

State Perspectives on Emerging Medicaid Pharmacy Policies and Practices

National Association of State Medicaid Directors
An Affiliate of the American Public Human Services Association

Powered by Avalere Health LLC

November 2006



Acknowledgements

For more information on the survey, please contact Andrea Maresca with NASMD at 202-682-0100 or Andrea Kastin with Avalere Health at 202-207-3477.

This survey represents the beginning of a new series of projects by the National Association of State Medicaid Directors (NASMD). The first in this collection, the pharmacy survey, provides us with a better understanding of pharmacy initiatives at the federal and state levels. In the near future, NASMD will be surveying states on Medicaid information technology systems, state Medicaid quality programs, and state Medicaid long-term care initiatives.

We would like to thank the more than 50 state officials who completed the comprehensive survey instrument and responded to follow-up questions. We recognize that this survey required a coordinated response from various individuals within each state Medicaid agency and we appreciate the time and effort that was devoted to providing thoughtful and detailed information. Thanks and deep appreciation must also be conveyed to the members of the NASMD and Centers for Medicare and Medicaid Services (CMS) Pharmacy Technical Advisory Group (TAG). Pharmacy TAG member guidance was invaluable in the development of the survey instrument as well as the publication.

Pharmacy TAG members include:
Lynn Mitchell, M.D., M.P.H., Chair
Dave Campana, R.Ph.
Del W. Swan, R.Ph.
Robert Reid, R.Ph.
Rhonda Driver, R.Ph.
Jerry Dubberly, Pharm.D.
Jerry Wells, R.Ph.
Mark-Richard Butt, M.S., R.Ph.
Terri Cathers, Pharm.D., R.Ph.

The NASMD executive committee provided essential leadership on this important project, and we would like to thank Elaine Ryan for her thoughtful guidance and assistance. Andrea Maresca served as the NASMD lead for this project, and Jamie Burgess and Ashley Trantham provided assistance in producing the survey. NASMD would also like to thank Avalere Health for their analytic support of this project, and would especially like to recognize Andrea Kastin, Michael Cheek, and Jon Blum of Avalere Health without whom this survey would not be possible. NASMD and Avalere plan to update the pharmacy survey annually.

With appreciation,

Martha Roherty
Director
*National Association of State Medicaid Directors
An Affiliate of the American Public Human Services
Association*

Executive Summary

The Medicare Modernization Act of 2003 (MMA, P.L. 108-173) and the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) made significant changes in policies governing Medicaid-financed pharmacy benefits. To provide state Medicaid officials and federal policymakers with preliminary insights on the impact of the MMA and DRA changes, the National Association of State Medicaid Directors (NASMD) surveyed state pharmacy administrators on several broad topics, including:

- > Short-term MMA programmatic impacts;
- > Preliminary ideas about DRA impact on states; and
- > Changes states have made to improve pharmacy benefit quality and efficiency.

The survey, conducted in collaboration with Avalere Health LLC, was completed and analyzed during the summer of 2006. This report is based on state Medicaid program officials' survey responses. NASMD and Avalere attempted to faithfully interpret the responses from 47 states. Key findings include:

Finding 1. Short-term MMA Impacts

To date, most states report that the shift of dual eligibles to the Medicare Part D drug benefit has not had a substantial financial impact. Furthermore, some states implemented policies to supplement Medicare Part D coverage for certain low-income Medicare beneficiaries.

Finding 2. Preliminary DRA Insights

With CMS guidance pending on major provisions of the DRA, states are still assessing the new law's impact on Medicaid pharmacy policies. More than two-thirds of states, however, noted that they do not expect the DRA to reduce their spending on pharmacy benefits significantly.

Finding 3. Medicaid Managed Care

States generally give Medicaid managed care organizations (MCOs) considerable flexibility to develop drug formularies for the individuals and classes of drugs covered by the MCO. Nearly one fourth of states, however, "carve out" a portion of their pharmacy program to retain state control of pharmacy benefits for specific beneficiary groups and classes of drugs.

Finding 4. Prescription Drug Bulk Purchasing Pools

Several states participate in bulk-purchasing pools and the option is being considered in others. Meanwhile, some states have found it more effective to develop their own Medicaid pharmacy policies.

Finding 5. Pharmacy Benefit Management Strategies

States continue to use a variety of mechanisms to manage both cost and use of prescription drugs, while coordinating such efforts with evidence-based pharmacy quality programs.

Finding 6. Medical Benefit Reimbursement

States are developing strategies to comply with the DRA requirement that Medicaid programs collect rebates on all physician-administered drugs by January 1, 2008.

For additional survey information please see:

- > Appendix A. Survey Design and Methodology
- > Appendix B. Glossary
- > Appendix C. State-by-state Data Charts

Snapshot of the Medicaid Program Pharmacy Benefit

Medicaid Demographics

- There are approximately 55 million Medicaid beneficiaries, which constitutes approximately 19 percent of the total population (2003).¹ The demographic breakdown of the Medicaid population is as follows:²
 - > 49.6 percent are children aged 17 and under
 - > 25.6 percent are adults between the ages of 18 and 64
 - > 14.2 percent are blind or disabled individuals under age 64
 - > 10.5 percent are elderly
- The average number of prescription drugs used per month: ^{3*}
 - > Per Medicaid beneficiary: 3.3
 - > Per individual dually eligible for Medicaid and Medicare: 5.8
 - > Per institutionalized individual: 7.2

Medicaid Spending on Prescription Drugs

- Medicaid programs constituted 19 percent of national prescription drug spending (2003).⁴
- Medicaid programs spent \$36.6 billion on prescription drugs which is 12.5 percent of total Medicaid spending (2004).⁵
- Prescription drugs for individuals dually eligible for both Medicare and Medicaid cost the Medicaid program \$15.2 billion (2003).⁶

Medicaid Pharmacy Benefit Design

- 44 state Medicaid programs, including the District of Columbia, have implemented preferred drug lists.⁷
- A significant majority of states impose prior authorization on certain drugs.⁸ Approximately 3.4 percent of Medicaid prescription drug claims required prior authorization—accounting for 7.5 percent of total Medicaid prescription drug spending.⁹
- 47 states and the District of Columbia impose prescribing or dispensing limits on prescription drugs (2004).¹⁰
- 10 state Medicaid programs do not charge co-payments for prescription drugs (2004).¹¹
- 9 states do not require pharmacists to dispense generic multi-source drugs (2004).¹²

* These statistics from the Kaiser Family Foundation report the average number of monthly prescriptions dispensed to all Medicaid beneficiaries. These numbers were broken down further by dual eligibles and by Medicaid beneficiaries residing in nursing homes and other institutions. While states do not uniformly track this data, a subset of states were able to provide estimates. States excluded from these estimates include: AL, DE, GA, HI, KY, ME, MT, NV, NM, OH, RI, TN, VT, WV.

FINDING 1. Short-term MMA Impacts

To date, most states report that the shift of dual eligibles to the Medicare Part D drug benefit has not had a substantial financial impact. Additionally, some states implemented policies to supplement Medicare Part D coverage for certain low-income Medicare beneficiaries.

- 14 states report paying about the same for drug coverage for full benefit dual eligible beneficiaries through the Part D clawback as they were when these beneficiaries were enrolled in the Medicaid drug benefit. 12 states report they are paying more and 8 states report paying less (Figure 1A).
- 27 states report that they were unsure of Part D's impact on Medicaid waiver budget neutrality and cost-effectiveness. 13 states report that Part D has not and 6 states report that it has impacted budget neutrality or cost-effectiveness.
- 19 states report no percentage decrease in supplemental rebates following the transition of full benefit dual eligibles to the Part D program.*
 - > 10 states report a percentage decrease in the amount collected.
- 26 states report no change in the number of manufacturers providing supplemental rebates. 3 states report a decrease in the number of manufacturers providing rebates while 5 report an increase.
- 44 states report that they will keep existing utilization management controls in place after all dual eligibles transition to Medicare Part D, but a number of states are assisting low-income

beneficiaries with costs associated with Medicare Part D (Figure 1B and Appendix C, Chart 1).

- > 10 states provide assistance to dual eligible beneficiaries for Part D co-payments.
- > 7 states provide assistance to low-income beneficiaries for Part D coinsurance.
- > 8 states provide assistance to low-income beneficiaries with Part D premiums and deductibles.

Long-term Care

- 15 states report that Medicare-eligible nursing facility residents with pending Medicaid applications are experiencing difficulty accessing Part D-covered medication. 22 states were unsure how common this problem was while 7 thought it seldom occurred.
- 22 states report permitting retroactive billing for Medicaid long-term care beneficiaries up to the date of Part D enrollment even though Part D plans do not permit this.

* Note: Statistics reported in this section are subject to change in 2007 due to a lag in the collection of supplemental rebates. It is possible that supplemental rebates collected in 2006 may not reflect the transition of dual eligibles into the Medicare Part D drug benefit in all states.

MMA PART D DRUG BENEFIT

On January 1, 2006, Medicare Part D prescription drug coverage began for approximately 6.2 million beneficiaries dually eligible for both full Medicaid and Medicare benefits (dual eligibles).¹³ Prior to 2006 these individuals received drug coverage from state Medicaid programs. Non-institutional dual eligibles receive federal assistance with Medicare Part D cost sharing, but they are responsible for drug co-payments.

States and federal officials have been monitoring the potential change in state drug expenditures and impact on utilization for full-benefit dual eligibles. States have focused on the potential impact in two major areas: (1) the MMA requirement that states make payments to the federal government approximately equal to 2003 drug spending on behalf of dual eligibles, commonly referred to as the “clawback”; and (2) the impact on quality and care management that may be jeopardized by states’ loss of control over low-income Medicare beneficiaries’ prescription drug use.

States and Part D plans have two possible areas for collaboration. First, the Part D benefit structure for dual eligibles leaves cost sharing gaps that Medicaid programs could fill, or “wrap-around.”

Second, Part D plans must design and establish Medication Therapy Management Programs (MTMPs) that limit adverse events and drug interactions, and help beneficiary subpopulations experience the best possible therapeutic outcomes. Plans are not currently required to coordinate MTMPs with state Medicaid programs (see page 13 for additional information).

FIGURE 1A State Part D Clawback Amounts Compared with Medicaid Payments Prior to January 2006

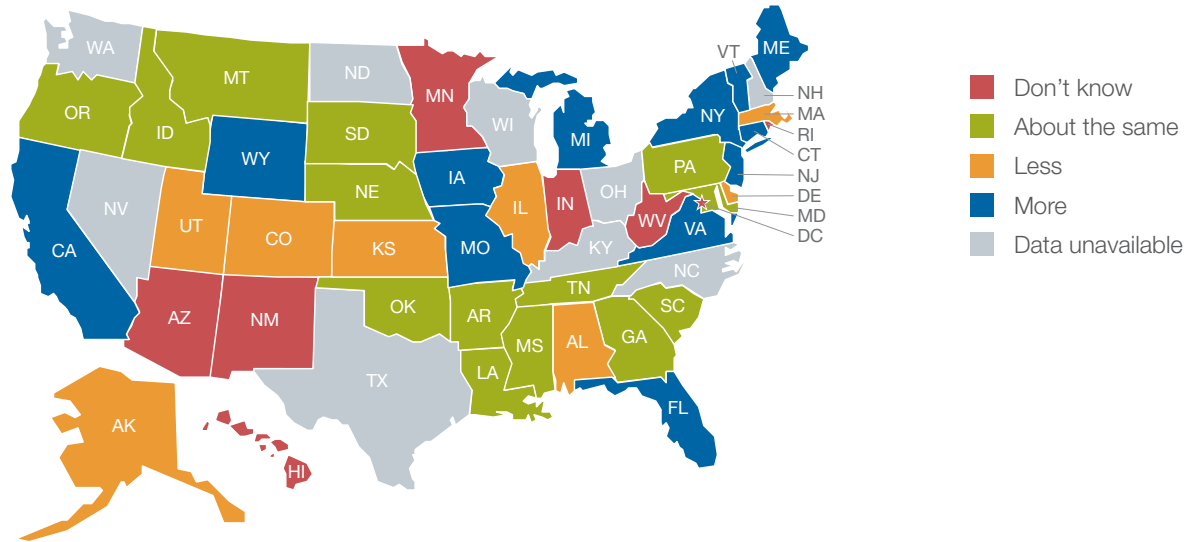
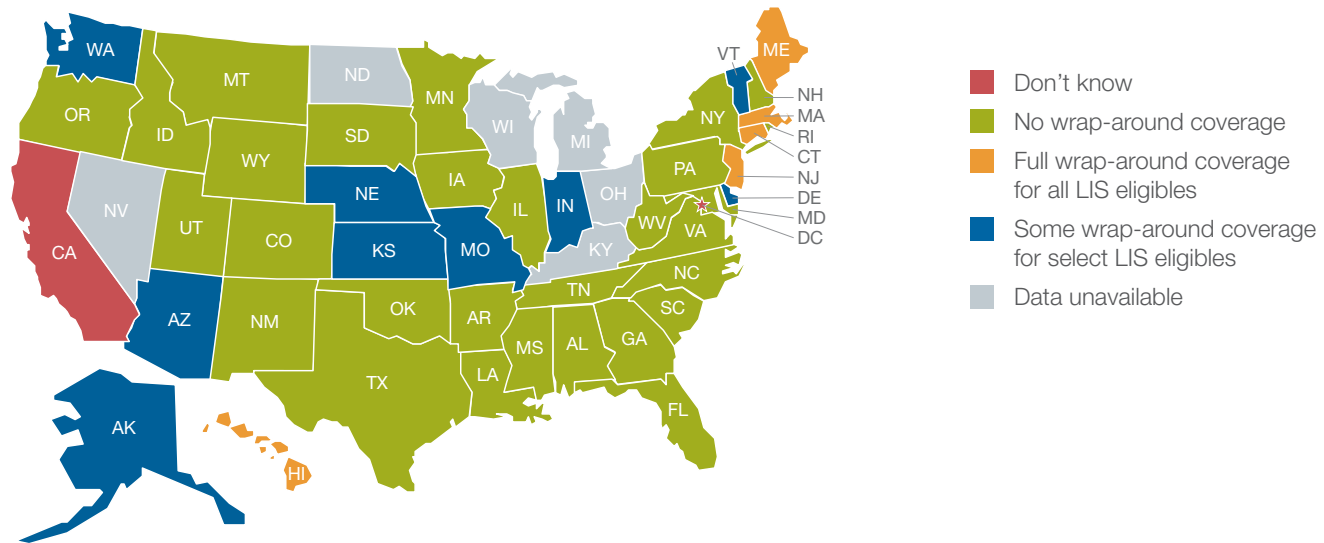


FIGURE 1B State Medicaid Coverage of Medicare Part D Cost Sharing for Low-income Individuals



FINDING 2. Preliminary DRA Insights

With CMS guidance pending on major provisions of the DRA, states are still assessing the new law's impact on Medicaid pharmacy policies. More than two-thirds of states, however, noted that they do not expect the DRA to reduce their spending on pharmacy benefits significantly.

- 23 states report that they are unlikely to increase prescription drug cost sharing requirements for prescription drugs dispensed in an outpatient setting and 11 states report that they will not increase those cost sharing requirements (Figure 2A).
- 15 states report that they will not increase cost sharing for non-preferred drugs while 12 have not yet come to a decision (Figure 2B).
- 31 states report that the DRA grants little to moderate flexibility to develop pharmacy policies. 3 states report that the DRA does not provide new flexibilities to develop Medicaid pharmacy policies. No states reported that the DRA provides significant new flexibility (Appendix C, Chart 3).
- 20 states report that they do not expect the DRA provisions to result in a reduction in pharmacy costs. 16 states reported they do expect the DRA to reduce pharmacy costs, and 10 states could not estimate financial impact at the time of the survey (Figure 2C).
- 16 states report that they do not yet know if they will apply for Medicaid transformation grants specifically to increase generic utilization. 7 states will likely apply for a grant to increase generic utilization, and 23 states will not seek transformation grant funds to increase generic use.*
- 22 states report that they have not yet determined whether they will use a DRA benchmark benefit plan to modify their Medicaid pharmacy benefit. 10 will not use this option; 11 states likely will not use this option, but have not yet decided; and 3 states may use this state plan option, but have not yet decided.

* Data collected prior to the deadline for states to submit grant proposals to the Centers for Medicare and Medicaid Services.

“We’re cutting reimbursement on generic medications, which [already] save our budget money. Generic medications are not driving our budget; brand name medications are driving the budget. We will need to increase [generic] reimbursement on the dispensing fee side, which will probably negate any perceived savings...”

– STATE RESPONDENT

DRA PHARMACY PROVISIONS

The DRA made several changes to the Medicaid program to enhance state flexibility. This flexibility is intended to improve accuracy in reimbursement for prescription drugs and provide additional prescription drug spending control tools. States are awaiting federal guidance on some provisions and continue to assess the possible impacts of the following DRA Medicaid pharmacy changes:

- Changes in the federal upper payment limits for drugs with two or more therapeutically and pharmaceutically equivalent drugs
- Availability of monthly Average Manufacturer's Price (AMP)
- Refinement of AMP to exclude prompt-pay discounts to wholesalers
- Mandating state collection of rebates on physician-administered drugs
- Modification of the definition of Medicaid “best price” to include the lowest price for “authorized generics”
- Provision of optional state authority to enforce beneficiary cost-sharing
- Inclusion of pharmacy in Medicaid oversight efforts

FIGURE 2A State Plans to Increase or Implement DRA Drug Cost Sharing Provisions

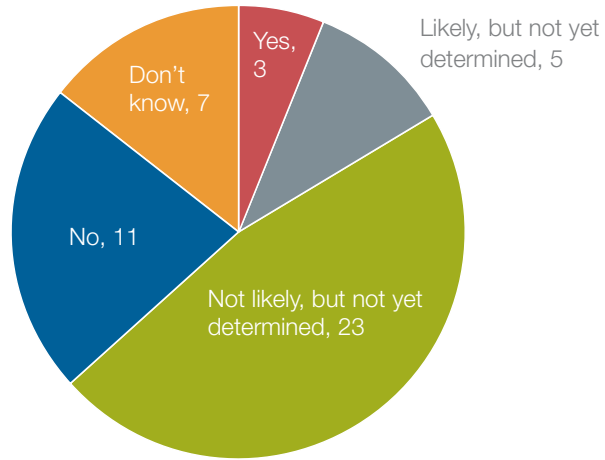
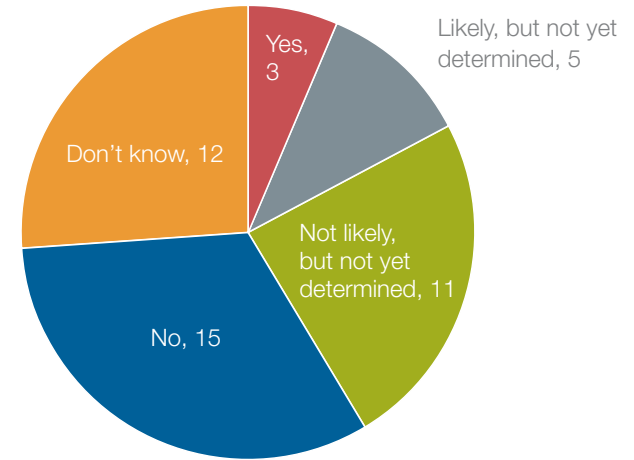
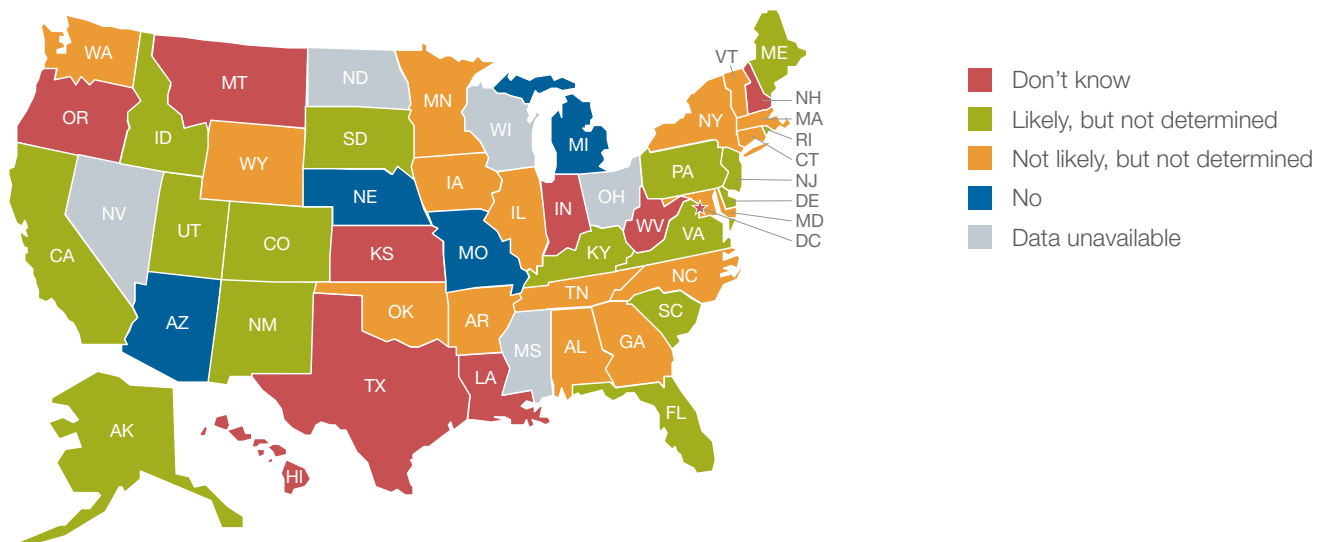


FIGURE 2B State Plans to Increase Cost Sharing for Non-Preferred Drugs



The charts indicate the number of state respondents that fall into each category.

FIGURE 2C Likelihood that Deficit Reduction Act of 2005 Provisions Will Reduce Medicaid Outpatient Prescription Drug Costs



FINDING 3. Medicaid Managed Care

States generally give Medicaid managed care organizations (MCOs) considerable flexibility to develop drug formularies for the individuals and classes of drugs covered by the MCO. Nearly one-fourth of states, however, “carve out” a portion of their pharmacy program to retain state control of pharmacy benefits for specific beneficiary groups and classes of drugs.

- 12 states report giving risk-based Medicaid MCOs great to significant amounts of flexibility in formulary development and maintenance, while another 12 states provide them with moderate flexibility (Figure 3A).
- 9 states with risk-based Medicaid managed care report carving out all drugs from managed care contracts (Appendix C Chart 4).
- 12 states report carving out pharmacy benefits for specific populations, specific drugs, and/or specific drug classes. Almost one-fifth of respondents indicated they carve out for anti-psychotics or mental health drugs (Appendix C Chart 4).
- 21 states report that they do not permit risk-based Medicaid managed care plans to provide drug coverage to aged, blind, or disabled (ABD) populations (Figure 3B).
- Of the 16 states permitting ABD populations to receive drug coverage from risk-based Medicaid managed care, one reports that it requires plans to modify conventional pharmacy utilization management strategies (e.g., step therapy) for this population.

MEDICAID MANAGED CARE

Most states use a combination of managed care and fee-for-service systems to deliver Medicaid pharmacy benefits. Many states use some form of Medicaid managed care to improve care coordination and produce more predictable state Medicaid budget targets. Some research has shown that risk-based Medicaid managed care—contrasted with other forms of Medicaid managed care—produces more definitive outcomes both in quality of care and cost effectiveness.¹⁴ Over the last decade, there has been significant growth in the number of Medicaid beneficiaries enrolled in risk-based managed care organizations (MCOs) that serve both the private sector and the Medicaid program as well as risk-based MCOs that only serve Medicaid beneficiaries.

Between 1990 and 2002, the number of states using risk-based managed care increased from 28 to 41.¹⁵ Some states, however, “carve out” coverage for certain classes of prescription drugs from Medicaid managed care contracts. Individuals that need drugs in carved-out classes receive coverage through the fee-for-service Medicaid program.

Beneficiaries who are categorically eligible under transitional Medicaid or women and child coverage groups are more likely to be enrolled in an MCO. Enrollment of people with more intense health care needs—people who are dually eligible and people who are eligible under other aged, blind, and disabled eligibility groups—is currently not as common, but enrollment of dual eligibles has increased in recent years.

FIGURE 3A Flexibility Given to Medicaid Managed Care Organizations to Develop Pharmacy Policies

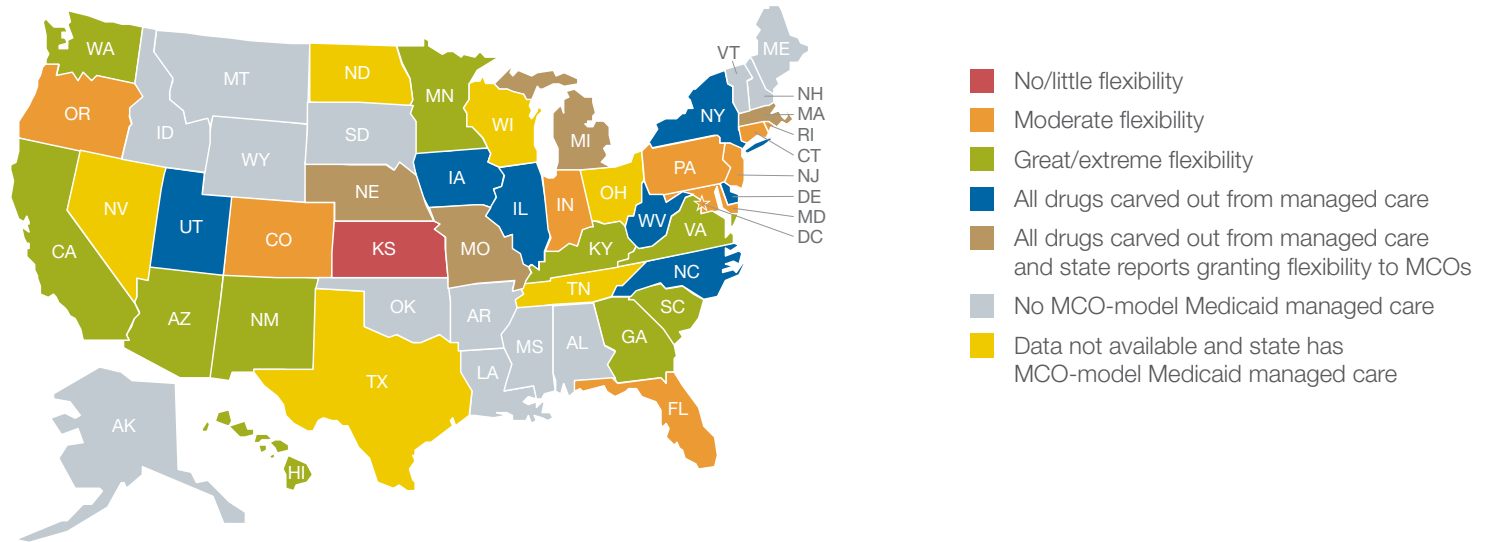
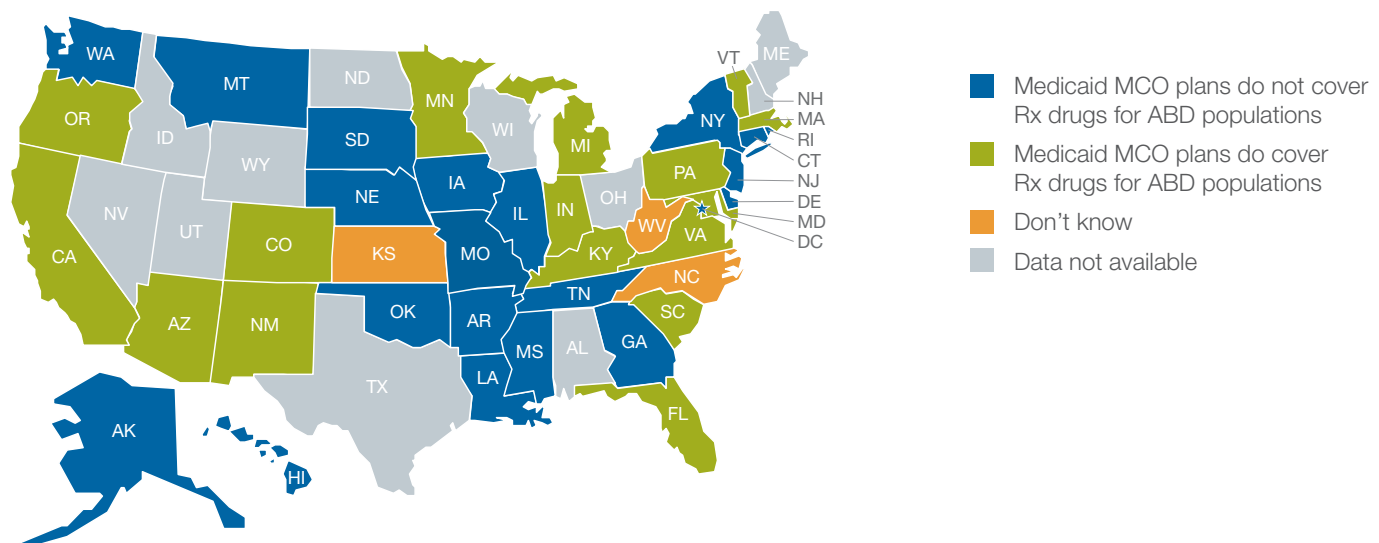


FIGURE 3B Medicaid Managed Care Organization Prescription Drug Coverage of Aged, Blind, or Disabled (ABD) Populations



FINDING 4. Prescription Drug Bulk Purchasing Pools

Several states participate in bulk-purchasing pools and the option is being considered in others. Meanwhile, some states have found it more effective to develop their own Medicaid pharmacy policies.

Multi-State Pools

- 17 states report participation in multi-state purchasing pools and four states report exploring the possibility of joining a pool (Figure 4A, Appendix C Chart 5).
- Nearly 19 million Medicaid enrollees receive pharmacy benefits in states which participate in bulk purchasing pools.
- All 17 states that participate in multi-state purchasing pools report they have maintained flexibility in creating preferred drug lists.
- 9 of the 17 pool participants report operational savings:
 - > 1 state reports saving over \$6 million;
 - > 4 states report saving between \$3 and \$6 million;
 - > 2 states report saving between \$1 and \$3 million;
 - > 2 states report saving under a million; and
 - > 1 state reported it did not save any money.

- 30 states have chosen not to participate in a multi-state pool for a variety of reasons (Figure 4B):
 - > 14 states report that it is more cost effective not to join, noting a combination of administrative burden, lack of autonomy in developing pharmacy policies, and less favorable rebate collection as barriers to participation;
 - > 3 states report state policy barriers to participation; and
 - > 2 states report that because they did not have PDLs, they were not considering a multi-state pool.

Intra-State Pools

- 3 Medicaid programs (LA, NY, and WA) report participating in intra-state pools and 3 report that they are considering this option.
- The remaining 44 Medicaid programs report that they have chosen not to participate in intra-state pools for similar reasons to those outlined for non-participants in multi-state pools (Figure 4C).

“The Medicare Part D drug benefit resulted in the loss of dually eligible members, reducing the state’s bargaining power by nearly \$200 million. The SSDC will increase the number of lives involved in the negotiations... [and] supplemental rebates for both the federal government and the states involved.”

PRESCRIPTION DRUG BULK PURCHASING POOLS

In 2004, building on initiatives started by states as early as 1999, the Centers for Medicare & Medicaid Services (CMS) approved states’ ability to form multi-state prescription drug purchasing pools. Since that time, a number of states have formed purchasing coalitions to negotiate lower rebate contracts on prescription drugs purchased for their Medicaid programs. According to participating states, these partnerships have helped to reduce Medicaid fee-for-service spending on prescription drugs.

Currently, three multi-state pools are operating that increase state rebate negotiating power by pooling Medicaid populations. These are:

The First Health Multi-State Pooling Agreement

It was the first pool approved by CMS (April 22, 2004) and was initially called the National Medicaid Pooling Initiative.

The TOP\$ Pool

TOP\$ is administered by Provider Synergies. CMS approved the pool on May 28, 2005.

The Sovereign States Drug Consortium (SSDC)

SSDC is administered by MedMetrics Health Partners, a nonprofit Pharmacy Benefit Manager.

Intra-State Pools

Although less common than multi-state purchasing pools, intra-state pools have helped states contain costs. In at least three states, Medicaid agencies have teamed with other state agencies within their state to leverage their purchasing power.

FIGURE 4A State Medicaid Program Participation in Multi-State Prescription Drug Bulk Purchasing Pools

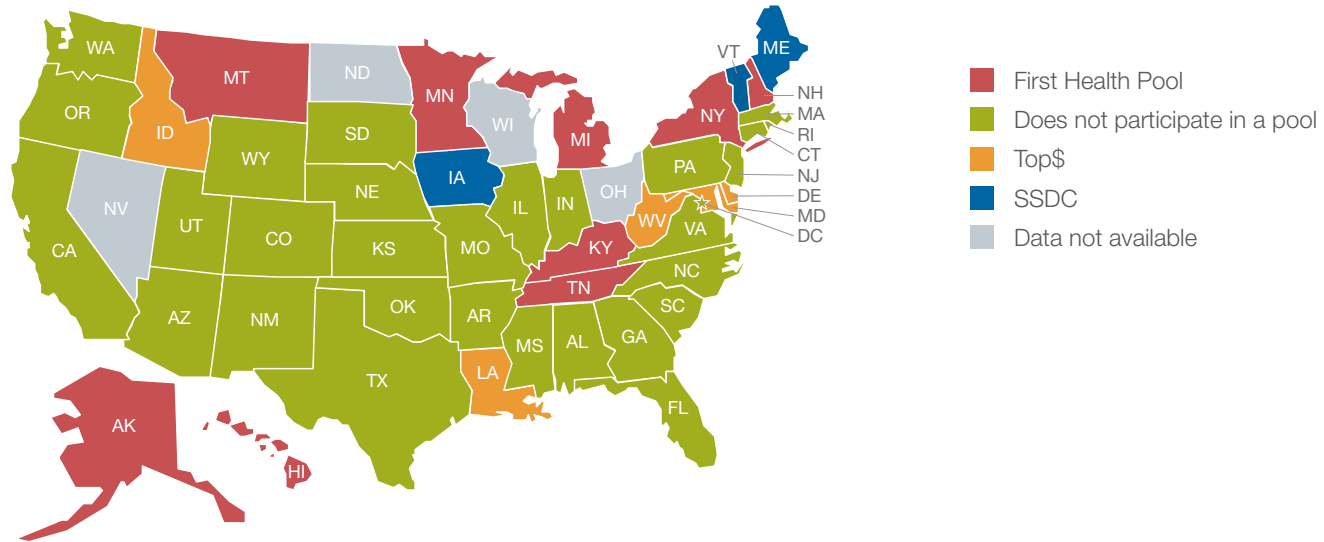


FIGURE 4B Reasons Why States Are Not Joining MULTI-STATE Purchasing Pools

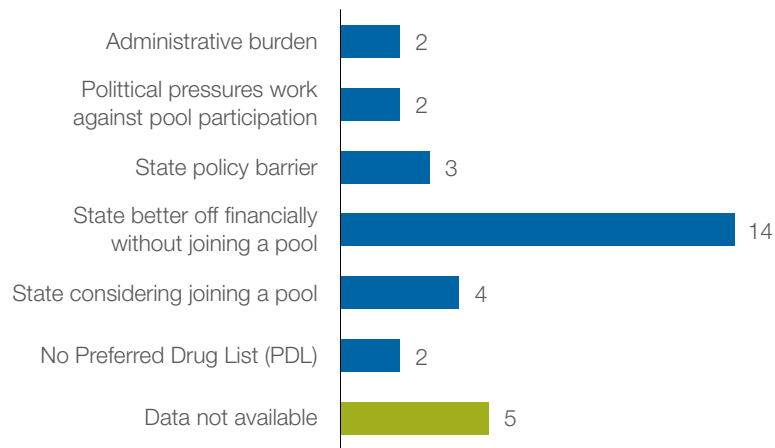
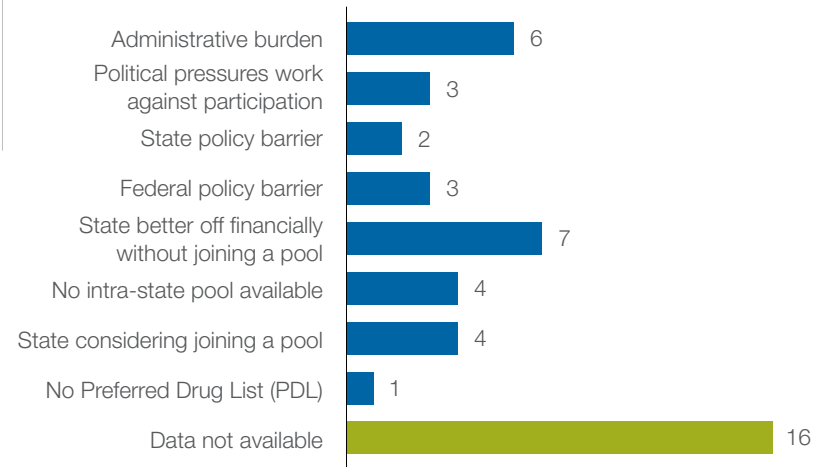


FIGURE 4C Reasons Why States Are Not Joining INTRA-STATE Purchasing Pools



Please note that responses displayed in figures 4B and 4C are not mutually exclusive.

FINDING 5. Pharmacy Benefit Management Strategies

States continue to use a variety of mechanisms to manage both cost and use of prescription drugs, while coordinating such efforts with evidence-based pharmacy quality programs.

Medication Management Programs

- 29 states report operating Medicaid medication management programs and/or polypharmacy programs across a variety of Medicaid programs and benefits (Figure 5A and Appendix C Chart 6).
- 33 states report that they do not work with Part D MTMPs in monitoring dual eligibles' drug utilization and therapeutic outcomes, 3 states do not have these programs in place, and 7 are considering collaborating with Part D plans.

Drug Comparative Effectiveness Information

- 38 states report that drug Comparative Effectiveness Reviews (CERs) are useful when developing Medicaid pharmacy policy. This includes 12 of the 15 states participating in the Drug Effectiveness Review Project (DERP) (Figure 5B).
- In addition to CERs, states report that they use many other information sources when developing Medicaid pharmacy policy, including (1) studies published in peer-reviewed journals; (2) national experts; (3) local prescribers and pharmacists; and (4) drug compendia (Figure 5C).

Other management strategies include the following:

- 9 states report using information system tools to match beneficiary medical records with pharmacy claims to ensure that only appropriate prescriptions are filled. 7 states are working on similar system upgrades.
- 27 states report that the supplemental rebate amount for specific drugs is useful to know when developing pharmacy policies.

Pay-for-Performance Initiatives

- 2 states report use of a pay-for-performance initiative related to their Medicaid pharmacy program.

MEDICAID MEDICATION MANAGEMENT PROGRAMS

Many states have developed Medicaid medication management programs. These programs are intended to reduce polypharmacy issues such as drug contraindications and drug-drug interactions. Targeted beneficiaries are typically those with complex medication regimens—such as long-term care (LTC) users and people with mental illness. Operationally, medication management programs obtain formulary exception approvals needed to dispense a medication, manage medications in the context of a comprehensive medical and provider history, and conduct regular drug utilization and drug regimen reviews.¹⁶ Programs work both to improve quality of care received and to reduce Medicaid pharmacy costs

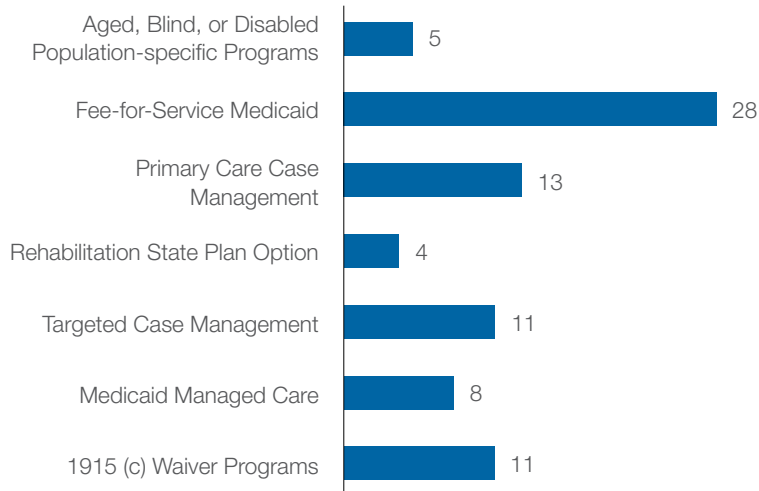
EVIDENCE-BASED MEDICINE

States are also using evidence-based reviews to inform their Medicaid pharmacy policies. Clinical evidence reviews and advice from medical experts help states develop pharmacy utilization management tools that yield greater cost-effectiveness and higher quality of care. Fifteen state Medicaid programs have joined Oregon Health and Science University's Center for Evidence-Based Policy's Drug Effectiveness Review Project (DERP).¹⁶ These states help guide the development of DERP's drug comparative effectiveness reviews (CERs) on specific prescription drugs and drug classes, and use this information to inform their own Medicaid pharmacy policymaking.

PAY-FOR-PERFORMANCE

Although pay-for-performance initiatives are increasingly prevalent in medical services delivery, only two states reported operating a pay-for-performance initiative related to pharmacy. However, state Medicaid agencies are participating in a new national organization, the Pharmacy Quality Alliance (PQA), which seeks to develop quality and reporting metrics.

FIGURE 5A State Administration of Medicaid Medication Management Programs



Please note that responses displayed in figure 5A are not mutually exclusive.

FIGURE 5B State Assessment of CER Usefulness When Developing Medicaid Pharmacy Policy

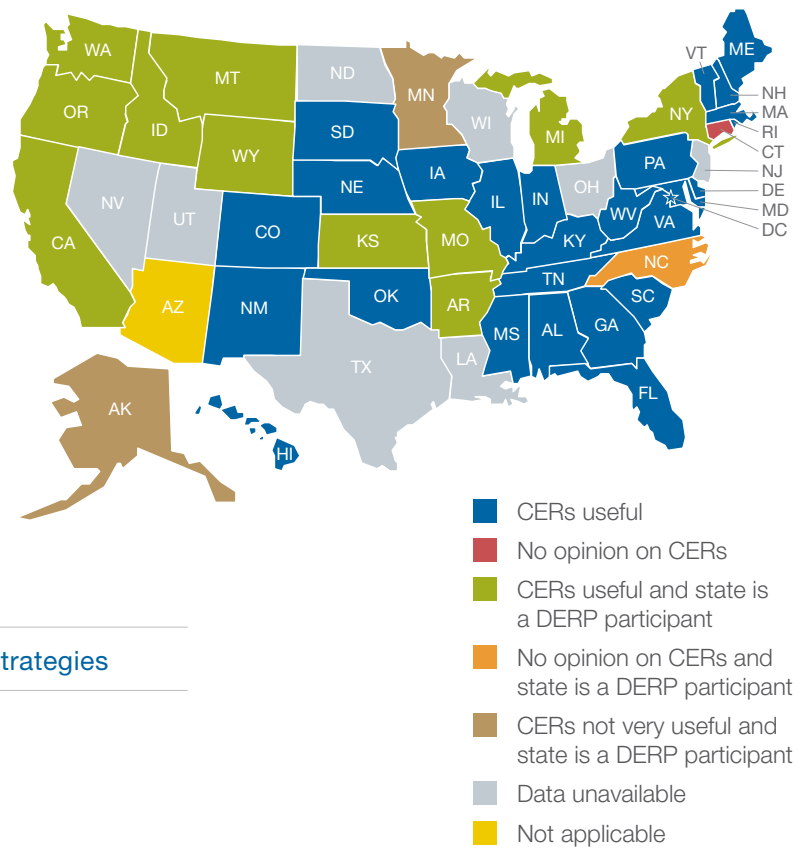
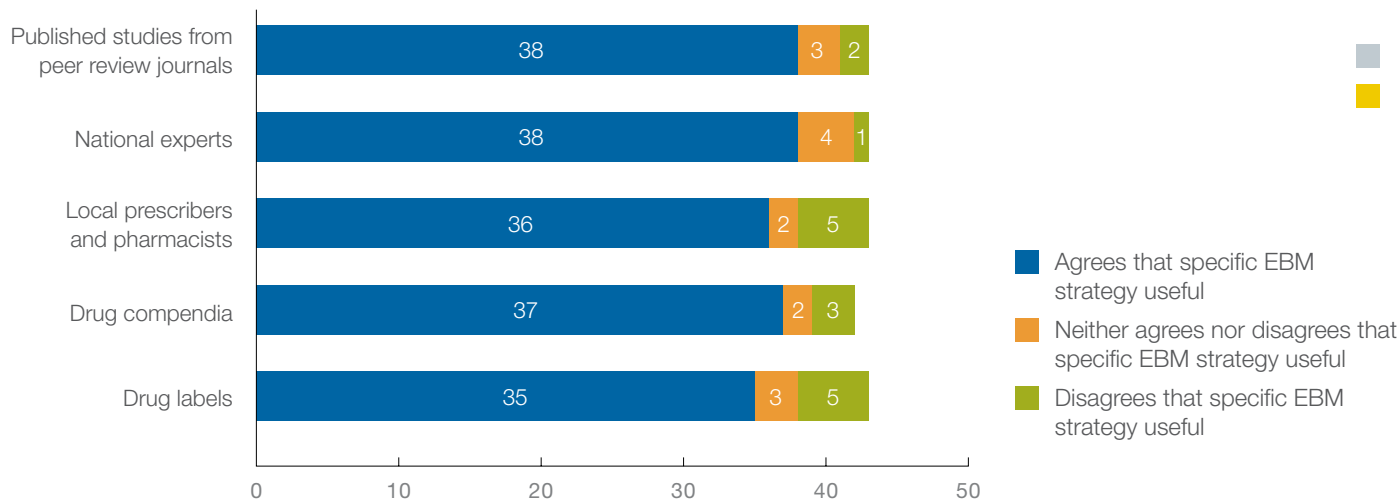


FIGURE 5C State Assessment of Evidence-Based Medicine (EBM) Strategies



FINDING 6. Reimbursement under the Medicaid Medical Benefit

States are developing strategies to comply with the DRA requirement that Medicaid programs collect rebates on all physician-administered drugs by January 1, 2008.

- 29 states report collecting rebates on some, but not all physician-administered drugs (Figure 6A).
- 29 states report that they currently match J-codes to NDCs in order to collect rebates on all physician-administered drugs. 15 states are in the process of matching J-codes to NDCs in order to collect rebates on all physician-administered drugs (Appendix C Chart 7).
- 20 states did not report a specific date for when they will begin collecting rebates on all physician-administered drugs (Appendix C Chart 8).
 - > 8 states are scheduled to begin collecting rebates on all physician-administered drugs in 2007.
 - > 3 states anticipate that their systems will be operational in 2008.
- 17 states report having Medicaid claims processing systems that allow for billing of NDC codes for physician-administered drugs, and 13 states are currently working on upgrades. 11 states report not having this capability for the medical benefit (Figure 6B).

Other Information on Drugs Reimbursed by Medicaid's Medical Benefit:

- 19 states report that they have not determined whether they will change drug reimbursement rates or physician fees for drugs paid under the medical benefit next year.
 - > 10 states report that they are not likely to change reimbursement.
 - > 3 states report they are likely to decrease reimbursement for drugs covered under the medical benefit.
 - > 4 states report they are likely to increase drug reimbursement rates or physician fees for drugs paid under the medical benefit next year.
- 16 states report that it is unclear whether the state would consider implementing an ASP-based reimbursement system.
 - > 14 states report that they are not considering ASP.
 - > 1 state reports considering ASP for outpatient pharmacy (e.g., retail benefit).
 - > 4 states report considering ASP for medical benefit drug reimbursement.

REBATES FOR PHYSICIAN-ADMINISTERED DRUGS REIMBURSED UNDER THE MEDICAID MEDICAL BENEFIT

Prior to the DRA, Medicaid programs generally had not been collecting rebates on physician-administered drugs because they have had difficulty in identifying the codes necessary to collect rebates. However, the DRA mandates that state Medicaid programs collect rebates on all drugs administered to Medicaid beneficiaries in a physician's office. The DRA requires states to do so as of January 1, 2006, for single source drugs and by January 1, 2008, for multiple source drugs.

Two codes may be used to bill for physician-administered drugs: J-codes and National Drug Codes (NDCs). When providers bill Medicaid for drugs they administer to their Medicaid patients, they use J-Codes, which encompass many different brands and forms of a specific drug. J-codes do not capture the level of specificity needed for Medicaid programs to collect all manufacturer rebates.

In order to comply with the DRA's mandate, states can implement Medicaid systems that match J-Codes to NDCs. NDCs capture a level of specificity that J-Codes do not, which is necessary to collect full Medicaid rebates on all physician-administered drugs.

AVERAGE SALES PRICE (ASP)

Under the MMA, Medicare has changed its reimbursement methodology for physician-administered drugs from a formula based on Average Wholesale Price (AWP) to one based on ASP. Now that CMS uses an ASP-based system, Medicaid programs might make a similar change in reimbursement methodology. According to survey findings, however, it does not appear that many states are considering this option to leverage their purchasing power.

FIGURE 6A Collection of Rebates on Physician-Administered Drugs

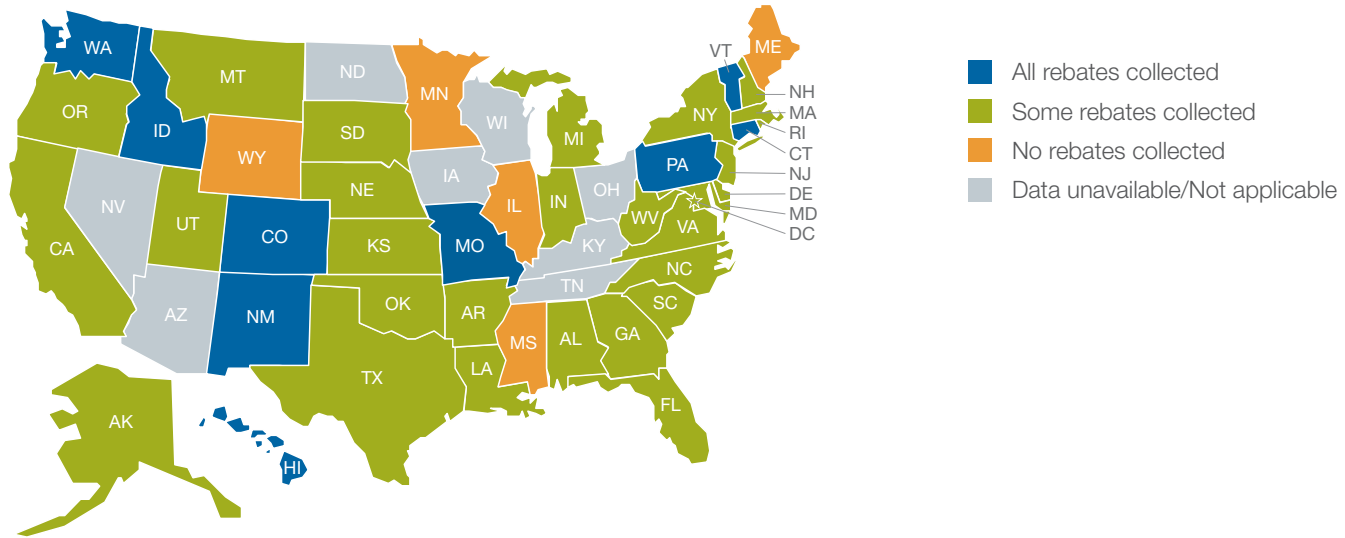
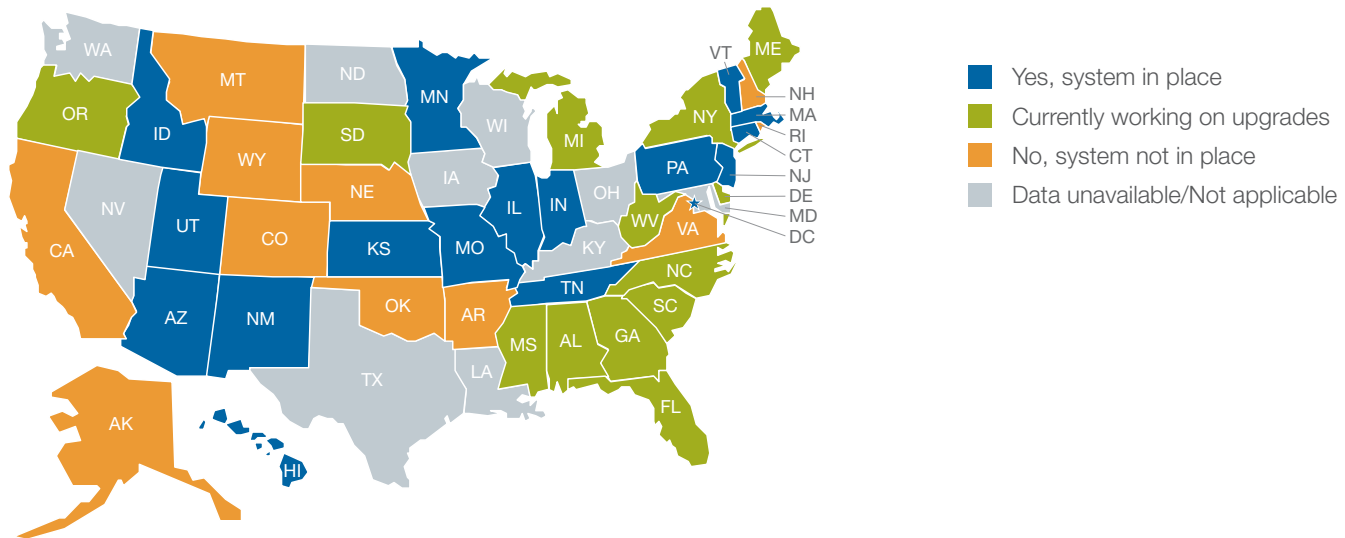


FIGURE 6B Medicaid Claims Processing Systems that Allow for the Billing of NDCs



Policy and Practice Outlook

This report provides a detailed snapshot of state pharmacy practices and state officials' perspectives on key policy changes during the summer of 2006. As states gain experience from Medicare Modernization Act (MMA, P.L. 108-173) drug program implementation and amend their state Medicaid plans using Deficit Reduction Act (DRA, P.L. 109-171) provisions, this document will help policymakers and Medicaid stakeholders assess the impact of these landmark pieces of legislation on state pharmacy coverage policy and practice.

MMA implementation and DRA enactment mark two of the most significant changes in Medicaid policy since the creation of the program 41 years ago. First, on January 1, 2006, more than six million beneficiaries dually eligible for Medicare and Medicaid (duals) moved from state Medicaid pharmacy assistance rolls into the Medicare Part D program. During the Part D transition period, states implemented special provisions to ensure uninterrupted drug coverage. Under targeted demonstration authority, the Centers for Medicare and Medicaid Services (CMS) initiated payment arrangements intended to reimburse states for duals' drug coverage during Part D implementation. The MMA also requires states to reimburse the federal government for a portion of duals' drug costs (i.e., "clawback payments"). Some preliminary state projections indicate that future state clawback payments could consume state Medicaid savings generated from the transition of the duals' drug coverage to Medicare Part D.

Second, the DRA created new state pharmacy benefit design options including the flexibility to: (a) design alternative benefit packages and impose additional cost sharing requirements; (b) restructure and increase transparency in

pharmacy pricing; and (c) implement additional fraud and abuse controls. The DRA contains 39 sections that make a wide range of changes to the Medicaid program. To date, CMS has issued several phases of guidance but is still in the process of developing DRA pharmacy guidance with the exception of cost sharing for prescription drugs and physician-administered drugs.

Finally, as the federal government refines and implements the MMA and DRA, respectively, states are implementing new and innovative pharmacy initiatives intended to improve health care outcomes for Medicaid beneficiaries. States are experimenting with programs that increase transparency in pricing through website postings and other public information campaigns. In many instances, states are partnering with CMS to implement these programs under the Section 1115 Research and Demonstration waiver authority.

As with the MMA and DRA, it is too soon to evaluate the impact of these state efforts on beneficiaries, states, and other Medicaid stakeholders. However, as 2006 draws to a close, three additional factors are poised to shape Medicaid pharmacy policy further. In November 2006, 36 of the nation's governors are up for (re)-election. A change in state executive control may shift the current direction of the state's pharmacy policies. Additionally, states are closely monitoring the Congressional races. A shift in House and/or Senate party control could impact federal Medicaid policy priorities. Lastly, the final report of the federal Medicaid Commission is due in December 2006. The Commission report could include further recommendations to alter to Medicaid-financed drug coverage.

APPENDIX A: Survey Design and Methodology

The 2006 Medicaid Pharmacy Survey was a web-based, cross-sectional survey of state Medicaid programs and is intended to provide a better understanding of various aspects of Medicaid pharmacy policy. Specific lines of inquiry included: (a) Medicaid provisions of the Deficit Reduction Act of 2005 (DRA); (b) drug reimbursement methodology; (c) Medicaid managed care formulary development; (d) drug purchasing pool participation; (e) coordination with Medicare Part D; (f) the use of medication management programs; and (g) the use of evidence-based medicine when developing Medicaid pharmacy policy. The survey was conducted from June through July 2006 and was jointly administered by the National Association of Medicaid Directors (NASMD) and Avalere Health. The data displayed throughout the report are direct survey responses of state Medicaid program officials. NASMD and Avalere attempted to interpret these responses accurately.

The sampling frame included each state, District of Columbia (DC), and US territory Medicaid program and was specifically focused on soliciting responses from the states – including the District of Columbia. Forty-seven states (including DC) and 2 territories completed the survey. Of the 47 state respondents there were 27 Medicaid pharmacy directors, 8 pharmacy consultants, 3 pharmacy operations managers, 3 deputy administrators, 3 senior medical policy

managers: 1 pharmacy services specialist, 1 Medicaid director, and 1 state pharmacist. Survey non-respondents include ND, NV, OH, and WI. The territories' responses were omitted from this report due to the dramatic structural differences of their Medicaid programs when compared to state Medicaid programs.

The survey instrument consisted of 121 multiple-choice questions. However, some questions required respondents to provide text answers. For those questions that indicate state policy direction, aggregate data is presented. Prior to the survey's launch, survey questions were reviewed by the NASMD and Centers for Medicare and Medicaid Services (CMS) Pharmacy Technical Advisory Group (TAG). Respondents were sent both a text version of the survey, and a link to the web-based version.

Although 47 states participated in the survey, the response rates vary across questions given the survey's length and specificity. Additionally, given the dynamic nature of Medicaid policy, answers are subject to change and only describe the Medicaid pharmacy policy environment as it existed in June and July 2006.

APPENDIX B: Glossary

1915(c) Home and Community-Based Service Waivers:

Section 1915(c) Medicaid waivers are tools used by states to obtain federal Medicaid matching funds to provide long-term care to individuals in settings other than institutions. Waivers must be approved by CMS and are good for three years, after which they may be renewed every five years.¹⁷

Authorized Generic Drugs: Generic drugs sold (or licensed) by the manufacturer of the brand-name drug.

Average Manufacturer Price (AMP): The average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. AMP was a benchmark created by Congress in 1990 in calculating Medicaid rebates. The Congressional Budget Office estimates AMP to be about 20 percent less than Average Wholesale Price (AWP) for more than 200 drug products frequently purchased by Medicaid recipients.¹⁸

Average Sales Price (ASP): ASP is the weighted average of all non-federal sales to wholesalers and is net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, whether it is paid to the wholesaler or the retailer.¹⁹

Average Wholesale Price (AWP): A national average of list prices charged by wholesalers to pharmacies. AWP is sometimes referred to as a “sticker price” because it is not the actual price that larger purchasers normally pay. For example, in a study of prices paid by retail pharmacies in eleven states, the average acquisition price was 18.3 percent below AWP. Discounts for HMOs and other large purchasers can be even greater.²⁰

Benchmark Benefit Plan: Under the Deficit Reduction Act of 2005 (DRA), states can create benchmark equivalent plans for certain Medicaid populations that provide alternative Medicaid coverage packages. Benchmark plans must have coverage equivalent to one of the following: Federal Employee Health Benefits Plan, the plan offered to state employees, the HMO plan with the largest commercial enrollment in the state, or a plan approved by the Secretary of the Department of Health and Human Services.

Best Price (BP): Medicaid agencies pay best price for prescription drugs which include lowest price available to any wholesaler, retailer, provider, health maintenance organization (HMO), nonprofit entity, or the government. Best price excludes prices to the Indian Health Service (IHS), Department of Veterans Affairs (DVA), Department of Defense (DoD), the Public Health Service (PHS), 340B covered entities, Federal Supply Schedule (FSS), and state pharmaceutical assistance programs, depot prices, and nominal pricing. BP includes cash discounts, free goods that are contingent upon purchase, volume discounts, and rebates.²¹

Budget Neutral: A requirement of Medicaid Section 1115 waivers that a change to the Medicaid program not allowable by statute must not increase Medicaid costs above projected spending levels.

Comparative Effectiveness Review: A report that synthesizes available clinical evidence on effectiveness and safety comparisons between drugs in the same class.

Drug Effectiveness Review Project (DERP): The DERP is a consortium of 15 states and 2 organizations that commission prescription drug comparative effectiveness reviews.

APPENDIX B: Glossary

Drug Compendia: Drug compendia provide listings of medically accepted uses for over-the-counter and prescription drugs. Listings frequently include information such as FDA-approved dosing and indications for the drug, and may also include other indications generally accepted by the medical community. Providers and payers use drug compendia when determining what to prescribe and cover, respectively.

Federal Upper Limit (FUL): The FUL is the ceiling on federal match for payment amounts to pharmacists for the prescription drugs they dispense to Medicaid beneficiaries. The payment ceiling for each drug is set at 150 percent of the published price for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules.

J-Code: Drug reimbursement codes used by physicians specifically for physician-administered drugs, such as immunosuppressive drugs. The majority of these are injectable, however, there are some that may be administered orally. J-codes are more general than National Drug Codes in that they can represent many brands and forms of a particular drug.

Medicaid Medical Benefit: Portion of the Medicaid program that reimburses for medical services furnished by a physician or medical professional. This includes physician-administered prescription drugs and biologics. It does not include self-administered prescription drugs dispensed to a Medicaid beneficiary by an outpatient pharmacy.

Medicaid Transformation Grant: The Deficit Reduction Act of 2005 (DRA) authorizes new grant funds to states to work with the Centers for Medicare and Medicaid Services (CMS) on the adoption of innovative methods to improve

Medicaid's effectiveness and efficiency. There is \$150 million in grant funds available to states in FYs 2007 and 2008. CMS outlined the following as permissible use of grant money: implementation of health information technology; reduction of fraud, waste and abuse; implementation of medication risk management programs, which may include the efforts to increase generic drug utilization; and increasing access to care for the uninsured.²²

Medicare Advantage Prescription Drug Plan (MA-PD): A managed care plan (e.g., HMO, PPO) which provides all Medicare benefits, including Medicare Part D prescription drug coverage.

Medicare Prescription Drug Plan (PDP): A “stand-alone” insurance product that can be purchased by Medicare beneficiaries, and that provides prescription drug coverage to supplement Medicare Parts A (hospital insurance) and Part B (outpatient medical insurance).

Medication Management Program: Medication Management Programs (MMPs) are intended to reduce polypharmacy issues such as drug contraindications and drug-drug interactions. Targeted Medicaid beneficiaries are typically people with complex medication regimens—such as long-term care (LTC) users and persons with mental illness. Operationally, MMPs obtain formulary exception approvals needed to dispense a medication, manage medications in the context of a comprehensive medical and provider history, and conduct regular drug utilization and drug regimen reviews.²³

National Drug Code (NDC): A unique 10-digit 3-segment number used to identify drug products. The NDC includes information about a drug's manufacturer, strength, dosage form, package size, and package type.²⁴

Outpatient Prescription Drug Benefit: An optional Medicaid program benefit through which Medicaid beneficiaries can fill prescriptions for Medicaid-covered drugs at a pharmacy or outpatient facility.

Pharmacy Benefit Manager (PBM): An organization that provides administrative services in processing and analyzing prescription claims for pharmacy benefit and coverage programs. PBM services can include contracting with a network of pharmacies; establishing payment levels for provider pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs. Many PBMs also operate mail-order pharmacies or have arrangements to include prescription availability through mail order pharmacies.²⁵

Physician-Administered Drugs: Drugs, such as oncology drugs, that can only be administered to a patient by a physician in a physician's office. Under Medicaid, these drugs are reimbursed under the medical benefit, not the outpatient prescription drug benefit.

Preferred Drug List (PDL): A list of covered drugs that a state Medicaid program agrees to provide without prior authorization. All other medically necessary drugs require prior authorization.²⁶

Prior Authorization: Policy of a state Medicaid program that requires a pharmacist to obtain approval from the state or a subcontractor before dispensing a drug.²⁷

Rebate: Medicaid drug rebates are mandated under federal law. The actual cost to Medicaid programs for brand-name prescription drugs is reduced by the mandated

rebate amount, which is currently 15.1 percent off of AMP or the manufacturer's best price, whichever is lower. The statutory rebate is the same across state fee-for-service Medicaid programs. The rebates are shared between the state and the federal government. Many states negotiate additional rebates, referred to as supplemental rebates, with drug manufacturers.

Rehabilitation State Plan Option: Medicaid includes a benefit targeted to persons with disabilities (defined in 42 CFR 440.130(d)). The rehabilitative services option gives states the flexibility to design service packages that include "any medical or remedial service recommended by a physician or other practitioners. States may develop psychiatric rehabilitation services including independent living, medication education, medication management, social skills training, counseling, and therapy. Collateral services also are permissible including training family caregivers. Service can be delivered in a variety of settings.

Supplemental Rebate: In addition to federally mandated rebates, some states choose to pursue supplemental rebates. Supplemental rebates are additional payments by pharmaceutical manufacturers negotiated directly with individual states. Manufacturers offer supplemental rebates in exchange for having their products receive preferred status on the state's PDL.

Targeted Case Management: Targeted case management programs commonly take a holistic approach to managing beneficiary care. Such programs enroll extremely vulnerable, non-institutionalized beneficiaries who typically have complex combinations of medical conditions to ensure (1) appropriate medical care coordination, and (2) that social and educational needs are met.

CHART 1: Reported Medicaid Coverage of Part D Cost Sharing Requirements for Lower-Income Medicare Beneficiaries

State	Reported Mechanisms Through Which State Medicaid Programs Are Coordinating with Part D for Lower-Income Medicare Beneficiaries							
	Co-payments for dual eligibles		Co-insurance for individuals earning between 135-150% Federal Poverty Level (FPL)		Deductibles for individuals earning between 135-150% FPL		Premiums for individuals earning between 135-150% FPL	
	Yes	No	Yes	No	Yes	No	Yes	No
Minnesota		✓		✓		✓		✓
Mississippi		✓		✓		✓		✓
Missouri	✓		✓		✓			✓
Montana		✓		✓		✓		✓
Nebraska	✓			✓		✓		✓
New Hampshire		✓		✓		✓		✓
New Jersey	✓		✓		✓		✓	
New Mexico		✓		✓		✓		
New York		✓		✓		✓		✓
North Carolina		✓		✓		✓		✓
Oklahoma		✓		✓		✓		✓
Oregon		✓		✓		✓		✓
Pennsylvania		✓		✓		✓		
Rhode Island		✓		✓		✓		✓
South Carolina		✓		✓		✓		✓
South Dakota		✓		✓		✓		✓
Tennessee		✓		✓		✓		✓
Texas		✓		✓		✓		✓
Utah		✓		✓		✓		✓
Vermont		✓	✓		✓		✓	
Virginia		✓		✓		✓		✓
Washington	✓			✓		✓		✓
West Virginia		✓		✓		✓		✓
Wyoming		✓		✓		✓		✓
TOTAL	10	33	7	36	8	33	8	31

*State data is unavailable where there are no checkmarks listed.

APPENDIX C: State-by-State Data Charts

CHART 2: State Reported Actions Necessary to Implement DRA Medicaid Pharmacy Changes

State	Make co-payments enforceable			Modification of federal upper payment limit (FUL) for multiple source drugs			Switch from AWP to AMP for pharmacy reimbursement			Change the methodology Medicaid uses to reimburse for physician-administered drugs		
	State legislature approval	State agency approval only	Both state agency and legislature approval	State legislature approval	State agency approval only	Both state agency and legislature approval	State legislature approval	State agency approval only	Both state agency and legislature approval	State legislature approval	State agency approval only	Both state agency and legislature approval
Alabama	✓										✓	
Alaska		✓			✓						✓	
Arizona	✓											
Arkansas												
California	✓				✓		✓			✓		
Colorado								✓			✓	
Connecticut	✓			✓			✓			✓		
Delaware		✓			✓						✓	
District of Columbia	✓			✓			✓			✓		
Florida					✓		✓				✓	
Georgia					✓		✓					
Hawaii												
Idaho	✓							✓		✓		
Illinois		✓			✓			✓			✓	
Indiana	✓				✓			✓				
Iowa				✓			✓			✓		
Kansas		✓			✓			✓			✓	
Kentucky	✓											
Louisiana												
Maine			✓			✓			✓			✓
Maryland		✓			✓			✓			✓	
Massachusetts	✓				✓			✓			✓	
Michigan								✓			✓	

CHART 2: State Reported Actions Necessary to Implement DRA Medicaid Pharmacy Changes

State	Make co-payments enforceable			Modification of federal upper payment limit (FUL) for multiple source drugs			Switch from AWP to AMP for pharmacy reimbursement			Change the methodology Medicaid uses to reimburse for physician-administered drugs		
	State legislature approval	State agency approval only	Both state agency and legislature approval	State legislature approval	State agency approval only	Both state agency and legislature approval	State legislature approval	State agency approval only	Both state agency and legislature approval	State legislature approval	State agency approval only	Both state agency and legislature approval
Minnesota					✓		✓			✓		
Mississippi					✓			✓				
Missouri			✓		✓			✓			✓	
Montana		✓			✓			✓			✓	
Nebraska		✓			✓			✓			✓	
New Hampshire					✓		✓				✓	
New Jersey	✓			✓			✓			✓		
New Mexico		✓			✓			✓			✓	
New York	✓			✓			✓			✓		
North Carolina					✓			✓			✓	
Oklahoma	✓			✓			✓					
Oregon		✓			✓			✓			✓	
Pennsylvania	✓				✓		✓				✓	
Rhode Island											✓	
South Carolina		✓			✓		✓				✓	
South Dakota		✓			✓			✓			✓	
Tennessee					✓			✓				
Texas		✓			✓			✓			✓	
Utah		✓			✓			✓				
Vermont	✓			✓			✓				✓	
Virginia			✓		✓				✓			✓
Washington			✓					✓			✓	
West Virginia		✓			✓			✓			✓	
Wyoming		✓			✓			✓			✓	
TOTAL	14	15	4	7	28	1	14	22	2	8	26	2

*State data is unavailable where there are no checkmarks listed.

APPENDIX C: State-by-State Data Charts

CHART 3: Reported Flexibility Granted by DRA to States to Craft Medicaid Pharmacy Policy

State	Reported Flexibility Granted by DRA to States to Craft Medicaid Pharmacy Policy					
	Abundant amount of flexibility	Great amount of flexibility	Moderate amount of flexibility	A little flexibility	No flexibility	Don't know
Alabama					✓	
Alaska						✓
Arizona				✓		
Arkansas						✓
California			✓			
Colorado			✓			
Connecticut						✓
Delaware			✓			
District of Columbia						✓
Florida			✓			
Georgia			✓			
Hawaii						✓
Idaho				✓		
Illinois				✓		
Indiana						✓
Iowa				✓		
Kansas						✓
Kentucky			✓			
Louisiana				✓		
Maine			✓			
Maryland			✓			
Massachusetts						✓
Michigan				✓		

CHART 3: Reported Flexibility Granted by DRA to States to Craft Medicaid Pharmacy Policy

State	Reported Flexibility Granted by DRA to States to Craft Medicaid Pharmacy Policy					
	Abundant amount of flexibility	Great amount of flexibility	Moderate amount of flexibility	A little flexibility	No flexibility	Don't know
Minnesota				✓		
Mississippi			✓			
Missouri						✓
Montana					✓	
Nebraska					✓	
New Hampshire						✓
New Jersey			✓			
New Mexico			✓			
New York				✓		
North Carolina				✓		
Oklahoma				✓		
Oregon						✓
Pennsylvania				✓		
Rhode Island			✓			
South Carolina			✓			
South Dakota			✓			
Tennessee				✓		
Texas			✓			
Utah			✓			
Vermont				✓		
Virginia				✓		
Washington						✓
West Virginia						✓
Wyoming				✓		
TOTAL	0	0	16	15	3	13

*State data is unavailable where there are no checkmarks listed.

APPENDIX C: State-by-State Data Charts

CHART 4: State Reported Medicaid Managed Care Drug “Carve Out” Data

State	Drugs “Carved Out” from Medicaid Managed Care Capitation Rates				Carved out classes and drugs
	None	All	Not applicable	Select classes or specific drugs	
Alabama					
Alaska	✓				
Arizona				✓	Drugs to treat HIV/AIDS; Anti-psychotics
Arkansas	✓				
California				✓	Drugs to treat HIV/AIDS; Anti-psychotics
Colorado				✓	MMA excluded drugs
Connecticut	✓				
Delaware		✓			
District of Columbia	✓				
Florida	✓				
Georgia	✓				
Hawaii				✓	Clozaril
Idaho	✓				
Illinois		✓			
Indiana	✓				
Iowa		✓			
Kansas				✓	Drugs to treat hemophilia
Kentucky				✓	Anti-psychotics; Other drugs dispensed by a psychiatrist
Louisiana			✓		
Maine					
Maryland				✓	Anti-psychotics and other mental health drugs
Massachusetts		✓			
Michigan				✓	Drugs to treat HIV/AIDS; Anti-psychotics
Minnesota	✓				

CHART 4: State Reported Medicaid Managed Care Drug “Carve Out” Data

State	Drugs “Carved Out” from Medicaid Managed Care Capitation Rates				Carved out classes and drugs
	None	All	Not applicable	Select classes or specific drugs	
Mississippi			✓		
Missouri				✓	Drugs to treat HIV/AIDS
Montana			✓		
Nebraska		✓			
New Hampshire			✓		
New Jersey				✓	Drugs to treat HIV/AIDS; Anti-psychotics; Drugs to treat hemophilia; Drugs for the aged, blind, or disabled (ABD) populations
New Mexico	✓				
New York		✓			
North Carolina		✓			
Oklahoma	✓				
Oregon				✓	First Data Bank standard therapeutic classes 7 and 11 in addition to Depakote, Lamictal, and generic therepeutic equivalents
Pennsylvania	✓				
Rhode Island	✓				
South Carolina	✓				
South Dakota			✓		
Tennessee	✓				
Texas					
Utah		✓			
Vermont	✓				
Virginia	✓				
Washington				✓	Drugs to treat HIV/AIDS; All mental health drugs; drugs for the aged, blind, or disabled (ABD) populations;
Family planning drugs					
West Virginia		✓			
Wyoming			✓		
TOTAL	17	9	6	12	

*State data is unavailable where there are no checkmarks listed.

APPENDIX C: State-by-State Data Charts

CHART 5: Reported Participation in Multi-State and Intra-State Prescription Drug Purchasing Pools

State	Multi-State Pool Participation				Total # of Lives Covered Under the Pool	Intra-State Pool Participation	
	State does not participate in a multi-state pool	First Health	Top\$	Sovereign States Drug Consortium		No	Yes
Alabama	✓					✓	
Alaska		✓			3,500,000	✓	
Arizona	✓					✓	
Arkansas	✓					✓	
California	✓					✓	
Colorado	✓					✓	
Connecticut	✓					✓	
Delaware			✓		130,000	✓	
District of Columbia	✓					✓	
Florida	✓					✓	
Georgia	✓					✓	
Hawaii		✓			14,000	✓	
Idaho			✓			✓	
Illinois	✓					✓	
Indiana	✓					✓	
Iowa				✓	less than 1,000,000	✓	
Kansas	✓					✓	
Kentucky		✓				✓	
Louisiana			✓		90,000		✓
Maine				✓	1,000,000	✓	
Maryland			✓		31,000 to 552,000 depending on class of drug	✓	
Massachusetts	✓					✓	
Michigan		✓			less than 3,000,000	✓	

CHART 5: Reported Participation in Multi-State and Intra-State Prescription Drug Purchasing Pools

State	Multi-State Pool Participation				Total # of Lives Covered Under the Pool	Intra-State Pool Participation	
	State does not participate in a multi-state pool	First Health	Top\$	Sovereign States Drug Consortium		No	Yes
Minnesota		✓			15,000	✓	
Mississippi	✓					✓	
Missouri	✓					✓	
Montana		✓			8,500	✓	
Nebraska	✓					✓	
New Hampshire		✓				✓	
New Jersey	✓					✓	
New Mexico	✓					✓	
New York		✓			6,000,000		✓
North Carolina	✓					✓	
Oklahoma	✓					✓	
Oregon	✓					✓	
Pennsylvania	✓					✓	
Rhode Island	✓					✓	
South Carolina	✓					✓	
South Dakota	✓					✓	
Tennessee		✓			Over 3,000,000	✓	
Texas	✓					✓	
Utah	✓					✓	
Vermont				✓	131,975	✓	
Virginia	✓					✓	
Washington	✓						✓
West Virginia			✓		300,000	✓	
Wyoming	✓					✓	
TOTAL	30	9	5	3	14	44	3

*State data is unavailable where there are no checkmarks listed.

APPENDIX C: State-by-State Data Charts

CHART 6: Reported Use of Medicaid Medication Management Programs in Various Medicaid Program Types

State	No Medicaid medication management program	Yes, state has Medicaid medication management program	1915(c) Waiver Programs		Medicaid managed care		Targeted Case Management programs		Rehabilitation State Plan Option programs		Primary Care Case Management programs		FFS Medicaid		For ABD populations	
			Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Alabama	✓															
Alaska		✓		✓		✓		✓				✓	✓			✓
Arizona	✓															
Arkansas		✓		✓		✓		✓	✓		✓		✓			✓
California																
Colorado		✓		✓				✓					✓			
Connecticut																
Delaware		✓	✓					✓		✓		✓	✓	✓		✓
District of Columbia		✓	✓		✓		✓				✓		✓		✓	
Florida		✓	✓		✓		✓				✓		✓			✓
Georgia	✓															
Hawaii	✓															
Idaho	✓															
Illinois		✓	✓		✓			Not applicable	Not applicable		✓		✓			✓
Indiana	✓															
Iowa		✓											✓			✓
Kansas		✓		✓		✓	✓						✓			✓
Kentucky		✓	✓				✓			Not applicable	✓		✓			✓
Louisiana		✓				✓							✓			✓
Maine		✓		✓				✓		✓	✓		✓		✓	
Maryland	✓															
Massachusetts																
Michigan		✓			✓		✓						✓			✓

CHART 6: Reported Use of Medicaid Medication Management Programs in Various Medicaid Program Types

State	No Medicaid medication management program	Yes, state has Medicaid medication management program	1915(c) Waiver Programs		Medicaid managed care		Targeted Case Management programs		Rehabilitation State Plan Option programs		Primary Care Case Management programs		FFS Medicaid		For ABD populations	
			Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Minnesota		✓					✓		Not applicable		Not applicable		✓			✓
Mississippi		✓		✓				✓	Not applicable		Not applicable		✓			✓
Missouri		✓		✓			✓		✓		✓		✓			✓
Montana	✓															
Nebraska		✓				✓		✓				✓	✓			✓
New Hampshire	✓															
New Jersey		✓						✓		✓	Not applicable			✓		✓
New Mexico	✓															
New York		✓				✓		✓		✓			✓			✓
North Carolina		✓		✓		✓		✓		✓		✓	✓			✓
Oklahoma		✓	✓								✓		✓		✓	
Oregon		✓	✓		✓		✓				✓		✓			✓
Pennsylvania		✓	✓		✓						✓		✓			✓
Rhode Island		✓	✓					Not applicable		Not applicable		Not applicable		✓		✓
South Carolina		✓	✓		✓			✓	✓		✓		✓			✓
South Dakota		✓		✓	✓			✓		✓	✓		✓			✓
Tennessee	✓															
Texas																
Utah																
Vermont	✓															
Virginia		✓	Not applicable			✓	Not applicable		Not applicable		✓		✓		✓	
Washington		✓		✓	Not applicable		✓		✓			✓	✓			✓
West Virginia	✓															
Wyoming		✓	✓		Not applicable		Not applicable		Not applicable		Not applicable		✓			✓
TOTAL	13	29	11	10	8	8	11	10	4	6	13	5	28	1	5	23

*State data is unavailable where there are no checkmarks listed.

APPENDIX C: State-by-State Data Charts

CHART 7: Reported Dates States Will Begin Matching Physician-Administered Drug J-Codes to National Drug Codes

State	Date J-codes to NDC Matching Will Begin for States			
	2007	2008	Don't know	Already matched
Alabama	✓			
Alaska		✓		
Arizona				
Arkansas			✓	
California				✓
Colorado				✓
Connecticut				✓
Delaware	✓			
District of Columbia				
Florida				✓
Georgia	✓			
Hawaii				✓
Idaho				
Illinois			✓	
Indiana	✓			
Iowa			✓	
Kansas	✓			
Kentucky				
Louisiana			✓	
Maine			✓	
Maryland			✓	
Massachusetts	✓			
Michigan			✓	

CHART 7: Reported Dates States Will Begin Matching Physician-Administered Drug J-Codes to National Drug Codes

State	Date J-codes to NDC Matching Will Begin for States			
	2007	2008	Don't know	Already matched
Minnesota	✓			
Mississippi	✓			
Missouri			✓	
Montana			✓	
Nebraska	✓			
New Hampshire			✓	
New Jersey				
New Mexico				✓
New York			✓	
North Carolina	✓			
Oklahoma		✓		
Oregon			✓	
Pennsylvania				
Rhode Island	✓			
South Carolina	✓			
South Dakota			✓	
Tennessee			✓	
Texas				
Utah	✓			
Vermont				✓
Virginia	✓			
Washington				✓
West Virginia			✓	
Wyoming	✓			
TOTAL	15	2	15	8

*State data is unavailable where there are no checkmarks listed.

APPENDIX C: State-by-State Data Charts

CHART 8: Reported Dates States will Collect Rebates on All Physician-Administered Drugs

State	When Collection of Rebates for All Physician-Administered Drugs Will Commence			
	2007	2008	Don't know	Other (write-in responses)
Alabama	✓			
Alaska				When a new MMIS is implemented
Arizona	Not applicable			
Arkansas				
California			✓	
Colorado			✓	
Connecticut				
Delaware	✓			
District of Columbia			✓	
Florida				Began October 1, 2006
Georgia	✓			
Hawaii				
Idaho				
Illinois	✓			
Indiana				Will begin as soon as possible
Iowa			✓	
Kansas	✓			
Kentucky				
Louisiana			✓	
Maine			✓	
Maryland			✓	
Massachusetts			✓	
Michigan			✓	


CHART 8: Reported Dates States will Collect Rebates on All Physician-Administered Drugs

State	When Collection of Rebates for All Physician-Administered Drugs Will Commence			
	2007	2008	Don't know	Other (write-in responses)
Minnesota		✓		
Mississippi			✓	
Missouri				
Montana			✓	
Nebraska			✓	
New Hampshire			✓	
New Jersey			✓	
New Mexico			✓	
New York			✓	
North Carolina			✓	
Oklahoma		✓		
Oregon			✓	
Pennsylvania				
Rhode Island	✓			
South Carolina	✓			
South Dakota			✓	
Tennessee				
Texas				
Utah	✓			
Vermont				
Virginia		✓		
Washington				
West Virginia			✓	
Wyoming	✓			
TOTAL	8	3	20	3

*State data is unavailable where there are no checkmarks listed.

End Notes

- 1 Kaiser Family Foundation. State Health Facts: Medicaid Enrollment as a Percent of Total Population, 2003, available at www.statehealthfacts.org.
- 2 Kaiser Family Foundation. Distribution of Medicaid Enrollees by Enrollment Group, FY2003, available at www.statehealthfacts.org.
- 3 Crowley, Jeffrey S. and Deb Ashner. *State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey*, 2005 Update, Kaiser Family Foundation October 2005.
- 4 Kaiser Family Foundation. Prescription Drug Trends, June 2006, available at <http://www.kff.org/rxdrugs/upload/3057-05.pdf#search=%22medicaid%2019%25%20of%20total%20prescription%20drug%20spending%22>.
- 5 Smith, Cynthia, et al., *National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending*, Health Affairs January/February 2006.
- 6 Holahan, John and Arunabh Ghosh. *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003*, Kaiser Family Foundation July 2005.
- 7 Avalere Health proprietary research analysis, spring 2006.
- 8 Crowley, Jeffrey S. and Deb Ashner. *State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update*, Kaiser Family Foundation October 2005.
- 9 Ibid.
- 10 National Pharmaceutical Council. *Pharmaceutical Benefits Under State Medical Assistance Programs, 2004*, available at <http://www.npcnow.org/resources/PharmBenefitsMedicaid.asp>.
- 11 Ibid.
- 12 Ibid.
- 13 Kaiser Commission on Medicaid and the Uninsured. *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries*, July 2005. Available at [http://www.kff.org/medicaid/upload/409104%20Final\(v2\).pdf#search=%226.2%20million%20dual%20eligibles%22](http://www.kff.org/medicaid/upload/409104%20Final(v2).pdf#search=%226.2%20million%20dual%20eligibles%22).
- 14 Kaye, Neva. *Medicaid Managed Care Looking Forward, Looking Backward*, National Academy for State Health Policy June 2005.
- 15 Ibid.
- 16 OHSU DERP website, available at <http://www.ohsu.edu/drugeffectiveness/description/index.htm>.
- 17 National Association of State Medicaid Directors. Medicaid Waiver Definitions, available at <http://www.nasmd.org/waivers/waivers.htm>.
- 18 Health Resources and Services Administration. *Glossary of Pharmacy-Related Terms*, available at <http://www.hrsa.gov/opa/glossary.htm>.
- 19 Ibid.
- 20 Ibid.
- 21 Ibid.
- 22 Centers for Medicare and Medicaid Services (CMS). State Medicaid Director Letter July 25, 2006, available at <http://www.cms.hhs.gov/smdl/downloads/SMD072506.pdf>.
- 23 Reester, Hiedi. Anne Tumlinson and Jon Blum. Dual Eligible Home and Community Based Waiver Program Participants and the New Medicare Drug Benefit, The Kaiser Family Foundation, October 2005.
- 24 US Food and Drug Administration. National Drug Code Directory, available at <http://www.fda.gov/cder/ndc/index.htm>.
- 25 Health Resources and Services Administration. *Glossary of Pharmacy-Related Terms*, available at <http://www.hrsa.gov/opa/glossary.htm>.
- 26 Crowley, Jeffrey S. and Deb Ashner. *State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update*, Kaiser Family Foundation October 2005.
- 27 Ibid.



**National Association of
State Medicaid Directors**
810 First Street, NE, Suite 500
Washington, DC 20002-4267
www.nasmd.org

Avalere Health LLC
1350 Connecticut Avenue, NW
Suite 900
Washington, DC 20036
www.avalerehealth.net