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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006
WEST VIRGINIA

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
WEST VIRGINIA, 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]	392745 (A)	75126 (E)	317619 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	367737 (B)	50270 (F)	317467 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	342876 (C)	50261 (G)	292615 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	6968 (D)	6481 (H)	487 (L)

Source: Data for this table are from the MAX 2006 file for West Virginia, released by CMS in 9/2009. 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 West Virginia in 2006 was $327,446,113, of which $1,191,692 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]

WEST VIRGINIA, 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	**342,876**	**23,356**	**98,486**	**55,559**	**165,214**	**261**	**2,733,477**	**245,446**	**1,053,742**	**257,247**	**1,174,476**	**2,566**
Age												
5 and younger	63,391	0	1,995	0	61,396	0	448,273	0	18,789	0	429,484	0
6-14	77,664	0	6,367	26	71,271	0	586,073	0	69,281	128	516,664	0
15-20	42,299	0	5,313	4,508	32,478	0	305,141	0	57,150	20,103	227,888	0
21-44	84,178	0	36,522	47,550	66	40	611,888	0	392,414	218,711	425	338
45-64	49,274	0	45,590	3,460	3	221	508,993	0	488,523	18,227	15	2,228
65-74	11,489	9,992	1,486	11	0	0	125,244	109,820	15,371	53	0	0
75-84	8,244	7,532	709	3	0	0	86,318	79,089	7,207	22	0	0
85 and older	6,337	5,832	504	1	0	0	61,547	56,537	5,007	3	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	196,516	16,344	51,203	46,180	82,528	261	1,530,802	172,809	551,214	217,031	587,182	2,566
Male	146,360	7,012	47,283	9,379	82,686	0	1,202,675	72,637	502,528	40,216	587,294	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	325,033	22,567	94,531	52,412	155,275	248	2,599,198	237,075	1,012,120	242,589	1,104,954	2,460
African American	17,504	777	3,893	3,103	9,718	13	131,392	8,227	40,933	14,463	67,663	106
Other/unknown	339	12	62	44	221	0	2,887	144	689	195	1,859	0
Use of Nursing Facilities[c]												
Entire year	6,968	6,108	858	2	0	0	69,770	60,441	9,326	3	0	0
Part year	3,784	2,920	855	9	0	0	36,654	28,103	8,486	65	0	0
None	332,124	14,328	96,773	55,548	165,214	261	2,627,053	156,902	1,035,930	257,179	1,174,476	2,566
Maintenance Assistance Status												
Cash	110,328	12,907	76,809	20,369	243	0	1,107,570	146,884	860,929	98,123	1,634	0
Medically needy	26,108	1,365	11,535	12,679	529	0	160,192	11,088	85,765	59,453	3,886	0
Poverty-related	12,991	617	1,541	2,971	7,601	261	88,051	6,433	15,700	12,348	51,004	2,566
Other/unknown	193,449	8,467	8,601	19,540	156,841	0	1,377,664	81,041	91,348	87,323	1,117,952	0
Dual Medicare Status[d]												
Full dual, all year	47,004	21,817	24,704	477	5	1	506,842	229,928	274,085	2,776	41	12
Full dual, part year	3,257	1,097	2,096	64	0	0	33,949	11,529	21,747	673	0	0
Non-dual, all year	292,615	442	71,686	55,018	165,209	260	2,192,686	3,989	757,910	253,798	1,174,435	2,554
Managed Care (MC) Status												
Fee-for-service (FFS) all year	171,507	23,355	94,762	16,760	36,375	255	1,669,407	245,441	1,028,631	83,286	309,507	2,542
FFS part year, with Rx claims	71,476	0	2,702	23,544	45,224	6	187,349	0	14,091	65,089	108,145	24
FFS part year, no Rx claims	19,767	1	152	3,605	16,009	0	50,144	5	804	9,335	40,000	0

Source: Data for this table are from the MAX 2006 file for West Virginia, released by CMS in 9/2009. 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]

WEST VIRGINIA, 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	**77.2**	**15.4**	**$952**	**$62**	**$5,090**	**18.7**	**342,876**
Age							
5 and younger	84.0	6.1	288	47	1,424	20.2	63,391
6-14	80.9	8.0	551	69	2,044	26.9	77,664
15-20	80.5	9.6	624	65	3,292	18.9	42,299
21-44	78.9	19.7	1,224	62	4,984	24.6	84,178
45-64	78.0	42.8	2,696	63	10,451	25.8	49,274
65-74	41.3	6.1	216	36	8,606	2.5	11,489
75-84	36.3	3.2	38	12	18,073	0.2	8,244
85 and older	32.8	2.7	27	10	27,569	0.1	6,337
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	37.0	4.1	93	23	16,686	0.6	23,356
Disabled	76.4	33.5	2,283	68	10,033	22.8	98,486
Adults	82.6	13.8	675	49	2,137	31.6	55,559
Children	81.6	6.8	369	55	1,486	24.8	165,214
Unknown	90.4	43.5	3,258	75	12,481	26.1	261
Gender							
Female	79.0	17.2	1,014	59	5,292	19.2	196,516
Male	74.8	13.0	867	67	4,819	18.0	146,360
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	77.6	15.7	969	62	5,155	18.8	325,033
African American	70.6	9.9	622	63	3,901	15.9	17,504
Other/unknown	68.4	10.8	961	89	4,541	21.2	339
Use of Nursing Facilities[f]							
Entire year	40.2	10.7	427	40	45,185	0.9	6,968
Part year	53.3	17.0	836	49	31,437	2.7	3,784
None	78.3	15.5	964	62	3,949	24.4	332,124
Maintenance Assistance Status							
Cash	74.5	29.1	1,914	66	7,117	26.9	110,328
Medically needy	77.1	20.9	1,317	63	5,927	22.2	26,108
Poverty related	75.7	7.1	355	50	1,659	21.4	12,991
Other/unknown	78.9	7.4	394	53	4,052	9.7	193,449

Source: Data for this table are from the MAX 2006 file for West Virginia, released by CMS in 9/2009. 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]
WEST VIRGINIA, 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	**1.9**	**$119**	**18.7**	**22.8**	**41.0**	**9.9**	**13.3**	**8.0**	**5.1**	**$639**	**342,876**	**2,733,477**
Age												
5 and younger	0.9	41	20.2	16.0	59.2	9.5	8.4	3.9	2.9	201	63,391	448,273
6-14	1.1	73	26.9	19.1	53.1	10.1	10.5	3.9	3.4	271	77,664	586,073
15-20	1.3	86	18.9	19.5	47.2	12.0	12.7	5.0	3.8	456	42,299	305,141
21-44	2.7	168	24.6	21.1	28.7	12.2	19.3	11.1	7.6	686	84,178	611,888
45-64	4.1	261	25.8	22.0	19.6	7.7	19.8	21.0	9.9	1,012	49,274	508,993
65-74	0.6	20	2.5	58.7	32.0	3.8	3.4	1.6	0.5	790	11,489	125,244
75-84	0.3	4	0.2	63.7	30.9	3.7	1.5	0.1	0.0	1,726	8,244	86,318
85 and older	0.3	3	0.1	67.2	27.8	3.4	1.4	0.1	0.0	2,839	6,337	61,547
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	63.0	30.3	3.7	2.3	0.5	0.1	1,588	23,356	245,446
Disabled	3.1	213	22.8	23.6	26.5	9.4	19.0	15.2	6.3	938	98,486	1,053,742
Adults	3.0	146	31.6	17.4	29.1	13.6	19.1	10.6	10.1	462	55,559	257,247
Children	1.0	52	24.8	18.4	55.1	9.9	9.4	3.9	3.4	209	165,214	1,174,476
Unknown	4.4	331	26.1	9.6	15.3	13.4	33.3	23.4	5.0	1,270	261	2,566
Gender												
Female	2.2	130	19.2	21.0	39.6	10.1	14.0	9.2	6.2	679	196,516	1,530,802
Male	1.6	106	18.0	25.2	42.9	9.6	12.3	6.4	3.6	587	146,360	1,202,675
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.0	121	18.8	22.4	40.9	10.0	13.4	8.2	5.2	645	325,033	2,599,198
African American	1.3	83	15.9	29.4	43.0	8.6	10.5	5.3	3.1	520	17,504	131,392
Other/unknown	1.3	113	21.2	31.6	40.1	8.8	13.6	4.4	1.5	533	339	2,887
Use of Nursing Facilities[f]												
Entire year	1.1	43	0.9	59.8	24.5	6.3	4.7	2.0	2.7	4,513	6,968	69,770
Part year	1.8	86	2.7	46.7	32.4	5.9	4.8	4.7	5.5	3,245	3,784	36,654
None	2.0	122	24.4	21.7	41.4	10.0	13.5	8.2	5.1	499	332,124	2,627,053
Maintenance Assistance Status												
Cash	2.9	191	26.9	25.5	27.4	9.1	17.3	13.5	7.3	709	110,328	1,107,570
Medically needy	3.4	215	22.2	22.9	22.2	11.4	21.3	13.9	8.3	966	26,108	160,192
Poverty related	1.0	52	21.4	24.3	48.4	10.2	10.0	4.3	2.8	245	12,991	88,051
Other/unknown	1.0	55	9.7	21.1	50.8	10.2	10.1	4.3	3.6	569	193,449	1,377,664

Source: Data for this table are from the MAX 2006 file for West Virginia, released by CMS in 9/2009. 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]
WEST VIRGINIA, 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	**1.9**	**$119**	**$62**	**0.6**	**$84**	**$131**	**0.1**	**$11**	**$100**	**1.2**	**$25**	**$21**
Age												
5 and younger	0.9	41	47	0.3	28	112	0.1	3	39	0.5	10	18
6-14	1.1	73	69	0.5	58	117	0.1	3	59	0.5	12	24
15-20	1.3	86	65	0.5	64	132	0.1	5	84	0.8	17	22
21-44	2.7	168	62	0.8	118	145	0.1	14	112	1.8	37	21
45-64	4.1	261	63	1.3	176	131	0.3	30	118	2.5	55	22
65-74	0.6	20	36	0.1	11	115	0.0	2	117	0.4	6	14
75-84	0.3	4	12	0.0	1	93	0.0	0	85	0.3	3	9
85 and older	0.3	3	10	0.0	1	89	0.0	0	101	0.3	2	8
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	23	0.0	4	109	0.0	1	113	0.3	4	11
Disabled	3.1	213	68	1.1	151	144	0.2	20	115	1.9	42	22
Adults	3.0	146	49	0.8	93	116	0.1	14	109	2.0	38	19
Children	1.0	52	55	0.4	38	106	0.1	3	52	0.5	11	21
Unknown	4.4	331	75	1.7	254	150	0.2	29	118	2.5	47	19
Gender												
Female	2.2	130	59	0.7	89	128	0.1	13	102	1.4	28	20
Male	1.6	106	67	0.6	77	137	0.1	8	96	0.9	21	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.0	121	62	0.6	85	131	0.1	11	100	1.2	25	21
African American	1.3	83	63	0.4	60	136	0.1	6	95	0.8	17	21
Other/unknown	1.3	113	89	0.5	82	155	0.1	15	213	0.7	16	24
Use of Nursing Facilities[e]												
Entire year	1.1	43	40	0.2	27	133	0.0	4	110	0.8	11	14
Part year	1.8	86	49	0.4	56	139	0.1	9	115	1.3	22	17
None	2.0	122	62	0.7	86	131	0.1	11	100	1.2	25	21
Maintenance Assistance Status												
Cash	2.9	191	66	0.9	134	141	0.2	18	112	1.8	39	22
Medically needy	3.4	215	63	1.1	147	138	0.2	22	126	2.2	46	21
Poverty related	1.0	52	50	0.3	35	110	0.1	5	69	0.7	13	19
Other/unknown	1.0	55	53	0.4	39	109	0.1	4	65	0.6	12	20

Source: Data for this table are from the MAX 2006 file for West Virginia, released by CMS in 9/2009. 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 West Virginia, 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.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]

WEST VIRGINIA, 2006

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	0.4	0.1	0.0	0.3	$17	$9	$1	$7	$46	$146	$61	$25	554,771	$25,637,457	179,644	52.4	1,490,107
Biologicals	0.5	0.5	0.0	0.0	573	570	1	3	1199	1,200	623	1,234	2,760	3,309,287	783	0.2	5,776
Antineoplastic Agents	0.6	0.2	0.0	0.4	186	168	1	17	295	679	258	46	11,908	3,508,931	1,857	0.5	18,907
Endocrine/Metabolic Drugs	0.7	0.2	0.0	0.4	39	28	2	9	57	124	53	22	426,680	24,414,913	72,746	21.2	633,376
Cardiovascular Agents	1.4	0.5	0.2	0.8	65	34	20	11	45	71	117	14	678,611	30,607,926	47,650	13.9	469,281
Respiratory Agents	0.6	0.3	0.0	0.3	32	26	2	5	55	99	49	16	650,198	35,785,995	127,088	37.1	1,104,327
Gastrointestinal Agents	0.6	0.4	0.0	0.2	62	56	3	4	97	143	274	15	316,634	30,723,393	52,966	15.4	491,642
Genitourinary Agents	0.3	0.1	0.1	0.2	19	9	6	4	56	80	93	26	52,342	2,924,879	18,586	5.4	150,617
CNS Drugs	1.1	0.4	0.1	0.7	81	60	9	12	70	163	101	18	923,798	64,979,736	85,798	25.0	803,493
Stimulants/Anti-obesity/Anorexia	1.0	0.8	0.0	0.2	97	89	1	8	97	111	183	42	166,441	16,226,419	18,609	5.4	166,794
Miscellaneous Psychological/ Neurological Agents	0.5	0.4	0.0	0.1	144	139	0	5	311	345	127	87	8,072	2,506,827	1,743	0.5	17,390
Analgesics and Anesthetics	0.8	0.1	0.0	0.7	28	10	4	14	37	195	310	20	666,711	24,941,064	104,900	30.6	885,322
Neuromuscular Agents	0.8	0.3	0.0	0.5	76	55	2	19	90	177	109	38	412,995	37,239,139	52,111	15.2	491,716
Nutritional Products	0.5	0.1	0.0	0.3	10	4	0	5	20	31	12	15	74,392	1,452,219	19,257	5.6	149,959
Hematological Agents	0.6	0.3	0.0	0.4	53	47	0	5	82	177	36	15	86,696	7,137,134	13,967	4.1	133,875
Topical Products	0.3	0.1	0.0	0.2	15	11	0	4	52	98	56	24	243,271	12,728,517	95,307	27.8	822,372
Miscellaneous Products	0.6	0.3	0.0	0.3	164	132	6	26	269	498	210	82	7,253	1,949,750	1,223	0.4	11,882
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	8	0	0	0	43	0	0	0	4,233	180,835	2,388	0.7	23,527
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.	5,287,766	326,254,421	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for West Virginia, released by CMS in 9/2009. 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 West Virginia, 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.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]

WEST VIRGINIA, 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
ANTICONVULSANT	$33,331,386	41,765	12.2	412,650	0.7	$113	$81
ANTIPSYCHOTICS	31,697,649	23,984	7.0	241,336	0.6	210	131
ULCER DRUGS	26,547,815	52,186	15.2	498,117	0.5	106	53
ANTIDEPRESSANTS	24,948,429	70,148	20.5	651,182	0.6	68	38
ANTIASTHMATIC	24,931,556	99,249	28.9	909,636	0.4	71	27
ANTIHYPERLIPIDEMIC	16,531,901	25,160	7.3	271,137	0.6	101	61
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	16,226,419	22,538	6.6	203,362	0.8	97	80
ANALGESICS - Narcotic	14,430,307	122,907	35.8	1,045,444	0.4	32	14
ANTIDIABETIC	13,775,449	25,196	7.3	262,006	0.7	77	53
DERMATOLOGICAL	9,181,072	90,603	26.4	804,046	0.2	55	11
Total	211,601,983	573,736	n.a.	5,298,916	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for West Virginia, released by CMS in 9/2009. 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.