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Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003

December 2003

THE HENRY J. KAISER FAMILY FOUNDATION

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Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003

Prepared by:

Jeffrey S. Crowley and Deb Ashner
Health Policy Institute, Georgetown University

and

Linda Elam, Kaiser Commission on Medicaid and the Uninsured

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EXECUTIVE SUMMARY

Today, Medicaid is fundamental to the provision of outpatient drugs to the low-income population and is particularly important for low-income people with disabilities and elderly beneficiaries who depend on prescription drugs to maintain or improve their health and functioning. The prescription drug benefit is one of the fastest growing components of Medicaid spending and one of the program's most widely utilized services. Medicaid is estimated to spend $27.5 billion in 2003 on outpatient prescription drugs and outpatient prescription drug spending accounts for 12% of Medicaid spending on benefits. This spending is largely directed toward people with disabilities and elderly beneficiaries who, in 2000, constituted approximately 27% of Medicaid beneficiaries, but who accounted for roughly 85% of Medicaid drug spending.

Pharmaceutical spending growth has been an important contributor to increased health care costs in all sectors, including Medicaid. Outpatient prescription drugs are an optional service under Medicaid, the federal/state partnership that provides health coverage to low-income people, but all states provide this important benefit. Despite mounting drug costs, state Medicaid programs have remained committed to maintaining prescription drug coverage in recognition of the importance of this benefit to the populations they serve. The drug benefit has been particularly important to dual eligibles in the absence of a Medicare drug benefit.[1] However, primarily as a consequence of decreased state tax revenues, state budgets are tight and Medicaid programs are being squeezed—every state has implemented or is planning Medicaid pharmaceutical cost containment activities in FY 2004.[2]

In early 2003 (February-May), the Kaiser Commission on Medicaid and the Uninsured, working with the Health Policy Institute at Georgetown University, conducted a survey of state Medicaid pharmacy programs. Forty-two states plus the District of Columbia responded to the survey.[3] The 2003 survey updates a survey conducted in 2000,[4] and, where possible, changes and trends between the surveys are reported in this report. The findings of the current survey reflect Medicaid prescription drug policies in effect in early 2003, and provide important background information to assess the coming changes as dual eligibles move to Medicare Part D. This survey covers utilization management policies, payment and purchasing policies, utilization review policies, and policies for managed care enrollees and persons residing in institutions. For ease of reference, throughout this report, references to "states" should be inferred to include the District of Columbia.

In general, when states elect to cover outpatient prescription drugs through Medicaid, they must cover all Food and Drug Administration (FDA)-approved pharmaceuticals of every manufacturer that has signed a federal drug rebate agreement with the Secretary of Health and Human Services (HHS).[5] Within this general framework, states have considerable discretion in designing and managing the prescription drug benefit. However, because people on Medicaid have low-incomes and tend to have higher health care needs, federal law provides a number of safeguards to the benefit. As a result, Medicaid beneficiaries have access to a wide array of drugs and have a number of protections such as limits on

co-payments that may be charged to certain populations, timely review of prior authorization requests, the provision of emergency supplies of drugs while awaiting state approval, and the right to appeal if approval is not granted.

Key Findings

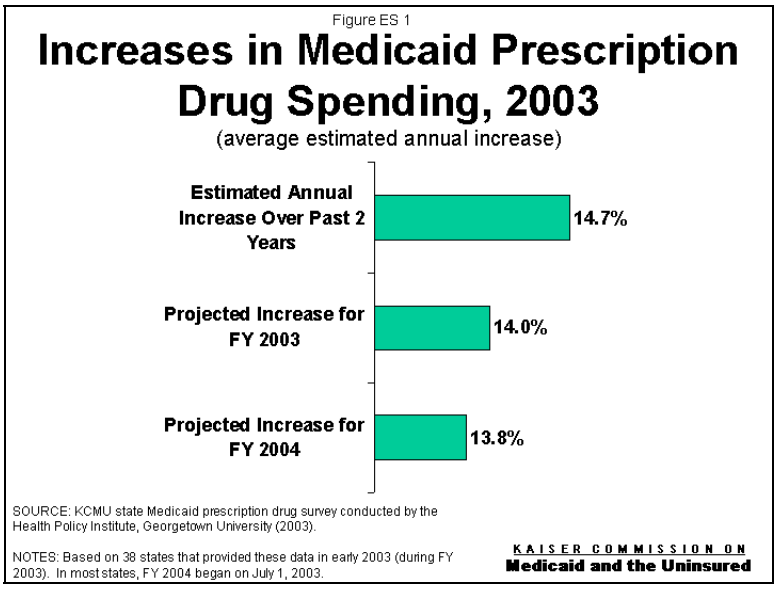
State officials anticipate that prescription drug spending growth will continue at a rapid pace, however there is wide variation in the amount of growth states project. Based on 38 responses, states anticipate that Medicaid prescription drug spending will increase roughly 14% over the current year, slightly lower growth than over the last three years. (Figure ES1).

- ESTIMATED INCREASE OVER LAST TWO YEARS: The average estimated annual increase in prescription drug costs over the last two years (FY 2001 and FY 2002) was 14.7% (based on 38 states reporting in 2003), and ranged from roughly 4% to 25% per year.

- PROJECTED INCREASE FOR FY 2003: The average projected cost growth in FY 2003 (which ended on June 30, 2003 in most states), was 14.0%, ranging from a decline of roughly 1% from the previous year to a 27% increase.

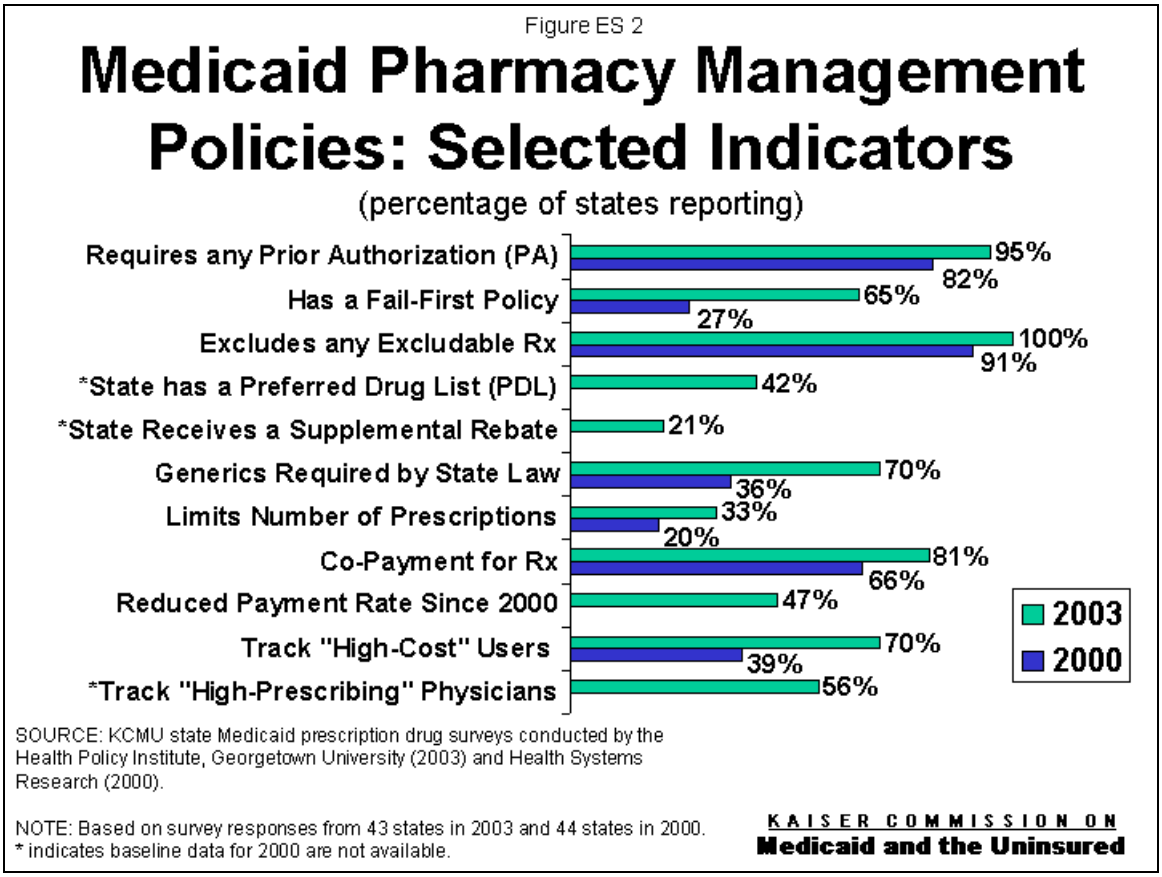
- PROJECTED INCREASE FOR FY 2004: Projected average cost growth in FY 2004 (the current fiscal year, with projections being made in early 2003) was 13.8%, ranging from a decline of about 5% from the previous year to a 23% increase.

Figure ES 1



States have been hit hard by prescription drug spending growth and have been challenged to take advantage of the tools available to them to manage the Medicaid outpatient drug benefit while maintaining beneficiary access **(Figure ES 2)**.

Figure ES 2



By nearly every measure, states are more aggressively managing the Medicaid prescription drug benefit in 2003 than in 2000.

- PRIOR AUTHORIZATION (PA): Ninety-five percent of states in 2003 (41 of 43 states) require prior approval or authorization for at least some prescription drugs, an increase from the 82% of states reporting the use of PA in 2000 (36 of 44 states). Many states do not impose PA on certain drug categories, such as antiretrovirals for HIV/AIDS or mental health drugs in order to assure that patient access to these critical products is not unduly impeded. For all drug classes surveyed, states reported a greater use of PA in 2003 than in 2000. In many cases, the percentage of states requiring PA for a specific class of drug increased dramatically.

- FAIL-FIRST/STEP THERAPY REQUIREMENTS: In fail first or step therapy, a particular product may not be dispensed unless it is documented that a designated product has been tried and is inappropriate for the patient. Roughly two-thirds of states in the 2003 survey reported fail-first policies (28 of 43 states), more than a doubling since 2000 when only 27% of states had fail first policies (12 of 44 states).

- EXCLUDED DRUGS: Although Medicaid covers most drugs, states are allowed to exclude certain drugs or drug categories that are specified in Medicaid law, for example, drugs with a high potential of abuse or drugs used for cosmetic purposes.

Every state (43 of 43 states reporting in 2003) excludes at least some of the prescription drugs that are excludable by the Medicaid law.

- PREFERRED DRUG LISTS (PDLs): Nearly half of the states (18 of 43 states reporting in 2003) operate PDLs. A PDL must be established by a committee appointed by the Governor (or the state drug use review board) and must include physicians, pharmacists, and other appropriate individuals. These lists are typically mediated through prior authorization, and even when a drug is not on a state's PDL, Medicaid law requires that it be made available through prior approval from the state. In addition, nine states are pursuing supplemental rebates from manufacturers in return for placing their drugs on the PDL.

- SUPPLEMENTAL REBATES: States are permitted to negotiate additional rebates with pharmaceutical manufacturers, in addition to the federal rebate, although a relatively small number of states do so (9 of 43 reporting in 2003). The leverage for these rebates typically comes from the institution of a state Medicaid PDL.

- GENERICS: Seventy percent of states require the prescribing of generics or generic substitution when available (30 of 43 states reporting in 2003), roughly twice as many states that required the dispensing of generics in 2000 (16 of 44 states). Even when generics are required, 93% of states allow for an override if the prescriber deems it medically necessary.

- QUANTITY LIMITS: States may limit quantities of drugs dispensed in a number ways, whether through the number of prescriptions a beneficiary may have in a period of time or the number of refills permitted per prescription. In 2003, 14 states (or about a third of responding states) reported limiting prescriptions allowed per month, up from a fifth of states in 2000. Ninety-eight percent of states (42 of 43 states reporting in 2003) limit the quantity of a drug that can be dispensed at one time.

- COST-SHARING: Thirty-five of 43 states in 2003 reported cost sharing for prescription drugs, when permitted. Medicaid cost sharing is limited to nominal payments ($0.50 - $3.00) and drugs are not supposed to be withheld if patients do not pay co-payments, although seven of the 35 states charging co-payments reported that drugs can be withheld for lack of payment. In most cases, when states charge cost-sharing they apply this policy to all populations eligible for cost-sharing, including the elderly, people with disabilities, and parents. Children under age 18, pregnant women with respect to services relating to pregnancy or any other medical condition that may complicate the pregnancy, terminally ill individuals receiving hospice care, and inpatients in hospitals, nursing facilities, or intermediate care facilities for persons with mental retardation (ICF/MRs) who are required to contribute all, but a minimal amount of their income for their medical care are exempted from cost-sharing.[6] States may impose higher cost sharing for waiver populations.

- OVER-THE-COUNTER (OTC): Thirty-nine of 43 states reporting in 2003 cover some OTCs. The extent of OTC coverage varies dramatically from state to state. A

smaller number of states (12 of 43 states reporting in 2003) cover drugs that were previously available by prescription and that are newly available as OTCs.

- PAYMENT RATES: Nearly half of the states (18 of 38 states reporting in both 2000 and 2003) reduced their pharmacy reimbursement by increasing the discount taken off of estimated acquisition cost.

- MONITORING: States are required by law to review Medicaid drug utilization. Seventy percent of states (30 of 43 states reporting in 2003) track "high-cost" users of prescription drugs, a 30% increase since 2000 (17 of 44 states). Fifty-six percent of states also track "high-prescribing" physicians (24 of 43 states reporting in 2003).

- INSTITUTIONAL SPENDING: The Medicaid law expressly states that provisions described in this report do not apply to institutionalized persons, however, as institutional spending is a significant proportion of overall state prescription drug spending, they are examined here. The average state estimate of the percentage of total Medicaid prescription drug spending for persons residing in institutions was 21% (based on 20 states reporting in 2003) and ranged from 6% to 33% of total drug spending. Half of the states (23 of 43 states reporting in 2003) indicated that they carve out institutional drug spending—meaning they separate payment for drugs from an institutional payment rate and purchase drugs on a fee-for-service basis

Policy Implications

In order to protect the sick and poor population it serves, Medicaid law limits the types of management tools that are permitted and extent to which states can use them. Given these safeguards, states are constantly working to balance cost control with appropriate patient access to prescription drugs.

Most states have taken advantage of most of the tools available to them to manage prescription drug utilization and constrain cost growth. For every year that state budgets are tight, and states are forced to identify ways to reduce spending, they have a diminishing range of tools available to them to reduce pharmaceutical costs.

Greater federal and state efforts are needed to examine the impact of cost control activities on beneficiary access to medically necessary prescription drugs. As states employ more and more cost-constraining strategies and as they become more aggressive in using tools such as prior authorization or drug limits, more attention needs to be placed on examining and protecting beneficiary access to prescription drugs.

Future progress in constraining drug costs may be difficult for states to achieve on their own. If states are approaching the limit of what they can achieve in constraining pharmaceutical cost growth through tight management of the outpatient prescription drug benefit, future progress in limiting drug costs may depend on policy changes at the federal level. One approach is to increase the size of the federal Medicaid drug rebate. Many

states are exploring or implementing supplemental rebates, raising the possibility that the federal rebate formula should be revisited. Outside of Medicaid, some advocates and policy makers have proposed more far reaching reforms of drug pricing and promotion in the United States, often using practices in other developed nations as models.

Conclusion

The importance of prescription drugs in the clinical management of many health conditions continues to grow with the discovery of new medications and with improvements to existing therapies. The promise of new therapeutics is exciting both for its potential to bring new treatments to previously untreatable or poorly treated conditions and for its potential to play a role in improving the quality of life of many individuals—while reducing other costs in the health system.

For state Medicaid programs, the prospect of a future with new and improved drugs must also be balanced with the daunting challenge of financing the provision of these medications. Medicaid plays a unique role in providing access to prescription drugs to the neediest and costliest cohorts of Americans (low-income people with severe disabilities and low-income elderly individuals). Financing new medications that often demand top dollar in comparison to older drugs is especially challenging at the same time that Medicaid programs adapt to changing demographics that will undoubtedly lead to more people with disabilities and elderly beneficiaries who need many services, including pharmaceuticals. Because of the clear benefits to be gained by individual Medicaid beneficiaries and the health of the general public by ensuring that Medicaid beneficiaries can access the full compliment of pharmaceuticals, it will be worth the effort for policy makers to ensure that these challenges are overcome.

Finally, the enactment of a Medicare drug benefit will have a major impact on Medicaid and many of the people it serves. Among those who will be most affected by the new Medicare law are the dual eligibles. As of January 1, 2006 dual eligibles will be covered by Medicare Part D and not Medicaid for prescription drugs. The full implications of this change for duals – including many nursing home residents and Medicaid waiver participants – and for states are yet to be determined. [7]

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[1] The recently enacted Medicare drug benefit, once implemented, will significantly impact Medicaid's prescription drug utilization profile. Dual eligibles (those Medicare beneficiaries currently receiving Medicaid coverage for services including prescription drugs) will no longer receive prescription drugs through Medicaid as of January 1, 2006.

[2] Smith, V., Ramesh, R., Gifford, K., Ellis, E., and Wachino, V., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004: Results from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2003.

[3] The eight states that did not respond to the 2003 survey were AL, IN, NV, OH, OR, RI, TN, and WY. In 2000, 43 states and DC responded; the seven states that did not respond were AZ, CO, OH, OK, TN, TX, and WI.

[4] Schwalberg R, Bellamy H, Giffin M, Miller C, Williams SS, Elam L., *Medicaid Outpatient Prescription Drug Benefits: Findings From a National Survey and Selected Case Study Highlights*. Kaiser Commission on Medicaid and the Uninsured, Washington D.C. October 2001.

[5] §1902(a)(54) of the Social Security Act.
[6] §1916(a)(2) of the Social Security Act.
[7] For more information on the Medicare drug benefit and its likely impact on beneficiaries and states, please see the following documents, which can be accessed at www.kff.org:

- Guyer J. *Implications of the New Medicare Law for Dual Eligibles: 10 Key Questions and Answers*, and *The New Medicare Prescription Drug Benefit Law: Implications for State Medicaid Programs*. Kaiser Commission on Medicaid and the Uninsured. December 2003;
- Guyer J. Smith V, Kramer S, Guyer J. *Coordinating Medicaid and Medicare Prescription Drug Coverage: Findings From a Focus Group Discussion with Medicaid Directors,* Kaiser Commission on Medicaid and the Uninsured, November 2003;
- Bruen B, Holahan J. *Shifting the Cost of Dual Eligibles: Implications For States and the Federal Government.* Kaiser Commission on Medicaid and the Uninsured, November 2003;
- Schnieder A. "Dual Eligibles in Nursing Facilities and Medicare Drug Coverage," a Nov. 13, 2003 briefing note.

INTRODUCTION

Today, Medicaid is fundamental to the provision of outpatient drugs to the low-income population and is particularly important for low-income people with disabilities and elderly beneficiaries who depend on prescription drugs to maintain or improve their health and functioning. The prescription drug benefit is one of the fastest growing components of Medicaid spending and one of the program's most widely utilized services. Medicaid is estimated to spend $27.5 billion in 2003 on outpatient prescription drugs and outpatient prescription drug spending accounts for 12% of Medicaid spending on benefits. This spending is largely directed toward people with disabilities and elderly beneficiaries who, in 2000, constituted approximately 27% of Medicaid beneficiaries, but who accounted for roughly 85% of Medicaid drug spending.

Pharmaceutical spending growth has been an important contributor to increased health care costs in all sectors, including Medicaid. Outpatient prescription drugs are an optional service under Medicaid, the federal/state partnership that provides health coverage to low-income people, but all states provide this important benefit. (Table 1 outlines prescription drug coverage options by state.) Despite mounting drug costs, state Medicaid programs have remained committed to maintaining prescription drug coverage in recognition of the importance of this benefit to the populations they serve.[1] The drug benefit has been particularly important to dual eligibles in the absence of a Medicare drug benefit. [1] However, primarily as a consequence of decreased state tax revenues, state budgets are tight and Medicaid programs are being squeezed—every state has implemented or is planning Medicaid pharmaceutical cost containment activities in FY 2004.[2]

Tighter management of the pharmacy benefit can be important not just in controlling costs, but in improving the quality of care. In many instances, state policies that are part of an overall strategy to limit cost growth also are critical to ensuring that beneficiaries receive appropriate drug therapies consistent with current clinical practice standards, and that do not interact with other medications. At the same time, state efforts to constrain pharmacy spending have the potential to create significant barriers to appropriate drug access for some beneficiaries. The challenge for policy makers at both the federal and state levels is to recognize the need for a balanced approach to cost-containment as they make changes to this essential benefit.

States have a fixed array of tools available to them to constrain spending on Medicaid prescription drugs and to ensure that pharmaceuticals are only provided when they are medically necessary. In early 2003 (February-May), the Kaiser Commission on Medicaid and the Uninsured, with the Health Policy Institute at Georgetown University, conducted a survey of state Medicaid pharmacy programs. Forty-two states plus the District of Columbia responded to the survey. [3, 4] This survey updates an earlier survey conducted in 2000.[5] Where possible, changes and trends between the surveys are

reported in this brief. The findings of this survey reflect policies in effect in early 2003, and some states may have implemented new policies since that time.

UTILIZATION MANAGEMENT

In general, when states elect to cover outpatient prescription drugs through Medicaid, they must cover all Food and Drug Administration (FDA)-approved pharmaceuticals made by every manufacturer that has signed a federal drug rebate agreement with the Secretary of Health and Human Services (HHS).[6] Within this general framework, states have considerable discretion in designing and managing the prescription drug benefit.

The survey examined state utilization management policies in eight areas:

1. Dispensing Limits;
2. Excluded Drugs;
3. Preferred Drug Lists (PDLs) and Formularies;
4. Prior Authorization (PA);
5. Fail-First and Step Therapy;
6. Generic Drugs;
7. Cost-Sharing; and,
8. Coverage of Over-the-Counter (OTC) Medications

Dispensing Limits
Table 2

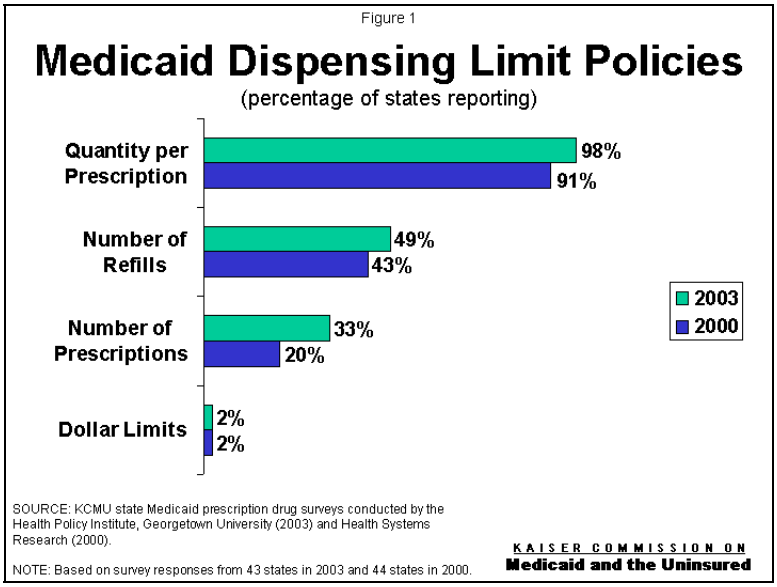
Federal Medicaid law requires states to ensure that benefits they provide are "sufficient in amount, duration, and scope to reasonably achieve (their) purpose".[7] Nonetheless, this does not prevent states from placing limits on the amount, duration and scope of benefits. Under federal regulations, states may place "appropriate" limits on a service based on "medical necessity or on utilization control procedures".[8] The Medicaid law also permits states, "to 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". [9]

Most Medicaid programs (42 of 43 states reporting in 2003) have limits on the quantity of medication that can be dispensed per prescription, and a growing number have limits on number of refills per prescription and the number of prescriptions a beneficiary can have at one time before the state requires prior authorization **(Figure 1)**. Every state

Dispensing Limits: State policies that restrict the quantity of prescription drugs that Medicaid will purchase for a Medicaid beneficiary.

reporting any dispensing limits reported imposing a limit on the quantity dispensed per prescription. Only the District of Columbia reported imposing a dollar limit on prescription drugs ($1,500 per 30-day supply of a drug).

Figure 1



Excluded Drugs

Table 3

The Medicaid law provides four circumstances when states can exclude coverage for prescription drugs:[10]

Excluded Drugs:
Prescription drugs for which a state Medicaid program does not provide coverage.

1) States can exclude drugs if the prescribed use is not for a medically accepted condition.[11] The law further defines medically accepted condition in a way that allows states to exclude drugs not approved by the FDA or listed in recognized compendia.[12, 13] This permits states to exclude drug coverage for drugs that are in clinical trials or that have not yet received FDA approval (based on safety and efficacy) and drugs that have been determined to be ineffective.

2) The following drugs or classes of drugs (or their medical uses) may be restricted from coverage or otherwise restricted: 1) Drugs when used for anorexia, weight loss, or weight gain; 2) drugs when used to promote fertility; 3) drugs when used for cosmetic purposes or hair growth; 4) drugs when used for the symptomatic relief of coughs and colds; 5) drugs when used to promote smoking cessation; 6) prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; 7) nonprescription drugs; 8) 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; 9) barbiturates; and, 10) benzodiazepines.[14] (Note: These listed exclusions were enacted into law in the Omnibus Budget Reconciliation Act of 1990 and are sometimes referred to as "OBRA exclusions" or "OBRA-90" exclusions.)

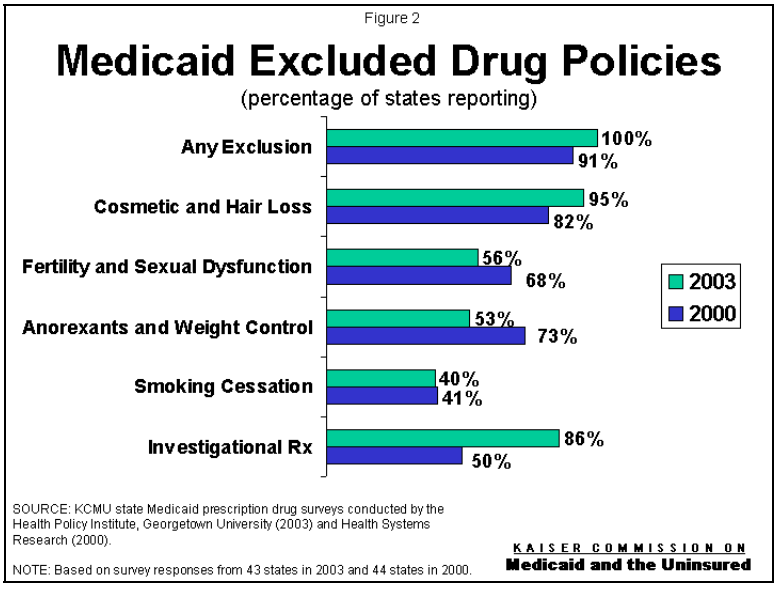
3) Drugs can be excluded if this restriction is part of a drug rebate agreement between a manufacturer and HHS; and,

4) The state has established a formulary meeting specific requirements, subject to prior authorization.

Every state (43 of 43 states reporting in 2003) restricts coverage for at least some prescription drugs **(Figure 2)**. The most commonly applied exclusions are for cosmetic and hair loss drugs (41 of 43 states reporting in 2003) and investigational drugs (37 of 43 states reporting in 2003). Investigational drugs are the category of excludable drugs that experienced the greatest change in state policies since 2000. The number of states excluding investigational drugs rose from 22 of 44 states in 2000 to 37 of 43 states in 2003.

A smaller number of states exclude coverage for both fertility and sexual dysfunction drugs (24 of 43 states reporting in 2003), although the number rises (26 of 43 states reporting in 2003) for exclusions that apply only to fertility drugs. Anorexant and weight control drugs and smoking cessation drugs are the least likely of the excludable drugs to be excluded (23 and 17 of 43 states reporting in 2003, respectively).

Figure 2



Preferred Drug Lists (PDLs) and Formularies

Table 4

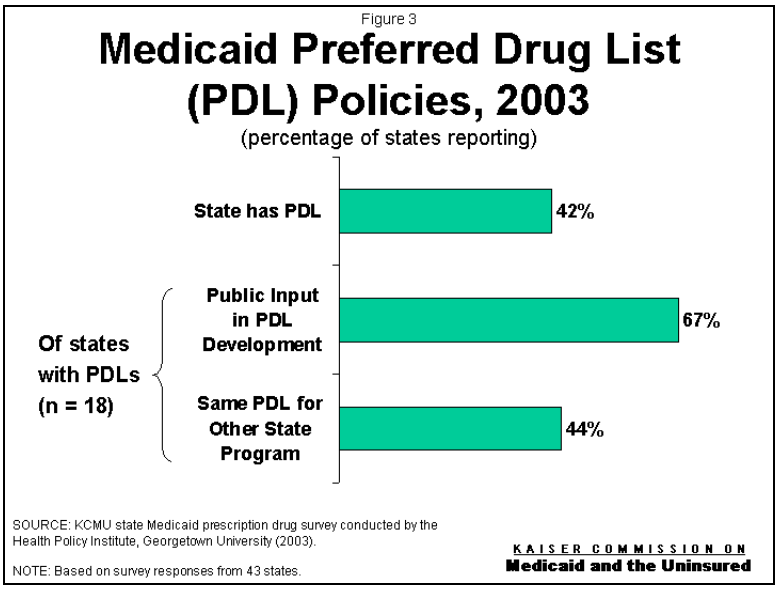
Preferred drug lists (PDLs) are equivalent to formularies. The Medicaid law permits states to establish formularies subject to certain requirements.[15] The formulary must be established by a committee appointed by the Governor (or the state drug use review board) and must include physicians, pharmacists, and other appropriate individuals. The formulary must include all drugs made by manufacturers with rebate agreements in effect with HHS (except for excludable drugs) unless the drug excluded from the formulary, "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".[16] The Secretary is also permitted to impose additional requirements to "achieve program savings consistent with protecting the health of program beneficiaries".[17]

The development and implementation of PDLs in some state Medicaid programs has met with controversy. Some states that have implemented PDLs have faced lawsuits from the pharmaceutical industry claiming that the PDL was in violation of the formulary requirements of the Medicaid law. Additionally, some beneficiary groups have opposed the institution of PDLS citing potential drug access problems. Nonetheless, ongoing cost pressure is likely to cause states to consider the establishment of PDL programs.

Preferred Drug List (PDL):
A list of covered prescription drugs that a state Medicaid program agrees to provide without prior authorization.

All other medically necessary pharmaceuticals require prior authorization.

Nearly half of the states have PDLs (18 of 43 states reporting in 2003) **(Figure 3)**. Of states with PDLs, the majority provide for public input in determining which drugs are included on the list (12 of 18 states reporting in 2003). Forty-four percent of the states with PDLs apply the PDL to other state programs, such as drug coverage for state employees or the State Children's Health Insurance (SCHIP) program (8 of 18 states reporting in 2003).



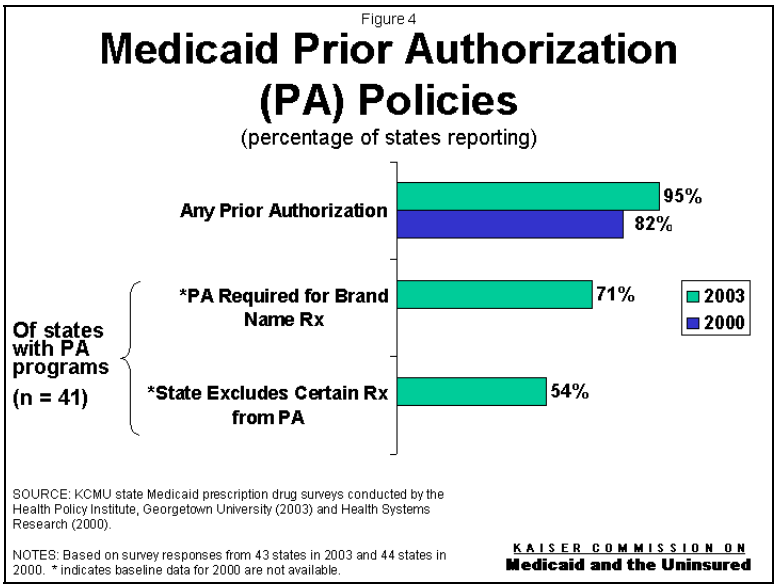
Prior Authorization (PA)

Tables 5-9

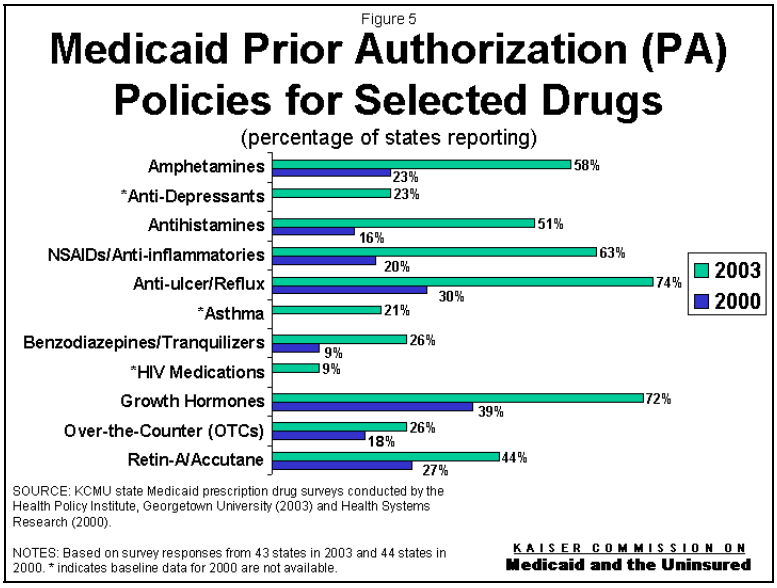
The Medicaid law permits states to subject any covered outpatient prescription drug to prior authorization (PA).[18] States that require prior authorization must have a system for providing approval that ensures that a response will be provided within 24 hours (by telephone or otherwise) and, except for excludable drugs, they must dispense at least a 72-hour supply of a requested drug in cases of an emergency (as defined by the Secretary).[19]

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

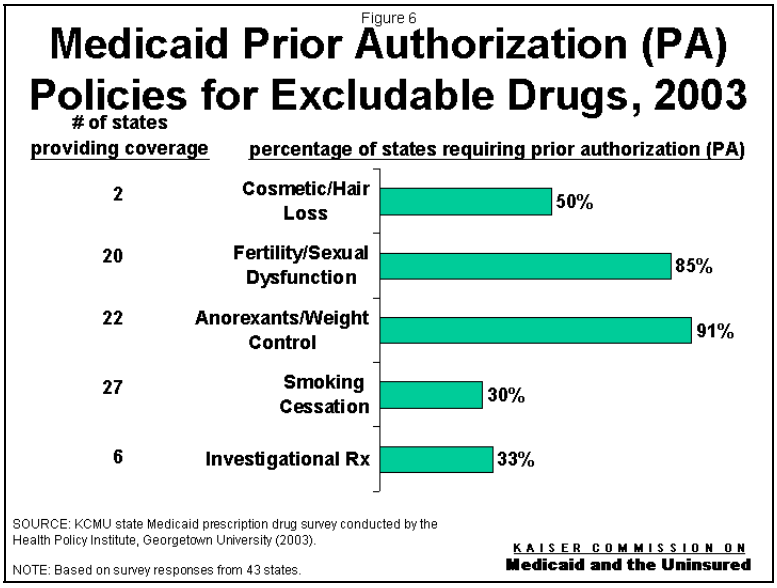
Most states use PA as part of their utilization management activities (41 of 43 states reporting in 2003) **(Figure 4)**. More than two-thirds of states with PA programs (29 of 41 states reporting in 2003) require PA before dispensing brand name drugs. More than half of the states with PA programs, however, identify specific types or classes of drugs that they exclude from PA (22 of 41 states reporting in 2003). Some states reported that they exclude most drugs from PA, whereas other states exclude drugs for specific conditions (such as HIV/AIDS), and still other states reported that they exclude specific individual drugs from PA.



The use of PA by states is growing **(Figure 5)**. For all drug classes surveyed, states reported a greater use of PA in 2003 than in 2000. In many cases, the percentage of states requiring PA for a specific class of drug increased dramatically. For several drug classes, the percentage of states requiring PA more than doubled, including amphetamines (25 of 43 states in 2003 vs. 10 of 44 states in 2000), non-steroidal anti-inflammatory drugs (NSAIDs) (27 of 43 states in 2003 vs. 9 of 44 states in 2000), anti-ulcer/reflux medications (32 of 43 states in 2003 vs. 13 of 44 states in 2000), and benzodiazepines and other tranquilizers (11 of 43 states in 2003 vs. 4 of 44 states in 2000).



When states decide to cover excludable drugs, they frequently require PA before the drugs can be dispensed **(Figure 6)**. In 2003, 1 of only 2 states providing coverage for cosmetic/hair growth drugs, 17 of 20 states providing coverage for fertility and sexual dysfunction drugs, and 20 of 22 states providing coverage for anorexants/weight control drugs require PA (out of 43 states responding in 2003). States are less likely to require PA for smoking cessation and investigational drugs. Roughly one-third of states providing coverage for smoking cessation (8 of 27 states) and investigational drugs (2 of 6 states) require PA (out of 43 states reporting in 2003).

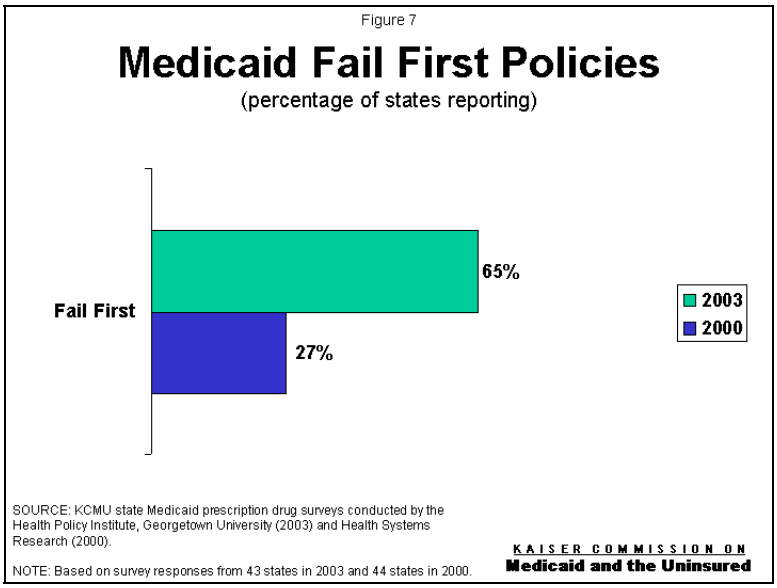


Fail First and Step Therapy Policies
Table 10

Fail-first or step therapy policies are a variation of prior authorization. Under these policies, a physician must generally demonstrate that an alternative therapy is ineffective or otherwise inappropriate for the individual before the requested drug can be dispensed.

Fail First/Step Therapy Requirement: Policy that requires an individual to use and fail on a particular drug (generally a low cost alternative) before a state Medicaid program will pay for another drug.

As with PA policies more generally, states have increased their reliance on fail-first policies **(Figure 7)**. Roughly two-thirds of states use fail-first policies: 28 of 43 states reporting in 2003 vs. 12 of 44 states in 2000. In general, when states adopt fail-first policies, they apply them to commonly-prescribed medications, such as NSAIDs, the anti-ulcer proton-pump inhibitors (PPIs) and COX-II inhibitors for arthritis. Some states also require beneficiaries to fail on generics before dispensing brand-name alternatives.



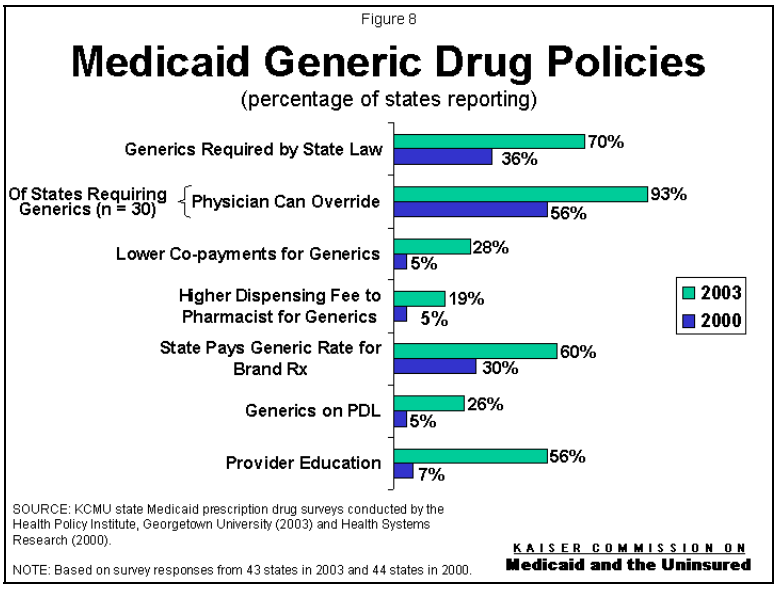
Generic Drug Policies
Tables 11 and 12

As discussed previously, Medicaid law generally requires states to provide coverage for all FDA-approved medications by manufacturers with rebate agreements in effect with the federal government. Medicaid law does not, however, prevent states from requiring or encouraging the use of generic medications.

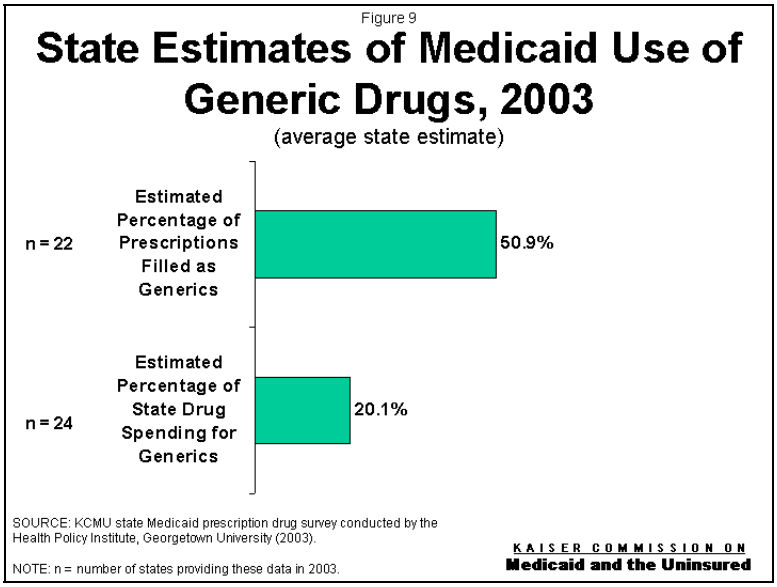
Seventy percent of states require the dispensing of generics (30 of 43 states in 2003 vs. 16 of 44 states in 2000) **(Figure 8)**. All, but two states that require generics, however, report that physicians can override this policy by writing "brand medically necessary" when writing the prescription (28 of 30 states that require generics in 2003). States also employ numerous approaches to encouraging the use of generics. By every measure, states have become more aggressive in encouraging the use of generics since 2000. The percentage of states that pay the generic rate for brand name drugs has doubled since 2000 (26 of 43 states in 2003 vs. 13 of 44 states in 2000). States also rely heavily on provider education as a strategy for encouraging the use of generics (24 of 43 states in 2003 vs. 3 of 44 states in 2000). Smaller numbers of

Generic Drug: A generic drug is identical, or bioequivalent to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the branded price.

states also charge lower co-payments for generic drugs (12 of 43 states in 2003 vs. 2 of 44 states in 2000), pay higher dispensing fees to pharmacists for generics (8 of 43 states in 2003 vs. 2 of 44 states in 2000), and automatically place generics on the PDL (11 of 43 states in 2003 vs. 2 of 44 states in 2000).



States were asked to estimate the percentage of prescriptions filled that were generic. The average response was 51% and ranged from 34% to 72% **(Figure 9)**. States were also asked to estimate the percentage of state outpatient drug spending that is for generics. The average response was 20% and ranged from 10% to 44%.



Cost-Sharing
Table 13

Medicaid permits states to charge "nominal" cost-sharing to certain groups of beneficiaries for certain services. Medicaid law prohibits cost-sharing for the following groups: children under age 18; pregnant women with respect to services relating to pregnancy or any other medical condition that may complicate the pregnancy; terminally ill individuals receiving hospice care; and inpatients in hospitals, nursing facilities, or intermediate care facilities for persons with mental retardation (ICF/MRs) who are required to contribute all, but a minimal amount of their income for their medical care.[20]

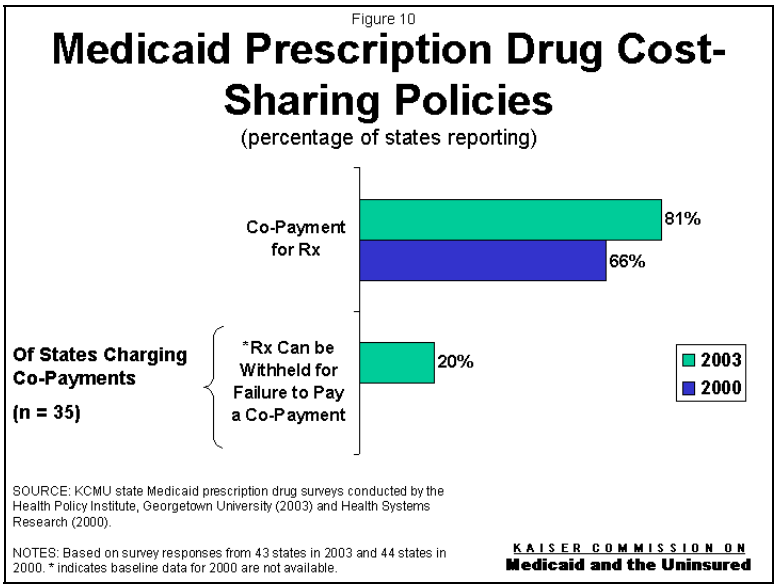
Cost-Sharing: Medicaid policy that requires a beneficiary to pay a portion of the cost of a service. In the case of prescription drugs, states have the option of requiring certain beneficiaries to pay a "nominal" co-payment, although a state cannot deny a beneficiary a drug based on the failure to pay the co-payment.

When cost-sharing is permitted, states are required to prohibit providers from denying care or services to an eligible individual on account of an individual's inability to pay a co-payment.[21]

The vast majority of states charge eligible beneficiaries co-payments for outpatient prescription drugs (35 of 43 states reporting in 2003 vs. 29 of 44 states in 2000) **(Figure 10)**. When states charge co-payments, they generally apply them to all eligible beneficiary groups, including the elderly, people with disabilities, and parents. A small number of states (Florida, Missouri, and New Mexico) apply prescription drug co-payments to only a small proportion of their overall Medicaid population.

Although the Medicaid law prohibits denial of prescription drugs based on failure to pay the co-payment, a small number of states (7 of 35 states reporting that they require cost-sharing) reported restrictions on prescription drugs for failure to pay copayments, especially for repeat violations.

Figure 10



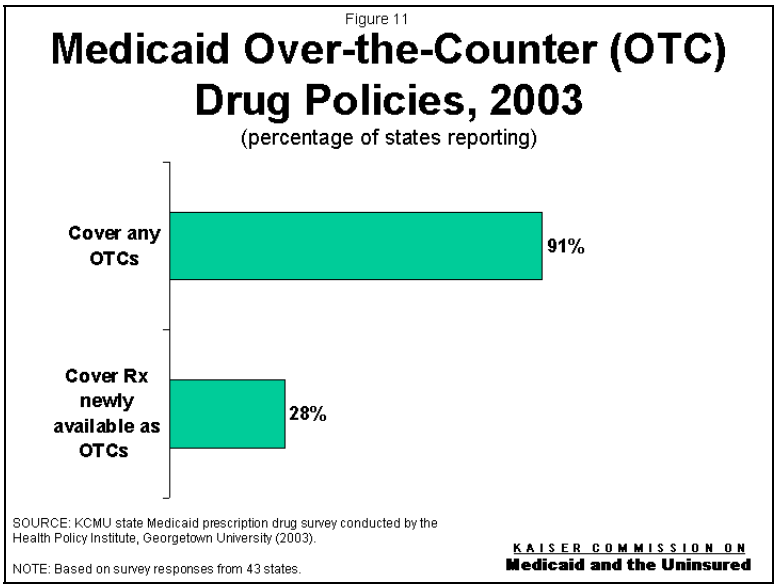
Over-the-Counter Medications (OTCs)

Table 14

Medicaid permits states to cover over-the-counter medications (OTCs), but the Medicaid law does not extend the same policies to OTCs that apply to prescription medications. The Medicaid law's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirement that requires states to cover all medically necessary covered Medicaid services for children applies to OTCs (states may require a prescription written by a physician as evidence of medical necessity). For adult beneficiaries in all eligibility groups, states have broad flexibility in deciding whether and how to cover OTCs.

Over-the-Counter Medications (OTCs): Drugs that are available without a prescription.

Thirty-nine of 43 states reporting in 2003 cover some OTCs **(Figure 11)**. The extent of OTC coverage varies dramatically from state to state. A smaller number of states (12 of 43 states reporting in 2003) cover OTCs that were previously available by prescription and that are newly available as OTCs.



PAYMENT AND PURCHASING POLICIES
Tables 15-17

States have considerable discretion in setting payment rates for Medicaid outpatient prescription drugs. The overall price for Medicaid drugs consists of three components: 1) the amount the state pays the pharmacist for the drug itself; 2) the amount of the dispensing fee that that state pays the pharmacist for filling the prescription; and, 3) the size of the rebate that the state receives from the drug manufacturer for purchasing the drug.

Payment for the drug itself: The Medicaid law does not set any minimum payment standards, but it does establish maximum payments for which states can receive a federal match.

For brand name drugs (i.e. drugs still under patent), and multi-source drugs with fewer than 3 therapeutically equivalent generics, the maximum payment cannot exceed the lesser of the drug's estimated acquisition cost (EAC) plus a dispensing fee or the provider's usual and customary charges to the general public. Each state determines its own EAC, and in most states is based on the average wholesale price (AWP). AWP is a price determined by the drug manufacturer and is the suggested price that wholesalers charge retail pharmacists for the drug. Most states set their EAC as AWP minus some percentage discount. The actual cost paid for drugs by pharmacies is generally believed to be well below AWP, providing a justification for the discount. A study in 1999 by the HHS Office of the Inspector General estimated that the actual acquisition cost for pharmacies was AWP – 21.84%.[22] A smaller number of states set their EAC based on the wholesale acquisition cost (WAC), an estimate of the wholesaler's cost for the drug plus a percentage add-on.[23]

For generic drugs (i.e., multi-source drugs with at least 3 therapeutic equivalents), federal matching payments are limited by the Federal Upper Limit (FUL). The FUL is set at 150% of the published price for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules.[24] Medicaid regulations stipulate, however, that the FUL payment ceiling does not apply if a prescribing physician (in his or her own handwriting) specifies that a specific brand is medically necessary.[25]

Virtually all states (42 of 43 reporting in 2003) set their EAC on the basis of AWP. Florida, Maryland, and Missouri use both AWP and WAC. Massachusetts is the only state that indicated that it determined its EAC based on WAC.

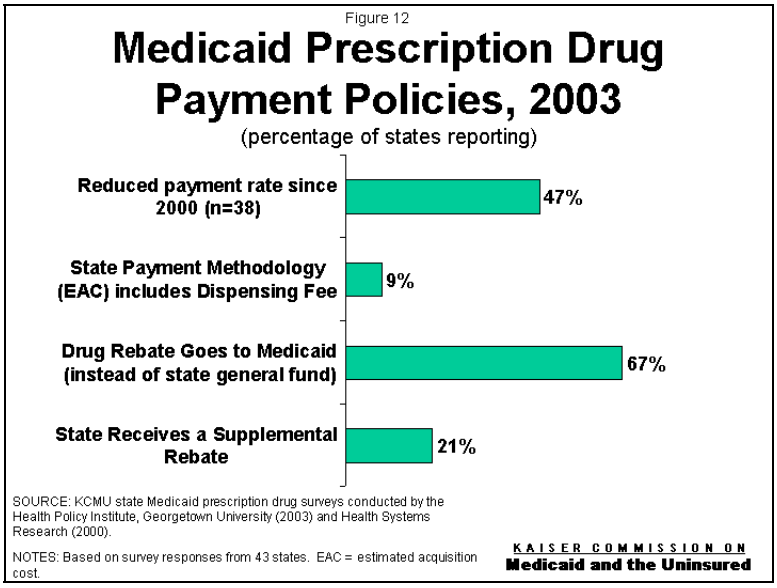
Nearly half of the states (18 of 38 states reporting in both 2000 and 2003) have reduced their payment rate since 2000—through increasing the discount taken off of AWP **(Figure 12)**. Relatively few states (4 of 43 reporting in 2003) include their dispensing fee when calculating the EAC. When states receive drug rebate payments, it is at their discretion to return these funds to Medicaid or return them to the state's general fund. Two-thirds of the states (29 of 43 reporting in 2003) return drug rebate payments to Medicaid.

Dispensing fee: The Medicaid law and the payment ceilings described above permit states to pay a "reasonable" dispensing fee to the pharmacist. Federal regulations do not define what is reasonable, and there is significant variation in the fees paid by states.

Drug rebates: The actual cost to Medicaid for prescription drugs is reduced by the rebates that manufacturers pay to states. The federal rebate is based on agreements between the manufacturer and the Secretary of HHS and is uniform across the states. Some states, however, have negotiated supplemental rebates directly with manufacturers. The federal rebate extends only to drugs purchased by states on a fee-for-service basis. When states purchase drugs through capitated managed care programs, the managed care organizations are permitted to negotiate their own discounts.

A relatively small number of states (9 of 43 reporting in 2003) reported that they receive supplemental rebates from drug manufacturers. The leverage for these rebates typically comes from the institution of a state Medicaid PDL.

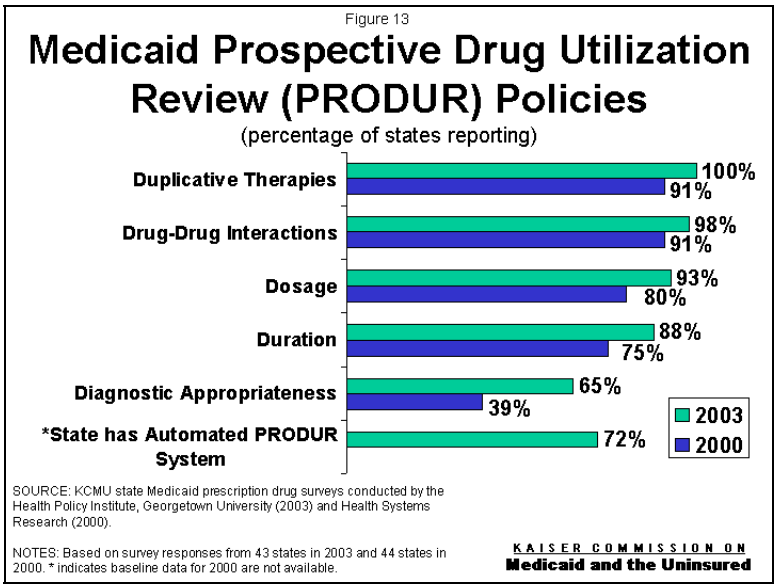
States were asked to list the five most commonly dispensed prescription drugs and the five most costly drugs (in terms of total state expenditures). The five most commonly dispensed drugs, according to states rankings are albuterol (for asthma), furosemide (a diuretic used to control hypertension) hydrocodone (pain medication), Celebrex (an anti-inflammatory used for arthritis) and the antibiotic amoxicillin. The five most costly drugs, according to states' rankings are Zyprexa and Risperdal (both antipsychotics), Prevacid, and Prilosec (both anti ulcer medications) and Celebrex (an anti-inflammatory). To view these data for individual states, see Tables 16 and 17.



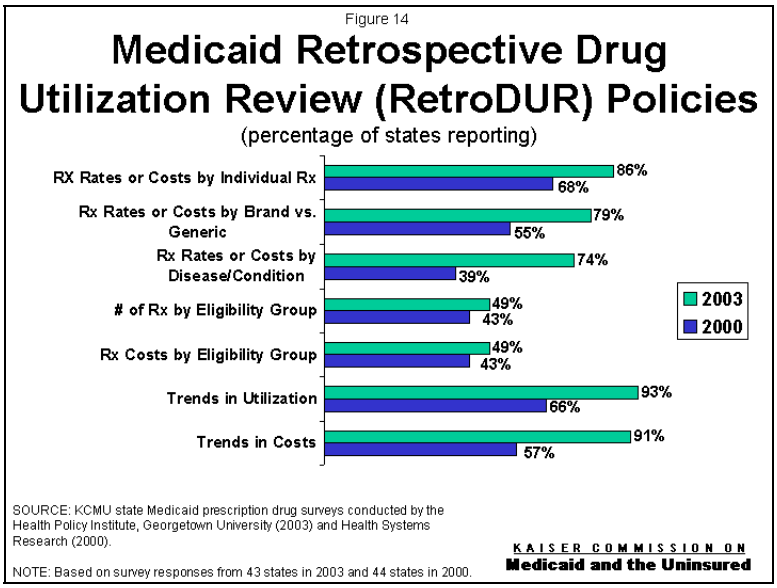
UTILIZATION REVIEW AND MONITORING
Tables 18-22

Medicaid law requires states to operate drug utilization review (DUR) programs. These include prospective drug utilization review (PRODUR), which takes place before a drug is dispensed and retrospective drug utilization review (RetroDUR), which takes place after the drug is dispensed.[26] The emphasis of PRODUR is on protecting the health and safety of beneficiaries receiving prescription drugs and the emphasis of RetroDUR is on identifying fraud, abuse, and gross overuse of prescription medications. States have frequently identified PRODUR and RetroDUR as among the easiest to implement and most effective utilization management and cost control strategies.

The vast majority of states, although not all states, conduct PRODUR activities using the criteria established in the Medicaid law **(Figure 13)**. In 2003, all states reported reviewing for duplicative therapies, and most states review for drug-to-drug interactions (42 of 43 states), incorrect dosage (40 of 43 states), inappropriate duration (38 of 43 states), and diagnostic appropriateness (28 of 43 states). Although not a requirement, more than two-thirds (31 of 43 states) reported that their PRODUR systems are automated.

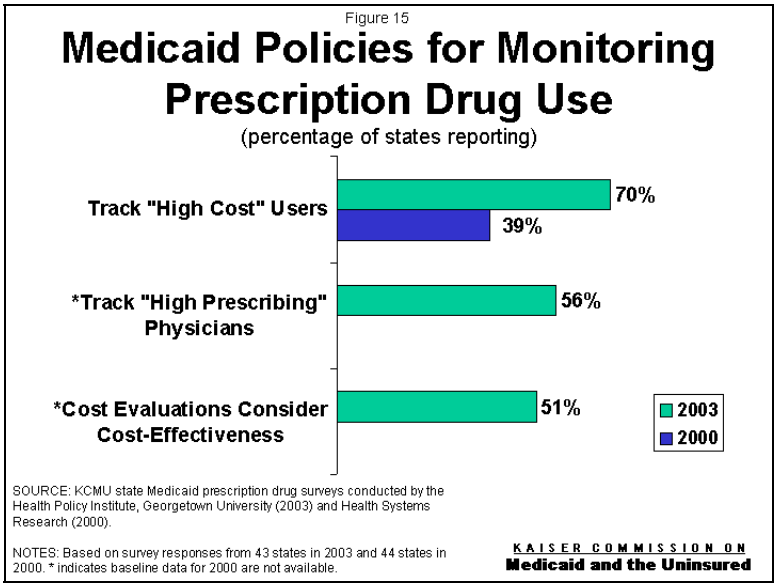


Medicaid requires states to conduct RetroDUR, although the law is not as specific regarding the criteria for the review as it is for PRODUR. In 2003, nearly all states (40 of 43) monitor trends in utilization, trends in costs (39 of 43 states), and drug costs for each individual drug (37 of 43 states) **(Figure 14)**. A large majority of states also review drug costs on the basis of brand name versus generic status (34 of 43 states) and drug costs by condition (32 of 43 states). Nearly half of the states also monitor the number of drugs by eligibility group (21 of 43 states reporting in 2003), and drug costs by eligibility group (21 of 43 states reporting in 2003).



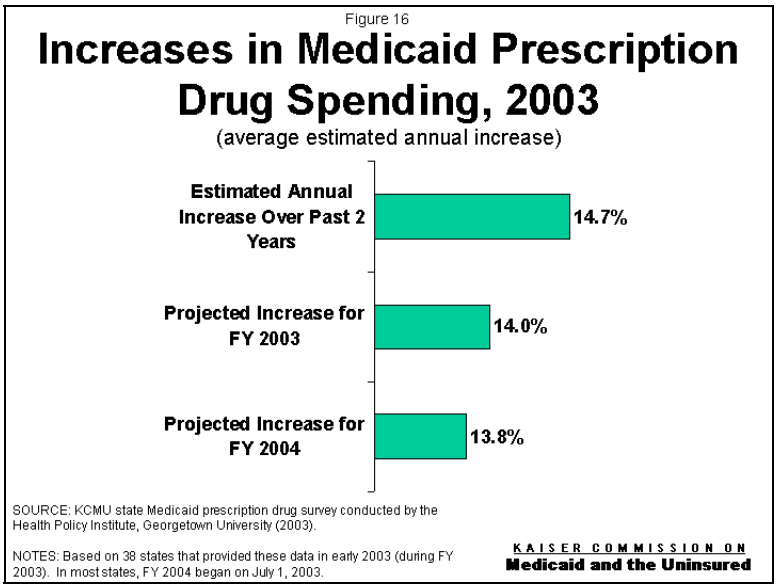
States also monitor prescription drug use by tracking both “high-cost users” and “high prescribing physicians” **(Figure 15)**. Seventy percent of states (30 of 43 states

reporting in 2003) reported that they track high-cost users. Several states indicated that these users are identified by selecting the top 100 or 200 beneficiaries on the basis of their monthly drug costs. At least one state reported tracking high users of certain "abusable" drugs. Many states (24 of 43 states reporting in 2003) reported that they track high-prescribing physicians. Similarly, several states reported that they identify high prescribers on the basis of total cost to the state in a given month. Educational letters and personal visits were commonly cited by states as interventions used to address high-prescribing physicians. Half of the states (22 of 43 reporting in 2003) indicated that they consider cost-effectiveness when conducting cost evaluations. Of these respondents, many indicated that cost-effectiveness is considered through the use of disease management programs.



States were asked to give estimates of their recent cost experience in purchasing prescription drugs and their projections for the next two years **(Figure 16)**. The average estimated annual increase in prescription drug costs over the last two years was 15% (based on 37 states reporting) and ranged from 4% to 25% per year. The average projected cost growth in FY 2003 (which ended on June 30, 2003 in most states), was 14%, and ranged from a decline of 1% from the previous year to an increase of 27%. Projected average cost growth in FY 2004 (the current fiscal year, with projections being made in early 2003 was 14%, and ranged from a decline of 5% from the previous year to a 23.1% increase.

Figure 16



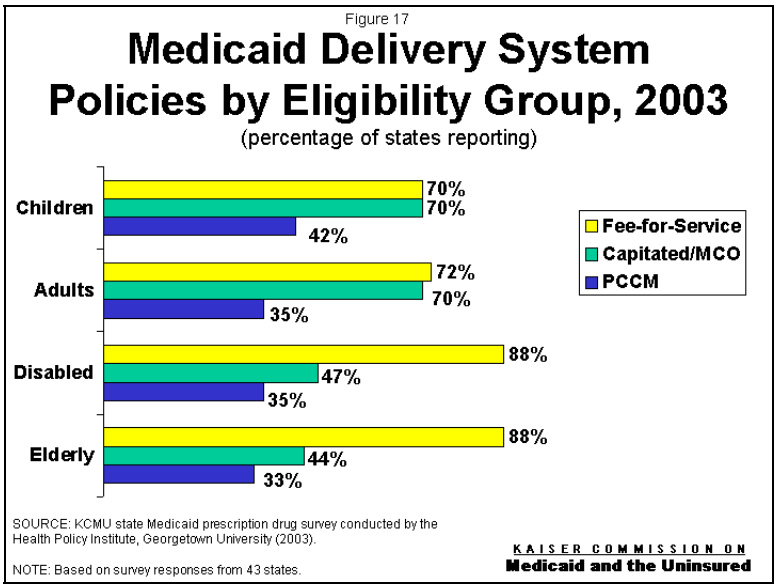
PRESCRIPTION DRUG POLICIES FOR MANAGED CARE ENROLLEES
Tables 23-25

State Medicaid programs deliver health care and long-term services to beneficiaries through more than one type of delivery system. Fee-for-service was previously the only type of delivery system in Medicaid. Medicaid law also gives beneficiaries a right to freedom-of-choice of health care providers. Over time, through state initiatives in which managed care enrollment was voluntary and through the use of Medicaid waivers wherein federal approval was required to waive the freedom-of-choice provision in order to mandate managed care enrollment, the use of managed care has grown. The Balanced Budget Act of 1997 (BBA) also gave states new authority to mandate managed care enrollment through amending their Medicaid plans without seeking waivers, thereby creating even more opportunities for states to employ managed care models.

While managed care exists on a continuum and in many forms, there are two dominant types of managed delivery systems: capitated managed care and primary care case management (PCCM) programs. Capitated managed care programs are operated through contracts by the state Medicaid program with managed care organizations (MCOs), purchasing a package of health care and other services for Medicaid beneficiaries by paying a negotiated per person rate. In this type of arrangement, much of the state's risk for the costs of health care and provision of covered services is shifted onto the MCO. States with capitated managed care programs can include some or all covered Medicaid benefits in the contract with the MCO, therefore, states may purchase prescription drug benefits on a capitated or fee-for-service basis. In PCCM programs, the state contracts with a PCCM agency to perform certain health care administrative functions. This usually involves the primary care case manager serving as a gatekeeper for services, and conducting utilization review before approving access to

specialty care. In PCCM arrangements, the state continues to pay for services approved by the PCCM on a fee-for-service basis.

Most states employ more than one type of delivery system for their Medicaid beneficiaries. States also may employ more than one type of delivery system for each eligibility group. For example, through a waiver, a state may operate a capitated managed care program in the urban areas of the state for some beneficiaries, while operating a fee-for-service system in rural areas. Some states serve all eligibility groups through all 3 of the major types of delivery systems. Most states operate fee-for-service and capitated managed care programs for at least some Medicaid beneficiaries **(Figure 17)**. A sizable minority of states also operate PCCM programs. More states serve people with disabilities and the elderly in fee-for-service systems than non-disabled children and adults (38 of 43 states reporting in 2003 for people with disabilities and the elderly, respectively vs. 30 and 31 states, for non-disabled children and adults, respectively). Conversely, more states serve non-disabled children and adults in capitated managed care programs than people with disabilities and the elderly in capitated managed care programs (30 of 43 states reporting in 2003 for non-disabled children and adults vs. 20 and 19 for people with disabilities and the elderly, respectively). A third or more of the states serve all eligibility groups through PCCM programs. Eighteen states use PCCM programs to serve non-disabled children, 15 states use PCCM programs to serve non-disabled adults and people with disabilities, and 14 states use PCCM programs to service the elderly (out of 43 states reporting in 2003).



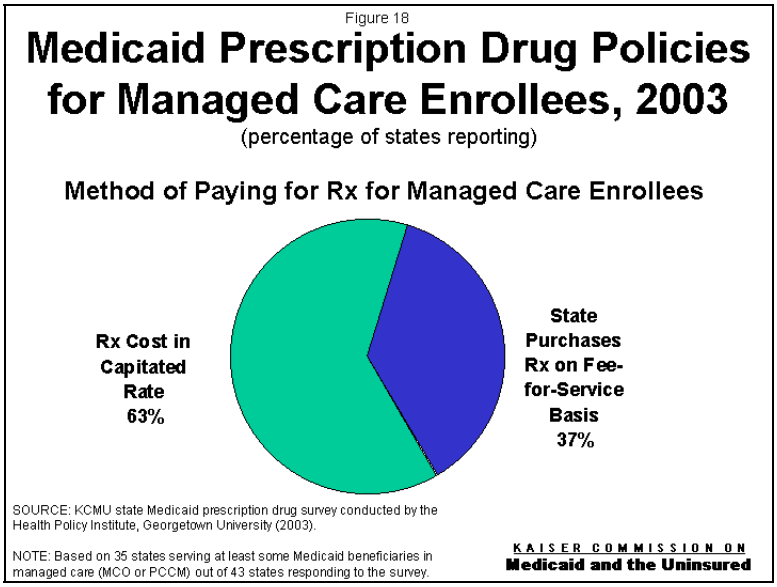
Of states that serve at least some beneficiaries through capitated managed care programs, the majority purchase prescription drugs by including drug costs in the capitated rate paid to MCOs (22 of 35 states with capitated managed care programs in 2003, out of a total response from 43 states) **(Figure 18)**. One-third of states with

capitated managed care programs (13 of 35 states, out of a total response from 43 states) indicate that they purchase prescription drugs on a fee-for-service basis.

Figure 18

Medicaid Prescription Drug Policies for Managed Care Enrollees, 2003

(percentage of states reporting)



SOURCE: KCMU state Medicaid prescription drug survey conducted by the Health Policy Institute, Georgetown University (2003).

NOTE: Based on 35 states serving at least some Medicaid beneficiaries in managed care (MCO or PCCM) out of 43 states responding to the survey.

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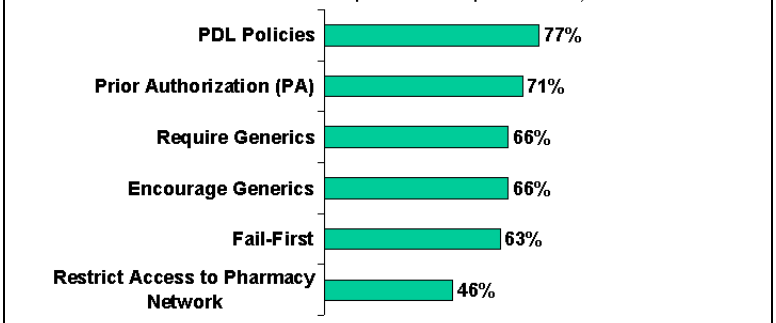
The level of discretion that states give MCOs in managing the prescription drug benefit has significant implications for beneficiary access and cost containment. Roughly two-thirds of states with capitated managed care programs give MCOs discretion to set their own policies in a broad range of areas, including PDL policies, PA policies, requiring or encouraging generics, and establishing fail-first policies **(Figure 19)**. Less than half of the states (16 of 35 states with capitated managed care programs, out of a response from 43 states in 2003) permit MCOs to restrict access to only certain pharmacies within an MCO network.

Figure 19

Medicaid MCO or PCCM Discretion to Set Pharmacy Policies, 2003

(percentage of states reporting that MCOs or PCCMS can set their own policies and procedures)



SOURCE: KCMU state Medicaid prescription drug survey conducted by the Health Policy Institute, Georgetown University (2003).

NOTE: Based on 35 states serving at least some Medicaid beneficiaries in managed care (MCO or PCCM) out of 43 states responding to the survey.

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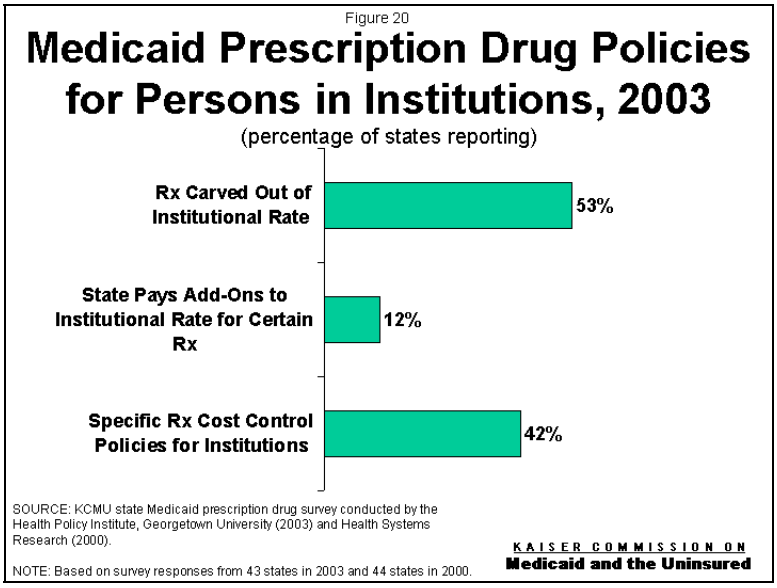
PRESCRIPTION DRUG POLICIES FOR PERSONS RESIDING IN INSTITUTIONS
Table 26

The Medicaid law provisions described in this report apply only to Medicaid beneficiaries receiving prescription drugs on an outpatient basis. The law expressly states that they do not apply to persons in inpatient settings including hospitals, nursing homes, and ICF/MRs.[27] Medicaid spending on prescription drugs for persons residing in institutions [including hospitals, nursing homes, ICF/MRs, and institutions for mental diseases (IMDs)], comprise a significant proportion of overall state prescription drug spending, thereby meriting an examination of state purchasing and management practices in institutional settings.

States were asked to estimate the percentage of total Medicaid prescription drug spending for persons residing in institutions. The average response was 21% (based on 20 states reporting in 2003) and ranged from 6% to 33% of total drug spending. States were asked how they administer the institutional prescription drug benefit **(Figure 20)**. Half of the states (23 of 43 states reporting in 2003) indicated that they carve out institutional drug spending—meaning they separate payment for drugs from an institutional payment rate and purchase drugs on a fee-for-service basis. The remaining half of the states presumably include prescription drug costs in a bundled institutional payment rate. A small number of states (5 of 43 states reporting in 2003) pay an add-on to the institutional rate for certain drug costs, such as OTCs and vitamins. Forty-two percent of states (18 of 43 states reporting in 2003) have pharmacy cost control policies that are unique to the institutional setting.

Figure 20



POLICY IMPLICATIONS

This survey has shown that states are taking advantage of the tools available to them to manage the Medicaid outpatient prescription drug benefit. By design, however, states are limited in terms of how aggressively they can constrain the Medicaid drug benefit because of the vulnerability of the populations served. To plan for the future, policy makers should consider the following:

- **Most states have taken advantage of the full range of tools available to them for managing prescription drug utilization and to constrain cost growth.**

On virtually every measure, between 2000 and 2003, more states have taken advantage of the flexibility in the Medicaid law to manage prescription drug use and to monitor prescribing practices. For every year that state budgets are tight, and states are forced to identify ways to reduce spending, they have a diminishing range of tools available to them to reduce pharmaceutical costs. Additionally, states have probably considered many pharmacy utilization tools that they are not currently using. Whether states rejected various utilization management approaches out of concerns for beneficiary access, feasibility, or administrative burden, the remaining tools are increasingly less attractive to states, having been considered and rejected in the past.

As has been shown, states have broad flexibility within Medicaid to manage the pharmacy benefit. New flexibility, such as greater latitude to tailor benefits to specific populations, is unlikely to lead to meaningful cost savings. Nonetheless, new flexibility could come at a potentially great cost to the subset of Medicaid beneficiaries who rely extensively on prescriptions and who are disproportionately responsible for a major portion of pharmacy spending. Tailoring benefits packages to deny benefits to certain beneficiaries is unlikely to yield results. If the groups denied the benefit were lower utilizers of prescription drugs there would not be much cost savings to gain, and if the groups with the greatest needs were denied the benefit, undue hardship and increases in other health care costs would likely ensue. Moreover, since Medicaid programs would continue to be responsible for other health care costs, achieving marginal cost-savings in prescription drugs may come at the expense of poorer health outcomes and higher overall Medicaid spending.

- **Greater federal and state efforts are needed to examine the impact of cost control activities on beneficiary access to medically necessary prescription drugs.**

This survey did not assess beneficiary access to pharmaceuticals or variations in quality of the Medicaid prescription drug benefit. Federal and state governments are facing a large and increasing burden in providing a comprehensive drug benefit to a needy population. As states employ more and more cost-constraining strategies and as they become more aggressive in using tools such as prior authorization or drug limits, more

attention needs to be placed on examining and protecting beneficiary access to prescription drugs.

- **Future progress in constraining drug costs may depend on policy change at the federal level.**

If states are approaching the limit of what they can achieve in constraining pharmaceutical cost growth through tight management of the outpatient prescription drug benefit, future progress in limiting drug costs may depend on policy changes at the federal level.

One federal approach is to increase the size of the Medicaid drug rebate. While this survey indicates that nine states receive supplemental rebates, negotiating them is challenging for many states. Small states are at a great disadvantage in negotiating rebates with manufacturers because they may not generate high enough volumes of business for the drug manufacturers to have meaningful bargaining power. Additionally, political pressure in many states would make it impossible to seek supplemental rebates. A change in the Medicaid law would have the advantage of leveraging all outpatient prescription drugs purchased by every Medicaid program. While pharmaceutical manufacturers would likely strenuously oppose such a move, it is unlikely that they would no longer be willing to participate in Medicaid.

Outside of Medicaid, some advocates and policy makers have proposed more far reaching reforms of how drugs are priced in the United States. Some have advocated models used by many other developed nations to place certain limits on pharmaceutical prices. While such reform seems remote at the present time, it holds the greatest potential to give states the most significant and long-term relief in financing their Medicaid pharmacy programs. Additionally, one factor that is believed to have contributed to increasing prescription drug costs is direct-to-consumer marketing of pharmaceuticals. Since federal regulations related to direct marketing to consumers was changed in the late 1990's, there has been an explosion of pharmaceutical manufacturer spending on television and print advertisements of drug products for consumers. Some health policy analysts have asserted that increases in Medicaid drug costs can be directly tied to this new ability to market to consumers. Policy makers may wish to consider new prohibitions or restrictions on marketing of pharmaceuticals to consumers.

CONCLUSION

The importance of prescription drugs in the clinical management of many health conditions continues to grow with the discovery of new medications and with improvements to existing therapies. The promise of new therapeutics is exciting both for its potential to bring new treatments to previously untreatable or poorly treated conditions and for its potential to play a role in improving the quality of life of many individuals—while reducing other costs in the health system.

For state Medicaid programs, the prospect of a future with new and improved drugs must also be balanced with the daunting challenge of financing the provision of these medications. Medicaid plays a unique role in providing access to prescription drugs to the neediest and costliest cohorts of Americans (low-income people with severe disabilities and low-income elderly individuals). Financing new medications that often demand top dollar in comparison to older drugs is especially challenging at the same time that Medicaid programs adapt to changing demographics that will undoubtedly lead to more people with disabilities and elderly beneficiaries who need many services, as well as many pharmaceuticals. Because of the clear benefits to be gained by individual Medicaid beneficiaries and the health of the general public by ensuring that Medicaid beneficiaries can access the full compliment of pharmaceuticals, it will be worth the effort for policy makers to ensure that these challenges are overcome.

Finally, the enactment of a Medicare drug benefit will have a major impact on Medicaid and many of the people it serves. Among those who will be most affected by the new Medicare law are the dual eligibles. As of January 1, 2006, dual eligibles will no longer have Medicaid drug coverage but will receive prescription drugs through Medicare Part D. All of the implications of this change for duals – including many nursing home residents and Medicaid waiver participants – are yet to be determined. In addition, state Medicaid programs will experience major change as payments for this large drug consuming population shift to Medicare. As all stakeholders begin to grasp the details of how Medicare Part D will operate, understanding the dynamics and complexities of serving the dual eligibles under Medicaid can help to identify ways that a Medicare drug benefit can best serve these poorest and sickest beneficiaries.

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[1] The recently enacted Medicare drug benefit, once implemented, will significantly impact Medicaid's prescription drug utilization profile. Dual eligibles (those Medicare beneficiaries currently receiving Medicaid coverage for services including prescription drugs) will no longer receive prescription drugs through Medicaid as of January 1, 2006.

[2] Smith, V., Ramesh, R., Gifford, K., Ellis, E., and Wachino, V., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004: Results from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2003.

[3] The eight states that did not respond to the 2003 survey were AL, IN, NV, OH, OR, RI, TN, and WY. In 2000, 43 states and DC responded; the seven states that did not respond were AZ, CO, OH, OK, TN, TX, and WI.

[4] For ease of reference, throughout this report, references to "states" should be inferred to include the District of Columbia.

[5] Schwalberg R, Bellamy H, Giffin M, Miller C, Williams SS, Elam L., *Medicaid Outpatient Prescription Drug Benefits: Findings From a National Survey and Selected Case Study Highlights*. Kaiser Commission on Medicaid and the Uninsured, Washington D.C. October 2001.

[6] §1902(a)(54) of the Social Security Act.

[7] §1903(i) of the Social Security Act. See first sentence after (20).

[8] 42 CFR 440.230 (d).

[9] §1927(d)(6) of the Social Security Act.

[10] §1927(d)(1)(B) of the Social Security Act.

[11] §1927(d)(1)(B)(i) of the Social Security Act.

[12] §§1927 (k)(6) and (g)(1)(B)(i) of the Social Security Act.

[13] The Medicaid law recognizes the following compendia: the American Hospital Formulary Service Drug Information; the United States Pharmacopoeia Drug Information; the DRUGDEX Information System; and the American Medical Association Drug Evaluations.

[14] §1927(d)(2) of the Social Security Act.
[15] §1927(d)(4) of the Social Security Act.
[16] §1927(d)(4)(C) of the Social Security Act.
[17] §1927(d)(4)(E) of the Social Security Act.
[18] §1927(d)(1)(A) of the Social Security Act.
[19] §1927(d)(5) of the Social Security Act.
[20] §1916(a)(2) of the Social Security Act.
[21] §1916(e) of the Social Security Act.
[22] Office of the Inspector General, *Medicaid Pharmacy – Actual Acquisition Cost of Brand Name Prescription Drug Products* (August 10, 2001) (A-06-00-00023) http://oig.hhs.gov/oas/reports/region6/60000023.htm.
[23] Schneider A and Elam L. *Medicaid: Purchasing Prescription Drugs*. Kaiser Commission on Medicaid and the Uninsured, January 2002.
[24] 42 CFR 447.332(b).
[25] 42 CFR 447.331(c).
[26] §1927(g) of the Social Security Act.
[27] §1927(k)(3) of the Social Security Act.

STATE-BY-STATE TABLES

Table 1: Medicaid Prescription Drug Coverage Options, by State.

STATE	**Medicaid Rx Coverage** *Categorically Needy*	*Medically Needy**	*Specific State Policies to Cover QMBs/SLMBs*	*Pharmacy Plus Waiver*	*Eligible Populations*
Alabama					
Alaska	●				
Arkansas	●	●			
Arizona**	●				
California	●	●			
Colorado	●				
Connecticut	●	●			
Delaware	●				
District of Columbia	●	●			
Florida	●	●	●	●	Medicare beneficiaries ≥ 65
Georgia	●	●			
Hawaii	●	●			
Idaho	●				
Illinois	●	●		●	≥ 65, below 200% FPL
Indiana					
Iowa	●	●			
Kansas	●	●			
Kentucky	●	●			
Louisiana	●	●			
Maine	●	●			
Maryland	●	●	●		
Massachusetts	●	●			
Michigan	●	●			
Minnesota	●	●			
Mississippi	●				
Missouri	●				
Montana	●	●			
Nebraska	●	●			
Nevada					
New Hampshire	●	●			
New Jersey	●	●			
New Mexico	●				
New York	●	●	●		
North Carolina	●	●	●		
North Dakota	●	●			
Ohio					
Oklahoma	●	●			
Oregon					
Pennsylvania	●	●			
Rhode Island					
South Carolina	●		●	●	≥ 65 w/o insurance
South Dakota	●				
Tennessee					
Texas	●	●	●		
Utah	●	●			
Vermont	●	●			
Virginia	●	●			
Washington	●	●			
West Virginia	●	●			
Wisconsin	●	●	●	●	≥ 65
Wyoming					
TOTAL	**43**	**33**	**7**	**4**	

Shaded text signifies states that did not respond to the survey. *Medically needy notes: New Jersey limits Rx coverage to pregnant women, children under 21, and long-term care recipients; Pennsylvania limits Rx coverage to children under 21, and long-term care recipients; Texas' medically needy program does not cover people with disabilities or the elderly, except in long-term care facilities; and Utah has different co-payment requirements and benefit limitations. **Survey does not reflect Arizona's policies for a small number of beneficiaries whose services are reimbursed on a fee-for-service basis.

Table 2: Medicaid Prescription Drug Dispensing Limits, by State.

STATE	*Any Limits*	*Amount of Rx*	*# of refills*	*# of Rx*
Alabama				
Alaska	●	30 days		
Arkansas*	●	31 days	5/6 months	6/month w/ PA request
Arizona	●	30 days/100 units		
California	●	100 days		6/month
Colorado	●	30 days		
Connecticut	●	30 days/240 units	5/6 months for non-controlled Rx	
Delaware	●	34 days/100 units		
District of Columbia**	●	30 days	3/4 months for maintenance	
Florida	●	34 days	6/month for specific Rx	4 brand/month, unlimited generics
Georgia	●	31 days		Adults: 5/month, kids: 6/month
Hawaii	●	30 days/100 units		
Idaho	●	34 days/100 units		
Illinois	●	30 days		
Indiana				
Iowa	●	30 days		
Kansas	●	31 days	1 year supply	5/month for single source
Kentucky	●	32 days	5/6 months	
Louisiana	●	30 days	5/6 months	8/month
Maine	●	30 days for brand	11/year	
Maryland	●	34 days	11/year for non-controlled	
Massachusetts	●	30-90 days	12/year	
Michigan	●	34 days	12/year	
Minnesota	●	3 months		
Mississippi	●	34 days	5/6 months	5/month; 7/month w/PA, no limit for LTC and <21
Missouri***	●	31 days		5/month
Montana	●	34 days		
Nebraska	●	90 days		
Nevada				
New Hampshire	●	30 days	1 year supply	
New Jersey	●	34 days/100 units	5/6 months	
New Mexico	●	34 days		
New York	●	Varies by drug	5/6 months	43/year
North Carolina^	●	34 days		6/month
North Dakota	●	34 days		
Ohio				
Oklahoma	●	34 days/100 units		3/month
Oregon				
Pennsylvania	●	34 days/100 units	5/6 months	
Rhode Island				
South Carolina	●	34 days		4/month
South Dakota	●	34 days		
Tennessee				
Texas****	●	180 days	5/180 days	3/month
Utah	●	1 month		
Vermont				
Virginia	●	34 days/100 units	5 controlled, 2 others	
Washington	●	34 days	2/30 days	>4 brand needs review
West Virginia	●	34 days	5/6 months	
Wisconsin	●	34 days/100 units	12/year	
Wyoming				
TOTAL	**42**	**42**	**21**	**14**

Shaded text signifies states that did not respond to the survey. Many states reported exceptions to above policies, such as with prior approval. Many states also have higher dispensing limits for maintenance Rx. *Arkansas long-term care patients have no refill limits. **The District of Columbia also has an expenditure limit of $1,500/30 day supply per Rx. ***Missouri allows exceptions for individuals with long-term chronic conditions. ****Since survey, Texas now limits individuals with unlimited prescriptions to 34 day supply. Persons limited to 3 Rx/month can still receive a 180 day supply. N/A = information not available. ^North Carolina has a 3 month supply of birth control tablets and HRT dialpaks. No state reported limits based on total Rx costs per person.

Table 3: Prescription Drugs Excluded from Medicaid Coverage, by State.

STATE	*Any Exclusion*	*Cosmetic and Hair Loss*	*Fertility/Sexual Dysfunction*	*Anorexants/ Weight Control*	*Smoking Cessation*	*Investigational Rx*
Alabama						
Alaska	●	●	●	●	●	●
Arkansas	●	●	●	●	●	●
Arizona*	●					
California	●	●				
Colorado	●	●		●		●
Connecticut**	●	●	●	●	●	●
Delaware	●	●	●			●
District of Columbia	●					●
Florida	●	●	●			●
Georgia***	●	●		●	●	●
Hawaii	●	●	●		●	●
Idaho****	●	●	●		●	●
Illinois^	●	●	●	●		●
Indiana						
Iowa	●	●			●	●
Kansas^^	●	●				
Kentucky	●	●	●		●	
Louisiana	●	●		●		●
Maine^^^	●	●				●
Maryland^^^	●	●	●	●		●
Massachusetts	●	●	●	●	●	
Michigan	●	●		●		●
Minnesota	●	●	●	●		●
Mississippi	●	●		●		●
Missouri	●	●		●	●	●
Montana	●	●				●
Nebraska	●	●	●	●	●	●
Nevada						
New Hampshire	●	●	●			●
New Jersey	●	●	●		●	●
New Mexico	●	●	●			●
New York	●	●		●		●
North Carolina	●	●				●
North Dakota	●	●	●			
Ohio						
Oklahoma	●	●	●	●		●
Oregon						
Pennsylvania	●	●	●	●		●
Rhode Island						
South Carolina	●	●	●	●	●	●
South Dakota	●	●	●	●	●	●
Tennessee						
Texas^^^^	●	●		●		●
Utah	●	●	●	●	●	●
Vermont	●	●				●
Virginia	●	●	●		●	●
Washington	●	●	●	●	●	●
West Virginia	●	●		●		●
Wisconsin	●	●				●
Wyoming						
TOTAL	**43**	**41**	**24**	**23**	**17**	**37**

Shaded text signifies states that did not respond to the survey. *Arizona permits each of its 14 MCOs to establish their own policies for excluding Rx, as permissible by federal law. **Connecticut excludes anorexants/weight control Rx, except for certain diagnosis codes. ***Georgia excludes fertility Rx, but covers sexual dysfunction Rx with restrictions. ****Idaho excludes coverage for anorexants/weight control Rx, but does cover Xenical for hypertriglyceridemia. ^Illinois excludes anorexants/weight control and fertility/sexual dysfunction, except for certain diagnosis codes. ^^Kansas limits Viagra coverage to 4 pills/month. ^^^Maine and Maryland exclude sexual dysfunction, but cover fertility Rx. ^^^^Texas excludes coverage for fertility Rx, but covers sexual dysfunction.

Table 4: Medicaid Preferred Drug List (PDL)* Policies, by State.

STATE	*State has PDL*	*Body that sets PDL Policies*	*Criteria for Inclusion of Rx on PDL*	*Public Input in PDL*	*PDL Used for Other State Programs*
Alabama					
Alaska					
Arkansas					
Arizona	●	MCO's set their own formularies	P&T review, evidence-based therapeutic value, rebateable		
California	●	Agency and Medi-Cal Contract Drug Advisory Committee (MDAC)	Efficacy, essential need, safety, misuse potential, and cost	●	
Colorado					
Connecticut					
Delaware					
District of Columbia					
Florida	●	Agency and P&T	P&T review, rebateable	●	
Georgia	●	Agency sets PDL w/ recommendations from DUR Board	P&T review, recommended by DUR reviews	●	SCHIP, State employees, and Board of Regents
Hawaii					
Idaho					
Illinois	●	Agency with outside input	Clinical efficacy, cost		SCHIP, Pharmacy Plus
Indiana					
Iowa					
Kansas	●	PDL Committee	Clinical equivalency and then cost	●	
Kentucky	●	Agency	Medically necessary, FDA approved	●	
Louisiana	●	Agency	P&T review	●	
Maine	●	Private contractor			Applies to other non-specified programs
Maryland					
Massachusetts	●	Agency clinical staff	Efficacy and safety		
Michigan	●	Agency and P&T	Clinical efficacy, cost	●	Applies to other non-specified programs
Minnesota	●	Agency pharmacists and committee of physicians and pharmacists	Therapeutic equivalents, proton pump inhibitors, ACE inhibitors & non-sedating antihistamines	●	General Assistance Medical Care, state prescription Rx program, and other state funded programs
Mississippi	●	P&T Committee	Evidence based		
Missouri					
Montana					
Nebraska					
Nevada					
New Hampshire					
New Jersey					
New Mexico					
New York					
North Carolina					
North Dakota					
Ohio					

STATE	*State has PDL*	*Body that sets PDL Policies*	*Criteria for Inclusion of Rx on PDL*	*Public Input in PDL*	*PDL Used for Other State Programs*
Oklahoma**	●	DUR Board		●	
Oregon					
Pennsylvania					
Rhode Island					
South Carolina					
South Dakota					
Tennessee					
Texas***	●	Agency	Rebateable, FDA approved		SCHIP, Children with special health care needs, and adults with kidney disease
Utah					
Vermont	●	DUR Board	Rebateable, not excluded by §1927	●	State prescription Rx programs
Virginia					
Washington	●	DUR Board	Safety, efficacy, outcomes, and cost	●	State employees and labor and industries (workers comp)
West Virginia	●	Agency and P&T	Safety, efficacy, and cost	●	
Wisconsin					
Wyoming					
TOTAL	**18**			**12**	**8**

Shaded text signifies states that did not respond to the survey. *Some states refer to their preferred drug list as a "formulary". P&T refers to a pharmaceutical and therapeutics committee. Nearly all states with PDLs subject all Medicaid beneficiaries to their PDL: In Kentucky, long-term care recipients are occasionally exempted from the PDL. In Mississippi, the PDL is voluntary, although cost-sharing for non-PDL Rx is higher. In Washington, the PDL applies only to fee-for-service beneficiaries. **Oklahoma's PDL is limited to H2 blockers/proton pump inhibitors, NSAIDs, ACE inhibitors, Calcium channel blockers, and ADHD Rx. ***Texas plans to implement a PDL by 03/01/04.

Table 5: Medicaid Prescription Drug Prior Authorization (PA) Policies, by State.

STATE	*Any PA*	*PA for Brand Name Rx*	*Specified PA Exclusions*
Alabama			
Alaska	●		
Arkansas	●	●	
Arizona*			
California**	●		HIV, cancer
Colorado	●	●	PPI, Oxycontin/Oxycodone ER, Epoetin, ED Rx, Growth Hormones
Connecticut			
Delaware	●	●	Long acting narcotics, emetics of the 5HT3 category, Epoetin, Renigel, Narcoleptic drugs, Alzheimer's Rx, Synagist, Regranex
District of Columbia	●	●	Rx with fewer than 3 generics
Florida	●	●	Birth control, HIV, insulin, mental health
Georgia***	●	●	
Hawaii	●		
Idaho****	●	●	Coumadin, Lanoxin, Dilantin, Sinemet CR, Rx with low therapeutic index
Illinois**	●	●	HIV/AIDS, Cancer, Birth Control
Indiana			
Iowa^	●	●	
Kansas^^	●	●	All mental health
Kentucky	●	●	
Louisiana	●	●	≈ 60 therapeutic classes
Maine	●	●	N/A
Maryland^^	●	●	
Massachusetts	●	●	
Michigan^^^	●	●	
Minnesota	●		Antipsychotics, blood clotting factors
Mississippi	●	●	Drugs on PDL; only 12 Rx classes require PA
Missouri^^^^	●	●	See website, www.dss.state.mo.us/dms
Montana	●	●	
Nebraska	●	●	Most Rx excluded
Nevada			
New Hampshire	●	●	Most are excluded
New Jersey	●		Based on state DUR standards
New Mexico	●	●	Most Rx excluded
New York	●	●	
North Carolina	●		Only 12 classes included
North Dakota	●		
Ohio			
Oklahoma	●		
Oregon			
Pennsylvania	●	●	
Rhode Island			
South Carolina	●	●	
South Dakota	●		N/A
Tennessee			
Texas	●		
Utah	●	●	N/A
Vermont	●	●	See website, www.path.state.vt.us/OVHA/PDL_menu/PDL_menu.htm
Virginia	●		
Washington	●		PA is required for brand name reimbursement for Rx paid at MAC or FUL rates
West Virginia	●	●	
Wisconsin	●	●	
Wyoming			
TOTAL	**41**	**29**	**22**

Shaded text signifies states that did not respond to the survey. *Arizona policies established by each of 14 MCOs. **California and Illinois PA policies based on drug evaluation, not brand/generic status. ***Georgia requires PA for brand name on MAC. All other PA Rx are based on clinical evaluations and not brand status. ****Idaho requires PA when less costly therapeutic alternative available. ^Iowa requires PA for Rx on Federal Upper Limit (FUL) and maximum allowable cost (MAC) lists. ^^Kansas and Maryland require PA for brand name, unless indicated "dispense as written". ^^^Michigan requires PA for brand name reimbursement for generic classes paid at MAC and for PDL non-preferred Rx. ^^^^Missouri requires PA for brand name reimbursement for generic classes paid at MAC or FUL rates. N/A = Exclusions provided, specific information not available.

Table 6: Medicaid Prior Authorization (PA) Requests and Appeals, by State.

STATE	*PA Requests (2002)*	*PA Denials (2002)*	*Special Appeal Mechanism*	*# of Appeals**
Alabama				
Alaska	1,200	Minimal	Medical justification can be submitted	
Arkansas	≈ 156,000	≈ 39%	Medical justification can be submitted	
Arizona			Second level appeal to Medicaid agency	
California	2,048,056	187,522	Providers have a two-tier appeals process	
Colorado	≈ 10,000	≈ 900	Appeals go to Administrative Law Judge	
Connecticut				
Delaware	8,000	5%	Request Medical Director review	
District of Columbia	N/A	N/A	1st level reconsideration and 2nd level QIO review	
Florida	≈ 37,500	≈ 21%	Agency/fiscal agent pharmacist available by phone or fax	
Georgia	N/A	N/A	Written appeal to PBM or agency	
Hawaii	13,922	N/A	Medical Standards Branch review before formal hearing	
Idaho	≈ 30,000	25		
Illinois	542,000	71,375	Medical justification can be submitted, written appeal to agency	
Indiana				
Iowa	56,000	≈ 5%	Exception to policy or written appeal to state	
Kansas	N/A	N/A	Can appeal to fiscal agent prior to fair hearing	100
Kentucky	329,969	30,629	Recipient can appeal denial	
Louisiana	> 75,000	N/A		
Maine	34,989	9		
Maryland	≈ 2,000	≤ 5%	Medical justification can be submitted	
Massachusetts	28,586	17,020		476
Michigan	≈ 160,000	≈ 3%	All denials reviewed by agency staff physicians	≈ 5,000
Minnesota	15,872	495		
Mississippi	178,000	15,482		
Missouri	≈ 70,000	≈ 23,600	Written appeal to Medicaid agency	≈ 400
Montana	25,000	≈ 21.3%	Written appeal to PA board, to be presented at DUR meeting	25
Nebraska	24,000	14,400	Written appeal to Medicaid agency	1,000
Nevada				
New Hampshire	7,475	1,839		
New Jersey**	600,298	22,767		
New Mexico	≈ 400-500	< 15%		
New York	≈ 10,300	0		
North Carolina	N/A	1%	Physician appeal can override decision	
North Dakota	N/A	N/A		
Ohio				
Oklahoma	95,210	28,085		
Oregon				
Pennsylvania	N/A	N/A		
Rhode Island				
South Carolina	N/A	N/A		
South Dakota	27	0		
Tennessee				
Texas	1,177	161		
Utah	2,361		Physicians can petition the DUR board.	
Vermont	19,859	120	Physician appeal can override decision	
Virginia				
Washington	1,618,370	20%	Medical Director review	
West Virginia	159,280	35,042	Medical Director review	
Wisconsin	77,349	243		9
Wyoming				
TOTAL			**24**	

Shaded text signifies states that did not respond to the survey. N/A = information not available. *Only a small number of states provided a number of appeals—their responses are listed. **New Jersey denials exclude sentinel effect resulting from pharmacy intervention. All states must provide for a fair hearing. Special appeal mechanisms are voluntary state programs that complement the fair hearing process.

Table 7: Selected Medicaid Drugs that Require Prior Authorization, by State (1 of 2 Tables).

STATE	*Amphetamines*	*Anti-Depressants*	*Antihistamines*	*Anti-inflammatories/ NSAIDs*	*Anti-ulcer/reflux*	*Asthma*	*Benzodiazepine/ Tranquilizers*	*HIV medications*	*Growth Hormones*	*Over-the-Counter (OTC)*	*Retin-A/ Accutane*	*Vasodilators*	*Vitamins*
Alabama													
Alaska									●	●			
Arkansas			●	●	●								
Arizona*													
California	●	●	●	●	●	●	●		●	●	●	●	●
Colorado	●				●				●	●	●		●
Connecticut													
Delaware									●		●		
District of Columbia	●	●	●	●	●	●	●	●	●		●	●	●
Florida**			●	●	●	●			●				●
Georgia***	●		●		●				●		●		
Hawaii	●		●	●	●				●	●			●
Idaho	●		●	●	●				●		●		
Illinois	●	●	●	●	●	●	●		●	●	●	●	●
Indiana													
Iowa****	●		●	●	●		●		●		●		●
Kansas	●				●		●		●				
Kentucky	●		●	●	●		●		●	●	●		●
Louisiana	●	●	●	●	●	●			●				
Maine	●		●	●	●				●	●	●		●
Maryland^									●				
Massachusetts		●	●	●	●			●	●				
Michigan^^	●		●	●	●	●			●	●	●		●
Minnesota		●	●	●	●								
Mississippi			●	●	●								
Missouri	●		●	●	●				●		●		
Montana				●	●						●		
Nebraska		●	●	●	●				●	●			
Nevada													
New Hampshire	●			●	●		●						
New Jersey	●	●		●	●	●	●	●	●		●		
New Mexico	●									●			
New York									●				
North Carolina	●			●					●				
North Dakota													
Ohio													
Oklahoma	●		●	●	●		●		●	●			●
Oregon													
Pennsylvania					●								
Rhode Island													
South Carolina	●			●	●						●		
South Dakota									●				
Tennessee													
Texas	●				●				●				
Utah^^^	●				●				●		●		
Vermont	●	●	●	●	●	●	●	●	●		●	●	
Virginia													
Washington	●		●	●	●				●		●		●
West Virginia	●	●	●	●	●	●	●		●		●		
Wisconsin				●	●				●				
Wyoming													
TOTAL	**25**	**10**	**22**	**27**	**32**	**9**	**11**	**4**	**31**	**11**	**19**	**4**	**12**

Shaded text signifies states that did not respond to the survey. *Arizona permits each of its 14 MCOs to establish their own prior authorization policies. **Florida requires PA for several classes only when prescribing brand name Rx. ***Georgia permits 1 antihistamine script per year w/o PA. ****Iowa requires PA for several classes of Rx only for single source Rx. ^Maryland requires a written diagnosis stating that amphetamines are not for weight control. ^^Michigan does not necessarily require PA for each Rx in a class. ^^^Utah requires PA for COX-II's.

Table 8: Selected Medicaid Drugs that Require Prior Authorization, by State (2 of 2 Tables).

STATE	*Cosmetic/ Hair Loss*	*Fertility/ Sexual Dysfunction*	*Anorexants/ Weight Control*	*Smoking Cessation*	*Investigational Rx*
Alabama					
Alaska	--	--	--	--	--
Arkansas	--	--	--	--	--
Arizona*					
California	--	●	●	●	●
Colorado	--	●	--	●	--
Connecticut	--	--	--	--	--
Delaware	--	--	●		--
District of Columbia	●	●	●		--
Florida	--	--	●		--
Georgia	--	●	--	--	--
Hawaii	--	--	●	--	--
Idaho	--	--	●	--	--
Illinois	--	--	--		--
Indiana					
Iowa	--	●	●		--
Kansas	--	●	●		
Kentucky	--	--	●	--	
Louisiana	--		--		--
Maine	--	●	●		--
Maryland	--	--	--		
Massachusetts	--	●	●	--	●
Michigan	--	--	--		--
Minnesota	--	--	--		--
Mississippi	--	●	--		--
Missouri	--	●	--	--	--
Montana	--	●	●	●	--
Nebraska	--	--	--	--	--
Nevada					
New Hampshire	--	--	●		--
New Jersey	--	--	●	--	--
New Mexico	--	●	●		--
New York	--	●	--	●	--
North Carolina	--	●		●	--
North Dakota	--	--	●		--
Ohio					
Oklahoma	--	--	●	●	--
Oregon					
Pennsylvania	--	--	--		--
Rhode Island					
South Carolina	--	--	--	--	--
South Dakota	--	--	--	--	--
Tennessee					
Texas	--		--		--
Utah	--	--	--	--	--
Vermont	--	●	●		--
Virginia	--	--	●	--	--
Washington**	--	--	--	--	--
West Virginia	--	●	--	●	--
Wisconsin	--	●	●	●	--
Wyoming					
TOTAL	**1**	**17**	**20**	**8**	**2**

Shaded text signifies states that did not respond to the survey. -- indicates Rx that are not covered/excluded. *Arizona permits each MCO to set its own policy. **Washington does not cover smoking cessation, except for pregnant women enrolled in a smoking cessation program.

Table 9: Medicaid Criteria for Imposing Prior Authorization (PA), by State.

STATE	*Criteria for Requiring Prior Authorization (PA)*
Alabama	
Alaska	State regulation. Additional information is available at http://www.medicaid.state.ar.us
Arkansas	DUR Board Review
Arizona	
California	Efficacy, essential need, safety, misuse potential, and cost
Colorado	OBRA 90 and abuse
Connecticut	
Delaware	FDA guidelines
District of Columbia	
Florida	
Georgia	Criteria based on FDA approved-indications and generally accepted care standards
Hawaii	
Idaho	When an effective generic equivalent or other less expensive equally effective therapeutic alternatives are available
Illinois	Medical necessity, FDA Guidelines, PDL
Indiana	
Iowa	DUR Review Board
Kansas	DUR review board and state regulations
Kentucky	Criteria are developed for each drug class on PA
Louisiana	Treatment failure, condition that prevents use of preferred drug, potential drug interaction between another medication and preferred product, intolerable side effects
Maine	Potential misuse or abuse, therapeutic step therapy, less expensive alternatives
Maryland	Ensure use is medically documented and used for appropriate diagnosis
Massachusetts	Medical necessity
Michigan	Clinical Review
Minnesota	Clinical and cost effectiveness, medical necessity, Rx that need monitoring, less costly drug available, newly developed or modified, or considered to be cosmetic.
Mississippi	High risk, problem-prone Rx
Missouri	FDA medically accepted use, DUR Board recommendations
Montana	
Nebraska	Expensive, diagnosis, and medical necessity
Nevada	
New Hampshire	Abuse, cost and high utilization
New Jersey	DUR standards by the State
New Mexico	Medical necessity
New York	If the drug has a high cost or impact on the health of the Medicaid population; requires monitoring of prescribing protocols to protect the efficacy of the drug and the public health; has a history of misuse or abuse; or appears to be used in the Medicaid population in amounts inconsistent with non-Medicaid usage patterns
North Carolina	
North Dakota	DUR Board provides recommendations to the Department
Ohio	
Oklahoma	
Oregon	
Pennsylvania	Depends on drug or drug class
Rhode Island	
South Carolina	
South Dakota	Clinical and cost factors, fail first on antipsychotic prior to using Clozapine
Tennessee	
Texas	PA conducted in house by DUR staff
Utah	Clinical criteria established by the DUR Board
Vermont	Clinical criteria established by the DUR Board
Virginia	
Washington	Narrow therapeutic indication, safety or high risk/benefit ratio, potential for abuse or misuse and high cost
West Virginia	FDA approved use, medically accepted use, or step therapy
Wisconsin	Specific to class by DHFS recommendation
Wyoming	

Shaded text signifies states that did not respond to the survey.

Table 10: Medicaid Use of Fail-First Prescription Drug Policies, by State.

STATE	*Uses Fail-First Requirement*	*Rx or Class of Rx*
Alabama		
Alaska	●	COX-II inhibitors
Arkansas	●	Enbrel, Humira, Kineret, Non-sedating antihistamines, NSAIDs, PPIs
Arizona*		
California	●	PA requests require info on products tried/considered. State will exempt individuals if prescriber shows reasons not to try first-line Rx (e.g. allergy to a drug class)
Colorado		
Connecticut		
Delaware	●	Fail on Phos-lo, then use Renogel. Fail on amphetamines, then use Provigil
District of Columbia	●	Must fail generic before brand approved
Florida		
Georgia		
Hawaii	●	
Idaho	●	COX-II inhibitors, PPIs, Non-sedating antihistamines. Must fail generic before brand approved
Illinois	●	COX-II inhibitors for people under 65 years of age and PDL products
Indiana		
Iowa	●	Anti-Acne, Benzodiazpines
Kansas		
Kentucky	●	Based on criteria requirements for specific drug classes
Louisiana		
Maine	●	
Maryland		
Massachusetts	●	NSAIDs
Michigan	●	For PDL non-preferred Rx, may apply in certain clinical PA situations
Minnesota	●	PPI's not on PDL must first try H2 blocker. COX-II inhibitors must first try NSAIDs
Mississippi	●	Non-sedating antihistamines, Embrol, NSAIDs, PPIs
Missouri	●	HMG CoA , Second generation antihistamines, ACE inhibitors. See website for updates
Montana	●	Benzodiazepines and NSAIDs
Nebraska	●	Low-sedating antihistamines, COX-II inhibitors, PPIs
Nevada		
New Hampshire	●	
New Jersey	●	Many drugs subject to DUR standards
New Mexico		
New York		
North Carolina		
North Dakota		
Ohio		
Oklahoma	●	Antiulcer, ACE inhibitors, ACE/CCB combinations & ACE/HCTZ combinations, calcium channel blockers, NSAIDs
Oregon		
Pennsylvania	●	COX-II inhibitors
Rhode Island		
South Carolina	●	Must fail generic before brand approved
South Dakota		
Tennessee		
Texas		
Utah	●	Anti-inflammatory TNF inhibitors, anti-inflammatory Interlukin-1 receptor antagonists, growth hormones, PPIs, and Xenical
Vermont	●	See website for clinical criteria, www.path.state.vt.us
Virginia	●	Anti-ulcer drugs
Washington	●	Non-first line agents. Must fail generic before brand approved
West Virginia	●	NSAIDs
Wisconsin		
Wyoming		
TOTAL	**28**	

Shaded text signifies states that did not respond to the survey. *Arizona's 14 MCOs set individual policies.

Table 11: Medicaid Policies for Generic Prescription Drugs, by State.

STATE	Generics Required		Generics Encouraged				
	Generics Required	*Physician Can Override*	*Lower Co-Pays for Generics*	*Higher Dispensing Fee to Pharmacist*	*State Pays Generic Rate for Brand Rx*	*Generics on PDL/ Formulary*	*State Educates Physicians on Use of Generics*
Alabama							
Alaska	●	●					●
Arkansas	●	●		●	●		●
Arizona				●			
California*		●			●		
Colorado	●	●	●				
Connecticut	●	●			●		
Delaware	●				●		●
District of Columbia	●	●					●
Florida	●	●	●		●		●
Georgia	●	●	●	●	●	●	●
Hawaii	●	●			●		●
Idaho**	●	●					
Illinois			●	●	●	●	
Indiana							
Iowa*					●		
Kansas					●		●
Kentucky	●	●				●	●
Louisiana						●	
Maine			●				●
Maryland	●	●	●	●	●	●	
Massachusetts	●			●	●	●	●
Michigan						●	
Minnesota	●	●					●
Mississippi	●	●	●		●		●
Missouri	●	●			●		
Montana	●	●					
Nebraska	●	●			●		●
Nevada							
New Hampshire	●	●	●		●		
New Jersey	●	●					
New Mexico					●		●
New York	●	●	●	●		●	●
North Carolina	●	●	●	●	●		●
North Dakota			●		●		●
Ohio							
Oklahoma	●	●				●	
Oregon							
Pennsylvania	●	●					
Rhode Island							
South Carolina	●	●			●		
South Dakota					●		
Tennessee							
Texas***	●	●			●		●
Utah	●						●
Vermont	●	●					●
Virginia			●		●		
Washington	●	●			●	●	●
West Virginia	●	●			●	●	●
Wisconsin					●		●
Wyoming							
TOTAL	**30**	**28**	**12**	**8**	**26**	**11**	**24**

Shaded text signifies states that did not respond to the survey. *California and Iowa require least costly, appropriate Rx. **Idaho includes brand name Rx in FUL and MAC lists. ***Texas does not require generics, but its MAC program functions in a similar manner.

Table 12: Estimated Medicaid Use of Generics (When Available), by State.

STATE	*Estimated % of Rx Filled as Generics*	*Estimated % of Total Rx Spending for Generics*
Alabama		
Alaska		
Arkansas	49.0%	
Arizona	72.0%	35.0%
California		
Colorado	50.6%	17.7%
Connecticut		
Delaware		
District of Columbia		
Florida	46.0%	21.0%
Georgia	49.0%	17.0%
Hawaii		
Idaho		
Illinois	62.0%	30.0%
Indiana		
Iowa	51.0%	20.0%
Kansas	59.0%	24.0%
Kentucky	57.0%	
Louisiana	49.0%	22.0%
Maine	49.8%	15.7%
Maryland	50.0%	18.0%
Massachusetts	52.0%	17.5%
Michigan	50.0%	14.2%
Minnesota	49.4%	14.6%
Mississippi	44.0%	44.0%
Missouri		
Montana		
Nebraska	50.0%	10.0%
Nevada		
New Hampshire		
New Jersey	33.7%	14.2%
New Mexico		
New York		
North Carolina	48.1%	14.5%
North Dakota	50.0%	17.6%
Ohio		
Oklahoma	50.0%	23.0%
Oregon		
Pennsylvania		
Rhode Island		
South Carolina		
South Dakota		
Tennessee		
Texas	48.0%	15.0%
Utah		
Vermont		
Virginia		
Washington	53.5%	17.4%
West Virginia	49.5%	20.6%
Wisconsin		
Wyoming		
AVERAGE	**50.9%**	**20.1%**

Shaded text signifies states that did not respond to the survey. Most estimates based on "educated guess" of State Medicaid Pharmacy officials and not on quantitative data analysis.

Table 13: Medicaid Prescription Drug Cost-Sharing Policies, by State.

STATE	*Populations Subject to Cost-Sharing*	*Co-Pay Amount*	*Rx Withheld for Failure to Pay Co-Pay****
Alabama			
Alaska	E, D, P	$2.00/Rx. P exempt if children <18	
Arkansas	E, D, P	$0-$10 Rx, co-pay $0.50; $10.01- $25 Rx, co-pay $1; $25.01-$50 Rx, co-pay $2; > $50 Rx, co-pay $3	
Arizona*			
California	E, D, P	$1/Rx, voluntary for E and D, foster P excluded from cost-sharing	
Colorado	E, D, P	$3/Rx, excludes individuals exceeding maximum annual co-pay of $150	
Connecticut	E, D, P	$1/Rx, excludes Rx for family planning drugs or supplies	
Delaware			
District of Columbia	E, D, P	$1/Rx	
Florida	Pharmacy Plus Only	$2/Rx for generics, $5/Rx for PDL, and $15/Rx for non-PDL	
Georgia	E, D, P	$0.50/Rx for PDL, $0.50-$3/Rx for non-PDL, depending on cost	
Hawaii			
Idaho			
Illinois	E, D, P	For regular Medicaid, no co-pay for generics and $3/Rx for brand name. For Pharmacy Plus, no co-pay if income < poverty level; if income > poverty level, $1/Rx for generics and $4/Rx for brand name	●
Indiana			
Iowa**	E, D, P	$1/Rx	
Kansas	E, D, P	Only 35% of enrollees have a $3 co-pay	
Kentucky	E, D, P	$1/Rx	●
Louisiana	E, D, P	$0.50-$3/Rx tied to cost of drug	
Maine	E, D, P	$0.50-$3/Rx tied to cost of drug and generic or brand name	
Maryland	E, D, P	$2/Rx for brand name only	
Massachusetts	E, D, P	$2/Rx	
Michigan	E, D, P	$1/Rx	●
Minnesota			
Mississippi	E, D, P	$1/Rx for generic, $2/Rx for brand preferred, $3/Rx for non-preferred	
Missouri	Uninsured Adults & Waiver Children	0-$10 Rx, co-pay $5.50; $10.01-$25 Rx, co-pay $6; $25.01 and higher Rx, co-pay $7; Waiver children up to 300% of poverty, co-pay $9/Rx	
Montana	E, D	Up to $5/Rx to a maximum of $25/month	
Nebraska	E, D, P	$2/Rx	●
Nevada			
New Hampshire	E, D, P	$0.50/Rx for generics and $1/Rx for brand name	
New Jersey			
New Mexico	Working Disabled and SCHIP	$2/Rx	
New York	E, D, P	$0.50/Rx for generics and OTCs, $2/Rx for brand name, excludes pregnant women and special needs children	
North Carolina	E, D, P	$1/Rx for generics and $3/Rx for brand name	
North Dakota	E, D, P	$3/Rx for brand name	
Ohio			
Oklahoma	E, D, P	<$29.99 Rx, then $1/Rx; ≥ $30, then $2/Rx	
Oregon			
Pennsylvania	E, D, P	$1/Rx	●
Rhode Island			
South Carolina	E, D, P	$2/Rx (Pharmacy Plus co-pays are $10/Rx for	

STATE	*Populations Subject to Cost-Sharing*	*Co-Pay Amount*	*Rx Withheld for Failure to Pay Co-Pay****
		generic, $15/Rx for brand, and $20/Rx for Rx requiring prior authorization)	
South Dakota	E, D, P	$2/Rx	
Tennessee			
Texas			
Utah	E, D, P	$3 to $15/month/person	●
Vermont	E, D, P	$0-$29.99 Rx, co-pay $1; $30.00 - $49.99 Rx, co-pay $2; ≥ $50 Rx, co-pay $3	
Virginia	E, D, P	$1/Rx for generic and $2/Rx for brand name	
Washington			
West Virginia	E, D, P	< $10 Rx, then $0.50/Rx, $10 -$24.99 Rx, then $1/Rx, > $25 Rx, then $2/Rx	●
Wisconsin	E, D, P	$1/Rx for legend Rx and $0.50 OTC	
Wyoming			
TOTAL	**35**		**7**

Shaded text signifies states that did not respond to the survey. E= elderly, D= disabled, P= parents. *Arizona implemented co-payments on 10/01/03 of $4 generic and $10 for brand if generic is available. The state also permits Rx to be withheld for failure to pay the co-payment. **On 07/01/03, Iowa implemented co-payments of $1/Rx for generic and $0.50 - $3.00/Rx for brand based on cost of Rx. ***Rx can be withheld in Illinois only with a waiver; in Kentucky, the pharmacy may not withhold service when the prescription is presented and the recipient must receive prior notice; in Michigan, Rx can be withheld on follow-up visits if beneficiary has reused to pay co-payments on previous visits and has received notice; in Nebraska, Rx may be withheld if patient doesn't pay subject to pharmacy credit policy and pharmacist must notify patient; in Pennsylvania, pharmacy may refuse refill if they can document that the patient is able to pay, but refuses; in West Virginia Rx may be withheld if there is clear evidence that the patient has the ability to pay; and in Wisconsin, Rx may be withheld for regular Medicaid and medically needy groups.

Table 14: Medicaid Over-the-Counter (OTC) Coverage Policies, by State.

STATE	*Covers any OTCs*	*How OTC Coverage Decisions are Made*	*Cover Rx newly available as OTC*
Alabama			
Alaska	●	DUR Committee	
Arkansas	●		●
Arizona	●	Cost effectiveness versus legend medication	
California	●	Decisions to add OTCs to the PDL are handled in same manner as legend Rx	
Colorado	●	Cover aspirin and insulin	
Connecticut	●	The following not covered: antacids, H2 blockers, birth control, diabetic supplements, vitamins, cough, cold, allergy, antihistamines, decongestants, topical and vaginal antifungals, and artificial tears	
Delaware	●	DUR Committee	●
District of Columbia	●		
Florida	●		
Georgia	●		
Hawaii	●		●
Idaho			
Illinois	●	Prescription is required	●
Indiana			
Iowa	●	Historically from DUR committee in coordination with PA suggestions	
Kansas	●	No nutritional supplements are included	●
Kentucky	●	Most new OTCs aren't added to the formulary which is based on CMS excludable guidelines	●
Louisiana	●	Limited coverage for OTCs	
Maine	●	Cost effectiveness versus legend medication	●
Maryland	●		
Massachusetts	●	Cost effectiveness versus legend medication	
Michigan	●	State P&T Committee recommendation	
Minnesota	●	Recommendation by Drug Formulary Committee. State mandates coverage for antacids, aspirin, formulary products and insulin	
Mississippi	●	Must be rebateable and cost-effective	
Missouri		07/01/02 OTC's became non-covered. 02/01/03 covered list of nonaligned OTCs less costly then their equivalent legend Rx	●
Montana	●	DUR Board	
Nebraska	●	Based on medical necessity and rebate availability	
Nevada			
New Hampshire	●	OTC coverage is under review	
New Jersey	●	EPSDT requirements and cover cost effective alternatives to legend Rx	
New Mexico	●		
New York	●	Cost effectiveness and prevention of more expensive interventions	
North Carolina**			
North Dakota	●	DUR Board	
Ohio			
Oklahoma	●	Covers insulin, family planning and OTC antihistamines for children	
Oregon			
Pennsylvania	●	Covers categories defined in regulation	●
Rhode Island			
South Carolina	●		●
South Dakota			
Tennessee			
Texas	●	Does not cover vitamins	●
Utah	●	Drug Program Managers	
Vermont	●		
Virginia	●	OTC list	
Washington	●	Covered if less costly than prescription; family planning is covered	
West Virginia	●	DUR board recommends OTC products to add to the OTC formulary	
Wisconsin	●	State Administrative Code	●
Wyoming			
TOTAL	**39**		**12**

Shaded text signifies states that did not respond to the survey.

Table 15: Medicaid Prescription Drug Payment Practices, by State.

STATE	*Estimated Acquisition Cost (EAC)*	*EAC Includes Dispensing Fee*	*Dispensing Fee*	*Rebate Payments go to Medicaid**	*State Receives a Supplemental Rebate*
Alabama					
Alaska	AWP-5%		$3.45- $11.46	●	
Arkansas	AWP-14% for brand name and AWP-20% for generic		$5.51	●	
Arizona**					
California	AWP-10%		$3.55	●	●
Colorado	AWP-13.5% for brand, AWP - 35% for generic		$4 retail, $1.89 institutional		
Connecticut	AWP-12%		$3.60	●	
Delaware	AWP-14%, AWP-16% for non-traditional pharmacy		$3.65	●	
District of Columbia	AWP-10%	●	$4.50		
Florida***	Lower of WAC+7%, or AWP-13.25%		$4.23 retail and $4.73 institutional	●	●
Georgia^	AWP-10%		For profit $4.63 and non-profit $4.33	●	
Hawaii	AWP-10.5%		$4.67	●	
Idaho	AWP-12%	●	$4.94 regular dose, $5.54 unit dose		
Illinois	Regular Medicaid: AWP-12% for single source and AWP-25% for multi-source Rx. Pharmacy Plus: AWP-14% for single source and AWP-25% for multi-source; MAC/ FUL (if applicable)		Regular Medicaid: $3.40 brand name, $4.60 generic Pharmacy Plus: $2.25 for both brand and generic	●	●
Indiana					
Iowa	AWP-10%		$5.17	●	
Kansas	AWP-13% for single source Rx, and AWP-27% for multi-source Rx		$3.40	●	
Kentucky	AWP-12%		$4.51		
Louisiana	AWP-13.5% for independent pharmacist, AWP-15% for retail chains		$5.77 maximum	●	●
Maine	AWP-13%		$3.35- $5.35, fees depend on whether it is a single ingredient or compound drug	●	
Maryland	AWP-10% or WAC+10%		$4.69 retail generic, $3.69 retail brand, $5.65 LTC generic, and $4.65 LTC brand		
Massachusetts	WAC+6%	●	$3.50 brand name and $5.00 generic	●	
Michigan	AWP-15.1% or 13.5%, depending on the # of pharmacy sites		$3.77, except compound Rx, compound Rx fee is $6-10		●
Minnesota	AWP-11.5%	●	Most Rx's $3.65, IV compounded $8.00/ bag for regular IV Rx, $14/bag for chemotherapy Rx, $30/bag for TPN solutions to 1 liter and $44/bag for TPN > 1 liter	●	●
Mississippi	AWP-12%		$3.91	●	

Missouri	AWP-10.43% or WAC+10%; MAC/FUL (if applicable)		In-state $8.04, $8.19 for LTC. Out-of-state, $4.09, $4.24 for LTC	●	
Montana	AWP-15%		$2- $4.70, and additional $0.75 for dispensing unit dose		
Nebraska	AWP-11%		$3.27-$5.00	●	
Nevada					
New Hampshire	AWP-12%		$2.50		
New Jersey	AWP-10%		$3.73; pharmacy adds $0.15 for impact allowance, $0.08 for pharmaceutical consultation, and $0.11 for 24-hour availability	●	
New Mexico	AWP-12.5%		$3.65		
New York	Lower of AWP-10%; FUL; or usual and customary		$3.50 brand name and $4.50 generic		
North Carolina	AWP-10%		$5.60 brand and $4.00 generic, no dispensing fees for same month refills	●	
North Dakota	AWP-10%		$5.10	●	
Ohio					
Oklahoma	AWP-12%		$4.15 maximum		
Oregon					
Pennsylvania	AWP-10%		$4.00	●	
Rhode Island					
South Carolina	AWP-10%		$4.05	●	
South Dakota	AWP-10.5%		$4.75-$5.55	●	
Tennessee					
Texas^^	Lesser of AWP – 15% or WAC + 12%		$5.27 + (EAC/0.98 - EAC)	●	
Utah	AWP-15%		$3.90 in urban areas, $4.40 in rural areas		
Vermont	AWP-11.9%		$4.25	●	●
Virginia	AWP-10.25%		$4.25	●	●
Washington	AWP-14%, AWP-50% for multisource drugs with 5 or more labelers		$4.20 to $5.20		
West Virginia	AWP-12%		$3.90 for a single ingredient, $4.90 for compound Rx	●	●
Wisconsin	AWP-11.25% or MAC price		$4.88 to $ 40.11	●	
Wyoming					
TOTAL		**4**		**29**	**9**

Shaded text signifies states that did not respond to the survey. *Drug rebate payments that do not go to the state's general fund; Virginia splits rebate payments between Medicaid and the general fund. ** Arizona's 14 MCOs set individual policies. ***Florida's dispensing fee became $.23 for all Rx on July 1, 2003. ^Georgia has a most favored pricing policy: If a provider accepts a lower rate than the state's standard rates, then they must bill Medicaid the lowest rate they accept from any payer. ^^Texas limits reimbursement to the MAC and has lower payment rates for Rx purchased from the manufacturer or central purchasing entity (i.e. chain warehouse).

Table 16: Most Commonly Dispensed Medicaid Prescription Drugs, by State.

STATE	1	Program Cost	Monthly Unit Cost	2	Program Cost	Monthly Unit Cost	3	Program Cost	Monthly Unit Cost	4	Program Cost	Monthly Unit Cost	5	Program Cost	Monthly Unit Cost
Alabama															
Alaska	Antidepressants	$4.7 Million	$57.08	Narcotic Analgesics	$5.3 Million	$71.89	Antipsychotic tranquilizers	$7.1 Million	$77.48	Anticonvulsants	$3 Million	$47.89	Antiulcerants	$3.9 M	$62.94
Arkansas*	Zithromax	$1.3 Million	$38.95	Furosemide	$189,000	$7.44	Hydrocodone /APAP	$297,000	$13.10	Albuterol	$471,000	$24.40	Amoxil	$209,000	$12.41
Arizona**															
California	Celebrex 200mg cap, 00025-1525-31	$74.3 Million	$2.61 **T**	Prevacid 30mg cap, 00300-3046-13	$78.5 Million	$4.23 **T**	Lipitor 10mg tab, 00071-0155-23	$35,072.44	$1.85 **T**	Codeine number 3, w/APAP 00093-0150-10	$4.1 Million	$0.21 **T**	Vioxx 25 mg tab, 00006-0110-68	$31.7 Million	$2.20 **T**
Colorado	Hydrocodone w APAP 5/550mg		$8.23 average cost	Lansoprazole 30mg		$126.07 average cost	Furosemide 40mg		$6.07 average cost	Albuterol 90 mg		$18.42	Furosemide 20mg		
Connecticut	Albuterol 90mg, 17gm		$7.47	Prozac, 00777-3105-30		$69.71	Ultram, 00045-0659-60		$68.17	Ibuprofen, 400mg, 100each		$3.38	Glucophage, 00087-6060-5		$56.87
Delaware	Albuterol 90mg, 17gm	$600,000 estimated	$7.47	Prevacid 30	$2.1 Million	$141.00	Percacet	$126,000	$9.00	Zyrtec10mg	$660,000 estimated	$57	Celebrex	$1.2 Million estimated	$113
District of Columbia	Albuterol 90mg, 17gm		$7.47	Codeine Phosphate/APAP, 38779-0679-40		$167.07	Furosemide, 20 mg, 100 each		$2.10	Diphenhydramine HCl Syrup 12.5 ml/5 ml, 450 ml			Ranitidine, 54569-4507-02		$26.74
Florida	Albuterol	$13.3 Million		Furosemide			Prevacid	$61.3 Million		Hydrocodone/APAP	$6 Million		Alaprazolam	$3.6 Million	
Georgia	Celebrex, 0025-1525	$13.5 Million	$92.24	Albuterol, 59930-1560	$2.8 Million	$23.19	Prilosec 00186-0742	$13.9 Million	$118.36	Zithromax, 00069, 3060	$4.3 Million	$38.99	Amoxil, 00029-6049	$1.4 Million	$13.55
Hawaii	Lipitor 10mg			Cimetidine 400mg			Albuterol inhaler 90mcg			Celebrex 200mg			Aspirin 81mg		
Idaho	Hydrocodone/ APAP 500, 7.5mg	$350,038	$0.19 **T**	Albuterol MDI	$524,417	$0.85 **T**	Amoxicilin 250 mg	$240,320	$0.04 **T**	Propoxyphene/APAP100/650	$309,837	$0.23 **T**	Furosemide 40	$134,710	$0.06 **T**
Illinois	Furosemide	$4.2 Million	$6.25	Prevacid	$70.4 Million	$120.06	Ibuprofen	$3.8 Million	$8.17	Albuterol	$8.7 Million	$22.11	Lisinopril	$8.4 Million	$23.83
Indiana															
Iowa	Rantidine 150mg		$17.68	Furosemide 40mg		$6.69	Albuterol 90ucg, 17gm		$22.82	Zoloft 100mg	$3.2 Million	$64.06	Hydrocodone B/Acetaminophen		$8.21
Kansas	Prilosec	$4.8 Million		Celebrex A	$3 Million		Furosemide		$183,470	Celexa	$1.7 Million		Prevacid		$2.6 Million
Kentucky	Ranitidine	$7.3 Million	$31.67	Furosemide	$918,048	$6.43	Lipitor	$12 Million	$80.73	Zithromax	$5.8 Million	$40.12	Albuterol	$3.2 Million	$24.65
Louisiana	Celecoxib	$9.9 Million		Loratadine	$7 Million		Omeprazole	$10.5 Million		Cetirizine	$4 Million		Lanasoprazole	$9.3 Million	
Maine	Protonix	$9.3 Million	$2.79 **T**	Hydrocodone/ APAP 5/500	$406,000	$0.04 **T**	Albuterol Inhaler	$1.1 Million	$0.81 **T**	Lipitor 10mg	$3.6 Million	$1.77 **T**	Metoprolol 50mg	$300,00	$0.09 **T**
Maryland	Risperdal	$18.8 Million	$152.41	Furosemide	$550,000	$4.48	Zyprexa	$30.4 Million	$275.68	Depakote	$8.4 Million	$88.18	Zoloft	$7.2 Million	$78.23
Massachusetts	Albuterol	$5.6 Million		Lipitor	$25.8 Million		Furosemide	$1.3 Million		Clonazepam	$3 Million		Neurontin	$25.5 Million	
Michigan	Hyrdocodone BIT/Acetaminophen	~$4 M	~$10.38	Furosemide	$1.45 M	~$5.01	Atorvastatin Calcium	$22.5 M	~$78.96	Levothyroxine Sodium	~$3.5 M	~$13.06	Paroxetine HCL	~$18.9 M	~$72.57
Minnesota***	Protonix 40mg	$13.8 Million	$107.67	Zoloft 100mg	$3.8 Million	$77.49	Lipitor 10mg	$3 Million	$70.51	Celexa 20mg	$3.1 Million	$82.06	Albuterol Inhaler	$703,301	$21.02
Mississippi	Furosemide	$1.2 Million		Hydrocodone	$2.5 Million		Norvasc	$8.3 Million		Zithromax	$5.2 Million		Proxyphene Napsylate w/APAP	$1.7 Million	
Missouri	Hydrocodone/APAP	$3.9 Million	$12.45	Furosemide	$2.4 Million	$8.09	Amoxicillin	$1.7 Million	$6.34	Potassium Supplements	$4.3 Million	$17.96	Levothyroxine	$4.4 Million	$17.96
Montana	Prilosec, 00186-0606-68		$321.37	Prozac 00777-3105-30		$71.30	Hydrocodone/ APAP 500mg-7.5mg, 100 each		$18.37	Zoloft 00049-429120-41		$216.86	Albuterol inhaler 90mcg, 17gm		$7.47
Nebraska	Propoxyphene napsylate 100mg/APAP	$496,444.78	$0.01 **T**	Furosemide 40mg	$231,627.06	$0.06 **T**	Sertraline 100mg	$2.5 Million	$2.36 **T**	Albuterol Inhaler	$720,797.84	$5.95	Lanasoprazole 30mg	$1.6 Million	$4.12
Nevada															
New Hampshire	Acetaminophen	$240,224	$0.07 **T**	Furosemide	$225,224	$0.16 **T**	Levothyroxine Sodium	$365,852	$0.39 **T**	Zoloft	$2.3 Million	$82.06	Amoxicillin	$183,154	$0.07
New Jersey	Celebrex 200mg	$9.2 Million	AWP- 10%	Prevacid 30mg	$9.4 Million	AWP-10%	Lipitor 10mg	$4.8 Million	AWP- 10%	Norvasc 5mg	$3.4 Million	AWP-10%	Proventil 9mg Inhaler	$1.5 Million generic, $0.2 Million brand-name	AWP-10%
New Mexico****	Prilosec 20mg, 00186-074231	$2.1 Million	$137.48	Ortho Tricyclen 00062-190315	$450,000	$36.50	Albuterol inhaler 17 gm, 59930156001	$275,000	$19.00	Lipitor 10mg 00071-015523	$720,000	$63.00	Fosamax 70mg, 00006-0031-3144	$675,000	$62.36
New York	Lipitor 10 mg	$35.6 Million	$68.95	Albuterol Aerosol	$12.2 Million	$25.08	Celebrex 200mg caps	$50.3 Million	$107.84	Prevacid 30mg caps	$58.8 Million	$136.34	Prilosec 20mg caps	$53.4 Million	$149.13
North Carolina	Hydrocodone/ APAPU	$4.8 Million	$0.22 **T**	Furosemide	$2.8 Million	$0.17 **T** Generic	Albuterol 90 mcg, 17gm inhalers and tablets	$5.7 Million	$0.26 **T**	Prevacid	$37.7 Million	$3.98 **T**	Norvasc U	$13.8 Million	$1.62 **T**
North Dakota	Furosemide	$221,171		Zoloft	$1.4 Million		Synthroid	$234,624		Potassium Chloride	$1.5 Million		Risperdal	$4.2 Million	

STATE	***1***	*Program Cost*	*Monthly Unit Cost*	***2***	*Program Cost*	*Monthly Unit Cost*	***3***	*Program Cost*	*Monthly Unit Cost*	***4***	*Program Cost*	*Monthly Unit Cost*	***5***	*Program Cost*	*Monthly Unit Cost*
Ohio															
Oklahoma	Furosemide	$629, 633		Hydrocodone	$1.5 Million		Ranitidine HCL	$1.7 Million		Risperdal	$10 Million		Potassium Chloride	$823,785	
Oregon															
Pennsylvania	Zithromax Tab 250 mg	$3.1 Million	$6.82	Albuterol inhaler 17Gm	$2.7 Million	$1.13	Levaquin Tab 500 mg.	$4.1 Million	$9.06	Cipro Tab 500mg	$3.2 Million	$4.92	Prevacid Cap 30mg	$21.1 Million	$4.16
Rhode Island															
South Carolina	Albuterol inhaler 90mcg	$1.8 Million	$30.81	Norvasc 10mg	$3.7 Million	$63.77	Lipitor 10mg	$3.4 Million	$60.53	Zyrtec 10mg	$2.8 Million	$51.14	Prilosec 20mg	$6.8 Million	$134.24
South Dakota	Prevacid 30mg, 00300-3046-13	$1 Million	$4.14	Furosemide 40 mg 100 each, 00378-0216-0	$52,764	$0.09	Celebrex 200 mg., 00025-1525-31	$667,311	$2.58	Zithromax 00069-3060-75	$28,716	$6.78	Prilosec 20mg, 00186-0742-31	$979,694	$4.13
Tennessee															
Texas	Ibuprofen	$6.3 Million		Hydrocodone Acetaminophen	$6.2 Million		Zithromax	$17.1 Million		Albuterol Sulphate	$5.8 Million		Furosemide	$2.7 Million	
Utah	Prevacid 00300304613	$2.5 Million	$113.75	Hydrocodone/APAP/7.5/500 52544038505	$243.5 Million	$11.67	Celebrex 00025152531	$1.5 Million	$85.60	Hydrocodone/APAP 5/500, 2544034905	$122,282.65	$61.91	Albuterol Inhaler 59930156001	$122,282.65	$23.90
Vermont	Prilosec, 00186-0606-68		$314.59	Lipitor, 54868-3934-00		$62.80	Albuterol, 90 mcg, 17 gm		$7.47	Prozac, 00777-3105-30		$69.79	Prevacid, 00300-3046-11		$329.02
Virginia^															
Washington	Hydrocodone/ APA, 500mg-7.5 mg 100each	$3.1 Million	$9.36	Furosemide	$1.3 Million	$6.58	Albuterol	$2.5 Million	$18.36	Rantidine	$1.7 Million	$12.56	Lipitor	$9.5 Million	$74.12
West Virginia	Ranitidine, GSN 011673	$1.1 Million	$13.91	Proxyphene Nopsylate, GSN 004273	$1.1 Million	$14.46	Albuterol, 90 mcg, GSN 005037	$1.5 Million	$23.72	Furosemide 40 mg, GSN 008209	$33,596	$5.39	Hydrocodone/acetaminophen 5-500mg, GSN 4204	$414,194	$6.99
Wisconsin	Analgesics Narcotics	$22.6 Million	$46.47	Antipsychotics Atypicals	$66.4 Million	$178.27	Antidepressants-SSRI's	$26.8 Million	$75.22	Diuretics Loop	$1.9 Million	$6.92	ACE inhibitors	$6.7 Million	$26.63
Wyoming															

Shaded text signifies states that did not respond to the survey. T= tablet cost, *Arkansas data are from 01/02 - 3/02. **Arizona data are collected by category not by drug, ***Minnesota data do not include gross cost rebates. ****New Mexico data are highly approximated cost figures. ^Virginia data are based on generic codes or by therapeutic class.

Table 17: Most Costly Medicaid Prescription Drugs (Total Expenditures), by State.

STATE	1	Population	Unit Cost	2	Population	Unit Cost	3	Population	Unit Cost	4	Population	Unit Cost	5	Population	Unit Cost
Alabama															
Alaska	Antipsychotic	Medicaid	$104.96	Narcotic Analgesics	Medicaid	$71.89	Antidepressants	Medicaid	$57.08	Unclassified Rx such as Nupogen, hemophiliac blood factors	Medicaid	$198.33	Antiulcerants	Medicaid	$89.28
Arkansas*	Zyprexa		$298.76	Synagis		$16.39	Risperdal		$157.84	Prevacid		$127	Zithromax		$38.95
Arizona**															
California	Zyprexa 10 mg 00002-4117-60		$8.21	Prevacid 30mg cap, 00300-3046-13			Celebrex 200mg cap, 00025-1525-31		$2.61	Prilosec 20mg cap 200186-0742-31		$4.38	Zyprexa 5mg tab, 00002-4115-60		$5.61
Colorado	Clozaril 100mg, 00078-012705		$187.78 Average cost	Clozapine 100mg, 00172-436060		$93.17 average cost	Albuterol Inhaler, 59930-156001		$14.96 Average cost	Fluoxetine 20mg, 00555-087702		$53.26 Average cost	Humidin 70/30, 000028-715001		
Connecticut															
Delaware	Prevacid 30		$141.00	Antihemophiliac Factor 8		$458	Synogest 100mg		$1,003.40	Nexium 40		$142	Zyprexa10		$275
District of Columbia															
Florida															
Georgia	Prilosec 00186-0742		$118.36	Celebrex 00025-1525		$92.24	Zyprexa 0002-4117		$350.49	Synagis 60574-4111		$1395.62	Vioxx 00006-0110		$73.65
Hawaii	Zyprexa 10mg			Oxycontin 80mg			Lipitor 10mg			Plavix 75mg			Celebrex 200mg		
Idaho	Zyprexa 10		$8.48	Prevacid 30		$4.07	Zyprexa 5		$5.58	Prilosec 20		$4.06	Seroquel 200		$4.83
Illinois	Prevacid		$120.06	Zyprexa		$271.06	Risperdal		$165.47	Zocor		$106.82	Seroquel		$195.78
Indiana															
Iowa	Zyprexa 10mg		$319.26	Zoloft 100mg		$64.06	Prevacid 30mg		$119.34	Risperdal 1mg		$117.15	Seroquel 200mg		$303.72
Kansas	Zyprexa	D	$210.55	Risperdal	D	$116.53	Seroquel	D	$117.42	Prilosec	E	$102.58	Neurontin	D	$83.90
Kentucky	Zyprexa	Adult	$307.48	Lipitor	Adult	$80.73	Risperdal	Adult	$178.99	Celebrex	Adult	$97.87	Neurontin	Adult	$120.55
Louisiana	Lansoprazole			Palivizumab			Celecoxib			Olanzapine			Clopidogrel		
Maine	Protonix 40mg	40-49	$2.79	Lipitor 10mg	70-79	$1.77	Celebrex 200mg	Over 60	$2.24	Zoloft 100mg	30-50	$2.07	Lipitor 20mg	50-79	$2.66
Maryland	Zyprexa		$275.68	Risperdal		$152.41	Prevacid		$121.06	Seroquel		$167.11	Depakote		$88.18
Massachusetts	Zyprexa	D	$55.6 Million	Risperdal	D	$32 Million	Seroquel	D	$27 Million	Lipitor	D	$25.8 Million	Neurontin	D	$25.5 Million
Michigan	Olanzipine		$309.43	Risperidone		$187.92	Quetiapine Fumarate		$190.73	Atorvastatin Calcium		$78.96	Pantoprazole Sodium Sesquihydrate		$93.52
Minnesota	Protonix 40mg		$107.67	Zyprexa 10mg		$415.59	Seroquel 200mg		$343.81	Zyprexa 15mg		$497.18	Zyprexa 5mg		$230.53
Mississippi	Zyprexa		$309.26	Prevacid		$131.72	Prilosec		$141.65	Risperdal		$181.62	Celebrex		$86
Missouri	Olanzapine	Permanently Totaled Disabled (PTD,) Old Age Assistance (OAA)	$295.53	Risperidone	PTD and OAA	$152.45	Celecoxib	PTD and OAA	$103.60	Quetiapine	PTD	$173.54	Atorvastatin	PTD	$82.22
Montana	Zyprexa			Risperdal			Prilosec			Prevacid			Oxycontin		
Nebraska	Lanasoprazole 30 mg	D	$4.12	Omeprozole 10mg	D	$3.67	Olanzapine 10mg	Mental health	$8.58	Celecoxib 200mg	D	$2.56	Gentraline 100mg	D	$2.36
Nevada															
New Hampshire	Zyprexa	MN	$7.37	Risperdal	MN	$3.23	Seroquel	MN	$2.16	Zoloft	MN	$2.16	Depakote	MN	$.97
New Jersey	Zyprexa 10mg.		AWP-10%	Prevacid 30mg		AWP-10%	Celebrex 200mg.		AWP-10%	Prilosec 20mg.		AWP-10	Combivir		AWP-10%
New Mexico***	Prilosec 20 mg	General/Medicaid	$137.48	Zyprexa 10 mg tab	General/Medicaid	$295	Prevacid 30mg cap	General/Medicaid	$127	Celebrex 200mg	General/Medicaid	$95.00	Zyprexa 5mg	Nursing Home	$170.00
New York	Zyprexa 10mg	Mental Health	$361.35	Combivir	AIDS	$579.93	Prevacid 30mg caps	Ulcer patients	$136.34	Prilosec 20mg caps		$149.13	Celebrex 200 mg caps		$107.84
North Carolina	Zyprexa	D	$7.51	Prevacid	Over 65	$3.98	Risperdal	D	$3.61	Prilosec	D	$4.25	Lipotor	Aged	$2.59
North Dakota	Zyprexa		$2.7 Million	Risperdal		$2.1 Million	Zoloft		$1.4 Million	Seroquel		$1.3 Million	Prevacid		$1 Million
Ohio															
Oklahoma	Zyprexa			Risperdal			Prevacid			Paxil			Zoloft		
Oregon															
Pennsylvania	Prevacid Cap 30mg		$4.16	Zyprexa Tab 10mg		$8.67	Prilosec Cap 200mg		$4.15	Celebrex Cap 200mg		$2.59	Zyprexa Tab 5mg		$5.70
Rhode Island															

STATE	***1***	*Population*	*Unit Cost*	***2***	*Population*	*Unit Cost*	***3***	*Population*	*Unit Cost*	***4***	*Population*	*Unit Cost*	***5***	*Population*	*Unit Cost*
South Carolina	Prilosec 20mg	E, D	$134.24	Zyprexa 10mg	E	$377.86	Prevacid 30mg	E, D	$128.67	Celebrex 200 mg	E	$100.39	Noravasc 10mg	E, D	$63.77
South Dakota	Zyprexa 10mg	D	$8.63	Prevacid 30mg	D	$4.14	Prilosec	D	$4.13	Celebrex 200mg	D	$2.58	Monarch-M	D	$.83
Tennessee															
Texas	Zyprexa		$69.90	Risperdal		$50.50	Celebrex		$30.60	Prevacid		$26.40	Prilosec		$24.80
Utah	Zyprexa		$694.60	Risperdal		$470.25	Seroquel		$240.46	Prevacid		$334.91	Zoloft		$127.13
Vermont	Zyprexa	D		Zocor	D, E		Protonix	D, E		Seroquel	D		Risperdal	D	
Virginia****															
Washington	Zyprexa		Avg. $280.81	Risperdal		$163.32	Neurontin		Avg. $125.45	Oxycontin		Avg, $190.76	Protonix		Avg. $87.67
West Virginia	Olanzapine 10mg, GSN 027960		$345.40	Fluoxetine 20mg, GSN 046214		$102.21	Paroxetine 20mg, GSN 046223	Unknown	$79.93	Gabapentin 300 mg, GSN 021414		$96.23	Setraline 100mg, GSN 046229		$81.57
Wisconsin	Antipsychotics Atypicals	MN	$178.27	PPIs	$127.95	MN	SSRIs	MN	$75.22	Analgesics-Narcotics	MN	$46.47	Anticonvulsants w/ secondary conditions	MN	$89.43
Wyoming															

Shaded text signifies states that did not respond to the survey. MN=Medically Needy, D=Disabled, E=Elderly. *Arkansas data are from 01/02 - 03/02. **Arizona data are collected by category, not by Rx. ***New Mexico data are highly approximated cost figures. ****Virginia data are based on generic codes or by therapeutic class. Dollar amounts for unit costs vary greatly: some states have furnished dose costs, other states monthly unit costs and finally yearly costs

Table 18: Medicaid Prospective Drug Utilization Review (PRODUR) Criteria, by State.

STATE	*Duplicative Therapies*	*Drug to Drug Interactions*	*Dosage*	*Duration*	*Diagnostic Appropriateness*	*Other*	*State has Automated System*
Alabama							
Alaska	●	●	●	●	●		●
Arkansas	●	●	●	●	●		●
Arizona	●	●	●	●	●		●
California	●	●	●	●	●		●
Colorado	●	●	●	●	●		●
Connecticut	●	●	●	●	●		●
Delaware	●	●	●	●	●	Compliance, Pregnancy	●
District of Columbia	●	●	●	●			●
Florida	●	●	●	●	●		●
Georgia	●	●	●	●			●
Hawaii	●	●	●	●	●		
Idaho	●		●	●			
Illinois	●	●	●		●	Early refill	●
Indiana							
Iowa	●	●	●	●		Early refill; excess supply; duplicate claim; dose and cost effectiveness (optional)	
Kansas	●	●	●	●	●		●
Kentucky	●	●				Early refill; ingredient duplication	
Louisiana	●	●		●	●		●
Maine	●	●	●	●	●		●
Maryland	●	●	●	●	●	Early refill	●
Massachusetts	●	●	●		●	Early refill	
Michigan	●	●	●	●		Early refill	●
Minnesota	●	●	●	●	●		
Mississippi	●	●	●	●	●		
Missouri	●	●	●	●	●		
Montana	●	●	●	●			●
Nebraska	●	●	●	●	●		●
Nevada							
New Hampshire	●	●	●	●			●
New Jersey	●	●	●	●	●		
New Mexico	●	●	●	●			●
New York	●	●	●	●	●		●
North Carolina	●	●	●	●		Diagnostic appropriateness as determined by DUR Board	
North Dakota	●	●	●	●			●
Ohio							
Oklahoma	●	●	●	●		Early refills	
Oregon							
Pennsylvania	●	●	●			Early or late refills	●
Rhode Island							
South Carolina	●	●	●	●	●		●
South Dakota	●	●	●	●	●		●
Tennessee							
Texas	●	●	●	●			●
Utah	●	●	●	●	●	Drug-Disease; addictive; toxicity; and early refill	
Vermont	●	●	●	●	●		●
Virginia	●	●	●	●	●		●
Washington	●	●	●	●	●		●
West Virginia	●	●	●	●			●
Wisconsin	●	●	●	●	●		●
Wyoming							
TOTAL	**43**	**42**	**41**	**39**	**28**		**31**

Shaded text signifies states that did not respond to the survey.

Table 19: Medicaid Retrospective Drug Utilization Review (RetroDUR) Criteria, by State.

STATE	Rx Rates or Costs, by Rx	Rx Rates or Costs, by Rx Class	Rx Rates or Costs by Brand vs. Generic	Rx Rates or Costs by Disease/ Condition	# of Rx by Eligibility Group	Rx Costs by Eligibility Group	Trends in Utilization	Trends in Costs
Alabama								
Alaska	●	●	●	●	●	●	●	●
Arkansas	●	●	●	●	●	●	●	●
Arizona*								
California	●	●		●			●	●
Colorado	●	●	●	●			●	●
Connecticut	●	●	●	●			●	●
Delaware	●	●		●			●	●
District of Columbia	●	●	●	●	●	●	●	●
Florida	●	●	●	●	●	●	●	●
Georgia	●	●	●	●	●	●	●	●
Hawaii	●	●	●	●	●	●	●	●
Idaho	●	●	●	●			●	●
Illinois		●	●	●			●	●
Indiana								
Iowa	●	●	●	●	●	●	●	●
Kansas	●	●	●	●	●	●	●	●
Kentucky		●		●			●	●
Louisiana	●	●	●	●			●	●
Maine	●	●	●	●	●	●	●	●
Maryland	●	●	●	●	●	●	●	●
Massachusetts	●	●	●		●	●	●	●
Michigan	●	●	●		●	●	●	●
Minnesota	●	●	●	●			●	●
Mississippi	●	●	●	●	●	●	●	●
Missouri	●	●		●	●	●	●	●
Montana	●	●	●				●	●
Nebraska	●	●	●	●			●	●
Nevada								
New Hampshire	●	●	●	●			●	●
New Jersey							●	●
New Mexico	●	●	●	●	●	●	●	●
New York	●	●	●	●	●	●	●	●
North Carolina	●	●	●	●	●	●	●	●
North Dakota	●	●	●	●	●	●	●	●
Ohio								
Oklahoma	●	●	●	●	●	●	●	●
Oregon								
Pennsylvania	●	●	●	●			●	●
Rhode Island								
South Carolina	●						●	●
South Dakota	●	●	●				●	
Tennessee								
Texas	●	●	●	●			●	●
Utah	●	●	●				●	●
Vermont								
Virginia								
Washington	●	●	●	●	●	●	●	●
West Virginia	●	●	●		●	●	●	●
Wisconsin	●	●	●	●			●	●
Wyoming								
TOTAL	**37**	**38**	**34**	**32**	**21**	**21**	**40**	**39**

Shaded text signifies states that did not respond to the survey.

Table 20: Medicaid Policies for Monitoring High-Cost Drug Users, High Prescribing Physicians and Prescription Drug Cost-Effectiveness, by State.

	Rx Users		*Physicians*			*Cost-Effectiveness*	
STATE	Track "High Cost" Users	Definition of "High Cost"	Track "High Prescribing" Physicians	Definition of "High Prescribing"	*Manner of Addressing Prescribing Patterns*	Cost Evaluations Consider Cost-Effectiveness	Method of Considering Cost-Effectiveness
Alabama							
Alaska	●	Highest ranked users			`	●	Look at users of Rx and other services
Arkansas			●		MD and patient letters		
Arizona	●	MCOs define	●	MCOs define	Education, letters	●	Done by MCOs
California	●	Audits and investigations	●	Audits and investigations	Audits and investigations	●	
Colorado	●	# of Rx and total $	●	Ingredient cost, average # of Rx, and brand %	Program Integrity Review	●	Review of PA
Connecticut	●		●				
Delaware	●	Total amount of claims	●	Large number of narcotics	Letters		
District of Columbia	●		●			●	
Florida	●	Rank in program and Prescriber Panel criteria	●		Letters and visits from pharmacy	●	P and T Committee
Georgia							
Hawaii	●		●	# of paid claims	Education, calls by staff, and provider bulletin		
Idaho					Education letters	●	Asthma and diabetes disease management
Illinois	●	High users of abusable Rx	●	Outliers	Audit & investigation; suspension; termination		
Indiana							
Iowa	●	Monthly report of users by $ paid and # of Rx	●	Top prescribing report by # of Rx and avg. cost	DUR letters to doctors	●	The evaluations are strictly reports based on POS information
Kansas	●	Outliers	●	Outliers	Education, letters	●	
Kentucky						●	P and T Committee
Louisiana			●	Top prescribers by $ of Rx	Education, letters		
Maine	●		●			●	
Maryland	●	Outliers	●	Quarterly volume of Rx	Letters		
Massachusetts	●	Monthly top 200 by $	●	Total $ prescribed, avg. cost, and brand use	Letters, phone calls		
Michigan	●	Outliers, audits, ad hoc reports	●	Outliers	*SURS investigations	●	MAC, CQI, Disease Management, PDL
Minnesota						●	
Mississippi	●		●	Outliers	Education, letters	●	
Missouri	●	High users by $	●	# of high cost Rx	Educational letters	●	New disease management

STATE	*Rx Users*		*Physicians*			*Cost-Effectiveness*	
	Track "High Cost" Users	Definition of "High Cost"	Track "High Prescribing" Physicians	Definition of "High Prescribing"	*Manner of Addressing Prescribing Patterns*	Cost Evaluations Consider Cost-Effectiveness	Method of Considering Cost-Effectiveness
Montana	●	Top 200 by $	●	Ingredient cost and # of Rx	In development		
Nebraska	●	Exceptional claims (> 250)				●	
Nevada							
New Hampshire	●	Audits, Lock-in Program and *SURS reports					
New Jersey	●	>12 Rx/month					
New Mexico	●	Monthly top 250 clients by # of Rx and $	●	Monthly top 100 doctors by # of Rx, ingredient cost, brand use		●	Varied methodologies
New York	●	Use of 100 mostly costly Rx	●	# of Rx	MDs required to use "Post and Clear" system		
North Carolina							
North Dakota	●	Top 1% of recipients by $, then by Rx volume	●	Based on cost and volume	Educational letters		
Ohio							
Oklahoma							
Oregon							
Pennsylvania	●	Ad hoc reports	●	Select an Rx, then use a high-low report	Integrity review or education intervention	●	Use the disease management approach
Rhode Island							
South Carolina						●	Awareness
South Dakota							
Tennessee							
Texas	●	> 9 Rx/month	●	Looks at specific therapy	Letters, visits, track behavior change		
Utah	●	University of Utah College tracks high cost clients					
Vermont			●			●	
Virginia							
Washington	●	Monthly top 1000	●	Monthly top 120	Personal visits	●	Pharmaco-economic evaluation before and after the intervention
West Virginia	●	Monthly top 100 cases by $	●	Monthly top 100 prescribers by $			
Wisconsin		High utilization, indirect cost analysis	●	Ad hoc	Refer to DHFS	●	Recipient lock-in program looks at all services, target intervention
Wyoming							
TOTAL	**30**		**24**			**22**	

Shaded text signifies states that did not respond to the survey. *SURS = State Utilization Review Services.

Table 21: State Estimates and Projections of Medicaid Pharmacy Cost Increases, by State.

STATE	*% increase in Rx costs over last 2 years (Yr 1/Yr 2)*	*Projected increase in Rx costs for FY 2003**	*Projected increase in Rx costs for FY 2004*
Alabama			
Alaska	(12%/28%)	20%	10%
Arkansas	17%		
Arizona			
California	46%	9.2%	12.7%
Colorado	13.25%	11%	
Connecticut		16-18%	16-18%
Delaware	20%	15%	
District of Columbia	(16%/14%)	11%	11%
Florida	(13%/ 11.25%)		
Georgia	18%	17%	
Hawaii			
Idaho	49%	4.57%	
Illinois	47%	27%	15%
Indiana			
Iowa	(18.1%/18.6%)	16.3%	
Kansas	(12%/13%)	14%	
Kentucky	(25%/6%)	6%	3%
Louisiana	20%	18- 19%	18-19%
Maine			
Maryland	(18%/14%)	12%	12%
Massachusetts	20%	5%	5%
Michigan	(6.1%/18%)		
Minnesota	38.22%	27%	11%
Mississippi	20%	0%	
Missouri	30%	15%	13%
Montana	(15.67%/15.67%)	7.33%	10.3
Nebraska	(20%/20%)	11.9%	18-25%
Nevada			
New Hampshire	(15%/7.5%)	18%	18%
New Jersey	(13.1%/4%)	-1%	-5.3%
New Mexico	22%		
New York	(22.4%/17.1%)	15-20%	15-20%
North Carolina	(23%/14%)	15.94%	23.1%
North Dakota	(16.5%/18.3%)	18%	18%
Ohio			
Oklahoma	(14.2%/24.3%)	17%	20%
Oregon			
Pennsylvania	(13.25%/27.25%)	14%	
Rhode Island			
South Carolina	(0%/20%)	20%	15%
South Dakota	33.5%	13.6%	14%
Tennessee			
Texas	17%	23%	22%
Utah	39.7%	18%	18%
Vermont	8%	12%	11%
Virginia		10%	
Washington	36%	6.8%	14%
West Virginia	30.2%	18.3%	13.3%
Wisconsin	28.2%	16.5%	14.9%
Wyoming			
AVERAGE	**14.70%**	**13.96%**	**13.83%**

Shaded text signifies states that did not respond to the survey. *For states responding to the survey, state fiscal year 2003 ended on June 30, 2003, except for Minnesota and New Mexico whose fiscal year ended on July 31, 2003; New York whose fiscal year ended on March 31, 2003; and Texas whose fiscal year ended on August 31, 2003.

Table 22: State Experience with Ease of Implementation of Various Utilization Management Strategies, by State.

STATE	*Utilization Management Strategies Ranked by Ease of Implementation*		
	1	*2*	*3*
Alabama			
Alaska	PRODUR	RetroDUR	Generics
Arkansas			
Arizona			
California	PA	PDL	
Colorado	PA	PDL	Cost-sharing
Connecticut	PRODUR	RetroDUR	Dispensing Limit
Delaware	PDL	Cost-sharing	Generics
District of Columbia	PRODUR	PA	Generics
Florida	Generics	PDL	PA
Georgia	PRODUR	RetroDUR	Dispensing Limit
Hawaii	Generic	Dispensing Limit	PA
Idaho	Payment	Generics	PA
Illinois	Cost-sharing	PRODUR	PDL
Indiana			
Iowa	Dispensing Limit	Generics	Cost-sharing
Kansas	PRODUR	Generics	Dispensing Limit
Kentucky	Dispensing Limit	Generics	Payment
Louisiana	Dispensing Limit	PA	PDL
Maine	Generics	PDL	Dispensing Limit
Maryland	Generics	PRODUR	RetroDUR
Massachusetts	Generics	Cost-sharing	PDL
Michigan	PRODUR	Automated edits	MAC Pricing
Minnesota	Generics	PA	PDL
Mississippi	PA	Dispensing Limit	PRODUR
Missouri	Generics	PRODUR	PA
Montana	Generics	PRODUR	PA
Nebraska	Payment	Cost-sharing	Generics
Nevada			
New Hampshire	Generics	PRODUR	RetroDUR
New Jersey	Fail-first	Generics	Dispensing Limit
New Mexico	Generics	Dispensing Limit	PRODUR
New York	Generics	Dispensing Limit	Cost-sharing
North Carolina	PRODUR	RetroDUR	Generics
North Dakota	PRODUR	Cost-sharing	Payment
Ohio			
Oklahoma	Dispensing Limit	Generics	Cost-sharing
Oregon			
Pennsylvania	PRODUR	Cost-sharing	PA
Rhode Island			
South Carolina	Dispensing Limit	PA	Generics
South Dakota	Cost-sharing	Payment	Generics
Tennessee			
Texas	Generics	Dispensing Limit	PRODUR
Utah			
Vermont	PDL (nr)	PA (nr)	Generics (nr)
Virginia	Dispensing Limit	Generics	Cost-sharing
Washington	Generics	PA	Dispensing Limit
West Virginia	Generics	Cost-sharing	PA
Wisconsin	Generics	PRODUR	RetroDUR
Wyoming			
AVERAGE			

Shaded text signifies states that did not respond to the survey. PA = Prior Authorization. Payment = payment policy changes. PDL = Formulary/PDL. nr = not ranked.

Table 23: Type of Delivery System for Medicaid Beneficiary Groups, by State.

STATE	Type of Delivery System*											
	Children			Adults			Disabled			Elderly		
	Fee-for-Service	Capitated/MCO	PCCM	Fee-for-Service	Capitated/MCO	PCCM	Fee-for-Service	Capitated/MCO	PCCM	Fee-for-Service	Capitated/MCO	PCCM
Alabama												
Alaska	●			●			●			●		
Arkansas	●			●			●			●		
Arizona	●	●		●	●		●	●		●	●	
California	●	●	●	●	●	●	●	●	●	●	●	●
Colorado	●	●	●	●	●		●	●	●	●	●	●
Connecticut	●	●		●	●		●	●		●	●	
Delaware		●	●		●		●			●		
District of Columbia		●			●		●			●		
Florida		●	●		●			●	●		●	●
Georgia	●		●	●		●	●			●		
Hawaii		●			●		●			●		
Idaho	●		●	●		●	●		●	●		●
Illinois	●	●		●	●		●			●	●	
Indiana												
Iowa	●			●			●			●		
Kansas	●	●	●	●	●	●	●		●	●		●
Kentucky	●	●	●	●	●	●	●	●	●	●	●	●
Louisiana	●			●			●			●		
Maine	●	●		●	●		●			●		
Maryland		●			●		●	●		●		
Massachusetts	●	●	●	●	●	●	●	●	●	●	●	●
Michigan	●	●		●	●		●	●		●		
Minnesota	●	●		●	●		●	●		●	●	
Mississippi	●			●			●			●		
Missouri		●			●		●			●		
Montana			●			●			●			●
Nebraska		●	●		●	●		●	●		●	●
Nevada												
New Hampshire	●	●		●	●		●	●		●	●	
New Jersey		●		●	●		●	●		●	●	
New Mexico		●			●			●			●	
New York	●	●		●	●		●	●		●	●	
North Carolina			●			●			●			●
North Dakota	●			●			●			●		
Ohio												
Oklahoma	●	●	●	●	●	●	●	●	●	●	●	●
Oregon												
Pennsylvania	●	●		●	●		●	●		●	●	
Rhode Island												
South Carolina	●	●	●	●	●	●	●	●	●	●	●	●
South Dakota	●			●			●			●		
Tennessee												
Texas		●			●		●	●		●	●	
Utah	●			●			●			●		
Vermont	●		●	●		●	●		●	●		●
Virginia	●	●	●	●	●	●	●	●	●	●	●	●
Washington	●	●	●	●	●	●	●			●		
West Virginia	●	●	●	●	●	●	●		●	●		
Wisconsin		●			●		●			●		
Wyoming												
TOTAL	**30**	**30**	**18**	**31**	**30**	**15**	**38**	**20**	**15**	**38**	**19**	**14**

Shaded text signifies states that did not respond to the survey. *Note: States can serve each population group through more than one type of delivery system. Responses provided are not intended to indicate the predominant delivery system for each group.

Table 24: Medicaid Policies for Delivering Prescription Drugs to Managed Care Enrollees, by State.

STATE	For Managed Care Enrollees			
	State Purchases Rx on Fee-For-Service Basis	*State Includes Rx Costs in MCO Capitation Rate*	*MCO Delivers Rx*	*PBM or Other Entity Delivers Rx*
Alabama				
Alaska				
Arkansas				
Arizona			●	
California*		●	●	
Colorado		●		
Connecticut		●		
Delaware	●			
District of Columbia		●	●	
Florida		●	●	
Georgia	●			
Hawaii		●	●	
Idaho	●			
Illinois		●	●	
Indiana				
Iowa				
Kansas		●	●	
Kentucky	●	●	●	
Louisiana				
Maine	●			
Maryland		●	●	
Massachusetts		●	●	
Michigan**		●	●	
Minnesota		●	●	
Mississippi				
Missouri		●	●	
Montana	●			
Nebraska	●			
Nevada				
New Hampshire	●			
New Jersey		●	●	
New Mexico		●	●	●
New York	●			
North Carolina	●			
North Dakota				
Ohio				
Oklahoma		●	●	
Oregon				
Pennsylvania		●	●	
Rhode Island				
South Carolina		●	●	
South Dakota				
Tennessee				
Texas	●			
Utah				
Vermont	●			●
Virginia		●	●	
Washington		●	●	
West Virginia	●			
Wisconsin		●	●	
Wyoming				
TOTAL	**13**	**22**	**21**	**2**

Shaded text signifies states that did not respond to the survey. *California purchases HIV medications and some psychotropic medications on a fee-for-service basis. **Michigan purchases psychotropic medications on a fee-for-service basis.

Table 25: Medicaid Policies Regarding MCO or PCCM Discretion to Set Pharmacy Management Policies, by State.

STATE	*State Permits MCO or PCCM to Set Own Policies and Procedures*					
	Formulary/ PDL Policy	*Prior Authorization (PA)*	*Require Generics*	*Encourage Generics*	*Fail-First*	*Restrict Access to Pharmacy Network*
Alabama						
Alaska						
Arkansas						
Arizona	●	●	●	●	●	●
California	●	●	●	●	●	
Colorado	●	●	●	●	●	●
Connecticut	●	●	●			
Delaware						
District of Columbia	●	●	●	●	●	●
Florida	●	●	●	●	●	●
Georgia						
Hawaii	●	●	●	●	●	●
Idaho						
Illinois*	●	●		●	●	●
Indiana						
Iowa						
Kansas	●	●	●	●	●	
Kentucky	●	●	●	●	●	
Louisiana						
Maine						
Maryland**	●	●	●	●	●	●
Massachusetts	●	●	●	●	●	●
Michigan***	●	●				
Minnesota	●	●	●	●	●	
Mississippi**	●	●	●	●	●	●
Missouri	●	●	●	●	●	●
Montana						
Nebraska						
Nevada						
New Hampshire						
New Jersey	●	●	●	●	●	●
New Mexico	●	●	●	●	●	●
New York						
North Carolina						
North Dakota						
Ohio						
Oklahoma	●	●	●	●	●	●
Oregon						
Pennsylvania	●	●	●	●	●	
Rhode Island						
South Carolina****	●	●	●	●	●	●
South Dakota						
Tennessee						
Texas						
Utah						
Vermont	●	●	●	●		
Virginia	●	●	●	●	●	●
Washington^	●	●	●	●	●	
West Virginia						
Wisconsin	●	●	●	●	●	●
Wyoming						
TOTAL	**25**	**25**	**23**	**23**	**22**	**16**

Shaded text signifies states that did not respond to the survey. *Illinois' MCO pharmaceutical benefit cannot be more restrictive than the fee-for-service pharmaceutical benefit. **Maryland and Mississippi permit restricted access to a pharmacy network, but do not permit requiring the use of mail-order pharmacies. ***Michigan requires MCOs to cover drugs on the PDL when medically necessary. ****South Carolina's MCO policies cannot be more restrictive than traditional Medicaid. ^Washington: If an MCO places an Rx on PA that is covered by Medicaid, then the MCO must cover an alternative in the same therapeutic class.

Table 26: Medicaid Policies for Delivering Prescription Drugs to Beneficiaries Residing in Institutions (*i.e. Nursing Homes*), by State.

STATE	*Estimated % of Rx Spending on Beneficiaries in Institutions*	*Rx Carved Out of Institutional Rate*	*Add-Ons to Institutional Rate*	*Specific Rx Cost-Control Policies*	*Planned Policy Changes*
Alabama					
Alaska		●		Using maximum limits for selected analgesics	
Arkansas	18%			PA, same for all recipients	
Arizona					
California	10%				
Colorado	30%			Return and reuse policy for selected Rx	
Connecticut			OTCs		
Delaware	33%	●		PA, Limit therapeutic duplications	
District of Columbia					Developing LTC program and increasing payment rates
Florida	15%	●			Strengthen FUL brand cap, establish PDL
Georgia		●		Audit high users (large number of Rx/month)	Possible capitation program for LTC
Hawaii		●		DUR, internal reviews	
Idaho					
Illinois	20%	●			
Indiana					
Iowa					
Kansas					
Kentucky	13%	●		PA requirements same as outpatients	
Louisiana	21%				
Maine					
Maryland*	25%	●	Dispensing Fee		
Massachusetts	15%	●	OTCs	Return and reuse policy for selected Rx and on-site audits	
Michigan**		●	State pays for unit does repackaging: $0.03/tab	Pharmacy audits	
Minnesota	14%	●		Return and reuse policy	
Mississippi		●		Return and reuse policy	
Missouri***	15%	●		Return and reuse policy	Several changes under consideration
Montana					Deny Rx refills
Nebraska	17%	●		Return and reuse policy	
Nevada					
New Hampshire		●		1 dispensing fee/month; post consumption and unit dose credit	
New Jersey	20%	●		Reviews conducted by pharmacy consultants	
New Mexico					
New York****					
North Carolina					
North Dakota	33%	●			
Ohio					

STATE	*Estimated % of Rx Spending on Beneficiaries in Institutions*	*Rx Carved Out of Institutional Rate*	*Add-Ons to Institutional Rate*	*Specific Rx Cost-Control Policies*	*Planned Policy Changes*
Oklahoma	32%	•		Early refill edit	Dispense only 30 day supply and limit 1 dispensing fee/Rx/month
Oregon					
Pennsylvania	31%	•		Limit dispensing fees for maintenance Rx to 1/30 days	
Rhode Island					
South Carolina	6%	•		Alternate reimbursement methodology, pays pharmacy to provide all Rx's for LTC	
South Dakota			Yes, unspecified		
Tennessee					
Texas	18%				
Utah		•			Implementing LTC return and reuse policy
Vermont				PA added to PDL	
Virginia					
Washington		•		Higher dispensing fee paid for true unit dose systems (return and credit)	
West Virginia		•			
Wisconsin	24%				
Wyoming					
TOTAL	**21% (Avg.)**	**23**	**5**	**20**	**7**

Shaded text signifies states that did not respond to the survey. *Maryland Rx costs are carved out of institutional rate only in fee-for-service. **Michigan carves out most Rx from the institutional rate, but not diabetes supplies, enteral formulas, and some OTCs. ***Missouri Rx costs are carved out of institutional rate, except for stock items. ****New York Rx costs are not carved out of institutional rate, except in limited circumstances.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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