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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
OREGON, 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]	538590 (A)	84833 (E)	453757 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	455386 (B)	63163 (F)	392223 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	212656 (C)	36340 (G)	176316 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	4244 (D)	3949 (H)	295 (L)

Source: Data for this table are from the MAX 2005 file for Oregon, 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 Oregon in 2005 was $240,837,952, of which $87,905,355 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]
OREGON, 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	**212,656**	**23,065**	**31,689**	**41,519**	**116,030**	**353**	**1,224,260**	**207,459**	**268,636**	**174,856**	**570,390**	**2,919**
Age												
5 and younger	51,634	0	765	115	50,754	0	229,049	0	5,989	537	222,523	0
6-14	47,215	0	1,959	88	45,168	0	259,111	0	17,238	493	241,380	0
15-20	26,224	0	2,000	4,517	19,704	3	136,916	0	16,688	16,240	103,973	15
21-44	44,989	1	11,067	33,447	396	78	234,899	12	92,185	139,692	2,491	519
45-64	19,082	34	15,441	3,342	1	264	152,831	281	132,400	17,803	1	2,346
65-74	7,147	6,952	180	7	0	8	64,529	62,994	1,428	68	0	39
75-84	8,520	8,418	100	2	0	0	77,900	76,851	1,028	21	0	0
85 and older	7,843	7,660	177	1	5	0	69,010	67,321	1,680	2	7	0
Unknown	2	0	0	0	2	0	15	0	0	0	15	0
Gender												
Female	123,730	16,399	16,005	33,669	57,304	353	714,952	149,919	138,193	140,080	283,841	2,919
Male	88,926	6,666	15,684	7,850	58,726	0	509,308	57,540	130,443	34,776	286,549	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	153,943	19,893	27,270	32,872	73,616	292	941,785	178,378	232,645	139,023	389,227	2,512
African American	7,940	434	1,258	1,634	4,608	6	37,055	4,033	8,823	4,770	19,393	36
Other/unknown	50,773	2,738	3,161	7,013	37,806	55	245,420	25,048	27,168	31,063	161,770	371
Use of Nursing Facilities[c]												
Entire year	4,244	3,641	600	3	0	0	36,775	31,317	5,454	4	0	0
Part year	3,185	2,333	838	9	2	3	26,774	19,721	6,912	85	22	34
None	205,227	17,091	30,251	41,507	116,028	350	1,160,711	156,421	256,270	174,767	570,368	2,885
Maintenance Assistance Status												
Cash	74,963	5,808	19,954	17,483	31,718	0	463,227	56,247	179,175	72,126	155,679	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	71,031	404	689	11,346	58,239	353	284,951	3,614	5,311	32,953	240,154	2,919
Other/unknown	66,662	16,853	11,046	12,690	26,073	0	476,082	147,598	84,150	69,777	174,557	0
Dual Medicare Status[d]												
Full dual, all year	33,837	21,456	12,176	189	2	14	313,598	193,955	118,283	1,246	24	90
Full dual, part year	2,503	1,198	1,292	12	1	0	20,808	10,524	10,182	97	5	0
Non-dual, all year	176,316	411	18,221	41,318	116,027	339	889,854	2,980	140,171	173,513	570,361	2,829
Managed Care (MC) Status												
Fee-for-service (FFS) all year	112,350	19,649	23,282	17,208	51,861	350	971,658	190,014	230,414	123,625	424,704	2,901
FFS part year, with Rx claims	29,576	2,656	6,200	9,513	11,204	3	117,383	14,498	31,030	26,397	45,440	18
FFS part year, no Rx claims	70,730	760	2,207	14,798	52,965	0	135,219	2,947	7,192	24,834	100,246	0

Source: Data for this table are from the MAX 2005 file for Oregon, 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]
OREGON, 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	**47.6**	**12.2**	**$719**	**$59**	**$5,314**	**13.5**	**212,656**
Age							
5 and younger	29.8	1.2	44	39	2,206	2.0	51,634
6-14	32.4	2.3	178	76	2,023	8.8	47,215
15-20	41.3	3.6	221	62	3,155	7.0	26,224
21-44	54.9	10.1	786	78	5,156	15.2	44,989
45-64	77.1	38.9	2,630	68	12,267	21.4	19,082
65-74	81.4	46.1	2,337	51	12,418	18.8	7,147
75-84	87.0	50.8	2,264	45	16,288	13.9	8,520
85 and older	89.7	48.4	1,904	39	18,392	10.4	7,843
Unknown	0.0	0.0	0	0	0	0.0	2
Basis of Eligibility[e]							
Aged	86.2	48.5	2,158	45	15,792	13.7	23,065
Disabled	75.5	33.7	2,632	78	12,503	21.1	31,689
Adults	49.1	5.2	239	46	3,442	6.9	41,519
Children	31.6	1.7	81	49	1,914	4.2	116,030
Unknown	84.4	19.2	1,131	59	12,671	8.9	353
Gender							
Female	51.1	14.3	753	53	5,590	13.5	123,730
Male	42.7	9.3	672	72	4,928	13.6	88,926
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	52.8	14.9	873	59	6,021	14.5	153,943
African American	35.8	7.2	433	60	4,730	9.2	7,940
Other/unknown	33.5	4.9	298	61	3,259	9.1	50,773
Use of Nursing Facilities[f]							
Entire year	94.4	62.7	2,960	47	39,608	7.5	4,244
Part year	94.5	56.1	2,735	49	25,998	10.5	3,185
None	45.9	10.5	642	61	4,283	15.0	205,227
Maintenance Assistance Status							
Cash	52.6	13.9	947	68	5,301	17.9	74,963
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	29.2	1.4	62	43	1,859	3.3	71,031
Other/unknown	61.5	21.8	1,164	53	9,008	12.9	66,662

Source: Data for this table are from the MAX 2005 file for Oregon, 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]
OREGON, 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	**2.1**	**$125**	**13.5**	**52.4**	**24.2**	**5.2**	**8.4**	**6.7**	**3.2**	**$923**	**212,656**	**1,224,260**
Age												
5 and younger	0.3	10	2.0	70.2	27.7	1.4	0.6	0.1	0.0	497	51,634	229,049
6-14	0.4	32	8.8	67.6	25.9	3.1	2.4	0.7	0.3	369	47,215	259,111
15-20	0.7	42	7.0	58.7	29.3	5.2	4.5	1.6	0.7	604	26,224	136,916
21-44	1.9	151	15.2	45.1	26.7	8.5	10.9	5.8	2.9	988	44,989	234,899
45-64	4.9	328	21.4	22.9	14.7	8.9	21.9	19.9	11.7	1,532	19,082	152,831
65-74	5.1	259	18.8	18.6	13.1	8.5	22.2	24.6	13.0	1,375	7,147	64,529
75-84	5.6	248	13.9	13.0	9.5	8.0	25.8	30.7	13.0	1,781	8,520	77,900
85 and older	5.5	216	10.4	10.3	7.8	8.0	29.6	34.1	10.2	2,090	7,843	69,010
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	2	15
Basis of Eligibility[e]												
Aged	5.4	240	13.7	13.8	10.1	8.1	26.0	29.9	12.0	1,756	23,065	207,459
Disabled	4.0	311	21.1	24.5	19.5	9.4	20.5	16.8	9.4	1,475	31,689	268,636
Adults	1.2	57	6.9	50.9	27.6	7.8	8.3	3.6	1.8	817	41,519	174,856
Children	0.3	17	4.2	68.4	27.0	2.4	1.6	0.4	0.2	389	116,030	570,390
Unknown	2.3	137	8.9	15.6	33.4	17.8	21.8	10.2	1.1	1,532	353	2,919
Gender												
Female	2.5	130	13.5	48.9	24.2	5.6	9.3	8.0	3.9	968	123,730	714,952
Male	1.6	117	13.6	57.3	24.1	4.5	7.1	4.9	2.1	861	88,926	509,308
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.4	143	14.5	47.2	24.7	5.8	10.0	8.3	4.0	984	153,943	941,785
African American	1.6	93	9.2	64.2	19.0	4.2	6.4	4.2	2.0	1,014	7,940	37,055
Other/unknown	1.0	62	9.1	66.5	23.3	3.3	4.0	2.2	0.8	674	50,773	245,420
Use of Nursing Facilities[f]												
Entire year	7.2	342	7.5	5.6	4.6	5.6	25.4	38.2	20.7	4,571	4,244	36,775
Part year	6.7	325	10.5	5.5	8.0	7.1	25.8	35.9	17.7	3,093	3,185	26,774
None	1.9	113	15.0	54.1	24.8	5.1	7.8	5.6	2.6	757	205,227	1,160,711
Maintenance Assistance Status												
Cash	2.3	153	17.9	47.4	24.7	6.6	10.6	7.2	3.5	858	74,963	463,227
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.4	15	3.3	70.8	24.3	2.6	1.7	0.5	0.2	463	71,031	284,951
Other/unknown	3.1	163	12.9	38.5	23.4	6.3	13.0	12.8	6.0	1,261	66,662	476,082

Source: Data for this table are from the MAX 2005 file for Oregon, 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]
OREGON, 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	**2.1**	**$125**	**$59**	**0.7**	**$90**	**$136**	**0.1**	**$5**	**$87**	**1.4**	**$30**	**$21**
Age												
5 and younger	0.3	10	39	0.1	7	117	0.0	0	41	0.2	2	13
6-14	0.4	32	76	0.2	28	144	0.0	1	75	0.2	4	18
15-20	0.7	42	62	0.3	34	123	0.0	2	70	0.4	7	18
21-44	1.9	151	78	0.6	114	192	0.1	6	111	1.3	30	23
45-64	4.9	328	68	1.4	225	158	0.1	16	124	3.3	87	26
65-74	5.1	259	51	1.6	180	116	0.1	8	69	3.4	71	21
75-84	5.6	248	45	1.7	172	98	0.1	8	56	3.7	68	19
85 and older	5.5	216	39	1.6	146	92	0.2	8	49	3.8	63	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.4	240	45	1.6	165	101	0.1	8	57	3.6	67	19
Disabled	4.0	311	78	1.3	228	181	0.1	14	123	2.6	69	27
Adults	1.2	57	46	0.3	39	120	0.0	3	82	0.9	16	18
Children	0.3	17	49	0.1	13	104	0.0	1	53	0.2	3	15
Unknown	2.3	137	59	0.7	102	156	0.0	3	63	1.6	32	20
Gender												
Female	2.5	130	53	0.7	90	121	0.1	5	78	1.7	35	21
Male	1.6	117	72	0.5	89	166	0.0	4	110	1.1	24	23
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.4	143	59	0.8	102	134	0.1	6	89	1.6	35	22
African American	1.6	93	60	0.5	66	143	0.0	4	106	1.1	23	22
Other/unknown	1.0	62	61	0.3	47	152	0.0	2	72	0.7	12	19
Use of Nursing Facilities[e]												
Entire year	7.2	342	47	2.1	226	110	0.2	14	60	4.9	101	21
Part year	6.7	325	49	1.9	221	116	0.2	11	68	4.6	92	20
None	1.9	113	61	0.6	82	141	0.0	5	93	1.2	27	22
Maintenance Assistance Status												
Cash	2.3	153	68	0.7	112	159	0.1	7	105	1.5	34	23
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.4	15	43	0.1	11	107	0.0	1	52	0.2	4	15
Other/unknown	3.1	163	53	0.9	115	122	0.1	6	76	2.0	42	21

Source: Data for this table are from the MAX 2005 file for Oregon, 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 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)

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, 2005

	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	$2	$4	$55	$186	$75	$18	157,874	$8,613,225	54,493	25.6	510,033
Biologicals	0.1	0.1	0.0	0.0	30	28	0	2	255	300	69	81	2,159	550,067	1,701	0.8	18,206
Antineoplastic Agents	0.6	0.2	0.0	0.4	107	87	0	20	181	540	173	47	8,061	1,456,901	1,398	0.7	13,556
Endocrine/Metabolic Drugs	0.9	0.3	0.1	0.5	39	28	3	8	43	92	49	15	258,958	11,146,597	30,740	14.5	284,851
Cardiovascular Agents	1.7	0.5	0.0	1.3	53	34	0	19	30	74	29	15	501,946	15,300,644	30,311	14.3	290,364
Respiratory Agents	0.5	0.2	0.0	0.3	32	27	0	4	59	109	55	15	151,151	8,896,912	29,758	14.0	282,365
Gastrointestinal Agents	0.7	0.2	0.0	0.5	38	30	0	8	56	145	56	16	136,906	7,717,168	21,021	9.9	204,759
Genitourinary Agents	0.5	0.2	0.0	0.3	26	20	1	5	53	92	60	21	40,893	2,187,548	8,672	4.1	85,459
CNS Drugs	1.4	0.6	0.0	0.8	118	98	1	18	82	156	123	23	537,962	44,072,824	45,400	21.3	373,459
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	71	63	1	7	87	104	161	33	39,037	3,390,018	5,684	2.7	47,772
Miscellaneous Psychological/ Neurological Agents	0.8	0.8	0.0	0.0	156	154	0	2	195	200	85	59	26,962	5,261,311	3,474	1.6	33,706
Analgesics and Anesthetics	0.8	0.1	0.0	0.7	45	12	7	26	54	181	216	35	313,150	16,853,930	41,385	19.5	378,680
Neuromuscular Agents	0.9	0.3	0.0	0.6	72	48	3	21	76	150	98	35	184,644	13,982,036	20,308	9.5	194,714
Nutritional Products	0.5	0.0	0.0	0.5	6	0	0	6	12	23	15	12	88,571	1,104,631	19,065	9.0	176,711
Hematological Agents	0.9	0.2	0.0	0.6	108	100	1	7	122	411	28	11	71,829	8,736,626	8,353	3.9	81,049
Topical Products	0.3	0.1	0.0	0.2	10	6	0	3	34	72	47	17	73,088	2,510,608	25,912	12.2	254,066
Miscellaneous Products	0.6	0.3	0.0	0.3	112	84	7	21	197	327	212	75	5,320	1,045,501	936	0.4	9,298
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	8	0	0	0	30	0	0	0	3,536	106,050	1,347	0.6	13,276
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.	2,602,047	152,932,597	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Oregon, 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 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 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]

OREGON, 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	$22,401,434	15,308	7.2	151,579	0.8	$190	$148
ANALGESICS - Narcotic	12,354,719	47,912	22.5	463,721	0.5	53	27
ANTIDEPRESSANTS	12,210,133	36,358	17.1	359,185	0.7	52	34
ANTICONVULSANT	10,920,140	14,360	6.8	145,632	0.8	94	75
ANTIASTHMATIC	7,438,594	29,076	13.7	285,944	0.4	70	26
MISC. HEMATOLOGICAL	6,252,467	2,834	1.3	27,895	0.7	321	224
ANTIDIABETIC	5,955,893	14,985	7.0	149,263	0.7	54	40
ANTIHYPERLIPIDEMIC	5,949,794	11,676	5.5	119,997	0.7	74	50
ULCER DRUGS	5,576,446	21,260	10.0	211,909	0.5	48	26
MISC PSYCHOTHERAPEUTIC AND NEUROLOGICAL	5,342,564	5,329	2.5	53,176	0.6	180	100
Total	94,402,184	199,098		1,968,301	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Oregon, 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.