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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2007
D.C.

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
D.C., 2007

Inclusion Criteria (2007)	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]	169612 (A)	21829 (E)	147783 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	165066 (B)	19313 (F)	145753 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	72628 (C)	19075 (G)	53553 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2147 (D)	1692 (H)	455 (L)

Source: Data for this table are from the MAX 2007 file for D.C., released by CMS in 3/2010. This table was produced on 10/06/2010.
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 2007 (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 2007, 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 2007 was $73,374,220, of which $1,354,294 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 27 states in 2007 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, MA, MI, NC, NH, NM, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NE, NY, TN, TX, and WV). These lists were constructed from the CMS 2007 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 reviewed prescription drug expenditures by type of managed care plan to determine whether enrollees in comprehensive MC plans had significant prescription drug expenditures during the year, since that would indicate that at least some prescription drugs were not included in the capitated benefit and were being provided on a fee-for-service basis. There were some states in which most, but not all, prescription drugs were included in the MC capitated benefit package. Mental health drugs, for example, may have been excluded. In those states, we excluded all the MC enrollees from the study population, but some of their drugs would have been included, potentially resulting in higher reported per-beneficiary use of those drugs than would have been the case if we had been able to exclude those drugs.
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 2007. 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 2007. 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., 2007

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**72,628**	**9,741**	**33,650**	**8,893**	**20,334**	**10**	**575,487**	**102,786**	**339,209**	**35,067**	**98,306**	**119**
Age												
5 and younger	8,911	0	617	4	8,290	0	35,880	0	4,559	16	31,305	0
6-14	8,604	1	1,667	3	6,933	0	51,040	10	14,812	14	36,204	0
15-20	7,373	0	1,589	794	4,990	0	48,781	0	15,673	2,830	30,278	0
21-44	16,148	4	9,492	6,537	115	0	118,923	32	94,092	24,343	456	0
45-64	18,591	26	17,094	1,462	0	9	182,748	225	175,384	7,032	0	107
65-74	6,156	3,663	2,417	75	0	1	65,627	38,733	26,236	646	0	12
75-84	4,260	3,623	622	15	0	0	45,939	38,941	6,848	150	0	0
85 and older	2,579	2,424	152	3	0	0	26,486	24,845	1,605	36	0	0
Unknown	6	0	0	0	6	0	63	0	0	0	63	0
Gender												
Female	39,972	6,844	15,832	7,142	10,144	10	312,427	73,099	163,464	26,911	48,834	119
Male	32,652	2,897	17,818	1,751	10,186	0	263,052	29,687	175,745	8,156	49,464	0
Unknown	4	0	0	0	4	0	8	0	0	0	8	0
Race												
White	2,240	527	1,428	147	137	1	20,503	5,357	13,891	607	636	12
African American	60,931	7,538	29,194	7,945	16,249	5	488,965	79,411	295,037	31,295	83,163	59
Other/unknown	9,457	1,676	3,028	801	3,948	4	66,019	18,018	30,281	3,165	14,507	48
Use of Nursing Facilities[c]												
Entire year	2,147	1,688	432	27	0	0	23,500	18,257	4,919	324	0	0
Part year	1,259	788	452	19	0	0	12,918	7,896	4,834	188	0	0
None	69,222	7,265	32,766	8,847	20,334	10	539,069	76,633	329,456	34,555	98,306	119
Maintenance Assistance Status												
Cash	33,111	2,418	20,767	5,245	4,681	0	280,820	26,638	218,436	20,122	15,624	0
Medically needy	17,828	2,285	7,053	2,919	5,571	0	112,339	23,232	59,221	11,423	18,463	0
Poverty-related	11,525	2,254	3,021	319	5,921	10	76,289	23,816	30,924	1,130	20,300	119
Other/unknown	10,164	2,784	2,809	410	4,161	0	106,039	29,100	30,628	2,392	43,919	0
Dual Medicare Status[d]												
Full dual, all year	18,332	8,295	9,605	430	1	1	196,752	88,427	104,433	3,868	12	12
Full dual, part year	743	376	355	12	0	0	7,928	3,929	3,856	143	0	0
Non-dual, all year	53,553	1,070	23,690	8,451	20,333	9	370,807	10,430	230,920	31,056	98,294	107
Managed Care (MC) Status												
Fee-for-service (FFS) all year	51,123	9,714	31,983	2,428	6,988	10	500,654	102,604	329,962	14,112	53,857	119
FFS part year, with Rx claims	4,536	7	736	1,739	2,054	0	19,342	50	4,876	6,354	8,062	0
FFS part year, no Rx claims	16,969	20	931	4,726	11,292	0	55,491	132	4,371	14,601	36,387	0

Source: Data for this table are from the MAX 2007 file for D.C., released by CMS in 3/2010. This table was produced on 10/06/2010.

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 2007. 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., 2007

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	**38.0**	**9.5**	**$992**	**$104**	**$15,384**	**6.4**	**72,628**
Age							
5 and younger	19.2	0.8	83	106	5,959	1.4	8,911
6-14	23.9	2.1	244	116	4,579	5.3	8,604
15-20	30.2	2.4	282	115	7,760	3.6	7,373
21-44	42.7	9.2	1,165	126	13,578	8.6	16,148
45-64	61.2	23.8	2,420	102	24,008	10.1	18,591
65-74	28.3	6.1	394	64	19,337	2.0	6,156
75-84	23.5	3.2	147	46	23,690	0.6	4,260
85 and older	21.9	2.6	102	39	31,804	0.3	2,579
Unknown	0.0	0.0	0	0	0	0.0	6
Basis of Eligibility[e]							
Aged	23.9	3.6	185	51	25,509	0.7	9,741
Disabled	55.7	18.2	1,941	107	21,692	8.9	33,650
Adults	26.9	2.3	249	107	3,702	6.7	8,893
Children	20.2	1.3	133	103	5,208	2.5	20,334
Unknown	70.0	6.8	912	134	5,330	17.1	10
Gender							
Female	38.4	9.8	925	94	14,681	6.3	39,972
Male	37.5	9.2	1,074	117	16,246	6.6	32,652
Unknown	0.0	0.0	0	0	0	0.0	4
Race							
White	39.4	11.9	1,342	113	21,941	6.1	2,240
African American	39.6	10.0	1,030	103	15,672	6.6	60,931
Other/unknown	27.4	6.0	663	111	11,974	5.5	9,457
Use of Nursing Facilities[f]							
Entire year	46.4	14.4	991	69	70,484	1.4	2,147
Part year	50.4	16.0	1,335	84	70,013	1.9	1,259
None	37.5	9.3	985	106	12,681	7.8	69,222
Maintenance Assistance Status							
Cash	44.5	13.3	1,384	104	14,144	9.8	33,111
Medically needy	34.4	7.3	706	97	18,669	3.8	17,828
Poverty related	19.3	2.0	174	85	6,094	2.9	11,525
Other/unknown	44.1	9.8	1,142	116	24,192	4.7	10,164

Source: Data for this table are from the MAX 2007 file for D.C., released by CMS in 3/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.
d. In eight states (DE, IA, IL, NE, NY, TN, TX, 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., 2007

				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	**1.2**	**$125**	**6.4**	**62.0**	**20.8**	**4.7**	**7.5**	**4.0**	**0.9**	**$1,941**	**72,628**	**575,487**
Age												
5 and younger	0.2	21	1.4	80.8	17.0	1.5	0.6	0.1	0.0	1,480	8,911	35,880
6-14	0.4	41	5.3	76.1	18.9	2.8	2.0	0.2	0.0	772	8,604	51,040
15-20	0.4	43	3.6	69.8	25.3	2.7	1.9	0.4	0.0	1,173	7,373	48,781
21-44	1.3	158	8.6	57.3	23.6	6.2	8.5	3.7	0.7	1,844	16,148	118,923
45-64	2.4	246	10.1	38.8	21.1	8.5	17.8	11.0	2.8	2,442	18,591	182,748
65-74	0.6	37	2.0	71.7	18.1	2.9	4.4	2.4	0.6	1,814	6,156	65,627
75-84	0.3	14	0.6	76.5	18.5	1.7	2.3	1.0	0.1	2,197	4,260	45,939
85 and older	0.3	10	0.3	78.1	17.6	1.3	2.0	0.9	0.1	3,097	2,579	26,486
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	6	63
Basis of Eligibility[e]												
Aged	0.3	18	0.7	76.1	17.9	1.9	2.6	1.3	0.2	2,418	9,741	102,786
Disabled	1.8	193	8.9	44.3	24.3	7.5	14.0	7.9	1.9	2,152	33,650	339,209
Adults	0.6	63	6.7	73.1	19.0	3.8	2.9	1.1	0.2	939	8,893	35,067
Children	0.3	27	2.5	79.8	17.2	1.8	1.1	0.1	0.0	1,077	20,334	98,306
Unknown	0.6	77	17.1	30.0	50.0	20.0	0.0	0.0	0.0	448	10	119
Gender												
Female	1.3	118	6.3	61.6	21.2	4.6	7.3	4.2	1.1	1,878	39,972	312,427
Male	1.1	133	6.6	62.5	20.3	4.8	7.8	3.8	0.7	2,017	32,652	263,052
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	4	8
Race												
White	1.3	147	6.1	60.6	19.1	4.7	8.8	5.5	1.2	2,397	2,240	20,503
African American	1.2	128	6.6	60.4	21.6	5.0	7.9	4.1	1.0	1,953	60,931	488,965
Other/unknown	0.9	95	5.5	72.6	16.3	3.2	4.8	2.7	0.5	1,715	9,457	66,019
Use of Nursing Facilities[f]												
Entire year	1.3	91	1.4	53.6	26.1	4.6	7.6	6.0	2.2	6,440	2,147	23,500
Part year	1.6	130	1.9	49.6	25.1	4.8	11.2	6.9	2.4	6,824	1,259	12,918
None	1.2	127	7.8	62.5	20.5	4.7	7.5	3.9	0.9	1,628	69,222	539,069
Maintenance Assistance Status												
Cash	1.6	163	9.8	55.5	22.0	5.8	9.7	5.5	1.5	1,668	33,111	280,820
Medically needy	1.2	112	3.8	65.6	18.8	4.8	7.1	3.2	0.5	2,963	17,828	112,339
Poverty related	0.3	26	2.9	80.7	15.2	1.6	1.7	0.7	0.1	921	11,525	76,289
Other/unknown	0.9	110	4.7	55.9	26.8	4.7	7.9	4.1	0.7	2,319	10,164	106,039

Source: Data for this table are from the MAX 2007 file for D.C., released by CMS in 3/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.
d. In eight states (DE, IA, IL, NE, NY, TN, TX, 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., 2007

	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	**1.2**	**$125**	**$104**	**0.4**	**$96**	**$213**	**0.0**	**$4**	**$113**	**0.7**	**$26**	**$36**
Age												
5 and younger	0.2	21	106	0.1	17	282	0.0	0	61	0.1	3	27
6-14	0.4	41	116	0.2	35	173	0.0	1	136	0.1	6	38
15-20	0.4	43	115	0.2	34	206	0.0	2	171	0.2	7	34
21-44	1.3	158	126	0.6	130	235	0.0	4	147	0.7	24	36
45-64	2.4	246	102	0.9	182	213	0.1	8	108	1.5	56	37
65-74	0.6	37	64	0.2	25	153	0.0	2	77	0.4	10	27
75-84	0.3	14	46	0.1	9	122	0.0	1	65	0.2	5	21
85 and older	0.3	10	39	0.1	6	105	0.0	1	67	0.2	3	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.3	18	51	0.1	11	130	0.0	1	70	0.2	6	23
Disabled	1.8	193	107	0.7	147	219	0.1	6	116	1.1	40	37
Adults	0.6	63	107	0.3	53	194	0.0	1	104	0.3	9	29
Children	0.3	27	103	0.1	22	178	0.0	1	121	0.1	5	33
Unknown	0.6	77	134	0.3	52	162	0.0	0	0	0.3	25	99
Gender												
Female	1.3	118	94	0.4	88	202	0.0	4	107	0.8	26	34
Male	1.1	133	117	0.5	104	226	0.0	4	121	0.6	25	39
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.3	147	113	0.5	108	221	0.0	5	140	0.8	34	44
African American	1.2	128	103	0.5	98	212	0.0	4	113	0.7	27	36
Other/unknown	0.9	95	111	0.3	77	221	0.0	3	105	0.5	16	33
Use of Nursing Facilities[e]												
Entire year	1.3	91	69	0.3	59	171	0.0	5	122	0.9	27	29
Part year	1.6	130	84	0.4	90	209	0.1	5	86	1.1	35	33
None	1.2	127	106	0.5	97	215	0.0	4	114	0.7	25	36
Maintenance Assistance Status												
Cash	1.6	163	104	0.6	124	219	0.0	5	116	0.9	33	35
Medically needy	1.2	112	97	0.4	80	214	0.0	3	92	0.8	29	38
Poverty related	0.3	26	85	0.1	18	198	0.0	1	129	0.2	7	33
Other/unknown	0.9	110	116	0.5	91	195	0.0	3	124	0.5	15	34

Source: Data for this table are from the MAX 2007 file for D.C., released by CMS in 3/2010. This table was produced on 10/06/2010.
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., 0.2 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]
D.C., 2007

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	0.9	0.6	0.0	0.3	$163	$140	$1	$22	$187	$234	$209	$82	109,268	$20,451,805	12,380	17.0	125,123
Biologicals	0.4	0.4	0.0	0.0	510	510	0	0	1438	1,438	0	0	269	386,892	113	0.2	758
Antineoplastic Agents	0.4	0.1	0.0	0.3	130	99	1	31	330	858	329	110	2,139	705,322	509	0.7	5,411
Endocrine/Metabolic Drugs	0.7	0.3	0.0	0.4	53	41	1	11	75	147	109	27	47,939	3,591,989	6,455	8.9	67,473
Cardiovascular Agents	1.4	0.3	0.1	1.0	69	34	6	28	49	112	74	28	147,866	7,260,004	9,933	13.7	105,514
Respiratory Agents	0.5	0.3	0.0	0.3	43	34	1	7	79	125	79	29	51,176	4,039,281	9,025	12.4	93,819
Gastrointestinal Agents	0.4	0.2	0.0	0.2	42	30	2	9	103	178	165	42	23,981	2,481,288	5,554	7.6	59,614
Genitourinary Agents	0.3	0.1	0.0	0.2	23	14	0	8	74	99	93	51	5,915	436,814	1,875	2.6	19,253
CNS Drugs	0.9	0.4	0.0	0.5	142	121	2	20	160	308	125	41	106,371	16,992,771	10,951	15.1	119,706
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	71	67	0	4	124	137	63	47	6,307	783,247	1,048	1.4	11,032
Miscellaneous Psychological/ Neurological Agents	0.3	0.2	0.0	0.1	83	75	0	8	274	302	70	148	2,255	618,141	666	0.9	7,457
Analgesics and Anesthetics	0.5	0.0	0.0	0.5	24	8	3	13	48	461	357	28	56,604	2,734,148	10,731	14.8	112,300
Neuromuscular Agents	0.7	0.2	0.0	0.4	63	40	6	18	92	186	180	40	56,805	5,238,438	7,490	10.3	82,605
Nutritional Products	0.4	0.0	0.0	0.4	6	0	0	6	14	36	19	14	22,161	320,483	4,994	6.9	53,065
Hematological Agents	0.5	0.2	0.0	0.3	77	71	0	5	146	411	26	15	20,499	2,994,085	3,552	4.9	38,982
Topical Products	0.4	0.1	0.0	0.2	24	14	2	8	66	120	105	35	30,598	2,027,771	8,342	11.5	84,915
Miscellaneous Products	0.3	0.2	0.0	0.1	140	126	0	14	479	690	275	127	1,890	906,085	623	0.9	6,474
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	14	0	0	0	67	0	0	0	770	51,362	326	0.4	3,612
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.	692,813	72,019,926	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for D.C., released by CMS in 3/2010. This table was produced on 10/06/2010.
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., 0.2 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 2007.
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., 2007

		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	$18,081,022	5,483	7.5	58,754	1.3	$240	$308
ANTIPSYCHOTICS	13,633,306	7,197	9.9	80,523	0.5	319	169
ANTICONVULSANT	4,860,212	6,641	9.1	73,763	0.6	117	66
ANTIASTHMATIC	3,040,837	8,613	11.9	89,925	0.4	97	34
ANTIDIABETIC	2,547,628	5,620	7.7	60,726	0.6	72	42
ANTIHYPERLIPIDEMIC	2,491,675	4,449	6.1	48,656	0.5	98	51
ANTIDEPRESSANTS	2,404,841	7,852	10.8	85,873	0.4	63	28
ANTIHYPERTENSIVE	1,826,192	8,439	11.6	91,029	0.5	38	20
ANALGESICS - Narcotic	1,800,134	10,249	14.1	110,957	0.3	52	16
HEMATOPOIETIC AGENTS	1,432,150	3,826	5.3	41,796	0.4	91	34
Total	52,117,997	68,369	n.a.	742,002	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for D.C., released by CMS in 3/2010. This table was produced on 10/06/2010.
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 2007. 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 2007. 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.