STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
CALIFORNIA

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
CALIFORNIA, 2003

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)		Number of Dual Eligible Beneficiaries (Cell)[g]		Number of Non-dual Eligible Beneficiaries (Cell)	
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	10,233,590	(A)	1,065,089	(E)	9,168,501	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	9,229,518	(B)	1,050,210	(F)	8,179,308	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	6,158,126	(C)	903,088	(G)	5,255,038	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	58,977	(D)	52,100	(H)	6,877	(L)

Source: Data for this table are from the MAX 2003 file for California, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. MAX data element "Eligible Months Count" was used to determine an individual's Medicaid eligibility. All individuals who had a value greater than zero were considered as beneficiaries and counted in Cell A.

b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2003 (based on MAX data element "Eligible Restricted Benefits Flag").

c. Cell C represents the study population for Tables 2 through 7. Cell C was obtained by excluding from Cell B beneficiaries who were in managed care (MC) plans that included prescription drugs in their capitated benefit package during all months of Medicaid eligibility in 2003, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.

d. The total Medicaid pharmacy reimbursement for California in 2003 was $4,024,228,484, of which $186,823,451 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

e. Enrollees in prepaid health plans (PHP) or managed care (MC) plans that did not provide a pharmacy benefit are treated as having fee-for-service pharmacy benefit coverage. There were 19 states in 2003 that had PHPs that did not include a pharmacy benefit: AL, AR, CA, CO, FL, GA, IA, KY, MA, MI, NY, OR, PA, SD, TN, TX, UT, WA, and WI. In addition, there were 7 states in which MC plans did not provide a pharmacy benefit: DE, IA, NE, NY, TX, UT, and WV. These lists were constructed from the CMS 2003 Medicaid Managed Care Enrollment Report [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer02.pdf] and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit package.

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2003. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.

g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the benficiary had a fee-for-service pharmacy benefit.

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2003. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

Characteristics of non-dual eligible beneficiaries represented by Cell J are shown in Appendix Table A.1 and characteristics of non-dual eligible beneficiaries and their benefit months included in Cell J but excluded from Cell K are shown in Appendix Table A.2. Characteristics of dual eligible beneficiaries represented by Cell F are shown in Appendix Table A.3, and characteristics of dual eligible beneficiaries and their benefit months included in Cell F but excluded from Cell G are shown in Appendix Table A.4.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; HMO = health maintenance organization; MAX = Medicaid Analytic Extract; MC = managed care; PCCM = primary care case management; PHP = prepaid health plan.

TABLE 2

CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY[a, b]

CALIFORNIA, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**6,158,126**	**583,664**	**856,264**	**2,915,710**	**1,802,485**	**3**	**46,156,295**	**6,200,692**	**9,312,611**	**20,692,777**	**9,950,201**	**14**
Age												
5 and younger	782,539	3	15,736	6	766,793	1	3,695,749	28	147,941	18	3,547,761	1
6-14	662,569	3	41,430	236	620,900	0	4,232,421	21	449,095	789	3,782,516	0
15-20	852,093	15	33,784	415,870	402,424	0	5,912,451	127	363,780	2,981,190	2,567,354	0
21-44	2,525,037	1,224	233,354	2,278,118	12,340	1	18,881,691	10,595	2,528,867	16,289,767	52,461	1
45-64	607,903	3,272	384,354	220,269	7	1	5,575,214	30,791	4,131,142	1,413,243	26	12
65-74	350,065	243,171	105,891	1,002	1	0	3,774,520	2,550,243	1,217,904	6,361	12	0
75-84	265,805	232,279	33,373	152	1	0	2,918,878	2,535,554	382,208	1,104	12	0
85 and older	112,101	103,697	8,342	57	5	0	1,165,351	1,073,333	91,674	305	39	0
Unknown	14	0	0	0	14	0	20	0	0	0	20	0
Gender												
Female	4,146,576	371,856	439,063	2,386,189	949,466	2	31,462,268	3,971,735	4,826,120	17,351,186	5,313,214	13
Male	2,011,533	211,807	417,201	529,521	853,003	1	14,693,977	2,228,955	4,486,491	3,341,591	4,636,939	1
Unknown	17	1	0	0	16	0	50	2	0	0	48	0
Race												
White	1,640,041	201,892	375,393	613,555	449,201	0	13,661,070	2,087,123	4,077,638	4,323,101	3,173,208	0
African American	544,868	32,774	139,593	205,800	166,701	0	4,075,577	340,688	1,509,006	1,297,113	928,770	0
Other/unknown	3,973,217	348,998	341,278	2,096,355	1,186,583	3	28,419,648	3,772,881	3,725,967	15,072,563	5,848,223	14
Use of Nursing Facilities[c]												
Entire year	58,977	45,429	13,486	27	35	0	613,643	465,682	147,376	213	372	0
Part year	52,878	34,315	18,195	302	66	0	517,134	323,389	191,198	2,023	524	0
None	6,046,271	503,920	824,583	2,915,381	1,802,384	3	45,025,518	5,411,621	8,974,037	20,690,541	9,949,305	14
Maintenance Assistance Status												
Cash	2,275,672	324,646	692,783	454,052	804,191	0	18,633,908	3,696,107	7,742,162	2,538,469	4,657,170	0
Medically needy	528,277	163,724	68,461	97,980	198,112	0	3,495,250	1,571,737	640,339	411,337	871,837	0
Poverty-related	409,587	72,634	44,108	95,476	197,369	0	2,519,509	701,996	423,441	516,318	877,754	0
Other/unknown	2,944,590	22,660	50,912	2,268,202	602,813	3	21,507,628	230,852	506,669	17,226,653	3,543,440	14
Dual Medicare Status[d]												
Full dual, all year	894,436	506,443	381,160	6,776	57	0	9,764,936	5,456,627	4,258,009	49,897	403	0
Full dual, part year	8,652	6,499	2,088	65	0	0	83,521	62,633	20,388	500	0	0
Non-dual, all year	5,255,038	70,722	473,016	2,908,869	1,802,428	3	36,307,838	681,432	5,034,214	20,642,380	9,949,798	14
Managed Care (MC) Status												
Fee-for-service (FFS) all year	5,065,591	573,638	822,625	2,592,084	1,077,242	2	42,335,542	6,147,439	9,129,861	19,588,078	7,470,151	13
FFS part year, with Rx claims	343,024	6,719	24,622	106,589	205,094	0	1,491,811	40,952	144,996	455,151	850,712	0
FFS part year, no Rx claims	749,511	3,307	9,017	217,037	520,149	1	2,328,942	12,301	37,754	649,548	1,629,338	1

Source: Data for this table are from the MAX 2003 file for California, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 2 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services. The total includes some beneficiaries with unknown basis of eligibility and some whose age categories are not consistent with basis of eligibility.

c. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2003. The “Full dual, part year” group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service pharmacy benefit; MAX = Medicaid Analytic Extract; MC = managed care; Rx = pharmacy benefit.

TABLE 3

ANNUAL MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFICIARY, BY BENEFICIARY CHARACTERISTIC[a, b]

CALIFORNIA, 2003

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**40.7 %**	**7.5**	**$623**	**$83**	**$3,002**	**20.8 %**	**6,158,126**
Age							
5 and younger	35.0	1.4	50	35	1,304	3.8	782,539
6-14	32.1	2.0	146	73	1,726	8.4	662,569
15-20	25.7	1.3	99	74	1,210	8.2	852,093
21-44	31.8	3.1	322	103	1,688	19.1	2,525,037
45-64	63.3	22.2	2,091	94	7,663	27.3	607,903
65-74	82.2	27.2	2,068	76	6,267	33.0	350,065
75-84	85.5	31.4	2,228	71	9,299	24.0	265,805
85 and older	86.0	31.9	1,947	61	15,191	12.8	112,101
Unknown	0.0	0.0	0	0	36	0.0	14
Basis of Eligibility[e]							
Aged	82.1	27.0	1,898	70	8,423	22.5	583,664
Disabled	80.9	29.1	2,798	96	11,581	24.2	856,264
Adults	26.7	1.1	74	65	590	12.5	2,915,710
Children	30.9	1.4	66	48	1,071	6.2	1,802,485
Unknown	33.3	9.0	945	105	1,375	68.7	3
Gender							
Female	40.2	7.0	537	76	2,603	20.6	4,146,576
Male	41.7	8.6	802	93	3,824	21.0	2,011,533
Unknown	29.4	0.9	14	16	589	2.4	17
Race							
White	50.0	13.0	1,105	85	5,115	21.6	1,640,041
African American	40.8	8.6	719	83	4,183	17.2	544,868
Other/unknown	36.8	5.2	411	80	1,967	20.9	3,973,217
Use of Nursing Facilities[f]							
Entire year	93.3	57.3	3,303	58	42,546	7.8	58,977
Part year	94.1	44.6	3,017	68	27,757	10.9	52,878
None	39.7	6.7	576	86	2,399	24.0	6,046,271
Maintenance Assistance Status							
Cash	58.9	14.4	1,232	85	5,076	24.3	2,275,672
Medically needy	48.8	13.3	981	74	8,052	12.2	528,277
Poverty related	41.9	6.7	566	85	2,404	23.5	409,587
Other/unknown	25.0	1.3	97	74	575	16.8	2,944,590

Source: Data for this table are from the MAX 2003 file for California, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 3 includes beneficiaries represented by Cell C of Table 1.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. In seven states (DE, IA, NE, NY, TX, UT, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.

d. In seven states (DE, IA, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; OTC = over-the-counter; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 4

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT *PER BENEFIT MONTH*, BY BENEFICIARY CHARACTERISTIC[a, b]

CALIFORNIA, 2003

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Number Beneficiaries	Benefit Months
All	**1.0**	**$83**	**20.8 %**	**59.3 %**	**25.8 %**	**4.6 %**	**7.2 %**	**2.6 %**	**0.4 %**	**$401**	**6,158,126**	**46,156,295**
Age												
5 and younger	0.3	11	3.8	65.0	31.3	2.6	1.0	0.1	0.0	276	782,539	3,695,749
6-14	0.3	23	8.4	67.9	28.1	2.3	1.4	0.2	0.0	270	662,569	4,232,421
15-20	0.2	14	8.2	74.3	23.2	1.4	0.9	0.1	0.0	174	852,093	5,912,451
21-44	0.4	43	19.1	68.2	25.9	2.2	2.6	0.9	0.2	226	2,525,037	18,881,691
45-64	2.4	228	27.3	36.7	20.8	10.3	21.4	9.3	1.7	836	607,903	5,575,214
65-74	2.5	192	33.0	17.8	27.1	16.0	28.4	9.4	1.3	581	350,065	3,774,520
75-84	2.9	203	24.0	14.5	23.4	16.3	32.1	11.9	1.8	847	265,805	2,918,878
85 and older	3.1	187	12.8	14.0	21.3	15.5	32.7	14.4	2.1	1,461	112,101	1,165,351
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	25	14	20
Basis of Eligibility[e]												
Aged	2.5	179	22.5	17.9	26.5	16.1	28.4	9.7	1.4	793	583,664	6,200,692
Disabled	2.7	257	24.2	19.1	26.5	13.4	27.3	11.7	2.0	1,065	856,264	9,312,611
Adults	0.2	10	12.5	73.3	24.3	1.3	0.9	0.1	0.0	83	2,915,710	20,692,777
Children	0.2	12	6.2	69.1	27.8	2.1	0.9	0.1	0.0	194	1,802,485	9,950,201
Unknown	1.9	202	68.7	66.7	0.0	33.3	0.0	0.0	0.0	295	3	14
Gender												
Female	0.9	71	20.6	59.8	26.6	4.1	6.6	2.5	0.4	343	4,146,576	31,462,268
Male	1.2	110	21.0	58.3	24.3	5.6	8.3	3.0	0.5	524	2,011,533	14,693,977
Unknown	0.3	5	2.4	70.6	23.5	5.9	0.0	0.0	0.0	200	17	50
Race												
White	1.6	133	21.6	50.0	26.0	6.2	11.4	5.4	1.0	614	1,640,041	13,661,070
African American	1.2	96	17.2	59.2	23.8	5.1	8.4	3.1	0.5	559	544,868	4,075,577
Other/unknown	0.7	58	20.9	63.2	26.1	3.9	5.3	1.4	0.2	275	3,973,217	28,419,648
Use of Nursing Facilities[f]												
Entire year	5.5	318	7.8	6.7	9.2	8.9	32.1	32.9	10.3	4,089	58,977	613,643
Part year	4.6	309	10.9	5.9	14.1	12.8	36.1	25.2	5.9	2,838	52,878	517,134
None	0.9	77	24.0	60.3	26.1	4.5	6.7	2.1	0.3	322	6,046,271	45,025,518
Maintenance Assistance Status												
Cash	1.8	150	24.3	41.1	30.2	8.6	14.3	5.0	0.7	620	2,275,672	18,633,908
Medically needy	2.0	148	12.2	51.2	22.0	7.2	12.0	6.2	1.4	1,217	528,277	3,495,250
Poverty related	1.1	92	23.5	58.1	27.1	5.3	7.2	2.1	0.3	391	409,587	2,519,509
Other/unknown	0.2	13	16.8	75.0	23.0	0.9	0.8	0.2	0.0	79	2,944,590	21,507,628

Source: Data for this table are from the MAX 2003 file for California, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 4 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. In seven states (DE, IA, NE, NY, TX, UT, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.

d. In seven states (DE, IA, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 5

AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC[a, b, c]

CALIFORNIA, 2003

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.0**	**$83**	**$83**	**0.5**	**$67**	**$142**	**0.0**	**$4**	**$81**	**0.5**	**$12**	**$25**
Age												
5 and younger	0.3	11	35	0.1	7	110	0.0	0	45	0.2	3	14
6-14	0.3	23	73	0.1	18	140	0.0	1	106	0.2	4	22
15-20	0.2	14	74	0.1	11	126	0.0	1	98	0.1	2	24
21-44	0.4	43	103	0.2	35	180	0.0	2	99	0.2	6	29
45-64	2.4	228	94	1.1	185	168	0.1	10	91	1.2	32	27
65-74	2.5	192	76	1.3	155	121	0.1	9	76	1.1	28	25
75-84	2.9	203	71	1.4	162	115	0.1	9	65	1.3	32	25
85 and older	3.1	187	61	1.4	145	105	0.2	8	49	1.5	34	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	2.5	179	70	1.3	143	114	0.1	8	64	1.2	28	24
Disabled	2.7	257	96	1.2	210	169	0.1	11	91	1.3	35	27
Adults	0.2	10	65	0.1	8	99	0.0	1	87	0.1	2	28
Children	0.2	12	48	0.1	9	111	0.0	1	78	0.2	3	17
Unknown	1.9	202	105	1.4	187	131	0.2	10	47	0.3	6	20
Gender												
Female	0.9	71	76	0.4	56	129	0.0	3	77	0.4	11	25
Male	1.2	110	93	0.5	89	166	0.1	5	88	0.6	16	27
Unknown	0.3	5	16	0.1	3	48	0.0	0	0	0.2	2	8
Race												
White	1.6	133	85	0.7	107	148	0.1	6	80	0.8	20	26
African American	1.2	96	83	0.5	77	160	0.1	4	77	0.6	15	24
Other/unknown	0.7	58	80	0.3	46	133	0.0	3	83	0.3	9	25
Use of Nursing Facilities[e]												
Entire year	5.5	318	58	2.2	237	107	0.3	14	43	3.0	66	22
Part year	4.6	309	68	1.9	238	126	0.2	13	53	2.4	57	24
None	0.9	77	86	0.4	63	146	0.0	4	87	0.4	11	26
Maintenance Assistance Status												
Cash	1.8	150	85	0.8	122	147	0.1	7	86	0.9	22	25
Medically needy	2.0	148	74	0.9	118	133	0.1	6	58	1.0	24	23
Poverty related	1.1	92	85	0.5	75	153	0.0	4	80	0.5	13	24
Other/unknown	0.2	13	74	0.1	10	113	0.0	1	87	0.1	2	30

Source: Data for this table are from the MAX 2003 file for California, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 5 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In California, 1.1 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007)

d. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

e. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 6

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY[a, b, c, d]

CALIFORNIA, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.2	$26	$22	$0	$3	$91	$193	$81	$20	3,928,131	$359,158,796	1,404,016	22.8 %	13,961,402
Biologicals	0.1	0.1	0.0	0.0	66	43	5	18	499	462	3,634	474	28,815	14,368,847	19,768	0.3	216,546
Antineoplastic Agents	0.4	0.1	0.0	0.2	107	80	2	24	274	568	229	103	211,494	57,988,297	50,147	0.8	543,800
Endocrine/Metabolic Drugs	0.5	0.2	0.1	0.2	39	28	7	5	80	111	77	32	5,133,494	408,810,413	1,024,418	16.6	10,423,757
Cardiovascular Agents	1.1	0.5	0.0	0.5	69	53	2	14	63	102	52	26	9,714,651	608,575,267	797,124	12.9	8,860,898
Respiratory Agents	0.5	0.2	0.0	0.2	28	20	2	5	60	90	107	25	4,079,960	243,890,457	846,857	13.8	8,852,518
Gastrointestinal Agents	0.5	0.3	0.0	0.2	57	51	1	5	114	173	145	27	3,139,540	358,048,561	565,721	9.2	6,264,884
Genitourinary Agents	0.3	0.2	0.0	0.0	18	16	0	1	70	80	50	28	867,432	60,415,924	333,056	5.4	3,408,826
CNS Drugs	0.9	0.5	0.0	0.4	108	92	4	12	118	186	119	30	6,853,018	807,355,053	683,623	11.1	7,485,179
Stimulants/Anti-obesity/Anorexia	0.5	0.3	0.0	0.1	52	39	4	9	114	133	128	69	156,175	17,799,520	31,901	0.5	343,216
Miscellaneous Psychological/ Neurological Agents	0.5	0.4	0.0	0.1	74	73	0	1	161	178	22	19	215,075	34,534,474	41,170	0.7	463,669
Analgesics and Anesthetics	0.5	0.2	0.0	0.3	33	27	1	6	71	176	112	18	4,990,309	355,477,680	1,019,985	16.6	10,743,236
Neuromuscular Agents	0.8	0.3	0.0	0.4	64	50	2	12	84	155	55	30	2,721,857	229,259,232	323,836	5.3	3,606,393
Nutritional Products	0.3	0.0	0.0	0.3	5	0	0	4	15	43	41	14	564,667	8,660,974	177,553	2.9	1,820,101
Hematological Agents	0.5	0.2	0.0	0.3	62	55	1	6	124	307	30	21	1,065,553	132,128,557	191,655	3.1	2,120,580
Topical Products	0.3	0.1	0.0	0.2	14	10	1	4	41	71	60	19	2,602,335	107,313,750	754,610	12.3	7,875,186
Miscellaneous Products	0.3	0.1	0.0	0.2	69	50	11	8	223	420	351	49	113,423	25,290,660	36,265	0.6	369,019
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	25	0	0	0	121	0	0	0	68,749	8,328,571	30,712	0.5	329,660
TOTAL NO. OF RX AND RX $	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	46,454,678	3,837,405,033	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for California, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 6 includes the beneficiaries represented by Cell C of Table 1. A beneficiary who used drugs from two or more categories was counted as a user for each category. Therefore, the sum of users across categories may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. For information about these therapeutic categories, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In California, 1.1 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2003.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; CNS = Central Nervous System; MAX = Medicaid Analytic Extract; n.a. = not applicable; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 7

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY TOP 10 DRUG GROUP[a, b, c]

CALIFORNIA, 2003

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$515,510,772	334,606	5.4 %	3,780,654	0.6	$229	$136
ULCER DRUGS	293,096,566	571,271	9.3	6,394,800	0.4	125	46
ANTIHYPERLIPIDEMIC	239,548,227	386,530	6.3	4,415,259	0.4	130	54
ANTIDEPRESSANTS	215,752,609	551,780	9.0	6,111,639	0.5	77	35
ANTIDIABETIC	215,167,675	467,267	7.6	5,221,721	0.5	85	41
ANTIVIRAL	204,284,140	103,177	1.7	1,124,369	0.5	404	182
ANALGESICS - ANTI-INFLAMMATORY	203,936,595	823,312	13.4	8,918,743	0.3	87	23
ANTICONVULSANT	197,102,467	307,383	5.0	3,458,295	0.6	98	57
ANTIHYPERTENSIVE	187,083,936	603,073	9.8	6,819,211	0.4	63	27
ANTIASTHMATIC	144,059,573	645,393	10.5	6,876,259	0.3	69	21
Total	2,415,542,560	4,793,792		53,120,950	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for California, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2003. A beneficiary who used drugs from two or more groups was counted as a user for each group. Therefore, the sum of users across drug groups may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. The top 10 drug groups were determined based on total Medicaid reimbursement in the state for 2003. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.