



Medicaid Prescription Drug Rebate Equalization (DRE) Policy Brief

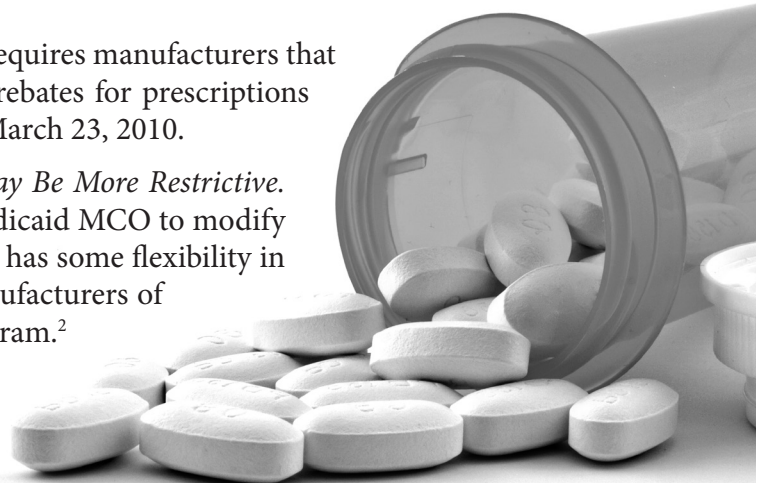
Background

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act and a reconciliation act enacting national health reform. These laws, collectively known as the *Affordable Care Act (ACA)*, also stipulate changes to the federal Medicaid drug rebate program. Specifically, the ACA allows states for the first time to collect federal drug rebates on prescriptions reimbursed under capitation arrangements with Medicaid managed care organizations (MCOs). This change was described as drug rebate equalization (DRE) in several stand-alone bills introduced in Congress, since it adds rebate parity between the Medicaid fee-for-service and capitated MCO sectors. Previously, federal drug rebates had been available only on Medicaid fee-for-service (FFS) prescriptions. To obtain rebate revenue, 14 of the 38 states with risk-based MCOs chose to exclude (or carve-out) some or all prescription drugs from their MCO contracts (Attachment 1).

CMS Guidance

The Centers for Medicare and Medicaid Services (CMS) has issued two letters to state Medicaid directors¹ providing implementation guidance on the Medicaid prescription drug rebate provisions in the ACA. Following are noteworthy clarifications provided by CMS:

1. *Drug Rebate Equalization Began March 23, 2010.* ACA requires manufacturers that participate in the federal drug rebate program to pay rebates for prescriptions reimbursed by Medicaid MCOs, effective on and after March 23, 2010.
2. *CMS Permits MCO Formulary Flexibility, But States May Be More Restrictive.* CMS indicated that (a) it does not plan to require a Medicaid MCO to modify its formulary because of DRE and (b) a Medicaid MCO has some flexibility in maintaining formularies regardless of whether the manufacturers of those drugs participate in the federal drug rebate program.² CMS, however, indicated that state Medicaid programs may establish their own requirements related to MCO formularies. These could be more restrictive than allowed under federal guidance.



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¹ Dear State Medicaid Director Letters, #10-006 (April 22, 2010) and #10-019 (September 28, 2010), available at <http://www.cms.gov/SMDL/SMD/>
² State FFS pharmacy expenditures are limited to manufacturers participating in the federal drug rebate program (See http://www.cms.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp for the list of participating manufacturers.)

3. *MCO Rebate Reporting Is Required for Pharmacy-Dispensed and Physician-Administered Drugs.* MCOs are responsible for collecting and reporting required rebate data to states for billing drug rebates to manufacturers. Drug rebate reporting data includes National Drug Code (NDC), metric units reimbursed, number of prescriptions, total amount reimbursed, Medicaid MCO amount reimbursed, and non-Medicaid amount reimbursed.³ MCOs must supply the required rebate data for drugs administered by physicians, clinics, and outpatient hospitals and for drugs dispensed by pharmacies.

Section 1927(a)(7) of the Social Security Act requires that states collect manufacturer rebates on physician-administered drugs, except vaccines, using NDCs. Under this mandate, practitioners, clinics, and outpatient hospitals must bill states with NDCs and pharmacy metric quantities in addition to the usual Healthcare Common Procedure Coding System (HCPCS) codes and HCPCS quantity units billed for these products. Reporting NDC information is *not* required for drug claims considered packaged or bundled, e.g., under an Outpatient Prospective Payment System and in select states for 340B drugs.

4. *MCO Capitation Rates Must Be Based on Actual Cost Experience for Rebates.* The ACA amended Section 1903(m)(2)(A) (xxiii) of the Social Security Act so that capitation rates paid to MCOs must be based on “actual cost experience related to [drug] rebates and subject to the Federal regulations [at 42 CFR 438.6] requiring actuarially sound rates.”
5. *340B Drugs Are Exempted from the Drug Rebate Program.* Drugs, which are subject to pricing discounts under Section 340B of the Public Health Service Act, are not subject to rebate requirements.

3 See <http://www.cms.gov/MedicaidDrugRebateProgram/downloads/utildataspecs.pdf>

Other Information on the Medicaid Drug Rebates

Following are miscellaneous facts regarding the Medicaid drug rebate program.

1. *On Average Across The Nation, State Medicaid Pharmacy Spending Is Offset 37% From Drug Rebate Revenue.* States received average federal rebates equal to 33% and state supplemental rebates at 4% of their Medicaid pharmacy spending during fiscal year 2009. (Attachment 2 provides state-by-state detail.)
2. *Medicaid Drug Rebates Do Not Impact Pharmacy Reimbursement.* Rebate revenue does not offset pharmacy, practitioner, and outpatient hospital reimbursement. Each state determines its own reimbursement methodology and rates for these providers.
3. *The Formula Used to Calculate Federal Rebates is Complex and Drug Specific.* Section 1927 of the Social Security Act requires manufacturers to sign rebate agreements with CMS or forego coverage of their drugs by state Medicaid programs.⁴ The formula for calculating a drug’s rebate is complex and drugs within the same therapeutic class do not have the same rebate percentages. Before January 1, 2010, brand rebates were based on the larger of (1) 15.1 percent of Average Manufacturer Price (AMP) or (2) the difference between AMP and Best Price, which may be increased (3) by a Consumer Price Index-Urban factor based on the change from a drug’s initial to its current AMP. Generic rebates were set at 11 percent of AMP. Quarterly, a



4 The statute also requires that a manufacturer enter into agreements with the 340B Drug Discount Program and Veterans Affairs to have its drugs covered under Medicaid.

participating manufacturer submits AMPs and Best Prices for its NDCs. CMS then calculates NDC-specific unit rebate amounts for a billing quarter and sends its results to states for billing manufacturers. Table 1 lists changes to the rebate calculation effective for January 1, 2010 that will also apply to MCO capitated prescriptions. The health reform law also stipulates that CMS “recapture” 100 percent of the savings from the changes below – instead of the current practice of sharing rebate revenue with a state based on a its share of federal funding called the Federal Medical Assistance Percentage (FMAP).

Table 1 – Key ACA Changes to the Medicaid Drug Rebate Program

Changes to the Federal Medicaid Rebate Formula	Amended Section in the Social Security Act
1. Increases the base unit rebate from 15.1% to 23.1% of AMP on most brand drugs – except limits (a) clotting factors and (b) drugs used exclusively for pediatric indications to 17.1% of AMP instead of 23.1%	Sec. 1927(c)(3)(B)
2. Applies an additional rebate to new formulations (line extensions) of existing oral solid brand drugs	Sec. 1927 (c)(2)
3. Increases the base unit rebate from 11 to 13 percent of AMP on generic drugs	Sec. 1927(c)(3)(B)
4. Authorizes a “Federal Rebate Recapture” of manufacturer rebate revenue collected by states from #1 – 3 above	Sec 1927(b)(1)

Implementation of DRE

States are challenged to implement the DRE at the same time they are carrying out other ACA mandates and addressing budget deficits. Because the law was not signed until the end of March 2010, the state’s January through March 2010 quarterly rebate billing could not include MCO pharmacy utilization. After operational issues are worked out between the states, MCOs, and CMS, states will make retroactive adjustments to previously billed 2010 quarters reflecting MCO claims.⁵ However, the savings the states stand to gain from this program mean that timely implementation is critical in a time of budget crisis.

States fall into two scenarios with respect to DRE, each posing different challenges to implementation. The first scenario is one in which states have included prescription drugs under their MCO contracts (carve-in). The second scenario involves states which, prior to passage of ACA, “carved-out” prescription drugs from their MCO contracts, in order to qualify for the federal drug rebate program. These two scenarios and recommendations for addressing their unique challenges are discussed in the next section.

State Scenarios for DRE Implementation

States with Prescription Drug Benefit Carve-Ins

Several states have recognized the value of allowing Medicaid MCOs to coordinate both the medical and pharmaceutical benefits for Medicaid enrollees and have, as a result, included the management of prescription drug benefit in MCO contracts. In fact, studies have shown that managed care provides drug coverage in a more cost-effective manner than fee-for-service programs, via formulary management, high generic fill rates, comprehensive drug utilization, and coordination of care.^{6,7,8,9} The MCO formularies are created specifically to better manage the patient population and are sensitive to their unique needs enhancing their effectiveness in providing quality care at a lower cost.

5 Section 1927 of the Social Security Act requires states to send invoices no later than 60 days after the end of a quarter and manufacturers are to pay the invoice within 30 days after receipt (8 days allowed for postal delays, allowing 38 total days).

6 The Lewin Group. Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs. October 2007.

7 The Lewin Group. Financial Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs. October 2007.

8 The Lewin Group. Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System. November 2003.

9 The Lewin Group. Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting. January 2003.

Challenges

MCO-Negotiated Rebates With Manufacturers Have Dropped Significantly. In states where MCO contracts include prescription drugs, MCOs manage their unique drug formularies and work with pharmaceutical manufacturers either directly or indirectly through their pharmacy benefit manager (PBM). As a result of this approach, MCO prescription drug costs (and in turn state costs) have been reduced by negotiated rebates received from manufacturers. Under the 2010 ACA provisions, the MCOs under contract with carve-in states must now submit prescription drug encounter information to the states. The states then collect federal rebates from manufacturers, which lowers state prescription drug costs. Now that states are receiving federal rebates for prescriptions paid by Medicaid MCOs, manufacturers have become less willing to enter into new or maintain the current rebate contracts with Medicaid MCOs and their PBMs. In cases where MCOs have existing contracts, the manufacturers have responded to the DRE by re-negotiating and lowering rebate offerings.

Because of this change, MCOs Are Paying More for Prescription Drugs. Rebate yields for Medicaid MCOs have been substantially reduced, beginning in most cases for claims filled in the second quarter of 2010, when the DRE provisions were implemented. This has occurred even for the largest of MCOs and their PBMs, and the trend toward fewer and lower rebate contracts between MCOs and manufacturers is expected to continue. As this revenue source dwindles, MCOs pay more for the prescription drugs provided to their enrollees resulting in additional costs to their programs.

Recommendations

1. *Because of the actuarial soundness requirements in Medicaid law, states must be prepared to adjust MCO capitation rates for cost increases resulting from lower rebate revenue. The new MCO rebate money the states receive from the DRE will much more than offset the increase in capitation rates.*
2. *States should share federal rebate money with the MCOs as an incentive to provide accurate data to submit for rebates, as the rebates can be more than 15% of the total cost of the states prescription drug program.*

The April 2010 CMS State Medicaid Director letter indicates, “MCO capitation rates must be based on actual cost experience related to rebates” and subject to actuarial soundness. Rates, therefore, must be increased by states in Medicaid MCO contracts to reflect increased MCO pharmacy costs. MCOs are able to share their rebate experience with state Medicaid programs and state-contracted actuaries to help facilitate *actuarially sound* adjustments, but to date, many states have been slow to engage in these discussions.

States with Prescription Drug Benefit Carve-Outs

Before passage of ACA, because of higher rebates offered in fee-for-service, some states excluded or “carved-out” the prescription drug benefit from Medicaid MCO contracts (Attachment 1). In these states, beneficiaries enrolled in Medicaid MCOs receive drug coverage through the state’s FFS program. Now that DRE has been approved in the ACA, some states are re-considering whether to continue a carve-out and may move in the direction of having Medicaid MCOs coordinate both medical and pharmaceutical benefits. Such decisions will vary from state-to-state, taking into consideration various factors between the MCOs’ and the state’s fee-for-service programs, e.g., differences in pharmacy reimbursement rates; efficiency of utilization controls; percentage of rebate revenue collected; provider tax implications with a carve-in; and the total “per member per month” pharmacy cost (offset by rebate returns).

Illinois and Texas, who previously always carved-out the pharmacy benefit, have already taken steps to carve-in pharmacy for their managed care programs under DRE. Other carve-out changes are likely once states have had an opportunity to receive MCO drug data and manufacturer rebate revenue.

Challenges

Some States May Mandate Drugs To Be Covered On MCO Formularies or Require a Single Formulary For All Plans To Utilize. As carve-in concepts are being considered by states, there have been occasional discussions raised in a few states indicating that single, statewide formularies with uniform utilization management requirements may be needed. At the inception of the DRE provisions, there had been confusion amongst states as to whether or not they would be required to mandate that type of change on the Medicaid MCOs.

States Moving from a Pharmacy Carve-out to Carve-in Must Become Aware of Lost MCO Rebate Revenue. States which have recently moved to a carve-in system must recognize, as mentioned above, MCOs now have reduced power to negotiate rebates with manufacturers. As a result, Medicaid MCOs now pay more for the prescription drugs, but state costs are reduced by federal drug rebates not shared with MCOs.

Recommendations

1. *First and foremost, all states should include management of pharmaceutical benefits in their contracts with Medicaid MCOs.* This allows MCOs to coordinate care with complete knowledge of patients' history of care and prescription drug usage, thereby improving a MCO's ability to provide higher quality of care at lower costs. These savings will, in turn, reduce the total medical cost of the Medicaid program to the federal and state governments.
 2. *States should allow MCOs the flexibility to continue managing their own formularies and utilization review programs.* This stance was affirmed by CMS in its September 2010 DRE guidance to state Medicaid directors. States should neither implement a single, statewide formulary nor mandate particular drugs from which MCO providers must prescribe. MCOs also should be given the flexibility to customize utilization management programs to ensure the cost-effective and safe use of drugs.

There is recognition on the federal government's part that formulary management is one of the key tools that MCOs have used successfully to hold down pharmacy costs and ensure appropriate utilization of pharmaceuticals. By managing their own formularies
 3. *States must adequately compensate MCOs in their capitation rates for managing pharmaceutical benefits based on actuarial soundness requirements.* Increases to MCO capitation rates must recognize that Medicaid MCOs are no longer able to negotiate large scale manufacturer drug rebates. Any assumptions surrounding rebate yields for MCOs should be conservative in nature and states should project rebate yields to approach zero in future rate periods. States should consider sharing rebates received from the federal drug rebate program with Medicaid MCOs as an inducement to submitting accurate prescription drug data.
- and utilization management programs, Medicaid MCOs provide drug coverage in a more cost-effective manner via formulary management, high generic fill rates, comprehensive drug utilization, and coordination of care. In addition, the MCO's formulary is developed by clinicians to ensure it meets the unique needs of the population the MCO serves. Without such management, a formulary mandated by the state may not actually serve the state's best long-term pharmacy cost management interests and will actually increase the cost of prescription drugs.

Conclusion

While DRE implementation remains a challenge, effective and timely implementation is vital. By combining the new federal prescription drug rebate revenue with existing MCO drug utilization management capabilities, Medicaid MCOs will achieve improved quality of care for Medicaid beneficiaries as well as substantial savings. These savings will, in turn, substantially reduce the cost of the Medicaid program to the federal and state governments which is critical during this time of budget pressure in the states.

Attachment 1 – Pharmacy Carve-Outs & Medicaid Risk-Based Capitated MCO Contracts (14 States Have Full Pharmacy Carve-Outs)

States	Rx Carve-Out	Partial Carve-Out Drugs/Classes & Comments
1. Arizona	None	
2. California*	Partial	AIDS Drugs, Dependency Treatment, and Psychiatric Drugs
3. Colorado	None	
4. Connecticut	Full	
5. Delaware	Full	
6. District of Columbia	Full	
7. Florida*	None	
8. Georgia	None	
9. Hawaii	None	
10. Illinois	Full	Proposing to eliminate its full carve-out after drug rebate equalization
11. Indiana	Full	Implemented December 31, 2009
12. Kansas	Partial	Antihemophilic Factors
13. Kentucky	None	
14. Maryland	Partial	Mental Health Drugs, and HIV/AIDS Drugs
15. Massachusetts	None	
16. Michigan*	Partial	Psychotropics, HIV/AIDS Drugs, and Select Other Drugs. Proposing to possibly remove carve-out at next contract cycle.
17. Minnesota	None	
18. Missouri*	Full	Implemented October 1, 2009
19. Nebraska	Full	
20. Nevada	None	
21. New Jersey	Partial	HIV/AIDS Drugs, Antipsychotics, Antihemophilic Factors, and Rxs for ABD population
22. New Mexico*	None	
23. New York	Full	
24. Ohio*	Full	Implemented February, 2010
25. Oregon	Partial	Mental Health Drugs
26. Pennsylvania	None	
27. Rhode Island	None	
28. South Carolina	None	
29. Tennessee	Full	
30. Texas*	Full	Proposing to eliminate full carve-out in May 2012
31. Vermont	See Comments	Vermont has a one-of-a-kind waiver that allows the state to be treated – in terms of both payment methodology and flexibility – as an MCO by the federal government. This means that CMS pays the state a “per member per month” amount for each Medicaid beneficiary.
32. Virginia	None	
33. Washington*	Partial	OTC Contraceptives, and Rxs Written by a DDS
34. West Virginia	Full	
35. Wisconsin	Full	Implemented February 1, 2008

* = States with Molina capitated plans.

Sources: 2007 State Perspectives Medicaid Pharmacy Policies and Practices, available at <http://www.nasmd.org/resources/docs/PharmacyRpt1107.pdf> and HMA state-by-state research

Notes:

- Iowa previously used a full carve-out, but eliminated MCO plan options
- Mississippi is implementing capitated managed care and is not planning a full pharmacy carve-out.
- Utah is listed as having a full pharmacy carve-out in the above source.

Attachment 2 – Medicaid Pharmacy Spending, Federal Fiscal Year 2009 (Includes Fee-For-Service and MCO Carve-Out Prescriptions)

States	Rx Drug Spending	Manufacturer Drug Rebates				Total Rebates		Net Spending
		Federal		State Supplemental				
Alabama	\$ 448,641,634	\$ 131,468,996	29%	\$ 13,871,354	3%	\$ 145,340,350	32%	\$ 303,301,284
Alaska	\$ 73,660,169	\$ 22,376,165	30%	\$ -	0%	\$ 22,376,165	30%	\$ 51,284,004
Arizona	\$ 6,650,856	\$ -	0%	\$ -	0%	\$ -	0%	\$ 6,650,856
Arkansas	\$ 303,484,057	\$ 109,133,081	36%	\$ 2,843,431	1%	\$ 111,976,512	37%	\$ 191,507,545
California	\$ 3,071,402,000	\$ 1,026,773,826	33%	\$ 302,557,247	10%	\$ 1,329,331,073	43%	\$ 1,742,070,927
Colorado	\$ 226,950,721	\$ 64,082,437	28%	\$ -	0%	\$ 64,082,437	28%	\$ 162,868,284
Connecticut	\$ 385,666,859	\$ 84,795,226	22%	\$ 9,303,684	2%	\$ 94,098,910	24%	\$ 291,567,949
Delaware	\$ 116,231,202	\$ 50,189,267	43%	\$ -	0%	\$ 50,189,267	43%	\$ 66,041,935
District of Columbia	\$ 84,969,008	\$ 21,054,156	25%	\$ 2,402,296	3%	\$ 23,456,452	28%	\$ 61,512,556
Florida	\$ 1,062,743,845	\$ 396,177,220	37%	\$ 83,909,663	8%	\$ 480,086,883	45%	\$ 582,656,962
Georgia	\$ 442,845,728	\$ 151,144,111	34%	\$ 21,425,476	5%	\$ 172,569,587	39%	\$ 270,276,141
Hawaii	\$ 77,468,903	\$ 18,216,203	24%	\$ 1,191,697	2%	\$ 19,407,900	25%	\$ 58,061,003
Idaho	\$ 103,842,869	\$ 41,710,166	40%	\$ 4,169,096	4%	\$ 45,879,262	44%	\$ 57,963,607
Illinois	\$ 989,865,932	\$ 351,373,993	35%	\$ 77,007,668	8%	\$ 428,381,661	43%	\$ 561,484,271
Indiana	\$ 302,073,002	\$ 135,051,407	45%	\$ 6,025,558	2%	\$ 141,076,965	47%	\$ 160,996,037
Iowa	\$ 235,797,697	\$ 76,377,827	32%	\$ 13,096,615	6%	\$ 89,474,442	38%	\$ 146,323,255
Kansas	\$ 158,131,350	\$ 56,663,476	36%	\$ 4,827,017	3%	\$ 61,490,493	39%	\$ 96,640,857
Kentucky	\$ 524,069,372	\$ 157,805,272	30%	\$ 22,849,603	4%	\$ 180,654,875	34%	\$ 343,414,497
Louisiana	\$ 871,329,715	\$ 210,926,809	24%	\$ 32,321,143	4%	\$ 243,247,952	28%	\$ 628,081,763
Maine	\$ 201,213,863	\$ 73,465,693	37%	\$ 13,906,539	7%	\$ 87,372,232	43%	\$ 113,841,631
Maryland	\$ 268,162,801	\$ 67,967,039	25%	\$ -	0%	\$ 67,967,039	25%	\$ 200,195,762
Massachusetts	\$ 476,415,023	\$ 149,835,961	31%	\$ -	0%	\$ 149,835,961	31%	\$ 326,579,062
Michigan	\$ 456,363,097	\$ 193,023,565	42%	\$ 13,231,860	3%	\$ 206,255,425	45%	\$ 250,107,672
Minnesota	\$ 241,940,071	\$ 87,567,196	36%	\$ 11,095,985	5%	\$ 98,663,181	41%	\$ 143,276,890
Mississippi	\$ 316,079,591	\$ 93,900,957	30%	\$ 14,709,434	5%	\$ 108,610,391	34%	\$ 207,469,200
Missouri	\$ 636,841,127	\$ 207,080,102	33%	\$ -	0%	\$ 207,080,102	33%	\$ 429,761,025
Montana	\$ 63,095,101	\$ 25,087,889	40%	\$ -	0%	\$ 25,087,889	40%	\$ 38,007,212
Nebraska	\$ 154,768,783	\$ 54,926,201	35%	\$ -	0%	\$ 54,926,201	35%	\$ 99,842,582
Nevada	\$ 88,022,274	\$ 29,974,804	34%	\$ 1,979,301	2%	\$ 31,954,105	36%	\$ 56,068,169
New Hampshire	\$ 77,608,959	\$ 29,402,483	38%	\$ 2,720,507	4%	\$ 32,122,990	41%	\$ 45,485,969
New Jersey	\$ 577,834,879	\$ 152,518,686	26%	\$ -	0%	\$ 152,518,686	26%	\$ 425,316,193
New Mexico	\$ 17,708,157	\$ 5,021,038	28%	\$ -	0%	\$ 5,021,038	28%	\$ 12,687,119
New York	\$ 3,674,701,016	\$ 1,098,114,682	30%	\$ 158,211,921	4%	\$ 1,256,326,603	34%	\$ 2,418,374,413
North Carolina	\$ 1,075,540,208	\$ 307,267,714	29%	\$ -	0%	\$ 307,267,714	29%	\$ 768,272,494
North Dakota	\$ 31,514,471	\$ 10,554,912	33%	\$ -	0%	\$ 10,554,912	33%	\$ 20,959,559
Ohio	\$ 476,608,881	\$ 182,914,547	38%	\$ 23,214,658	5%	\$ 206,129,205	43%	\$ 270,479,676
Oklahoma	\$ 361,453,943	\$ 118,639,225	33%	\$ -	0%	\$ 118,639,225	33%	\$ 242,814,718
Oregon	\$ 149,258,095	\$ 41,676,239	28%	\$ -	0%	\$ 41,676,239	28%	\$ 107,581,856
Pennsylvania	\$ 406,058,820	\$ 170,085,503	42%	\$ 14,653,124	4%	\$ 184,738,627	45%	\$ 221,320,193
Rhode Island	\$ 52,620,256	\$ 27,009,724	51%	\$ -	0%	\$ 27,009,724	51%	\$ 25,610,532
South Carolina	\$ 352,550,150	\$ 148,302,418	42%	\$ -	0%	\$ 148,302,418	42%	\$ 204,247,732
South Dakota	\$ 50,454,530	\$ 16,566,759	33%	\$ -	0%	\$ 16,566,759	33%	\$ 33,887,771
Tennessee	\$ 717,597,507	\$ 261,529,787	36%	\$ 28,842,822	4%	\$ 290,372,609	40%	\$ 427,224,898
Texas	\$ 1,994,785,341	\$ 770,115,115	39%	\$ -	0%	\$ 770,115,115	39%	\$ 1,224,670,226
Utah	\$ 142,935,778	\$ 47,420,831	33%	\$ 1,790	0.001%	\$ 47,422,621	33%	\$ 95,513,157
Vermont	\$ 2,881,537	\$ 997,406	35%	\$ 136,411	5%	\$ 1,133,817	39%	\$ 1,747,720
Virginia	\$ 228,269,379	\$ 84,927,683	37%	\$ 4,193,702	2%	\$ 89,121,385	39%	\$ 139,147,994
Washington	\$ 420,012,426	\$ 145,726,769	35%	\$ 6,894,911	2%	\$ 152,621,680	36%	\$ 267,390,746
West Virginia	\$ 344,813,072	\$ 125,544,225	36%	\$ 27,921,836	8%	\$ 153,466,061	45%	\$ 191,347,011
Wisconsin	\$ 465,420,037	\$ 181,443,672	39%	\$ 505,764	0.11%	\$ 181,949,436	39%	\$ 283,470,601
Wyoming	\$ 38,615,769	\$ 11,271,922	29%	\$ -	0%	\$ 11,271,922	29%	\$ 27,343,847
United States	\$ 24,047,969,861	\$ 8,025,200,385	33%	\$ 920,022,113	4%	\$ 8,945,222,498	37%	\$ 15,102,747,363

Sources: CMS-64 Quarterly Expense Report, special data request, Federal Fiscal Year 2009 (Oct 1 through Sep 30)