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

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OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
OREGON, 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]	579,169	(A)	83,499	(E)	495,670	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	443,317	(B)	62,070	(F)	381,247	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	224,518	(C)	37,187	(G)	187,331	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	4,298	(D)	4,038	(H)	260	(L)

Source: Data for this table are from the MAX 2004 file for Oregon, released by CMS in 01/2008. This table was produced on 03/25/2008.

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 Oregon in 2004 was $234,875,384, of which $87,329,922 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]

OREGON, 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	**224,518**	**23,695**	**29,928**	**45,935**	**124,707**	**253**	**1,252,027**	**217,573**	**267,477**	**189,540**	**575,458**	**1,979**
Age												
5 and younger	55,022	0	728	113	54,181	0	231,987	0	5,942	426	225,619	0
6-14	52,071	0	1,905	92	50,074	0	266,127	0	17,340	539	248,248	0
15-20	27,762	0	1,857	5,471	20,432	2	137,693	0	15,975	20,233	101,475	10
21-44	47,188	0	10,495	36,622	12	59	243,601	0	93,169	149,973	103	356
45-64	18,303	31	14,472	3,611	2	187	150,918	267	130,822	18,241	2	1,586
65-74	7,364	7,174	166	19	0	5	68,311	66,888	1,290	106	0	27
75-84	8,990	8,880	106	4	0	0	83,391	82,308	1,067	16	0	0
85 and older	7,816	7,610	199	3	4	0	69,995	68,110	1,872	6	7	0
Unknown	2	0	0	0	2	0		0	0	0	4	0
Gender												
Female	131,074	16,866	15,252	37,093	61,610	253	736,623	157,974	139,276	152,393	285,001	1,979
Male	93,443	6,829	14,676	8,841	63,097	0	4 515,403	59,599	128,201	37,146	290,457	0
Unknown	1	0	0	1	0	0		0	0	1	0	0
Race												
White	163,825	20,431	25,885	36,814	80,483	212	967,549	186,371	232,197	151,444	395,833	1,704
African American	8,905	495	1,235	1,971	5,202	2	1 43,203	4,655	10,113	6,567	21,849	19
Other/unknown	51,788	2,769	2,808	7,150	39,022	39	241,275	26,547	25,167	31,529	157,776	256
Use of Nursing Facilities[c]												
Entire year	4,298	3,710	587	1	0	0	38,209	32,732	5,466	11	0	0
Part year	3,197	2,346	822	25	4	0	27,054	20,004	6,814	191	45	0
None	217,023	17,639	28,519	45,909	124,703	253	1,186,764	164,837	255,197	189,338	575,413	1,979
Maintenance Assistance Status												
Cash	80,248	6,200	19,787	20,554	33,707	0	487,730	61,738	183,361	84,339	158,292	0
Medically needy	0	0	0	0	0	0		0	0	0	0	0
Poverty-related	79,381	295	586	11,410	66,837	253	306,190	2,482	4,424	34,039	263,266	1,979
Other/unknown	64,889	17,200	9,555	13,971	24,163	0	458,107	153,353	79,692	71,162	153,900	0
Dual Medicare Status[d]							0					
Full dual, all year	34,877	22,181	12,455	229	4	8	329,951	204,855	123,651	1,344	48	53
Full dual, part year	2,310	1,138	1,165	7	0	0	19,119	9,865	9,216	38	0	0
Non-dual, all year	187,331	376	16,308	45,699	124,703	245	902,957	2,853	134,610	188,158	575,410	1,926
Managed Care (MC) Status												
Fee-for-service (FFS) all year	111,678	20,944	22,855	16,609	51,025	245	967,348	205,123	238,144	116,877	405,264	1,940
FFS part year, with Rx claims	32,611	2,002	5,264	12,837	12,502	6	125,766	9,628	24,089	40,955	51,058	36
FFS part year, no Rx claims	80,229	749	1,809	16,489	61,180	2	158,913	2,822	5,244	31,708	119,136	3

Source: Data for this table are from the MAX 2004 file for Oregon, released by CMS in 01/2008. This table was produced on 03/25/2008.

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]

OREGON, 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	**46.3 %**	**11.8**	**$657**	**$56**	**$4,855**	**13.5 %**	**224,518**
Age							
5 and younger	27.9	1.0	36	35	1,943	1.9	55,022
6-14	28.9	2.1	159	77	1,819	8.7	52,071
15-20	39.8	3.3	188	57	2,963	6.3	27,762
21-44	56.7	10.1	742	74	4,914	15.1	47,188
45-64	80.4	40.6	2,584	64	11,659	22.2	18,303
65-74	82.5	46.9	2,222	47	11,668	19.0	7,364
75-84	88.0	50.9	2,148	42	15,366	14.0	8,990
85 and older	89.9	47.6	1,805	38	17,513	10.3	7,816
Unknown	0.0	0.0	0	0	0	0.0	2
Basis of Eligibility[e]							
Aged	86.9	48.6	2,058	42	14,931	13.8	23,695
Disabled	79.9	35.8	2,669	75	12,337	21.6	29,928
Adults	50.6	5.2	224	44	3,302	6.8	45,935
Children	28.8	1.5	67	45	1,706	3.9	124,707
Unknown	77.1	18.5	1,142	62	10,803	10.6	253
Gender							
Female	50.2	13.9	695	50	5,162	13.5	131,074
Male	40.7	8.8	604	69	4,426	13.7	93,443
Unknown	0.0	0.0	0	0	170	0.0	1
Race							
White	51.3	14.3	794	56	5,510	14.4	163,825
African American	38.1	7.6	407	54	4,374	9.3	8,905
Other/unknown	31.7	4.6	269	59	2,868	9.4	51,788
Use of Nursing Facilities[f]							
Entire year	95.4	62.4	2,807	45	36,900	7.6	4,298
Part year	94.6	58.2	2,771	48	24,335	11.4	3,197
None	44.6	10.1	584	58	3,934	14.8	217,023
Maintenance Assistance Status							
Cash	51.9	13.5	864	64	4,833	17.9	80,248
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	27.2	1.3	51	40	1,597	3.2	79,381
Other/unknown	62.6	22.6	1,144	51	8,869	12.9	64,889

Source: Data for this table are from the MAX 2004 file for Oregon, released by CMS in 01/2008. This table was produced on 03/25/2008.

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]

OREGON, 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**	**$118**	**13.5 %**	**53.7 %**	**23.2 %**	**5.1 %**	**8.4 %**	**6.6 %**	**3.0 %**	**$871**	**224,518**	**1,252,027**
Age												
5 and younger	0.2	9	1.9	72.1	25.9	1.3	0.5	0.1	0.0	461	55,022	231,987
6-14	0.4	31	8.7	71.1	22.9	2.6	2.3	0.8	0.3	356	52,071	266,127
15-20	0.7	38	6.3	60.2	27.7	5.0	4.7	1.6	0.7	597	27,762	137,693
21-44	2.0	144	15.1	43.3	27.3	8.9	11.6	6.1	2.9	952	47,188	243,601
45-64	4.9	313	22.2	19.6	15.2	8.9	22.7	21.7	11.8	1,414	18,303	150,918
65-74	5.1	240	19.0	17.5	13.8	8.8	22.7	25.0	12.2	1,258	7,364	68,311
75-84	5.5	232	14.0	12.0	9.9	8.4	26.3	30.4	13.0	1,657	8,990	83,391
85 and older	5.3	202	10.3	10.1	8.7	8.2	30.3	33.6	9.1	1,956	7,816	69,995
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	2	4
Basis of Eligibility[e]												
Aged	5.3	224	13.8	13.1	10.8	8.4	26.5	29.7	11.5	1,626	23,695	217,573
Disabled	4.0	299	21.6	20.1	20.6	9.6	21.9	18.3	9.5	1,380	29,928	267,477
Adults	1.2	54	6.8	49.4	27.9	8.2	8.8	3.9	1.8	800	45,935	189,540
Children	0.3	15	3.9	71.2	24.5	2.2	1.5	0.5	0.2	370	124,707	575,458
Unknown	2.4	146	10.6	22.9	28.9	16.6	21.7	9.5	0.4	1,381	253	1,979
Gender												
Female	2.5	124	13.5	49.8	23.6	5.6	9.4	7.9	3.7	918	131,074	736,623
Male	1.6	110	13.7	59.3	22.7	4.3	6.9	4.8	2.0	802	93,443	515,403
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	170	1	1
Race												
White	2.4	134	14.4	48.7	23.8	5.7	9.9	8.2	3.7	933	163,825	967,549
African American	1.6	84	9.3	61.9	20.9	4.1	6.6	4.6	1.9	902	8,905	43,203
Other/unknown	1.0	58	9.4	68.3	21.8	3.2	3.8	2.1	0.7	616	51,788	241,275
Use of Nursing Facilities[f]												
Entire year	7.0	316	7.6	4.6	5.1	6.2	26.8	37.6	19.6	4,151	4,298	38,209
Part year	6.9	328	11.4	5.4	6.0	5.9	27.6	35.2	19.8	2,876	3,197	27,054
None	1.8	107	14.8	55.4	23.8	5.0	7.7	5.6	2.4	719	217,023	1,186,764
Maintenance Assistance Status												
Cash	2.2	142	17.9	48.1	24.5	6.4	10.7	7.2	3.1	795	80,248	487,730
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.3	13	3.2	72.8	22.4	2.4	1.7	0.5	0.2	414	79,381	306,190
Other/unknown	3.2	162	12.9	37.4	22.6	6.6	13.8	13.5	6.2	1,256	64,889	458,107

Source: Data for this table are from the MAX 2004 file for Oregon, released by CMS in 01/2008. This table was produced on 03/25/2008.

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]
OREGON, 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**	**$118**	**$56**	**0.7**	**$85**	**$128**	**0.1**	**$7**	**$77**	**1.4**	**$26**	**$19**
Age												
5 and younger	0.2	9	35	0.1	6	104	0.0	1	41	0.2	2	12
6-14	0.4	31	77	0.2	27	142	0.0	1	75	0.2	4	17
15-20	0.7	38	57	0.3	29	108	0.0	3	68	0.4	7	18
21-44	2.0	144	74	0.6	109	177	0.1	9	98	1.2	26	21
45-64	4.9	313	64	1.5	219	149	0.2	23	104	3.2	72	22
65-74	5.1	240	47	1.6	166	107	0.2	13	64	3.3	60	18
75-84	5.5	232	42	1.7	162	93	0.2	11	50	3.5	59	17
85 and older	5.3	202	38	1.6	140	88	0.2	9	42	3.5	52	15
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.3	224	42	1.6	156	96	0.2	11	51	3.4	57	17
Disabled	4.0	299	75	1.3	221	172	0.2	20	106	2.5	57	23
Adults	1.2	54	44	0.3	37	108	0.0	3	70	0.9	14	17
Children	0.3	15	45	0.1	11	92	0.0	1	52	0.2	3	15
Unknown	2.4	146	62	0.7	113	165	0.1	4	61	1.6	29	18
Gender												
Female	2.5	124	50	0.8	87	113	0.1	8	69	1.6	29	18
Male	1.6	110	69	0.5	83	158	0.1	6	94	1.0	21	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.4	134	56	0.8	97	126	0.1	8	79	1.5	30	19
African American	1.6	84	54	0.4	60	134	0.1	5	71	1.1	19	18
Other/unknown	1.0	58	59	0.3	44	144	0.0	3	61	0.6	11	17
Use of Nursing Facilities[e]												
Entire year	7.0	316	45	2.1	220	104	0.4	19	51	4.5	76	17
Part year	6.9	328	48	2.1	234	110	0.3	16	57	4.5	77	17
None	1.8	107	58	0.6	77	132	0.1	6	82	1.2	23	19
Maintenance Assistance Status												
Cash	2.2	142	64	0.7	105	150	0.1	9	91	1.4	29	20
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.3	13	40	0.1	9	95	0.0	1	51	0.2	3	15
Other/unknown	3.2	162	51	1.0	115	114	0.1	10	68	2.0	37	18

Source: Data for this table are from the MAX 2004 file for Oregon, released by CMS in 01/2008. This table was produced on 03/25/2008.

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 Oregon, 0.2 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]

OREGON, 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	0.3	0.1	0.0	0.2	$17	$12	$1	$4	$57	$146	$75	$19	152,421	$8,657,279	53,655	23.9 %	496,814
Biologicals	0.1	0.1	0.0	0.0	32	27	1	4	277	289	407	214	1,461	405,374	1,188	0.5	12,677
Antineoplastic Agents	0.6	0.1	0.0	0.4	99	76	1	21	171	548	127	50	7,409	1,270,235	1,331	0.6	12,888
Endocrine/Metabolic Drugs	0.9	0.3	0.1	0.5	37	27	2	8	40	80	27	15	266,644	10,577,133	31,607	14.1	289,006
Cardiovascular Agents	1.7	0.4	0.0	1.3	47	26	1	19	28	67	33	15	510,823	14,095,152	30,834	13.7	297,500
Respiratory Agents	0.6	0.3	0.0	0.3	30	25	0	5	54	96	43	17	154,470	8,287,381	29,257	13.0	275,625
Gastrointestinal Agents	0.7	0.2	0.0	0.5	37	27	1	9	53	133	120	18	145,931	7,790,419	21,709	9.7	212,163
Genitourinary Agents	0.5	0.2	0.0	0.2	25	19	1	5	52	89	50	20	40,391	2,114,677	8,680	3.9	85,612
CNS Drugs	1.4	0.6	0.1	0.8	114	90	6	18	79	148	87	23	558,192	43,924,059	47,465	21.1	385,884
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	63	54	1	8	78	94	107	35	37,445	2,916,072	5,607	2.5	46,629
Miscellaneous Psychological/ Neurological Agents	0.7	0.6	0.0	0.0	134	131	1	2	196	204	109	59	23,940	4,687,890	3,618	1.6	35,018
Analgesics and Anesthetics	0.8	0.1	0.0	0.7	41	25	2	14	50	173	165	21	318,501	15,843,851	42,568	19.0	384,691
Neuromuscular Agents	1.0	0.3	0.1	0.5	72	43	15	14	75	135	134	26	186,755	13,957,264	20,220	9.0	194,063
Nutritional Products	0.5	0.0	0.0	0.5	7	0	1	6	13	24	17	12	90,928	1,165,327	19,670	8.8	178,243
Hematological Agents	0.9	0.2	0.1	0.6	106	97	2	6	117	414	39	10	72,552	8,477,034	8,234	3.7	80,349
Topical Products	0.3	0.1	0.0	0.2	9	6	1	3	33	65	57	16	71,877	2,342,551	25,575	11.4	249,204
Miscellaneous Products	0.6	0.2	0.0	0.3	101	69	13	19	178	344	282	60	5,193	922,468	907	0.4	9,153
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	7	0	0	0	25	0	0	0	4,518	111,296	1,562	0.7	15,589
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.	2,649,451	147,545,462	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Oregon, released by CMS in 01/2008. This table was produced on 03/25/2008.

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 Oregon, 0.2 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]

OREGON, 2004

Top 10 Drug Groups	Total Medicaid Rx $	Users			Among Users		
		Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$21,559,979	15,705	7.0 %	159,108	0.8	$177	$136
ANTIDEPRESSANTS	13,242,925	38,164	17.0	378,475	0.7	53	35
ANALGESICS - Narcotic	11,222,852	48,174	21.5	463,010	0.5	49	24
ANTICONVULSANT	11,086,536	14,396	6.4	146,942	0.8	93	75
ANTIASTHMATIC	6,684,038	28,199	12.6	276,810	0.4	63	24
MISC. HEMATOLOGICAL	5,801,461	2,828	1.3	28,239	0.7	299	205
ANTIDIABETIC	5,652,341	14,823	6.6	148,293	0.8	50	38
ULCER DRUGS	5,635,445	22,317	9.9	224,701	0.5	49	25
ANTIHYPERLIPIDEMIC	5,100,208	10,653	4.7	110,281	0.7	69	46
NEUROLOGICAL	4,766,395	5,115	2.3	50,848	0.5	181	94
Total	90,752,180	200,374		1,986,707	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Oregon, released by CMS in 01/2008. This table was produced on 03/25/2008.

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.