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

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OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
WASHINGTON, 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]	1199572 (A)	142020 (E)	1057552 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1136805 (B)	106018 (F)	1030787 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	723787 (C)	105061 (G)	618726 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	9154 (D)	8283 (H)	871 (L)

Source: Data for this table are from the MAX 2005 file for Washington, released by CMS in 10/2008. 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 Washington in 2005 was $688,801,986, of which $74,560,361 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]

WASHINGTON, 2005

	Number of Beneficiaries						Number of Benefit Months					
Beneficiary Characteristics	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**723,787**	**67,139**	**144,632**	**250,650**	**260,964**	**402**	**5,050,166**	**690,904**	**1,502,562**	**1,576,629**	**1,276,641**	**3,430**
Age												
5 and younger	106,091	1	3,889	5	102,196	0	461,883	6	37,455	10	424,412	0
6-14	120,274	1	10,185	331	109,757	0	705,324	12	111,465	2,001	591,846	0
15-20	114,117	7	8,777	56,440	48,893	0	773,450	76	92,788	420,649	259,937	0
21-44	237,863	25	53,743	183,902	118	75	1,666,107	207	556,146	1,108,745	446	563
45-64	78,080	141	67,689	9,930	0	320	751,483	1,265	702,396	45,005	0	2,817
65-74	27,156	26,785	334	30	0	7	288,415	285,992	2,231	142	0	50
75-84	23,275	23,258	9	8	0	0	241,954	241,829	63	62	0	0
85 and older	16,931	16,921	6	4	0	0	161,550	161,517	18	15	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	467,507	46,683	73,537	217,804	129,081	402	3,337,710	483,215	776,321	1,437,192	637,552	3,430
Male	256,245	20,450	71,088	32,843	131,864	0	1,712,233	207,626	726,157	139,424	639,026	0
Unknown	35	6	7	3	19	0	223	63	84	13	63	0
Race												
White	413,467	46,090	108,969	104,059	154,103	246	2,946,107	468,529	1,141,770	547,979	785,588	2,241
African American	40,228	2,223	12,123	10,366	15,501	15	263,468	23,065	122,494	47,297	70,499	113
Other/unknown	270,092	18,826	23,540	136,225	91,360	141	1,840,591	199,310	238,298	981,353	420,554	1,076
Use of Nursing Facilities[c]												
Entire year	9,154	7,626	1,525	3	0	0	93,669	77,939	15,718	12	0	0
Part year	9,368	6,656	2,674	34	4	0	86,891	60,363	26,337	167	24	0
None	705,265	52,857	140,433	250,613	260,960	402	4,869,606	552,602	1,460,507	1,576,450	1,276,617	3,430
Maintenance Assistance Status												
Cash	214,145	30,073	117,801	27,832	38,439	0	1,817,596	331,150	1,212,565	106,281	167,600	0
Medically needy	3,429	806	2,427	23	173	0	32,690	8,033	23,561	123	973	0
Poverty-related	156,939	1,156	1,889	39,850	113,642	402	799,966	10,055	18,150	233,185	535,146	3,430
Other/unknown	349,274	35,104	22,515	182,945	108,710	0	2,399,914	341,666	248,286	1,237,040	572,922	0
Dual Medicare Status[d]												
Full dual, all year	99,761	55,867	43,063	787	20	24	1,062,121	581,559	474,710	5,442	180	230
Full dual, part year	5,300	2,340	2,913	46	1	0	54,187	23,104	30,578	495	10	0
Non-dual, all year	618,726	8,932	98,656	249,817	260,943	378	3,933,858	86,241	997,274	1,570,692	1,276,451	3,200
Managed Care (MC) Status												
Fee-for-service (FFS) all year	478,095	66,598	137,793	171,820	101,498	386	4,286,902	687,183	1,461,032	1,298,242	837,154	3,291
FFS part year, with Rx claims	98,302	472	5,936	43,171	48,708	15	367,864	3,387	37,240	162,123	164,985	129
FFS part year, no Rx claims	147,390	69	903	35,659	110,758	1	395,400	334	4,290	116,264	274,502	10

Source: Data for this table are from the MAX 2005 file for Washington, released by CMS in 10/2008. 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]

WASHINGTON, 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	**50.4**	**14.1**	**$849**	**$60**	**$4,772**	**17.8**	**723,787**
Age							
5 and younger	36.7	1.5	76	50	2,330	3.3	106,091
6-14	38.1	2.9	273	95	1,728	15.8	120,274
15-20	34.1	2.6	177	68	1,917	9.2	114,117
21-44	48.2	9.1	684	75	3,919	17.4	237,863
45-64	84.3	47.5	2,982	63	11,445	26.1	78,080
65-74	88.5	51.4	2,489	48	10,237	24.3	27,156
75-84	90.7	54.7	2,407	44	14,625	16.5	23,275
85 and older	91.5	50.7	2,009	40	19,822	10.1	16,931
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	90.2	52.5	2,345	45	14,185	16.5	67,139
Disabled	85.3	39.3	2,866	73	11,920	24.0	144,632
Adults	34.5	2.1	77	36	1,638	4.7	250,650
Children	36.0	1.7	85	49	1,379	6.1	260,964
Unknown	89.8	26.0	2,137	82	16,763	12.8	402
Gender							
Female	50.0	14.6	783	54	4,598	17.0	467,507
Male	51.1	13.2	968	73	5,089	19.0	256,245
Unknown	42.9	20.7	1,090	53	3,945	27.6	35
Race							
White	58.9	18.9	1,154	61	6,078	19.0	413,467
African American	53.5	13.5	791	59	5,005	15.8	40,228
Other/unknown	36.9	6.9	390	57	2,736	14.2	270,092
Use of Nursing Facilities[f]							
Entire year	97.0	71.4	3,558	50	45,067	7.9	9,154
Part year	98.0	66.3	3,410	51	31,348	10.9	9,368
None	49.2	12.7	780	62	3,896	20.0	705,265
Maintenance Assistance Status							
Cash	73.4	27.1	1,770	65	6,654	26.6	214,145
Medically needy	92.4	48.5	3,579	74	12,305	29.1	3,429
Poverty related	41.3	2.1	86	42	1,859	4.6	156,939
Other/unknown	40.0	11.2	600	54	4,852	12.4	349,274

Source: Data for this table are from the MAX 2005 file for Washington, released by CMS in 10/2008. 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]

WASHINGTON, 2005

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	Number: Benefit Months
All	**2.0**	**$122**	**17.8**	**49.6**	**25.7**	**5.9**	**9.4**	**6.9**	**2.4**	**$684**	**723,787**	**5,050,166**
Age												
5 and younger	0.4	18	3.3	63.3	31.4	3.4	1.7	0.2	0.0	535	106,091	461,883
6-14	0.5	47	15.8	61.9	30.2	4.2	3.1	0.5	0.1	295	120,274	705,324
15-20	0.4	26	9.2	65.9	26.5	3.8	3.0	0.6	0.1	283	114,117	773,450
21-44	1.3	98	17.4	51.8	27.5	6.6	8.5	4.3	1.3	559	237,863	1,666,107
45-64	4.9	310	26.1	15.7	15.9	9.5	25.0	23.8	10.2	1,189	78,080	751,483
65-74	4.8	234	24.3	11.5	15.3	9.7	28.0	25.8	9.6	964	27,156	288,415
75-84	5.3	232	16.5	9.3	11.8	9.2	28.6	31.2	10.0	1,407	23,275	241,954
85 and older	5.3	211	10.1	8.5	9.8	9.1	31.8	33.1	7.6	2,077	16,931	161,550
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	5.1	228	16.5	9.8	12.7	9.4	29.2	29.5	9.2	1,378	67,139	690,904
Disabled	3.8	276	24.0	14.7	25.3	11.1	23.5	18.4	7.1	1,147	144,632	1,502,562
Adults	0.3	12	4.7	65.5	25.1	4.2	3.7	1.2	0.3	260	250,650	1,576,629
Children	0.4	17	6.1	64.0	29.9	3.7	2.1	0.3	0.0	282	260,964	1,276,641
Unknown	3.0	251	12.8	10.2	26.6	17.9	29.1	14.4	1.7	1,965	402	3,430
Gender												
Female	2.0	110	17.0	50.0	25.5	5.5	9.1	7.3	2.8	644	467,507	3,337,710
Male	2.0	145	19.0	48.9	26.3	6.5	10.2	6.3	1.8	762	256,245	1,712,233
Unknown	3.3	171	27.6	57.1	17.1	5.7	2.9	17.1	0.0	619	35	223
Race												
White	2.7	162	19.0	41.1	27.0	7.0	11.9	9.4	3.5	853	413,467	2,946,107
African American	2.1	121	15.8	46.5	27.9	6.9	10.1	6.5	2.1	764	40,228	263,468
Other/unknown	1.0	57	14.2	63.1	23.5	4.0	5.6	3.2	0.7	402	270,092	1,840,591
Use of Nursing Facilities[f]												
Entire year	7.0	348	7.9	3.0	5.9	6.1	26.2	40.2	18.6	4,404	9,154	93,669
Part year	7.1	368	10.9	2.0	6.3	7.1	28.3	38.0	18.2	3,380	9,368	86,891
None	1.8	113	20.0	50.8	26.3	5.8	9.0	6.1	2.0	564	705,265	4,869,606
Maintenance Assistance Status												
Cash	3.2	209	26.6	26.6	27.1	9.9	19.0	13.2	4.2	784	214,145	1,817,596
Medically needy	5.1	375	29.1	7.6	15.1	10.3	30.8	26.5	9.8	1,291	3,429	32,690
Poverty related	0.4	17	4.6	58.7	34.3	4.1	2.3	0.5	0.1	365	156,939	799,966
Other/unknown	1.6	87	12.4	60.0	21.2	4.1	6.6	5.8	2.3	706	349,274	2,399,914

Source: Data for this table are from the MAX 2005 file for Washington, released by CMS in 10/2008. 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]

WASHINGTON, 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	**2.0**	**$122**	**$60**	**0.7**	**$91**	**$140**	**0.1**	**$4**	**$81**	**1.3**	**$26**	**$20**
Age												
5 and younger	0.4	18	50	0.1	14	132	0.0	1	50	0.2	4	15
6-14	0.5	47	95	0.2	41	178	0.0	1	77	0.2	5	19
15-20	0.4	26	68	0.1	21	140	0.0	1	68	0.2	4	20
21-44	1.3	98	75	0.4	76	184	0.0	3	90	0.8	19	22
45-64	4.9	310	63	1.5	226	148	0.1	12	109	3.3	72	22
65-74	4.8	234	48	1.6	171	107	0.1	7	62	3.1	56	18
75-84	5.3	232	44	1.7	170	97	0.1	6	49	3.4	56	16
85 and older	5.3	211	40	1.6	148	93	0.2	8	47	3.5	55	15
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.1	228	45	1.7	166	100	0.1	7	53	3.3	56	17
Disabled	3.8	276	73	1.2	211	171	0.1	10	105	2.4	55	23
Adults	0.3	12	36	0.1	8	93	0.0	1	53	0.2	4	17
Children	0.4	17	49	0.1	13	101	0.0	1	61	0.2	3	16
Unknown	3.0	251	82	0.9	207	232	0.1	5	85	2.1	38	18
Gender												
Female	2.0	110	54	0.6	80	126	0.1	4	75	1.4	26	19
Male	2.0	145	73	0.7	114	165	0.0	4	95	1.2	26	21
Unknown	3.3	171	53	1.2	139	115	0.1	4	40	2.0	29	15
Race												
White	2.7	162	61	0.9	121	142	0.1	6	84	1.7	35	20
African American	2.1	121	59	0.6	91	143	0.1	4	80	1.4	25	19
Other/unknown	1.0	57	57	0.3	44	130	0.0	2	70	0.6	12	18
Use of Nursing Facilities[e]												
Entire year	7.0	348	50	2.2	248	115	0.2	13	54	4.6	87	19
Part year	7.1	368	51	2.1	260	124	0.2	15	72	4.8	93	19
None	1.8	113	62	0.6	85	143	0.0	4	85	1.2	24	20
Maintenance Assistance Status												
Cash	3.2	209	65	1.0	159	153	0.1	7	94	2.1	43	21
Medically needy	5.1	375	74	1.7	292	171	0.1	13	108	3.3	69	21
Poverty related	0.4	17	42	0.1	12	94	0.0	1	57	0.3	5	17
Other/unknown	1.6	87	54	0.5	64	123	0.0	3	69	1.1	20	19

Source: Data for this table are from the MAX 2005 file for Washington, released by CMS in 10/2008. 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 Washington, 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]

WASHINGTON, 2005

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.2	$23	$16	$2	$5	$69	$229	$78	$21	614,931	$42,694,930	202,553	28.0	1,870,369
Biologicals	0.1	0.1	0.0	0.0	44	28	1	15	377	290	1,756	727	8,264	3,118,650	6,417	0.9	70,510
Antineoplastic Agents	0.6	0.1	0.0	0.4	102	78	0	24	180	520	143	58	33,016	5,952,135	5,723	0.8	58,373
Endocrine/Metabolic Drugs	0.9	0.3	0.0	0.5	41	30	2	8	46	99	51	16	1,073,801	49,622,538	125,991	17.4	1,213,887
Cardiovascular Agents	1.8	0.5	0.0	1.2	56	40	0	16	32	76	21	13	2,101,533	66,698,527	114,748	15.9	1,194,418
Respiratory Agents	0.6	0.3	0.0	0.3	37	31	0	5	60	101	61	18	725,169	43,397,290	121,688	16.8	1,174,341
Gastrointestinal Agents	0.6	0.3	0.0	0.3	48	43	0	5	75	141	56	16	581,110	43,463,203	87,234	12.1	900,016
Genitourinary Agents	0.4	0.2	0.0	0.3	18	13	1	5	42	78	56	18	157,248	6,565,805	35,443	4.9	355,968
CNS Drugs	1.3	0.5	0.0	0.8	115	99	0	16	87	181	80	20	1,821,665	158,586,312	139,190	19.2	1,377,958
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	69	59	1	9	85	102	101	41	128,129	10,946,413	17,011	2.4	158,913
Miscellaneous Psychological/ Neurological Agents	0.8	0.8	0.0	0.0	196	196	0	0	237	239	72	24	66,250	15,706,345	7,666	1.1	80,044
Analgesics and Anesthetics	0.8	0.1	0.0	0.7	32	12	4	16	41	173	225	23	1,246,367	50,772,653	167,473	23.1	1,568,158
Neuromuscular Agents	0.9	0.3	0.0	0.6	72	47	3	22	80	165	89	38	745,792	59,522,063	80,479	11.1	825,652
Nutritional Products	0.5	0.0	0.0	0.5	8	0	0	7	16	28	16	15	224,792	3,524,470	53,524	7.4	458,946
Hematological Agents	0.8	0.3	0.1	0.5	116	109	1	6	144	425	24	12	221,113	31,928,643	26,419	3.7	274,476
Topical Products	0.4	0.1	0.0	0.2	14	9	0	5	41	84	47	22	418,326	17,049,408	121,056	16.7	1,189,546
Miscellaneous Products	0.2	0.2	0.0	0.1	43	32	4	7	172	209	284	86	25,854	4,441,704	10,511	1.5	104,059
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	8	0	0	0	28	0	0	0	8,803	250,536	2,992	0.4	32,344
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.	10,202,163	614,241,625	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Washington, released by CMS in 10/2008. 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 Washington, 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]

WASHINGTON, 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	$108,047,150	63,628	8.8	680,557	0.8	$211	$159
ANTICONVULSANT	52,073,743	59,687	8.2	638,209	0.8	105	82
ANTIDEPRESSANTS	42,429,803	138,173	19.1	1,423,920	0.6	47	30
ULCER DRUGS	34,355,182	93,581	12.9	989,646	0.6	62	35
ANTIASTHMATIC	31,856,330	112,799	15.6	1,142,091	0.4	69	28
ANTIHYPERLIPIDEMIC	30,583,239	54,854	7.6	602,769	0.7	73	51
ANALGESICS - Narcotic	28,108,104	190,851	26.4	1,885,738	0.4	33	15
ANTIDIABETIC	26,472,516	60,286	8.3	642,517	0.8	54	41
ANTIVIRAL	21,735,252	14,685	2.0	151,123	0.4	346	144
MISC. HEMATOLOGICAL	21,335,865	9,370	1.3	100,339	0.7	312	213
Total	396,997,184	797,914		8,256,909	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Washington, released by CMS in 10/2008. 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.