STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
D.C.

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
D.C., 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]	157,869	(A)	19,308	(E)	138,561	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	155,043	(B)	18,014	(F)	137,029	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	70,708	(C)	17,793	(G)	52,915	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	2,550	(D)	2,083	(H)	467	(L)

Source: Data for this table are from the MAX 2003 file for D.C., released by CMS in 04/2007. 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 D.C. in 2003 was $87,371,664, of which $1,290,040 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]

D.C., 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	**70,708**	**9,494**	**27,224**	**12,216**	**21,774**	**0**	**537,354**	**99,425**	**279,747**	**50,631**	**107,551**	**0**
Age												
5 and younger	8,718	0	558	4	8,156	0	35,725	0	3,989	24	31,712	0
6-14	10,596	0	1,602	2	8,992	0	60,158	0	13,636	10	46,512	0
15-20	6,311	0	923	819	4,569	0	40,008	0	8,316	2,641	29,051	0
21-44	16,167	4	8,072	8,040	51	0	112,129	33	83,360	28,524	212	0
45-64	15,921	30	12,619	3,272	0	0	151,652	244	132,407	19,001	0	0
65-74	5,869	3,368	2,436	65	0	0	62,389	35,014	27,016	359	0	0
75-84	4,591	3,766	811	14	0	0	49,188	40,251	8,865	72	0	0
85 and older	2,529	2,326	203	0	0	0	26,041	23,883	2,158	0	0	0
Unknown	6	0	0	0	6	0	64	0	0	0	64	0
Gender												
Female	40,203	6,831	13,518	9,168	10,686	0	302,309	72,736	142,968	34,786	51,819	0
Male	30,502	2,663	13,706	3,048	11,085	0	235,041	26,689	136,779	15,845	55,728	0
Unknown	3	0	0	0	3	4 0		0	0	0	4	0
Race												
White	2,203	586	1,263	199	155	0	20,755	6,091	12,916	980	768	0
African American	59,546	7,411	22,893	10,971	18,271	0	450,079	77,011	233,862	45,471	93,735	0
Other/unknown	8,959	1,497	3,068	1,046	3,348	0	66,520	16,323	32,969	4,180	13,048	0
Use of Nursing Facilities[c]												
Entire year	2,550	2,087	414	49	0	0	27,501	22,427	4,542	532	0	0
Part year	1,777	1,104	619	54	0	0	17,874	10,855	6,532	487	0	0
None	66,381	6,303	26,191	12,113	21,774	0	491,979	66,143	268,673	49,612	107,551	0
Maintenance Assistance Status												
Cash	36,042	2,909	19,831	7,063	6,239	0	290,521	32,494	211,321	25,253	21,453	0
Medically needy	15,289	3,324	4,643	2,880	4,442	0	99,607	32,487	40,003	11,875	15,242	0
Poverty-related	11,394	2,276	2,457	490	6,171	0	70,875	24,405	25,365	1,408	19,697	0
Other/unknown	7,983	985	293	1,783	4,922	0	76,351	10,039	3,058	12,095	51,159	0
Dual Medicare Status[d]												
Full dual, all year	17,325	8,164	8,790	368	3	0	185,260	86,715	95,888	2,637	20	0
Full dual, part year	468	257	196	15	0	0	4,914	2,726	2,069	119	0	0
Non-dual, all year	52,915	1,073	18,238	11,833	21,771	0	347,180	9,984	181,790	47,875	107,531	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	48,172	9,483	25,838	4,757	8,094	0	467,185	99,372	273,144	29,011	65,658	0
FFS part year, with Rx claims	4,648	5	589	1,951	2,103	0	18,050	32	3,552	6,444	8,022	0
FFS part year, no Rx claims	17,888	6	797	5,508	11,577	0	52,119	21	3,051	15,176	33,871	0

Source: Data for this table are from the MAX 2003 file for D.C., released by CMS in 04/2007. 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]

D.C., 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	**47.2 %**	**15.0**	**$1,217**	**$81**	**$11,864**	**10.3 %**	**70,708**
Age							
5 and younger	21.3	0.8	56	71	3,952	1.4	8,718
6-14	23.3	2.3	204	90	4,871	4.2	10,596
15-20	29.0	2.6	196	75	7,480	2.6	6,311
21-44	47.4	11.6	1,402	121	11,158	12.6	16,167
45-64	70.5	29.2	2,534	87	17,925	14.1	15,921
65-74	71.3	31.9	1,768	56	14,232	12.4	5,869
75-84	65.0	28.1	1,444	51	19,026	7.6	4,591
85 and older	45.5	18.1	866	48	27,252	3.2	2,529
Unknown	0.0	0.0	0	0	0	0.0	6
Basis of Eligibility[e]							
Aged	57.7	23.4	1,237	53	20,710	6.0	9,494
Disabled	70.5	28.1	2,451	87	18,229	13.4	27,224
Adults	32.8	3.5	406	117	3,653	11.1	12,216
Children	21.5	1.5	122	80	4,654	2.6	21,774
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	49.6	16.9	1,179	70	11,243	10.5	40,203
Male	44.0	12.5	1,268	101	12,683	10.0	30,502
Unknown	33.3	0.3	7	21	2,494	0.3	3
Race							
White	51.8	22.8	2,056	90	19,045	10.8	2,203
African American	47.4	14.9	1,209	81	11,939	10.1	59,546
Other/unknown	44.4	13.8	1,066	77	9,595	11.1	8,959
Use of Nursing Facilities[f]							
Entire year	17.6	12.8	723	56	59,213	1.2	2,550
Part year	55.0	24.2	1,672	69	49,331	3.4	1,777
None	48.1	14.8	1,224	83	9,042	13.5	66,381
Maintenance Assistance Status							
Cash	53.4	18.6	1,555	84	11,113	14.0	36,042
Medically needy	33.1	10.1	879	87	19,605	4.5	15,289
Poverty related	41.8	14.4	1,005	70	4,760	21.1	11,394
Other/unknown	53.7	9.4	645	69	10,563	6.1	7,983

Source: Data for this table are from the MAX 2003 file for D.C., released by CMS in 04/2007. 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]

D.C., 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	Number: Benefit Months
All	**2.0**	**$160**	**10.3 %**	**52.8 %**	**19.7 %**	**6.9 %**	**12.6 %**	**6.7 %**	**1.3 %**	**$1,561**	**70,708**	**537,354**
Age												
5 and younger	0.2	14	1.4	78.7	18.8	1.6	0.7	0.1	0.0	965	8,718	35,725
6-14	0.4	36	4.2	76.7	18.1	2.6	2.2	0.4	0.0	858	10,596	60,158
15-20	0.4	31	2.6	71.0	22.8	3.4	2.4	0.4	0.0	1,180	6,311	40,008
21-44	1.7	202	12.6	52.6	23.6	7.7	10.7	4.5	0.9	1,609	16,167	112,129
45-64	3.1	266	14.1	29.5	20.1	10.8	22.7	13.8	3.1	1,882	15,921	151,652
65-74	3.0	166	12.4	28.7	16.7	10.1	25.8	16.1	2.5	1,339	5,869	62,389
75-84	2.6	135	7.6	35.0	14.1	10.9	25.1	13.1	1.7	1,776	4,591	49,188
85 and older	1.8	84	3.2	54.5	11.7	7.2	16.9	8.5	1.2	2,647	2,529	26,041
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	6	64
Basis of Eligibility[e]												
Aged	2.2	118	6.0	42.3	14.7	9.4	21.2	10.7	1.6	1,978	9,494	99,425
Disabled	2.7	239	13.4	29.5	22.8	10.4	21.7	13.0	2.6	1,774	27,224	279,747
Adults	0.8	98	11.1	67.2	20.3	5.6	5.4	1.4	0.2	881	12,216	50,631
Children	0.3	25	2.6	78.5	17.8	2.2	1.4	0.2	0.0	942	21,774	107,551
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.2	157	10.5	50.4	19.4	7.2	13.8	7.8	1.5	1,495	40,203	302,309
Male	1.6	165	10.0	56.0	20.2	6.5	11.0	5.4	0.9	1,646	30,502	235,041
Unknown	0.3	5	0.3	66.7	33.3	0.0	0.0	0.0	0.0	1,871	3	4
Race												
White	2.4	218	10.8	48.2	14.8	6.8	16.4	10.7	3.1	2,021	2,203	20,755
African American	2.0	160	10.1	52.6	20.1	6.9	12.3	6.7	1.3	1,580	59,546	450,079
Other/unknown	1.9	144	11.1	55.6	18.1	6.6	13.1	5.9	0.8	1,292	8,959	66,520
Use of Nursing Facilities[f]												
Entire year	1.2	67	1.2	82.4	2.0	1.5	4.2	6.3	3.6	5,490	2,550	27,501
Part year	2.4	166	3.4	45.0	15.3	8.1	17.2	10.9	3.6	4,904	1,777	17,874
None	2.0	165	13.5	51.9	20.5	7.1	12.8	6.7	1.1	1,220	66,381	491,979
Maintenance Assistance Status												
Cash	2.3	193	14.0	46.6	20.5	7.8	15.0	8.4	1.6	1,379	36,042	290,521
Medically needy	1.5	135	4.5	66.9	14.0	4.8	8.3	4.7	1.3	3,009	15,289	99,607
Poverty related	2.3	162	21.1	58.2	15.5	6.1	12.5	6.7	1.0	765	11,394	70,875
Other/unknown	1.0	68	6.1	46.3	33.2	7.6	9.7	3.2	0.1	1,104	7,983	76,351

Source: Data for this table are from the MAX 2003 file for D.C., released by CMS in 04/2007. 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]

D.C., 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	**2.0**	**$160**	**$81**	**0.9**	**$133**	**$149**	**0.0**	**$2**	**$45**	**1.0**	**$25**	**$24**
Age												
5 and younger	0.2	14	71	0.1	12	158	0.0	0	37	0.1	2	18
6-14	0.4	36	90	0.3	32	125	0.0	1	75	0.1	3	23
15-20	0.4	31	75	0.2	27	116	0.0	0	54	0.2	4	22
21-44	1.7	202	121	0.8	178	220	0.0	2	52	0.8	21	26
45-64	3.1	266	87	1.3	223	167	0.1	3	43	1.7	40	24
65-74	3.0	166	56	1.3	125	96	0.1	3	43	1.6	38	23
75-84	2.6	135	51	1.2	100	87	0.1	3	42	1.4	31	22
85 and older	1.8	84	48	0.7	62	84	0.1	3	37	0.9	20	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	2.2	118	53	1.0	89	90	0.1	3	41	1.2	27	23
Disabled	2.7	239	87	1.2	200	164	0.1	3	46	1.4	35	24
Adults	0.8	98	117	0.4	88	222	0.0	1	46	0.4	9	22
Children	0.3	25	80	0.2	22	121	0.0	0	59	0.1	3	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.2	157	70	1.0	127	127	0.1	2	44	1.2	28	23
Male	1.6	165	101	0.8	142	187	0.0	2	46	0.8	21	25
Unknown	0.3	5	21	0.3	5	21	0.0	0	0	0.0	0	0
Race												
White	2.4	218	90	1.2	182	156	0.1	4	42	1.2	31	27
African American	2.0	160	81	0.9	133	151	0.0	2	45	1.0	25	24
Other/unknown	1.9	144	77	0.9	118	136	0.0	2	46	0.9	23	24
Use of Nursing Facilities[e]												
Entire year	1.2	67	56	0.5	51	98	0.1	3	31	0.6	13	22
Part year	2.4	166	69	1.0	132	134	0.1	4	39	1.3	30	23
None	2.0	165	83	0.9	138	152	0.0	2	47	1.0	25	24
Maintenance Assistance Status												
Cash	2.3	193	84	1.0	161	156	0.1	2	47	1.2	29	24
Medically needy	1.5	135	87	0.7	113	166	0.1	2	37	0.8	19	24
Poverty related	2.3	162	70	1.0	130	126	0.0	2	52	1.2	29	24
Other/unknown	1.0	68	69	0.5	56	114	0.0	1	47	0.5	11	23

Source: Data for this table are from the MAX 2003 file for D.C., released by CMS in 04/2007. 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 D.C., 0.2 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)

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]

D.C., 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	0.5	0.4	0.0	0.2	$132	$128	$0	$4	$255	$355	$52	$27	90,508	$23,094,939	16,755	23.7 %	174,411
Biologicals	0.2	0.2	0.0	0.0	127	127	0	0	752	797	0	31	208	156,507	140	0.2	1,228
Antineoplastic Agents	0.4	0.1	0.0	0.2	92	58	6	28	238	404	243	128	5,226	1,242,266	1,238	1.8	13,475
Endocrine/Metabolic Drugs	0.8	0.4	0.0	0.4	41	29	1	10	52	79	21	29	84,068	4,397,999	10,058	14.2	108,024
Cardiovascular Agents	1.6	0.6	0.0	1.0	66	44	1	21	41	71	38	22	298,912	12,370,713	17,133	24.2	187,454
Respiratory Agents	0.6	0.4	0.0	0.2	34	28	1	5	56	77	75	22	82,964	4,667,635	12,989	18.4	137,433
Gastrointestinal Agents	0.5	0.2	0.0	0.3	35	26	0	9	76	146	80	33	46,477	3,554,473	9,118	12.9	100,134
Genitourinary Agents	0.3	0.3	0.0	0.1	23	22	0	1	67	76	39	18	11,130	741,739	3,042	4.3	32,552
CNS Drugs	1.0	0.6	0.0	0.4	117	105	0	12	120	190	81	28	136,504	16,437,138	12,692	17.9	140,552
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	50	43	1	6	79	93	68	39	6,629	526,550	989	1.4	10,492
Miscellaneous Psychological/ Neurological Agents	0.4	0.4	0.0	0.0	57	54	0	3	138	140	0	103	3,156	434,440	671	0.9	7,570
Analgesics and Anesthetics	0.5	0.1	0.0	0.4	25	17	1	7	46	176	70	17	89,806	4,107,708	15,122	21.4	163,351
Neuromuscular Agents	0.8	0.3	0.0	0.4	50	40	1	9	67	120	36	23	72,640	4,831,534	8,609	12.2	95,908
Nutritional Products	0.5	0.0	0.0	0.4	6	0	0	6	14	16	15	14	35,712	489,813	7,030	9.9	75,459
Hematological Agents	0.6	0.2	0.0	0.3	92	87	1	4	159	369	22	15	31,312	4,970,568	4,890	6.9	53,816
Topical Products	0.5	0.2	0.0	0.2	24	17	2	6	53	72	64	30	62,494	3,326,765	12,898	18.2	137,419
Miscellaneous Products	0.3	0.2	0.0	0.1	87	72	4	11	272	380	255	97	2,086	568,288	621	0.9	6,531
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	21	0	0	0	105	0	0	0	1,552	162,549	727	1.0	7,764
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.	1,061,384	86,081,624	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for D.C., released by CMS in 04/2007. 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 D.C., 0.2 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]

D.C., 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
ANTIVIRAL	$19,644,670	7,129	10.1 %	75,609	0.5	$477	$260
ANTIPSYCHOTICS	12,612,868	8,554	12.1	97,151	0.6	225	130
ANTICONVULSANT	4,270,741	7,105	10.0	79,746	0.6	83	54
ANTIHYPERLIPIDEMIC	3,808,335	6,345	9.0	71,677	0.6	93	53
ANTIDIABETIC	3,636,791	9,716	13.7	107,535	0.6	56	34
ANTIHYPERTENSIVE	3,422,093	14,859	21.0	165,469	0.6	37	21
ANTIDEPRESSANTS	2,955,728	9,459	13.4	104,663	0.5	61	28
CALCIUM BLOCKERS	2,914,379	7,341	10.4	82,080	0.6	56	36
HEMATOPOIETIC AGENTS	2,597,639	4,204	5.9	44,908	0.4	158	58
ANTIASTHMATIC	2,563,758	10,365	14.7	111,378	0.4	63	23
Total	58,427,002	85,077		940,216	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for D.C., released by CMS in 04/2007. 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.