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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
PENNSYLVANIA, 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]	1,804,750	(A)	334,410	(E)	1,470,340	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1,726,682	(B)	297,668	(F)	1,429,014	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	752,499	(C)	164,344	(G)	588,155	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	41,663	(D)	39,161	(H)	2,502	(L)

Source: Data for this table are from the MAX 2003 file for Pennsylvania, 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 Pennsylvania in 2003 was $769,053,206, of which $3,701,106 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]

PENNSYLVANIA, 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	**752,499**	**121,707**	**146,434**	**124,011**	**360,347**	**0**	**5,106,556**	**1,098,605**	**1,245,782**	**576,737**	**2,185,432**	**0**
Age												
5 and younger	136,475	0	7,586	0	128,889	0	810,345	0	50,713	0	759,632	0
6-14	155,008	0	19,624	0	135,384	0	1,051,070	0	166,905	0	884,165	0
15-20	105,541	13	12,928	0	92,600	0	638,011	64	109,667	0	528,280	0
21-44	161,218	332	46,293	111,119	3,474	0	927,405	2,095	395,721	516,234	13,355	0
45-64	72,995	531	59,577	12,887	0	0	584,546	4,045	520,027	60,474	0	0
65-74	32,661	32,251	405	5	0	0	289,323	286,716	2,578	29	0	0
75-84	43,158	43,158	0	0	0	0	396,855	396,855	0	0	0	0
85 and older	45,443	45,422	21	0	0	0	409,001	408,830	171	0	0	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Gender												
Female	440,461	90,767	69,445	97,298	182,951	0	2,993,262	834,485	607,077	453,007	1,098,693	0
Male	312,038	30,940	76,989	26,713	177,396	0	2,113,294	264,120	638,705	123,730	1,086,739	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Race												
White	559,241	101,660	122,265	84,828	250,488	0	4,324,044	943,570	1,117,035	473,661	1,789,778	0
African American	116,543	13,180	15,080	23,513	64,770	0	488,094	109,409	81,560	61,209	235,916	0
Other/unknown	76,715	6,867	9,089	15,670	45,089	0	294,418	45,626	47,187	41,867	159,738	0
Use of Nursing Facilities[c]												
Entire year	41,663	37,735	3,924	4	0	0	431,726	389,114	42,607	5	0	0
Part year	35,746	31,610	4,054	73	9	0	302,154	269,575	32,138	396	45	0
None	675,090	52,362	138,456	123,934	360,338	0	4,372,676	439,916	1,171,037	576,336	2,185,387	0
Maintenance Assistance Status												
Cash	241,555	23,498	77,393	54,236	86,428	0	1,681,563	227,898	719,068	251,777	482,820	0
Medically needy	54,382	26,561	2,732	6,925	18,164	0	400,814	244,057	22,297	43,781	90,679	0
Poverty-related	289,355	16,890	50,266	22,997	199,202	0	1,854,110	139,350	362,652	81,272	1,270,836	0
Other/unknown	167,207	54,758	16,043	39,853	56,553	0	1,170,069	487,300	141,765	199,907	341,097	0
Dual Medicare Status[d]												
Full dual, all year	159,044	112,065	46,131	816	32	0	1,464,009	1,033,882	425,978	3,916	233	0
Full dual, part year	5,300	2,854	2,441	5	0	0	46,041	26,264	19,741	36	0	0
Non-dual, all year	588,155	6,788	97,862	123,190	360,315	0	3,596,506	38,459	800,063	572,785	2,185,199	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	488,781	110,233	108,759	62,772	207,017	0	4,423,744	1,055,085	1,130,145	443,556	1,794,958	0
FFS part year, with Rx claims	66,828	5,694	16,308	17,518	27,308	0	254,173	26,866	62,781	48,891	115,635	0
FFS part year, no Rx claims	196,890	5,780	21,367	43,721	126,022	0	428,639	16,654	52,856	84,290	274,839	0

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

PENNSYLVANIA, 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	**54.1 %**	**16.4**	**$1,017**	**$62**	**$6,762**	**15.0 %**	**752,499**
Age							
5 and younger	42.8	2.4	113	48	1,701	6.7	136,475
6-14	42.3	3.8	257	68	2,280	11.3	155,008
15-20	42.7	4.4	306	70	2,545	12.0	105,541
21-44	51.0	10.7	879	82	4,007	21.9	161,218
45-64	73.3	38.5	2,830	73	11,608	24.4	72,995
65-74	75.8	47.6	2,750	58	15,198	18.1	32,661
75-84	85.8	56.3	2,913	52	23,223	12.5	43,158
85 and older	89.8	52.9	2,507	47	27,337	9.2	45,443
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	84.5	52.5	2,720	52	22,534	12.1	121,707
Disabled	71.4	29.9	2,384	80	10,577	22.5	146,434
Adults	43.9	4.9	294	60	2,321	12.7	124,011
Children	40.4	2.6	135	52	1,413	9.6	360,347
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	56.7	19.2	1,125	59	7,594	14.8	440,461
Male	50.5	12.4	865	70	5,588	15.5	312,038
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	63.0	19.7	1,227	62	7,390	16.6	559,241
African American	28.8	7.8	470	60	5,855	8.0	116,543
Other/unknown	28.3	5.0	319	63	3,560	9.0	76,715
Use of Nursing Facilities[f]							
Entire year	97.2	76.9	3,951	51	43,504	9.1	41,663
Part year	95.2	56.5	2,919	52	26,403	11.1	35,746
None	49.3	10.5	735	70	3,455	21.3	675,090
Maintenance Assistance Status							
Cash	55.7	17.0	1,198	71	4,948	24.2	241,555
Medically needy	63.0	32.2	1,584	49	18,220	8.7	54,382
Poverty related	46.3	7.0	475	68	2,203	21.5	289,355
Other/unknown	62.6	26.5	1,511	57	13,545	11.2	167,207

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

PENNSYLVANIA, 2003

				Number of Rx, Percentage with:							Number	
Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	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]	Beneficiaries	Benefit Months
All	**2.4**	**$150**	**15.0 %**	**45.9 %**	**27.0 %**	**5.8 %**	**10.0 %**	**8.2 %**	**3.1 %**	**$996**	**752,499**	**5,106,556**
Age												
5 and younger	0.4	19	6.7	57.2	39.0	2.7	1.0	0.1	0.0	287	136,475	810,345
6-14	0.6	38	11.3	57.7	34.4	4.3	3.2	0.5	0.1	336	155,008	1,051,070
15-20	0.7	51	12.0	57.3	32.1	5.3	4.2	0.9	0.1	421	105,541	638,011
21-44	1.9	153	21.9	49.0	26.8	7.9	10.2	4.8	1.3	697	161,218	927,405
45-64	4.8	353	24.4	26.7	13.0	8.6	22.5	20.4	8.7	1,450	72,995	584,546
65-74	5.4	311	18.1	24.2	9.5	7.3	22.3	25.3	11.2	1,716	32,661	289,323
75-84	6.1	317	12.5	14.2	7.4	7.0	25.4	32.4	13.8	2,526	43,158	396,855
85 and older	5.9	279	9.2	10.2	7.7	8.0	29.5	33.7	10.9	3,037	45,443	409,001
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	5.8	301	12.1	15.5	8.2	7.5	26.1	30.8	11.9	2,496	121,707	1,098,605
Disabled	3.5	280	22.5	28.6	21.5	10.1	19.9	14.3	5.6	1,243	146,434	1,245,782
Adults	1.1	63	12.7	56.1	27.6	7.0	6.8	2.2	0.3	499	124,011	576,737
Children	0.4	22	9.6	59.6	35.3	3.2	1.7	0.2	0.0	233	360,347	2,185,432
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.8	166	14.8	43.3	26.1	6.0	11.0	9.9	3.8	1,117	440,461	2,993,262
Male	1.8	128	15.5	49.5	28.2	5.7	8.6	5.9	2.1	825	312,038	2,113,294
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.5	159	16.6	37.0	31.2	6.6	11.6	9.8	3.7	956	559,241	4,324,044
African American	1.9	112	8.0	71.2	13.6	3.6	5.7	4.4	1.5	1,398	116,543	488,094
Other/unknown	1.3	83	9.0	71.7	16.4	3.5	4.6	2.9	0.9	928	76,715	294,418
Use of Nursing Facilities[f]												
Entire year	7.4	381	9.1	2.8	4.8	5.6	25.9	39.8	21.1	4,198	41,663	431,726
Part year	6.7	345	11.1	4.8	7.0	7.8	28.6	35.7	16.0	3,124	35,746	302,154
None	1.6	114	21.3	50.7	29.4	5.8	8.0	4.8	1.3	533	675,090	4,372,676
Maintenance Assistance Status												
Cash	2.4	172	24.2	44.3	26.6	6.9	11.5	8.0	2.7	711	241,555	1,681,563
Medically needy	4.4	215	8.7	37.0	16.5	5.4	14.8	18.3	8.0	2,472	54,382	400,814
Poverty related	1.1	74	21.5	53.7	32.9	4.5	5.3	2.9	0.6	344	289,355	1,854,110
Other/unknown	3.8	216	11.2	37.4	20.5	6.8	14.4	14.6	6.3	1,936	167,207	1,170,069

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

PENNSYLVANIA, 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	**2.4**	**$150**	**$62**	**1.1**	**$116**	**$104**	**0.1**	**$4**	**$37**	**1.2**	**$29**	**$25**
Age												
5 and younger	0.4	19	48	0.2	15	94	0.0	1	46	0.2	4	16
6-14	0.6	38	68	0.3	31	96	0.0	1	80	0.2	5	25
15-20	0.7	51	70	0.4	41	104	0.0	2	70	0.3	8	26
21-44	1.9	153	82	0.9	122	139	0.1	5	63	0.9	26	29
45-64	4.8	353	73	2.3	276	122	0.2	10	52	2.4	67	29
65-74	5.4	311	58	2.5	236	97	0.3	8	30	2.7	66	25
75-84	6.1	317	52	2.7	240	87	0.3	8	24	3.0	68	22
85 and older	5.9	279	47	2.5	208	82	0.4	8	21	3.0	62	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.8	301	52	2.6	228	88	0.3	8	24	2.9	65	22
Disabled	3.5	280	80	1.7	223	130	0.1	9	60	1.7	49	29
Adults	1.1	63	60	0.5	49	104	0.0	1	41	0.6	13	24
Children	0.4	22	52	0.2	18	83	0.0	1	58	0.2	4	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.8	166	59	1.3	127	99	0.1	5	32	1.4	33	24
Male	1.8	128	70	0.9	101	116	0.1	4	49	0.9	23	26
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.5	159	62	1.2	123	104	0.1	5	37	1.2	31	25
African American	1.9	112	60	0.8	87	104	0.1	3	39	1.0	22	23
Other/unknown	1.3	83	63	0.6	65	107	0.1	2	37	0.6	16	24
Use of Nursing Facilities[e]												
Entire year	7.4	381	51	3.3	290	88	0.4	10	23	3.7	81	22
Part year	6.7	345	52	2.9	262	91	0.4	10	24	3.4	73	22
None	1.6	114	70	0.8	89	115	0.1	3	53	0.8	21	27
Maintenance Assistance Status												
Cash	2.4	172	71	1.1	135	117	0.1	5	51	1.2	32	27
Medically needy	4.4	215	49	1.9	163	84	0.3	6	23	2.2	46	21
Poverty related	1.1	74	68	0.5	58	109	0.0	2	55	0.5	13	26
Other/unknown	3.8	216	57	1.7	166	98	0.2	6	28	1.9	44	23

Source: Data for this table are from the MAX 2003 file for Pennsylvania, 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 Pennsylvania, 0.5 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]

PENNSYLVANIA, 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	$18	$14	$0	$4	$60	$102	$87	$24	764,396	$46,147,634	256,193	34.0 %	2,594,616
Biologicals	0.1	0.1	0.0	0.0	62	47	1	14	458	428	1,849	571	13,244	6,070,635	9,246	1.2	98,518
Antineoplastic Agents	0.6	0.2	0.0	0.3	165	130	4	31	292	574	302	96	56,190	16,422,524	10,332	1.4	99,294
Endocrine/Metabolic Drugs	0.8	0.4	0.1	0.3	39	29	3	7	47	75	19	23	1,100,546	51,676,695	133,787	17.8	1,334,624
Cardiovascular Agents	1.8	0.6	0.1	1.1	64	41	1	22	36	67	21	19	2,480,001	88,696,307	140,299	18.6	1,383,082
Respiratory Agents	0.6	0.3	0.0	0.2	31	24	1	5	54	75	72	23	987,384	53,559,208	171,829	22.8	1,747,977
Gastrointestinal Agents	0.8	0.4	0.0	0.3	66	52	1	13	87	122	167	40	860,146	75,132,914	113,960	15.1	1,138,873
Genitourinary Agents	0.5	0.4	0.0	0.1	30	28	0	2	62	72	43	21	203,144	12,521,826	40,609	5.4	411,479
CNS Drugs	1.3	0.8	0.0	0.5	106	88	2	16	82	116	101	30	2,096,944	171,598,963	166,943	22.2	1,622,530
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.2	51	43	2	7	75	86	69	41	156,292	11,663,951	22,395	3.0	227,398
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	95	93	0	2	137	140	20	81	145,731	20,014,360	21,097	2.8	210,706
Analgesics and Anesthetics	0.7	0.3	0.0	0.4	44	34	1	8	62	135	80	19	1,072,535	66,618,232	155,424	20.7	1,524,441
Neuromuscular Agents	1.0	0.5	0.0	0.5	72	54	2	16	73	118	57	32	828,264	60,071,089	83,731	11.1	835,054
Nutritional Products	0.5	0.0	0.0	0.4	9	0	0	8	20	33	21	19	317,098	6,250,742	71,067	9.4	685,813
Hematological Agents	1.1	0.3	0.2	0.5	95	85	4	7	91	244	15	15	511,303	46,423,375	49,765	6.6	486,558
Topical Products	0.4	0.2	0.0	0.2	16	10	1	4	40	61	52	22	649,486	26,001,290	157,601	20.9	1,628,623
Miscellaneous Products	0.3	0.1	0.0	0.1	43	32	4	7	146	240	232	48	32,723	4,771,566	10,906	1.4	111,127
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	12	0	0	0	60	0	0	0	28,617	1,710,789	12,941	1.7	137,231
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.	12,304,044	765,352,100	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Pennsylvania, 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 Pennsylvania, 0.5 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]

PENNSYLVANIA, 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	$89,925,953	82,809	11.0 %	845,085	0.7	$153	$106
ANTIDEPRESSANTS	66,694,875	154,570	20.5	1,540,164	0.7	66	43
ULCER DRUGS	63,861,554	111,344	14.8	1,132,584	0.6	95	56
ANTICONVULSANT	47,008,029	70,381	9.4	717,585	0.8	81	66
ANALGESICS - Narcotic	38,545,041	158,456	21.1	1,605,459	0.4	58	24
ANTIASTHMATIC	32,075,736	134,932	17.9	1,384,598	0.4	59	23
ANTIDIABETIC	31,156,583	71,437	9.5	723,848	0.7	58	43
ANTIHYPERLIPIDEMIC	29,387,169	46,962	6.2	492,273	0.7	89	60
ANTIHYPERTENSIVE	21,006,497	80,304	10.7	815,630	0.7	37	26
MISC. HEMATOLOGICAL	20,483,546	20,636	2.7	207,567	0.7	143	99
Total	440,144,983	931,831		9,464,793	n.a.	n.a.	n.a.

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