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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006
IOWA

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
IOWA, 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]	467347 (A)	77837 (E)	389510 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	455735 (B)	67324 (F)	388411 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	454327 (C)	67324 (G)	387003 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	11627 (D)	11145 (H)	482 (L)

Source: Data for this table are from the MAX 2006 file for Iowa, released by CMS in 5/2009. This table was produced on 02/12/2010.
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 Iowa in 2006 was $214,716,073, of which $148,216 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]

IOWA, 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	**454,327**	**34,512**	**66,753**	**123,607**	**229,201**	**254**	**4,160,459**	**350,854**	**737,550**	**970,515**	**2,099,163**	**2,377**
Age												
5 and younger	95,187	0	2,179	179	92,829	0	839,468	0	22,065	1,485	815,918	0
6-14	97,094	0	5,693	102	91,299	0	952,661	0	63,914	929	887,818	0
15-20	60,025	0	4,764	12,219	43,042	0	529,275	0	52,866	94,812	381,597	0
21-44	119,331	4	23,271	94,033	1,980	43	1,010,161	21	259,296	737,007	13,439	398
45-64	47,645	19	30,458	16,914	49	205	473,818	157	336,160	135,184	376	1,941
65-74	10,627	10,106	364	149	2	6	112,894	108,833	2,994	1,014	15	38
75-84	11,753	11,726	20	7	0	0	120,644	120,372	214	58	0	0
85 and older	12,665	12,657	4	4	0	0	121,538	121,471	41	26	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	267,739	24,910	33,500	94,172	114,903	254	2,437,485	255,304	372,595	755,279	1,051,930	2,377
Male	186,588	9,602	33,253	29,435	114,298	0	1,722,974	95,550	364,955	215,236	1,047,233	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	255,025	20,896	48,329	61,688	124,067	45	2,440,484	219,583	547,509	500,028	1,172,922	442
African American	30,799	692	4,636	7,755	17,711	5	291,296	7,533	50,249	63,118	170,336	60
Other/unknown	168,503	12,924	13,788	54,164	87,423	204	1,428,679	123,738	139,792	407,369	755,905	1,875
Use of Nursing Facilities[c]												
Entire year	11,627	10,323	1,299	0	5	0	124,693	109,798	14,835	0	60	0
Part year	7,336	6,212	1,097	20	7	0	66,822	55,138	11,432	173	79	0
None	435,364	17,977	64,357	123,587	229,189	254	3,968,944	185,918	711,283	970,342	2,099,024	2,377
Maintenance Assistance Status												
Cash	149,494	6,440	37,648	42,918	62,488	0	1,439,436	72,367	415,295	358,276	593,498	0
Medically needy	8,156	799	880	5,355	1,122	0	63,074	7,191	7,312	40,051	8,520	0
Poverty-related	132,568	788	1,029	12,928	117,569	254	1,142,753	8,629	10,760	78,011	1,042,976	2,377
Other/unknown	164,109	26,485	27,196	62,406	48,022	0	1,515,196	262,667	304,183	494,177	454,169	0
Dual Medicare Status[d]												
Full dual, all year	63,776	31,653	30,997	1,092	22	12	683,264	323,835	349,725	9,423	178	103
Full dual, part year	3,548	1,809	1,720	18	1	0	38,263	19,649	18,426	176	12	0
Non-dual, all year	387,003	1,050	34,036	122,497	229,178	242	3,438,932	7,370	369,399	960,916	2,098,973	2,274
Managed Care (MC) Status												
Fee-for-service (FFS) all year	447,802	34,512	66,711	121,682	224,643	254	4,117,224	350,854	737,244	958,776	2,067,973	2,377
FFS part year, with Rx claims	2,564	0	36	975	1,553	0	10,515	0	258	3,888	6,369	0
FFS part year, no Rx claims	1,183	0	6	221	956	0	3,780	0	48	637	3,095	0

Source: Data for this table are from the MAX 2006 file for Iowa, released by CMS in 5/2009. This table was produced on 02/12/2010.

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]
IOWA, 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	**56.6**	**7.0**	**$472**	**$68**	**$5,197**	**9.1**	**454,327**
Age							
5 and younger	68.0	3.7	207	55	2,217	9.3	95,187
6-14	58.7	5.2	462	89	2,233	20.7	97,094
15-20	55.3	6.2	483	78	3,620	13.3	60,025
21-44	54.7	8.4	534	64	5,351	10.0	119,331
45-64	48.6	17.2	1,129	66	10,843	10.4	47,645
65-74	41.7	5.5	206	37	12,425	1.7	10,627
75-84	38.4	3.3	65	20	15,748	0.4	11,753
85 and older	38.5	2.7	42	16	19,242	0.2	12,665
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	39.6	3.7	94	26	16,080	0.6	34,512
Disabled	65.3	20.4	1,701	83	17,450	9.8	66,753
Adults	48.2	5.9	302	51	2,072	14.6	123,607
Children	61.2	4.1	262	63	1,664	15.7	229,201
Unknown	88.2	25.8	1,820	71	15,355	11.9	254
Gender							
Female	57.6	7.5	446	60	5,012	8.9	267,739
Male	55.2	6.3	509	81	5,463	9.3	186,588
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	61.9	8.9	618	69	6,570	9.4	255,025
African American	58.6	5.7	396	69	3,249	12.2	30,799
Other/unknown	48.2	4.3	266	62	3,475	7.7	168,503
Use of Nursing Facilities[f]							
Entire year	46.2	7.4	293	40	32,237	0.9	11,627
Part year	54.5	9.6	485	50	21,669	2.2	7,336
None	56.9	6.9	477	69	4,197	11.4	435,364
Maintenance Assistance Status							
Cash	68.9	11.5	802	70	4,899	16.4	149,494
Medically needy	39.1	6.1	375	62	3,316	11.3	8,156
Poverty related	57.3	3.4	183	55	1,447	12.7	132,568
Other/unknown	45.7	5.9	410	70	8,592	4.8	164,109

Source: Data for this table are from the MAX 2006 file for Iowa, released by CMS in 5/2009. This table was produced on 02/12/2010.
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]

IOWA, 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	**0.8**	**$52**	**9.1**	**43.4**	**44.3**	**5.4**	**4.6**	**1.8**	**0.5**	**$568**	**454,327**	**4,160,459**
Age												
5 and younger	0.4	23	9.3	32.0	63.4	3.4	1.1	0.1	0.0	251	95,187	839,468
6-14	0.5	47	20.7	41.3	49.2	4.9	3.9	0.7	0.0	228	97,094	952,661
15-20	0.7	55	13.3	44.7	42.8	6.2	5.0	1.1	0.1	411	60,025	529,275
21-44	1.0	63	10.0	45.3	37.3	7.6	6.9	2.4	0.5	632	119,331	1,010,161
45-64	1.7	114	10.4	51.4	23.6	5.5	9.2	7.3	3.0	1,090	47,645	473,818
65-74	0.5	19	1.7	58.3	33.2	4.0	2.8	1.3	0.5	1,170	10,627	112,894
75-84	0.3	6	0.4	61.6	33.0	3.4	1.5	0.5	0.1	1,534	11,753	120,644
85 and older	0.3	4	0.2	61.5	34.3	2.7	1.1	0.3	0.0	2,005	12,665	121,538
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	0.4	9	0.6	60.4	33.8	3.3	1.7	0.6	0.2	1,582	34,512	350,854
Disabled	1.9	154	9.8	34.7	33.7	8.1	12.7	8.0	2.7	1,579	66,753	737,550
Adults	0.8	38	14.6	51.8	34.4	6.8	5.3	1.4	0.3	264	123,607	970,515
Children	0.5	29	15.7	38.8	54.3	4.2	2.3	0.3	0.0	182	229,201	2,099,163
Unknown	2.8	195	11.9	11.8	28.0	20.1	28.0	11.4	0.8	1,641	254	2,377
Gender												
Female	0.8	49	8.9	42.4	44.5	5.7	4.8	2.0	0.6	551	267,739	2,437,485
Male	0.7	55	9.3	44.8	44.0	4.9	4.5	1.5	0.3	592	186,588	1,722,974
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	0.9	65	9.4	38.1	46.2	6.5	6.0	2.4	0.7	687	255,025	2,440,484
African American	0.6	42	12.2	41.4	48.5	4.8	3.8	1.3	0.3	344	30,799	291,296
Other/unknown	0.5	31	7.7	51.8	40.6	3.8	2.7	0.9	0.2	410	168,503	1,428,679
Use of Nursing Facilities[f]												
Entire year	0.7	27	0.9	53.8	36.6	4.6	2.0	1.8	1.2	3,006	11,627	124,693
Part year	1.1	53	2.2	45.5	42.0	4.1	3.4	2.9	2.0	2,379	7,336	66,822
None	0.8	52	11.4	43.1	44.5	5.4	4.7	1.8	0.5	460	435,364	3,968,944
Maintenance Assistance Status												
Cash	1.2	83	16.4	31.1	49.3	7.3	7.5	3.6	1.2	509	149,494	1,439,436
Medically needy	0.8	49	11.3	60.9	25.3	5.3	5.8	2.2	0.4	429	8,156	63,074
Poverty related	0.4	21	12.7	42.7	51.7	3.8	1.7	0.2	0.0	168	132,568	1,142,753
Other/unknown	0.6	44	4.8	54.3	34.7	4.9	4.4	1.4	0.3	931	164,109	1,515,196

Source: Data for this table are from the MAX 2006 file for Iowa, released by CMS in 5/2009. This table was produced on 02/12/2010.

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]

IOWA, 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	**0.8**	**$52**	**$68**	**0.2**	**$37**	**$152**	**0.1**	**$7**	**$85**	**0.4**	**$7**	**$17**
Age												
5 and younger	0.4	23	55	0.1	16	154	0.1	3	50	0.3	4	15
6-14	0.5	47	89	0.3	39	154	0.1	4	81	0.2	4	18
15-20	0.7	55	78	0.3	41	160	0.1	8	77	0.3	6	17
21-44	1.0	63	64	0.3	43	156	0.1	10	92	0.6	10	16
45-64	1.7	114	66	0.5	79	145	0.1	15	115	1.1	20	19
65-74	0.5	19	37	0.1	12	111	0.0	2	84	0.4	5	13
75-84	0.3	6	20	0.0	3	81	0.0	1	68	0.3	3	11
85 and older	0.3	4	16	0.0	2	80	0.0	0	60	0.3	3	10
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.4	9	26	0.0	5	98	0.0	1	78	0.3	4	12
Disabled	1.9	154	83	0.6	116	181	0.2	17	107	1.1	21	20
Adults	0.8	38	51	0.2	24	125	0.1	8	87	0.5	7	14
Children	0.5	29	63	0.2	21	129	0.1	4	64	0.2	4	16
Unknown	2.8	195	71	0.8	138	167	0.2	26	124	1.7	31	18
Gender												
Female	0.8	49	60	0.2	33	140	0.1	8	84	0.5	8	16
Male	0.7	55	81	0.3	43	168	0.1	5	88	0.4	7	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.9	65	69	0.3	47	152	0.1	9	88	0.5	9	17
African American	0.6	42	69	0.2	32	164	0.1	5	86	0.4	6	16
Other/unknown	0.5	31	62	0.1	22	148	0.1	5	78	0.3	5	16
Use of Nursing Facilities[e]												
Entire year	0.7	27	40	0.1	17	138	0.0	3	86	0.5	7	14
Part year	1.1	53	50	0.2	34	137	0.1	6	108	0.7	13	17
None	0.8	52	69	0.2	38	152	0.1	7	85	0.4	7	17
Maintenance Assistance Status												
Cash	1.2	83	70	0.4	60	155	0.1	11	94	0.7	12	18
Medically needy	0.8	49	62	0.2	33	145	0.1	8	102	0.5	8	17
Poverty related	0.4	21	55	0.1	14	120	0.1	4	67	0.2	3	15
Other/unknown	0.6	44	70	0.2	33	160	0.1	6	82	0.4	6	16

Source: Data for this table are from the MAX 2006 file for Iowa, released by CMS in 5/2009. This table was produced on 02/12/2010.

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 Iowa, 0.1 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]

IOWA, 2006

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.0	0.1	0.2	$11	$5	$3	$3	$42	$137	$62	$17	426,257	$18,031,729	164,562	36.2	1,703,523
Biologicals	0.2	0.2	0.0	0.0	217	217	0	0	986	994	2,677	177	6,006	5,921,037	2,592	0.6	27,245
Antineoplastic Agents	0.6	0.2	0.0	0.4	168	152	1	14	305	930	192	38	5,766	1,759,545	985	0.2	10,470
Endocrine/Metabolic Drugs	0.4	0.1	0.1	0.2	25	15	8	3	58	124	60	15	268,985	15,523,263	59,185	13.0	615,630
Cardiovascular Agents	1.0	0.3	0.1	0.6	40	27	6	7	39	82	95	11	298,009	11,677,063	27,664	6.1	293,270
Respiratory Agents	0.3	0.2	0.0	0.2	20	16	1	3	59	103	68	16	363,860	21,572,540	101,103	22.3	1,070,524
Gastrointestinal Agents	0.4	0.2	0.0	0.2	32	22	6	4	78	141	381	17	141,664	11,006,388	32,371	7.1	340,500
Genitourinary Agents	0.2	0.1	0.1	0.1	15	7	7	2	61	94	78	20	30,948	1,894,228	11,903	2.6	124,390
CNS Drugs	0.9	0.3	0.1	0.5	77	60	10	8	87	181	105	17	666,255	58,077,179	71,288	15.7	751,242
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.1	81	75	3	3	106	120	108	31	171,166	18,195,418	20,799	4.6	225,314
Miscellaneous Psychological/ Neurological Agents	0.5	0.5	0.0	0.0	202	202	0	0	436	441	0	72	4,804	2,094,517	998	0.2	10,345
Analgesics and Anesthetics	0.4	0.0	0.0	0.4	17	8	2	7	42	191	268	18	314,241	13,144,464	73,812	16.2	758,213
Neuromuscular Agents	0.7	0.2	0.0	0.4	55	40	5	10	82	179	134	24	209,475	17,230,311	29,086	6.4	312,196
Nutritional Products	0.3	0.0	0.0	0.3	5	0	1	4	16	31	48	14	51,356	809,673	15,886	3.5	155,128
Hematological Agents	0.6	0.1	0.0	0.4	127	120	2	5	213	1,030	37	11	44,498	9,494,674	6,994	1.5	74,869
Topical Products	0.2	0.0	0.0	0.1	7	4	1	2	38	88	57	15	165,757	6,292,335	83,471	18.4	879,925
Miscellaneous Products	0.4	0.2	0.0	0.1	88	71	6	11	228	338	231	71	7,483	1,706,853	1,753	0.4	19,434
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	9	0	0	0	51	0	0	0	2,663	136,640	1,409	0.3	15,107
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.	3,179,193	214,567,857	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Iowa, released by CMS in 5/2009. This table was produced on 02/12/2010.

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 Iowa, 0.1 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]

IOWA, 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
ANTIPSYCHOTICS	$34,864,774	22,584	5.0	248,080	0.6	$224	$141
ANTIDEPRESSANTS	18,240,166	55,356	12.2	584,512	0.5	65	31
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	18,023,023	24,000	5.3	262,605	0.6	106	69
ANTICONVULSANT	15,774,498	20,876	4.6	229,452	0.7	103	69
ANTIASTHMATIC	15,664,072	69,202	15.2	741,245	0.3	77	21
MISC. HEMATOLOGICAL	7,970,689	1,424	0.3	15,129	0.5	985	527
ULCER DRUGS	7,366,886	29,656	6.5	315,059	0.3	70	23
ANTIDIABETIC	6,028,446	12,125	2.7	129,550	0.6	75	47
ANALGESICS - Narcotic	6,002,788	74,738	16.5	779,833	0.3	31	8
PASSIVE IMMUNIZING AGENTS	5,861,116	1,063	0.2	9,745	0.4	1,347	601
Total	135,796,458	311,024	n.a.	3,315,210	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Iowa, released by CMS in 5/2009. This table was produced on 02/12/2010.

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.