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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
OREGON, 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]	618,987	(A)	84,906	(E)	534,081	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	525,599	(B)	65,042	(F)	460,557	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	313,307	(C)	41,284	(G)	272,023	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	4,522	(D)	4,248	(H)	274	(L)

Source: Data for this table are from the MAX 2003 file for Oregon, released by CMS in 06/2007. 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 Oregon in 2003 was $229,930,406, of which $62,030,351 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]

OREGON, 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	**313,307**	**25,462**	**32,908**	**114,544**	**140,393**	**0**	**1,697,680**	**226,758**	**281,300**	**538,943**	**650,679**	**0**
Age												
5 and younger	63,347	0	865	84	62,398	0	274,534	0	6,759	295	267,480	0
6-14	58,342	0	2,286	83	55,973	0	295,016	0	19,333	411	275,272	0
15-20	32,245	1	1,990	8,267	21,987	0	158,311	12	16,257	34,266	107,776	0
21-44	92,045	38	11,776	80,206	25	0	458,299	234	100,558	357,396	111	0
45-64	41,298	143	15,440	25,713	2	0	280,781	1,177	133,923	145,669	12	0
65-74	8,355	7,979	210	166	0	0	73,380	71,223	1,376	781	0	0
75-84	9,509	9,382	115	12	0	0	86,142	85,034	1,059	49	0	0
85 and older	8,159	7,919	226	12	2	0	71,179	69,078	2,035	64	2	0
Unknown	7	0	0	1	6	0	38	0	0	12	26	0
Gender												
Female	176,645	18,255	16,995	72,424	68,971	0	979,022	165,615	146,949	346,557	319,901	0
Male	136,661	7,207	15,913	42,120	71,421	0	718,657	61,143	134,351	192,386	330,777	0
Unknown	1	0	0	0	1	1 0		0	0	0	1	0
Race												
White	235,653	22,004	28,375	93,975	91,299	0	1,323,314	195,210	243,950	439,134	445,020	0
African American	13,169	573	1,441	4,779	6,376	0	62,629	5,140	10,523	19,185	27,781	0
Other/unknown	64,485	2,885	3,092	15,790	42,718	0	311,737	26,408	26,827	80,624	177,878	0
Use of Nursing Facilities[c]												
Entire year	4,522	3,918	597	6	1	0	39,840	34,282	5,545	9	4	0
Part year	3,256	2,383	782	89	2	0	26,814	19,928	6,253	609	24	0
None	305,529	19,161	31,529	114,449	140,390	0	1,631,026	172,548	269,502	538,325	650,651	0
Maintenance Assistance Status												
Cash	81,159	6,533	21,873	19,186	33,567	0	490,219	62,044	190,601	80,339	157,235	0
Medically needy	3	0	3	0	0	3 0		0	3	0	0	0
Poverty-related	96,551	1,177	1,174	11,902	82,298	0	393,025	10,045	9,602	39,299	334,079	0
Other/unknown	135,594	17,752	9,858	83,456	24,528	0	814,433	154,669	81,094	419,305	159,365	0
Dual Medicare Status[d]												
Full dual, all year	37,700	23,168	13,256	1,268	8	0	338,877	207,557	124,360	6,891	69	0
Full dual, part year	3,584	1,742	1,833	9	0	0	30,406	15,094	15,227	85	0	0
Non-dual, all year	272,023	552	17,819	113,267	140,385	0	1,328,397	4,107	141,713	531,967	650,610	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	131,347	21,312	20,205	36,698	53,132	0	1,043,883	205,081	212,559	237,923	388,320	0
FFS part year, with Rx claims	73,143	3,184	9,980	39,975	20,004	0	368,517	17,108	56,865	195,268	99,276	0
FFS part year, no Rx claims	108,817	966	2,723	37,871	67,257	0	285,280	4,569	11,876	105,752	163,083	0

Source: Data for this table are from the MAX 2003 file for Oregon, released by CMS in 06/2007. 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]

OREGON, 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	**49.2 %**	**10.3**	**$536**	**$52**	**$3,904**	**13.7 %**	**313,307**
Age							
5 and younger	30.8	1.1	36	32	1,652	2.2	63,347
6-14	30.5	2.0	140	70	1,803	7.8	58,342
15-20	40.6	3.1	171	55	2,647	6.4	32,245
21-44	54.3	8.0	514	65	3,075	16.7	92,045
45-64	74.7	25.0	1,382	55	6,562	21.1	41,298
65-74	83.4	42.5	1,892	45	11,538	16.4	8,355
75-84	88.8	48.6	1,936	40	14,954	12.9	9,509
85 and older	89.9	44.9	1,641	37	16,593	9.9	8,159
Unknown	28.6	0.4	5	13	969	0.6	7
Basis of Eligibility[e]							
Aged	87.6	45.5	1,835	40	14,442	12.7	25,462
Disabled	82.3	34.7	2,457	71	12,172	20.2	32,908
Adults	53.6	6.4	277	43	2,068	13.4	114,544
Children	30.8	1.4	61	42	1,553	4.0	140,393
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	54.3	12.5	587	47	4,230	13.9	176,645
Male	42.6	7.5	471	63	3,483	13.5	136,661
Unknown	0.0	0.0	0	0	0	0.0	1
Race							
White	53.2	12.2	633	52	4,322	14.6	235,653
African American	40.1	6.3	311	50	3,659	8.5	13,169
Other/unknown	36.1	4.4	227	51	2,428	9.3	64,485
Use of Nursing Facilities[f]							
Entire year	96.4	60.3	2,668	44	33,223	8.0	4,522
Part year	96.7	56.6	2,469	44	23,173	10.7	3,256
None	48.0	9.1	484	53	3,265	14.8	305,529
Maintenance Assistance Status							
Cash	54.4	13.7	832	61	4,970	16.7	81,159
Medically needy	66.7	1.0	41	41	133	30.8	3
Poverty related	29.9	1.4	56	40	1,350	4.1	96,551
Other/unknown	59.7	14.7	701	48	5,085	13.8	135,594

Source: Data for this table are from the MAX 2003 file for Oregon, released by CMS in 06/2007. 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]

OREGON, 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**	**$99**	**13.7 %**	**50.8 %**	**25.7 %**	**5.9 %**	**8.8 %**	**6.0 %**	**2.7 %**	**$721**	**313,307**	**1,697,680**
Age												
5 and younger	0.3	8	2.2	69.2	28.6	1.5	0.6	0.1	0.0	381	63,347	274,534
6-14	0.4	28	7.8	69.5	24.9	2.6	2.2	0.6	0.3	357	58,342	295,016
15-20	0.6	35	6.4	59.4	29.5	5.0	4.2	1.4	0.6	539	32,245	158,311
21-44	1.6	103	16.7	45.7	28.7	8.5	10.3	4.6	2.2	618	92,045	458,299
45-64	3.7	203	21.1	25.3	21.5	10.4	20.3	14.8	7.7	965	41,298	280,781
65-74	4.8	216	16.4	16.6	15.9	9.1	22.2	24.5	11.6	1,314	8,355	73,380
75-84	5.4	214	12.9	11.2	11.3	8.6	25.9	30.8	12.1	1,651	9,509	86,142
85 and older	5.1	188	9.9	10.1	9.4	8.1	31.1	32.7	8.6	1,902	8,159	71,179
Unknown	0.1	1	0.6	71.4	28.6	0.0	0.0	0.0	0.0	179	7	38
Basis of Eligibility[e]												
Aged	5.1	206	12.7	12.4	12.3	8.7	26.4	29.4	10.8	1,622	25,462	226,758
Disabled	4.1	287	20.2	17.7	21.6	9.8	21.8	18.7	10.4	1,424	32,908	281,300
Adults	1.4	59	13.4	46.4	28.8	8.6	10.4	4.1	1.8	440	114,544	538,943
Children	0.3	13	4.0	69.2	26.7	2.2	1.4	0.4	0.2	335	140,393	650,679
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.3	106	13.9	45.7	26.7	6.6	10.1	7.5	3.4	763	176,645	979,022
Male	1.4	90	13.5	57.4	24.5	5.0	7.2	4.2	1.7	662	136,661	718,657
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	1	1
Race												
White	2.2	113	14.6	46.8	25.9	6.5	10.3	7.2	3.3	770	235,653	1,323,314
African American	1.3	66	8.5	59.9	23.7	4.9	6.3	3.6	1.6	769	13,169	62,629
Other/unknown	0.9	47	9.3	63.9	25.5	3.7	4.1	2.0	0.7	502	64,485	311,737
Use of Nursing Facilities[f]												
Entire year	6.8	303	8.0	3.6	5.5	6.7	26.8	39.0	18.4	3,771	4,522	39,840
Part year	6.9	300	10.7	3.3	7.2	6.8	26.5	36.8	19.4	2,814	3,256	26,814
None	1.7	91	14.8	52.0	26.2	5.9	8.4	5.2	2.3	612	305,529	1,631,026
Maintenance Assistance Status												
Cash	2.3	138	16.7	45.6	26.0	6.5	10.8	7.6	3.6	823	81,159	490,219
Medically needy	1.0	41	30.8	33.3	33.3	33.3	0.0	0.0	0.0	133	3	3
Poverty related	0.3	14	4.1	70.1	25.1	2.6	1.6	0.4	0.2	332	96,551	393,025
Other/unknown	2.4	117	13.8	40.3	26.0	7.9	12.8	9.1	4.0	847	135,594	814,433

Source: Data for this table are from the MAX 2003 file for Oregon, released by CMS in 06/2007. 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]

OREGON, 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**	**$99**	**$52**	**0.7**	**$76**	**$111**	**0.0**	**$2**	**$50**	**1.2**	**$21**	**$18**
Age												
5 and younger	0.3	8	32	0.1	6	86	0.0	0	39	0.2	2	11
6-14	0.4	28	70	0.2	23	127	0.0	1	84	0.2	4	18
15-20	0.6	35	55	0.3	28	99	0.0	1	57	0.3	6	17
21-44	1.6	103	65	0.6	83	140	0.0	2	70	1.0	18	18
45-64	3.7	203	55	1.3	154	120	0.1	4	58	2.3	45	19
65-74	4.8	216	45	1.7	160	92	0.1	4	36	3.0	52	17
75-84	5.4	214	40	1.9	157	82	0.1	4	28	3.3	53	16
85 and older	5.1	188	37	1.7	137	79	0.1	4	27	3.3	47	15
Unknown	0.1	1	13	0.0	0	0	0.0	0	0	0.1	1	13
Basis of Eligibility[d]												
Aged	5.1	206	40	1.8	152	84	0.1	4	30	3.2	50	16
Disabled	4.1	287	71	1.6	228	145	0.1	8	72	2.4	51	22
Adults	1.4	59	43	0.4	44	101	0.0	1	43	0.9	14	15
Children	0.3	13	42	0.1	10	85	0.0	0	45	0.2	3	14
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.3	106	47	0.8	80	99	0.1	2	42	1.4	23	17
Male	1.4	90	63	0.5	70	136	0.0	2	67	0.9	17	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.2	113	52	0.8	87	110	0.0	2	52	1.3	24	18
African American	1.3	66	50	0.4	49	116	0.0	2	42	0.9	15	17
Other/unknown	0.9	47	51	0.3	37	116	0.0	1	38	0.6	9	16
Use of Nursing Facilities[e]												
Entire year	6.8	303	44	2.4	227	93	0.2	6	31	4.2	70	17
Part year	6.9	300	44	2.4	223	94	0.2	6	36	4.3	71	16
None	1.7	91	53	0.6	70	113	0.0	2	53	1.0	19	18
Maintenance Assistance Status												
Cash	2.3	138	61	0.8	108	128	0.1	3	61	1.4	26	19
Medically needy	1.0	41	41	0.3	29	86	0.0	0	0	0.7	12	19
Poverty related	0.3	14	40	0.1	10	87	0.0	0	37	0.2	3	14
Other/unknown	2.4	117	48	0.9	88	102	0.1	2	44	1.5	26	17

Source: Data for this table are from the MAX 2003 file for Oregon, released by CMS in 06/2007. 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 Oregon, 0.3 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]

OREGON, 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	$19	$15	$0	$4	$61	$129	$88	$19	194,382	$11,795,849	74,830	23.9 %	635,146
Biologicals	0.1	0.1	0.0	0.0	47	36	4	8	355	321	2,209	395	1,587	562,756	1,171	0.4	11,950
Antineoplastic Agents	0.5	0.2	0.0	0.3	134	118	1	15	254	502	116	52	8,987	2,285,026	1,873	0.6	17,006
Endocrine/Metabolic Drugs	0.9	0.4	0.0	0.5	31	24	1	7	35	61	24	15	335,956	11,841,978	45,369	14.5	377,631
Cardiovascular Agents	1.6	0.4	0.0	1.2	39	22	1	17	25	58	22	15	583,748	14,745,320	42,767	13.7	373,814
Respiratory Agents	0.6	0.2	0.0	0.3	25	20	0	5	45	84	56	16	199,312	9,015,581	41,937	13.4	360,815
Gastrointestinal Agents	0.6	0.2	0.0	0.4	34	25	1	8	53	125	203	19	166,385	8,812,913	29,234	9.3	260,522
Genitourinary Agents	0.4	0.3	0.0	0.2	23	19	0	3	51	75	35	17	42,925	2,184,491	10,365	3.3	97,004
CNS Drugs	1.4	0.7	0.0	0.7	103	89	2	13	73	122	89	19	733,578	53,590,963	70,693	22.6	519,353
Stimulants/Anti-obesity/Anorexia	0.7	0.4	0.0	0.3	55	41	2	12	73	93	69	41	35,803	2,604,500	6,003	1.9	47,773
Miscellaneous Psychological/ Neurological Agents	0.5	0.4	0.0	0.1	84	78	0	6	167	180	0	90	18,086	3,017,840	3,919	1.3	35,843
Analgesics and Anesthetics	0.8	0.1	0.0	0.6	33	20	1	11	43	170	76	18	402,331	17,194,843	63,802	20.4	520,633
Neuromuscular Agents	0.9	0.4	0.0	0.5	67	54	1	12	73	128	49	25	241,818	17,678,866	30,973	9.9	263,392
Nutritional Products	0.5	0.0	0.0	0.4	6	0	1	5	13	29	18	12	97,788	1,236,738	23,077	7.4	199,214
Hematological Agents	0.9	0.2	0.1	0.6	80	72	1	7	93	336	21	11	75,374	7,015,080	9,519	3.0	87,775
Topical Products	0.3	0.1	0.0	0.2	8	6	0	3	29	58	44	14	84,339	2,484,478	32,855	10.5	297,830
Miscellaneous Products	0.6	0.2	0.1	0.3	123	86	19	19	199	374	302	58	7,216	1,437,636	1,262	0.4	11,643
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	12	0	0	0	51	0	0	0	7,765	395,197	3,552	1.1	33,946
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.	3,237,380	167,900,055	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Oregon, released by CMS in 06/2007. 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 Oregon, 0.3 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]

OREGON, 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	$21,688,175	18,112	5.8 %	173,520	0.8	$164	$125
ANTIDEPRESSANTS	17,917,858	53,543	17.1	483,816	0.7	56	37
ANTICONVULSANT	13,295,646	20,234	6.5	190,074	0.8	89	70
ANALGESICS - Narcotic	11,929,219	69,399	22.2	606,640	0.5	41	20
ANTIASTHMATIC	7,054,186	37,618	12.0	338,313	0.4	54	21
ANTIDIABETIC	6,167,478	20,085	6.4	182,765	0.7	46	34
ULCER DRUGS	6,124,591	29,667	9.5	273,667	0.5	48	22
ANTIVIRAL	5,178,111	3,930	1.3	34,999	0.4	361	148
ANTIHYPERLIPIDEMIC	4,856,180	12,757	4.1	120,074	0.6	64	40
MISC. HEMATOLOGICAL	4,497,468	2,940	0.9	28,076	0.7	235	160
Total	98,708,912	268,285		2,431,944	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Oregon, released by CMS in 06/2007. 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.