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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2005
OKLAHOMA

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
OKLAHOMA, 2005

Inclusion Criteria (2005)	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]	728609 (A)	106645 (E)	621964 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	710348 (B)	91755 (F)	618593 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	710348 (C)	91755 (G)	618593 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	14644 (D)	13304 (H)	1340 (L)

Source: Data for this table are from the MAX 2005 file for Oklahoma, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 2005 (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 2005, 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 2005 was $504,976,082, of which $1,654,619 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 26 states in 2005 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, 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 2005 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer05.pdf and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit package.

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2005. 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 N+B18D.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 beneficiary 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 2005. 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, 2005

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**710,348**	**55,018**	**91,908**	**103,038**	**456,251**	**4,133**	**6,562,988**	**568,661**	**973,206**	**712,619**	**4,282,037**	**26,465**
Age												
5 and younger	187,624	0	2,641	1	184,982	0	1,703,507	0	27,678	8	1,675,821	0
6-14	199,671	0	7,152	21	192,498	0	1,971,865	0	78,585	186	1,893,094	0
15-20	96,072	0	5,421	12,103	78,213	335	852,082	0	58,163	81,787	709,728	2,404
21-44	120,335	1	31,075	86,293	553	2,413	944,141	4	328,929	596,096	3,338	15,774
45-64	50,625	24	44,723	4,513	3	1,362	512,611	231	470,564	33,647	36	8,133
65-74	22,993	22,035	875	59	1	23	243,354	233,552	9,159	481	8	154
75-84	19,690	19,633	17	39	1	0	205,153	204,684	113	344	12	0
85 and older	13,338	13,325	4	9	0	0	130,275	130,190	15	70	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	417,172	40,570	48,589	98,177	225,703	4,133	3,772,866	422,741	518,310	682,779	2,122,571	26,465
Male	293,176	14,448	43,319	4,861	230,548	0	2,790,122	145,920	454,896	29,840	2,159,466	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	433,675	42,744	65,270	66,516	256,219	2,926	3,990,284	437,822	691,034	456,225	2,386,456	18,747
African American	110,745	5,914	15,567	16,080	72,785	399	1,066,718	63,149	165,147	124,148	711,820	2,454
Other/unknown	165,928	6,360	11,071	20,442	127,247	808	1,505,986	67,690	117,025	132,246	1,183,761	5,264
Use of Nursing Facilities[c]												
Entire year	14,644	12,207	2,420	11	6	0	144,610	118,500	25,985	64	61	0
Part year	7,102	5,450	1,631	13	6	2	67,572	51,155	16,214	113	72	18
None	688,602	37,361	87,857	103,014	456,239	4,131	6,350,806	399,006	931,007	712,442	4,281,904	26,447
Maintenance Assistance Status												
Cash	160,209	17,073	61,402	40,097	41,637	0	1,571,187	188,829	659,299	307,129	415,930	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	468,833	11,795	15,737	39,455	397,713	4,133	4,245,894	121,338	151,782	256,178	3,690,131	26,465
Other/unknown	81,306	26,150	14,769	23,486	16,901	0	745,907	258,494	162,125	149,312	175,976	0
Dual Medicare Status[d]												
Full dual, all year	84,495	48,814	34,910	674	31	66	888,360	503,515	378,416	5,617	328	484
Full dual, part year	7,260	4,693	2,531	36	0	0	79,228	51,071	27,791	366	0	0
Non-dual, all year	618,593	1,511	54,467	102,328	456,220	4,067	5,595,400	14,075	566,999	706,636	4,281,709	25,981
Managed Care (MC) Status												
Fee-for-service (FFS) all year	710,348	55,018	91,908	103,038	456,251	4,133	6,562,988	568,661	973,206	712,619	4,282,037	26,465
FFS part year, with Rx claims	0	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	0

Source: Data for this table are from the MAX 2005 file for Oklahoma, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 2005. 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, 2005

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	**65.7**	**10.5**	**$709**	**$68**	**$3,829**	**18.5**	**710,348**
Age							
5 and younger	64.9	3.7	192	52	1,899	10.1	187,624
6-14	57.8	4.1	338	82	1,693	20.0	199,671
15-20	60.4	5.1	349	68	2,542	13.7	96,072
21-44	64.8	10.6	796	75	4,852	16.4	120,335
45-64	84.4	34.8	2,676	77	11,001	24.3	50,625
65-74	87.8	38.9	2,387	61	8,472	28.2	22,993
75-84	91.4	44.7	2,484	56	11,571	21.5	19,690
85 and older	93.6	47.6	2,340	49	16,340	14.3	13,338
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	90.6	43.3	2,421	56	11,573	20.9	55,018
Disabled	83.9	29.4	2,638	90	11,845	22.3	91,908
Adults	59.5	5.9	253	43	2,166	11.7	103,038
Children	60.6	3.8	220	58	1,663	13.2	456,251
Unknown	52.9	5.6	300	54	3,065	9.8	4,133
Gender							
Female	67.1	11.8	719	61	3,854	18.7	417,172
Male	63.7	8.6	694	81	3,794	18.3	293,176
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	69.4	12.9	882	69	4,501	19.6	433,675
African American	59.0	8.0	552	69	3,226	17.1	110,745
Other/unknown	60.4	5.9	360	61	2,474	14.6	165,928
Use of Nursing Facilities[f]							
Entire year	98.1	78.0	4,269	55	30,433	14.0	14,644
Part year	97.2	57.1	3,312	58	21,002	15.8	7,102
None	64.7	8.6	606	71	3,086	19.6	688,602
Maintenance Assistance Status							
Cash	74.9	15.6	1,207	77	4,055	29.8	160,209
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	62.3	5.0	304	61	1,861	16.3	468,833
Other/unknown	67.4	31.8	2,059	65	14,731	14.0	81,306

Source: Data for this table are from the MAX 2005 file for Oklahoma, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 eight states (DE, IA, IL, 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 eight states (DE, IA, IL, 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, 2005

				Number of Rx, Percentage with:							Number	
Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	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]	Beneficiaries	Benefit Months
All	**1.1**	**$77**	**18.5**	**34.3**	**46.2**	**6.4**	**9.1**	**3.3**	**0.7**	**$414**	**710,348**	**6,562,988**
Age												
5 and younger	0.4	21	10.1	35.1	60.2	3.4	1.2	0.1	0.0	209	187,624	1,703,507
6-14	0.4	34	20.0	42.2	51.2	3.9	2.4	0.2	0.0	171	199,671	1,971,865
15-20	0.6	39	13.7	39.6	50.9	5.7	3.3	0.5	0.1	287	96,072	852,082
21-44	1.3	102	16.4	35.2	39.2	10.1	12.8	2.5	0.2	618	120,335	944,141
45-64	3.4	264	24.3	15.6	17.3	13.0	36.9	14.6	2.7	1,086	50,625	512,611
65-74	3.7	226	28.2	12.2	17.0	13.4	36.7	16.3	4.3	801	22,993	243,354
75-84	4.3	238	21.5	8.6	14.0	12.2	36.7	22.1	6.4	1,111	19,690	205,153
85 and older	4.9	240	14.3	6.4	10.7	10.6	36.0	29.1	7.2	1,673	13,338	130,275
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	4.2	234	20.9	9.4	14.4	12.3	36.5	21.6	5.8	1,120	55,018	568,661
Disabled	2.8	249	22.3	16.1	26.2	13.3	31.5	11.0	1.9	1,119	91,908	973,206
Adults	0.9	37	11.7	40.5	42.7	8.6	7.4	0.8	0.0	313	103,038	712,619
Children	0.4	23	13.2	39.4	54.9	3.8	1.7	0.1	0.0	177	456,251	4,282,037
Unknown	0.9	47	9.8	47.1	34.9	8.7	8.7	0.6	0.0	479	4,133	26,465
Gender												
Female	1.3	80	18.7	32.9	44.9	6.8	10.5	4.0	0.8	426	417,172	3,772,866
Male	0.9	73	18.3	36.3	48.0	5.9	7.2	2.2	0.5	399	293,176	2,790,122
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.4	96	19.6	30.6	45.4	7.3	11.3	4.5	1.0	489	433,675	3,990,284
African American	0.8	57	17.1	41.0	43.9	5.7	7.1	2.0	0.4	335	110,745	1,066,718
Other/unknown	0.6	40	14.6	39.6	49.8	4.6	4.8	1.0	0.2	273	165,928	1,505,986
Use of Nursing Facilities[f]												
Entire year	7.9	432	14.0	1.9	3.3	4.2	23.4	44.1	23.1	3,082	14,644	144,610
Part year	6.0	348	15.8	2.8	6.9	7.8	34.0	37.5	11.1	2,207	7,102	67,572
None	0.9	66	19.6	35.3	47.5	6.4	8.6	2.1	0.1	335	688,602	6,350,806
Maintenance Assistance Status												
Cash	1.6	123	29.8	25.1	38.8	11.6	20.7	3.7	0.1	414	160,209	1,571,187
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.6	34	16.3	37.7	53.1	4.8	3.8	0.6	0.0	206	468,833	4,245,894
Other/unknown	3.5	224	14.0	32.6	21.1	5.7	17.0	17.8	5.8	1,606	81,306	745,907

Source: Data for this table are from the MAX 2005 file for Oklahoma, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 eight states (DE, IA, IL, 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 eight states (DE, IA, IL, 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, 2005

	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	**1.1**	**$77**	**$68**	**0.4**	**$59**	**$150**	**0.0**	**$3**	**$96**	**0.7**	**$14**	**$20**
Age												
5 and younger	0.4	21	52	0.2	17	105	0.0	1	59	0.2	4	16
6-14	0.4	34	82	0.2	29	153	0.0	1	87	0.2	4	19
15-20	0.6	39	68	0.2	31	158	0.0	2	73	0.3	6	17
21-44	1.3	102	75	0.4	78	194	0.0	5	106	0.9	18	21
45-64	3.4	264	77	1.1	200	179	0.1	13	146	2.2	52	23
65-74	3.7	226	61	1.3	173	136	0.1	7	92	2.3	45	20
75-84	4.3	238	56	1.5	182	120	0.1	7	73	2.7	49	19
85 and older	4.9	240	49	1.6	176	109	0.1	8	66	3.1	55	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	4.2	234	56	1.4	178	123	0.1	7	78	2.6	49	19
Disabled	2.8	249	90	1.0	197	206	0.1	11	141	1.7	41	24
Adults	0.9	37	43	0.2	25	121	0.0	2	69	0.6	9	15
Children	0.4	23	58	0.2	19	115	0.0	1	70	0.2	4	17
Unknown	0.9	47	54	0.2	36	153	0.0	1	61	0.6	9	15
Gender												
Female	1.3	80	61	0.4	60	138	0.0	4	89	0.8	16	19
Male	0.9	73	81	0.3	59	171	0.0	3	111	0.5	11	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.4	96	69	0.5	74	150	0.0	4	97	0.9	18	21
African American	0.8	57	69	0.3	46	162	0.0	2	107	0.5	9	18
Other/unknown	0.6	40	61	0.2	31	142	0.0	2	80	0.4	7	18
Use of Nursing Facilities[e]												
Entire year	7.9	432	55	2.7	327	119	0.2	14	72	4.9	92	19
Part year	6.0	348	58	2.1	260	127	0.1	12	87	3.8	76	20
None	0.9	66	71	0.3	51	158	0.0	3	100	0.6	12	20
Maintenance Assistance Status												
Cash	1.6	123	77	0.5	98	182	0.0	5	112	1.0	20	20
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.6	34	61	0.2	26	129	0.0	2	76	0.3	6	18
Other/unknown	3.5	224	65	1.2	170	141	0.1	9	104	2.2	46	21

Source: Data for this table are from the MAX 2005 file for Oklahoma, released by CMS in 11/2008. This table was produced on 04/23/2009.

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, 0.3 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]
OKLAHOMA, 2005

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.2	$12	$7	$2	$3	$48	$121	$70	$18	874,363	$42,068,168	330,825	46.6	3,479,448
Biologicals	0.2	0.2	0.0	0.0	150	139	1	10	791	821	739	525	9,704	7,674,835	4,758	0.7	51,142
Antineoplastic Agents	0.5	0.1	0.0	0.4	85	57	0	28	187	681	188	75	31,671	5,928,842	6,891	1.0	70,039
Endocrine/Metabolic Drugs	0.4	0.2	0.0	0.3	27	19	3	5	61	125	76	19	651,674	39,526,574	137,908	19.4	1,460,068
Cardiovascular Agents	1.1	0.3	0.0	0.8	49	38	0	11	44	112	58	14	1,124,939	49,637,965	93,959	13.2	1,007,759
Respiratory Agents	0.4	0.2	0.0	0.2	28	25	0	2	67	104	73	13	716,603	48,132,174	164,195	23.1	1,748,548
Gastrointestinal Agents	0.5	0.2	0.0	0.3	36	29	0	7	70	137	49	24	483,443	33,833,702	88,690	12.5	940,893
Genitourinary Agents	0.3	0.2	0.0	0.1	20	17	1	3	68	104	69	24	111,129	7,503,293	35,550	5.0	367,554
CNS Drugs	0.8	0.4	0.0	0.4	89	81	0	8	105	200	137	17	1,061,546	111,673,728	119,081	16.8	1,259,426
Stimulants/Anti-obesity/Anorexia	0.6	0.4	0.0	0.2	48	42	0	6	81	113	116	27	143,995	11,681,407	22,081	3.1	241,435
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	132	130	0	2	194	199	125	80	66,150	12,828,752	9,231	1.3	96,923
Analgesics and Anesthetics	0.5	0.0	0.0	0.4	22	8	4	10	45	199	276	24	919,659	41,703,976	182,474	25.7	1,894,662
Neuromuscular Agents	0.7	0.2	0.0	0.4	48	33	2	13	72	174	77	29	484,414	35,002,994	68,518	9.6	736,660
Nutritional Products	0.4	0.0	0.0	0.3	7	1	0	5	19	42	27	16	174,939	3,237,326	49,502	7.0	488,067
Hematological Agents	0.6	0.2	0.0	0.3	133	128	1	5	238	546	81	16	123,332	29,344,745	20,473	2.9	219,979
Topical Products	0.2	0.1	0.0	0.1	11	8	0	3	46	87	48	21	416,769	19,255,060	169,142	23.8	1,813,254
Miscellaneous Products	0.2	0.1	0.0	0.0	22	19	2	2	147	156	500	69	25,085	3,696,448	15,123	2.1	165,408
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	5	0	0	0	26	0	0	0	22,901	591,474	9,983	1.4	109,671
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.	7,442,316	503,321,463	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Oklahoma, released by CMS in 11/2008. This table was produced on 04/23/2009.

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, 0.3 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 2005.

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, 2005

		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	$76,159,965	50,340	7.1	552,016	0.5	$260	$138
ANTIASTHMATIC	38,245,046	172,151	24.2	1,859,753	0.3	73	21
ANTICONVULSANT	29,668,960	46,814	6.6	511,875	0.6	98	58
ANTIDEPRESSANTS	28,939,002	101,393	14.3	1,080,362	0.4	61	27
ANALGESICS - Narcotic	25,963,409	214,686	30.2	2,249,922	0.3	39	12
ULCER DRUGS	25,834,835	80,872	11.4	866,679	0.4	74	30
MISC. HEMATOLOGICAL	22,602,601	10,726	1.5	117,843	0.5	383	192
ANTIHYPERLIPIDEMIC	21,496,424	34,667	4.9	387,037	0.4	134	56
ANTIDIABETIC	20,771,444	49,400	7.0	538,372	0.5	74	39
MISC PSYCHOTHERAPEUTIC AND NEUROLOGICAL	13,049,841	12,561	1.8	132,306	0.5	187	99
Total	302,731,527	773,610		8,296,165	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Oklahoma, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 2005. 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 2005. 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.