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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
OKLAHOMA, 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]	668,632	(A)	100,242	(E)	568,390	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	650,544	(B)	86,338	(F)	564,206	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	542,548	(C)	85,591	(G)	456,957	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	14,238	(D)	12,942	(H)	1,296	(L)

Source: Data for this table are from the MAX 2003 file for Oklahoma, released by CMS in 06/2007. This table was produced on 12/27/2007.

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 Oklahoma in 2003 was $295,215,161, of which $2,654,009 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]

OKLAHOMA, 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	**542,548**	**54,797**	**66,920**	**70,676**	**350,155**	**0**	**3,798,961**	**570,393**	**637,383**	**330,271**	**2,260,914**	**0**
Age												
5 and younger	142,953	7	1,433	1	141,512	0	870,020	18	10,616	1	859,385	0
6-14	153,408	8	4,063	26	149,311	0	1,047,921	56	34,859	139	1,012,867	0
15-20	69,888	7	3,387	7,706	58,788	0	452,162	47	29,666	36,157	386,292	0
21-44	83,659	19	23,873	59,230	537	0	505,360	158	228,590	274,298	2,314	0
45-64	36,808	202	33,032	3,570	4	0	343,161	1,749	322,932	18,453	27	0
65-74	21,793	20,641	1,062	88	2	0	231,607	220,693	10,103	787	24	0
75-84	19,790	19,697	55	38	0	0	207,602	206,806	489	307	0	0
85 and older	14,249	14,216	15	17	1	0	141,128	140,866	128	129	5	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Gender												
Female	316,102	40,833	35,263	66,510	173,496	0	2,197,858	429,002	338,430	311,411	1,119,015	0
Male	226,446	13,964	31,657	4,166	176,659	0	1,601,103	141,391	298,953	18,860	1,141,899	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Race												
White	344,379	42,751	49,485	45,875	206,268	0	2,564,106	442,303	482,873	226,144	1,412,786	0
African American	75,974	5,953	9,439	10,545	50,037	0	424,780	63,564	78,884	37,154	245,178	0
Other/unknown	122,195	6,093	7,996	14,256	93,850	0	810,075	64,526	75,626	66,973	602,950	0
Use of Nursing Facilities[c]												
Entire year	14,238	11,949	2,274	8	7	0	147,267	122,498	24,647	52	70	0
Part year	7,861	6,272	1,553	34	2	0	71,492	56,753	14,448	272	19	0
None	520,449	36,576	63,093	70,634	350,146	0	3,580,202	391,142	598,288	329,947	2,260,825	0
Maintenance Assistance Status												
Cash	154,700	18,956	43,455	40,150	52,139	0	1,153,123	209,863	403,230	192,127	347,903	0
Medically needy	38	8	26	2	2	0	145	24	106	7	8	0
Poverty-related	333,595	10,427	11,214	29,927	282,027	0	2,105,332	108,213	100,140	136,570	1,760,409	0
Other/unknown	54,215	25,406	12,225	597	15,987	0	540,361	252,293	133,907	1,567	152,594	0
Dual Medicare Status[d]												
Full dual, all year	81,320	50,418	30,092	780	30	0	851,468	527,896	317,536	5,744	292	0
Full dual, part year	4,271	2,594	1,645	32	0	0	46,582	28,726	17,529	327	0	0
Non-dual, all year	456,957	1,785	35,183	69,864	350,125	0	2,900,911	13,771	302,318	324,200	2,260,622	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	364,766	54,597	57,553	39,985	212,631	0	3,332,765	569,198	606,894	252,591	1,904,082	0
FFS part year, with Rx claims	49,733	163	5,250	12,826	31,494	0	168,722	1,052	20,133	36,968	110,569	0
FFS part year, no Rx claims	128,049	37	4,117	17,865	106,030	0	297,474	143	10,356	40,712	246,263	0

Source: Data for this table are from the MAX 2003 file for Oklahoma, released by CMS in 06/2007. This table was produced on 12/27/2007.

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]

OKLAHOMA, 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	**56.0 %**	**8.0**	**$539**	**$67**	**$3,637**	**14.8 %**	**542,548**
Age							
5 and younger	48.8	2.4	111	47	1,482	7.5	142,953
6-14	44.8	2.7	196	73	1,452	13.5	153,408
15-20	49.9	3.6	220	62	2,387	9.2	69,888
21-44	59.9	6.9	612	89	5,041	12.1	83,659
45-64	81.3	23.0	1,927	84	9,807	19.7	36,808
65-74	87.5	28.1	1,812	65	7,353	24.6	21,793
75-84	91.1	36.1	2,052	57	10,662	19.2	19,790
85 and older	93.1	41.7	2,034	49	15,277	13.3	14,249
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	90.3	34.6	1,958	57	10,604	18.5	54,797
Disabled	79.7	20.3	1,930	95	11,609	16.6	66,920
Adults	54.2	3.2	143	45	1,754	8.2	70,676
Children	46.4	2.5	131	53	1,403	9.4	350,155
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	58.7	9.2	572	62	3,701	15.5	316,102
Male	52.2	6.4	493	77	3,546	13.9	226,446
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	61.7	10.0	675	68	4,268	15.8	344,379
African American	39.9	5.4	379	71	3,053	12.4	75,974
Other/unknown	49.7	4.2	257	62	2,220	11.6	122,195
Use of Nursing Facilities[f]							
Entire year	98.2	73.5	3,821	52	29,006	13.2	14,238
Part year	97.0	46.9	2,646	56	17,503	15.1	7,861
None	54.2	5.6	418	74	2,733	15.3	520,449
Maintenance Assistance Status							
Cash	61.9	8.1	656	81	2,851	23.0	154,700
Medically needy	13.2	0.7	129	182	1,213	10.7	38
Poverty related	48.6	3.2	192	59	1,517	12.6	333,595
Other/unknown	84.4	36.9	2,343	63	18,926	12.4	54,215

Source: Data for this table are from the MAX 2003 file for Oklahoma, released by CMS in 06/2007. This table was produced on 12/27/2007.

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]

OKLAHOMA, 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	**1.1**	**$77**	**14.8 %**	**44.0 %**	**37.3 %**	**7.8 %**	**8.4 %**	**1.9 %**	**0.6 %**	**$519**	**542,548**	**3,798,961**
Age												
5 and younger	0.4	18	7.5	51.2	44.4	3.0	1.2	0.1	0.0	244	142,953	870,020
6-14	0.4	29	13.5	55.2	39.2	3.3	2.0	0.2	0.0	213	153,408	1,047,921
15-20	0.6	34	9.2	50.1	40.8	5.4	3.2	0.4	0.1	369	69,888	452,162
21-44	1.1	101	12.1	40.1	37.3	12.3	9.4	0.7	0.2	835	83,659	505,360
45-64	2.5	207	19.7	18.7	22.4	21.4	31.1	4.3	2.1	1,052	36,808	343,161
65-74	2.6	171	24.6	12.5	24.1	22.0	32.4	6.1	2.9	692	21,793	231,607
75-84	3.4	196	19.2	8.9	18.5	19.2	35.5	13.0	4.9	1,016	19,790	207,602
85 and older	4.2	205	13.3	6.9	14.0	15.3	35.8	23.2	4.8	1,543	14,249	141,128
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	3.3	188	18.5	9.7	19.5	19.3	34.4	13.1	4.1	1,019	54,797	570,393
Disabled	2.1	203	16.6	20.3	28.4	19.5	26.7	3.6	1.5	1,219	66,920	637,383
Adults	0.7	31	8.2	45.8	39.7	9.8	4.5	0.2	0.1	375	70,676	330,271
Children	0.4	20	9.4	53.6	41.4	3.3	1.6	0.1	0.0	217	350,155	2,260,914
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.3	82	15.5	41.3	37.1	8.7	9.9	2.2	0.8	532	316,102	2,197,858
Male	0.9	70	13.9	47.8	37.7	6.4	6.2	1.4	0.4	502	226,446	1,601,103
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.3	91	15.8	38.3	39.2	8.8	10.4	2.5	0.8	573	344,379	2,564,106
African American	1.0	68	12.4	60.1	25.7	6.4	6.4	1.1	0.3	546	75,974	424,780
Other/unknown	0.6	39	11.6	50.3	39.4	5.6	3.9	0.7	0.3	335	122,195	810,075
Use of Nursing Facilities[f]												
Entire year	7.1	369	13.2	1.8	4.1	5.7	27.6	43.6	17.2	2,804	14,238	147,267
Part year	5.2	291	15.1	3.0	9.6	11.3	38.7	29.9	7.5	1,925	7,861	71,492
None	0.8	61	15.3	45.8	38.7	7.8	7.4	0.3	0.1	397	520,449	3,580,202
Maintenance Assistance Status												
Cash	1.1	88	23.0	38.1	35.8	13.7	11.9	0.4	0.1	383	154,700	1,153,123
Medically needy	0.2	34	10.7	86.8	10.5	2.6	0.0	0.0	0.0	318	38	145
Poverty related	0.5	30	12.6	51.4	40.5	4.9	3.1	0.2	0.0	240	333,595	2,105,332
Other/unknown	3.7	235	12.4	15.6	22.6	8.8	30.9	16.4	5.7	1,899	54,215	540,361

Source: Data for this table are from the MAX 2003 file for Oklahoma, released by CMS in 06/2007. This table was produced on 12/27/2007.

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]

OKLAHOMA, 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	**1.1**	**$77**	**$67**	**0.5**	**$60**	**$126**	**0.0**	**$2**	**$54**	**0.6**	**$14**	**$23**
Age												
5 and younger	0.4	18	47	0.2	15	83	0.0	1	43	0.2	3	15
6-14	0.4	29	73	0.2	22	116	0.0	1	69	0.2	6	30
15-20	0.6	34	62	0.2	27	116	0.0	1	60	0.3	6	20
21-44	1.1	101	89	0.5	82	182	0.1	4	68	0.6	15	24
45-64	2.5	207	84	1.0	165	161	0.1	6	66	1.4	35	26
65-74	2.6	171	65	1.1	132	120	0.1	5	49	1.4	34	23
75-84	3.4	196	57	1.4	148	104	0.1	6	43	1.9	42	22
85 and older	4.2	205	49	1.6	148	93	0.2	6	34	2.4	51	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	3.3	188	57	1.3	142	106	0.1	5	42	1.9	41	22
Disabled	2.1	203	95	0.9	164	179	0.1	6	75	1.1	32	28
Adults	0.7	31	45	0.2	22	104	0.0	1	38	0.4	7	16
Children	0.4	20	53	0.2	16	90	0.0	1	53	0.2	4	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.3	82	62	0.5	64	117	0.1	3	50	0.7	16	22
Male	0.9	70	77	0.4	55	142	0.0	2	63	0.5	12	25
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.3	91	68	0.6	71	126	0.1	3	55	0.7	17	23
African American	1.0	68	71	0.4	52	135	0.0	2	56	0.5	14	26
Other/unknown	0.6	39	62	0.2	30	122	0.0	2	49	0.3	7	19
Use of Nursing Facilities[e]												
Entire year	7.1	369	52	2.7	276	101	0.2	8	35	4.2	86	21
Part year	5.2	291	56	2.0	219	110	0.2	7	41	3.0	65	22
None	0.8	61	74	0.4	48	136	0.0	2	60	0.4	10	24
Maintenance Assistance Status												
Cash	1.1	88	81	0.5	70	151	0.0	3	65	0.6	15	26
Medically needy	0.2	34	182	0.1	33	339	0.0	0	14	0.1	1	13
Poverty related	0.5	30	59	0.2	24	106	0.0	1	51	0.3	6	21
Other/unknown	3.7	235	63	1.5	181	121	0.1	6	48	2.1	47	23

Source: Data for this table are from the MAX 2003 file for Oklahoma, released by CMS in 06/2007. This table was produced on 12/27/2007.

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 Oklahoma, 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]

OKLAHOMA, 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	0.1	$13	$10	$0	$3	$52	$87	$66	$20	488,359	$25,478,088	201,203	37.1 %	1,932,934
Biologicals	0.2	0.2	0.0	0.0	139	124	0	15	766	745	225	1,014	4,215	3,230,740	2,346	0.4	23,297
Antineoplastic Agents	0.4	0.1	0.0	0.3	91	52	2	38	210	478	158	120	23,590	4,955,142	5,408	1.0	54,449
Endocrine/Metabolic Drugs	0.5	0.2	0.0	0.2	26	21	2	4	56	89	35	20	398,322	22,313,200	84,058	15.5	847,476
Cardiovascular Agents	1.0	0.3	0.0	0.7	44	30	2	13	44	96	40	20	745,842	33,076,163	70,529	13.0	744,383
Respiratory Agents	0.4	0.2	0.0	0.2	24	20	0	3	63	96	50	21	331,069	20,955,428	89,567	16.5	875,188
Gastrointestinal Agents	0.5	0.2	0.0	0.3	35	27	1	7	67	141	181	23	282,877	19,081,615	52,900	9.8	546,402
Genitourinary Agents	0.3	0.3	0.0	0.1	23	21	0	2	68	84	40	22	76,851	5,224,867	22,804	4.2	224,632
CNS Drugs	0.8	0.5	0.0	0.3	86	77	1	8	109	170	113	26	654,306	71,564,531	82,618	15.2	829,205
Stimulants/Anti-obesity/Anorexia	0.6	0.3	0.0	0.2	43	30	3	10	76	97	72	47	66,252	5,028,707	12,024	2.2	116,703
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	102	100	0	2	163	170	129	43	34,415	5,602,574	5,192	1.0	54,932
Analgesics and Anesthetics	0.4	0.1	0.0	0.4	23	16	1	6	52	192	86	18	472,082	24,713,675	108,391	20.0	1,058,255
Neuromuscular Agents	0.6	0.3	0.0	0.3	48	37	2	9	76	139	51	29	293,489	22,404,986	45,191	8.3	465,066
Nutritional Products	0.4	0.0	0.0	0.3	8	0	1	7	20	32	26	19	120,762	2,452,792	34,113	6.3	310,997
Hematological Agents	0.5	0.2	0.1	0.3	84	67	2	15	161	318	37	59	87,393	14,096,316	15,793	2.9	167,270
Topical Products	0.2	0.1	0.0	0.1	10	7	1	3	41	65	46	21	238,571	9,786,721	96,825	17.8	978,240
Miscellaneous Products	0.2	0.1	0.0	0.1	36	27	5	5	175	202	333	76	11,222	1,968,766	5,475	1.0	54,213
Unknown Therapeutic Category	0.1	0.0	0.0	0.0	6	0	0	0	40	0	0	0	15,681	626,841	10,708	2.0	107,949
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.	4,345,298	292,561,152	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Oklahoma, released by CMS in 06/2007. This table was produced on 12/27/2007.

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 Oklahoma, 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]

OKLAHOMA, 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	$7,549,048	7,491	1.4 %	45,733	0.7	$222	$165
ANTIDEPRESSANTS	4,688,420	16,484	3.0	100,048	0.6	78	47
ANTICONVULSANT	4,581,802	7,744	1.4	52,132	0.8	109	88
ANALGESICS - Narcotic	3,456,390	25,338	4.7	131,376	0.5	55	26
ANTIASTHMATIC	3,219,052	20,684	3.8	100,149	0.5	69	32
ULCER DRUGS	2,944,647	9,585	1.8	61,795	0.5	90	48
ANTIDIABETIC	2,435,870	7,330	1.4	52,312	0.6	78	47
ANTIHYPERLIPIDEMIC	2,061,502	3,792	0.7	29,863	0.5	142	69
ANALGESICS - ANTI-INFLAMMATORY	1,541,290	8,313	1.5	46,477	0.4	76	33
ANTIHYPERTENSIVE	1,491,782	9,237	1.7	68,005	0.6	39	22
Total	33,969,803	115,998		687,890	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Oklahoma, released by CMS in 06/2007. This table was produced on 12/27/2007.

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.