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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006
D.C.

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
D.C., 2006

Inclusion Criteria (2006)	Number of Dual and Nondual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Nondual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	167174 (A)	21291 (E)	145883 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	163519 (B)	19454 (F)	144065 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	70697 (C)	19196 (G)	51501 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2345 (D)	1833 (H)	512 (L)

Source: Data for this table are from the MAX 2006 file for D.C., released by CMS in 4/2009. This table was produced on 02/11/2010.
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 2006 (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 2006, 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 D.C. in 2006 was $71,474,465, of which $1,242,748 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 29 states in 2006 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, KY, MA, MI, MS, NC, NH, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, and WI. In addition, there were 10 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NC, NE, NY, TN, TX, UT, and WV). These lists were constructed from the CMS 2006 Medicaid Managed Care Enrollment Report 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 2006. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.
g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the 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 2006. 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]

D.C., 2006

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**70,697**	**8,918**	**32,126**	**10,378**	**19,275**	**0**	**565,899**	**93,228**	**325,443**	**50,844**	**96,384**	**0**
Age												
5 and younger	8,239	0	569	8	7,662	0	34,517	0	4,319	30	30,168	0
6-14	8,407	0	1,674	3	6,730	0	51,113	0	15,309	16	35,788	0
15-20	6,992	0	1,475	747	4,770	0	46,456	0	14,022	2,527	29,907	0
21-44	16,126	8	8,478	7,540	100	0	119,323	80	84,424	34,436	383	0
45-64	17,735	29	15,760	1,946	0	0	175,367	263	162,520	12,584	0	0
65-74	6,235	3,529	2,607	99	0	0	66,261	37,050	28,308	903	0	0
75-84	4,382	3,302	1,052	28	0	0	46,937	35,319	11,335	283	0	0
85 and older	2,568	2,050	511	7	0	0	25,787	20,516	5,206	65	0	0
Unknown	13	0	0	0	13	0	138	0	0	0	138	0
Gender												
Female	38,991	6,192	15,733	7,639	9,427	0	307,962	65,506	163,683	31,955	46,818	0
Male	31,705	2,726	16,393	2,738	9,848	0	257,935	27,722	161,760	18,887	49,566	0
Unknown	1	0	0	1	0	0	2	0	0	2	0	0
Race												
White	2,266	530	1,394	213	129	0	20,885	5,339	13,364	1,551	631	0
African American	59,397	6,816	27,979	8,974	15,628	0	479,209	71,202	283,762	42,082	82,163	0
Other/unknown	9,034	1,572	2,753	1,191	3,518	0	65,805	16,687	28,317	7,211	13,590	0
Use of Nursing Facilities[c]												
Entire year	2,345	1,850	455	40	0	0	24,914	19,499	4,951	464	0	0
Part year	1,484	834	630	19	1	0	14,697	7,963	6,548	174	12	0
None	66,868	6,234	31,041	10,319	19,274	0	526,288	65,766	313,944	50,206	96,372	0
Maintenance Assistance Status												
Cash	36,204	2,541	22,170	6,502	4,991	0	312,060	28,041	233,127	34,357	16,535	0
Medically needy	17,024	2,656	6,357	3,101	4,910	0	109,003	25,800	54,807	11,911	16,485	0
Poverty-related	10,649	2,434	3,062	293	4,860	0	75,553	26,079	32,003	1,078	16,393	0
Other/unknown	6,820	1,287	537	482	4,514	0	69,283	13,308	5,506	3,498	46,971	0
Dual Medicare Status[d]												
Full dual, all year	18,269	7,521	9,900	847	1	0	195,327	79,408	107,311	8,599	9	0
Full dual, part year	927	376	536	15	0	0	10,057	4,106	5,779	172	0	0
Non-dual, all year	51,501	1,021	21,690	9,516	19,274	0	360,515	9,714	212,353	42,073	96,375	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	50,184	8,878	30,549	3,775	6,982	0	495,136	92,976	316,944	30,083	55,133	0
FFS part year, with Rx claims	4,533	15	741	1,753	2,024	0	19,297	114	4,580	6,275	8,328	0
FFS part year, no Rx claims	15,980	25	836	4,850	10,269	0	51,466	138	3,919	14,486	32,923	0

Source: Data for this table are from the MAX 2006 file for D.C., released by CMS in 4/2009. This table was produced on 02/11/2010.

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 2006. 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]

D.C., 2006

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	**40.3**	**10.2**	**$993**	**$98**	**$13,833**	**7.2**	**70,697**
Age							
5 and younger	21.1	0.9	74	85	5,852	1.3	8,239
6-14	25.1	2.5	264	107	5,140	5.1	8,407
15-20	30.7	2.9	319	111	8,552	3.7	6,992
21-44	43.7	10.2	1,219	120	12,429	9.8	16,126
45-64	62.7	24.8	2,358	95	20,912	11.3	17,735
65-74	36.6	6.7	405	61	15,072	2.7	6,235
75-84	31.0	4.1	197	48	19,814	1.0	4,382
85 and older	25.9	3.0	126	41	29,052	0.4	2,568
Unknown	0.0	0.0	0	0	0	0.0	13
Basis of Eligibility[e]							
Aged	30.2	4.3	209	49	20,114	1.0	8,918
Disabled	56.7	18.2	1,786	98	19,112	9.3	32,126
Adults	33.0	6.3	782	123	7,141	11.0	10,378
Children	21.4	1.5	149	97	5,731	2.6	19,275
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	41.2	10.3	909	88	13,286	6.8	38,991
Male	39.1	10.0	1,098	110	14,505	7.6	31,705
Unknown	0.0	0.0	0	0	0	0.0	1
Race							
White	42.4	12.4	1,337	107	20,405	6.6	2,266
African American	41.5	10.5	1,016	97	14,134	7.2	59,397
Other/unknown	31.7	7.3	760	105	10,201	7.4	9,034
Use of Nursing Facilities[f]							
Entire year	48.2	16.7	1,063	64	64,167	1.7	2,345
Part year	56.5	17.0	1,363	80	61,891	2.2	1,484
None	39.6	9.8	983	100	11,001	8.9	66,868
Maintenance Assistance Status							
Cash	46.9	14.3	1,426	100	14,607	9.8	36,204
Medically needy	35.5	7.6	683	90	18,545	3.7	17,024
Poverty related	22.9	2.7	215	79	5,057	4.2	10,649
Other/unknown	44.0	6.7	692	104	11,664	5.9	6,820

Source: Data for this table are from the MAX 2006 file for D.C., released by CMS in 4/2009. This table was produced on 02/11/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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]

D.C., 2006

				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	**1.3**	**$124**	**7.2**	**59.7**	**22.4**	**4.7**	**7.7**	**4.4**	**1.0**	**$1,728**	**70,697**	**565,899**
Age												
5 and younger	0.2	18	1.3	78.9	18.7	1.6	0.7	0.1	0.0	1,397	8,239	34,517
6-14	0.4	43	5.1	74.9	19.3	2.9	2.5	0.4	0.0	845	8,407	51,113
15-20	0.4	48	3.7	69.3	24.7	2.7	2.6	0.6	0.1	1,287	6,992	46,456
21-44	1.4	165	9.8	56.3	23.8	6.1	8.7	4.3	0.8	1,680	16,126	119,323
45-64	2.5	238	11.3	37.3	21.9	8.1	17.7	12.0	3.0	2,115	17,735	175,367
65-74	0.6	38	2.7	63.4	25.9	3.1	4.6	2.4	0.6	1,418	6,235	66,261
75-84	0.4	18	1.0	69.0	24.9	2.1	2.7	1.1	0.3	1,850	4,382	46,937
85 and older	0.3	13	0.4	74.1	21.2	1.2	2.1	1.1	0.2	2,893	2,568	25,787
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	13	138
Basis of Eligibility[e]												
Aged	0.4	20	1.0	69.8	23.6	1.9	2.9	1.4	0.3	1,924	8,918	93,228
Disabled	1.8	176	9.3	43.3	26.1	7.2	13.5	8.0	2.0	1,887	32,126	325,443
Adults	1.3	160	11.0	67.0	19.0	4.1	5.6	3.7	0.5	1,458	10,378	50,844
Children	0.3	30	2.6	78.6	17.7	2.0	1.5	0.2	0.0	1,146	19,275	96,384
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.3	115	6.8	58.8	23.4	4.7	7.5	4.4	1.1	1,682	38,991	307,962
Male	1.2	135	7.6	60.9	21.3	4.7	7.9	4.4	0.9	1,783	31,705	257,935
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	1	2
Race												
White	1.4	145	6.6	57.6	21.7	5.2	8.9	5.3	1.4	2,214	2,266	20,885
African American	1.3	126	7.2	58.5	23.0	4.9	8.0	4.5	1.1	1,752	59,397	479,209
Other/unknown	1.0	104	7.4	68.3	18.9	3.2	5.6	3.5	0.5	1,400	9,034	65,805
Use of Nursing Facilities[f]												
Entire year	1.6	100	1.7	51.8	26.2	3.0	8.2	7.6	3.2	6,040	2,345	24,914
Part year	1.7	138	2.2	43.5	28.8	5.3	11.7	8.1	2.6	6,249	1,484	14,697
None	1.2	125	8.9	60.4	22.2	4.7	7.6	4.2	0.9	1,398	66,868	526,288
Maintenance Assistance Status												
Cash	1.7	165	9.8	53.1	23.3	5.6	10.1	6.3	1.6	1,695	36,204	312,060
Medically needy	1.2	107	3.7	64.5	19.7	4.6	6.9	3.5	0.7	2,896	17,024	109,003
Poverty related	0.4	30	4.2	77.1	17.9	1.7	2.3	0.9	0.1	713	10,649	75,553
Other/unknown	0.7	68	5.9	56.0	31.8	4.5	5.7	2.0	0.1	1,148	6,820	69,283

Source: Data for this table are from the MAX 2006 file for D.C., released by CMS in 4/2009. This table was produced on 02/11/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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]

D.C., 2006

	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	**1.3**	**$124**	**$98**	**0.5**	**$96**	**$185**	**0.0**	**$4**	**$121**	**0.7**	**$23**	**$33**
Age												
5 and younger	0.2	18	85	0.1	14	217	0.0	0	50	0.1	3	23
6-14	0.4	43	107	0.2	37	155	0.0	1	92	0.2	6	36
15-20	0.4	48	111	0.2	40	189	0.0	2	145	0.2	6	30
21-44	1.4	165	120	0.6	136	212	0.0	5	140	0.7	24	34
45-64	2.5	238	95	1.0	180	183	0.1	9	123	1.5	50	34
65-74	0.6	38	61	0.2	27	128	0.0	2	84	0.4	10	24
75-84	0.4	18	48	0.1	12	104	0.0	1	81	0.3	5	21
85 and older	0.3	13	41	0.1	8	92	0.0	0	57	0.2	4	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.4	20	49	0.1	13	108	0.0	1	69	0.3	6	21
Disabled	1.8	176	98	0.7	134	191	0.1	7	127	1.0	35	34
Adults	1.3	160	123	0.8	141	185	0.0	4	116	0.5	15	30
Children	0.3	30	97	0.2	24	163	0.0	1	90	0.1	5	31
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.3	115	88	0.5	87	175	0.0	5	116	0.8	24	31
Male	1.2	135	110	0.5	108	197	0.0	4	129	0.6	23	35
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.4	145	107	0.5	108	206	0.1	8	145	0.8	30	38
African American	1.3	126	97	0.5	97	184	0.0	4	121	0.7	24	33
Other/unknown	1.0	104	105	0.5	86	189	0.0	3	105	0.5	16	30
Use of Nursing Facilities[e]												
Entire year	1.6	100	64	0.5	67	139	0.0	5	101	1.0	29	27
Part year	1.7	138	80	0.6	99	178	0.0	4	80	1.1	35	31
None	1.2	125	100	0.5	98	188	0.0	4	124	0.7	23	33
Maintenance Assistance Status												
Cash	1.7	165	100	0.7	129	190	0.0	6	127	0.9	30	33
Medically needy	1.2	107	90	0.4	79	180	0.0	3	106	0.7	24	34
Poverty related	0.4	30	79	0.1	22	166	0.0	1	108	0.2	7	30
Other/unknown	0.7	68	104	0.4	57	163	0.0	2	105	0.3	9	31

Source: Data for this table are from the MAX 2006 file for D.C., released by CMS in 4/2009. This table was produced on 02/11/2010.

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 D.C., 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.medi-span.com/master-drug-database.aspx

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]

D.C., 2006

	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	0.9	0.6	0.0	0.3	$156	$137	$1	$18	$170	$213	$162	$68	116,094	$19,781,517	12,299	17.4	126,661
Biologicals	0.3	0.3	0.0	0.0	349	349	0	0	1193	1,228	0	34	239	285,146	106	0.1	817
Antineoplastic Agents	0.4	0.1	0.0	0.3	98	64	1	33	264	763	284	117	2,400	634,697	608	0.9	6,451
Endocrine/Metabolic Drugs	0.7	0.3	0.0	0.4	48	35	3	10	69	131	167	25	47,937	3,313,539	6,616	9.4	69,711
Cardiovascular Agents	1.3	0.5	0.0	0.8	64	42	3	18	49	90	104	23	146,385	7,128,097	10,297	14.6	110,914
Respiratory Agents	0.6	0.3	0.0	0.3	39	30	1	8	70	112	76	29	57,514	4,003,560	9,744	13.8	102,189
Gastrointestinal Agents	0.4	0.2	0.0	0.2	41	30	4	7	97	161	468	29	26,923	2,602,939	5,875	8.3	63,405
Genitourinary Agents	0.3	0.1	0.0	0.1	22	12	5	5	73	92	101	41	6,210	452,425	1,977	2.8	20,445
CNS Drugs	0.9	0.4	0.1	0.4	134	114	6	14	149	277	103	33	110,997	16,521,374	11,267	15.9	123,540
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	67	64	0	3	114	126	100	38	6,745	771,159	1,100	1.6	11,535
Miscellaneous Psychological/ Neurological Agents	0.4	0.3	0.0	0.1	105	95	0	9	275	301	149	147	2,246	617,439	528	0.7	5,881
Analgesics and Anesthetics	0.5	0.0	0.0	0.5	27	9	3	15	53	236	329	33	58,305	3,089,968	10,842	15.3	114,502
Neuromuscular Agents	0.7	0.2	0.0	0.5	60	40	1	19	85	178	58	41	56,170	4,746,791	7,228	10.2	79,618
Nutritional Products	0.4	0.0	0.0	0.4	6	0	0	5	14	23	21	14	23,883	339,517	5,489	7.8	57,859
Hematological Agents	0.5	0.1	0.0	0.4	71	62	0	8	134	433	27	23	21,926	2,942,037	3,836	5.4	41,722
Topical Products	0.4	0.1	0.0	0.2	23	13	2	8	62	110	82	35	32,968	2,059,397	8,671	12.3	90,148
Miscellaneous Products	0.4	0.2	0.0	0.1	145	125	1	19	410	593	232	139	2,185	895,098	588	0.8	6,163
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	31	0	0	0	136	0	0	0	346	47,017	135	0.2	1,517
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.	719,473	70,231,717	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for D.C., released by CMS in 4/2009. This table was produced on 02/11/2010.

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.medi-span.com/master-drug-database.aspx.

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 D.C., 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.medi-span.com/master-drug-database.aspx.

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2006.

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]

D.C., 2006

		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
ANTIVIRAL	$17,320,144	6,184	8.7	67,459	1.2	$213	$257
ANTIPSYCHOTICS	13,129,955	7,332	10.4	82,017	0.5	292	160
ANTICONVULSANT	4,355,837	6,264	8.9	69,527	0.6	106	63
ANTIASTHMATIC	2,501,394	8,032	11.4	84,852	0.3	85	29
ANTIDEPRESSANTS	2,476,588	7,999	11.3	87,887	0.4	64	28
ANTIHYPERLIPIDEMIC	2,474,216	4,400	6.2	48,811	0.5	102	51
ANTIDIABETIC	2,337,887	5,820	8.2	63,214	0.6	66	37
ANALGESICS - Narcotic	1,861,034	9,598	13.6	103,895	0.3	55	18
ANTIHYPERTENSIVE	1,761,795	8,529	12.1	93,092	0.5	38	19
ULCER DRUGS	1,527,665	5,062	7.2	54,963	0.3	89	28
Total	49,746,515	69,220	n.a.	755,717	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for D.C., released by CMS in 4/2009. This table was produced on 02/11/2010.

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 2006. 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 2006. For information about these drug groups, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.

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.