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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
PENNSYLVANIA, 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]	2029894 (A)	366138 (E)	1663756 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1930424 (B)	308823 (F)	1621601 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	795908 (C)	164052 (G)	631856 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	39937 (D)	36981 (H)	2956 (L)

Source: Data for this table are from the MAX 2005 file for Pennsylvania, released by CMS in 1/2009. 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 Pennsylvania in 2005 was $936,802,053, of which $44,244,561 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]
PENNSYLVANIA, 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	**795,908**	**117,559**	**163,423**	**141,893**	**371,632**	**1,401**	**5,438,634**	**1,063,005**	**1,372,681**	**677,286**	**2,315,331**	**10,331**
Age												
5 and younger	139,511	7	8,317	0	131,187	0	846,700	14	54,913	0	791,773	0
6-14	158,710	9	21,982	0	136,719	0	1,109,759	16	190,741	0	919,002	0
15-20	114,520	7	14,476	0	100,003	34	712,257	11	123,047	0	589,037	162
21-44	179,864	13	50,276	125,314	3,681	580	1,040,969	31	423,739	598,234	15,468	3,497
45-64	85,378	25	68,019	16,563	0	771	663,953	117	578,260	79,012	0	6,564
65-74	33,754	33,373	353	12	0	16	298,905	296,793	1,981	23	0	108
75-84	41,658	41,655	0	3	0	0	383,496	383,481	0	15	0	0
85 and older	42,471	42,470	0	1	0	0	382,544	382,542	0	2	0	0
Unknown	42	0	0	0	42	0	51	0	0	0	51	0
Gender												
Female	462,992	88,273	77,936	107,163	188,219	1,401	3,169,592	811,851	669,708	516,364	1,161,338	10,331
Male	332,916	29,286	85,487	34,730	183,413	0	2,269,042	251,154	702,973	160,922	1,153,993	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	584,403	95,059	134,313	97,153	256,832	1,046	4,552,431	884,501	1,215,816	561,084	1,883,293	7,737
African American	118,588	14,186	17,146	24,626	62,413	217	515,106	121,735	93,312	62,084	236,322	1,653
Other/unknown	92,917	8,314	11,964	20,114	52,387	138	371,097	56,769	63,553	54,118	195,716	941
Use of Nursing Facilities[c]												
Entire year	39,937	35,554	4,380	2	1	0	417,965	370,301	47,660	3	1	0
Part year	28,106	23,876	4,120	94	7	9	224,076	192,752	30,805	404	36	79
None	727,865	58,129	154,923	141,797	371,624	1,392	4,796,593	499,952	1,294,216	676,879	2,315,294	10,252
Maintenance Assistance Status												
Cash	267,545	24,122	83,926	64,909	94,588	0	1,842,211	231,720	768,848	303,873	537,770	0
Medically needy	27,387	191	502	7,274	19,420	0	158,176	1,781	2,919	48,456	105,020	0
Poverty-related	306,163	18,599	60,550	23,996	201,617	1,401	1,985,530	150,810	438,276	80,903	1,305,210	10,331
Other/unknown	194,813	74,647	18,445	45,714	56,007	0	1,452,717	678,694	162,638	244,054	367,331	0
Dual Medicare Status[d]												
Full dual, all year	156,912	106,126	49,757	930	18	81	1,457,804	987,313	463,872	5,701	124	794
Full dual, part year	7,140	4,026	3,104	10	0	0	59,853	35,559	24,213	81	0	0
Non-dual, all year	631,856	7,407	110,562	140,953	371,614	1,320	3,920,977	40,133	884,596	671,504	2,315,207	9,537
Managed Care (MC) Status												
Fee-for-service (FFS) all year	520,613	105,829	119,294	74,015	220,142	1,333	4,779,812	1,020,499	1,237,931	546,108	1,965,326	9,948
FFS part year, with Rx claims	64,213	5,779	18,891	16,759	22,747	37	242,134	26,772	73,841	45,093	96,170	258
FFS part year, no Rx claims	211,082	5,951	25,238	51,119	128,743	31	416,688	15,734	60,909	86,085	253,835	125

Source: Data for this table are from the MAX 2005 file for Pennsylvania, released by CMS in 1/2009. 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]
PENNSYLVANIA, 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	**53.6**	**16.7**	**$1,121**	**$67**	**$7,357**	**15.2**	**795,908**
Age							
5 and younger	42.8	2.4	137	58	2,074	6.6	139,511
6-14	42.8	4.0	302	75	2,722	11.1	158,710
15-20	42.7	4.7	372	80	3,013	12.3	114,520
21-44	50.3	10.9	939	86	4,463	21.0	179,864
45-64	72.1	38.4	3,040	79	12,516	24.3	85,378
65-74	75.5	50.8	3,103	61	17,144	18.1	33,754
75-84	83.9	59.0	3,174	54	25,094	12.6	41,658
85 and older	87.9	55.8	2,769	50	30,465	9.1	42,471
Unknown	0.0	0.0	0	0	0	0.0	42
Basis of Eligibility[e]							
Aged	82.9	55.5	3,008	54	24,783	12.1	117,559
Disabled	71.4	30.6	2,617	86	11,752	22.3	163,423
Adults	43.2	5.2	324	62	2,702	12.0	141,893
Children	40.3	2.7	160	60	1,685	9.5	371,632
Unknown	63.7	17.5	4,168	238	8,463	49.2	1,401
Gender							
Female	56.2	19.6	1,234	63	8,257	14.9	462,992
Male	50.0	12.6	965	77	6,106	15.8	332,916
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	62.5	20.0	1,353	68	7,923	17.1	584,403
African American	29.6	8.8	563	64	6,973	8.1	118,588
Other/unknown	28.0	5.6	379	68	4,285	8.8	92,917
Use of Nursing Facilities[f]							
Entire year	97.3	86.6	4,650	54	51,344	9.1	39,937
Part year	94.2	55.3	3,111	56	27,429	11.3	28,106
None	49.6	11.4	851	75	4,168	20.4	727,865
Maintenance Assistance Status							
Cash	54.2	17.0	1,273	75	5,714	22.3	267,545
Medically needy	38.2	3.5	202	57	2,540	7.9	27,387
Poverty related	46.3	7.9	591	75	2,741	21.6	306,163
Other/unknown	66.3	32.0	1,876	59	17,545	10.7	194,813

Source: Data for this table are from the MAX 2005 file for Pennsylvania, released by CMS in 1/2009. 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]
PENNSYLVANIA, 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	**2.4**	**$164**	**15.2**	**46.4**	**26.8**	**5.8**	**9.6**	**8.1**	**3.4**	**$1,077**	**795,908**	**5,438,634**
Age												
5 and younger	0.4	23	6.6	57.2	39.3	2.5	1.0	0.1	0.0	342	139,511	846,700
6-14	0.6	43	11.1	57.2	34.5	4.3	3.4	0.5	0.1	389	158,710	1,109,759
15-20	0.8	60	12.3	57.3	31.7	5.4	4.4	1.0	0.2	484	114,520	712,257
21-44	1.9	162	21.0	49.7	26.3	7.8	10.1	4.8	1.3	771	179,864	1,040,969
45-64	4.9	391	24.3	27.9	12.8	8.6	21.4	20.1	9.1	1,609	85,378	663,953
65-74	5.7	350	18.1	24.5	9.0	6.8	21.1	25.6	13.1	1,936	33,754	298,905
75-84	6.4	345	12.6	16.1	7.0	6.3	23.1	31.8	15.7	2,726	41,658	383,496
85 and older	6.2	307	9.1	12.1	6.8	7.0	27.2	34.1	12.8	3,382	42,471	382,544
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	42	51
Basis of Eligibility[e]												
Aged	6.1	333	12.1	17.1	7.5	6.7	24.0	30.9	13.9	2,741	117,559	1,063,005
Disabled	3.6	312	22.3	28.6	21.1	10.1	19.5	14.6	6.0	1,399	163,423	1,372,681
Adults	1.1	68	12.0	56.8	27.0	6.9	6.9	2.2	0.3	566	141,893	677,286
Children	0.4	26	9.5	59.7	35.3	3.1	1.7	0.2	0.0	271	371,632	2,315,331
Unknown	2.4	565	49.2	36.3	25.1	10.6	16.8	9.7	1.4	1,148	1,401	10,331
Gender												
Female	2.9	180	14.9	43.8	25.9	5.9	10.5	9.7	4.2	1,206	462,992	3,169,592
Male	1.8	142	15.8	50.0	28.0	5.6	8.4	5.8	2.2	896	332,916	2,269,042
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.6	174	17.1	37.5	31.2	6.6	11.2	9.6	4.0	1,017	584,403	4,552,431
African American	2.0	130	8.1	70.4	13.5	3.6	6.1	4.6	1.9	1,605	118,588	515,106
Other/unknown	1.4	95	8.8	72.0	16.0	3.4	4.5	3.0	1.1	1,073	92,917	371,097
Use of Nursing Facilities[f]												
Entire year	8.3	444	9.1	2.7	3.5	4.3	22.1	40.9	26.5	4,906	39,937	417,965
Part year	6.9	390	11.3	5.8	6.9	7.3	27.4	34.5	18.0	3,440	28,106	224,076
None	1.7	129	20.4	50.4	28.8	5.8	8.2	5.2	1.5	633	727,865	4,796,593
Maintenance Assistance Status												
Cash	2.5	185	22.3	45.8	25.9	6.6	10.8	7.9	3.0	830	267,545	1,842,211
Medically needy	0.6	35	7.9	61.8	30.0	4.6	2.8	0.6	0.2	440	27,387	158,176
Poverty related	1.2	91	21.6	53.7	31.7	4.6	5.7	3.4	0.9	423	306,163	1,985,530
Other/unknown	4.3	252	10.7	33.7	19.6	6.5	15.1	16.8	8.3	2,353	194,813	1,452,717

Source: Data for this table are from the MAX 2005 file for Pennsylvania, released by CMS in 1/2009. 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]
PENNSYLVANIA, 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	**2.4**	**$164**	**$67**	**1.0**	**$120**	**$124**	**0.1**	**$9**	**$85**	**1.4**	**$35**	**$26**
Age												
5 and younger	0.4	23	58	0.1	18	138	0.0	1	50	0.2	4	17
6-14	0.6	43	75	0.3	35	114	0.0	2	81	0.2	6	24
15-20	0.8	60	80	0.3	48	137	0.0	3	70	0.4	9	25
21-44	1.9	162	86	0.7	117	165	0.1	11	124	1.1	34	31
45-64	4.9	391	79	1.9	279	146	0.2	24	122	2.8	87	31
65-74	5.7	350	61	2.3	257	113	0.2	14	68	3.3	79	24
75-84	6.4	345	54	2.5	252	100	0.2	13	53	3.6	80	22
85 and older	6.2	307	50	2.3	220	94	0.3	13	50	3.6	75	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	6.1	333	54	2.4	241	101	0.2	13	55	3.5	78	22
Disabled	3.6	312	86	1.5	229	154	0.2	19	121	2.0	63	32
Adults	1.1	68	62	0.4	46	123	0.0	5	100	0.7	17	26
Children	0.4	26	60	0.2	20	111	0.0	1	66	0.2	5	20
Unknown	2.4	565	238	0.9	456	493	0.1	27	298	1.3	57	43
Gender												
Female	2.9	180	63	1.1	130	118	0.1	9	77	1.6	41	25
Male	1.8	142	77	0.8	106	138	0.1	8	105	1.0	28	28
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.6	174	68	1.0	127	125	0.1	9	86	1.4	38	26
African American	2.0	130	64	0.8	97	122	0.1	5	84	1.2	28	24
Other/unknown	1.4	95	68	0.6	72	128	0.0	4	75	0.8	19	25
Use of Nursing Facilities[e]												
Entire year	8.3	444	54	3.2	322	101	0.3	18	53	4.7	105	22
Part year	6.9	390	56	2.6	278	109	0.3	18	64	4.1	94	23
None	1.7	129	75	0.7	95	136	0.1	7	102	1.0	27	28
Maintenance Assistance Status												
Cash	2.5	185	75	1.0	136	138	0.1	10	101	1.4	38	28
Medically needy	0.6	35	57	0.2	24	106	0.0	2	69	0.3	8	24
Poverty related	1.2	91	75	0.5	68	135	0.1	5	100	0.7	18	28
Other/unknown	4.3	252	59	1.7	182	110	0.2	12	67	2.4	58	24

Source: Data for this table are from the MAX 2005 file for Pennsylvania, released by CMS in 1/2009. 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 Pennsylvania, 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]
PENNSYLVANIA, 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	$19	$11	$3	$5	$63	$156	$76	$25	805,828	$51,039,616	266,587	33.5	2,736,350
Biologicals	0.2	0.1	0.0	0.0	97	74	4	18	629	640	738	568	14,012	8,818,097	8,696	1.1	91,360
Antineoplastic Agents	0.6	0.2	0.0	0.4	187	137	9	41	297	763	658	93	62,523	18,548,662	10,333	1.3	99,258
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.5	43	29	5	9	52	101	62	18	1,241,321	64,062,706	146,723	18.4	1,478,371
Cardiovascular Agents	1.9	0.7	0.0	1.2	72	51	1	20	38	74	26	17	2,775,410	106,618,633	149,244	18.8	1,477,209
Respiratory Agents	0.5	0.3	0.0	0.2	35	30	1	3	64	95	61	16	934,031	59,637,486	166,914	21.0	1,720,481
Gastrointestinal Agents	0.6	0.3	0.0	0.3	44	34	1	9	73	136	75	26	663,682	48,700,837	107,796	13.5	1,111,890
Genitourinary Agents	0.5	0.3	0.0	0.1	33	27	1	5	66	80	74	32	233,746	15,358,197	45,095	5.7	463,188
CNS Drugs	1.3	0.7	0.0	0.6	115	94	2	19	86	138	120	30	2,275,535	196,383,381	174,482	21.9	1,709,874
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.1	69	64	1	5	91	103	84	35	215,425	19,529,891	27,515	3.5	281,525
Miscellaneous Psychological/ Neurological Agents	0.9	0.9	0.0	0.0	142	140	0	2	159	160	117	116	247,023	39,179,828	27,238	3.4	275,638
Analgesics and Anesthetics	0.7	0.1	0.0	0.6	46	17	9	20	64	161	203	35	1,199,708	77,036,296	167,779	21.1	1,658,018
Neuromuscular Agents	1.0	0.3	0.0	0.6	80	48	5	27	82	150	108	44	898,849	73,567,544	91,228	11.5	919,281
Nutritional Products	0.5	0.0	0.0	0.4	9	1	0	8	19	36	22	19	343,037	6,657,772	74,111	9.3	726,745
Hematological Agents	1.1	0.4	0.1	0.6	123	113	2	8	112	294	17	13	592,180	66,404,156	54,943	6.9	541,438
Topical Products	0.4	0.2	0.0	0.2	19	13	1	5	47	77	52	24	707,015	33,101,024	167,949	21.1	1,754,786
Miscellaneous Products	0.3	0.2	0.0	0.1	55	44	3	8	177	277	237	59	37,462	6,634,822	11,681	1.5	120,993
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	13	0	0	0	47	0	0	0	27,246	1,278,544	9,578	1.2	102,092
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.	13,274,033	892,557,492	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Pennsylvania, released by CMS in 1/2009. 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 Pennsylvania, 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]
PENNSYLVANIA, 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	$112,462,318	86,977	10.9	890,874	0.7	$176	$126
ANTIDEPRESSANTS	67,477,635	163,792	20.6	1,650,371	0.7	62	41
ANTICONVULSANT	59,635,373	75,250	9.5	774,971	0.8	95	77
ANALGESICS - Narcotic	49,182,108	182,888	23.0	1,864,447	0.4	62	26
ANTIHYPERLIPIDEMIC	43,305,772	69,221	8.7	727,155	0.7	91	60
ANTIASTHMATIC	43,266,359	147,695	18.6	1,530,497	0.4	72	28
MISC PSYCHOTHERAPEUTIC AND NEUROLOGICAL	39,465,356	35,476	4.5	362,269	0.7	156	109
ULCER DRUGS	39,191,781	120,537	15.1	1,258,048	0.5	58	31
ANTIDIABETIC	38,219,186	80,676	10.1	821,199	0.8	60	47
HEMATOPOIETIC AGENTS	31,841,351	36,956	4.6	369,184	0.6	156	86
Total	524,047,239	999,468		10,249,015	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Pennsylvania, released by CMS in 1/2009. 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.