STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2004
D.C.

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

SUPPLEMENTAL TABLES

APPENDIX TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
D.C., 2004

Inclusion Criteria (2004)	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]	162,905	(A)	19,778	(E)	143,127	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	160,250	(B)	18,446	(F)	141,804	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	72,528	(C)	18,188	(G)	54,340	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	2,609	(D)	2,109	(H)	500	(L)

Source: Data for this table are from the MAX 2004 file for D.C., released by CMS in 02/2008. This table was produced on 03/06/2008.

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 2004 (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 2004, 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 D.C. in 2004 was $105,459,322, of which $2,164,472 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 23 states in 2004 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NY, OK, OR, PA, SC, 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) and one state (NV) in which MC plans provided a pharmacy benefit for nonduals but not for duals. These lists were constructed from the CMS 2004 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer04.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 pa

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 2004. 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 2004. 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]

D.C., 2004

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**72,528**	**9,427**	**29,545**	**12,390**	**21,166**	**0**	**553,921**	**97,500**	**293,984**	**58,741**	**103,696**	**0**
Age												
5 and younger	8,536	0	534	4	7,998	0	34,259	0	3,751	10	30,498	0
6-14	10,046	0	1,680	7	8,359	0	57,596	0	14,185	25	43,386	0
15-20	6,694	0	1,121	869	4,704	0	42,467	0	10,183	2,819	29,465	0
21-44	16,757	6	8,333	8,333	85	0	115,781	47	81,794	33,650	290	0
45-64	17,209	38	14,099	3,071	1	0	164,613	348	142,884	21,380	1	0
65-74	6,069	3,442	2,544	83	0	0	64,322	35,710	27,956	656	0	0
75-84	4,618	3,670	926	22	0	0	48,997	38,762	10,046	189	0	0
85 and older	2,580	2,271	308	1	0	0	25,830	22,633	3,185	12	0	0
Unknown	19	0	0	0	19	0	56	0	0	0	56	0
Gender												
Female	40,700	6,691	14,500	9,135	10,374	0	307,275	69,855	149,120	38,095	50,205	0
Male	31,828	2,736	15,045	3,255	10,792	0	246,646	27,645	144,864	20,646	53,491	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	2,340	582	1,367	242	149	0	20,916	5,623	13,213	1,362	718	0
African American	60,869	7,319	25,251	10,782	17,517	0	465,682	75,782	250,620	50,146	89,134	0
Other/unknown	9,319	1,526	2,927	1,366	3,500	0	67,323	16,095	30,151	7,233	13,844	0
Use of Nursing Facilities[c]												
Entire year	2,609	2,107	452	50	0	0	27,874	22,405	4,921	548	0	0
Part year	1,869	1,018	800	51	0	0	18,232	9,670	8,091	471	0	0
None	68,050	6,302	28,293	12,289	21,166	0	507,815	65,425	280,972	57,722	103,696	0
Maintenance Assistance Status												
Cash	37,119	2,843	21,029	7,401	5,846	0	302,751	31,040	218,574	32,953	20,184	0
Medically needy	16,460	3,188	5,377	3,119	4,776	0	102,347	30,583	42,865	12,467	16,432	0
Poverty-related	11,100	2,247	2,780	424	5,649	0	72,315	24,148	28,756	1,334	18,077	0
Other/unknown	7,849	1,149	359	1,446	4,895	0	76,508	11,729	3,789	11,987	49,003	0
Dual Medicare Status[d]												
Full dual, all year	17,702	8,005	9,092	602	3	0	188,535	84,486	98,290	5,726	33	0
Full dual, part year	486	231	227	28	0	0	5,261	2,469	2,517	275	0	0
Non-dual, all year	54,340	1,191	20,226	11,760	21,163	0	360,125	10,545	193,177	52,740	103,663	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	50,729	9,409	28,134	5,132	8,054	0	486,469	97,374	287,072	38,017	64,006	0
FFS part year, with Rx claims	4,701	12	660	1,957	2,072	0	18,622	90	3,809	6,619	8,104	0
FFS part year, no Rx claims	17,098	6	751	5,301	11,040	0	48,830	36	3,103	14,105	31,586	0

Source: Data for this table are from the MAX 2004 file for D.C., released by CMS in 02/2008. This table was produced on 03/06/2008.

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 2004. 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]

D.C., 2004

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	**48.3 %**	**15.9**	**$1,424**	**$89**	**$12,178**	**11.7 %**	**72,528**
Age							
5 and younger	21.7	0.8	64	78	4,401	1.5	8,536
6-14	24.2	2.4	247	105	4,796	5.1	10,046
15-20	29.5	2.7	248	93	8,009	3.1	6,694
21-44	48.1	11.9	1,585	133	11,377	13.9	16,757
45-64	70.9	30.6	2,925	95	18,368	15.9	17,209
65-74	72.2	33.5	1,995	60	14,282	14.0	6,069
75-84	64.1	28.6	1,583	55	18,004	8.8	4,618
85 and older	44.7	17.9	895	50	26,105	3.4	2,580
Unknown	0.0	0.0	0	0	0	0.0	19
Basis of Eligibility[e]							
Aged	56.5	23.7	1,325	56	19,423	6.8	9,427
Disabled	69.7	28.0	2,647	95	18,105	14.6	29,545
Adults	36.2	5.9	780	132	4,910	15.9	12,390
Children	21.9	1.6	139	90	4,932	2.8	21,166
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	50.9	17.9	1,371	77	11,535	11.9	40,700
Male	45.0	13.5	1,493	111	13,001	11.5	31,828
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	50.8	22.1	2,172	98	18,871	11.5	2,340
African American	49.0	16.0	1,423	89	12,365	11.5	60,869
Other/unknown	43.3	13.8	1,246	90	9,280	13.4	9,319
Use of Nursing Facilities[f]							
Entire year	17.4	12.6	759	60	57,827	1.3	2,609
Part year	55.5	25.5	1,906	75	51,464	3.7	1,869
None	49.3	15.8	1,437	91	9,349	15.4	68,050
Maintenance Assistance Status							
Cash	55.3	19.9	1,850	93	12,294	15.0	37,119
Medically needy	32.5	9.2	829	91	17,750	4.7	16,460
Poverty related	44.6	16.4	1,317	80	4,865	27.1	11,100
Other/unknown	53.5	10.9	811	74	10,288	7.9	7,849

Source: Data for this table are from the MAX 2004 file for D.C., released by CMS in 02/2008. This table was produced on 03/06/2008.

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]

D.C., 2004

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	**2.1**	**$187**	**11.7 %**	**51.7 %**	**19.3 %**	**6.8 %**	**13.4 %**	**7.4 %**	**1.3 %**	**$1,595**	**72,528**	**553,921**
Age												
5 and younger	0.2	16	1.5	78.3	19.3	1.7	0.7	0.1	0.0	1,097	8,536	34,259
6-14	0.4	43	5.1	75.8	18.6	2.8	2.4	0.4	0.0	836	10,046	57,596
15-20	0.4	39	3.1	70.5	23.4	3.1	2.4	0.6	0.0	1,262	6,694	42,467
21-44	1.7	229	13.9	51.9	23.5	7.8	11.5	4.4	0.9	1,647	16,757	115,781
45-64	3.2	306	15.9	29.1	18.7	10.3	23.7	15.0	3.3	1,920	17,209	164,613
65-74	3.2	188	14.0	27.8	14.9	10.5	26.9	17.4	2.5	1,348	6,069	64,322
75-84	2.7	149	8.8	35.9	13.0	9.2	26.1	14.4	1.3	1,697	4,618	48,997
85 and older	1.8	89	3.4	55.3	10.4	7.0	17.9	8.4	0.9	2,608	2,580	25,830
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	19	56
Basis of Eligibility[e]												
Aged	2.3	128	6.8	43.5	13.0	8.8	22.1	11.2	1.4	1,878	9,427	97,500
Disabled	2.8	266	14.6	30.3	21.8	9.9	21.9	13.4	2.6	1,820	29,545	293,984
Adults	1.2	165	15.9	63.8	20.2	6.2	7.1	2.3	0.3	1,036	12,390	58,741
Children	0.3	28	2.8	78.1	18.1	2.0	1.5	0.3	0.0	1,007	21,166	103,696
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.4	182	11.9	49.1	19.4	6.8	14.6	8.5	1.6	1,528	40,700	307,275
Male	1.7	193	11.5	55.0	19.3	6.8	12.0	5.9	0.9	1,678	31,828	246,646
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	243	11.5	49.2	14.0	7.0	16.5	10.6	2.8	2,111	2,340	20,916
African American	2.1	186	11.5	51.0	19.8	6.9	13.5	7.4	1.3	1,616	60,869	465,682
Other/unknown	1.9	173	13.4	56.7	17.3	6.3	12.6	6.2	0.8	1,285	9,319	67,323
Use of Nursing Facilities[f]												
Entire year	1.2	71	1.3	82.6	1.6	1.2	5.6	5.7	3.3	5,413	2,609	27,874
Part year	2.6	195	3.7	44.5	14.2	7.4	18.7	11.4	3.8	5,276	1,869	18,232
None	2.1	193	15.4	50.7	20.2	7.0	13.6	7.3	1.2	1,253	68,050	507,815
Maintenance Assistance Status												
Cash	2.4	227	15.0	44.7	20.4	7.8	16.1	9.3	1.7	1,507	37,119	302,751
Medically needy	1.5	133	4.7	67.5	14.2	4.8	8.2	4.3	1.0	2,855	16,460	102,347
Poverty related	2.5	202	27.1	55.4	14.9	6.1	14.4	8.0	1.1	747	11,100	72,315
Other/unknown	1.1	83	7.9	46.5	31.2	7.6	10.6	3.8	0.3	1,055	7,849	76,508

Source: Data for this table are from the MAX 2004 file for D.C., released by CMS in 02/2008. This table was produced on 03/06/2008.

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]

D.C., 2004

	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	**2.1**	**$187**	**$89**	**0.9**	**$148**	**$169**	**0.1**	**$9**	**$97**	**1.1**	**$29**	**$26**
Age												
5 and younger	0.2	16	78	0.1	13	197	0.0	0	49	0.1	3	19
6-14	0.4	43	105	0.3	39	150	0.0	1	89	0.1	4	26
15-20	0.4	39	93	0.2	34	149	0.0	1	66	0.2	4	24
21-44	1.7	229	133	0.8	192	252	0.1	12	122	0.9	25	29
45-64	3.2	306	95	1.3	240	187	0.2	17	110	1.8	49	28
65-74	3.2	188	60	1.3	140	108	0.1	7	61	1.7	41	24
75-84	2.7	149	55	1.1	110	97	0.1	6	58	1.4	33	23
85 and older	1.8	89	50	0.7	64	91	0.1	4	44	1.0	22	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	2.3	128	56	1.0	94	98	0.1	5	55	1.2	29	23
Disabled	2.8	266	95	1.2	210	183	0.1	14	105	1.5	42	27
Adults	1.2	165	132	0.6	141	248	0.1	8	119	0.6	16	26
Children	0.3	28	90	0.2	25	142	0.0	1	68	0.1	3	23
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.4	182	77	1.0	139	145	0.1	10	88	1.3	33	25
Male	1.7	193	111	0.8	158	208	0.1	9	111	0.9	26	28
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.5	243	98	1.1	192	176	0.2	13	83	1.2	38	31
African American	2.1	186	89	0.9	147	169	0.1	10	99	1.1	30	26
Other/unknown	1.9	173	90	0.8	141	166	0.1	7	84	1.0	25	25
Use of Nursing Facilities[e]												
Entire year	1.2	71	60	0.4	52	116	0.1	4	47	0.6	14	22
Part year	2.6	195	75	1.0	146	149	0.2	12	79	1.5	37	25
None	2.1	193	91	0.9	153	172	0.1	10	101	1.1	30	27
Maintenance Assistance Status												
Cash	2.4	227	93	1.0	181	178	0.1	11	100	1.3	34	26
Medically needy	1.5	133	91	0.6	104	176	0.1	8	88	0.8	22	28
Poverty related	2.5	202	80	1.1	157	148	0.1	11	99	1.4	35	26
Other/unknown	1.1	83	74	0.5	65	128	0.0	3	79	0.6	14	26

Source: Data for this table are from the MAX 2004 file for D.C., released by CMS in 02/2008. This table was produced on 03/06/2008.

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 D.C., 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)

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]

D.C., 2004

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per 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	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.5	0.3	0.0	0.2	$155	$137	$8	$10	$283	$407	$228	$56	101,665	$28,757,009	17,689	24.4 %	185,460
Biologicals	0.2	0.2	0.0	0.0	190	188	0	2	819	954	119	74	273	223,563	147	0.2	1,174
Antineoplastic Agents	0.4	0.1	0.0	0.3	85	45	3	36	207	484	266	120	5,441	1,127,984	1,216	1.7	13,245
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.4	44	31	2	11	56	107	32	26	89,697	5,066,353	10,600	14.6	114,155
Cardiovascular Agents	1.6	0.6	0.0	1.0	73	50	1	21	44	78	44	22	329,522	14,572,225	18,327	25.3	200,741
Respiratory Agents	0.6	0.4	0.0	0.2	37	32	0	5	61	84	43	22	87,900	5,325,254	13,436	18.5	142,595
Gastrointestinal Agents	0.5	0.2	0.0	0.3	39	29	1	9	82	155	50	33	51,173	4,192,824	9,841	13.6	108,344
Genitourinary Agents	0.3	0.2	0.0	0.1	24	20	2	2	71	86	54	25	11,652	824,794	3,206	4.4	34,386
CNS Drugs	1.0	0.5	0.0	0.4	137	119	3	15	137	226	94	33	150,245	20,537,284	13,621	18.8	149,848
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	60	55	1	5	94	106	78	41	8,106	758,245	1,214	1.7	12,640
Miscellaneous Psychological/ Neurological Agents	0.4	0.4	0.0	0.0	90	84	2	5	211	223	110	127	4,273	900,451	883	1.2	9,980
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	28	17	3	9	51	186	217	19	96,831	4,944,136	16,172	22.3	174,969
Neuromuscular Agents	0.8	0.2	0.1	0.4	56	32	14	9	74	140	107	23	77,804	5,781,175	9,317	12.8	103,404
Nutritional Products	0.5	0.0	0.0	0.5	7	0	0	6	14	17	17	14	39,191	560,799	7,634	10.5	81,870
Hematological Agents	0.6	0.2	0.0	0.3	91	84	2	4	154	344	43	15	33,463	5,137,287	5,159	7.1	56,662
Topical Products	0.4	0.2	0.0	0.2	26	17	2	7	59	85	72	33	65,683	3,870,491	13,883	19.1	148,255
Miscellaneous Products	0.4	0.2	0.0	0.2	105	80	7	18	294	427	460	116	2,367	695,274	642	0.9	6,626
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	4	0	0	0	15	0	0	0	1,314	19,702	415	0.6	4,755
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.	1,156,600	103,294,850	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for D.C., released by CMS in 02/2008. This table was produced on 03/06/2008.

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 D.C., 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 2004.

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]

D.C., 2004

		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
ANTIVIRAL	$24,893,416	8,051	11.1 %	86,596	0.6	$501	$287
ANTIPSYCHOTICS	16,116,240	9,357	12.9	105,519	0.6	254	153
ANTICONVULSANT	5,151,140	7,530	10.4	84,011	0.6	95	61
ANTIHYPERLIPIDEMIC	4,806,296	7,841	10.8	88,467	0.6	97	54
ANTIDIABETIC	4,006,492	10,420	14.4	115,540	0.6	59	35
ANTIHYPERTENSIVE	3,860,763	15,942	22.0	177,300	0.6	38	22
ANTIDEPRESSANTS	3,390,420	10,366	14.3	114,321	0.5	62	30
CALCIUM BLOCKERS	3,184,800	7,628	10.5	84,933	0.6	59	37
ANTIASTHMATIC	3,046,730	10,934	15.1	117,112	0.4	71	26
ANALGESICS - Narcotic	2,755,269	13,634	18.8	150,548	0.3	54	18
Total	71,211,566	101,703		1,124,347	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for D.C., released by CMS in 02/2008. This table was produced on 03/06/2008.

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 2004. 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 2004. 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.