201,875	\$6,629
South Carolina	\$3,641,714,949	861,216	\$4,229
South Dakota	\$541,910,489	123,590	\$4,385
Tennessee	\$5,459,293,763	1,729,589	\$3,156
Texas	\$12,524,526,333	3,339,796	\$3,750
Utah	\$1,200,789,487	285,370	\$4,208
Vermont	\$641,738,944	154,664	\$4,149
Virginia	\$3,180,990,089	709,488	\$4,484
Washington	\$4,524,032,645	1,077,070	\$4,200
West Virginia	\$1,829,967,627	373,154	\$4,904
Wisconsin	\$3,921,363,613	829,287	\$4,729
Wyoming	\$324,630,777	66,605	\$4,874

Source: CMS, MSIS Report, FY 2003.

Drug Payments and Recipients, 2003

State	Total Drug Payments	Total Drug Recipients	Drug Payments Per Recipient
National Total	\$33,714,314,456	26,075,011	\$1,293
Alabama	\$537,070,779	527,855	\$1,017
Alaska	\$99,756,988	75,501	\$1,321
Arizona	\$4,139,726	7,616	\$544
Arkansas	\$325,829,229	432,556	\$753
California	\$4,019,645,375	2,868,468	\$1,401
Colorado	\$251,367,181	197,128	\$1,275
Connecticut	\$402,380,645	119,698	\$3,362
Delaware	\$110,942,313	99,634	\$1,113
District of Columbia	\$82,817,543	34,424	\$2,406
Florida	\$2,062,349,922	1,309,456	\$1,575
Georgia	\$1,003,853,892	1,222,323	\$821
Hawaii	\$96,404,644	41,748	\$2,309
Idaho	\$137,360,436	133,592	\$1,028
Illinois	\$1,258,646,834	1,227,361	\$1,025
Indiana	\$655,689,109	459,938	\$1,426
Iowa	\$325,270,012	258,417	\$1,259
Kansas	\$235,117,999	165,599	\$1,420
Kentucky	\$693,988,604	512,351	\$1,355
Louisiana	\$783,761,071	758,388	\$1,033
Maine	\$278,812,700	245,562	\$1,135
Maryland	\$380,007,833	204,994	\$1,854
Massachusetts	\$938,275,647	640,437	\$1,465
Michigan	\$753,841,353	610,641	\$1,235
Minnesota	\$336,444,933	201,366	\$1,671
Mississippi	\$568,265,605	547,268	\$1,038
Missouri	\$953,324,877	526,991	\$1,809
Montana	\$86,637,045	74,400	\$1,164
Nebraska	\$197,698,309	196,184	\$1,008
Nevada	\$110,070,582	76,745	\$1,434
New Hampshire	\$117,004,510	85,787	\$1,364
New Jersey	\$757,754,210	297,997	\$2,543
New Mexico	\$108,079,641	99,931	\$1,082
New York	\$4,000,289,361	2,623,805	\$1,525
North Carolina	\$1,263,258,395	1,015,932	\$1,243
North Dakota	\$56,433,414	47,738	\$1,182
Ohio	\$1,569,067,697	1,054,737	\$1,488
Oklahoma	\$290,182,401	302,424	\$960
Oregon	\$251,539,420	240,228	\$1,047
Pennsylvania	\$769,962,791	404,586	\$1,903
Rhode Island	\$141,126,655	57,605	\$2,450
South Carolina	\$559,908,608	614,417	\$911
South Dakota	\$72,883,705	68,361	\$1,066
Tennessee	\$1,772,766,619	1,175,224	\$1,508
Texas	\$1,921,877,468	2,475,742	\$776
Utah	\$146,490,144	160,312	\$914
Vermont	\$129,301,879	115,381	\$1,121
Virginia	\$506,529,241	325,047	\$1,558
Washington	\$597,415,127	438,618	\$1,362
West Virginia	\$339,840,738	285,582	\$1,190
Wisconsin	\$610,280,050	361,969	\$1,686
Wyoming	\$42,551,196	46,947	\$906

Source: CMS, MSIS Report, FY 2003.

Drug Payment Trends, Percent Change 2002-2003

State	2002	2003	Percent Change
National Total	\$28,408,181,719	\$33,714,314,456	18.68%
Alabama	\$454,370,478	\$537,070,779	18.20%
Alaska	\$83,324,085	\$99,756,988	19.72%
Arizona	\$4,338,712	\$4,139,726	-4.59%
Arkansas	\$279,644,642	\$325,829,229	16.52%
California	\$3,402,508,001	\$4,019,645,375	18.14%
Colorado	\$202,286,461	\$251,367,181	24.26%
Connecticut	\$356,980,484	\$402,380,645	12.72%
Delaware	\$100,112,623	\$110,942,313	10.82%
District of Columbia	\$68,050,981	\$82,817,543	21.70%
Florida	\$1,736,991,594	\$2,062,349,922	18.73%
Georgia	\$749,552,199	\$1,003,853,892	33.93%
Hawaii	\$81,453,811	\$96,404,644	18.35%
Idaho	\$121,780,793	\$137,360,436	12.79%
Illinois	\$1,222,947,241	\$1,258,646,834	2.92%
Indiana	\$636,357,519	\$655,689,109	3.04%
Iowa	\$277,753,942	\$325,270,012	17.11%
Kansas	\$220,800,602	\$235,117,999	6.48%
Kentucky	\$661,409,737	\$693,988,604	4.93%
Louisiana	\$682,557,080	\$783,761,071	14.83%
Maine	\$250,331,526	\$278,812,700	11.38%
Maryland	\$320,313,995	\$380,007,833	18.64%
Massachusetts	\$952,790,939	\$938,275,647	-1.52%
Michigan	\$674,898,273	\$753,841,353	11.70%
Minnesota	\$294,838,630	\$336,444,933	14.11%
Mississippi	\$568,084,274	\$568,265,605	0.03%
Missouri	\$799,910,014	\$953,324,877	19.18%
Montana	\$77,980,883	\$86,637,045	11.10%
Nebraska	\$196,526,107	\$197,698,309	0.60%
Nevada	\$90,134,969	\$110,070,582	22.12%
New Hampshire	\$98,836,636	\$117,004,510	18.38%
New Jersey	\$686,301,522	\$757,754,210	10.41%
New Mexico	\$92,674,018	\$108,079,641	16.62%
New York	\$3,413,404,507	\$4,000,289,361	17.19%
North Carolina	\$1,069,140,895	\$1,263,258,395	18.16%
North Dakota	\$51,749,961	\$56,433,414	9.05%
Ohio	\$1,330,569,382	\$1,569,067,697	17.92%
Oklahoma	\$267,549,002	\$290,182,401	8.46%
Oregon	\$269,936,847	\$251,539,420	-6.82%
Pennsylvania	\$719,243,402	\$769,962,791	7.05%
Rhode Island	\$126,331,040	\$141,126,655	11.71%
South Carolina	\$456,976,916	\$559,908,608	22.52%
South Dakota	\$63,654,623	\$72,883,705	14.50%
Tennessee	\$573,588,021	\$1,772,766,619	209.07%
Texas	\$1,591,828,224	\$1,921,877,468	20.73%
Utah	\$140,520,420	\$146,490,144	4.25%
Vermont	\$115,623,970	\$129,301,879	11.83%
Virginia	\$453,663,058	\$506,529,241	11.65%
Washington	\$549,216,380	\$597,415,127	8.78%
West Virginia	\$274,613,136	\$339,840,738	23.75%
Wisconsin	\$455,720,622	\$610,280,050	33.92%
Wyoming	\$38,008,542	\$42,551,196	11.95%

Source: CMS, MSIS Report, FY 2002 and FY 2003.

Rankings Based on Drug Payments

State	2003		% of Total 2003		2002	
	Payments	Ranking	Medicaid Drug Payments		Payments	Ranking
California	\$4,019,645,375	1	11.92%		\$3,402,508,001	2
New York	\$4,000,289,361	2	11.87%		\$3,413,404,507	1
Florida	\$2,062,349,922	3	6.12%		\$1,736,991,594	3
Texas	\$1,921,877,468	4	5.70%		\$1,591,828,224	4
Tennessee	\$1,772,766,619	5	5.26%		\$573,588,021	17
Ohio	\$1,569,067,697	6	4.65%		\$1,330,569,382	5
North Carolina	\$1,263,258,395	7	3.75%		\$1,069,140,895	7
Illinois	\$1,258,646,834	8	3.73%		\$1,222,947,241	6
Georgia	\$1,003,853,892	9	2.98%		\$749,552,199	10
Missouri	\$953,324,877	10	2.83%		\$799,910,014	9
Massachusetts	\$938,275,647	11	2.78%		\$952,790,939	8
Louisiana	\$783,761,071	12	2.32%		\$682,557,080	13
Pennsylvania	\$769,962,791	13	2.28%		\$719,243,402	11
New Jersey	\$757,754,210	14	2.25%		\$686,301,522	12
Michigan	\$753,841,353	15	2.24%		\$674,898,273	14
Kentucky	\$693,988,604	16	2.06%		\$661,409,737	15
Indiana	\$655,689,109	17	1.94%		\$636,357,519	16
Wisconsin	\$610,280,050	18	1.81%		\$455,720,622	21
Washington	\$597,415,127	19	1.77%		\$549,216,380	19
Mississippi	\$568,265,605	20	1.69%		\$568,084,274	18
South Carolina	\$559,908,608	21	1.66%		\$456,976,916	20
Alabama	\$537,070,779	22	1.59%		\$454,370,478	22
Virginia	\$506,529,241	23	1.50%		\$453,663,058	23
Connecticut	\$402,380,645	24	1.19%		\$356,980,484	24
Maryland	\$380,007,833	25	1.13%		\$320,313,995	25
West Virginia	\$339,840,738	26	1.01%		\$274,613,136	29
Minnesota	\$336,444,933	27	1.00%		\$294,838,630	26
Arkansas	\$325,829,229	28	0.97%		\$279,644,642	27
Iowa	\$325,270,012	29	0.96%		\$277,753,942	28
Oklahoma	\$290,182,401	30	0.86%		\$267,549,002	31
Maine	\$278,812,700	31	0.83%		\$250,331,526	32
Oregon	\$251,539,420	32	0.75%		\$269,936,847	30
Colorado	\$251,367,181	33	0.75%		\$202,286,461	34
Kansas	\$235,117,999	34	0.70%		\$220,800,602	33
Nebraska	\$197,698,309	35	0.59%		\$196,526,107	35
Utah	\$146,490,144	36	0.43%		\$140,520,420	36
Rhode Island	\$141,126,655	37	0.42%		\$126,331,040	37
Idaho	\$137,360,436	38	0.41%		\$121,780,793	38
Vermont	\$129,301,879	39	0.38%		\$115,623,970	39
New Hampshire	\$117,004,510	40	0.35%		\$98,836,636	41
Delaware	\$110,942,313	41	0.33%		\$100,112,623	40
Nevada	\$110,070,582	42	0.33%		\$90,134,969	43
New Mexico	\$108,079,641	43	0.32%		\$92,674,018	42
Alaska	\$99,756,988	44	0.30%		\$83,324,085	44
Hawaii	\$96,404,644	45	0.29%		\$81,453,811	45
Montana	\$86,637,045	46	0.26%		\$77,980,883	46
District of Columbia	\$82,817,543	47	0.25%		\$68,050,981	47
South Dakota	\$72,883,705	48	0.22%		\$63,654,623	48
North Dakota	\$56,433,414	49	0.17%		\$51,749,961	49
Wyoming	\$42,551,196	50	0.13%		\$38,008,542	50
Arizona	\$4,139,726	51	0.01%		\$4,338,712	51

Source: CMS, MSIS Report, FY 2002 and FY 2003.

Drugs as a Percentage of Total Payments, 2003

State	Drug Payments	Total Payments	Percent of Total Payments
National Total	\$33,714,314,456	\$233,205,998,192	14.5%
Alabama	\$537,070,779	\$3,471,319,724	15.5%
Alaska	\$99,756,988	\$835,515,131	11.9%
Arizona	\$4,139,726	\$3,285,364,385	0.1%
Arkansas	\$325,829,229	\$2,211,952,987	14.7%
California	\$4,019,645,375	\$25,812,495,569	15.6%
Colorado	\$251,367,181	\$2,268,794,322	11.1%
Connecticut	\$402,380,645	\$3,359,497,127	12.0%
Delaware	\$110,942,313	\$750,252,370	14.8%
District of Columbia	\$82,817,543	\$1,199,837,436	6.9%
Florida	\$2,062,349,922	\$11,104,376,050	18.6%
Georgia	\$1,003,853,892	\$5,357,550,658	18.7%
Hawaii	\$96,404,644	\$753,463,428	12.8%
Idaho	\$137,360,436	\$867,160,476	15.8%
Illinois	\$1,258,646,834	\$9,391,357,857	13.4%
Indiana	\$655,689,109	\$3,950,802,203	16.6%
Iowa	\$325,270,012	\$1,996,207,221	16.3%
Kansas	\$235,117,999	\$1,614,744,381	14.6%
Kentucky	\$693,988,604	\$3,557,820,183	19.5%
Louisiana	\$783,761,071	\$3,614,909,979	21.7%
Maine	\$278,812,700	\$2,074,246,677	13.4%
Maryland	\$380,007,833	\$4,398,301,341	8.6%
Massachusetts	\$938,275,647	\$6,391,977,781	14.7%
Michigan	\$753,841,353	\$6,479,029,763	11.6%
Minnesota	\$336,444,933	\$4,701,612,364	7.2%
Mississippi	\$568,265,605	\$2,569,776,154	22.1%
Missouri	\$953,324,877	\$4,406,852,103	21.6%
Montana	\$86,637,045	\$536,372,686	16.2%
Nebraska	\$197,698,309	\$1,282,568,106	15.4%
Nevada	\$110,070,582	\$881,323,024	12.5%
New Hampshire	\$117,004,510	\$786,014,720	14.9%
New Jersey	\$757,754,210	\$6,029,601,253	12.6%
New Mexico	\$108,079,641	\$2,033,478,397	5.3%
New York	\$4,000,289,361	\$35,206,760,472	11.4%
North Carolina	\$1,263,258,395	\$6,521,288,060	19.4%
North Dakota	\$56,433,414	\$444,803,367	12.7%
Ohio	\$1,569,067,697	\$10,235,239,405	15.3%
Oklahoma	\$290,182,401	\$2,128,524,455	13.6%
Oregon	\$251,539,420	\$2,115,608,505	11.9%
Pennsylvania	\$769,962,791	\$9,450,026,724	8.1%
Rhode Island	\$141,126,655	\$1,338,212,632	10.5%
South Carolina	\$559,908,608	\$3,641,714,949	15.4%
South Dakota	\$72,883,705	\$541,910,489	13.4%
Tennessee	\$1,772,766,619	\$5,459,293,763	32.5%
Texas	\$1,921,877,468	\$12,524,526,333	15.3%
Utah	\$146,490,144	\$1,200,789,487	12.2%
Vermont	\$129,301,879	\$641,738,944	20.1%
Virginia	\$506,529,241	\$3,180,990,089	15.9%
Washington	\$597,415,127	\$4,524,032,645	13.2%
West Virginia	\$339,840,738	\$1,829,967,627	18.6%
Wisconsin	\$610,280,050	\$3,921,363,613	15.6%
Wyoming	\$42,551,196	\$324,630,777	13.1%

Source: CMS, MSIS Report, FY 2003.

Drugs as a Percentage of Total Payments, 1997 – 2003*

State	1997	1998	1999	2000	2001	2002	2003
National Total	9.7%	9.5%	10.8%	11.8%	12.7%	13.3%	14.5%
Alabama	14.4%	12.4%	16.6%	13.9%	13.3%	14.2%	15.5%
Alaska	8.8%	10.0%	9.9%	11.3%	11.9%	12.1%	11.9%
Arizona	0.8%	0.1%	0.1%	0.1%	0.2%	0.2%	0.1%
Arkansas	10.4%	11.0%	13.4%	13.6%	14.4%	13.9%	14.7%
California	11.7%	10.9%	11.9%	13.5%	14.1%	14.4%	15.6%
Colorado	8.6%	7.7%	8.0%	8.5%	9.1%	9.3%	11.1%
Connecticut	8.3%	7.7%	8.3%	9.3%	10.3%	11.0%	12.0%
Delaware	12.6%	9.9%	11.6%	12.5%	13.6%	15.4%	14.8%
District of Columbia	5.4%	5.6%	5.9%	7.0%	7.5%	6.6%	6.9%
Florida	15.8%	16.4%	16.3%	18.4%	17.4%	17.7%	18.6%
Georgia	11.0%	12.3%	14.3%	16.2%	17.3%	15.6%	18.7%
Hawaii	-	7.8%	8.4%	9.8%	12.0%	11.7%	12.8%
Idaho	10.4%	12.9%	13.2%	14.1%	14.8%	15.4%	15.8%
Illinois	9.1%	9.4%	10.6%	10.8%	11.5%	13.4%	13.4%
Indiana	12.3%	12.7%	13.7%	15.6%	16.7%	17.1%	16.6%
Iowa	11.4%	11.4%	12.4%	13.2%	13.9%	15.0%	16.3%
Kansas	11.4%	13.0%	12.7%	13.7%	13.9%	14.7%	14.6%
Kentucky	13.9%	13.2%	13.8%	15.9%	18.5%	19.1%	19.5%
Louisiana	13.5%	14.8%	16.0%	18.2%	19.3%	21.1%	21.7%
Maine	13.2%	16.3%	12.1%	13.4%	14.0%	14.6%	13.4%
Maryland	7.8%	6.0%	6.7%	7.4%	8.1%	8.7%	8.6%
Massachusetts	10.3%	10.8%	12.0%	12.6%	13.8%	14.9%	14.7%
Michigan	10.2%	8.6%	6.8%	7.7%	11.4%	11.4%	11.6%
Minnesota	6.6%	5.9%	6.1%	6.8%	7.0%	6.6%	7.2%
Mississippi	14.6%	16.1%	17.2%	20.5%	22.7%	22.7%	22.1%
Missouri	15.3%	14.9%	17.2%	18.4%	18.8%	19.6%	21.6%
Montana	11.2%	11.7%	13.4%	14.0%	14.7%	14.6%	16.2%
Nebraska	11.5%	12.3%	13.2%	14.1%	14.8%	15.7%	15.4%
Nevada	7.1%	7.5%	8.8%	10.0%	10.6%	12.5%	12.5%
New Hampshire	8.2%	9.1%	12.3%	12.4%	13.2%	13.3%	14.9%
New Jersey	10.4%	10.1%	11.2%	12.4%	12.9%	12.5%	12.6%
New Mexico	7.7%	4.8%	4.2%	4.6%	4.7%	5.2%	5.3%
New York	5.1%	5.6%	7.6%	9.1%	10.0%	10.8%	11.4%
North Carolina	10.7%	11.6%	14.3%	16.4%	17.6%	17.7%	19.4%
North Dakota	7.7%	8.1%	9.1%	10.6%	11.5%	12.2%	12.7%
Ohio	9.9%	10.5%	12.0%	12.4%	13.9%	14.5%	15.3%
Oklahoma	10.7%	-	11.7%	11.1%	10.8%	12.0%	13.6%
Oregon	5.0%	6.4%	7.7%	9.5%	11.8%	12.6%	11.9%
Pennsylvania	11.8%	8.6%	9.9%	8.4%	9.0%	8.4%	8.1%
Rhode Island	7.1%	6.7%	8.5%	8.4%	9.6%	10.1%	10.5%
South Carolina	9.9%	11.1%	10.5%	12.1%	14.2%	13.5%	15.4%
South Dakota	8.7%	8.7%	10.0%	11.1%	12.3%	12.6%	13.4%
Tennessee	0.0%	0.0%	0.0%	0.0%	0.0%	12.1%	32.5%
Texas	10.2%	11.5%	11.7%	12.1%	13.8%	14.3%	15.3%
Utah	12.0%	11.1%	10.5%	10.5%	11.0%	11.6%	12.2%
Vermont	14.4%	12.4%	16.0%	19.2%	19.6%	19.0%	20.1%
Virginia	13.4%	13.4%	14.9%	15.4%	15.4%	15.0%	15.9%
Washington	14.7%	12.0%	11.8%	16.0%	17.1%	12.6%	13.2%
West Virginia	10.6%	12.0%	14.6%	15.5%	16.4%	17.4%	18.6%
Wisconsin	10.9%	10.5%	12.4%	11.8%	12.2%	12.6%	15.6%
Wyoming	8.1%	8.9%	11.2%	12.8%	13.3%	13.6%	13.1%

*Hawaii did not report on time for FY 1997 and FY 1999 and was excluded from the national totals for those years. Hawaii also did not report for FY 2000. CMS included their FY 1999 data in the FY 2000 MSIS Report. Oklahoma did not report for FY 1998 and was excluded from the national total for that year.

Source: CMS, HCFA-2082 Reports, FY 1997 - FY 1998 and MSIS Reports, FY 1999 – FY 2003.

Total Drug Recipients *

State	1997	1998	1999	2000	2001	2002	2003
National Total	20,943,872	19,324,605	19,428,344	20,324,675	21,910,532	24,424,493	26,075,011
Alabama	412,739	395,290	405,330	438,529	464,695	500,789	527,855
Alaska	42,174	43,734	52,070	60,273	65,278	70,550	75,501
Arizona	80,450	56,796	5,545	7,034	9,761	7,805	7,616
Arkansas	254,079	262,907	280,552	290,749	321,920	356,233	432,556
California	3,158,386	2,644,430	2,252,441	2,491,537	2,489,050	2,651,229	2,868,468
Colorado	156,631	147,033	151,537	160,265	143,167	153,520	197,128
Connecticut	120,522	108,331	108,754	113,101	116,785	123,704	119,698
Delaware	68,672	69,027	73,093	78,167	85,350	125,461	99,634
District of Columbia	64,494	57,733	37,862	38,129	35,324	45,216	34,424
Florida	1,024,555	1,014,372	991,927	1,078,631	1,165,866	1,245,841	1,309,456
Georgia	846,963	805,923	843,353	882,309	978,404	1,076,904	1,222,323
Hawaii	-	32,222	35,837	37,316	39,288	39,320	41,748
Idaho	79,961	86,775	81,980	92,776	112,357	125,537	133,592
Illinois	1,008,740	959,472	966,790	1,013,387	1,068,687	1,199,933	1,227,361
Indiana	352,814	323,811	361,661	420,071	464,975	490,386	459,938
Iowa	221,061	215,173	213,144	212,178	221,690	245,711	258,417
Kansas	170,167	155,875	153,054	158,334	158,515	157,618	165,599
Kentucky	494,293	429,102	366,051	425,721	476,774	489,416	512,351
Louisiana	563,864	552,481	551,698	581,356	628,574	689,973	758,388
Maine	139,524	137,816	143,548	149,262	194,288	224,664	245,562
Maryland	256,423	176,403	159,779	163,410	171,747	181,101	204,994
Massachusetts	559,215	613,186	671,741	671,716	671,756	659,626	640,437
Michigan	688,882	589,818	436,848	435,723	551,680	577,785	610,641
Minnesota	227,027	203,220	184,075	179,879	187,854	190,577	201,366
Mississippi	391,328	368,609	375,573	415,925	478,409	526,923	547,268
Missouri	395,478	353,902	412,597	447,068	472,645	493,230	526,991
Montana	62,092	58,641	59,182	58,918	63,352	67,365	74,400
Nebraska	151,973	145,408	155,136	166,031	178,634	194,889	196,184
Nevada	55,876	50,903	48,534	51,170	58,699	71,950	76,745
New Hampshire	71,692	70,339	71,039	73,313	73,489	78,861	85,787
New Jersey	347,105	309,849	301,022	299,356	305,962	296,059	297,997
New Mexico	184,502	96,637	55,018	67,239	75,892	122,098	99,931
New York	1,667,927	1,803,428	2,024,870	2,173,856	2,458,197	2,567,595	2,623,805
North Carolina	779,229	764,886	812,234	827,389	907,741	949,795	1,015,932
North Dakota	39,654	37,675	37,780	38,964	39,758	44,428	47,738
Ohio	786,322	702,143	796,720	777,632	934,632	997,246	1,054,737
Oklahoma	207,441	-	222,456	221,985	252,025	276,111	302,424
Oregon	149,461	148,258	174,931	193,924	223,580	242,865	240,228
Pennsylvania	763,255	580,749	520,221	416,498	461,114	464,848	404,586
Rhode Island	46,817	44,852	49,277	49,809	50,411	53,729	57,605
South Carolina	359,910	401,611	446,893	474,470	542,768	576,136	614,417
South Dakota	47,845	46,588	50,780	53,666	58,212	64,948	68,361
Tennessee^	3	1	0	0	0	916,968	1,175,224
Texas	1,986,178	1,894,447	1,853,348	1,852,828	1,917,398	2,153,316	2,475,742
Utah	105,676	126,953	130,682	133,224	136,719	152,268	160,312
Vermont	83,057	58,037	89,547	103,635	109,578	112,227	115,381
Virginia	396,719	383,880	377,588	344,877	334,008	319,196	325,047
Washington	292,733	274,463	301,907	339,611	385,408	423,758	438,618
West Virginia	280,550	267,398	274,894	262,675	269,174	276,338	285,582
Wisconsin	265,987	221,508	224,165	267,417	262,238	309,795	361,969
Wyoming	33,426	32,510	33,280	33,342	36,704	42,652	46,947

Note: Recipients are defined as individuals who received drugs, not as everyone eligible to receive drugs.

*Hawaii did not report on time for FY 1997. They are excluded from the national total for that year. Oklahoma did not report for FY 1998. They are excluded from the national total for that year.

^Until 2002, Tennessee did not report drug recipients because beneficiaries are enrolled in managed care & receive pharmaceutical benefits through these plans.

Source: CMS, HCFA-2082 Report, FY 1997 - FY1998 and MSIS Report, FY 1999 - FY 2003.

***Appendix C:
Medicaid Rebate Law***

NOTE: This section is current at press time and has not been revised to reflect any future changes that may result from the Deficit Reduction Act.

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 7 - SOCIAL SECURITY

SUBCHAPTER XIX - GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

Sec. 1396r-8. Payment for covered outpatient drugs¹

(a) Requirement for rebate agreement

(1) In general

In order for payment to be available under section 1396b(a) of this title or under part B of title XVIII for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement described in subsection (b) of this section with the Secretary, on behalf of States (except that, the Secretary may authorize a State to enter directly into agreements with a manufacturer), and must meet the requirements of paragraph (5)(with respect to drugs purchased by a covered entity on or after the first day of the first month that begins after November 4, 1992) and paragraph (6). Any agreement between a State and a manufacturer prior to April 1, 1991, shall be deemed to have been entered into on January 1, 1991, and payment to such manufacturer shall be retroactively calculated as if the agreement between the manufacturer and the State had been entered into on January 1, 1991. If a manufacturer has not entered into such an agreement before March 1, 1991, such an agreement, subsequently entered into, shall become effective as of the date on which the agreement is entered into or, at State option, on any date thereafter on or before the first day of the calendar quarter that begins more than 60 days after the date of the agreement is entered into.

(2) Effective date

Paragraph (1) shall first apply to drugs dispensed under this subchapter on or after January 1, 1991.

(3) Authorizing payment for drugs not covered under rebate agreements

Paragraph (1), and section 1396b(i)(10)(A) of this title, shall not apply to the dispensing of a single source drug or innovator multiple source drug if (A)(i) the State has made a determination that the availability of the drug is essential to the health of beneficiaries under the State Plan for medical assistance; (ii) such drug has been given a rating of 1-A by the Food and Drug Administration; and (iii)(I) the physician has obtained approval for use of the drug in advance of its dispensing in accordance with a prior authorization program described in subsection (d) of this section, or (II) the Secretary has reviewed and approved the State's determination under subparagraph (A); or (B) the Secretary determines that in the first calendar quarter of 1991, there were extenuating circumstances.

(4) Effect on existing agreements

In the case of a rebate agreement in effect between a State and a manufacturer on November 5, 1990, such agreement, for the initial agreement period specified therein, shall be considered to be a rebate agreement in compliance with this section with respect to that State, if the State agrees to report to the Secretary any rebates paid pursuant to the agreement and such agreement provides for a minimum aggregate rebate of 10 percent of the State's total expenditures under the State Plan for coverage of the manufacturer's drugs under this subchapter. If, after the initial agreement period, the State establishes to the satisfaction of the Secretary that an agreement in effect on November 5, 1990, provides for rebates that are at least as large as the rebates otherwise required under this section, and the State agrees to report any rebates under the agreement to the Secretary, the agreement shall be considered to be a rebate agreement in compliance with the section for the renewal periods of such agreement.

¹ This is section 1927 of the Social Security Act. It is codified as Section 1396r-8 of Title 42 of the United States Code.

(5) Limitation on prices of drugs purchased by covered entities

(A) Agreement with Secretary

A manufacturer meets the requirements of this paragraph if the manufacturer has entered into an agreement with the Secretary that meets the requirements of section 256b of this title with respect to covered outpatient drugs purchased by a covered entity on or after the first day of the first month that begins after November 4, 1992.

(B) “Covered entity” defined

In this subsection, the term “covered entity” means an entity described in section 256b(a)(4) of this title.

(C) Establishment of alternative mechanism to ensure against duplicate discounts or rebates

If the Secretary does not establish a mechanism under section 256b(a)(5)(A) of this title within 12 months of November 4, 1992, the following requirements shall apply:

(i) Entities

Each covered entity shall inform the single State agency under section 1396a(a)(5) of this title when it is seeking reimbursement from the State Plan for medical assistance described in section 1396d(a)(12) of this title with respect to a unit of any covered outpatient drug which is subject to an agreement under section 256b(a) of this title.

(ii) State agency

Each such single State agency shall provide a means by which a covered entity shall indicate on any drug reimbursement claims form (or format, where electronic claims management is used) that a unit of the drug that is the subject of the form is subject to an agreement under section 256b of this title, and not submit to any manufacturer a claim for a rebate payment under subsection (b) of this section with respect to such a drug.

(D) Effect of subsequent amendments

In determining whether an agreement under subparagraph (A) meets the requirements of section 256b of this title, the Secretary shall not take into account any amendments to such section that are enacted after November 4, 1992.

(E) Determination of compliance

A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 256b of this title (as in effect immediately after November 4, 1992) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after November 4, 1992.

(6) Requirements relating to master agreements for drugs procured by Department of Veterans Affairs and certain other Federal agencies

(A) In general

A manufacturer meets the requirements of this paragraph if the manufacturer complies with the provisions of section 8126 of title 38, including the requirement of entering into a master agreement with the Secretary of Veterans Affairs under such section.

(B) Effect of subsequent amendments

In determining whether a master agreement described in subparagraph (A) meets the requirements of section 8126 of title 38, the Secretary shall not take into account any amendments to such section that are enacted after November 4, 1992.

(C) Determination of compliance

A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 8126 of title 38, (as in effect immediately after November 4, 1992) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after November 4, 1992.

(b) Terms of rebate agreement

(1) Periodic rebates

(A) In general

A rebate agreement under this subsection shall require the manufacturer to provide, to each State Plan approved under this subchapter, a rebate for a rebate period in an amount specified in subsection (c) of this section for covered outpatient drugs of the manufacturer dispensed after December 31, 1990, for which payment was made under the State Plan for such period. Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.

(B) Offset against medical assistance

Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) of this section or an agreement described in subsection (a)(4) of this section) in any quarter shall be considered to be a reduction in the amount expended under the State Plan in the quarter for medical assistance for purposes of section 1396b(a)(1) of this title.

(2) State provision of information

(A) State responsibility

Each State agency under this subchapter shall report to each manufacturer not later than 60 days after the end of each rebate period and in a form consistent with a standard reporting format established by the Secretary, information on the total number of units of each dosage form and strength and package size of each covered outpatient drug dispensed after December 31, 1990, for which payment was made under the plan during the period, and shall promptly transmit a copy of such report to the Secretary.

(B) Audits

A manufacturer may audit the information provided (or required to be provided) under subparagraph (A). Adjustments to rebates shall be made to the extent that information indicates that utilization was greater or less than the amount previously specified.

(3) Manufacturer provision of price information

(A) In general. -- Each manufacturer with an agreement in effect under this section shall report to the Secretary --

(i) not later than 30 days after the last day of each rebate period under the agreement (beginning on or after January 1, 1991), on the average manufacturer price (as defined in subsection (k)(1) of this section) and, (for single source drugs and innovator multiple source drugs), the manufacturer's best price (as defined in subsection (c)(2)(B) of this section) for covered outpatient drugs for the rebate period under the agreement;

(ii) not later than 30 days after the date of entering into an agreement under this section on the average manufacturer price (as defined in subsection (k)(1) of this section) as of October 1, 1990 for each of the manufacturer's covered outpatient drugs; and

(iii) for calendar quarters beginning on or after January 1, 2004, in conjunction with reporting required under clause (i) and by National Drug Code (including package size)—

(I) the manufacturer's average sales price (as defined in section 1847A(c)) and the total number of units specified under section 1847A(b)(2)(A);

(II) if required to make payment under section 1847A, the manufacturer's wholesale acquisition cost, as defined in subsection (c)(6) of such section; and

(III) information on those sales that were made at a nominal price or otherwise described in section 1847A(c)(2)(B);

for a drug or biological described in subparagraph (C), (D), (E), or (G) of section 1842 (o)(1) or section 1881(b)(13)(A)(ii).

Information reported under this subparagraph is subject to audit by the Inspector General of the Department of Health and Human Services.

(B) Verification surveys of average manufacturer price and manufacturer's average sales price
The Secretary may survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed \$100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of section 1320a-7a of this title (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(C) Penalties

(i) Failure to provide timely information

In the case of a manufacturer with an agreement under this section that fails to provide information required under subparagraph (A) on a timely basis, the amount of the penalty shall be increased by \$10,000 for each day in which such information has not been provided and such amount shall be paid to the Treasury, and, if such information is not reported within 90 days of the deadline imposed, the agreement shall be suspended for services furnished after the end of such 90-day period and until the date such information is reported (but in no case shall such suspension be for a period of less than 30 days).

(ii) False information

Any manufacturer with an agreement under this section that knowingly provides false information is subject to a civil money penalty in an amount not to exceed \$100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(D) Confidentiality of information

Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph or under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A)(ii) of this section (other than the wholesale acquisition cost for purposes of carrying out section 1847A) is confidential and shall not be disclosed by the Secretary or the Secretary of Veterans Affairs or a State agency (or contractor therewith) in a

form which discloses the identity of a specific manufacturer or wholesaler, prices charged for drugs by such manufacturer or wholesaler, except-

- (i) as the Secretary determines to be necessary to carry out this section, to carry out section 1847A (including the determination and implementation of the payment amount), or to carry out section 1847B,
- (ii) to permit the Comptroller General to review the information provided, and
- (iii) to permit the Director of the Congressional Budget Office to review the information provided.

The previous sentence shall also apply to information disclosed under section 1860D-2(d)(2) or 1860D-4(c)(2)(E) and drug pricing data reported under the first sentence of section 1860D-31(i)(1).

(4) Length of agreement

(A) In general

A rebate agreement shall be effective for an initial period of not less than 1 year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

(B) Termination

(i) By the Secretary

The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination.

(ii) By a manufacturer

A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

(iii) Effectiveness of termination

Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

(iv) Notice to States

In the case of a termination under this subparagraph, the Secretary shall provide notice of such termination to the States within not less than 30 days before the effective date of such termination.

(v) Application to terminations of other agreements

The provisions of this subparagraph shall apply to the terminations of agreements described in section 256b(a)(1) of this title and master agreements described in section 8126(a) of title 38.

(C) Delay before reentry

- (c) In the case of any rebate agreement with a manufacturer under this section which is terminated, another such agreement with the manufacturer (or a successor manufacturer) may not be entered into until a period of 1 calendar quarter has elapsed since the date of the termination, unless the Secretary finds good cause for an earlier reinstatement of such an agreement.

Determination of amount of rebate

- (1) Basic rebate for single source drugs and innovator multiple source drugs

(A) In general

Except as provided in paragraph (2), the amount of the rebate specified in this subsection for a rebate period (as defined in subsection (k)(8) of this section) with respect to each dosage form and strength of a single source drug or an innovator multiple source drug shall be equal to the product of -

- (i) the total number of units of each dosage form and strength paid for under the State Plan in the rebate period (as reported by the State); and
- (ii) subject to subparagraph (B)(ii), the greater of -
 - (I) the difference between the average manufacturer price and the best price (as defined in subparagraph (C)) for the dosage form and strength of the drug, or
 - (II) the minimum rebate percentage (specified in subparagraph (B)(i)) of such average manufacturer price, for the rebate period.

(B) Range of rebates required

(i) Minimum rebate percentage

For purposes of subparagraph (A)(ii)(II), the “minimum rebate percentage” for rebate periods beginning -

- (I) after December 31, 1990, and before October 1, 1992, is 12.5 percent;
- (II) after September 30, 1992, and before January 1, 1994, is 15.7 percent;
- (III) after December 31, 1993, and before January 1, 1995, is 15.4 percent;
- (IV) after December 31, 1994, and before January 1, 1996, is 15.2 percent; and
- (V) after December 31, 1995, is 15.1 percent.

(ii) Temporary limitation on maximum rebate amount

In no case shall the amount applied under subparagraph (A)(ii) for a rebate period beginning -

- (I) before January 1, 1992, exceed 25 percent of the average manufacturer price; or
- (II) after December 31, 1991, and before January 1, 1993, exceed 50 percent of the average manufacturer price.

(C) “Best price” defined

For purposes of this section -

(i) In general

The term “best price” means, with respect to a single source drug or innovator multiple source drug of a manufacturer, the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding -

- (I) any prices charged on or after October 1, 1992, to the Indian Health Service, the Department of Veterans Affairs, a State home receiving funds under section 1741 of title 38, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B) of this section (including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act);
- (II) any prices charged under the Federal Supply Schedule of the General Services Administration;
- (III) any prices used under a State pharmaceutical assistance program; and
- (IV) any depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government;
- (V) the prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under section 1860D-31; and
- (VI) any prices charged which are negotiated by a prescription drug plan under part D of title XVIII, by an MA-PD plan under part C of such title with respect to covered part D drugs or by a qualified retiree prescription drug plan (as defined in section 1860D-22(a)(2)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such title.

(ii) Special rules

The term “best price” -

(I) shall be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section);

(II) shall be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package; and

(III) shall not take into account prices that are merely nominal in amount.

(iii) Application of auditing and recordkeeping requirements

With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.

(2) Additional rebate for single source and innovator multiple source drugs

(A) In general

The amount of the rebate specified in this subsection for a rebate period, with respect to each dosage form and strength of a single source drug or an innovator multiple source drug, shall be increased by an amount equal to the product of -

(i) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the State Plan for the rebate period; and

(ii) the amount (if any) by which -

(I) the average manufacturer price for the dosage form and strength of the drug for the period, exceeds

(II) the average manufacturer price for such dosage form and strength for the calendar quarter beginning July 1, 1990 (without regard to whether or not the drug has been sold or transferred to an entity, including a division or subsidiary of the manufacturer, after the first day of such quarter), increased by the percentage by which the consumer price index for all urban consumers (United States city average) for the month before the month in which the rebate period begins exceeds such index for September 1990.

(B) Treatment of subsequently approved drugs

In the case of a covered outpatient drug approved by the Food and Drug Administration after October 1, 1990, clause (ii)(II) of subparagraph (A) shall be applied by substituting “the first full calendar quarter after the day on which the drug was first marketed” for “the calendar quarter beginning July 1, 1990” and “the month prior to the first month of the first full calendar quarter after the day on which the drug was first marketed” for “September 1990.”

(3) Rebate for other drugs

(A) In general

The amount of the rebate paid to a State for a rebate period with respect to each dosage form and strength of covered outpatient drugs (other than single source drugs and innovator multiple source drugs) shall be equal to the product of -

(i) the applicable percentage (as described in subparagraph (B)) of the average manufacturer price for the dosage form and strength for the rebate period, and

(ii) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the State Plan for the rebate period.

(B) “Applicable percentage” defined

For purposes of subparagraph (A)(i), the “applicable percentage” for rebate periods beginning-

(i) before January 1, 1994, is 10 percent, and

(ii) after December 31, 1993, is 11 percent.

(d) Limitations on coverage of drugs

(1) Permissible restrictions

(A) A State may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of paragraph (5).

(B) A State may exclude or otherwise restrict coverage of a covered outpatient drug if -

- (i) the prescribed use is not for a medically accepted indication (as defined in subsection (k)(6) of this section);
- (ii) the drug is contained in the list referred to in paragraph (2);
- (iii) the drug is subject to such restrictions pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) of this section or in effect pursuant to subsection (a)(4) of this section; or
- (iv) the State has excluded coverage of the drug from its formulary established in accordance with paragraph (4).

(2) List of drugs subject to restriction

The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

- (A) Agents when used for anorexia, weight loss, or weight gain.
- (B) Agents when used to promote fertility.
- (C) Agents when used for cosmetic purposes or hair growth.
- (D) Agents when used for the symptomatic relief of cough and colds.
- (E) Agents when used to promote smoking cessation.
- (F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- (G) Nonprescription drugs.
- (H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
- (I) Barbiturates.
- (J) Benzodiazepines.

(3) Update of drug listings

The Secretary shall, by regulation, periodically update the list of drugs or classes of drugs described in paragraph (2) or their medical uses, which the Secretary has determined, based on data collected by surveillance and utilization review programs of State medical assistance programs, to be subject to clinical abuse or inappropriate use.

(4) Requirements for formularies

A State may establish a formulary if the formulary meets the following requirements:

(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State (or, at the option of the State, the State's drug use review board established under subsection (g)(3) of this section).

(B) Except as provided in subparagraph (C), the formulary includes the covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under subsection (a) of this section (other than any drug excluded from coverage or otherwise restricted under paragraph (2)).

(C) A covered outpatient drug may be excluded with respect to the treatment of a specific disease or condition for an identified population (if any) only if, based on the drug's labeling

(or, in the case of a drug the prescribed use of which is not approved under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) but is a medically accepted indication, based on information from the appropriate compendia described in subsection (k)(6) of this section), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

(D) The State Plan permits coverage of a drug excluded from the formulary (other than any drug excluded from coverage or otherwise restricted under paragraph (2)) pursuant to a prior authorization program that is consistent with paragraph (5).

(E) The formulary meets such other requirements as the Secretary may impose in order to achieve program savings consistent with protecting the health of program beneficiaries. A prior authorization program established by a State under paragraph (5) is not a formulary subject to the requirements of this paragraph.

(5) Requirements of prior authorization programs

A State Plan under this subchapter may require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6) of this section) only if the system providing for such approval –

(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

(6) Other permissible restrictions

A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals in any manner authorized under this chapter.

(e) Treatment of pharmacy reimbursement limits

(1) In general

During the period beginning on January 1, 1991, and ending on December 31, 1994 –

(A) a State may not reduce the payment limits established by regulation under this subchapter or any limitation described in paragraph (3) with respect to the ingredient cost of a covered outpatient drug or the dispensing fee for such a drug below the limits in effect as of January 1, 1991, and

(B) except as provided in paragraph (2), the Secretary may not modify by regulation the formula established under sections 447.331 through 447.334 of title 42, Code of Federal Regulations, in effect on November 5, 1990, to reduce the limits described in subparagraph (A).

(2) Special rule

If a State is not in compliance with the regulations described in paragraph (1)(B), paragraph (1)(A) shall not apply to such State until such State is in compliance with such regulations.

(3) Effect on State maximum allowable cost limitations

This section shall not supersede or affect provisions in effect prior to January 1, 1991, or after December 31, 1994, relating to any maximum allowable cost limitation established by a State for payment by the State for covered outpatient drugs, and rebates shall be made under this section without regard to whether or not payment by the State for such drugs is subject to such a limitation or the amount of such a limitation.

(4) Establishment of upper payment limits

The Secretary shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

(f) Repealed and redesignated

(g) Drug use review

(1) In general

(A) In order to meet the requirement of section 1396b(i)(10)(B) of this title, a State shall provide, by not later than January 1, 1993, for a drug use review program described in paragraph (2) for covered outpatient drugs in order to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results. The program shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs including education on therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

(i) compendia which shall consist of the following:

(I) American Hospital Formulary Service Drug Information;

(II) United States Pharmacopeia-Drug Information; and

(III) the DRUGDex information System.

(ii) the peer-reviewed medical literature.

(C) The Secretary, under the procedures established in section 1396b of this title, shall pay to each State an amount equal to 75 per centum of so much of the sums expended by the State Plan during calendar years 1991 through 1993 as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of this subsection.

(D) States shall not be required to perform additional drug use reviews with respect to drugs dispensed to residents of nursing facilities which are in compliance with the drug regimen review procedures prescribed by the Secretary for such facilities in regulations implementing section 1396r of this title, currently at section 483.60 of title 42, Code of Federal Regulations.

(2) Description of program

Each drug use review program shall meet the following requirements for covered outpatient drugs:

(A) Prospective drug review

(i) The State plan shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this subchapter, typically at the point-of-sale or point of distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. Each State shall use the compendia and literature referred to in paragraph (1)(B) as its source of standards for such review.

(ii) As part of the State's prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this subchapter by pharmacists which includes at least the following:

(I) The pharmacist must offer to discuss with each individual receiving benefits under this subchapter or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist's professional judgment (consistent with State law respecting the provision of such information), the pharmacist deems significant including the following:

(aa) The name and description of the medication.

(bb) The route, dosage form, dosage, route of administration, and duration of drug therapy.

(cc) Special directions and precautions for preparation, administration and use by the patient.

(dd) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

(ee) Techniques for self-monitoring drug therapy.

(ff) Proper storage.

(gg) Prescription refill information.

(hh) Action to be taken in the event of a missed dose.

(II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this subchapter:

(aa) Name, address, telephone number, date of birth (or age) and gender.

(bb) Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

(cc) Pharmacist comments relevant to the individual's drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this subchapter or caregiver of such individual refuses such consultation.

(B) Retrospective drug use review

The program shall provide, through its mechanized drug claims processing and information retrieval systems (approved by the Secretary under section 1396b(r) of this title) or otherwise, for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits under this subchapter, or associated with specific drugs or groups of drugs.

(C) Application of standards

The program shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using the compendia and literature referred to in paragraph (1)(B) as the source of standards for such assessment) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care and to conserve program funds or personal expenditures.

(D) Educational program

The program shall, through its State drug use review board established under paragraph (3), either directly or through contracts with accredited health care educational institutions, State medical societies or State pharmacists associations/societies or other organizations as specified by the State, and using data provided by the State drug use review board on common drug therapy problems, provide for active and ongoing educational outreach programs (including the activities described in paragraph (3)(C)(iii) of this subsection) to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices.

(3) State drug use review board

(A) Establishment

Each State shall provide for the establishment of a drug use review board (hereinafter referred to as the "DUR Board") either directly or through a contract with a private organization.

(B) Membership

The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

- (i) The clinically appropriate prescribing of covered outpatient drugs.
- (ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs.
- (iii) Drug use review, evaluation, and intervention.
- (iv) Medical quality assurance.

The membership of the DUR Board shall be made up at least 1/3 but no more than 51 percent licensed and actively practicing physicians and at least 1/3 licensed and actively practicing pharmacists.

(C) Activities

The activities of the DUR Board shall include but not be limited to the following:

- (i) Retrospective DUR as defined in section.
- (ii) Application of standards as defined in paragraph (2)(C).
- (iii) Ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews performed under this subsection. Intervention programs shall include, in appropriate instances, at least:

- (I) information dissemination sufficient to ensure the ready availability to physicians and pharmacists in the State of information concerning its duties, powers, and basis for its standards;
- (II) written, oral, or electronic reminders containing patient-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;
- (III) use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted

for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions; and
(IV) intensified review or monitoring of selected prescribers or dispensers. The Board shall re-evaluate interventions after an appropriate period of time to determine if the intervention improved the quality of drug therapy, to evaluate the success of the interventions and make modifications as necessary.

(D) Annual report

Each State shall require the DUR Board to prepare a report on an annual basis. The State shall submit a report on an annual basis to the Secretary which shall include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The Secretary shall utilize such report in evaluating the effectiveness of each State's drug use review program.

(h) Electronic claims management

(1) In general

In accordance with chapter 35 of title 44 (relating to coordination of Federal information policy), the Secretary shall encourage each State agency to establish, as its principal means of processing claims for covered outpatient drugs under this subchapter, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

(2) Encouragement

In order to carry out paragraph (1) -

(A) for calendar quarters during fiscal years 1991 and 1992, expenditures under the State Plan attributable to development of a system described in paragraph (1) shall receive Federal financial participation under section 1396b(a)(3)(A)(i) of this title (at a matching rate of 90 percent) if the State acquires, through applicable competitive procurement process in the State, the most cost-effective telecommunications network and automatic data processing services and equipment; and

(B) the Secretary may permit, in the procurement described in subparagraph (A) in the application of part 433 of title 42, Code of Federal Regulations, and parts 95, 205, and 307 of title 45, Code of Federal Regulations, the substitution of the State's request for proposal in competitive procurement for advance planning and implementation documents otherwise required.

(i) Annual report

(1) In general

Not later than May 1 of each year the Secretary shall transmit to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives a report on the operation of this section in the preceding fiscal year.

(2) Details

Each report shall include information on –

- (A) ingredient costs paid under this subchapter for single source drugs, multiple source drugs, and nonprescription covered outpatient drugs;
- (B) the total value of rebates received and number of manufacturers providing such rebates;
- (C) how the size of such rebates compare with the size of rebates offered to other purchasers of covered outpatient drugs;
- (D) the effect of inflation on the value of rebates required under this section;
- (E) trends in prices paid under this subchapter for covered outpatient drugs; and
- (F) Federal and State administrative costs associated with compliance with the provisions of this subchapter.

(j) Exemption of organized health care settings

(1) Covered outpatient drugs dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1396b(m) of this title, are not subject to the requirements of this section.

(2) The State Plan shall provide that a hospital (providing medical assistance under such Plan) that dispenses covered outpatient drugs using drug formulary systems, and bills the Plan no more than the hospital's purchasing costs for covered outpatient drugs (as determined under the State Plan) shall not be subject to the requirements of this section.

(3) Nothing in this subsection shall be construed as providing that amounts for covered outpatient drugs paid by the institutions described in this subsection should not be taken into account for purposes of determining the best price as described in subsection (c) of this section.

(k) Definitions

In this section -

(1) Average manufacturer price

The term "average manufacturer price" means, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts.

(2) Covered outpatient drug

Subject to the exceptions in paragraph (3), the term "covered outpatient drug" means -

(A) of those drugs which are treated as prescribed drugs for purposes of section 1396d(a)(12) of this title, a drug which may be dispensed only upon prescription (except as provided in paragraph (5)), and -

(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357) or which is approved under section 505(j) of such Act (21 U.S.C. 355(j));

(ii) (I) which was commercially used or sold in the United States before October 10, 1962, or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a "new drug" (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p))) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act (21 U.S.C.

331, 332(a), 334(a)) to enforce section 502(f) or 505(a) of such Act (21 U.S.C. 352(f), 355(a)); or

(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(e)) on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling; and

(B) a biological product, other than a vaccine which -

(i) may only be dispensed upon prescription,

(ii) is licensed under section 262 of this title, and

(iii) is produced at an establishment licensed under such section to produce such product; and

(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356).

(3) Limiting definition

The term “covered outpatient drug” does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this subchapter as part of payment for the following and not as direct reimbursement for the drug):

(A) Inpatient hospital services.

(B) Hospice services.

(C) Dental services, except that drugs for which the State Plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

(D) Physicians’ services.

(E) Outpatient hospital services.

(F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded.

(G) Other laboratory and x-ray services.

(H) Renal dialysis.

Such term also does not include any such drug or product for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological used for a medical indication which is not a medically accepted indication. Any drug, biological product, or insulin excluded from the definition of such term as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (C)(1)(C) of this section) for such drug, biological product, or insulin.

(4) Nonprescription drugs

If a State Plan for medical assistance under this subchapter includes coverage of prescribed drugs as described in section 1396d(a)(12) of this title and permits coverage of drugs which may be sold

without a prescription (commonly referred to as “over-the-counter” drugs), if they are prescribed by a physician (or other person authorized to prescribe under State law), such a drug shall be regarded as a covered outpatient drug.

(5) Manufacturer

The term “manufacturer” means any entity which is engaged in -

(A) the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or

(B) in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

(6) Medically accepted indication

The term “medically accepted indication” means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in subsection (g)(1)(B)(i) of this section.

(7) Multiple source drug; innovator multiple source drug; noninnovator multiple source drug; single source drug

(A) Defined

(i) Multiple source drug

The term “multiple source drug” means, with respect to a rebate period, a covered outpatient drug (not including any drug described in paragraph (5)) for which there are 2 or more drug products which -

(I) are rated as therapeutically equivalent (under the Food and Drug Administration’s most recent publication of “Approved Drug Products with Therapeutic Equivalence Evaluations”),

(II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and

(III) are sold or marketed in the State during the period.

(ii) Innovator multiple source drug The term “innovator multiple source drug” means a multiple source drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(iii) Noninnovator multiple source drug

The term “noninnovator multiple source drug” means a multiple source drug that is not an innovator multiple source drug.

(iv) Single source drug

The term “single source drug” means a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

(B) Exception

Subparagraph (A)(i)(II) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (A)(i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C).

(C) Definitions

For purposes of this paragraph -

(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity;

So in original. Probably should be “pharmaceutically”.

(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence; and

(iii) a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State.

(8) Rebate period

The term “rebate period” means, with respect to an agreement under subsection (a) of this section, a calendar quarter or other period specified by the Secretary with respect to the payment of rebates under such agreement.

(9) State agency

The term “State agency” means the agency designated under section 1396a(a)(5) of this title to administer or supervise the administration of the State Plan for medical assistance.

***Appendix D:
Federal Upper Limits for
Multiple Source Products***

The following list of multiple source drugs meets the criteria set forth in 42 CFR 447.332 and §1927(e) of the Social Security Act, as amended by OBRA 1993. The development of the current Federal Upper Limit (FUL) listing has been accomplished by computer. Payments for multiple source drugs identified and listed in the accompanying addendum must not exceed, in the aggregate, payment levels determined by applying to each drug entity a reasonable dispensing fee (established by the State and specified in the State Plan), plus an amount based on the limit per unit which CMS has determined to be equal to a 150 percent applied to the lowest price listed (in package sizes of 100 units, unless otherwise noted) in any of the published compendia of cost information of drugs. Issued by CMS on November 20, 2001 the initial listing was based on data current as of April 2001 from the First Data Bank (Blue Book), Medi-Span, and the Red Book. The listing was revised to reflect additional changes (i.e., additions, deletions, pricing changes) through September 27, 2006. The list does not reference the commonly known brand names. However, the brand names are included in the FUL listing provided to the State agencies in electronic media format. The FUL price list is in pdf format at <http://www.cms.hhs.gov/FederalUpperLimits/Downloads/ChangesMadeToTransmittal37.pdf>.

In accordance with current policy, Federal financial participation will not be provided for any drug on the FUL listing for which the Food and Drug Administration (FDA) has issued a notice of an opportunity for a hearing as a result of the Drug Efficacy Study and Implementation (DESI) program and which has been found to be less than effective or is identical, related, or similar (IRS) to the DESI drug. The DESI drug is identified by the FDA or reported by the drug manufacturer for purposes of the Medicaid drug rebate program.

The November 20, 2001 list has been amended with all changes to be implemented no later than October 27, 2006 .

Generic Name	Upper Limit per Unit (Source)
Acebutolol Hydrochloride	
Eq 200 mg base, Capsule, Oral 100	\$0.3567 B
Eq 400 mg base, Capsule, Oral 100	0.5315 B
Acetaminophen; Butalbital; Caffeine	
500 mg; 50mg; 40 mg, Tablet, Oral 100	0.6870 B
Acetaminophen; Codeine Phosphate	
300 mg; 15 mg, Tablet, Oral 100	0.1500 R
300 mg; 30 mg, Tablet, Oral 100	0.2137 B
300 mg; 60 mg, Tablet, Oral 100	0.3833 B
Acetaminophen; Hydrocodone Bitartrate	
500 mg; 5 mg, Capsule, Oral 100	0.1943 B
500 mg /15 ml; 7.5 mg/15 ml Elixir, Oral 473 ml	0.0633 R
500 mg, 2.5 mg, Tablet, Oral 100	0.2190 B
500 mg; 5 mg, Tablet, Oral 100	0.0833 B
500 mg; 7.5 mg, Tablet, Oral 100	0.1739 B
500 mg; 10 mg, Tablet, Oral 100	0.4603 B
650 mg; 7.5 mg, Tablet, Oral 100	0.1410 B
650 mg; 10 mg, Tablet, Oral 100	0.1852 R
660 mg; 10 mg, Tablet, Oral 100	0.5284 B
750 mg; 7.5 mg, Tablet, Oral 100	0.1407 R

Generic Name	Upper Limit per Unit (Source)
Acetaminophen; Oxycodone Hydrochloride	
325 mg; 5 mg, Tablet, Oral 100	0.1493 B
500 mg; 5 mg, Capsule, Oral 100	0.2248 B
650 mg; 10 mg, Tablet, Oral, 100	1.4187 R
Acetaminophen; Propoxyphene Hydrochloride	
650 mg; 65 mg, Tablet, Oral 100	0.1090 B
Acetaminophen; Propoxyphene Napsylate	
650 mg; 100 mg, Tablet, Oral 100	0.1800 R
Acetylcysteine	
10%, Solution, Inhalation, Oral, 10 ml	0.9780 B
Acyclovir	
200 mg, Capsule, Oral 100	0.1478 B
400 mg, Tablet, Oral 100	0.2334 B
800 mg, Tablet, Oral 100	0.4667 B
Albuterol Sulfate	
Eq 0.083% base, Solution, Inhalation 3ml	0.1150 B
Eq 0.5% base, Solution, Inhalation 20 ml	0.2333 B
4 mg, Tablet, Oral 100	0.1425 B
Alclometasone Dipropionate	
0.05%, Cream, Topical, 45 gm	0.8283 B
0.05%, Ointment, Topical, 45 gm	0.8283 B
Allopurinol	
100 mg, Tablet, Oral 100	0.0784 B
300 mg, Tablet, Oral 100	0.1013 B
Alprazolam	
0.25 mg, Tablet, Oral 100	0.0614 R
0.5 mg, Tablet, Oral 100	0.0698 B
0.5 mg, Tablet, Extended Release, Oral 60	1.9343 B
1 mg, Tablet, Oral 100	0.0885 B
1 mg, Tablet, Extended Release, Oral 60	2.4065 B
2 mg, Tablet, Oral 100	0.1745 R
2 mg, Tablet, Extended Release, Oral 60	3.1940 B
3 mg, Tablet, Extended Release, Oral 60	4.7907 B
Amantadine Hydrochloride	
50 mg/5 ml, Syrup, Oral 480 ml	0.0656 M
Amiloride Hydrochloride; Hydrochlorothiazide	
Eq 5 mg Anhydrous; 50 mg, Tablet, Oral 100	0.0675 B

Generic Name	Upper Limit per Unit (Source)
Amiodarone Hydrochloride 200 mg, Tablet, Oral 60	1.6875 B
Amitriptyline Hydrochloride 10 mg, Tablet, Oral 100	0.0608 B
25 mg, Tablet, Oral 100	0.0653 B
50 mg, Tablet, Oral 100	0.0666 B
75 mg, Tablet, Oral 100	0.1425 B
100 mg, Tablet, Oral 100	0.1500 R
150 mg, Tablet, Oral 100	0.2430 B
Amoxicillin 250 mg, Capsule, Oral 100	0.0675 B
500 mg, Capsule, Oral 100	0.1302 R
125 mg/5 ml, Powder for Reconstitution, Oral 150	0.0194 B
250 mg/5 ml, Powder for Reconstitution, Oral 100	0.0281 B
Amoxicillin; Clavulanic Acid 200 mg/5 ml; 28.5 mg/5 ml, Powder for Reconstitution, Oral, 100	0.2850 B
400 mg/5 ml; 57 mg/5 ml, Powder for Reconstitution, Oral, 100	0.5347 B
Ampicillin/Ampicillin Trihydrate 250 mg, Capsule, Oral 100	0.1736 B
500 mg, Capsule, Oral 100	0.2991 B
Anagrelide Hydrochloride 0.5 mg, Capsule, Oral, 100	0.4395 B
1 mg, Capsule, Oral, 100	0.8790 B
Aspirin; Butalbital; Caffeine 325 mg; 50 mg; 40 mg, Tablet, Oral 100	0.2400 R
Aspirin; Carisoprodol 325 mg; 200 mg, Tablet, Oral 100	0.2708 B
Atenolol 25 mg, Tablet, Oral 100	0.0975 B
50 mg, Tablet, Oral 100	0.1058 B
100 mg, Tablet, Oral 100	0.1943 B
Atenolol; Chlorthalidone 50 mg; 25 mg, Tablet, Oral 100	0.1762 B
100 mg; 25 mg, Tablet, Oral 100	0.2549 B
Atropine Sulfate; Diphenoxylate Hydrochloride 0.025 mg; 2.5 mg, Tablet, Oral 100	0.1088 B

Generic Name	Upper Limit per Unit (Source)
Baclofen	
10 mg, Tablet, Oral, 100	0.4492 B
20 mg, Tablet, Oral, 100	0.8438 B
Benazepril Hydrochloride	
5 mg, Tablet, Oral, 100	0.4905 R
10 mg, Tablet, Oral, 100	0.4905 R
20 mg, Tablet, Oral, 100	0.4905 R
40 mg, Tablet, Oral, 100	0.4905 R
Benazepril Hydrochloride; Hydrochlorothiazide	
5 mg; 6.25 mg, Tablet, Oral, 100	0.4958 B
10 mg; 12.5 mg, Tablet, Oral, 100	0.4958 B
20 mg; 12.5 mg, Tablet, Oral, 100	0.4958 B
20 mg; 25 mg, Tablet, Oral, 100	0.4958 B
Benzonatate	
100 mg, Capsule, Oral 100	0.4387 B
Benztropine Mesylate	
0.5 mg, Tablet, Oral 100	0.1227 B
1 mg, Tablet, Oral 100	0.1502 B
2 mg, Tablet, Oral 100	0.1930 B
Betamethasone Dipropionate	
Eq 0.05% base, Cream, Topical 15 gm	0.2330 B
Eq 0.05% base, Lotion, Topical 60 ml	0.1500 B
Betamethasone Dipropionate; Clotrimazole	
0.05%; 1%, Cream, Topical, 15 gm	1.4820 B
0.05%; 1%, Lotion, Topical, 30 gm	1.8115 B
Betamethasone Valerate	
Eq 0.1% base, Cream, Topical 45 gm	0.1197 B
Bethanechol Chloride	
5 mg, Tablet, Oral, 100	0.4889 R
10 mg, Tablet, Oral, 100	0.9171 R
25 mg, Tablet, Oral, 100	1.7079 R
50 mg, Tablet, Oral, 100	1.9565 R
Bisoprolol Fumarate; Hydrochlorothiazide	
2.5 mg; 6.25 mg, Tablet, Oral 100	1.0260 B
5 mg; 6.25 mg, Tablet, Oral 100	1.0260 B
10 mg; 6.25 mg, Tablet, Oral 100	0.8250 B
Brimonidine Tartrate	
0.2%, Solution/Drops, Ophthalmic, 5 ml	4.5000 B

Generic Name	Upper Limit per Unit (Source)
Brompheniramine Maleate/Dextromethorphan Hydrobromide/ Pseudoephedrine Hydrochloride 2 mg/10 mg/30 mg per 5 ml, Syrup, Oral, 480 ml	0.0387 B
Bumetanide 0.5 mg, Tablet, Oral 100 1 mg, Tablet, Oral 100 2 mg, Tablet, Oral 100	0.1743 B 0.2814 B 0.4708 B
Buspirone Hydrochloride 5 mg, Tablet, Oral 100 10 mg, Tablet, Oral 100 15 mg, Tablet, Oral 60	0.2964 B 0.3942 B 0.4470 B
Captopril 12.5 mg, Tablet, Oral 100 50 mg, Tablet, Oral, 100 100 mg, Tablet, Oral 100	0.0232 B 0.0390 B 0.1080 B
Captopril; Hydrochlorothiazide 25 mg; 15 mg, Tablet, Oral 100 50 mg; 25 mg, Tablet, Oral 100	0.2360 B 0.3702 B
Carbamazepine 100 mg, Tablet, Chewable, Oral, 100 200 mg, Tablet, Oral 100	0.1965 R 0.1500 R
Carbidopa; Levodopa 10 mg; 100 mg, Tablet, Oral 100 25 mg; 100 mg, Tablet, Oral 100 25 mg; 250 mg, Tablet, Oral 100	0.3644 B 0.4455 B 0.5145 B
Carisoprodol 350 mg, Tablet, Oral 100	0.3743 B
Carteolol Hydrochloride 1%, Solution/Drops, Ophthalmic 10 ml	3.6775 R
Cefadroxil/Cefadroxil Hemihydrate Eq 500 mg base, Capsule, Oral 50	2.4837 B
Cefprozil 125 mg/5 ml, Suspension, Oral, 100 250 mg/5ml, Suspension, Oral, 100	0.4080 B 0.7394 B
Cefuroxime Axetil 250 mg, Tablet, Oral, 20 500 mg, Tablet, Oral, 20	2.5425 B 4.7475 B

Generic Name	Upper Limit per Unit (Source)
Cephalexin	
Eq 250 mg base, Capsule, Oral 100	0.1835 R
Eq 500 mg base, Capsule, Oral 100	0.3641 R
Chlordiazepoxide Hydrochloride	
5 mg, Capsule, Oral 100	0.1140 B
10 mg, Capsule, Oral 100	0.0877 B
Chlorhexidine Gluconate	
0.12%, Solution, Dental 480 ml	0.0109 B
Chlorpropamide	
100 mg, Tablet, Oral 100	0.2325 B
250 mg, Tablet, Oral 100	0.4917 B
Chlorzoxazone	
500 mg, Tablet, Oral 100	0.0757 B
Cholestyramine	
Eq 4 gm Resin/Packet, Powder, Oral 60	1.2767 B
Ciclopirox	
0.77%, Cream, Topical, 30 gm	1.6610 B
Cilostazol	
50 mg, Tablet, Oral, 60	1.7790 B
100 mg, Tablet, Oral 60	1.0388 B
Cimetidine	
200 mg, Tablet, Oral 100	0.1313 B
300 mg, Tablet, Oral 100	0.1313 B
400 mg, Tablet, Oral 100	0.1071 R
800 mg, Tablet, Oral 100	0.2775 B
Cimetidine Hydrochloride	
Eq 300 mg base/ 5 ml Solution, Oral , 240 ml	0.1139 B
Ciprofloxacin Hydrochloride	
0.3%, Solution/Drops, Ophthalmic, 5ml	7.5690 B
250 mg, Tablet, Oral, 100	0.3750 B
500 mg, Tablet, Oral, 100	0.4500 B
750 mg, Tablet, Oral, 100	0.4800 B
Citalopram Hydrobromide	
EQ 10 mg Base/5 ml, Solution, Oral, 240 ml	0.4231 B
10 mg, Tablet, Oral, 100	0.2963 B
20 mg, Tablet, Oral, 100	0.3090 B
40 mg, Tablet, Oral, 100	0.3224 B

Generic Name	Upper Limit per Unit (Source)
Clarithromycin	
250 mg, Tablet, Oral, 60	2.3725 B
500 mg, Tablet, Oral, 60	2.3725 B
Clindamycin Hydrochloride	
Eq 150 mg base, Capsule, Oral 100	0.9180 R
Clindamycin Phosphate	
Eq 1%, Base, Lotion, Topical, 60 ml	0.7988 B
Eq 1% Base, Solution, Topical 60 ml	0.2060 R
1%, Swab, Topical, 60	0.6300 B
Clobetasol Propionate	
0.05%, Cream, Topical 30 gm	0.8315 B
Clomiphene Citrate	
50 mg, Tablet, Oral, 30	3.5500 B
Clomipramine Hydrochloride	
25 mg, Capsule, Oral 100	0.3322 R
50 mg, Capsule, Oral 100	0.5138 B
75 mg, Capsule, Oral 100	0.6623 B
Clonazepam	
0.5 mg, Tablet, Oral 100	0.2455 B
1 mg, Tablet, Oral 100	0.2852 B
2 mg, Tablet, Oral 100	0.3903 B
Clonidine Hydrochloride	
0.1 mg, Tablet, Oral 100	0.0968 B
0.2 mg, Tablet, Oral 100	0.1350 B
0.3 mg, Tablet, Oral 100	0.1830 B
Clorazepate Dipotassium	
3.75 mg, Tablet, Oral 100	0.8350 B
7.5 mg, Tablet, Oral 100	1.0388 B
15 mg, Tablet, Oral 100	1.4094 B
Clotrimazole	
1%, Solution, Topical, 10 ml	0.4725 B
Cromolyn Sodium	
4%, Solution/ Drops, Ophthalmic 10 ml	3.3750 B
Cyclobenzaprine Hydrochloride	
5 mg, Tablet, Oral, 100	0.2475 R
10 mg, Tablet, Oral 100	0.1302 B

Generic Name	Upper Limit per Unit (Source)
Demeclocycline Hydrochloride	
150 mg, Tablet, Oral, 100	9.4950 B
300 mg, Tablet, Oral, 48	17.1875 B
Desipramine Hydrochloride	
25 mg, Tablet, Oral, 100	0.2835 B
50 mg, Tablet, Oral, 100	0.5339 B
75 mg, Tablet, Oral, 100	1.0304 B
100 mg, Tablet, Oral, 100	1.3539 B
150 mg, Tablet, Oral, 50	1.9617 B
Desonide	
0.05%, Ointment, Topical 60 gm	0.4077 B
0.05%, Cream, Topical 100	0.2337 B
Dexamethasone; Neomycin Sulfate; Polymyxin B Sulfate	
0.1%; Eq 3.5 mg base/gm; 10,000 units/gm, Ointment, Ophthalmic 3 gm	1.0714 B
Dextroamphetamine Sulfate	
10 mg, Tablet, Oral, 100	0.3435 B
Diazepam	
2 mg, Tablet, Oral 100	0.0423 B
5 mg, Tablet, Oral 100	0.0718 B
10 mg, Tablet, Oral 100	0.0573 B
Diclofenac Potassium	
50 mg, Tablet, Oral 100	0.8625 B
Diclofenac Sodium	
50 mg, Tablet, Delayed Release, Oral 100	0.4748 R
75 mg, Tablet, Delayed Release, Oral 100	0.5850 R
Dicyclomine Hydrochloride	
10 mg, Capsule, Oral 100	0.1222 B
20 mg, Tablet, Oral 100	0.1185 B
Digoxin	
0.125 mg, Tablet, Oral, 100	0.2132 B
Diltiazem Hydrochloride	
30 mg, Tablet, Oral 100	0.1019 B
60 mg, Tablet, Oral 100	0.1114 B
90 mg, Tablet, Oral 100	0.2312 B
120 mg, Tablet, Oral 100	0.2331 B
Diphenhydramine Hydrochloride	
12.5 mg/5 ml, Elixir, Oral 120 ml	0.0137 B

Generic Name	Upper Limit per Unit (Source)
Dipivefrin Hydrochloride 0.1%, Solution/Drops, Ophthalmic 5 ml	0.8700 B
Doxazosin Mesylate 1 mg, Tablet, Oral 100	0.5918 B
2 mg, Tablet, Oral 100	0.5918 B
4 mg, Tablet, Oral 100	0.6210 B
8 mg, Tablet, Oral 100	0.6518 B
Doxepin Hydrochloride Eq 10 mg base, Capsule, Oral 100	0.0891 R
Eq 25 mg base, Capsule, Oral 100	0.1822 B
Eq 50 mg base, Capsule, Oral 100	0.1447 R
Eq 75 mg base, Capsule, Oral 100	0.2052 R
Eq 100 mg base, Capsule, Oral 100	0.4174 B
Eq 10 mg base/ml, Concentrate, Oral 120 ml	0.1145 R
Doxycycline Hyclate Eq 50 mg base, Capsule, Oral 50	0.1317 B
Eq 100 mg base, Capsule, Oral 50	0.1491 B
Eq 100 mg base, Tablet, Oral 50	0.1287 B
Doxycycline Hydrochloride Eq 50 mg base, Capsule, Oral 50	0.0945 R
Eq 100 mg base, Capsule, Oral 50	0.1215 R
Enalapril Maleate 2.5 mg, Tablet, Oral, 100	0.4334 B
5 mg, Tablet, Oral, 100	0.5490 B
10 mg, Tablet, Oral, 100	0.6863 B
20 mg, Tablet, Oral, 100	0.9150 B
Erythromycin 2%, Solution, Topical 60 ml	0.0687 B
2%, Gel, Topical, 30 gm	0.6250 B
0.5%, Ointment, Ophthalmic, 3 gm	1.0714 B
Estazolam 1 mg, Tablet, Oral 100	0.5925 R
2 mg, Tablet, Oral 100	0.6449 R
Estradiol 0.5 mg, Tablet, Oral 100	0.1791 B
1 mg, Tablet, Oral 100	0.2175 B
2 mg, Tablet, Oral 100	0.3060 B

Generic Name	Upper Limit per Unit (Source)
Estropipate	
0.75 mg, Tablet, Oral 100	0.2754 B
1.5 mg, Tablet, Oral 100	0.3450 B
3 mg, Tablet, Oral 100	0.8622 B
Ethinyl Estradiol; Norgestimate	
0.035 mg; 0.25 mg, Tablet, Oral, 28	1.1637 B
Etodolac	
200 mg, Capsule, Oral 100	0.5850 B
400 mg, Tablet, Oral 100	0.3923 R
500 mg, Tablet, Oral 100	0.7500 R
Famotidine	
20 mg, Tablet, Oral 100	0.1500 B
40 mg, Tablet, Oral 100	0.3000 B
Fenoprofen Calcium	
Eq 600 mg base, Tablet, Oral 100	0.2400 R
Flecainide Acetate	
50 mg, Tablet, Oral, 100	0.8610 B
100 mg, Tablet, Oral, 100	1.4070 B
150 mg, Tablet, Oral, 100	1.9328 B
Fluconazole	
50 mg, Tablet, Oral, 30	0.5000 B
100 mg, Tablet, Oral, 30	0.8825 B
200 mg, Tablet, Oral, 30	1.4075 B
Fluocinonide	
0.05%, Cream, Topical 60 gm	0.0790 R
0.05%, Gel, Topical 60 gm	0.4965 R
0.05%, Solution, Topical 60 ml	0.2483 R
Fluocinonide Emulsified Base (Fluocinonide-E)	
0.05%, Cream, Topical, 60 gm	0.2453 R
Fluoxetine Hydrochloride	
10 mg, Capsule, Oral 100	0.5850 B
20 mg, Capsule, Oral 100	0.2520 B
40 mg Capsule, Oral 30	4.0125 B
20 mg/5ml, Solution, Oral 120 ml	0.7500 R
10 mg, Tablets, Oral 30	0.6000 B
Fluphenazine Hydrochloride	
1 mg, Tablet, Oral 100	0.2273 B
2.5 mg, Tablet, Oral 100	0.2775 B
5 mg, Tablet, Oral 100	0.3546 B
10 mg, Tablet, Oral 100	0.5099 R

Generic Name	Upper Limit per Unit (Source)
Flurazepam Hydrochloride	
15 mg, Capsule, Oral 100	0.0975 B
30 mg, Capsule, Oral 100	0.1148 B
Flurbiprofen	
100 mg, Tablet, Oral 100	0.2438 B
Flurbiprofen Sodium	
0.03%, Solution/Drops, Ophthalmic 2ml	4.0679 B
Fluticasone Propionate	
0.005%, Ointment, Topical, 30 gm	1.1110 B
0.05% Cream, Topical, 30 gm	1.1110 B
Folic Acid	
1 mg, Tablet, Oral, 100	0.2858 B
Furosemide	
10 mg/ml, Solution, Oral 60 ml	0.1300 B
20 mg, Tablet, Oral 100	0.0563 B
40 mg, Tablet, Oral 100	0.0599 B
80 mg, Tablet, Oral 100	0.1043 B
Gabapentin	
100 mg, Capsule, Oral, 100	0.5234 B
300 mg, Capsule, Oral, 100	1.3083 B
400 mg, Capsule, Oral, 100	1.5696 B
600 mg, Tablet, Oral, 100	2.4704 B
800 mg, Tablet, Oral, 100	2.9586 B
Gemfibrozil	
600 mg, Tablet, Oral 500	0.3800 B
Gentamicin Sulfate	
Eq 0.1% Base, Cream, Topical, 15 gm	0.2000 B
Eq 0.1% Base, Ointment, Topical, 15 gm	0.2000 B
Eq 0.3% Base, Solution/Drops, Ophthalmic 5 ml	0.5700 B
Glimepiride	
1 mg, Tablet, Oral, 100	0.1341 B
2 mg, Tablet, Oral, 100	0.2174 B
4 mg, Tablet, Oral, 100	0.4100 B
Glipizide	
5 mg, Tablet, Oral 100	0.0699 B
10 mg, Tablet, Oral 100	0.1192 B

Generic Name	Upper Limit per Unit (Source)
Glyburide	
1.25 mg, Tablet, Oral 100	0.1244 R
1.5 mg, Tablet, Oral 100	0.1875 R
2.5 mg, Tablet, Oral 100	0.1893 R
3 mg, Tablet, Oral 100	0.2175 R
5 mg, Tablet, Oral 100	0.2831 R
Glyburide; Metformin Hydrochloride	
1.25mg; 250 mg, Tablet, Oral, 100	0.8405 B
2.5 mg; 500 mg, Tablet, Oral, 100	1.0026 B
5 mg; 500 mg, Tablet, Oral, 100	1.0026 B
Gramicidin; Neomycin Sulfate; Polymyxin B Sulfate	
0.025 mg/ml; Eq 1.75 mg base/ml; 10,000 units/ml Solution/Drops, Ophthalmic 10 ml	2.0250 B
Guanfacine Hydrochloride	
Eq 1 mg base, Tablet, Oral 100	0.5250 B
Eq 2 mg base, Tablet, Oral 100	0.7200 B
Halobetasol Propionate	
0.05%, Ointment, Topical, 50 gm	1.4766 B
0.05%, Cream, Topical, 50 gm	1.4766 B
Haloperidol Lactate	
Eq 2 mg base/ml, Concentrate, Oral 120 ml	0.1369 B
Hydrochlorothiazide	
25 mg, Tablet, Oral, 1000	0.0577 R
50 mg, Tablet, Oral, 1000	0.1019 R
Hydrochlorothiazide; Propranolol Hydrochloride	
25 mg; 40 mg, Tablet, Oral 100	0.0877 B
25 mg; 80 mg, Tablet, Oral 100	0.1320 B
Hydrochlorothiazide; Spironolactone	
25 mg; 25 mg, Tablet, Oral 100	0.3463 B
Hydrochlorothiazide; Triamterene	
25 mg; 37.5 mg, Capsule, Oral 100	0.3177 B
25 mg; 37.5 mg, Tablet, Oral 100	0.1683 R
50 mg; 75 mg, Tablet, Oral 100	0.0488 B
Hydrocortisone	
0.5%, Cream, Topical, 30 gm	0.0510 M
1%, Cream, Topical 30 gm	0.0572 B
2.5%, Cream, Topical 30 gm	0.1820 B
1%, Lotion, Topical 120 ml	0.0572 B
2.5%, Lotion, Topical 59 ml	0.6814 B

Generic Name	Upper Limit per Unit (Source)
Hydrocortisone Valerate	
0.2%, Cream, Topical, 45 gm	0.6583 B
0.2%, Ointment, Topical 45 gm	0.6583 R
Hydroxychloroquine Sulfate	
200 mg, Tablet, Oral 100	0.8535 B
Hydroxyzine Hydrochloride	
10 mg/5 ml, Syrup, Oral 480 ml	0.0159 B
10 mg, Tablet, Oral 100	0.4865 R
25 mg, Tablet, Oral 100	0.6744 B
50 mg, Tablet, Oral 100	0.8222 B
Hydroxyzine Pamoate	
Eq 25 mg HCL, Capsule, Oral 100	0.1150 B
Eq 50 mg HCL, Capsule, Oral 100	0.1572 B
Ibuprofen	
400 mg, Tablet, Oral 100	0.0493 B
600 mg, Tablet, Oral 100	0.0573 B
800 mg, Tablet, Oral 100	0.0590 B
Imipramine Hydrochloride	
10 mg, Tablet, Oral 100	0.2643 B
25 mg, Tablet, Oral 100	0.3551 B
50 mg, Tablet, Oral 100	0.4604 B
Indapamide	
1.25 mg, Tablet, Oral 100	0.1035 B
2.5 mg, Tablet, Oral 100	0.1125 B
Ipratropium Bromide	
0.02%, Solution for Inhalation, 2.500 ml, 25s	0.1080 R
Isoniazid	
100 mg, Tablet, Oral, 100	0.0561 B
300 mg, Tablet, Oral 100	0.0890 B
Isosorbide Dinitrate	
5 mg, Tablet, Oral 100	0.0217 R
10 mg, Tablet, Oral 100	0.0228 R
20 mg, Tablet, Oral 100	0.0558 B
Isosorbide Mononitrate	
10 mg, Tablet, Oral 100	0.6110 R
20 mg, Tablet, Oral 100	0.4950 B
60 mg, Tablet, Extended Release, Oral 100	0.2025 B

Generic Name	Upper Limit per Unit (Source)
Ketoconazole 200 mg, Tablet, Oral 100	2.2500 R
Ketorolac Tromethamine 10 mg, Tablet, Oral 100	0.6773 M
Labetalol Hydrochloride 100 mg, Tablet, Oral 100	0.2157 B
200 mg, Tablet, Oral 100	0.3582 B
300 mg, Tablet, Oral 100	0.5363 B
Lactulose 10 gm/15 ml, Solution, Oral 480 ml	0.0219 B
Leflunomide 10 mg, Tablet, Oral, 30	2.5000 R
20 mg, Tablet, Oral, 30	2.5000 R
Levobunolol Hydrochloride 0.25%, Solution/Drops, Ophthalmic 10 ml	1.2749 B
0.5%, Solution/Drops, Ophthalmic 10 ml	1.4925 B
Levothyroxine Sodium 0.025 mg, Tablet, Oral, 100	0.2318 B
0.05 mg, Tablet, Oral, 100	0.2633 B
0.075 mg, Tablet, Oral, 100	0.2910 B
0.088 mg, Tablet, Oral, 100	0.2955 B
0.1 mg, Tablet, Oral, 100	0.2985 B
0.112 mg, Tablet, Oral, 100	0.3443 B
0.125 mg, Tablet, Oral, 100	0.3495 B
0.15 mg, Tablet, Oral, 100	0.3600 B
0.175 mg, Tablet, Oral, 100	0.4275 B
0.2 mg, Tablet, Oral, 100	0.4418 B
0.3 mg, Tablet, Oral, 100	0.6023 B
Lidocaine Hydrochloride 2%, Solution, Oral 100 ml	0.0315 R
Lisinopril 2.5 mg, Tablet, Oral, 100	0.3855 B
5 mg, Tablet, Oral, 100	0.5783 B
10 mg, Tablet, Oral, 100	0.5970 B
20 mg, Tablet, Oral, 100	0.6390 B
30 mg, Tablet, Oral, 100	0.9038 B
40 mg, Tablet, Oral, 100	0.9345 B

Generic Name	Upper Limit per Unit (Source)
Lisinopril ; Hydrochlorothiazide	
10 mg ; 12.5 mg, Tablet, Oral, 100	0.6450 B
20 mg ; 12.5 mg, Tablet, Oral, 100	0.6983 B
20 mg ; 25 mg, Tablet, Oral, 100	0.7065 B
Lithium Carbonate	
300 mg, Capsule, Oral, 1000	0.1382 B
Lorazepam	
0.5 mg, Tablet, Oral 100	0.4350 B
1 mg, Tablet, Oral 100	0.5718 B
2 mg, Tablet, Oral 100	0.8483 B
Lovastatin	
10 mg, Tablet, Oral 60	0.7487 B
20 mg, Tablet, Oral 60	1.2488 B
40 mg, Tablet, Oral 60	3.2012 B
Meclizine Hydrochloride	
12.5 mg, Tablet, Oral 100	0.0599 B
25 mg, Tablet, Oral 100	0.0420 B
Medroxyprogesterone Acetate	
2.5 mg, Tablet, Oral 100	0.2025 B
5 mg, Tablet, Oral 100	0.3061 B
10 mg, Tablet, Oral 100	0.3787 B
Megestrol Acetate	
20 mg, Tablet, Oral 100	0.3489 B
40 mg, Tablet, Oral 100	0.6755 B
Meloxicam	
7.5 mg, Tablet, Oral, 100	0.2100 B
15 mg, Tablet, Oral, 100	0.2850 B
Meperidine Hydrochloride	
50 mg, Tablet, Oral 100	0.5370 B
100 mg, Tablet, Oral 100	1.0347 B
Metformin Hydrochloride	
500 mg, Tablet, Oral 100	0.3557 B
750 mg, Tablet, Oral, 100	1.1498 B
850 mg, Tablet, Oral 100	0.3863 B
1000 mg, Tablet, Oral, 100	0.4597 B

Generic Name	Upper Limit per Unit (Source)
Methazolamide	
25 mg, Tablet, Oral 100	0.3150 R
50 mg, Tablet, Oral 100	0.4650 R
Methenamine Mandelate	
1 gm, Tablet, Oral 100	0.2923 B
Methimazole	
5 mg, Tablet, Oral 100	0.4212 R
10 mg, Tablet, Oral 100	0.7176 R
Methocarbamol	
500 mg, Tablet, Oral 100	0.1463 B
750 mg, Tablet, Oral 100	0.1792 B
Methotrexate Sodium	
Eq 2.5 mg base, Tablet, Oral 100	1.2637 B
Methylphenidate Hydrochloride	
5 mg, Tablet, Oral 100	0.3020 B
10 mg, Tablet, Oral 100	0.4224 B
20 mg, Tablet, Oral 100	0.6180 B
Methylprednisolone	
4 mg, Tablet, Oral 100	0.2849 B
Metoclopramide	
10 mg, Tablet, Oral 100	0.1095 B
Metoclopramide Hydrochloride	
Eq 5 mg base/5 ml, Solution, Oral 480 ml	0.0155 B
Eq 5 mg base, Tablet, Oral 100	0.1842 B
Eq 10 mg base, Tablet, Oral 100	0.1089 B
Metoprolol Tartrate	
25 mg, Tablet, Oral 100	0.0720 B
50 mg, Tablet, Oral 100	0.0500 B
100 mg, Tablet, Oral 100	0.0690 B
Metronidazole	
0.75%, Cream, Topical, 45 gm	1.6263 B
250 mg, Tablet, Oral 100	0.0849 B
500 mg, Tablet, Oral 100	0.2184 B
Mexiletine Hydrochloride	
200 mg, Capsule, Oral 100	0.9712 R

Generic Name	Upper Limit per Unit (Source)
Minocycline Hydrochloride	
Eq 50 mg base, Capsule, Oral 100	0.9000 B
Eq 100 mg base, Capsule, Oral 50	1.8000 B
75 mg, Capsule, Oral, 100	1.9575 R
Minoxidil	
2.5 mg, Tablet, Oral 100	0.3170 B
10 mg, Tablet, Oral 100	0.6965 B
Mirtazapine	
15 mg, Tablet, Oral, 30	1.6300 B
30 mg, Tablet, Oral, 30	1.6775 B
45 mg, Tablet, Oral, 30	1.7100 B
Mometasone Furoate	
0.1%, Cream, Topical, 45 gm	0.7333 B
0.1%, Ointment, Topical, 45 gm	0.9333 B
Mupirocin	
2%, Ointment, Topical, 22 gm	1.8839 B
Nadolol	
20 mg, Tablet, Oral 100	0.4650 B
40 mg, Tablet, Oral 100	0.4289 B
80 mg, Tablet, Oral 100	0.8025 B
Naltrexone Sodium	
50 mg, Tablet, Oral 100	4.0400 B
Naphazoline Hydrochloride	
0.1%, Solution/Drops, Ophthalmic 15 ml	0.3140 R
Naproxen	
250 mg, Tablet, Oral 100	0.1044 R
375 mg, Tablet, Oral 100	0.1383 R
500 mg, Tablet, Oral 100	0.1805 B
Niacin	
500 mg, Tablet, Oral 100	0.0390 B
Nicardipine Hydrochloride	
20 mg, Capsule, Oral 100	0.3375 B
30 mg, Capsule, Oral 100	0.4050 B
Nizatidine	
150 mg, Capsule, Oral, 60	1.8307 B
300 mg, Capsule, Oral, 30	3.6615 B

Generic Name	Upper Limit per Unit (Source)
Nortriptyline Hydrochloride	
Eq 10 mg base, Capsule, Oral 100	0.1019 B
Eq 25 mg base, Capsule, Oral 100	0.1406 B
Eq 50 mg base, Capsule, Oral 100	0.1722 B
Eq 75 mg base, Capsule, Oral 100	0.2203 B
Nystatin	
100,000 units/gm, Cream, Topical 30 gm	0.0755 B
100,000 units/gm, Ointment, Topical 15 gm	0.1019 B
100,000 Units/Gram, Powder, Topical, 15 gm	1.7480 B
Nystatin; Triamcinolone Acetonide	
100,000 units/gm; 0.1%, Cream, Topical 30 gm	0.0975 B
Ofloxacin	
0.3%, Solution/Drops, Ophthalmic, 5 ml	6.7470 B
Omeprazole	
10 mg, Capsule, Delayed Release Pellets, Oral 100	3.5463 B
20 mg, Capsule, Delayed Release Pellets, Oral 100	3.9790 B
Oxaprozin	
600 mg, Tablet, Oral 100	0.6758 B
Oxazepam	
10 mg, Capsule, Oral 100	0.5363 B
15 mg, Capsule, Oral 100	0.5709 B
30 mg, Capsule, Oral 100	1.2337 R
Oxybutynin Chloride	
5 mg/5 ml, Syrup, Oral, 473 ml	0.0825 R
5 mg, Tablet, Oral 100	0.1260 R
Oxycodone Hydrochloride	
5 mg, Capsule, Oral, 100	0.2138 B
20 mg/ml, Concentrate, Oral, 30 ml	0.9500 B
5 mg, Tablet, Oral, 100	0.2399 B
15 mg, Tablet, Oral, 100	0.6695 M
30 mg, Tablet, Oral, 100	1.3094 M
10 mg, Tablet, Extended Release, Oral, 100	0.9610 B
20 mg, Tablet, Extended Release, Oral, 100	1.8374 B
40 mg, Tablet, Extended Release, Oral, 100	3.2601 B
80 mg, Tablet, Extended Release, Oral, 100	6.1175 B
Paroxetine Hydrochloride	
10 mg, Tablet, Oral, 30	2.4300 R
20 mg, Tablet, Oral, 30	2.5200 R
30 mg, Tablet, Oral, 30	2.6100 R
40 mg, Tablet, Oral, 30	2.7000 R

Generic Name	Upper Limit per Unit (Source)
Penicillin V Potassium	
250 mg, Tablet, Oral, 100	0.2112 B
500 mg, Tablet, Oral, 100	0.3590 B
Pentoxifylline	
400 mg, Tablet, Extended Release, Oral 100	0.3147 B
Perphenazine	
2 mg, Tablet, Oral 100	0.3473 R
16 mg, Tablet, Oral 100	1.3833 B
Phenytoin	
125 mg/5 ml, Suspension, Oral, 237 ml	0.1521 B
Piroxicam	
10 mg, Capsule, Oral 100	0.0891 B
20 mg, Capsule, Oral 100	0.1131 B
Polymyxin B Sulfate; Trimethoprim Sulfate	
10,000 units/ml; Eq 1 mg base/ml, Solution/Drops, Ophthalmic 10 ml	1.2360 B
Potassium Chloride	
8 MEQ, Tablet, Extended Release, Oral 100	0.1044 B
10 MEQ, Tablet, Extended Release, Oral, 100	0.2538 B
20 MEQ, Tablet, Extended Release, Oral, 100	0.4625 B
Prednisolone	
15 mg/5 ml, Syrup, Oral 480 ml	0.2081 B
Prednisolone Acetate	
1%, Suspension/Drops, Ophthalmic 10 ml	1.6950 B
Prednisone	
5 mg, Tablet, Oral, 100	0.0203 R
10 mg, Tablet, Oral, 100	0.0615 B
20 mg, Tablet, Oral, 100	0.0804 B
Primidone	
250 mg, Tablet, Oral 100	0.8055 R
Probenecid	
500 mg, Tablet, Oral 100	0.7059 B
Prochlorperazine Maleate	
Eq 5 mg base, Tablet, Oral 100	0.3986 B
Eq 10 mg base, Tablet, Oral 100	0.5766 B

Generic Name	Upper Limit per Unit (Source)
Promethazine Hydrochloride	
12.5 mg, Suppository, Rectal, 12	0.9612 B
25 mg, Suppository, Rectal, 12	1.0362 B
Propafenone Hydrochloride	
150 mg, Tablet, Oral 100	1.1049 B
225 mg, Tablet, Oral 100	1.5624 B
Propranolol Hydrochloride	
10 mg, Tablet, Oral 100	0.0585 B
20 mg, Tablet, Oral 100	0.0705 B
40 mg, Tablet, Oral 100	0.0848 B
80 mg, Tablet, Oral 100	0.1020 B
Pseudoephedrine Hydrochloride; Tripolidine Hydrochloride	
60 mg; 2.5 mg, Tablet, Oral 100	0.0336 B
Pyridostigmine Bromide	
60 mg, Tablet, Oral, 100	0.5832 B
Ranitidine Hydrochloride	
Eq 150 mg base, Tablet, Oral, 100	0.1088 R
Eq 300 mg base, Tablet, Oral 30	0.2025 B
Ribavirin	
2000 mg, Capsule, Oral, 84	7.5764 B
Rifampin	
300 mg, Capsule, Oral, 100	1.8860 B
Rimantadine Hydrochloride	
100 mg, Tablet, Oral, 100	1.5120 B
Selegiline Hydrochloride	
5 mg, Tablet, Oral 60	0.7658 R
Selenium Sulfide	
2.5%, Lotion/Shampoo, Topical 120 ml	0.0750 B
Sotalol Hydrochloride (Does Not Apply to the "AF" Versions)	
80 mg, Tablet, Oral, 100	1.7850 B
120 mg, Tablet, Oral, 100	2.3550 B
160 mg, Tablet, Oral, 100	2.9250 B
240 mg, Tablet, Oral, 100	3.9750 B
Spironolactone	
25 mg, Tablet, Oral 100	0.3000 B

Generic Name	Upper Limit per Unit (Source)
Sucralfate 1 gm, Tablet, Oral 100	0.3690 B
Sulfacetamide Sodium 10%, Solution/Drops, Ophthalmic 15 ml	0.1530 B
Sulfamethoxazole; Trimethoprim 400 mg; 80 mg, Tablet, Oral 100	0.1325 B
800 mg; 160 mg, Tablet, Oral 100	0.3788 R
Sulfasalazine 500 mg, Tablet, Oral 100	0.1565 B
Sulindac 150 mg, Tablet, Oral 100	0.3317 B
200 mg, Tablet, Oral 100	0.4289 B
Tamoxifen Citrate 10 mg, Tablet, Oral, 60	0.9713 B
20 mg, Tablet, Oral, 30	1.9425 B
Temazepam 15 mg, Capsule, Oral 100	0.1365 B
30 mg, Capsule, Oral 100	0.1748 B
Terazosin Hydrochloride Eq 1 mg base, Capsule, Oral 100	0.6000 B
Eq 2 mg base, Capsule, Oral 100	0.6000 B
Eq 5 mg base, Capsule, Oral 100	0.6000 B
Eq 10 mg base, Capsule, Oral 100	0.6000 B
Terconazole 0.4%, Cream, Vaginal ,45 gm	0.9650 B
30 mg, Capsule, Oral 100	0.1748 B
Tetracycline Hydrochloride 500 mg, Capsule, Oral 100	0.0975 B
Theophylline 200 mg, Tablet, Extended Release, Oral, 100	0.2160 R
300 mg, Tablet, Extended Release, Oral, 100	0.2625 R
Thiothixene 1 mg, Capsule, Oral 100	0.1388 B
2 mg, Capsule, Oral 100	0.1860 B
5 mg, Capsule, Oral 100	0.2963 B
10 mg, Capsule, Oral 100	0.4065 B

Generic Name	Upper Limit per Unit (Source)
Ticlopidine Hydrochloride 250 mg, Tablet, Oral 60	0.2732 B
Timolol Maleate Eq 0.25% base, Solution/Drops, Ophthalmic 10 ml Eq 0.5% base, Solution/Drops, Ophthalmic 15 ml	0.6975 B 0.9000 B
Tizanidine Hydrochloride 2 mg, Tablet, Oral, 150 4 mg, Tablet, Oral, 150	0.6499 B 0.7899 B
Tobramycin 0.3%, Solution/Drops, Ophthalmic 5 ml	0.6720 B
Torsemide 100 mg, Tablet, Oral, 100	2.9175 B
Tramadol Hydrochloride 50 mg, Tablet, Oral, 100	0.3068 B
Trazodone Hydrochloride 50 mg, Tablet, Oral 100 100 mg, Tablet, Oral 100 150 mg, Tablet, Oral 100	0.0742 R 0.1140 B 0.3113 B
Tretinoin 0.025%, Cream, Topical, 45 gm	1.5693 B
Triamcinolone Acetonide 0.1%, Cream, Topical 80 gm 0.5%, Cream, Topical 15 gm 0.1%, Ointment, Topical 80 gm	0.0469 B 0.2370 B 0.0502 B
Triazolam 0.125 mg, Tablet, Oral 100 0.25 mg, Tablet, Oral 10	0.3012 B 0.3251 B
Trihexyphenidyl Hydrochloride 2 mg, Tablet, Oral 100 5 mg, Tablet, Oral 100	0.1275 B 0.2295 B
Trimethobenzamide Hydrochloride 300 mg, Capsule, Oral, 100	1.0193 B
Tropicamide 0.5%, Solution/Drops, Ophthalmic 15 ml 1%, Solution/Drops, Ophthalmic 15 ml	0.6550 B 0.7000 B

Generic Name	Upper Limit per Unit (Source)
Valproic Acid	
250 mg, Capsule, Oral 100	0.5250 B
250 mg/5 ml, Syrup, Oral 480 ml	0.0594 M
Verapamil Hydrochloride	
120 mg, Capsule, Extended Release, Oral 100	0.8250 B
180 mg, Capsule, Extended Release, Oral 100	0.8700 B
240 mg, Capsule, Extended Release, Oral 100	0.4350 B
40 mg, Tablet, Oral 100	0.1509 B
80 mg, Tablet, Oral 100	0.0735 B
120 mg, Tablet, Oral 100	0.1110 B
180 mg, Tablet, Extended Release, Oral 100	0.4838 B
240 mg, Tablet, Extended Release, Oral 100	0.4350 B
Warfarin Sodium	
1 mg, Tablet, Oral, 100	0.5403 B
2 mg, Tablet, Oral, 100	0.5639 B
2.5 mg, Tablet, Oral, 100	0.5816 B
3 mg, Tablet, Oral, 100	0.5843 B
4 mg, Tablet, Oral, 100	0.5856 B
5 mg, Tablet, Oral, 100	0.5897 B
6 mg, Tablet, Oral, 100	0.8364 B
7.5 mg, Tablet, Oral, 100	0.8649 B
10 mg, Tablet, Oral, 100	0.8970 B
Zidovudine	
300 mg, Tablet, Oral, 60	3.6503 B
Zonisamide	
25 mg, Capsule, Oral, 100	0.5213 R
50 mg, Capsule, Oral, 100	1.0218 R
100 mg Capsule, Oral, 100	1.1742 B

Appendix E: Glossary

GLOSSARY OF MEDICAL, MEDICAID, AND MANAGED CARE TERMS

<i>Term</i>	<i>Definition</i>
Access	A patient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation and affordability of care.
Actual Acquisition Cost (AAC)	The pharmacist's net payment made to purchase a drug product, after taking into account such items as purchasing allowances, discounts, and rebates.
Actual Charge	The amount a physician or other provider actually bills a patient for a particular medical service, procedure or supply in a specific instance. The actual charge may differ from the usual, customary, prevailing, and/or reasonable charge.
Acute Care	Medical treatment rendered to individuals whose illnesses or health problems are of a short-term or episodic nature. Acute care facilities are those hospitals that mainly serve persons with short-term health problems.
Additional Drug Benefit List	A list of pharmaceutical products approved by a health plan and employer for dispensing in larger quantities than the standards covered under a benefit package in order to facilitate long-term patient use. The list is subject to periodic review and modification by the health plan. Also called "drug maintenance list."
Adjudication	Processing a claim through a series of edits in order to determine proper payment.
Administrative Costs	The costs incurred by a carrier, such as an insurance company or HMO, for services such as claims processing, billing and enrollment, and overhead costs. Administrative costs can be expressed as a percentage of premiums or on a per member per month basis. Additional costs that are often expressed as administrative include those related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, insurer profit, quality assurance activities, medical libraries and risk management.
Administrative Services Only (ASO)	An insurance arrangement requiring the employer to be at risk for the cost of health care services provided, while a separate company delivers administrative services. This is a common arrangement when an employer sponsors a self-funded health care program.
Adverse Selection	A term used to describe a situation in which a health plan disproportionately enrolls a population that is prone to higher than average utilization of benefits, thereby driving up costs and increasing financial risk.

<i>Term</i>	<i>Definition</i>
Aged	For purposes of Medicare enrollment, persons 65 years of age or over are considered to be aged. Medicaid eligibility is determined on the basis of financial need for people who meet Supplemental Security Income (SSI) eligibility criteria (aged, blind, or disabled individuals) and Temporary Assistance for Needy Families (TANF) criteria (adults and children). Eligibility determinations are made for an entire economic unit or “case” (sometimes a family) based on whether or not one member of a case meets the criteria. For example, an “aged” case could consist of a 66 year old male and his 63 year old wife. In contrast, a disabled enrollee could be over 65 years of age. May also be defined as “Elderly.”
Agency for Healthcare Research and Quality (AHRQ)	A Federal agency under Health and Human Services (HHS) whose purpose is to enhance the quality and effectiveness of health care by funding healthcare services research, conducting health technology assessments and outcomes studies, and developing and disseminating clinical practice guidelines.
Aid to Families with Dependent Children (AFDC)	A State-based Federal cash assistance program for low-income families. In all States, AFDC reciprocity may be used to establish Medicaid eligibility. Now known as Temporary Assistance for Needy Families (TANF).
Allied Health Personnel	Specially trained and licensed (when necessary) health workers other than physicians, dentists, optometrists, chiropractors, podiatrists and nurses. The term is sometimes used synonymously with paramedical personnel, all health workers who perform tasks that must otherwise be performed by a physician, or health workers who do not usually engage in independent practice.
Allowable Charge	The maximum fee that a third party will reimburse a provider for a given service. An allowable charge may not be the same amount as either a reasonable or customary charge.
Allowable Costs	Charges for services rendered or supplies furnished by a health provider, which qualify for an insurance reimbursement.
Ambulatory Care	All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services which do not require an overnight stay.
Ambulatory Surgery	Any minor surgical procedures that can be performed at any type of medical facility on an outpatient basis, i.e., not requiring an overnight stay.
American National Standards Institute (ANSI)	A nonprofit organization that coordinates the development of voluntary national standards in both the public and private sectors.
Ancillary Charge	(1) The fee associated with additional service performed prior to and/or secondary to a significant procedure. (2) Also referred to as hospital “extras” or miscellaneous hospital charges. They are supplementary to a hospital’s daily room and board charge. They include such items as charges for drugs, medicines and dressings, lab services, X-ray examinations, and use of the operating room.

<i>Term</i>	<i>Definition</i>
Ancillary Services	Hospital services other than room, board, and professional services. They may include X-rays, lab tests, or anesthesia.
Antitrust	A legal term encompassing a variety of efforts on the part of government to assure that sellers do not conspire to restrain trade or fix prices for their goods or services in the market.
Any Willing Provider	A requirement that a health insurance plan or a health maintenance organization (HMO) must sign a contract for the delivery of health care services with any provider in the area that would like to provide such services to the plan's or HMO's enrollees, and can meet the terms of a contract.
Assignee	The person to whom the rights to a health insurance policy are assigned, either in part or in whole, by the original policyholder.
Assignment of Benefits	A method under which a claimant requests that his/her benefits under a claim be paid to some designated person or institution, usually a physician or hospital.
At-Risk	Accepting prepayment as full coverage for a predetermined health care benefit and assuming financial liability for any loss that occurs when premiums paid are less than the cost of services provided.
Authorization	As it applies to managed care, authorization is the approval of care, such as hospitalization.
Average Cost Per Claim	The average dollar amount of administrative and/or medical services rendered for the unit of measure within each expenditure category. The calculation is \$amount / #of units.
Average Manufacturer Price (AMP)	The average price paid by wholesalers for products distributed to the retail class of trade.
Average Wholesale Price (AWP)	The published suggested wholesale price of a drug. It is often used by pharmacies as a cost basis for pricing prescriptions.
Barriers To Access	Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing/improving health coverage.
Behavioral Health Care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
Beneficiary	An individual who receives benefits from or is covered by an insurance policy or other health care financing program. Also known as a "member," "enrollee," "subscriber," or "insured."
Benefit	A service provided under an insurance policy or prepayment plan.
Benefit Maximum	Specifies a dollar limit for the total reimbursement of health care costs during a benefit period.
Benefit Package	Services an insurer, government agency, or health plan offers to a group or individual under the terms of a contract.

<i>Term</i>	<i>Definition</i>
Best Price	For purposes of Medicaid rebate calculations, lowest price paid for a product by any purchaser other than Federal agencies and State pharmaceutical assistance programs.
Biological Equivalents	Those chemical equivalents which, when administered in the same amounts, will provide the same biological or physiological availability, as measured by blood levels, urine levels, etc.
Blue Book (MDBT)	The generic name for a widely used pricing guide entitled the <i>American Druggist First Databank Annual Directory of Pharmaceuticals</i> . Brand name and generic drugs are listed by product, manufacturer, National Drug or Universal Price Codes, direct price and average wholesale price (AWP). Other pricing guides are the <i>Red Book</i> and <i>Medispan's Pricing Guide</i> .
Brand Name	Name identifying a drug as the product of a specific pharmaceutical company. Also known as proprietary trademark name.
Cafeteria Plan	An employee benefit plan under which all participants are permitted to choose among two or more benefit options according to their needs and/or ability to pay. Also called a <i>flexible benefit plan</i> or "flex plan."
Capitation	A method of payment in which a health plan, such as an HMO or a specific health care provider, receives a fixed amount for each person eligible to receive services (\$ per member per month), which is made whether or not the covered person becomes an active patient and without regard to the number and mix of services used by that patient.
Capitation Fund	A fund based on the number of members multiplied by the budgeted or capitated amount each member pays. Some HMOs, in lieu of reimbursing physicians on a direct capitation basis, may establish such a fund. Physicians are then reimbursed on a fee-for-service basis from the capitation fund. The HMO monitors patient visits for over-utilization; patients exceeding the norm are notified.
Card Programs	The use of a drug benefit identification card which, when presented to a participating pharmacy by employees or their dependents, usually entitles them to receive the medication for a copay.
Care Coordinator	A primary health care practitioner: (1) who provides primary care services to an enrollee, (2) who is generally responsible for coordinating the enrollee's health care, and (3) with whom, other than in an emergency, a patient must consult to obtain a referral to a specialist provider in order to obtain the highest level of benefits available under a health plan. Care coordinators are sometimes called "gatekeepers."
Carve Out	A decision to purchase separately a service that is typically a part of an indemnity or HMO plan. Example: an HMO may "carve out" the behavioral health benefits and select a specialized vendor to supply these services on a stand-alone basis.

<i>Term</i>	<i>Definition</i>
Case Management	(1) A process whereby covered persons with specific health care needs are identified and a plan designed to efficiently utilize health care resources is formulated and implemented to achieve the optimum patient outcome in the most cost-effective manner. (2) A utilization management program that assists the patient in determining the most appropriate and cost-effective treatment plan. It is used for patients who have prolonged expensive or chronic conditions, helps determine the treatment location (hospital, or other institution, or home), and authorizes payment for such care if it is not covered under the patient's benefit agreement.
Case Manager	An experienced professional (e.g., nurse, doctor or social worker) who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.
Categorically Needy	Under Medicaid, categorically needy are aged, blind, or disabled individuals or families and children who meet financial eligibility requirements for TANF, Supplemental Security Income, or an optional State supplement.
Center for Medicaid and State Operations (CMSO)	The agency within the Centers for Medicare and Medicaid Services (CMS) with responsibility for administering the Medicaid and The Children's Health Insurance Program (CHIP).
Centers for Medicare and Medicaid Services (CMS)	The government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs. Formerly known as the Health Care Financing Administration (HCFA).
Certificate of Need (CON)	A certificate issued by a government body, where required, to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, or offer a new or different health service. Such issuance recognizes that a facility or services, when available, will meet the needs of those for whom it is intended.
Chain Pharmacy	One of a group of pharmacies, usually three or more, under the same management or ownership.
Charity Care Pools	The assets of several funds combined to cover health care costs to the poor and uninsured. The pools are established by organizations such as hospitals and insurance companies to offset a portion of the cost for providing health care to the indigent.
Chemical Equivalents	Those multiple-source drug products containing identical amounts of the same active ingredients, in equivalent dosage forms, and meeting existing physical/chemical standards.
Chronic Care	Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing homes, and mental hospitals may be considered chronic care facilities.

<i>Term</i>	<i>Definition</i>
Claim	Information on medical services provided that is submitted by a provider or a covered person from which processing for payment to the provider or covered person is made. The term generally refers to the liability for health care services received by covered persons.
Claims Administration	A carrier function involving the review of health insurance claims submitted for payment, by individual claim or in the aggregate. Claims administration, as it relates to professional review programs, is an identification procedure, screening treatment or charge pattern, for subsequent peer review and adjudication.
Claims Clearinghouse System	A system which allows electronic claims submission through a single source.
Claims Review	The method by which an enrollee's health care service claims are reviewed before reimbursement is made. The purpose of this monitoring system is to validate the medical appropriateness of the provided services and to be sure the cost of the service is not excessive.
Clearinghouse Capability	A company capable of submitting electronic and/or paper claims to several third-party payers.
Clinical Indicator	A tool or marker used to monitor and evaluate care to assure desirable outcomes and to explain or prevent undesirable outcomes.
Clinical Outcome	The status of the patient's health, especially after receipt of medical care services. Assessment of outcomes may be dependent upon targeted goals, clinical markers, and the ability to provide objective measurements.
Clinical Practice Guidelines	Guidelines that specify the appropriate course(s) of treatment for specified health conditions.
Closed-Panel HMO	Generally offers the services of a relatively limited number of health care providers, e.g., physicians employed by the HMO. Staff- and group-model HMOs are usually referred to as being in this category.
CMS MSIS Report	The CMS MSIS Report, formerly the HCFA-2082 Report, is the basic source of State-reported eligibility and claims data on the Medicaid population, their characteristics, utilization, and payments. Through FY 1998, the HCFA-2082 was an annual State submitted report designed to collect aggregate statistical data on Medicaid eligibles, recipients, services, and expenditures during each federal fiscal year. States summarized and reported the data processed through their own Medicaid claims processing and payment systems unless they opted to participate in the Medicaid Statistical Information System (MSIS) where the 2082 Report was produced by CMS. State-by-State national summary tables were developed based on the 2082 Reports. As a result of legislation enacted by The Balanced Budget Act of 1997, States, beginning in FY 1999, are required to submit all of their eligibility and claims data on a quarterly basis through MSIS. The State requirement for completing the HCFA-2082 Report has been eliminated.

<i>Term</i>	<i>Definition</i>
CMS-64 Report	The CMS-64 Report is a product of the financial budget and grant system. It is a statement of expenditures for the Medicaid program that States submit to CMS 30 days after each quarter. The Report is an accounting statement of actual expenditures made by the States for which they are entitled to receive Federal reimbursement under Title XIX for that quarter. Along with The CMS MSIS Report, it is one of the primary sources for Medicaid statistical data.
Coinsurance	The portion of covered health care costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.
Commercial Managed Care Organization (Comp-MCO)	A health maintenance organization with a contract §1876 or a Medicare + Choice organization, a provider sponsored organization, or any private or public organization which meets the requirements of §1902(w). They provide comprehensive services to commercial and/or Medicare, as well as Medicaid enrollees.
Community Rating	A method of determining a premium structure that is influenced not by the expected level of benefit utilization by specific groups, but by expected utilization by the population as a whole. Most often based on the entire population of a metropolitan statistical area (MSA). The intent is to spread risk over a large number of covered lives.
Competitive Medical Plan (CMP)	A status granted by the Federal government to an organization meeting specified criteria, enabling that organization to obtain a Medicare risk contract.
Compliance	The degree to which patients follow treatment recommendations.
Comprehensive Benefits Plan	A variation of the major medical plan which carries copayment requirements, usually 10-20 percent of all health expenses and deductibles ranging from \$100 to \$1,000.
Concurrent Drug Evaluation	An electronic assessment of claims at the point of service to detect potential problems that should be addressed prior to dispensing drugs to patients.
Consolidated Omnibus Reconciliation Act (COBRA)	A Federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance coverage has been terminated.
Consumer Price Index (CPI)	A price index constructed monthly by the U.S. Department of Labor using retail prices of goods and services sold in large cities across the country.
Continuous Quality Improvement (CQI)	A formal process of constantly seeking better ways to achieve stated goals.
Continuum of Care	A range of clinical services provided to an individual or group, which may reflect treatment rendered during a single inpatient hospitalization, or care for multiple conditions over a lifetime. The continuum provides a basis for analyzing quality, cost and utilization over the long term.

<i>Term</i>	<i>Definition</i>
Contract Pharmacy System	Pharmaceutical benefit delivery arrangement in which an HMO contracts with community pharmacies (chain or selected independents) to provide medications to members. Reimbursement may be by fee-for-service, capitation, or some other arrangement.
Contributory Program	A method of payment for group coverage in which part of the premium is paid by the employee and part is paid by the employer or union.
Copay/Copayment	A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as \$10 for an office visit. The covered person is usually responsible for payment at the time the care is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayments are flat or variable dollar amounts and coinsurance is a defined percentage of the charges for services rendered.
Cosmetic Procedures	Those procedures which involve physical appearance, but which do not correct or materially improve a physiological function and are not deemed medically necessary.
Cost Sharing	Any provision of a health insurance policy that requires the insured to pay some portion of medical expenses. The general term includes deductibles, copayments, and coinsurance.
Cost Shifting	The redistribution of payment sources. Typically, cost shifting occurs when one payer obtains a discount on provider services, and the providers increase costs to another payer to make up the difference.
Cost-Based Reimbursement	Payment by third-party insurers in which the amount is based on the cost to the provider of delivering services.
Cost-Effectiveness	Usually considered as a ratio, the cost-effectiveness of a drug or procedure, for example, relates the cost of that drug or procedure to the health benefits resulting from it. In health terms, it is often expressed as the cost per year per life saved.
Counter Detailing	A process of re-educating or influencing prescribers in a closed or controlled HMO plan. Usually done in order to gain more compliance with a formulary. In a counter-detailing program, techniques used by pharmaceutical sales representatives are adapted to a “counter” objective, i.e., to provide doctors with basic pharmacological information designed to influence their prescribing habits.
Coverage	Entire range of protection provided under an insurance contract.
Covered Expenses	Medical and related costs, experienced by those covered under the policy, that qualify for reimbursement under terms of the insurance contract.
Covered Services	The specific services and supplies for which Medicaid will provide reimbursement. Covered services under Medicaid consist of a combination of mandatory and optional services within each State.

<i>Term</i>	<i>Definition</i>
Credentialing	A process of review to approve a provider who applies to participate in a health plan. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan.
Customary Charge	The charge a physician or supplier usually bills his patients for furnishing a particular service or supply is called the customary charge.
Customary, Prevailing, and Reasonable Charges	Method of reimbursement which limits payment to the lowest of the following: physician's actual charge, physician's median charge in a recent prior period (customary), or the 75th percentile of charges in the same time period (prevailing).
Day Supply Maximum	The maximum amount of medication a person may receive at one time, usually the amount needed for 30 (acute) or 90 (maintenance) days of therapy, as defined by the drug benefit.
Deductible	An amount the insured person must pay before payments for covered services begin. For example, an insurance plan might require the insured to pay the first \$250 of covered expenses during a calendar year before the insurance company will begin payment.
Demand	The amount of care a population seeks to obtain through the health delivery system.
Dependent	An individual who relies on an employee for support or obtains health coverage through a spouse, parent, or grandparent who is the covered person.
Depot Price	The price(s) available to any depot of the Federal government, for purchase of drugs from the manufacturer through the depot system of procurement.
Diagnosis Center	Freestanding or hospital-based facility that specializes in diagnosing illnesses and injuries.
Diagnosis Related Group (DRG)	A system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex and presence of complications. This system of classification is used as a financing mechanism to reimburse hospital and selected other providers for services rendered.
Disability	(1) Any condition that results in functional limitations that interfere with an individual's ability to perform his/her customary work and which results in substantial limitation in one of more major life activities. (2) Condition(s) that prevent or limit an individual's ability to engage in normal activities. These may be temporary.
Disability Income Insurance	Type of health insurance that periodically pays a disabled subscriber to replace income lost during the period of disability.
Disease Management	An effort to improve patient outcomes and lower costs by organizing managed care initiatives around patients with a particular disease or condition.
Dismemberment	Loss of body parts stemming from accidental physical injury.

<i>Term</i>	<i>Definition</i>
Dispense As Written (DAW)	A prescribing directive issued by physicians to indicate that the pharmacy should not in any way alter a prescription. Such alterations are usually done in order to substitute a generic drug for the brand name drug ordered.
Dispensing, Fill or Professional Fee	The amount paid to a pharmacy for each prescription, in addition to the negotiated formula for reimbursing ingredient cost.
Dispensing or Prescribing Limits	Limitations on the number of prescriptions per month, or the amount of medication that may be prescribed in a given time frame.
Disproportionate Share Hospital (DSH)	A disproportionate share hospital (DSH) is a hospital that serves a disproportionate number of low-income patients with special needs and receives a payment adjustment for providing such services. In addition to certain requirements for the provision of obstetrical services to individuals entitled to medical assistance, a hospital is deemed to be a disproportionate share hospital if 1) the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or 2) the hospital's low-income utilization rate exceeds 25 percent.
Drug Detailing	Presenting information about a brand name drug product to prescribers to educate them about its activity, uses, side effects, proper dosage and administration, etc.
Drug Formulary	A listing of prescription medications which are preferred for use by a health plan and which may be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan. A plan that has adopted an "open or voluntary" formulary allows coverage for both formulary and non-formulary medications. A plan that has adopted a "closed, select or mandatory" formulary limits coverage to those drugs in the formulary.
Drug Use Evaluation (DUE)	Evaluations of prescribing patterns of prescribers to specifically determine the appropriateness of drug therapy. There are three forms of DUE: prospective (before or at the time of prescription dispensing), concurrent (during the course of drug therapy), and retrospective (after the therapy has been completed). Same as "Drug Utilization Review."
Drug Utilization	The prescribing, dispensing, administering and ingestion or use of pharmaceutical products.
Drug Utilization Review (DUR)	A quantitative evaluation of prescription drug use, physician prescribing patterns or patient drug utilization to determine the appropriateness of drug therapy. Most often focuses on over-utilization.
Dual Eligibles	The term describes a population of low-income elderly and individuals with disabilities who qualify for both Medicare and Medicaid coverage. While Medicare covers basic health services, including physician and hospital care, dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as long-term care and prescription drugs. However starting in 2006, coverage of prescription drugs for dual eligibles will shift from Medicaid to Medicare.

<i>Term</i>	<i>Definition</i>
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	The EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.
Electronic Data Interchange (EDI)	The computer-to-computer exchange of business or other information. The data may be in either a standardized or priority format.
Employee Benefits Program	Health insurance and other benefits, beyond salaries, offered to employees at their place of work. The employer typically picks up all or part of the cost of these benefits.
Employee Retirement Income Security Act of 1974, Public Law 93-406 (ERISA)	A Federal Act passed in 1974, that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA have been held to be exempt from State insurance laws.
Enrollment	The total number of covered persons in a health plan. Also refers to the process by which a health plan signs up groups and individuals for membership, or the number of enrollees who sign up in any one group.
Estimated Acquisition Cost (EAC)	An estimate of the price generally, and currently, paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.
Exclusions	Specific conditions or circumstances listed in the contract or employee benefit plan for which the policy or plan will not provide benefit payments.
Exclusivity Clause	A part of a contract which prohibits physicians from contracting with more than one health maintenance organization or preferred provider organization.
Expenditures	Under Medicaid, "expenditures" refers to an amount paid out by a State agency for the covered medical expenses of eligible participants.
Experience Rating	The process of setting rates based partially or in whole on previous claims experience and projected required revenues for a future policy year for a specific group or pool of groups.
Experimental, Investigational or Unproven Procedures	Medical, surgical, psychiatric, substance abuse or other health care services, supplies, treatments, procedures, drug therapies or devices that are determined by the health plan (at the time it makes a determination regarding coverage in a particular case) to be either: not generally accepted by informed health care professionals in the U.S. as effective in treating the condition, illness or diagnosis for which their use is proposed; or not proven by scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.
Extended Care	Long-term care, ranging from routine assistance for daily activities to sophisticated medical and nursing care for those needing it. The care, covered under certain insurance policies, can be provided in homes, day-care centers or other facilities.

<i>Term</i>	<i>Definition</i>
Family Planning Services	Any medically approved means, including diagnosis, treatment, drugs, supplies and devices, and related counseling which are furnished or prescribed by or under the supervision of a physician for individuals of childbearing age for purposes of enabling such individuals freely to determine the number or spacing of their children.
Favorable Selection	A tendency for utilization of health services in a population group to be lower than expected or estimated.
Federal Financial Participation	The technical term for Federal Medicaid matching funds paid to States for allowable expenditures for Medicaid services or administrative costs.
Federal Medical Assistance Percentage (FMAP)	The Federal Medical Assistance Percentage (FMAP) determines that Federal government's share of medical assistance expenditures under each State's Medicaid program. Each year, the FMAP is established by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. The FMAP is defined in Section 1933(d) of the Social Security Act.
Federal Poverty Level (FPL)	The Federal government's working definition of poverty is used as the reference point for the income standard for Medicaid eligibility for certain categories of beneficiaries. The Federal Poverty Level is the administrative version of the poverty measure and is issued by the Department of Health and Human Services (HHS). It is a simplification of the poverty thresholds and is used in determining financial eligibility for certain Federal programs. The FPL is also referred to as the Federal poverty guidelines.
Federal Upper Limits (FUL)	The upper limit amount that Medicaid can reimburse for a drug product if there are three or more generic versions of the product rated therapeutically equivalent and at least three suppliers listed in the current editions of published national compendia. These limits are intended to assure that the Federal government acts as a prudent buyer of drugs. The upper limits program seeks to achieve savings by taking advantage of current market prices.
Federally Qualified Health Center (FQHC)	Federally Qualified Health Centers are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for The Homeless. These centers may qualify as Medicaid providers of services if: 1) The facility receives a grant under sections 329, 330, or 340 of The Public Health Services Act; 2) HRSA recommends, and the HHS Secretary determines, that the facility meets the requirements of the grant; or 3) The Secretary determines that a facility may qualify through waivers of the requirements (such a waiver cannot exceed two years).
Federally Qualified HMOs	HMOs that meet certain Federally stipulated provisions aimed at protecting consumers: e.g., providing a broad range of basic health services, assuring financial solvency, and monitoring the quality of care. HMOs must apply to the Federal government for qualification. The Office of Prepaid Health Care of CMS administers the process.

<i>Term</i>	<i>Definition</i>
Fee Maximum	The maximum amount a participating provider may be paid for a specific health care service provided to a covered person under a specific contract. Sometimes called “fee max.”
Fee Schedule	A listing of codes and related services with pre-established payment amounts that could be percentages of billed charges, flat rates or maximum allowable amounts.
Fee-for-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment that does not exceed their billed charge for each unit of service provided. Fees are paid as care is rendered.
First-Dollar Coverage	Health policies that pay all or a portion of medical expenses upon enrollment, without a deductible charge.
Fiscal Agent	A contractor that processes or pays vendor claims on behalf of a Medicaid agency.
Fiscal Intermediary	The agent that has contracted with providers of service to process claims for reimbursement under health care coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making audits of providers’ records.
Fiscal Year	Any predetermined set of 12 months for which annual accounts are kept. The Federal government’s fiscal year extends from Oct. 1 to the following Sept. 30.
Fixed Fee	An established “fee” schedule for pharmacy services allowed by certain government and private third-party programs in lieu of cost-of-doing business markups.
Formulary	See “Drug Formulary.”
Free-Standing Hospital	Any hospital that is not affiliated with a multihospital system.
Freedom-of-Choice (FOC)	Legislation requiring managed care organizations to allow members to choose providers whether or not they connect with the plans (often coupled with any willing provider (AWP) legislation).
Gatekeeper	See “Care Coordinator.”
Generic Drug	A chemically equivalent copy of a brand name drug whose patent has expired. Drug formulations must be of identical composition with respect to the active ingredient (i.e., meet official standards of identity, purity, and quality of active ingredient). Also called generic equivalent or non-innovator multiple source drug.
Generic Equivalent	See “Generic Drug.”
Generic Substitution	Dispensing a generic drug in place of a brand name medication.
Global Target	A financing method identical to a global budget except that no enforcement mechanism is used to keep providers and hospitals within budget (i.e., providers and hospitals will receive additional funding if their costs exceed their budgeted payments).

<i>Term</i>	<i>Definition</i>
HCFA 1500	A universal form developed by the government agency previously known as the Health Care Financing Administration (HCFA, now CMS), for providers of services to bill professional fees to health carriers.
HCFA Common Procedural Coding System (HCPCS)	A listing of services, procedures and supplies offered by physicians and other providers. HCPCS includes current procedural terminology (CPT) codes, national alphanumeric codes and local alphanumeric codes. The national codes are developed by CMS in order to supplement CPT codes. They include physician services not included in CPT as well as non-physician services such as ambulance, physical therapy and durable medical equipment. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are 5-digit codes, the first digit a letter followed by four numbers. HCPCS codes beginning with A through V are national; those beginning with W through Z are local.
Health Care Financing Administration (HCFA)	See “Centers for Medicare and Medicaid Services.”
Health Care Prepayment Plan (HCPP)	A cost contract with the CMS that prepays a health plan a flat amount per month to provide Medicare-eligible Part B medical services to enrolled members. Members pay premiums to cover the Medicare coinsurance, deductibles and copayments, plus any additional non-Medicare covered services that the plan provides. The HCPP does not arrange for Part A services.
Health Insurance	Financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.
Health Insurance Flexibility and Accountability (HIFA) Waiver	A Medicaid and State Children’s Health Insurance Program (SCHIP) demonstration waiver, using Section 1115 waiver authority, that offers States greater flexibility in setting benefits and cost-sharing for some groups of Medicaid beneficiaries. States can use the waiver to cut benefits and /or increase cost-sharing for certain Medicaid beneficiaries and invest resulting savings into expanding coverage of uninsured individuals through Medicaid and SCHIP.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Public Law 104-191, a law which requires each State’s Medicaid Management Information System (MMIS) to have the capacity to exchange data with the Medicare program and contains “administrative simplification” provisions that require State Medicaid Programs to use standard codes for electronic transactions relating to the processing of health claims.
Health Insuring Organization (HIO)	An entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

<i>Term</i>	<i>Definition</i>
Health Maintenance Organizations (HMO's)	(1) An entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. There are four basic models of HMOs: staff model, group model, network model and individual practice association; (2) Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO: (a) An organized system for providing health care or otherwise assuring health care delivery in a geographic area, (b) An agreed upon set of basic and supplemental health maintenance and treatment services, and (c) A voluntary enrolled group of people.
Health Plan	An organization that provides a defined set of benefits; this term usually refers to an HMO-like entity, as opposed to an indemnity insurer.
Health Plan Employer Data and Information Set (HEDIS)	A core set of performance measures to assist employers and other health purchasers in understanding the value of health care purchases and evaluating health plan performance. HEDIS 2005 is currently used and distributed by NCQA (National Committee for Quality Assurance).
HMO - Group Model	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
HMO - Individual Practice Association (IPA)	A health care model that contracts with physicians and other community health care providers, to provide services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
HMO - Network Model	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his/her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
HMO - Staff Model	A health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
Home and Community-Based Waivers	See "Section 1915(c) Waivers."
Home Health Agency (HHA)	A facility or program licensed, certified or otherwise authorized pursuant to State and Federal laws to provide health care services in the home.
Home Health Services	Services and items furnished to an individual who is under the care of a physician by a home health agency or by others under arrangements made by such agency. Services are furnished under a plan established and periodically reviewed by a physician. They are provided on a visiting basis in an individual's home and include: nursing, physical therapy, dietary, counseling, and social services; part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services, medical supplies and appliances (other than drugs and biologicals); home health aide services; and services of interns and residents.

<i>Term</i>	<i>Definition</i>
Hospice	A program that provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency. Originally a medieval name for a way station for crusaders where they could be replenished, refreshed, and cared for, hospice is used here for an organized program of care for people going through life's "last station." The whole family is considered the unit of care, and care extends through their period of mourning.
Indemnity Insurance	An insurance program in which the insured person is reimbursed or the provider is paid for covered expenses after services are rendered.
Innovator Multiple-Source Drug	An innovator multiple-source drug is a multiple source drug that was originally marketed under an original new drug application approved by the FDA.
Inpatient Hospital Services	Items and services furnished to a resident patient of a hospital by the hospital. May include such items as: bed and board; nursing and related services; diagnostic and therapeutic services; and medical or surgical services.
Integrated Behavioral Health	A carve-out benefit plan that combines independent managed care services into what is designed as a seamless delivery system for behavioral health concerns. Components could include employee assistance services, a telephone counseling triage, utilization management, behavioral health treatment networks, claims payment, and data management.
Integrated Delivery System	A generic term referring to a joint effort of physician/hospital integration for a variety of purposes. Some models of integration include physician-hospital organization, group practice without walls, integrated provider organization and medical foundation.
Intensive Care	Skilled nursing services, usually in a hospital, prescribed by a physician for individuals with serious medical conditions and delivered with the guidance of a registered nurse.
Intergovernmental Transfer (IGT)	The transfer of non-Federal public funds from a local government (or locally owned hospital or nursing facility) to the State Medicaid agency, or from another State agency (or State-owned hospital) to the State Medicaid agency, usually for the purpose of providing the State share of a Medicaid expenditure in order to draw down Federal matching funds.
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	The ICF/MR benefit is an optional Medicaid benefit for States. Section 1905(d) of the Social Security Act created this benefit to fund "institutions" (4 or more beds) for people with mental retardation, and specifies that these institutions must provide health and/or rehabilitative services.
International Classification of Diseases, 9th Edition (Clinical Modification) (ICD-9-CM)	A listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communications on claim forms.

<i>Term</i>	<i>Definition</i>
Investigational Treatments	Medical treatments, including drugs waiting for FDA approval, that are considered experimental and, therefore, may not be covered by insurance plans. The definition of experimental currently varies from plan to plan.
Laboratory and Radiological Services	Professional and technical laboratory and radiological services ordered by a licensed practitioner, provided in an office or similar facility (other than a hospital outpatient department or clinic) or by a qualified lab.
Legend Drug	A drug that, by law, can be obtained only by prescription and bears the label, "Caution: Federal law prohibits dispensing without a prescription." See "Prescription Medication."
Lifetime Maximum Benefit	A limitation on financial coverage for health care for an individual stated by an insurer. This amount serves as a cap on contractual liability and can be exceeded only in rare and unusual circumstances.
Long-Term Care	A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.
Magnetic Resonance Imaging	State-of-the-art machine used as a diagnostic tool, using magnetic fields to produce comprehensive pictures of the anatomy.
Managed Care	(1) A system of health care delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to high quality, cost-effective health care; (2) A systemized approach which seeks to ensure the provision of the right health care at the right time, place and cost.
Managed Care Organization (MCO)	Broad term that encompasses various types of health plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point-of-Service plans (POSs) and Provider-Sponsored Organizations (PSOs). Often used to refer to a health plan that is similar to an HMO but which does not have an HMO license and serves only Medicaid beneficiaries.
Mandated Benefits	Those benefits which health plans are required by State or Federal law to provide to policyholders and eligible dependents.
Maximum Allowable Cost, or "Reasonable Cost Range"	A fixed maximum cost for which the pharmacist can be reimbursed for selected products, as identified in a "formulary."
Maximum Out-of-Pocket Costs	The limit on total member copayments, deductibles and coinsurance under a benefit contract.

<i>Term</i>	<i>Definition</i>
Means Testing	The policy of basing eligibility for benefits upon an individual's lack of means, as measured by his or her income or resources. Means testing, by definition, requires the disclosure of personal financial information by an applicant as a condition of eligibility. Medicaid and SCHIP are means tested programs.
Medicaid	A Federally aided State-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad Federal guidelines, States determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program. Also referred to as State Medical Assistance Programs.
Medicaid Buy-In	A provision in certain health reform proposals whereby the uninsured would be allowed to purchase Medicaid coverage by paying premiums on a sliding scale based on income.
Medicaid Management Information System (MMIS)	Federally developed guidelines for a computer system designed to achieve national standardization of Medicaid claims processing, payment, review and reporting for all health care claims.
Medicaid-only Managed Care Organization (Mcaid-MCO)	An MCO that provides comprehensive services to Medicaid beneficiaries but not commercial or Medicare enrollees.
Medicaid Statistical Information System (MSIS)	The information system developed by CMS to collect detailed data on eligibility, utilization, and payments for services covered by State Medicaid programs.
Medical Assistance	The term used in the Federal Medicaid statute (Title XIX of the Social Security Act) to refer to payment for items and services covered under a State's Medicaid program.
Medical Care Advisory Committee (MCAC)	A committee, consisting of physicians, other health professionals, Medicaid beneficiaries, and the director of the public health or welfare agency, appointed by the Medicaid agency director to participate in policy development and administration of a State's Medicaid program.
Medical Necessity	The evaluation of health care services to determine if they are: medically appropriate and required to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
Medical Savings Account (MSA)	A non-taxable savings account used to cover medical expenses. Based loosely on the idea of individual retirement accounts.
Medically Needy	Under Medicaid, medically needy cases are aged, blind, or disabled individuals or families and children who are not otherwise eligible for Medicaid, and whose income resources are above the limits for eligibility as categorically needy (TANF or SSI) but are within limits set under the Medicaid State Plan.

<i>Term</i>	<i>Definition</i>
Medicare	A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B). Recent legislation has expanded the Medicare program to include an HMO option (Part C) and a prescription drug benefit (Part D). See "Medicare Prescription Drug, Improvement and Modernization Act of 2003."
Medicare Beneficiary	A person designated by the Social Security Administration as entitled to receive Medicare benefits.
Medicare Payment Advisory Commission (MedPAC)	A Federal commission established under the Balanced Budget Act of 1997 to advise and assist Congress and the Department of Health and Human Services in maintaining and updating the Medicare prospective payment system. MedPAC replaces and assumes the responsibilities of the Physician Payment Review Commission (PPRC) and the Prospective Payment Assessment Commission (ProPAC).
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)	The Medicare Prescription Drug, Improvement, and Modernization Act (Public Law 108-173), also known as the Medicare Modernization Act (MMA) was enacted December 8, 2003. It enacted the Prescription Drug Program (Medicare Part D) effective January 2006, under which Medicare will assume responsibility for the prescription drug needs of beneficiaries eligible for both Medicare and Medicaid. It also enacted the temporary Medicare Prescription Drug Discount Card Program, effective June 2004-December 2005. Many other amendments to the Medicare and Medicaid programs were also enacted, including coverage of an initial preventive physical examination, cardiovascular screening blood tests, and diabetes screening tests. Health Savings Accounts were also authorized. Medicare payment limits were established for certain hospital outpatient departments.
Medicare Supplemental Insurance	A policy guaranteeing that a health plan will pay a policyholder's coinsurance, deductible and copayments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit. In essence, the product pays for the portion of the cost of services not covered by Medicare. Also called "Medigap" or "Medicare wrap."
Medigap (Medicare Supplemental Insurance)	See "Medicare Supplemental Insurance."
Members	A participant in a health plan (member or eligible dependent). Also used to describe an individual specified within a subscriber contract that may receive health care services according to the terms of the subscriber policy. Also known as "beneficiary," "enrollee," "subscriber," or "insured."
Modified Fee-for-Service	A system in which providers are paid on a fee-for-service basis, with certain fee maximums for each procedure.

<i>Term</i>	<i>Definition</i>
Most Favored Nations Discount or Clause	A contractual agreement that stipulates that a vendor must provide to a particular payor the lowest prices that would be available to any purchaser. The Federal government often invokes most favored nation clauses for health care contracts.
Multiple-Source Drug	A multiple-source drug is one that is marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or under a proprietary name and without such a name.
National Committee for Quality Assurance (NCQA)	A national organization founded in 1979 composed of 14 directors representing consumers, purchasers, and providers of managed health care. It accredits quality assurance programs in prepaid managed health care organizations, and develops and coordinates programs for assessing the quality of care and service in the managed care industry, including the HEDIS quality measures.
National Drug Code (NDC)	A national classification system for identification of drugs. Similar to the Universal Product Code (UPC).
Network Plan	A phrase that generally refers to arrangements where providers contract with payers or a managed care plan to provide services for patients enrolled in the managed care plan. See "Managed Care."
Nurse-Midwife Services	Nurse-midwife services are those concerned with the management of care of mothers and newborns throughout the maternity cycle. OBRA 1980 required that payment be made for providing nurse-midwife services to categorically needy recipients to the extent that the nurse-midwife is authorized to practice under State law or regulation. States are also required to offer direct reimbursement to nurse-midwives as one of the payment options. Nurse-midwives must be registered nurses who are either certified by an organization recognized by the Secretary of HHS or who have completed a program of study and clinical experience that has been approved by the Secretary.
Nursing Facility (NF)	A facility in either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in a hospital.
Nursing Facility Services	All services furnished to inpatients of, and billed for by, a formally certified nursing facility that meets standards set by Secretary of DHHS.
Other Practitioners' Services	Health care services of licensed practitioners other than physicians and dentists.
Out-of-Pocket Costs/Expenses (OOPs)	The portion of payments for health services required to be paid by the enrollee, including copayments, coinsurance and deductibles.
Out-of-Pocket Limit	The total payments toward eligible expenses that a covered person funds for him/herself and/or dependents: i.e., deductibles, copays and coinsurance - as defined per the contract. Once this limit is reached, benefits will increase to 100% for health services received during the rest of that calendar year. Some out-of-pocket costs (e.g., mental health, penalties for non-precertification, etc.) are not eligible for out-of-pocket limits.

<i>Term</i>	<i>Definition</i>
Outcome Measures	Assessments which gauge the effect or results of treatment for a particular disease or condition. Outcome measures include such parameters as: the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity and health status.
Outcomes Management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying - often in a formal program of continuous quality improvement.
Outcomes Research	Studies aimed at measuring the effect of a given product, procedure, or medical technology on health or costs.
Outlier	An observation in a distribution that is outside a certain range, often defined as two or three standard deviations from the mean or exceeding a specific percentile. Frequently refers to a case or hospital stay that is unusually long or expensive for its type, or to a physician practice that uses an abnormally high or low volume of resources.
Outpatient Services	Outpatient services are medical and other services provided on a non-resident basis (patients are not admitted to the facility) by a hospital or other qualified facility, such as a mental health clinic, rural health clinic, mobile X-ray unit, or freestanding dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, and X-ray and other radiation therapy.
Over-the-Counter (OTC)	A drug product that does not require a prescription under Federal or State law.
Participating Provider	A provider who has contracted with the health plan to provide medical services to covered persons. The provider may be a hospital, pharmacy, other facility or a physician who has contractually accepted the terms and conditions as set forth by the health plan.
Patient Health Status Survey	Questionnaire used to solicit patient perceptions regarding the state of their health. Questions may be general and address overall health status with regard to a specific condition (e.g., an arthritic patient's ability to make a fist or an asthmatic patient's ability to climb a flight of stairs).
Patient Satisfaction Survey	Questionnaire used to solicit the perceptions the plan enrollees or patients have regarding how a health plan meets their medical needs and how the delivery of care is handled, (e.g., waiting time, access to treatments).
Payer	A general term indicating the responsible party for the payment of medical care service expenses. Payers may be patients, insurance companies, government agencies, or a combination of these.
Pediatric Nurse Practitioner and Family Nurse Practitioner Services	Services furnished as authorized under State law by a registered professional nurse who meets a State's advanced educational and clinical practice requirements, whether or not the practitioner is under the supervision of or associated with a physician or other health care provider.

<i>Term</i>	<i>Definition</i>
Peer Review	The evaluation of quality of total health care provided, by medical staff with equivalent training.
Peer Review Organization (PRO)	An entity established by the Tax Equity and Fiscal Responsibility Act of 1982 (TERFA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates, and reducing lengths of stay while insuring against inadequate treatment. Also known as "Professional Standards Review Organization."
Personal Support Services	Personal support services consist of a variety of services including personal care, targeted case management, home and community-based care for functionally disabled elderly, rehabilitative services, hospice services, and nurse-midwife, nurse practitioner, and private duty nursing services.
Pharmacy And Therapeutics (P&T) Committee	An organized panel of physicians and pharmacists from varying practice specialties, who function as an advisory panel to the plan regarding the safe and effective use of prescription medications. Often comprises the official organizational line of communication between the medical and pharmacy components of the health plan. A major function of such a committee is to develop, manage and administer a drug formulary.
Pharmaceutical Benefits Manager (PBM)	An entity that is responsible for managing prescription benefits.
Physician	Any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received.
Physician-Hospital Organization (PHO)	A legal entity formed by a hospital and a group of physicians to further mutual interests and to achieve market objectives. A PHO generally combines physicians and a hospital into a single organization for the purpose of obtaining payer contracts. Doctors maintain ownership of their practices and agree to accept managed care patients according to the terms of a professional service agreement with the PHO. The PHO serves as a collective negotiating and contracting unit. It is typically owned and governed jointly by a hospital and shareholder physicians.
Point-Of-Service (POS) Plan	A health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. POS can be provided in several ways: an HMO may allow members to obtain limited services from non-participating providers; an HMO may provide non-participating benefits through a supplemental major medical policy; a PPO may be used to provide both participating and non-participating levels of coverage and access; or various combinations of the above may be used.
Portability	Requirement that health plans guarantee continuous coverage without waiting periods for persons moving between plans.

<i>Term</i>	<i>Definition</i>
Practice Guideline	Systematically developed statements on medical practice that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions. Managed care organizations frequently use these guidelines to evaluate appropriateness and medical necessity of care. Terms used synonymously include practice parameters, standard treatment protocols and clinical practice guidelines.
Practice Parameters	See “Practice Guidelines.”
Practice Variation	An assessment of the patterns of a practitioner’s practice to determine if the provider’s care is significantly different from others with similar practices. If there is a significant difference, the practitioner’s practice is analyzed to determine the reasons for the variation and whether that practitioner’s practice patterns should be modified.
Pre-Certification Review	See “Utilization Review.”
Pre-Existing Condition (PEC)	Any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person’s effective date of coverage under the master group contract.
Preferred Provider Organization (PPO)	A program in which contracts are established with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits (fewer copayments) for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons are generally allowed benefits for non-participating providers’ services, usually on an indemnity basis with significantly higher copayments. A PPO arrangement can be insured or self-funded. Providers may be, but are not necessarily, paid on a discounted fee-for-service basis.
Prepaid Group Practice Plans	Organized medical groups of essentially full-time physicians in appropriate specialties, as well as other professional and subprofessional personnel, who, for regular compensation, undertake to provide comprehensive care to an enrolled population for premium payments that are made in advance by the consumer and/or their employers.
Prepaid Health Plan (PHP)	An entity that provides a non-comprehensive set of services on either capitated risk or non-risk basis or the entity provides comprehensive services on a non-risk basis.
Prescribed Drugs	Prescribed drugs are drugs dispensed by a licensed pharmacist on the prescription of a practitioner licensed by law to administer such drugs, and drugs dispensed by a licensed practitioner to his own patients. This item does not include a practitioner’s drug charges that are not separable from his other charges, or drugs covered by a hospital bill.
Prescription Medication	A drug which has been approved by the Food and Drug Administration and which can, under Federal and State law, be dispensed only pursuant to a prescription order from a duly licensed prescriber, usually a physician.
Preventive Care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examinations, immunization and well person care.

<i>Term</i>	<i>Definition</i>
Primary Care	Basic or general health care traditionally provided by family practice, pediatrics and internal medicine. See also “Secondary Care.”
Primary Care Case Management (PCCM)	Managed care arrangements where primary care providers receive a per capita management fee to coordinate a patient's care in addition to reimbursement (fee-for-service or capitation) for the medical services they provide.
Primary Care Physician (PCP)	The primary care practitioner (e.g., internist, family/general practitioner, pediatrician, and in some cases, OB/Gyn) in managed care organizations who determines whether the presenting patient needs to see a specialist or requires other non-routine services. See Care Coordinator.
Prior Authorization	The process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.
Prospective Financing	Financing for health care services based on prices or budgets determined prior to the delivery of service. Payments can be per unit of service, per member, or per time period. In all its forms prospective financing differs from cost-based reimbursement, under which a provider is paid for costs incurred.
Protocol	See “Practice Guidelines.”
Provider Network	See “Network Plan.”
Providers	A physician, hospital, group practice, nurse, nursing home, pharmacy or any individual or group of individuals that provides a health care service.
Qualified Medicare Beneficiary (QMB)	An individual who qualifies for Medicare Part A, whose income does not exceed 100 percent of the Federal poverty level, and whose resources do not exceed twice the SSI resource-eligibility standard. Medicaid coverage of QMBs is limited to payments of their Medicare cost-sharing charges, such as Medicare premiums, coinsurance, and copayment amounts.
Quality Assurance (QA) or Quality Improvement (QI)	A formal set of activities to review and affect the quality of services provided. Quality assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.
Rate Setting	A form of financing under which hospitals or nursing homes are paid prices that are prospectively determined, generally by a State agency. Prospectively determined prices may be paid by all payers for all covered services, as in all payer systems, or by only some payers. The unit of payment can be service, patient, or time period. See “Prospective Financing.”
Rational Drug Therapy	Prescribing the right drug for the right patient, at the right time, in the right amount, and with due consideration of relative cost.

<i>Term</i>	<i>Definition</i>
Reasonable Charge	In processing claims for Supplementary Medical Insurance benefits, carriers use CMS guidelines to establish the reasonable charge for services rendered. The reasonable charge is the lowest of: the actual charge billed by the physician or supplier; the charge the physician or supplier customarily bills his patients for the same services, and the prevailing charge which most physicians or suppliers in that locality bill for the same service. Increases in the physicians' prevailing charge levels are recognized only to the extent justified by an index reflecting changes in the costs of practice and in general earnings.
Reasonable Cost	In processing claims for health insurance benefits, intermediaries use CMS guidelines to determine the reasonable cost incurred by the individual providers in furnishing covered services to enrollees. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, excluding any costs that are unnecessary in the efficient delivery of services covered by the insurance program.
Rebate	A monetary amount that is returned to a payer from a prescription drug manufacturer based upon utilization by a covered person or purchases by a provider.
Recipient	A recipient of Medicaid is an individual who has been determined to be eligible for Medicaid and who has used medical services covered under Medicaid.
Referral	The process of sending a patient from one practitioner to another for health care services. Health plans may require that designated primary care providers authorize a referral for coverage of specialty services.
Restrictive Formulary	A term often used synonymously with closed formulary. See "Drug Formulary."
Retrospective Review	Determination of medical necessity and/or appropriate billing practice for services already rendered.
Risk	Responsibility for paying for or otherwise providing a level of health care services based on an unpredictable need for these services.
Risk Contract	(1) An agreement between a State Medicaid program and an HMO or competitive medical plan requiring the HMO to furnish at a minimum all Medicaid covered services to Medicaid eligible enrollees for an annually determined, fixed monthly payment rate from the State government. The HMO is then liable for services regardless of their extent, expense or degree. (2) An agreement between a provider and payer, or intermediary, on behalf of a payer, that requires the provider to furnish all specified services for a specified enrollee for a set fee, usually prepaid, and for a set period of time (usually one year). The provider is then liable for services regardless of their extent, expense or degree. Such stated limitations for such liability are stated in advance and may be subject to reinsurance.

<i>Term</i>	<i>Definition</i>
Rural Health Clinic	A rural health clinic is an outpatient facility which is primarily engaged in furnishing physician and other medical and health services, which meets certain other requirements designed to ensure the health and safety of the individuals served by the clinic. The clinic must be located in an area that is not urbanized as defined by the Census Bureau and that is designated by the Secretary of DHHS either as an area with a shortage of personal health services, or as a health manpower shortage area, and has filed an agreement with the Secretary not to charge any individual or other person for items or services for which such individual is entitled to have payment made by Medicare, except for the amount of any deductible or coinsurance amount applicable.
Secondary Care	Services provided by medical specialists, such as cardiologists, urologists and dermatologists, who generally do not have first contact with patients. See also "Primary Care."
Section 1115 Waivers	Section 1115 of the Social Security Act grants the Secretary of Health and Human Services broad authority to waive certain laws relating to Medicaid for the purpose of conducting pilot, experimental or demonstration projects. Section 1115 demonstration waivers allow States to change provisions of their Medicaid programs, including: eligibility requirements, the scope of services available, the freedom to choose a provider, a provider's choice to participate in a plan, the method of reimbursing providers, and the statewide application of the program. Projects typically run three to five years.
Section 1915(b) Waivers	Section 1915(b) of the Social Security Act authorizes the Secretary of Health and Human Services to waive compliance with certain portions of the Medicaid statute that prevent a State from mandating Medicaid beneficiaries obtain their care from a single provider or health plan. Section 1915(b) waivers allow States to operate mandatory managed care programs in all or portions of the State while continuing to receive Federal Medicaid matching funds. Waivers must be approved by the Centers for Medicare & Medicaid Services (CMS).
Section 1915(c) Waivers	Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to allow State Medicaid programs to offer special services to beneficiaries at risk of institutionalization in a nursing facility or facility for the mentally retarded. These services, which would otherwise not qualify for Federal matching funds, include case management, homemaker/home health aide services, rehabilitation services, and respite care. They also include, in the case of individuals, with chronic mental illness, day treatment and partial hospitalization, psychosocial rehabilitation, and clinic services. Also known as home and community-based (HCBS) waivers.
Self-Referral Restrictions	Restrictions on or prohibitions against providers referring patients to a designated health service (e.g., pharmacies, clinical laboratories, and outpatient surgery) in which the provider or the provider's immediate family member has a financial interest.
Sin Taxes	Taxes imposed on items considered harmful to public health interests, such as tobacco and alcohol.

<i>Term</i>	<i>Definition</i>
Single-Source Drug	A single-source drug is a covered outpatient drug which is produced or distributed under an original new drug application approved by the FDA, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.
Single State Agency	The agency within State government designated as responsible for administration of the State Medicaid Plan. The Single State Agency is not required to administer the entire Medicaid program. It may delegate certain functions or supervise other State agencies, private contractors, or both.
Skilled Nursing Facility (SNF)	See "Nursing Facility."
Specified Low-Income Medicare Beneficiary (SLMB) Program	These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid as a dual eligible. Medicaid pays their Medicare Part B premiums only, but they are not eligible for Medicaid payment for their Medicare cost-sharing obligations.
Spend-Down	Under Medicaid, "spend-down" refers to a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements.
State Buy-In	The term given to the process by which a State may provide Supplementary Medical Insurance coverage for its needy eligible persons through an agreement with the Federal government under which the State pays the premiums for them.
State Children's Health Insurance Program (SCHIP)	As part of the Balanced Budget Act of 1997, Congress created SCHIP as a Federal/State partnership with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance. SCHIP is designed to provide coverage to "targeted low-income children." A "targeted low-income child" is one who resides in a family with income below 200% of the Federal Poverty Level (FPL) or whose family has an income 50% higher than the State's Medicaid eligibility threshold. Unlike Medicaid, SCHIP is a block grant awarded to the States each year. Children who are eligible for Medicaid are not eligible for SCHIP.
State Mandated Benefits Laws	State laws requiring insurance contracts to provide coverage for certain health services (e.g., in vitro fertilization) or services provided by certain health care providers (e.g., audiologists). Self-insureds are exempt from these requirements.
State Medical Assistance Programs	See "Medicaid."
State Pharmacy Assistant Programs	State authorized programs to provide pharmaceutical coverage or assistance to low-income and/or persons with disabilities who do not qualify for Medicaid. Also known as Expanded Drug Benefit Programs.
State Plan	The Medicaid State Plan is a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

<i>Term</i>	<i>Definition</i>
State Plan Amendment	A State that wishes to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement rates must amend its State Medicaid Plan to reflect the proposed change. The State must submit the State Plan Amendment to CMS for approval.
Stop Loss	That point at which a third party has reinsurance to protect against the overly large single claim or the excessively high aggregate claim during a given period of time. Large employers, who are self-insured, may also purchase “reinsurance” for stop-loss purposes.
Supplemental Security Income (SSI)	A Federal cash assistance program for low-income aged, blind and disabled individuals established by Title XVI of the Social Security Act. States may use SSI income limits to establish Medicaid eligibility.
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	The Federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which defined the primary and secondary coverage responsibilities of the Medicare program.
Temporary Assistance to Needy Families (TANF)	Federal-State welfare program which replaces Aid to Families with Dependent Children. Authorized by the 1996 Welfare Reform Act. States may use TANF to establish Medicaid eligibility.
Therapeutic Alternatives	Drug products containing different chemical entities but which should provide similar treatment effects, the same pharmacological action or chemical effect when administered to patients in therapeutically equivalent doses.
Therapeutic Substitution	Dispensing by a pharmacist of a product different from that which was prescribed, but which is deemed to be therapeutically equivalent. In most States such a practice requires the prescribing physician’s authorization before the substitution may occur. A pharmacy and therapeutics committee (P&T) most often approves the rationale for therapeutic equivalency prior to such practice.
Third-Party Administrator (TPA)	An independent person or corporate entity (third party) that administers group benefits, claims and administration for a self-insured company/group. A TPA does not underwrite the risk.
Third-Party Liability	Under Medicaid, third-party liability exists if there is any entity (i.e., other government programs or insurance) which is or may be liable to pay all or part of the medical cost or injury, disease, or disability of an applicant or recipient of Medicaid.
Total Quality Management (TQM)	See “Continuous Quality Improvement.”
Title XIX	See “ Medicaid.”
Universal Access	The availability of affordable public or private insurance coverage for every United States citizen or legal resident. There is no guarantee, however, that all individuals will actually choose to purchase or have the funds to purchase coverage. See “Universal Coverage.”
Universal Coverage	The guaranteed provision of at least basic health care services to every United States citizen or legal resident. See “Universal Access.”

<i>Term</i>	<i>Definition</i>
Usual, Customary and Reasonable Charges	A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.
Utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per 100 or 1,000 persons eligible for the service.
Utilization Management (UM)	A process of integrating review and case management of services in a cooperative effort with other parties, including patients, providers, and payers.
Utilization Review	A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
Vaccines for Children Program (VCF)	A program under which the Federal government, through the Centers for Disease Control and Prevention, purchases and distributes pediatric vaccines to States at no charge and the State, in turn, arranges for the immunization of Medicaid-eligible and uninsured children through public and private physicians or other authorized providers.
Vendor	A medical vendor is an institution, agency, organization, or individual practitioner that provides health or medical products and/or services either to a medical provider, who in turn interfaces with patients, or directly to the public.
Vendor Payments	In welfare programs, direct payments are made by the State to providers such as physicians, pharmacists and health care institutions rather than to the welfare recipient himself.
Waiver	A rider or clause in a health insurance contract excluding an insurer's liability for some sort of pre-existing illness or injury. Also refers to a plan amendment, such as a CMS waiver or State Plan modification.
Withhold	"At-risk" portion of a claim deducted and withheld by the health plan before payment is made to a participating physician as an incentive for appropriate utilization and quality of care. This amount – for example, 20% of the claim – remains within the plan and is credited to the doctor's account. Can be used where the plan needs additional funds to pay for claims. The withhold may be returned to the physician in varying levels which are determined based on analysis of his/her performance or productivity compared against his/her peers. Also called "physician contingency reserve (PCR)."

ACRONYMS

AABD	Aid to Aged, Blind, and Disabled
AAC	Actual Acquisition Cost
AHRQ	Agency for Health Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
AMP	Average Manufacturer Price
ANSI	American National Standards Institute
ARF	Area Resource File
ASO	Administrative Services Only
AWP	Any Willing Provider <i>or</i> Average Wholesale Price
BBA	Balanced Budget Act of 1997
BIPA	Benefits Improvement and Protection Act
BLS	Bureau of Labor Statistics
CHIP	See SCHIP
CFR	Code of Federal Regulations
CMP	Competitive Medical Plan
CMS	Centers for Medicare and Medicaid Services (formerly HCFA)
CMSO	CMS' Center for Medicaid and State Operations
CNAB	Categorically Needy Aid to the Blind
CNAFDC	Categorically Needy Aid to Families with Dependent Children
CNAPTD	Categorically Needy Aid to the Permanently and Totally Disabled
CNOAA	Categorically Needy Old Age Assistance
COBRA	Consolidated Omnibus Reconciliation Act of 1985
COM-MCO	Commercial Managed Care Organization
CON	Certificate of Need
CPI	Consumer Price Index
CPR	Customary Prevailing, and Reasonable (charges)
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
DAW	Dispense As Written
DBA	Doing Business As
DEFRA	Deficit Reduction Act of 1984
DESI	Drug Efficacy Study and Implementation
DHHS	Department of Health and Human Services
DRGs	Diagnostic Related Groupings
DSH	Disproportionate Share Hospital
DUE	Drug Use Evaluation
DUR	Drug Utilization Review
EAC	Estimated Acquisition Cost
EDI	Electronic Data Interchange

EPSDT	Early and Periodic Screening, Diagnostic and Treatment
ERISA	Employee Retirement Income Security Act
ESRD	End Stage Renal Disease
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentage
FOC	Freedom of Choice
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FUL	Federal Upper Limits
FY	Fiscal Year
HCFA	Health Care Financing Administration (see CMS)
HCPCS	HCFA Common Procedural Coding System
HCPP	Health Care Prepayment Plan
HEDIS	Health Plan Employer Data and Information Set
HH	Home Health
HIFA	Health Insurance Flexibility and Accountability
HIO	Health Insuring Organizations
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HRSA	Health Resources and Services Administration
ICF-MR	Intermediate Care Facility for the Mentally Retarded
IGT	Intergovernmental Transfer
IPA	Individual Practice Association
MAC	Maximum Allowable Cost
MAIC	Maximum Allowable Ingredient Cost
MCAC	Medical Care Advisory Committee
MCAID-MCO	Medicaid-only Managed Care Organization
MCO	Managed Care Organization
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
MMIS	Medicaid Management Information System
MNAB	Medically Needy Aid to the Blind
MNAFDC	Medically Needy Aid to Families with Dependent Children
MNAPTD	Medically Needy Aid to the Permanently and Totally Disabled
MNOAA	Medically Needy Old Age Assistance
MQC	Medicaid Quality Control
MSA	Medical Savings Account
MSIS	Medicaid Statistical Information System
NDC	National Drug Code
NF	Nursing Facility
NP	Nurse Practitioner

OACT	Office of the Actuary
OASDI	Old Age, Survivors, and Disability Insurance
OBRA	Omnibus Budget Reconciliation Act
OHS	Outpatient Hospital Services
OMB	Office of Management and Budget
ORD	Office of Research and Demonstrations
OT	Occupational Therapy
OTC	Over-the-Counter (drugs)
P&T	Pharmacy and Therapeutics Committee
PA	Physician's Assistant <i>or</i> Prior Authorization
PBM	Pharmaceutical Benefits Manager
PCCM	Primary Care Case Management
PCF	Program Characteristics File
PCP	Primary Care Physician
PHP	Prepaid Health Plan
PMPM	Per Member Per Month
PHO	Physician-Hospital Organization
POS	Point-of-Service
PPO	Preferred Provider Organization
PRO	Peer Review Organization
ProPAC	Prospective Payment Assessment Commission
PT	Physical Therapy
QA/QI	Quality Assurance/Quality Improvement
QMB	Qualified Medicare Beneficiary
RHC	Rural Health Clinic
RPH	Registered Pharmacist
Rx	Pharmaceutical
SCHIP	State Children's Health Insurance Program
SFO	State Funds Only
SLMB	Specified Low-Income Medicare Beneficiary
SSA	Social Security Administration
SSI	Supplemental Security Income
SSP	State Supplemental Payments
TANF	Temporary Assistance for Needy Families
TDOC	Total Days of Care
TEFRA	Tax Equity & Fiscal Responsibility Act
Title XIX	Title XIX of The Social Security Act (See Medicaid)
TPA	Third-Party Administrator
TQM	Total Quality Management
UCR	Usual, Customary and Reasonable
UM	Utilization Management
UR	Utilization Review

VCF Vaccines for Children Program

WAC Weighted Average Cost *or* Wholesale Acquisition Cost