STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2004
WEST VIRGINIA

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OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
WEST VIRGINIA, 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]	380,934	(A)	62,667	(E)	318,267	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	368,456	(B)	50,317	(F)	318,139	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	353,919	(C)	50,314	(G)	303,605	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	6,684	(D)	6,268	(H)	416	(L)

Source: Data for this table are from the MAX 2004 file for West Virginia, released by CMS in 02/2008. 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 West Virginia in 2004 was $394,692,484, of which $3,459,862 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]

WEST VIRGINIA, 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	**353,919**	**24,389**	**96,713**	**57,788**	**174,414**	**615**	**2,839,695**	**251,567**	**1,013,656**	**315,645**	**1,253,433**	**5,394**
Age												
5 and younger	66,403	0	2,269	35	64,099	0	469,869	0	21,076	155	448,638	0
6-14	83,626	0	6,586	107	76,933	0	638,971	0	69,604	685	568,682	0
15-20	42,934	0	4,997	4,592	33,339	6	314,659	0	52,738	26,037	235,845	39
21-44	86,938	0	36,977	49,699	36	226	662,254	0	390,492	269,760	236	1,766
45-64	46,757	0	43,046	3,330	6	375	473,591	0	451,144	18,868	29	3,550
65-74	11,696	10,206	1,461	22	0	7	125,338	110,186	14,994	122	0	36
75-84	9,062	8,213	845	3	0	1	92,709	84,335	8,353	18	0	3
85 and older	6,502	5,970	532	0	0	0	62,301	57,046	5,255	0	0	0
Unknown	1	0	0	0	1	0		0	0	0	3	0
Gender												
Female	202,262	17,304	50,414	47,339	86,591	614	1,604,573	179,949	532,365	264,333	622,541	5,385
Male	151,657	7,085	46,299	10,449	87,823	1	3 1,235,122	71,618	481,291	51,312	630,892	9
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	334,985	23,543	92,857	54,441	163,542	602	2,692,945	242,769	974,530	296,509	1,173,862	5,275
African American	18,450	827	3,788	3,269	10,554	12	0 143,113	8,610	38,462	18,733	77,201	107
Other/unknown	484	19	68	78	318	1	3,637	188	664	403	2,370	12
Use of Nursing Facilities[c]												
Entire year	6,684	5,938	745	0	1	0	65,865	57,986	7,878	0	1	0
Part year	4,188	3,259	921	7	1	0	40,683	31,161	9,464	50	8	0
None	343,047	15,192	95,047	57,781	174,412	615	2,733,147	162,420	996,314	315,595	1,253,424	5,394
Maintenance Assistance Status												
Cash	114,434	13,287	78,565	22,261	321	0	1,123,339	149,406	850,211	121,313	2,409	0
Medically needy	20,829	993	9,179	9,768	889	0	141,019	6,612	68,691	58,717	6,999	0
Poverty-related	36,581	317	756	5,037	29,856	615	189,433	3,312	7,679	22,131	150,917	5,394
Other/unknown	182,075	9,792	8,213	20,722	143,348	0	1,385,904	92,237	87,075	113,484	1,093,108	0
Dual Medicare Status[d]												
Full dual, all year	48,862	23,362	24,890	569	6	35	511,782	241,621	266,534	3,278	51	298
Full dual, part year	1,452	490	923	39	0	0	15,350	5,287	9,649	414	0	0
Non-dual, all year	303,605	537	70,900	57,180	174,408	580	2,312,563	4,659	737,473	311,953	1,253,382	5,096
Managed Care (MC) Status												
Fee-for-service (FFS) all year	241,908	24,388	93,536	35,181	88,202	601	2,203,821	251,561	992,305	209,641	745,018	5,296
FFS part year, with Rx claims	61,455	0	2,353	14,572	44,520	10	217,461	0	12,477	47,994	156,929	61
FFS part year, no Rx claims	15,087	1	120	2,075	12,890	1	47,847	6	608	5,748	41,484	1
MC all year, with FFS Rx claims	35,469	0	704	5,960	28,802	3	370,566	0	8,266	52,262	310,002	36

Source: Data for this table are from the MAX 2004 file for West Virginia, released by CMS in 02/2008. 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]

WEST VIRGINIA, 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	**78.5 %**	**19.4**	**$1,105**	**$57**	**$4,924**	**22.4 %**	**353,919**
Age							
5 and younger	72.7	4.8	214	45	1,313	16.3	66,403
6-14	74.3	6.7	432	65	1,926	22.4	83,626
15-20	74.1	7.8	459	59	3,033	15.1	42,934
21-44	80.7	19.8	1,201	61	4,808	25.0	86,938
45-64	87.4	50.0	2,987	60	10,320	28.9	46,757
65-74	88.3	58.4	3,009	52	10,932	27.5	11,696
75-84	90.4	61.8	2,892	47	18,341	15.8	9,062
85 and older	91.8	56.2	2,426	43	26,087	9.3	6,502
Unknown	0.0	0.0	0	0	0	0.0	1
Basis of Eligibility[e]							
Aged	90.0	59.0	2,816	48	17,355	16.2	24,389
Disabled	85.8	39.8	2,533	64	9,863	25.7	96,713
Adults	78.2	10.7	470	44	1,984	23.7	57,788
Children	72.8	5.5	281	52	1,405	20.0	174,414
Unknown	86.8	29.3	2,246	77	9,481	23.7	615
Gender							
Female	81.1	22.4	1,215	54	5,191	23.4	202,262
Male	74.9	15.5	959	62	4,569	21.0	151,657
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	79.0	19.9	1,129	57	4,995	22.6	334,985
African American	69.1	11.9	695	59	3,669	18.9	18,450
Other/unknown	66.1	11.0	648	59	3,480	18.6	484
Use of Nursing Facilities[f]							
Entire year	97.5	75.9	3,599	47	42,655	8.4	6,684
Part year	96.2	72.0	3,481	48	31,874	10.9	4,188
None	77.9	17.7	1,028	58	3,860	26.6	343,047
Maintenance Assistance Status							
Cash	84.2	36.0	2,160	60	7,000	30.9	114,434
Medically needy	81.6	21.7	1,253	58	5,226	24.0	20,829
Poverty related	64.5	4.6	231	50	948	24.3	36,581
Other/unknown	77.3	11.8	602	51	4,384	13.7	182,075

Source: Data for this table are from the MAX 2004 file for West Virginia, released by CMS in 02/2008. 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]

WEST VIRGINIA, 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	**2.4**	**$138**	**22.4 %**	**21.5 %**	**38.8 %**	**9.9 %**	**15.1 %**	**10.3 %**	**4.3 %**	**$614**	**353,919**	**2,839,695**
Age												
5 and younger	0.7	30	16.3	27.3	54.3	7.5	6.6	2.7	1.5	186	66,403	469,869
6-14	0.9	57	22.4	25.7	51.3	9.1	8.8	3.0	2.1	252	83,626	638,971
15-20	1.1	63	15.1	25.9	48.0	10.4	10.1	3.5	2.2	414	42,934	314,659
21-44	2.6	158	25.0	19.3	33.0	13.4	19.9	10.1	4.3	631	86,938	662,254
45-64	4.9	295	28.9	12.6	14.0	9.5	27.6	27.1	9.3	1,019	46,757	473,591
65-74	5.4	281	27.5	11.7	10.5	8.1	26.6	31.3	11.9	1,020	11,696	125,338
75-84	6.0	283	15.8	9.6	7.8	7.4	25.6	35.5	14.1	1,793	9,062	92,709
85 and older	5.9	253	9.3	8.2	8.0	7.0	29.0	36.2	11.7	2,723	6,502	62,301
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	1	3
Basis of Eligibility[e]												
Aged	5.7	273	16.2	10.0	9.1	7.6	27.0	33.8	12.5	1,683	24,389	251,567
Disabled	3.8	242	25.7	14.2	23.1	11.4	25.5	19.7	6.2	941	96,713	1,013,656
Adults	2.0	86	23.7	21.8	37.1	13.4	15.8	7.0	4.8	363	57,788	315,645
Children	0.8	39	20.0	27.2	52.2	8.3	7.5	2.8	1.9	196	174,414	1,253,433
Unknown	3.3	256	23.7	13.2	26.8	16.4	23.6	17.2	2.8	1,081	615	5,394
Gender												
Female	2.8	153	23.4	18.9	37.3	10.2	16.2	12.2	5.3	654	202,262	1,604,573
Male	1.9	118	21.0	25.1	40.8	9.7	13.7	7.8	3.0	561	151,657	1,235,122
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	140	22.6	21.0	38.6	10.1	15.4	10.5	4.4	621	334,985	2,692,945
African American	1.5	90	18.9	30.9	41.7	8.0	11.0	6.2	2.3	473	18,450	143,113
Other/unknown	1.5	86	18.6	33.9	38.6	9.3	10.3	5.6	2.3	463	484	3,637
Use of Nursing Facilities[f]												
Entire year	7.7	365	8.4	2.5	5.2	4.9	23.3	40.6	23.6	4,329	6,684	65,865
Part year	7.4	358	10.9	3.8	5.2	6.8	24.0	39.5	20.6	3,281	4,188	40,683
None	2.2	129	26.6	22.1	39.8	10.1	14.9	9.4	3.7	485	343,047	2,733,147
Maintenance Assistance Status												
Cash	3.7	220	30.9	15.8	24.6	11.3	23.9	18.2	6.1	713	114,434	1,123,339
Medically needy	3.2	185	24.0	18.4	25.5	13.0	23.6	14.0	5.5	772	20,829	141,019
Poverty related	0.9	45	24.3	35.5	44.6	8.6	7.5	2.7	1.1	183	36,581	189,433
Other/unknown	1.5	79	13.7	22.7	48.0	9.0	10.2	6.4	3.7	576	182,075	1,385,904

Source: Data for this table are from the MAX 2004 file for West Virginia, released by CMS in 02/2008. 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]

WEST VIRGINIA, 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	**2.4**	**$138**	**$57**	**0.9**	**$96**	**$106**	**0.1**	**$10**	**$67**	**1.4**	**$32**	**$24**
Age												
5 and younger	0.7	30	45	0.3	22	81	0.1	2	38	0.3	6	17
6-14	0.9	57	65	0.5	45	97	0.0	3	61	0.4	9	24
15-20	1.1	63	59	0.4	46	103	0.1	4	62	0.6	13	24
21-44	2.6	158	61	0.9	107	123	0.2	13	82	1.6	38	24
45-64	4.9	295	60	1.8	200	111	0.3	23	76	2.8	72	25
65-74	5.4	281	52	2.0	192	97	0.3	18	55	3.1	71	23
75-84	6.0	283	47	2.1	191	90	0.4	17	47	3.5	74	21
85 and older	5.9	253	43	1.9	163	87	0.4	17	44	3.6	73	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.7	273	48	2.0	184	92	0.3	17	49	3.3	72	21
Disabled	3.8	242	64	1.4	168	120	0.2	18	79	2.1	55	26
Adults	2.0	86	44	0.6	53	91	0.1	7	65	1.3	26	20
Children	0.8	39	52	0.4	29	83	0.0	2	48	0.4	8	21
Unknown	3.3	256	77	1.2	187	157	0.2	10	55	1.9	59	30
Gender												
Female	2.8	153	54	1.0	105	103	0.2	11	64	1.6	37	23
Male	1.9	118	62	0.7	84	112	0.1	8	76	1.1	26	25
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.5	140	57	0.9	97	106	0.1	10	68	1.4	33	24
African American	1.5	90	59	0.6	64	111	0.1	6	63	0.9	20	23
Other/unknown	1.5	86	59	0.6	65	105	0.1	4	50	0.8	17	23
Use of Nursing Facilities[e]												
Entire year	7.7	365	47	2.6	240	94	0.5	25	50	4.6	100	22
Part year	7.4	358	48	2.5	236	96	0.5	25	55	4.5	97	22
None	2.2	129	58	0.8	90	108	0.1	9	70	1.2	30	24
Maintenance Assistance Status												
Cash	3.7	220	60	1.3	152	114	0.2	16	75	2.1	52	25
Medically needy	3.2	185	58	1.1	125	114	0.2	14	82	1.9	46	24
Poverty related	0.9	45	50	0.3	31	90	0.1	3	52	0.5	10	21
Other/unknown	1.5	79	51	0.6	56	92	0.1	5	52	0.8	18	22

Source: Data for this table are from the MAX 2004 file for West Virginia, released by CMS in 02/2008. 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 West Virginia, 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]

WEST VIRGINIA, 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	0.3	0.1	0.0	0.2	$17	$11	$1	$5	$49	$84	$60	$26	606,335	$29,849,878	198,142	56.0 %	1,750,352
Biologicals	0.4	0.4	0.0	0.0	468	436	11	21	1099	1,053	1,689	3,931	1,816	1,995,494	518	0.1	4,263
Antineoplastic Agents	0.5	0.1	0.0	0.4	110	76	2	32	200	561	222	78	20,111	4,017,566	3,625	1.0	36,681
Endocrine/Metabolic Drugs	0.7	0.3	0.1	0.3	39	28	3	8	52	95	26	23	600,041	31,450,023	85,598	24.2	807,355
Cardiovascular Agents	1.6	0.6	0.1	1.0	66	45	3	19	41	78	43	19	1,225,879	50,170,275	72,984	20.6	756,002
Respiratory Agents	0.6	0.3	0.0	0.2	33	27	1	5	54	79	40	19	765,819	41,251,235	140,680	39.7	1,268,746
Gastrointestinal Agents	0.6	0.2	0.0	0.4	39	30	1	8	63	123	59	23	402,632	25,481,885	64,653	18.3	649,427
Genitourinary Agents	0.4	0.2	0.0	0.1	21	16	2	3	57	75	52	26	87,834	4,981,180	24,944	7.0	233,995
CNS Drugs	1.2	0.4	0.1	0.6	85	61	6	18	74	140	90	28	1,095,472	80,700,204	97,204	27.5	949,677
Stimulants/Anti-obesity/Anorexia	0.9	0.7	0.0	0.2	73	64	0	9	85	96	77	47	137,349	11,641,076	17,389	4.9	158,817
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	116	114	1	1	165	171	104	45	40,906	6,755,249	5,602	1.6	58,480
Analgesics and Anesthetics	0.7	0.1	0.0	0.6	29	15	1	13	40	146	200	21	814,271	32,534,075	123,709	35.0	1,135,500
Neuromuscular Agents	0.8	0.3	0.1	0.4	69	40	17	12	85	151	126	29	472,797	40,201,194	58,339	16.5	584,122
Nutritional Products	0.5	0.0	0.0	0.4	10	1	0	8	19	19	16	19	130,521	2,442,318	27,528	7.8	251,289
Hematological Agents	0.7	0.3	0.1	0.4	56	46	3	7	77	161	61	17	149,134	11,476,624	19,980	5.6	204,658
Topical Products	0.3	0.1	0.0	0.2	14	8	1	5	47	74	52	28	292,331	13,686,928	105,300	29.8	962,114
Miscellaneous Products	0.5	0.1	0.0	0.3	106	77	8	21	227	519	234	74	8,905	2,019,533	1,855	0.5	19,028
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	8	0	0	0	24	0	0	0	24,069	577,885	7,142	2.0	73,530
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.	6,876,222	391,232,622	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for West Virginia, released by CMS in 02/2008. 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 West Virginia, 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]

WEST VIRGINIA, 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	$38,895,931	31,808	9.0 %	336,747	0.6	$185	$116
ANTICONVULSANT	35,342,281	47,405	13.4	494,588	0.7	104	71
ANTIDEPRESSANTS	32,703,694	89,628	25.3	893,115	0.6	66	37
ANTIASTHMATIC	26,521,933	108,802	30.7	1,040,613	0.4	65	25
ANTIHYPERLIPIDEMIC	22,907,066	34,813	9.8	382,629	0.6	97	60
ULCER DRUGS	21,130,141	67,916	19.2	697,504	0.5	63	30
ANTIDIABETIC	19,276,997	38,738	10.9	414,329	0.7	68	47
ANALGESICS - Narcotic	18,840,620	145,423	41.1	1,363,196	0.4	35	14
ANTIHYPERTENSIVE	11,886,289	48,261	13.6	513,052	0.7	35	23
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	11,641,276	21,833	6.2	200,220	0.7	85	58
Total	239,146,228	634,627		6,335,993	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for West Virginia, released by CMS in 02/2008. 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.