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

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
KANSAS, 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]	329,864	(A)	55,959	(E)	273,905	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	319,143	(B)	47,435	(F)	271,708	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	285,621	(C)	47,361	(G)	238,260	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	9,150	(D)	8,791	(H)	359	(L)

Source: Data for this table are from the MAX 2003 file for Kansas, 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 Kansas in 2003 was $241,341,790, of which $5,803,704 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]

KANSAS, 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	**285,621**	**28,101**	**49,671**	**47,506**	**160,343**	**0**	**2,143,704**	**279,684**	**524,192**	**254,966**	**1,084,862**	**0**
Age												
5 and younger	75,039	0	1,516	0	73,523	0	477,830	0	14,894	0	462,936	0
6-14	68,708	0	5,072	0	63,636	0	508,060	0	52,210	0	455,850	0
15-20	34,171	0	3,643	7,393	23,135	0	245,056	0	38,140	41,094	165,822	0
21-44	56,260	18	18,362	37,831	49	0	399,830	153	198,457	200,966	254	0
45-64	23,368	75	21,014	2,279	0	0	233,596	586	220,120	12,890	0	0
65-74	8,607	8,540	64	3	0	0	89,941	89,554	371	16	0	0
75-84	9,522	9,522	0	0	0	0	95,484	95,484	0	0	0	0
85 and older	9,946	9,946	0	0	0	0	93,907	93,907	0	0	0	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Gender												
Female	164,654	20,969	25,721	39,307	78,657	0	1,229,673	211,072	274,303	212,425	531,873	0
Male	120,938	7,132	23,950	8,199	81,657	0	913,981	68,612	249,889	42,541	552,939	0
Unknown	29	0	0	0	29	0	50	0	0	0	50	0
Race												
White	185,124	22,923	37,792	32,131	92,278	0	1,423,580	226,243	399,884	170,983	626,470	0
African American	45,935	2,476	8,040	8,209	27,210	0	342,034	25,925	85,631	45,590	184,888	0
Other/unknown	54,562	2,702	3,839	7,166	40,855	0	378,090	27,516	38,677	38,393	273,504	0
Use of Nursing Facilities[c]												
Entire year	9,150	8,466	684	0	0	0	89,181	82,352	6,829	0	0	0
Part year	6,613	5,358	1,254	0	1	0	63,944	50,582	13,358	0	4	0
None	269,858	14,277	47,733	47,506	160,342	0	1,990,579	146,750	504,005	254,966	1,084,858	0
Maintenance Assistance Status												
Cash	113,572	7,234	35,146	29,201	41,991	0	898,056	80,814	379,849	163,266	274,127	0
Medically needy	7,161	1,884	4,354	367	556	0	57,820	16,626	37,750	1,282	2,162	0
Poverty-related	112,380	679	724	12,374	98,603	0	700,137	5,883	7,001	52,684	634,569	0
Other/unknown	52,508	18,304	9,447	5,564	19,193	0	487,691	176,361	99,592	37,734	174,004	0
Dual Medicare Status[d]												
Full dual, all year	45,015	25,812	18,917	276	10	0	464,779	256,202	206,606	1,870	101	0
Full dual, part year	2,346	1,074	1,263	9	0	0	25,072	11,456	13,514	102	0	0
Non-dual, all year	238,260	1,215	29,491	47,221	160,333	0	1,653,853	12,026	304,072	252,994	1,084,761	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	215,384	28,063	49,087	30,592	107,642	0	1,919,004	279,489	520,548	201,481	917,486	0
FFS part year, with Rx claims	23,498	22	461	7,681	15,334	0	98,104	135	3,072	28,540	66,357	0
FFS part year, no Rx claims	46,739	16	123	9,233	37,367	0	126,596	60	572	24,945	101,019	0

Source: Data for this table are from the MAX 2003 file for Kansas, 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]

KANSAS, 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	**59.3 %**	**14.1**	**$825**	**$59**	**$5,388**	**15.3 %**	**285,621**
Age							
5 and younger	48.4	2.4	101	42	1,598	6.3	75,039
6-14	48.8	4.2	282	66	2,129	13.2	68,708
15-20	55.4	6.0	396	66	3,685	10.8	34,171
21-44	63.1	12.8	950	74	6,302	15.1	56,260
45-64	83.5	45.2	2,942	65	14,171	20.8	23,368
65-74	87.3	53.4	2,719	51	12,623	21.5	8,607
75-84	91.9	59.4	2,775	47	16,400	16.9	9,522
85 and older	94.3	55.3	2,315	42	19,732	11.7	9,946
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	91.3	56.1	2,592	46	16,415	15.8	28,101
Disabled	83.1	35.4	2,564	72	14,653	17.5	49,671
Adults	54.0	4.2	179	43	1,909	9.4	47,506
Children	47.9	3.1	167	54	1,616	10.4	160,343
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	62.0	16.6	889	54	5,460	16.3	164,654
Male	55.7	10.8	737	68	5,291	13.9	120,938
Unknown	6.9	0.1	1	20	18	7.5	29
Race							
White	64.6	18.0	1,056	59	6,650	15.9	185,124
African American	50.9	9.0	523	58	3,883	13.5	45,935
Other/unknown	48.4	5.4	294	55	2,373	12.4	54,562
Use of Nursing Facilities[f]							
Entire year	97.9	69.2	3,197	46	27,467	11.6	9,150
Part year	97.6	67.4	3,535	52	22,674	15.6	6,613
None	57.1	10.9	678	62	4,216	16.1	269,858
Maintenance Assistance Status							
Cash	61.5	15.2	962	63	5,288	18.2	113,572
Medically needy	67.5	24.3	1,860	76	7,261	25.6	7,161
Poverty related	47.4	2.5	108	44	1,310	8.2	112,380
Other/unknown	78.9	35.1	1,922	55	14,076	13.7	52,508

Source: Data for this table are from the MAX 2003 file for Kansas, 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]

KANSAS, 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	**1.9**	**$110**	**15.3 %**	**40.7 %**	**35.7 %**	**6.2 %**	**9.0 %**	**6.4 %**	**2.1 %**	**$718**	**285,621**	**2,143,704**
Age												
5 and younger	0.4	16	6.3	51.6	43.8	3.2	1.3	0.1	0.0	251	75,039	477,830
6-14	0.6	38	13.2	51.2	39.4	4.7	4.1	0.6	0.0	288	68,708	508,060
15-20	0.8	55	10.8	44.6	41.8	6.6	5.7	1.3	0.1	514	34,171	245,056
21-44	1.8	134	15.1	36.9	36.6	9.3	11.2	4.9	1.1	887	56,260	399,830
45-64	4.5	294	20.8	16.5	17.9	10.5	24.8	22.1	8.3	1,418	23,368	233,596
65-74	5.1	260	21.5	12.7	14.1	9.4	25.2	27.2	11.4	1,208	8,607	89,941
75-84	5.9	277	16.9	8.1	10.0	7.5	26.7	34.3	13.4	1,636	9,522	95,484
85 and older	5.9	245	11.7	5.7	7.8	7.2	30.6	38.6	10.0	2,090	9,946	93,907
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Basis of Eligibility[e]												
Aged	5.6	261	15.8	8.7	10.5	8.0	27.7	33.6	11.5	1,649	28,101	279,684
Disabled	3.4	243	17.5	16.9	26.9	11.8	23.6	15.6	5.1	1,389	49,671	524,192
Adults	0.8	33	9.4	46.0	40.2	7.5	4.9	1.2	0.1	356	47,506	254,966
Children	0.5	25	10.4	52.1	41.4	3.8	2.3	0.3	0.0	239	160,343	1,084,862
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	119	16.3	38.0	35.4	6.4	9.6	7.9	2.7	731	164,654	1,229,673
Male	1.4	98	13.9	44.3	36.1	6.0	8.0	4.4	1.1	700	120,938	913,981
Unknown	0.0	1	7.5	93.1	6.9	0.0	0.0	0.0	0.0	10	29	50
Race												
White	2.3	137	15.9	35.4	35.1	7.1	11.0	8.5	2.8	865	185,124	1,423,580
African American	1.2	70	13.5	49.1	34.8	5.2	6.5	3.5	0.8	521	45,935	342,034
Other/unknown	0.8	42	12.4	51.6	38.2	4.0	4.1	1.6	0.4	342	54,562	378,090
Use of Nursing Facilities[f]												
Entire year	7.1	328	11.6	2.1	5.0	5.1	27.5	42.2	18.0	2,818	9,150	89,181
Part year	7.0	366	15.6	2.4	5.3	6.9	27.6	41.2	16.6	2,345	6,613	63,944
None	1.5	92	16.1	42.9	37.5	6.2	7.9	4.3	1.2	572	269,858	1,990,579
Maintenance Assistance Status												
Cash	1.9	122	18.2	38.5	34.6	7.6	11.3	6.3	1.7	669	113,572	898,056
Medically needy	3.0	230	25.6	32.5	21.4	10.6	20.0	13.0	2.5	899	7,161	57,820
Poverty related	0.4	17	8.2	52.6	41.7	3.8	1.7	0.2	0.0	210	112,380	700,137
Other/unknown	3.8	207	13.7	21.1	27.1	7.8	17.9	19.0	7.2	1,516	52,508	487,691

Source: Data for this table are from the MAX 2003 file for Kansas, 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]

KANSAS, 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	**1.9**	**$110**	**$59**	**0.9**	**$90**	**$102**	**0.1**	**$2**	**$36**	**0.9**	**$17**	**$19**
Age												
5 and younger	0.4	16	42	0.2	13	71	0.0	0	40	0.2	3	14
6-14	0.6	38	66	0.4	33	94	0.0	1	61	0.2	4	20
15-20	0.8	55	66	0.5	48	102	0.0	1	37	0.3	6	18
21-44	1.8	134	74	0.9	113	132	0.1	3	51	0.9	18	20
45-64	4.5	294	65	2.1	241	115	0.1	6	45	2.3	47	21
65-74	5.1	260	51	2.3	208	89	0.2	5	27	2.6	47	18
75-84	5.9	277	47	2.6	218	83	0.2	5	23	3.1	53	17
85 and older	5.9	245	42	2.4	188	79	0.3	6	21	3.2	51	16
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.6	261	46	2.4	204	84	0.2	5	23	3.0	51	17
Disabled	3.4	243	72	1.6	203	124	0.1	5	50	1.6	34	21
Adults	0.8	33	43	0.3	27	86	0.0	1	24	0.4	6	14
Children	0.5	25	54	0.3	21	83	0.0	1	45	0.2	3	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.2	119	54	1.0	97	95	0.1	2	31	1.1	20	18
Male	1.4	98	68	0.7	82	115	0.0	2	51	0.7	14	21
Unknown	0.0	1	20	0.0	0	0	0.0	0	0	0.0	1	20
Race												
White	2.3	137	59	1.1	112	103	0.1	3	36	1.2	22	19
African American	1.2	70	58	0.6	58	104	0.0	1	37	0.6	11	18
Other/unknown	0.8	42	55	0.4	36	92	0.0	1	34	0.4	6	17
Use of Nursing Facilities[e]												
Entire year	7.1	328	46	3.0	256	85	0.3	7	24	3.8	65	17
Part year	7.0	366	52	3.0	287	95	0.3	10	37	3.7	68	19
None	1.5	92	62	0.7	76	106	0.0	2	40	0.7	14	19
Maintenance Assistance Status												
Cash	1.9	122	63	0.9	101	110	0.1	2	39	0.9	18	19
Medically needy	3.0	230	76	1.4	194	137	0.1	5	53	1.5	31	21
Poverty related	0.4	17	44	0.2	14	72	0.0	1	42	0.2	3	15
Other/unknown	3.8	207	55	1.8	167	95	0.1	5	32	1.9	35	19

Source: Data for this table are from the MAX 2003 file for Kansas, 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 Kansas, 0.4 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]

KANSAS, 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	$15	$12	$0	$3	$53	$90	$60	$19	316,381	$16,641,259	111,623	39.1 %	1,092,231
Biologicals	0.4	0.4	0.0	0.0	512	434	39	39	1188	1,125	1,836	1,630	1,405	1,669,108	355	0.1	3,263
Antineoplastic Agents	0.5	0.2	0.0	0.3	104	85	2	17	202	429	115	57	12,282	2,484,197	2,314	0.8	23,846
Endocrine/Metabolic Drugs	0.8	0.4	0.1	0.3	33	27	2	5	43	71	16	15	397,022	16,876,358	50,385	17.6	510,411
Cardiovascular Agents	1.6	0.5	0.0	1.0	48	33	1	14	30	62	22	14	740,545	22,200,380	43,936	15.4	459,913
Respiratory Agents	0.5	0.3	0.0	0.2	27	23	0	4	52	70	45	21	346,738	18,087,483	67,980	23.8	674,877
Gastrointestinal Agents	0.7	0.4	0.0	0.3	54	48	0	6	76	118	107	18	263,426	19,955,423	35,733	12.5	371,836
Genitourinary Agents	0.5	0.4	0.0	0.1	27	25	0	2	59	72	28	18	72,500	4,275,947	15,315	5.4	155,886
CNS Drugs	1.1	0.8	0.0	0.4	115	102	2	11	100	135	123	28	641,056	64,206,278	54,652	19.1	557,887
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.2	48	42	1	6	69	80	43	36	76,517	5,299,628	11,013	3.9	109,367
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	94	92	0	2	136	140	0	53	29,732	4,032,022	4,210	1.5	43,059
Analgesics and Anesthetics	0.7	0.2	0.0	0.5	33	25	1	7	50	129	59	16	425,297	21,154,681	63,054	22.1	632,069
Neuromuscular Agents	0.9	0.4	0.0	0.5	65	52	1	12	70	121	34	26	324,803	22,821,975	33,010	11.6	349,064
Nutritional Products	0.6	0.0	0.0	0.5	9	0	1	8	17	19	23	16	112,247	1,911,535	21,264	7.4	202,008
Hematological Agents	0.8	0.3	0.1	0.5	55	47	1	7	66	186	14	14	95,711	6,358,675	11,181	3.9	115,880
Topical Products	0.3	0.1	0.0	0.1	9	7	0	3	35	58	43	18	152,279	5,383,723	55,687	19.5	567,196
Miscellaneous Products	0.5	0.2	0.0	0.3	102	84	6	12	200	397	218	43	8,746	1,750,960	1,658	0.6	17,137
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	6	0	0	0	38	0	0	0	11,336	428,454	6,591	2.3	66,630
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.	4,028,023	235,538,086	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Kansas, 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 Kansas, 0.4 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]

KANSAS, 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	$41,441,068	33,331	11.7 %	360,026	0.7	$172	$115
ANTIDEPRESSANTS	20,523,652	55,345	19.4	573,611	0.6	60	36
ANTICONVULSANT	19,015,050	27,989	9.8	303,024	0.8	83	63
ULCER DRUGS	15,679,720	33,964	11.9	360,252	0.5	82	44
ANALGESICS - Narcotic	11,129,140	67,166	23.5	685,588	0.4	42	16
ANTIASTHMATIC	10,848,298	54,452	19.1	552,951	0.3	57	20
ANTIDIABETIC	9,328,284	21,860	7.7	234,761	0.7	55	40
ANTIHYPERLIPIDEMIC	7,296,402	13,237	4.6	146,312	0.6	79	50
ANALGESICS - ANTI-INFLAMMATORY	6,997,505	36,033	12.6	378,141	0.3	58	19
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	5,295,874	13,815	4.8	140,952	0.5	69	38
Total	147,554,993	357,192		3,735,618	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Kansas, 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.