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

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OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
TEXAS, 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]	3,728,699	(A)	541,529	(E)	3,187,170	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	3,455,188	(B)	375,222	(F)	3,079,966	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	3,328,865	(C)	372,731	(G)	2,956,134	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	61,393	(D)	56,662	(H)	4,731	(L)

Source: Data for this table are from the MAX 2003 file for Texas, 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 Texas in 2003 was $2,009,772,121, of which $6,155,493 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]

TEXAS, 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	**3,328,865**	**272,044**	**373,621**	**476,737**	**2,206,463**	**0**	**25,846,308**	**2,913,535**	**3,899,964**	**2,658,494**	**16,374,315**	**0**
Age												
5 and younger	1,095,995	5	15,923	42	1,080,025	0	8,040,187	27	159,057	380	7,880,723	0
6-14	903,474	2	39,409	511	863,552	0	7,016,739	19	423,338	3,105	6,590,277	0
15-20	368,562	21	26,885	78,998	262,658	0	2,605,438	112	285,307	417,846	1,902,173	0
21-44	493,248	252	122,823	369,965	208	0	3,351,321	1,481	1,291,423	2,057,398	1,019	0
45-64	193,992	440	166,422	27,120	10	0	1,901,368	3,186	1,719,014	179,093	75	0
65-74	108,482	106,768	1,624	87	3	0	1,183,148	1,166,522	16,007	600	19	0
75-84	100,835	100,425	401	9	0	0	1,096,685	1,092,187	4,445	53	0	0
85 and older	64,274	64,131	134	5	4	0	651,416	650,001	1,373	19	23	0
Unknown	3	0	0	0	3	6 0		0	0	0	6	0
Gender												
Female	1,899,488	192,088	192,704	429,728	1,084,968	0	14,551,478	2,071,682	2,035,570	2,384,558	8,059,668	0
Male	1,429,345	79,951	180,915	47,008	1,121,471	0	11,294,722	841,834	1,864,392	273,935	8,314,561	0
Unknown	32	5	2	1	24	0	108	19	2	1	86	0
Race												
White	880,235	123,855	144,941	142,690	468,749	0	6,996,859	1,289,317	1,523,330	774,530	3,409,682	0
African American	617,585	38,340	95,276	99,812	384,157	0	4,612,451	415,619	990,452	548,743	2,657,637	0
Other/unknown	1,831,045	109,849	133,404	234,235	1,353,557	0	14,236,998	1,208,599	1,386,182	1,335,221	10,306,996	0
Use of Nursing Facilities[c]												
Entire year	61,393	53,169	8,220	3	1	0	626,703	538,395	88,302	4	2	0
Part year	31,801	25,444	6,305	43	9	0	308,577	244,891	63,280	325	81	0
None	3,235,671	193,431	359,096	476,691	2,206,453	0	24,911,028	2,130,249	3,748,382	2,658,165	16,374,232	0
Maintenance Assistance Status												
Cash	893,492	172,447	340,092	128,260	252,693	0	8,146,941	1,925,205	3,531,563	726,375	1,963,798	0
Medically needy	76,289	0	0	75,818	471	0	477,420	0	0	475,692	1,728	0
Poverty-related	1,862,258	1,874	1,532	209,368	1,649,484	0	13,080,942	17,302	14,997	957,120	12,091,523	0
Other/unknown	496,826	97,723	31,997	63,291	303,815	0	4,141,005	971,028	353,404	499,307	2,317,266	0
Dual Medicare Status[d]												
Full dual, all year	364,253	261,254	101,238	1,718	43	0	3,928,973	2,808,160	1,109,192	11,274	347	0
Full dual, part year	8,478	5,767	2,692	18	1	0	86,720	58,974	27,547	194	5	0
Non-dual, all year	2,956,134	5,023	269,691	475,001	2,206,419	0	21,830,615	46,401	2,763,225	2,647,026	16,373,963	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	2,274,380	249,648	317,681	322,955	1,384,096	0	20,360,962	2,681,138	3,388,957	2,096,661	12,194,206	0
FFS part year, with Rx claims	510,827	3,284	17,732	93,539	396,272	0	1,550,127	13,151	82,256	261,060	1,193,660	0
FFS part year, no Rx claims	218,125	467	2,317	23,622	191,719	0	631,640	1,720	10,089	59,361	560,470	0
MC all year, with FFS Rx claims	325,533	18,645	35,891	36,621	234,376	0	3,303,579	217,526	418,662	241,412	2,425,979	0

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

TEXAS, 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	**75.7 %**	**9.8**	**$602**	**$61**	**$3,571**	**16.9 %**	**3,328,865**
Age							
5 and younger	77.7	6.5	202	31	1,930	10.5	1,095,995
6-14	69.0	5.3	295	55	1,349	21.8	903,474
15-20	68.7	5.4	338	62	2,190	15.4	368,562
21-44	77.1	8.9	714	80	4,680	15.3	493,248
45-64	83.3	25.2	2,155	86	10,967	19.7	193,992
65-74	89.5	28.1	2,091	75	8,529	24.5	108,482
75-84	92.3	36.3	2,374	66	12,337	19.2	100,835
85 and older	94.3	44.4	2,409	54	17,771	13.6	64,274
Unknown	33.3	1.3	65	49	708	9.2	3
Basis of Eligibility[e]							
Aged	91.7	34.9	2,266	65	12,099	18.7	272,044
Disabled	82.8	21.9	2,072	95	11,789	17.6	373,621
Adults	76.6	5.9	285	48	2,375	12.0	476,737
Children	72.4	5.6	216	39	1,387	15.6	2,206,463
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	77.6	10.8	641	60	3,743	17.1	1,899,488
Male	73.2	8.6	550	64	3,344	16.4	1,429,345
Unknown	28.1	3.3	172	52	1,521	11.3	32
Race							
White	77.3	14.6	990	68	5,772	17.1	880,235
African American	71.0	8.8	549	63	3,314	16.6	617,585
Other/unknown	76.5	7.9	434	55	2,600	16.7	1,831,045
Use of Nursing Facilities[f]							
Entire year	98.0	73.3	4,119	56	28,777	14.3	61,393
Part year	94.7	50.9	3,030	60	23,066	13.1	31,801
None	75.1	8.2	511	62	2,901	17.6	3,235,671
Maintenance Assistance Status							
Cash	80.0	14.4	1,186	82	5,560	21.3	893,492
Medically needy	68.9	6.3	390	62	2,771	14.1	76,289
Poverty related	72.6	5.3	201	38	1,322	15.2	1,862,258
Other/unknown	80.7	19.0	1,087	57	8,550	12.7	496,826

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

TEXAS, 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	**1.3**	**$78**	**16.9 %**	**24.3 %**	**48.9 %**	**11.9 %**	**9.8 %**	**3.5 %**	**1.6 %**	**$460**	**3,328,865**	**25,846,308**
Age												
5 and younger	0.9	28	10.5	22.3	56.3	10.8	7.1	2.2	1.3	263	1,095,995	8,040,187
6-14	0.7	38	21.8	31.0	53.4	7.6	5.6	1.6	0.8	174	903,474	7,016,739
15-20	0.8	48	15.4	31.3	50.8	8.3	6.6	2.1	0.9	310	368,562	2,605,438
21-44	1.3	105	15.3	22.9	46.7	14.6	10.7	3.2	1.9	689	493,248	3,351,321
45-64	2.6	220	19.7	16.7	25.7	22.3	24.6	6.8	3.9	1,119	193,992	1,901,368
65-74	2.6	192	24.5	10.5	27.2	26.2	24.8	7.6	3.7	782	108,482	1,183,148
75-84	3.3	218	19.2	7.7	22.0	22.9	27.1	14.9	5.5	1,134	100,835	1,096,685
85 and older	4.4	238	13.6	5.7	15.1	15.8	31.2	25.9	6.4	1,753	64,274	651,416
Unknown	0.7	33	9.2	66.7	0.0	0.0	33.3	0.0	0.0	354	3	6
Basis of Eligibility[e]												
Aged	3.3	212	18.7	8.3	22.5	22.5	27.1	14.6	5.0	1,130	272,044	2,913,535
Disabled	2.1	199	17.6	17.2	33.9	19.6	20.8	5.5	2.9	1,129	373,621	3,899,964
Adults	1.1	51	12.0	23.4	49.9	13.1	8.8	3.1	1.7	426	476,737	2,658,494
Children	0.8	29	15.6	27.6	54.5	8.9	6.1	1.8	1.0	187	2,206,463	16,374,315
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.4	84	17.1	22.4	48.5	12.5	10.8	4.0	1.9	489	1,899,488	14,551,478
Male	1.1	70	16.4	26.8	49.5	10.9	8.6	2.8	1.3	423	1,429,345	11,294,722
Unknown	1.0	51	11.3	71.9	12.5	9.4	3.1	0.0	3.1	451	32	108
Race												
White	1.8	125	17.1	22.7	43.3	12.8	12.9	5.7	2.6	726	880,235	6,996,859
African American	1.2	74	16.6	29.0	45.2	10.5	9.9	3.6	1.7	444	617,585	4,612,451
Other/unknown	1.0	56	16.7	23.5	52.9	11.9	8.3	2.4	1.1	334	1,831,045	14,236,998
Use of Nursing Facilities[f]												
Entire year	7.2	404	14.3	2.0	3.5	5.2	27.7	44.1	17.5	2,819	61,393	626,703
Part year	5.2	312	13.1	5.3	10.1	11.3	33.7	30.1	9.5	2,377	31,801	308,577
None	1.1	66	17.6	24.9	50.2	12.0	9.3	2.4	1.3	377	3,235,671	24,911,028
Maintenance Assistance Status												
Cash	1.6	130	21.3	20.0	41.0	18.0	16.0	3.2	1.7	610	893,492	8,146,941
Medically needy	1.0	62	14.1	31.1	44.4	16.1	7.5	0.6	0.3	443	76,289	477,420
Poverty related	0.8	29	15.2	27.4	53.6	9.3	6.4	2.2	1.1	188	1,862,258	13,080,942
Other/unknown	2.3	130	12.7	19.3	46.3	9.7	11.8	9.3	3.6	1,026	496,826	4,141,005

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

TEXAS, 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	**1.3**	**$78**	**$61**	**0.6**	**$63**	**$105**	**0.1**	**$3**	**$45**	**0.6**	**$12**	**$20**
Age												
5 and younger	0.9	28	31	0.4	20	53	0.1	2	26	0.4	6	13
6-14	0.7	38	55	0.3	31	88	0.0	2	43	0.3	5	18
15-20	0.8	48	62	0.4	39	108	0.0	2	57	0.4	7	18
21-44	1.3	105	80	0.6	87	150	0.1	4	70	0.7	14	21
45-64	2.6	220	86	1.3	184	146	0.1	6	71	1.2	30	24
65-74	2.6	192	75	1.4	160	118	0.1	4	53	1.1	27	24
75-84	3.3	218	66	1.7	179	107	0.1	5	44	1.5	34	22
85 and older	4.4	238	54	2.0	188	94	0.2	6	36	2.2	44	20
Unknown	0.7	33	49	0.5	31	62	0.0	0	0	0.2	2	9
Basis of Eligibility[d]												
Aged	3.3	212	65	1.6	173	107	0.1	5	44	1.5	33	22
Disabled	2.1	199	95	1.0	167	162	0.1	7	81	1.0	24	25
Adults	1.1	51	48	0.4	39	92	0.0	2	41	0.6	10	17
Children	0.8	29	39	0.3	22	65	0.1	2	32	0.3	5	15
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.4	84	60	0.7	67	103	0.1	3	43	0.7	13	19
Male	1.1	70	64	0.5	57	109	0.1	3	47	0.5	10	20
Unknown	1.0	51	52	0.5	43	92	0.0	0	0	0.5	8	16
Race												
White	1.8	125	68	0.9	102	116	0.1	4	54	0.9	18	21
African American	1.2	74	63	0.5	60	111	0.0	2	52	0.6	11	19
Other/unknown	1.0	56	55	0.5	45	94	0.1	3	38	0.5	9	18
Use of Nursing Facilities[e]												
Entire year	7.2	404	56	3.3	324	98	0.2	9	37	3.6	70	20
Part year	5.2	312	60	2.4	251	104	0.2	8	43	2.6	53	20
None	1.1	66	62	0.5	54	107	0.1	3	45	0.5	10	19
Maintenance Assistance Status												
Cash	1.6	130	82	0.8	109	138	0.1	4	63	0.7	17	23
Medically needy	1.0	62	62	0.4	50	115	0.0	2	49	0.5	11	20
Poverty related	0.8	29	38	0.3	21	64	0.1	2	32	0.4	5	15
Other/unknown	2.3	130	57	1.1	105	99	0.1	4	41	1.1	21	19

Source: Data for this table are from the MAX 2003 file for Texas, 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 Texas, 0.8 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007)

d. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

e. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 6

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY[a, b, c, d]

TEXAS, 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	$15	$12	$1	$3	$51	$80	$68	$20	4,545,011	$232,409,831	1,752,172	52.6 %	15,590,577
Biologicals	0.7	0.0	0.1	0.5	####	656	204	926	2715	17,738	1,578	1,884	356	966,385	50	0.0	541
Antineoplastic Agents	0.4	0.1	0.0	0.3	93	62	2	29	243	546	190	113	103,343	25,130,990	26,176	0.8	269,362
Endocrine/Metabolic Drugs	0.4	0.2	0.0	0.1	28	24	1	3	66	99	31	24	2,340,411	155,228,312	577,694	17.4	5,470,808
Cardiovascular Agents	1.0	0.4	0.0	0.5	51	40	1	11	53	96	49	20	4,063,932	215,168,404	397,958	12.0	4,203,327
Respiratory Agents	0.4	0.2	0.0	0.2	18	15	1	3	42	67	33	14	6,330,592	266,157,363	1,610,444	48.4	14,397,492
Gastrointestinal Agents	0.4	0.2	0.0	0.2	34	29	1	5	79	115	148	27	1,696,558	134,801,417	400,508	12.0	3,955,575
Genitourinary Agents	0.3	0.2	0.0	0.1	19	18	0	1	64	74	46	22	448,709	28,681,463	173,015	5.2	1,500,245
CNS Drugs	0.7	0.4	0.0	0.3	79	70	2	7	106	167	154	22	3,358,367	355,308,479	453,708	13.6	4,504,733
Stimulants/Anti-obesity/Anorexia	0.6	0.4	0.0	0.1	50	44	2	4	91	101	83	46	453,891	41,253,558	84,873	2.5	820,594
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	86	85	0	1	148	152	0	51	194,553	28,790,819	31,526	0.9	334,767
Analgesics and Anesthetics	0.3	0.1	0.0	0.2	16	11	1	3	46	149	28	15	3,496,794	159,819,525	1,114,017	33.5	10,256,681
Neuromuscular Agents	0.6	0.3	0.0	0.3	50	40	2	8	86	157	75	27	1,516,006	130,454,604	256,599	7.7	2,621,930
Nutritional Products	0.3	0.0	0.0	0.2	6	1	1	3	18	28	26	15	774,722	14,303,887	311,694	9.4	2,598,072
Hematological Agents	0.5	0.2	0.0	0.2	75	68	1	5	160	313	33	25	600,842	96,262,919	132,149	4.0	1,282,531
Topical Products	0.3	0.1	0.0	0.1	11	8	1	2	40	61	54	18	2,604,556	104,741,027	1,078,014	32.4	9,914,470
Miscellaneous Products	0.3	0.1	0.0	0.2	87	65	12	10	261	606	380	50	31,472	8,225,480	9,107	0.3	95,011
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	5	0	0	0	31	0	0	0	189,857	5,912,165	142,688	4.3	1,254,157
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.	32,749,972	2,003,616,628	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Texas, 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 Texas, 0.8 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]

TEXAS, 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	$212,824,348	168,439	5.1 %	1,793,545	0.5	$237	$119
ANTIASTHMATIC	114,784,889	732,542	22.0	7,006,233	0.2	68	16
ANTIDEPRESSANTS	108,486,121	321,962	9.7	3,262,432	0.4	78	33
ANTICONVULSANT	108,074,297	165,541	5.0	1,768,394	0.6	111	61
ULCER DRUGS	103,227,955	335,367	10.1	3,407,296	0.3	87	30
ANTIDIABETIC	92,118,268	224,778	6.8	2,426,369	0.4	86	38
ANALGESICS - ANTI-INFLAMMATORY	90,207,415	803,492	24.1	7,759,295	0.2	53	12
ANTIHYPERLIPIDEMIC	73,098,665	138,974	4.2	1,541,269	0.4	131	47
ANTIHYPERTENSIVE	63,498,837	270,601	8.1	2,939,258	0.4	52	22
DERMATOLOGICAL	62,722,324	1,089,953	32.7	10,489,122	0.2	39	6
Total	1,029,043,119	4,251,649		42,393,213	n.a.	n.a.	n.a.

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