STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
WEST VIRGINIA

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

SUPPLEMENTAL TABLES

APPENDIX TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
WEST VIRGINIA, 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]	369,039	(A)	60,926	(E)	308,113	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	357,835	(B)	49,811	(F)	308,024	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	348,232	(C)	49,806	(G)	298,426	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	7,250	(D)	6,786	(H)	464	(L)

Source: Data for this table are from the MAX 2003 file for West Virginia, 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 West Virginia in 2003 was $357,683,874, of which $3,217,609 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]

WEST VIRGINIA, 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	**348,232**	**24,304**	**92,095**	**59,444**	**172,389**	**0**	**3,127,495**	**249,946**	**991,076**	**380,939**	**1,505,534**	**0**
Age												
5 and younger	66,452	0	1,847	546	64,059	0	572,255	0	19,143	5,502	547,610	0
6-14	83,447	0	5,818	772	76,857	0	765,399	0	65,095	7,558	692,746	0
15-20	41,545	20	4,627	5,465	31,433	0	351,394	155	50,862	35,430	264,947	0
21-44	85,042	226	35,371	49,412	33	0	696,041	1,426	384,115	310,300	200	0
45-64	44,153	112	40,803	3,234	4	0	456,870	893	433,884	22,078	15	0
65-74	11,668	9,767	1,889	10	2	0	125,280	105,290	19,930	53	7	0
75-84	9,155	8,093	1,058	4	0	0	94,953	83,933	11,003	17	0	0
85 and older	6,768	6,086	681	1	0	0	65,293	58,249	7,043	1	0	0
Unknown	2	0	1	0	1	0	10	0	1	0	9	0
Gender												
Female	199,247	17,430	48,219	48,367	85,231	0	1,763,048	180,655	523,605	314,662	744,126	0
Male	148,985	6,874	43,876	11,077	87,158	0	1,364,447	69,291	467,471	66,277	761,408	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	329,215	23,434	88,499	55,867	161,415	0	2,961,025	240,932	952,937	357,119	1,410,037	0
African American	18,246	825	3,489	3,468	10,464	0	159,856	8,566	37,061	23,147	91,082	0
Other/unknown	771	45	107	109	510	0	6,614	448	1,078	673	4,415	0
Use of Nursing Facilities[c]												
Entire year	7,250	6,403	847	0	0	0	71,277	62,120	9,157	0	0	0
Part year	3,694	2,897	793	4	0	0	35,333	27,330	7,979	24	0	0
None	337,288	15,004	90,455	59,440	172,389	0	3,020,885	160,496	973,940	380,915	1,505,534	0
Maintenance Assistance Status												
Cash	119,560	13,755	79,562	26,066	177	0	1,200,851	155,854	872,795	170,812	1,390	0
Medically needy	6,853	749	3,654	2,419	31	0	40,826	4,350	23,366	12,978	132	0
Poverty-related	182,343	605	669	15,957	165,112	0	1,542,890	4,998	7,071	99,045	1,431,776	0
Other/unknown	39,476	9,195	8,210	15,002	7,069	0	342,928	84,744	87,844	98,104	72,236	0
Dual Medicare Status[d]												
Full dual, all year	48,436	22,932	24,959	538	7	0	512,529	237,235	271,762	3,471	61	0
Full dual, part year	1,370	445	901	24	0	0	14,545	4,653	9,647	245	0	0
Non-dual, all year	298,426	927	66,235	58,882	172,382	0	2,600,421	8,058	709,667	377,223	1,505,473	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	280,639	24,300	90,978	42,667	122,694	0	2,689,241	249,922	983,194	295,583	1,160,542	0
FFS part year, with Rx claims	31,749	4	905	9,987	20,853	0	131,315	24	5,696	35,154	90,441	0
FFS part year, no Rx claims	9,845	0	42	1,916	7,887	0	33,454	0	243	5,360	27,851	0
MC all year, with FFS Rx claims	25,999	0	170	4,874	20,955	0	273,485	0	1,943	44,842	226,700	0

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

WEST VIRGINIA, 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	**79.9 %**	**19.4**	**$1,018**	**$52**	**$4,665**	**21.8 %**	**348,232**
Age							
5 and younger	75.2	5.2	206	39	1,260	16.4	66,452
6-14	77.2	7.0	393	56	1,864	21.1	83,447
15-20	75.3	8.1	426	53	2,950	14.5	41,545
21-44	81.2	19.9	1,122	56	4,619	24.3	85,042
45-64	87.8	50.3	2,782	55	9,618	28.9	44,153
65-74	88.0	57.3	2,752	48	10,502	26.2	11,668
75-84	90.8	60.0	2,685	45	17,134	15.7	9,155
85 and older	92.3	54.5	2,267	42	24,480	9.3	6,768
Unknown	0.0	0.0	0	0	0	0.0	2
Basis of Eligibility[e]							
Aged	89.9	56.3	2,549	45	16,285	15.7	24,304
Disabled	86.4	40.6	2,389	59	9,244	25.8	92,095
Adults	79.1	11.0	453	41	2,166	20.9	59,444
Children	75.4	5.9	265	45	1,441	18.4	172,389
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	82.5	22.4	1,121	50	4,991	22.5	199,247
Male	76.6	15.5	880	57	4,228	20.8	148,985
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	80.4	19.9	1,040	52	4,727	22.0	329,215
African American	71.5	12.1	641	53	3,577	17.9	18,246
Other/unknown	69.8	10.8	622	58	3,739	16.6	771
Use of Nursing Facilities[f]							
Entire year	97.3	71.6	3,325	46	39,342	8.5	7,250
Part year	96.0	67.8	3,187	47	29,102	11.0	3,694
None	79.4	17.8	945	53	3,652	25.9	337,288
Maintenance Assistance Status							
Cash	84.7	35.6	1,966	55	6,547	30.0	119,560
Medically needy	80.9	23.5	1,393	59	5,794	24.0	6,853
Poverty related	75.6	6.0	260	43	1,222	21.3	182,343
Other/unknown	85.5	31.9	1,582	50	14,671	10.8	39,476

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

WEST VIRGINIA, 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	**2.2**	**$113**	**21.8 %**	**20.1 %**	**44.1 %**	**9.7 %**	**13.7 %**	**9.3 %**	**3.1 %**	**$519**	**348,232**	**3,127,495**
Age												
5 and younger	0.6	24	16.4	24.8	63.1	6.5	3.8	1.2	0.6	146	66,452	572,255
6-14	0.8	43	21.1	22.8	60.3	8.3	6.2	1.5	0.9	203	83,447	765,399
15-20	1.0	50	14.5	24.7	53.7	10.3	8.2	2.1	1.1	349	41,545	351,394
21-44	2.4	137	24.3	18.8	35.4	13.8	19.9	9.2	2.8	564	85,042	696,041
45-64	4.9	269	28.9	12.2	14.6	9.6	27.2	27.8	8.7	930	44,153	456,870
65-74	5.3	256	26.2	12.0	11.0	7.9	26.2	31.9	11.1	978	11,668	125,280
75-84	5.8	259	15.7	9.2	8.7	7.2	26.8	36.0	12.1	1,652	9,155	94,953
85 and older	5.6	235	9.3	7.7	7.9	7.8	30.1	36.6	10.0	2,538	6,768	65,293
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	2	10
Basis of Eligibility[e]												
Aged	5.5	248	15.7	10.1	9.9	7.9	27.6	33.7	10.8	1,584	24,304	249,946
Disabled	3.8	222	25.8	13.6	23.5	11.3	25.3	20.5	5.8	859	92,095	991,076
Adults	1.7	71	20.9	20.9	41.8	14.0	15.5	5.4	2.5	338	59,444	380,939
Children	0.7	30	18.4	24.6	60.8	7.5	4.8	1.3	0.8	165	172,389	1,505,534
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.5	127	22.5	17.5	42.3	10.1	14.8	11.2	4.0	564	199,247	1,763,048
Male	1.7	96	20.8	23.4	46.6	9.1	12.1	6.9	2.0	462	148,985	1,364,447
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.2	116	22.0	19.6	44.0	9.8	13.9	9.6	3.2	526	329,215	2,961,025
African American	1.4	73	17.9	28.5	47.5	7.8	9.3	5.3	1.7	408	18,246	159,856
Other/unknown	1.3	73	16.6	30.2	46.3	9.7	9.7	2.9	1.2	436	771	6,614
Use of Nursing Facilities[f]												
Entire year	7.3	338	8.5	2.7	5.7	5.8	24.9	40.7	20.1	4,002	7,250	71,277
Part year	7.1	333	11.0	4.0	5.7	5.8	27.3	38.9	18.3	3,043	3,694	35,333
None	2.0	106	25.9	20.6	45.4	9.8	13.3	8.3	2.6	408	337,288	3,020,885
Maintenance Assistance Status												
Cash	3.5	196	30.0	15.3	26.0	11.8	23.9	18.0	5.0	652	119,560	1,200,851
Medically needy	3.9	234	24.0	19.1	18.6	11.5	27.2	18.6	4.8	973	6,853	40,826
Poverty related	0.7	31	21.3	24.4	59.7	7.9	5.4	1.6	1.0	144	182,343	1,542,890
Other/unknown	3.7	182	10.8	14.5	31.7	11.0	18.3	17.3	7.2	1,689	39,476	342,928

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

WEST VIRGINIA, 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	**2.2**	**$113**	**$52**	**0.9**	**$84**	**$94**	**0.1**	**$3**	**$39**	**1.2**	**$26**	**$22**
Age												
5 and younger	0.6	24	39	0.3	18	69	0.0	1	36	0.3	5	16
6-14	0.8	43	56	0.4	33	83	0.0	3	68	0.3	7	22
15-20	1.0	50	53	0.4	38	87	0.0	2	59	0.5	10	21
21-44	2.4	137	56	0.9	103	108	0.1	3	41	1.4	31	22
45-64	4.9	269	55	2.0	200	98	0.1	5	34	2.7	63	24
65-74	5.3	256	48	2.2	186	86	0.2	5	27	3.0	65	22
75-84	5.8	259	45	2.2	184	82	0.2	6	27	3.3	68	21
85 and older	5.6	235	42	2.0	162	80	0.2	6	26	3.4	67	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.5	248	45	2.1	176	83	0.2	6	27	3.1	65	21
Disabled	3.8	222	59	1.6	168	106	0.1	5	40	2.1	49	24
Adults	1.7	71	41	0.6	50	81	0.1	2	31	1.0	19	18
Children	0.7	30	45	0.3	22	71	0.0	2	53	0.3	6	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.5	127	50	1.0	93	90	0.1	3	34	1.4	30	21
Male	1.7	96	57	0.7	72	100	0.1	3	52	0.9	21	23
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.2	116	52	0.9	86	94	0.1	3	39	1.2	27	22
African American	1.4	73	53	0.6	55	94	0.0	2	43	0.8	16	21
Other/unknown	1.3	73	58	0.6	57	95	0.0	2	42	0.6	14	22
Use of Nursing Facilities[e]												
Entire year	7.3	338	46	2.7	237	88	0.3	8	30	4.3	92	21
Part year	7.1	333	47	2.7	237	88	0.2	7	29	4.1	88	21
None	2.0	106	53	0.8	79	94	0.1	3	40	1.1	24	22
Maintenance Assistance Status												
Cash	3.5	196	55	1.5	146	100	0.1	4	38	2.0	45	23
Medically needy	3.9	234	59	1.6	176	112	0.1	4	39	2.3	53	24
Poverty related	0.7	31	43	0.3	22	70	0.0	2	50	0.4	7	19
Other/unknown	3.7	182	50	1.5	133	91	0.1	5	32	2.1	44	21

Source: Data for this table are from the MAX 2003 file for West Virginia, 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 West Virginia, 0.6 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]

WEST VIRGINIA, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.2	$15	$10	$0	$4	$46	$71	$70	$24	649,756	$30,025,326	206,380	59.3 %	2,042,349
Biologicals	0.4	0.4	0.0	0.0	388	370	7	11	1024	998	2,128	2,126	1,938	1,984,620	574	0.2	5,111
Antineoplastic Agents	0.5	0.2	0.0	0.3	131	104	3	24	251	487	179	82	18,987	4,763,616	3,530	1.0	36,430
Endocrine/Metabolic Drugs	0.7	0.3	0.1	0.2	33	25	2	6	47	76	17	23	610,816	28,772,823	85,209	24.5	863,427
Cardiovascular Agents	1.6	0.6	0.0	1.0	61	42	0	19	38	69	27	19	1,182,456	44,948,201	69,484	20.0	738,330
Respiratory Agents	0.5	0.3	0.0	0.2	26	20	2	4	50	73	60	20	798,117	40,005,360	150,374	43.2	1,526,081
Gastrointestinal Agents	0.6	0.3	0.0	0.4	39	29	1	9	61	115	198	24	413,483	25,312,197	61,459	17.6	648,471
Genitourinary Agents	0.3	0.3	0.0	0.1	18	17	0	1	53	65	37	18	84,323	4,475,699	24,704	7.1	246,014
CNS Drugs	1.1	0.5	0.0	0.6	78	63	1	13	70	121	108	23	1,064,107	74,558,250	93,769	26.9	961,366
Stimulants/Anti-obesity/Anorexia	0.8	0.5	0.0	0.2	56	45	1	10	72	83	65	46	114,645	8,289,581	14,760	4.2	149,216
Miscellaneous Psychological/ Neurological Agents	0.6	0.5	0.0	0.1	76	73	0	3	135	143	61	56	30,522	4,125,080	5,108	1.5	54,245
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	23	12	0	10	35	130	57	19	764,425	27,122,334	121,502	34.9	1,204,981
Neuromuscular Agents	0.7	0.3	0.0	0.4	56	45	1	10	75	131	50	26	449,282	33,625,417	57,693	16.6	603,732
Nutritional Products	0.5	0.0	0.0	0.4	9	1	1	8	18	17	16	18	129,928	2,357,566	27,363	7.9	263,782
Hematological Agents	0.7	0.3	0.0	0.4	51	44	1	7	73	157	26	17	135,930	9,864,136	18,422	5.3	191,901
Topical Products	0.3	0.1	0.0	0.1	11	7	0	3	40	60	51	23	287,195	11,344,928	104,304	30.0	1,068,482
Miscellaneous Products	0.4	0.1	0.0	0.3	79	57	8	14	179	403	217	53	8,324	1,490,101	1,830	0.5	18,942
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	10	0	0	0	51	0	0	0	27,334	1,401,030	14,273	4.1	146,729
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.	6,771,568	354,466,265	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for West Virginia, 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 West Virginia, 0.6 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]

WEST VIRGINIA, 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	$34,962,260	30,083	8.6 %	325,919	0.6	$174	$107
ANTIDEPRESSANTS	31,247,806	87,900	25.2	913,798	0.5	64	34
ANTICONVULSANT	29,379,743	43,853	12.6	471,197	0.7	91	62
ANTIASTHMATIC	23,286,928	106,659	30.6	1,114,427	0.4	60	21
ULCER DRUGS	20,680,594	62,331	17.9	668,824	0.5	66	31
ANTIHYPERLIPIDEMIC	18,996,474	30,212	8.7	336,602	0.6	91	56
ANTIDIABETIC	17,482,428	36,959	10.6	401,292	0.7	64	44
ANALGESICS - Narcotic	15,541,569	139,648	40.1	1,399,488	0.4	31	11
ANTIHYPERTENSIVE	11,158,188	45,900	13.2	497,138	0.6	35	22
ANTIHISTAMINES	9,818,841	88,623	25.4	926,255	0.2	47	11
Total	212,554,831	672,168		7,054,940	n.a.	n.a.	n.a.

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