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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
OREGON, 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]	524127 (A)	86732 (E)	437395 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	451935 (B)	63088 (F)	388847 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	211249 (C)	33706 (G)	177543 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	4054 (D)	3795 (H)	259 (L)

Source: Data for this table are from the MAX 2006 file for Oregon, released by CMS in 7/2009. 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 Oregon in 2006 was $124,310,015, of which $60,390,485 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]

OREGON, 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	**211,249**	**21,307**	**30,368**	**41,628**	**117,534**	**412**	**1,193,287**	**192,681**	**258,366**	**170,059**	**568,534**	**3,647**
Age												
5 and younger	52,481	0	756	0	51,725	0	229,451	0	5,800	0	223,651	0
6-14	47,568	0	1,981	10	45,577	0	255,602	0	17,388	39	238,175	0
15-20	26,497	0	1,970	4,700	19,826	1	137,656	0	16,543	16,571	104,533	9
21-44	44,617	1	10,437	33,693	400	86	227,585	12	87,806	136,992	2,162	613
45-64	18,397	33	14,827	3,219	1	317	146,943	289	127,254	16,421	6	2,973
65-74	6,494	6,318	165	3	0	8	58,580	57,160	1,349	19	0	52
75-84	7,682	7,607	73	2	0	0	70,595	69,913	668	14	0	0
85 and older	7,512	7,348	159	1	4	0	66,872	65,307	1,558	3	4	0
Unknown	1	0	0	0	1	0	3	0	0	0	3	0
Gender												
Female	123,505	15,065	15,261	34,575	58,192	412	696,621	138,646	132,885	139,654	281,789	3,647
Male	87,744	6,242	15,107	7,053	59,342	0	496,666	54,035	125,481	30,405	286,745	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	150,366	18,245	26,051	32,630	73,090	350	908,715	165,029	223,094	134,863	382,592	3,137
African American	7,935	392	1,053	1,656	4,824	10	33,947	3,514	7,409	4,154	18,783	87
Other/unknown	52,948	2,670	3,264	7,342	39,620	52	250,625	24,138	27,863	31,042	167,159	423
Use of Nursing Facilities[c]												
Entire year	4,054	3,492	562	0	0	0	35,795	30,521	5,274	0	0	0
Part year	3,017	2,216	786	13	1	1	25,418	18,826	6,482	92	12	6
None	204,178	15,599	29,020	41,615	117,533	411	1,132,074	143,334	246,610	169,967	568,522	3,641
Maintenance Assistance Status												
Cash	74,652	5,155	18,958	17,747	32,792	0	444,481	50,790	173,061	69,531	151,099	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	73,876	507	997	11,883	60,077	412	302,281	4,236	7,881	34,203	252,314	3,647
Other/unknown	62,721	15,645	10,413	11,998	24,665	0	446,525	137,655	77,424	66,325	165,121	0
Dual Medicare Status[d]												
Full dual, all year	30,875	19,653	11,029	174	3	16	285,929	179,019	105,741	1,012	26	131
Full dual, part year	2,831	1,248	1,566	17	0	0	23,441	10,734	12,581	126	0	0
Non-dual, all year	177,543	406	17,773	41,437	117,531	396	883,917	2,928	140,044	168,921	568,508	3,516
Managed Care (MC) Status												
Fee-for-service (FFS) all year	110,992	18,720	22,905	16,573	52,390	404	959,044	182,248	228,728	118,266	426,201	3,601
FFS part year, with Rx claims	24,752	1,199	4,383	9,417	9,745	8	88,416	5,012	18,631	25,304	39,423	46
FFS part year, no Rx claims	75,505	1,388	3,080	15,638	55,399	0	145,827	5,421	11,007	26,489	102,910	0

Source: Data for this table are from the MAX 2006 file for Oregon, released by CMS in 7/2009. 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]

OREGON, 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	**37.7**	**4.6**	**$303**	**$66**	**$4,926**	**6.1**	**211,249**
Age							
5 and younger	27.7	1.0	41	40	2,249	1.8	52,481
6-14	29.4	2.2	203	93	1,895	10.7	47,568
15-20	39.8	3.5	233	67	3,125	7.5	26,497
21-44	48.6	6.6	477	73	4,808	9.9	44,617
45-64	60.5	19.6	1,259	64	11,642	10.8	18,397
65-74	35.6	3.7	132	35	10,891	1.2	6,494
75-84	36.2	2.5	48	19	14,954	0.3	7,682
85 and older	36.4	2.2	37	17	18,013	0.2	7,512
Unknown	0.0	0.0	0	0	847	0.0	1
Basis of Eligibility[e]							
Aged	36.0	2.7	68	25	14,768	0.5	21,307
Disabled	57.7	16.8	1,381	82	11,683	11.8	30,368
Adults	47.6	4.9	232	47	3,441	6.7	41,628
Children	29.2	1.5	88	57	1,887	4.6	117,534
Unknown	83.5	21.2	1,474	70	14,904	9.9	412
Gender							
Female	40.3	5.0	282	56	5,153	5.5	123,505
Male	34.2	3.9	331	85	4,607	7.2	87,744
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	41.6	5.4	358	66	5,589	6.4	150,366
African American	26.6	2.8	186	67	4,420	4.2	7,935
Other/unknown	28.3	2.4	162	67	3,119	5.2	52,948
Use of Nursing Facilities[f]							
Entire year	50.2	8.1	348	43	41,419	0.8	4,054
Part year	57.7	12.3	672	55	26,574	2.5	3,017
None	37.2	4.4	296	68	3,881	7.6	204,178
Maintenance Assistance Status							
Cash	42.5	7.7	579	76	4,898	11.8	74,652
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	27.5	1.3	57	46	1,844	3.1	73,876
Other/unknown	44.1	4.8	262	55	8,589	3.1	62,721

Source: Data for this table are from the MAX 2006 file for Oregon, released by CMS in 7/2009. 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]

OREGON, 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**	**$54**	**6.1**	**62.3**	**25.9**	**4.1**	**4.4**	**2.1**	**1.2**	**$872**	**211,249**	**1,193,287**
Age												
5 and younger	0.2	9	1.8	72.3	25.9	1.2	0.5	0.1	0.0	514	52,481	229,451
6-14	0.4	38	10.7	70.6	23.4	2.8	2.2	0.6	0.3	353	47,568	255,602
15-20	0.7	45	7.5	60.2	28.1	5.0	4.3	1.5	0.8	602	26,497	137,656
21-44	1.3	94	9.9	51.4	26.6	7.4	8.5	3.9	2.3	943	44,617	227,585
45-64	2.5	158	10.8	39.5	23.6	7.5	14.0	9.8	5.5	1,458	18,397	146,943
65-74	0.4	15	1.2	64.4	26.8	3.9	2.8	1.4	0.7	1,207	6,494	58,580
75-84	0.3	5	0.3	63.8	29.8	3.2	2.0	0.9	0.4	1,627	7,682	70,595
85 and older	0.2	4	0.2	63.6	31.5	2.4	1.6	0.7	0.1	2,024	7,512	66,872
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	282	1	3
Basis of Eligibility[e]												
Aged	0.3	8	0.5	64.0	29.5	3.1	2.1	0.9	0.4	1,633	21,307	192,681
Disabled	2.0	162	11.8	42.3	25.8	7.4	12.2	7.9	4.4	1,373	30,368	258,366
Adults	1.2	57	6.7	52.4	26.8	7.5	8.0	3.3	2.0	842	41,628	170,059
Children	0.3	18	4.6	70.8	25.0	2.2	1.5	0.4	0.2	390	117,534	568,534
Unknown	2.4	167	9.9	16.5	32.5	17.5	25.2	7.5	0.7	1,684	412	3,647
Gender												
Female	0.9	50	5.5	59.7	26.9	4.6	4.9	2.5	1.4	914	123,505	696,621
Male	0.7	59	7.2	65.8	24.5	3.4	3.7	1.6	0.9	814	87,744	496,666
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	59	6.4	58.4	27.7	4.7	5.2	2.6	1.4	925	150,366	908,715
African American	0.6	43	4.2	73.4	17.5	3.4	3.4	1.4	1.0	1,033	7,935	33,947
Other/unknown	0.5	34	5.2	71.7	22.3	2.4	2.3	0.9	0.5	659	52,948	250,625
Use of Nursing Facilities[f]												
Entire year	0.9	39	0.8	49.8	34.8	5.4	3.9	3.8	2.3	4,691	4,054	35,795
Part year	1.5	80	2.5	42.3	35.8	4.8	6.0	6.5	4.6	3,154	3,017	25,418
None	0.8	53	7.6	62.8	25.6	4.0	4.4	2.0	1.1	700	204,178	1,132,074
Maintenance Assistance Status												
Cash	1.3	97	11.8	57.5	24.8	5.1	6.7	3.8	2.1	823	74,652	444,481
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.3	14	3.1	72.5	23.1	2.3	1.5	0.4	0.1	451	73,876	302,281
Other/unknown	0.7	37	3.1	55.9	30.6	4.9	5.1	2.2	1.3	1,206	62,721	446,525

Source: Data for this table are from the MAX 2006 file for Oregon, released by CMS in 7/2009. 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]

OREGON, 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**	**$54**	**$66**	**0.2**	**$39**	**$176**	**0.0**	**$3**	**$97**	**0.6**	**$12**	**$21**
Age												
5 and younger	0.2	9	40	0.0	7	148	0.0	1	41	0.2	2	13
6-14	0.4	38	93	0.2	33	187	0.0	1	64	0.2	4	19
15-20	0.7	45	67	0.2	35	141	0.0	2	80	0.4	8	19
21-44	1.3	94	73	0.3	68	207	0.0	5	113	0.9	20	22
45-64	2.5	158	64	0.6	107	168	0.1	8	119	1.8	43	25
65-74	0.4	15	35	0.1	9	127	0.0	1	71	0.3	5	15
75-84	0.3	5	19	0.0	2	76	0.0	0	38	0.2	3	12
85 and older	0.2	4	17	0.0	2	73	0.0	0	41	0.2	2	10
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.3	8	25	0.0	4	104	0.0	0	55	0.3	3	12
Disabled	2.0	162	82	0.6	121	211	0.1	7	120	1.3	34	26
Adults	1.2	57	47	0.3	36	131	0.0	4	98	0.9	17	19
Children	0.3	18	57	0.1	14	134	0.0	1	59	0.2	3	16
Unknown	2.4	167	70	0.7	126	184	0.1	7	103	1.6	34	20
Gender												
Female	0.9	50	56	0.2	34	151	0.0	3	99	0.6	13	20
Male	0.7	59	85	0.2	46	213	0.0	2	93	0.5	11	23
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.9	59	66	0.2	43	174	0.0	3	102	0.6	13	22
African American	0.6	43	67	0.2	32	171	0.0	1	70	0.4	10	22
Other/unknown	0.5	34	67	0.1	26	194	0.0	2	77	0.4	7	19
Use of Nursing Facilities[e]												
Entire year	0.9	39	43	0.2	24	129	0.0	1	61	0.7	14	20
Part year	1.5	80	55	0.3	52	158	0.0	3	84	1.1	25	23
None	0.8	53	68	0.2	39	178	0.0	3	98	0.5	12	21
Maintenance Assistance Status												
Cash	1.3	97	76	0.4	72	197	0.0	5	112	0.9	21	24
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.3	14	46	0.1	10	131	0.0	1	70	0.2	3	15
Other/unknown	0.7	37	55	0.2	26	147	0.0	2	80	0.5	9	19

Source: Data for this table are from the MAX 2006 file for Oregon, released by CMS in 7/2009. 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 Oregon, 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]

OREGON, 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	0.3	0.0	0.0	0.2	$12	$8	$1	$4	$48	$254	$47	$19	80,357	$3,865,516	34,863	16.5	315,800
Biologicals	0.1	0.1	0.0	0.0	51	51	0	0	392	413	0	36	1,478	579,686	1,082	0.5	11,303
Antineoplastic Agents	0.6	0.2	0.0	0.3	137	123	0	14	239	535	0	40	2,932	701,069	515	0.2	5,108
Endocrine/Metabolic Drugs	0.6	0.2	0.0	0.4	29	21	1	7	50	112	44	18	73,490	3,703,728	14,820	7.0	126,846
Cardiovascular Agents	1.0	0.3	0.0	0.7	41	28	2	11	39	102	80	15	94,146	3,712,639	10,098	4.8	90,632
Respiratory Agents	0.4	0.2	0.0	0.2	24	20	0	3	57	113	41	14	76,320	4,343,697	19,407	9.2	182,148
Gastrointestinal Agents	0.5	0.1	0.0	0.3	30	21	4	5	65	151	236	16	34,730	2,265,718	8,200	3.9	75,789
Genitourinary Agents	0.3	0.1	0.0	0.2	14	8	3	4	50	101	95	20	8,973	444,563	3,468	1.6	31,684
CNS Drugs	1.1	0.3	0.1	0.7	80	61	6	13	75	179	97	20	251,164	18,887,011	31,029	14.7	235,806
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	77	70	1	6	93	110	133	32	34,462	3,187,791	4,880	2.3	41,596
Miscellaneous Psychological/ Neurological Agents	0.3	0.2	0.0	0.1	98	95	0	3	323	386	0	51	2,383	769,646	844	0.4	7,847
Analgesics and Anesthetics	0.7	0.0	0.0	0.6	34	10	3	21	51	219	288	35	133,528	6,827,147	23,559	11.2	200,873
Neuromuscular Agents	0.8	0.3	0.0	0.5	58	45	1	12	74	167	97	24	83,944	6,214,695	11,690	5.5	108,002
Nutritional Products	0.3	0.0	0.0	0.3	3	0	0	3	10	34	14	9	34,992	347,828	11,885	5.6	106,157
Hematological Agents	0.6	0.1	0.0	0.5	192	186	0	6	318	2,148	25	12	20,235	6,433,855	3,483	1.6	33,443
Topical Products	0.2	0.0	0.0	0.2	6	3	0	2	30	90	39	16	27,703	823,109	15,261	7.2	142,581
Miscellaneous Products	0.7	0.4	0.0	0.3	183	138	7	38	254	335	150	145	2,964	752,048	426	0.2	4,116
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	12	0	0	0	56	0	0	0	1,062	59,784	497	0.2	4,975
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.	964,863	63,919,530	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Oregon, released by CMS in 7/2009. 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 Oregon, 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]

OREGON, 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	$8,332,290	6,209	2.9	60,717	0.6	$214	$137
MISC. HEMATOLOGICAL	5,423,166	465	0.2	4,445	0.6	2,180	1,220
ANALGESICS - Narcotic	5,015,726	26,114	12.4	241,699	0.4	50	21
ANTICONVULSANT	4,929,224	7,960	3.8	81,050	0.7	87	61
ANTIDEPRESSANTS	4,363,809	15,809	7.5	152,615	0.5	55	29
ANTIASTHMATIC	3,535,455	16,800	8.0	163,222	0.3	72	22
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	2,791,415	4,882	2.3	46,553	0.7	88	60
ANTIDIABETIC	1,997,556	5,511	2.6	54,016	0.5	68	37
ULCER DRUGS	1,891,630	10,488	5.0	102,931	0.4	42	18
ANTIVIRAL	1,585,031	1,442	0.7	13,996	0.3	354	113
Total	39,865,302	95,680	n.a.	921,244	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Oregon, released by CMS in 7/2009. 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.