STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2004
OKLAHOMA

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
OKLAHOMA, 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]	690,487	(A)	102,512	(E)	587,975	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	672,225	(B)	87,580	(F)	584,645	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	672,225	(C)	87,580	(G)	584,645	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	14,679	(D)	13,353	(H)	1,326	(L)

Source: Data for this table are from the MAX 2004 file for Oklahoma, released by CMS in 01/2008. 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 Oklahoma in 2004 was $430,041,676, of which $4,146,781 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]

OKLAHOMA, 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	**672,225**	**53,876**	**86,546**	**87,411**	**444,392**	**0**	**6,199,809**	**558,365**	**911,391**	**608,465**	**4,121,588**	**0**
Age												
5 and younger	183,200	14	2,338	0	180,848	0	1,648,261	67	25,212	0	1,622,982	0
6-14	193,880	9	6,498	29	187,344	0	1,894,757	66	72,429	213	1,822,049	0
15-20	89,063	15	4,971	8,695	75,382	0	784,035	104	53,029	58,815	672,087	0
21-44	104,985	17	29,879	74,279	810	0	835,486	131	314,240	516,733	4,382	0
45-64	46,054	214	41,559	4,276	5	0	466,658	1,845	433,252	31,509	52	0
65-74	22,230	20,907	1,249	72	2	0	235,809	222,420	12,703	662	24	0
75-84	19,380	19,292	46	41	1	0	203,323	202,432	479	400	12	0
85 and older	13,433	13,408	6	19	0	0	131,480	131,300	47	133	0	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Gender												
Female	388,704	39,823	45,763	82,887	220,231	0	3,525,346	416,728	485,282	580,858	2,042,478	0
Male	283,521	14,053	40,783	4,524	224,161	0	2,674,463	141,637	426,109	27,607	2,079,110	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	411,206	41,820	61,698	54,609	253,079	0	3,782,322	430,773	648,196	374,364	2,328,989	0
African American	107,436	5,862	14,467	15,206	71,901	0	1,034,514	62,350	154,159	119,279	698,726	0
Other/unknown	153,583	6,194	10,381	17,596	119,412	0	1,382,973	65,242	109,036	114,822	1,093,873	0
Use of Nursing Facilities[c]												
Entire year	14,679	12,252	2,407	15	5	0	147,135	121,316	25,640	119	60	0
Part year	7,186	5,484	1,670	27	5	0	67,775	50,724	16,789	217	45	0
None	650,360	36,140	82,469	87,369	444,382	0	5,984,899	386,325	868,962	608,129	4,121,483	0
Maintenance Assistance Status												
Cash	174,751	18,561	60,631	48,874	46,685	0	1,665,315	205,918	646,580	365,412	447,405	0
Medically needy	0	0	0	0	0	0		0	0	0	0	0
Poverty-related	447,510	12,140	13,785	37,759	383,826	0	4,035,449	126,489	131,646	240,920	3,536,394	0
Other/unknown	49,964	23,175	12,130	778	13,881	0	499,045	225,958	133,165	2,133	137,789	0
Dual Medicare Status[d]												
Full dual, all year	81,946	48,861	32,401	652	32	0	862,736	507,321	349,742	5,327	346	0
Full dual, part year	5,634	3,477	2,123	34	0	0	60,981	37,518	23,134	329	0	0
Non-dual, all year	584,645	1,538	52,022	86,725	444,360	0	5,276,092	13,526	538,515	602,809	4,121,242	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	672,225	53,876	86,546	87,411	444,392	0	6,199,809	558,365	911,391	608,465	4,121,588	0
FFS part year, with Rx claims	0	0	0	0	0	0		0	0	0	0	0
FFS part year, no Rx claims	0	0	0	0	0	0		0	0	0	0	0

Source: Data for this table are from the MAX 2004 file for Oklahoma, released by CMS in 01/2008. 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]

OKLAHOMA, 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	**65.0 %**	**9.7**	**$634**	**$66**	**$3,487**	**18.2 %**	**672,225**
Age							
5 and younger	61.8	3.2	164	51	1,620	10.1	183,200
6-14	54.5	3.6	288	80	1,465	19.6	193,880
15-20	59.8	4.8	303	63	2,313	13.1	89,063
21-44	72.1	10.7	797	75	4,773	16.7	104,985
45-64	85.0	31.7	2,380	75	9,777	24.3	46,054
65-74	87.6	34.9	2,089	60	7,680	27.2	22,230
75-84	91.8	41.7	2,279	55	11,224	20.3	19,380
85 and older	93.7	45.3	2,176	48	16,226	13.4	13,433
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	90.7	40.0	2,182	55	11,093	19.7	53,876
Disabled	83.2	26.6	2,348	88	10,809	21.7	86,546
Adults	69.5	6.4	262	41	2,060	12.7	87,411
Children	57.4	3.3	185	56	1,420	13.0	444,392
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	67.8	11.1	656	59	3,559	18.4	388,704
Male	61.1	7.7	603	78	3,389	17.8	283,521
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	69.5	11.9	794	67	4,160	19.1	411,206
African American	57.1	7.2	469	65	2,760	17.0	107,436
Other/unknown	58.3	5.3	319	60	2,195	14.5	153,583
Use of Nursing Facilities[f]							
Entire year	98.1	74.9	4,020	54	30,523	13.2	14,679
Part year	97.3	53.4	3,059	57	19,539	15.7	7,186
None	63.9	7.7	530	69	2,700	19.6	650,360
Maintenance Assistance Status							
Cash	72.4	13.4	995	74	3,361	29.6	174,751
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	59.9	4.6	266	58	1,637	16.2	447,510
Other/unknown	84.9	42.0	2,667	64	20,509	13.0	49,964

Source: Data for this table are from the MAX 2004 file for Oklahoma, released by CMS in 01/2008. 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]

OKLAHOMA, 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	**1.0**	**$69**	**18.2 %**	**35.0 %**	**46.5 %**	**6.4 %**	**8.9 %**	**2.6 %**	**0.6 %**	**$378**	**672,225**	**6,199,809**
Age												
5 and younger	0.4	18	10.1	38.2	58.2	2.7	0.9	0.1	0.0	180	183,200	1,648,261
6-14	0.4	29	19.6	45.5	49.0	3.3	2.0	0.2	0.0	150	193,880	1,894,757
15-20	0.5	34	13.1	40.2	50.7	5.5	3.1	0.4	0.0	263	89,063	784,035
21-44	1.3	100	16.7	27.9	45.4	11.6	13.1	1.9	0.2	600	104,985	835,486
45-64	3.1	235	24.3	15.0	19.6	14.8	37.9	10.5	2.1	965	46,054	466,658
65-74	3.3	197	27.2	12.4	19.9	15.3	36.8	12.2	3.5	724	22,230	235,809
75-84	4.0	217	20.3	8.2	15.8	14.2	37.1	19.1	5.6	1,070	19,380	203,323
85 and older	4.6	222	13.4	6.3	12.0	11.9	36.3	27.5	5.9	1,658	13,433	131,480
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	3.9	211	19.7	9.3	16.5	14.1	36.7	18.5	4.9	1,070	53,876	558,365
Disabled	2.5	223	21.7	16.8	28.0	14.5	31.3	7.9	1.5	1,026	86,546	911,391
Adults	0.9	38	12.7	30.5	51.2	10.1	7.6	0.5	0.0	296	87,411	608,465
Children	0.4	20	13.0	42.6	52.8	3.1	1.4	0.1	0.0	153	444,392	4,121,588
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.2	72	18.4	32.2	46.3	7.1	10.5	3.3	0.7	392	388,704	3,525,346
Male	0.8	64	17.8	38.9	46.8	5.4	6.7	1.8	0.4	359	283,521	2,674,463
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.3	86	19.1	30.5	46.5	7.4	11.2	3.6	0.8	452	411,206	3,782,322
African American	0.7	49	17.0	42.9	43.3	5.5	6.5	1.5	0.3	287	107,436	1,034,514
Other/unknown	0.6	35	14.5	41.7	48.7	4.3	4.4	0.8	0.1	244	153,583	1,382,973
Use of Nursing Facilities[f]												
Entire year	7.5	401	13.2	1.9	3.8	4.7	25.4	44.3	19.8	3,045	14,679	147,135
Part year	5.7	324	15.7	2.7	7.8	8.6	36.8	35.1	9.1	2,072	7,186	67,775
None	0.8	58	19.6	36.1	47.9	6.4	8.2	1.3	0.1	293	650,360	5,984,899
Maintenance Assistance Status												
Cash	1.4	104	29.6	27.6	40.2	11.7	18.4	2.0	0.0	353	174,751	1,665,315
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.5	29	16.2	40.1	51.9	4.2	3.3	0.5	0.1	182	447,510	4,035,449
Other/unknown	4.2	267	13.0	15.1	20.7	7.5	25.5	23.9	7.2	2,053	49,964	499,045

Source: Data for this table are from the MAX 2004 file for Oklahoma, released by CMS in 01/2008. 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]

OKLAHOMA, 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	**1.0**	**$69**	**$66**	**0.4**	**$52**	**$144**	**0.1**	**$5**	**$77**	**0.6**	**$12**	**$20**
Age												
5 and younger	0.4	18	51	0.1	14	105	0.0	1	43	0.2	3	15
6-14	0.4	29	80	0.2	23	137	0.0	1	64	0.2	5	28
15-20	0.5	34	63	0.2	27	138	0.0	2	65	0.3	6	17
21-44	1.3	100	75	0.4	76	191	0.1	8	101	0.9	16	19
45-64	3.1	235	75	1.0	176	177	0.2	18	107	2.0	41	21
65-74	3.3	197	60	1.1	146	132	0.2	13	73	2.0	38	19
75-84	4.0	217	55	1.4	160	117	0.2	13	58	2.4	44	19
85 and older	4.6	222	48	1.5	159	105	0.3	12	47	2.8	51	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	3.9	211	55	1.3	155	119	0.2	13	59	2.3	43	19
Disabled	2.5	223	88	0.9	172	201	0.1	16	111	1.5	35	23
Adults	0.9	38	41	0.2	25	114	0.1	3	66	0.6	10	15
Children	0.4	20	56	0.1	16	107	0.0	1	50	0.2	4	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.2	72	59	0.4	53	133	0.1	5	72	0.7	14	19
Male	0.8	64	78	0.3	50	163	0.0	4	86	0.5	10	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.3	86	67	0.5	65	144	0.1	6	80	0.8	16	20
African American	0.7	49	65	0.2	37	153	0.0	3	73	0.5	9	19
Other/unknown	0.6	35	60	0.2	27	139	0.0	3	62	0.4	6	17
Use of Nursing Facilities[e]												
Entire year	7.5	401	54	2.5	296	116	0.4	23	55	4.5	82	18
Part year	5.7	324	57	1.9	239	124	0.3	20	66	3.4	65	19
None	0.8	58	69	0.3	44	152	0.0	4	82	0.5	10	20
Maintenance Assistance Status												
Cash	1.4	104	74	0.5	80	173	0.1	7	94	0.9	18	20
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.5	29	58	0.2	22	121	0.0	2	62	0.3	5	18
Other/unknown	4.2	267	64	1.5	199	137	0.2	18	73	2.5	50	20

Source: Data for this table are from the MAX 2004 file for Oklahoma, released by CMS in 01/2008. 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 Oklahoma, 0.4 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]

OKLAHOMA, 2004

	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
Therapeutic Category	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	0.2	0.1	0.0	0.1	$12	$8	$1	$3	$48	$98	$74	$18	760,028	$36,609,706	301,767	44.9 %	3,163,891
Biologicals	0.3	0.2	0.0	0.0	252	236	0	15	1003	1,096	125	476	6,951	6,968,942	2,790	0.4	27,646
Antineoplastic Agents	0.4	0.1	0.0	0.4	80	43	1	36	183	717	159	97	27,623	5,062,663	6,201	0.9	63,273
Endocrine/Metabolic Drugs	0.4	0.2	0.1	0.2	25	19	2	4	57	115	39	18	573,285	32,951,598	124,867	18.6	1,315,095
Cardiovascular Agents	1.1	0.3	0.0	0.7	44	31	2	11	41	106	44	15	1,003,045	40,981,532	87,514	13.0	938,809
Respiratory Agents	0.4	0.2	0.0	0.2	23	21	0	2	62	99	44	14	587,740	36,206,939	145,476	21.6	1,547,735
Gastrointestinal Agents	0.5	0.1	0.0	0.3	28	20	2	6	60	148	64	21	381,521	23,078,245	77,515	11.5	822,293
Genitourinary Agents	0.3	0.2	0.0	0.1	20	15	2	3	66	98	52	26	101,389	6,730,498	33,662	5.0	344,304
CNS Drugs	0.8	0.4	0.0	0.4	86	74	3	9	107	201	100	21	956,973	102,251,400	113,007	16.8	1,191,952
Stimulants/Anti-obesity/Anorexia	0.6	0.3	0.0	0.2	45	35	1	9	79	106	73	39	123,947	9,800,373	20,060	3.0	219,353
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	121	119	0	2	193	199	115	62	52,803	10,173,753	7,970	1.2	83,821
Analgesics and Anesthetics	0.5	0.1	0.0	0.4	21	14	2	6	46	199	233	15	809,304	37,257,510	168,488	25.1	1,740,527
Neuromuscular Agents	0.6	0.2	0.1	0.4	49	28	12	9	75	158	116	23	430,205	32,387,042	62,000	9.2	665,990
Nutritional Products	0.4	0.0	0.0	0.3	7	1	1	6	19	32	27	18	164,019	3,121,548	47,633	7.1	466,246
Hematological Agents	0.5	0.2	0.1	0.3	118	95	4	19	217	478	67	66	108,252	23,450,303	18,562	2.8	199,105
Topical Products	0.2	0.1	0.0	0.1	9	6	1	3	43	78	49	21	361,216	15,366,945	153,705	22.9	1,642,595
Miscellaneous Products	0.1	0.1	0.0	0.0	20	17	2	2	137	151	411	57	20,669	2,831,391	12,633	1.9	138,459
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	5	0	0	0	26	0	0	0	25,432	664,507	11,697	1.7	127,822
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.	6,494,402	425,894,895	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Oklahoma, released by CMS in 01/2008. 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 Oklahoma, 0.4 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]

OKLAHOMA, 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
ANTIPSYCHOTICS	$67,477,101	47,764	7.1 %	524,009	0.5	$253	$129
ANTIDEPRESSANTS	29,767,547	95,484	14.2	1,014,056	0.4	68	29
ANTIASTHMATIC	28,418,839	147,118	21.9	1,587,781	0.3	66	18
ANTICONVULSANT	27,268,733	42,341	6.3	462,981	0.6	101	59
ANALGESICS - Narcotic	23,476,483	194,001	28.9	2,021,716	0.3	41	12
MISC. HEMATOLOGICAL	17,978,195	9,472	1.4	103,886	0.5	369	173
ANTIDIABETIC	17,134,679	44,006	6.5	477,144	0.5	70	36
ULCER DRUGS	16,966,212	71,289	10.6	764,862	0.4	62	22
ANTIHYPERLIPIDEMIC	16,398,894	28,239	4.2	315,149	0.4	131	52
ANALGESICS - ANTI-INFLAMMATORY	10,602,040	70,437	10.5	744,574	0.2	58	14
Total	255,488,723	750,151		8,016,158	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Oklahoma, released by CMS in 01/2008. 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.