STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
ARIZONA

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
ARIZONA, 2003

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)		Number of Dual Eligible Beneficiaries (Cell)[g]		Number of Non-dual Eligible Beneficiaries (Cell)	
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	372,756	(A)	119,670	(E)	253,086	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	357,835	(B)	99,874	(F)	1,106,687	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	136,001	(C)	8,610	(G)	127,391	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	47	(D)	35	(H)	12	(L)

Source: Data for this table are from the MAX 2003 file for Arizona, released by CMS in 06/2007. This table was produced on 11/01/2007.

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 2003 (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 2003, 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 Arizona in 2003 was $4,344,074, of which $1,745,962 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 19 states in 2003 that had PHPs that did not include a pharmacy benefit: AL, AR, CA, CO, FL, GA, IA, KY, MA, MI, NY, OR, PA, SD, TN, TX, UT, WA, and WI. In addition, there were 7 states in which MC plans did not provide a pharmacy benefit: DE, IA, NE, NY, TX, UT, and WV. These lists were constructed from the CMS 2003 Medicaid Managed Care Enrollment Report [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer02.pdf] 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 2003. 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 benficiary 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 2003. 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]

ARIZONA, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**136,001**	**3,784**	**10,952**	**60,250**	**61,015**	**0**	**1,032,093**	**33,969**	**113,148**	**411,587**	**473,389**	**0**
Age												
5 and younger	22,767	1	411	0	22,355	0	165,336	12	3,981	0	161,343	0
6-14	28,494	0	927	0	27,567	0	235,321	0	9,943	0	225,378	0
15-20	17,490	0	618	5,779	11,093	0	134,293	0	6,364	41,261	86,668	0
21-44	44,332	0	2,396	41,936	0	0	307,598	0	23,513	284,085	0	0
45-64	16,066	2	3,951	12,113	0	0	123,994	12	39,903	84,079	0	0
65-74	4,049	1,755	1,988	306	0	0	39,351	15,426	22,216	1,709	0	0
75-84	2,111	1,470	555	86	0	0	20,468	13,975	6,128	365	0	0
85 and older	691	556	106	29	0	0	5,731	4,544	1,100	87	0	0
Unknown	1	0	0	1	0	1 0		0	0	1	0	0
Gender												
Female	72,366	2,490	5,646	33,645	30,585	0	566,007	22,931	59,471	244,632	238,973	0
Male	63,635	1,294	5,306	26,605	30,430	0	466,086	11,038	53,677	166,955	234,416	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Race												
White	10,072	378	573	6,205	2,916	0	16,707	1,504	2,197	8,833	4,173	0
African American	1,508	14	108	799	587	0	2,551	41	409	1,186	915	0
Other/unknown	124,421	3,392	10,271	53,246	57,512	0	1,012,835	32,424	110,542	401,568	468,301	0
Use of Nursing Facilities[c]												
Entire year	47	30	17	0	0	0	66	38	28	0	0	0
Part year	275	93	154	22	6	0	2,000	451	1,279	227	43	0
None	135,679	3,661	10,781	60,228	61,009	0	1,030,027	33,480	111,841	411,360	473,346	0
Maintenance Assistance Status												
Cash	68,356	2,086	9,598	26,853	29,819	0	587,817	22,788	104,631	204,035	256,363	0
Medically needy	0	0	0	0	0	0 0		0	0	0	0	0
Poverty-related	27,045	771	448	1,796	24,030	0	192,456	6,009	3,444	10,073	172,930	0
Other/unknown	40,600	927	906	31,601	7,166	0	251,820	5,172	5,073	197,479	44,096	0
Dual Medicare Status[d]												
Full dual, all year	8,168	3,274	3,742	1,151	1	0	77,333	30,752	40,040	6,529	12	0
Full dual, part year	442	198	210	34	0	0	1,891	912	872	107	0	0
Non-dual, all year	127,391	312	7,000	59,065	61,014	0	952,869	2,305	72,236	404,951	473,377	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	107,438	2,979	9,332	46,294	48,833	0	939,316	30,497	105,885	368,861	434,073	0
FFS part year, with Rx claims	1,454	138	313	403	600	0	7,860	707	1,829	2,204	3,120	0
FFS part year, no Rx claims	27,109	667	1,307	13,553	11,582	0	84,917	2,765	5,434	40,522	36,196	0

Source: Data for this table are from the MAX 2003 file for Arizona, released by CMS in 06/2007. This table was produced on 11/01/2007.

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 2003. 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]

ARIZONA, 2003

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	**4.7 %**	**0.3**	**$19**	**$66**	**$2,712**	**0.7 %**	**136,001**
Age							
5 and younger	5.4	0.1	13	97	3,160	0.4	22,767
6-14	3.6	0.1	6	62	1,413	0.4	28,494
15-20	3.8	0.1	20	153	2,308	0.9	17,490
21-44	3.8	0.2	19	86	2,551	0.7	44,332
45-64	5.9	0.7	34	48	4,593	0.7	16,066
65-74	12.9	1.5	64	43	4,573	1.4	4,049
75-84	14.2	1.6	54	33	4,028	1.3	2,111
85 and older	14.5	1.4	50	35	3,520	1.4	691
Unknown	0.0	0.0	0	0	1,879	0.0	1
Basis of Eligibility[e]							
Aged	11.7	1.3	54	42	3,650	1.5	3,784
Disabled	15.0	1.8	165	92	10,893	1.5	10,952
Adults	3.0	0.1	5	39	1,845	0.3	60,250
Children	4.2	0.1	5	41	2,042	0.2	61,015
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	5.5	0.3	16	48	3,138	0.5	72,366
Male	3.9	0.2	23	93	2,229	1.0	63,635
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	0.9	0.1	3	53	1,132	0.3	10,072
African American	1.7	0.1	2	21	1,416	0.1	1,508
Other/unknown	5.1	0.3	21	66	2,856	0.7	124,421
Use of Nursing Facilities[f]							
Entire year	34.0	7.8	315	41	28,702	1.1	47
Part year	79.3	17.6	792	45	49,010	1.6	275
None	4.6	0.3	17	69	2,609	0.7	135,679
Maintenance Assistance Status							
Cash	6.8	0.5	32	70	3,865	0.8	68,356
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	3.9	0.1	7	57	1,924	0.3	27,045
Other/unknown	1.9	0.1	6	45	1,297	0.4	40,600

Source: Data for this table are from the MAX 2003 file for Arizona, released by CMS in 06/2007. This table was produced on 11/01/2007.

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 seven states (DE, IA, NE, NY, 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 seven states (DE, IA, NE, NY, 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]

ARIZONA, 2003

				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	**0.0**	**$3**	**0.7 %**	**95.3 %**	**4.1 %**	**0.3 %**	**0.2 %**	**0.1 %**	**0.0 %**	**$357**	**136,001**	**1,032,093**
Age												
5 and younger	0.0	2	0.4	94.6	5.3	0.1	0.1	0.0	0.0	435	22,767	165,336
6-14	0.0	1	0.4	96.4	3.4	0.1	0.0	0.0	0.0	171	28,494	235,321
15-20	0.0	3	0.9	96.2	3.4	0.1	0.1	0.0	0.1	301	17,490	134,293
21-44	0.0	3	0.7	96.2	3.3	0.2	0.1	0.1	0.0	368	44,332	307,598
45-64	0.1	4	0.7	94.1	4.4	0.7	0.6	0.1	0.1	595	16,066	123,994
65-74	0.2	7	1.4	87.1	9.4	1.4	1.6	0.3	0.2	471	4,049	39,351
75-84	0.2	6	1.3	85.8	10.0	1.5	1.6	0.6	0.5	416	2,111	20,468
85 and older	0.2	6	1.4	85.5	9.3	1.4	2.3	0.4	1.0	424	691	5,731
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	1,879	1	1
Basis of Eligibility[e]												
Aged	0.1	6	1.5	88.3	7.9	1.2	1.5	0.5	0.5	407	3,784	33,969
Disabled	0.2	16	1.5	85.0	11.1	1.6	1.7	0.4	0.3	1,054	10,952	113,148
Adults	0.0	1	0.3	97.0	2.7	0.2	0.1	0.0	0.0	270	60,250	411,587
Children	0.0	1	0.2	95.8	4.0	0.1	0.1	0.0	0.0	263	61,015	473,389
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	0.0	2	0.5	94.5	4.8	0.3	0.3	0.1	0.1	401	72,366	566,007
Male	0.0	3	1.0	96.1	3.3	0.2	0.2	0.1	0.0	304	63,635	466,086
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	0.0	2	0.3	99.1	0.4	0.3	0.1	0.0	0.0	683	10,072	16,707
African American	0.0	1	0.1	98.3	0.8	0.4	0.4	0.1	0.0	837	1,508	2,551
Other/unknown	0.0	3	0.7	94.9	4.5	0.3	0.3	0.1	0.0	351	124,421	1,012,835
Use of Nursing Facilities[f]												
Entire year	5.5	224	1.1	66.0	4.3	2.1	4.3	8.5	14.9	20,440	47	66
Part year	2.4	109	1.6	20.7	33.1	9.8	16.7	7.3	12.4	6,739	275	2,000
None	0.0	2	0.7	95.4	4.1	0.3	0.2	0.0	0.0	344	135,679	1,030,027
Maintenance Assistance Status												
Cash	0.1	4	0.8	93.2	5.8	0.4	0.4	0.1	0.0	449	68,356	587,817
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.0	1	0.3	96.1	3.7	0.1	0.1	0.0	0.0	270	27,045	192,456
Other/unknown	0.0	1	0.4	98.1	1.5	0.1	0.1	0.1	0.1	209	40,600	251,820

Source: Data for this table are from the MAX 2003 file for Arizona, released by CMS in 06/2007. This table was produced on 11/01/2007.

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 seven states (DE, IA, NE, NY, 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 seven states (DE, IA, NE, NY, 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]

ARIZONA, 2003

	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	**0.0**	**$3**	**$66**	**0.0**	**$2**	**$187**	**0.0**	**$0**	**$50**	**0.0**	**$0**	**$15**
Age												
5 and younger	0.0	2	97	0.0	2	391	0.0	0	53	0.0	0	11
6-14	0.0	1	62	0.0	1	160	0.0	0	43	0.0	0	12
15-20	0.0	3	153	0.0	2	417	0.0	0	611	0.0	0	13
21-44	0.0	3	86	0.0	2	278	0.0	0	43	0.0	0	13
45-64	0.1	4	48	0.0	3	122	0.0	0	25	0.1	1	17
65-74	0.2	7	43	0.0	5	100	0.0	0	21	0.1	2	17
75-84	0.2	6	33	0.1	4	76	0.0	0	17	0.1	2	14
85 and older	0.2	6	35	0.1	5	83	0.0	0	13	0.1	1	12
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.1	6	42	0.0	5	102	0.0	0	15	0.1	1	15
Disabled	0.2	16	92	0.1	14	244	0.0	0	61	0.1	2	17
Adults	0.0	1	39	0.0	1	127	0.0	0	34	0.0	0	12
Children	0.0	1	41	0.0	1	119	0.0	0	58	0.0	0	11
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	0.0	2	48	0.0	2	129	0.0	0	61	0.0	0	14
Male	0.0	3	93	0.0	3	267	0.0	0	34	0.0	0	16
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.0	2	53	0.0	2	156	0.0	0	25	0.0	1	18
African American	0.0	1	21	0.0	1	66	0.0	0	0	0.0	0	11
Other/unknown	0.0	3	66	0.0	2	187	0.0	0	50	0.0	0	15
Use of Nursing Facilities[e]												
Entire year	5.5	224	41	1.9	170	91	0.2	3	18	3.5	52	15
Part year	2.4	109	45	0.7	75	115	0.1	2	29	1.7	32	19
None	0.0	2	69	0.0	2	197	0.0	0	53	0.0	0	14
Maintenance Assistance Status												
Cash	0.1	4	70	0.0	3	201	0.0	0	52	0.0	1	15
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.0	1	57	0.0	1	160	0.0	0	27	0.0	0	11
Other/unknown	0.0	1	45	0.0	1	114	0.0	0	22	0.0	0	17

Source: Data for this table are from the MAX 2003 file for Arizona, released by CMS in 06/2007. This table was produced on 11/01/2007.

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 Arizona, 0.6 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 combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007)

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]

ARIZONA, 2003

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	0.2	0.1	0.0	0.1	$11	$8	$0	$2	$59	$137	$67	$20	5,611	$330,361	3,182	2.3 %	31,243
Biologicals	0.1	0.1	0.0	0.0	72	27	45	0	586	313	1,855	29	66	38,702	49	0.0	536
Antineoplastic Agents	0.4	0.2	0.0	0.3	155	138	1	16	356	887	121	60	216	77,003	51	0.0	496
Endocrine/Metabolic Drugs	0.4	0.1	0.0	0.2	21	14	1	6	53	126	14	24	4,379	232,622	1,144	0.8	11,221
Cardiovascular Agents	0.7	0.2	0.0	0.5	19	12	0	7	29	73	10	14	6,503	189,185	991	0.7	9,920
Respiratory Agents	0.2	0.1	0.0	0.1	10	8	0	2	39	73	51	12	3,655	142,391	1,542	1.1	14,854
Gastrointestinal Agents	0.3	0.1	0.0	0.1	30	28	0	2	109	195	0	17	2,071	225,157	756	0.6	7,470
Genitourinary Agents	0.2	0.1	0.0	0.1	9	8	0	1	44	66	0	11	500	21,774	245	0.2	2,327
CNS Drugs	0.4	0.2	0.0	0.2	22	19	0	3	54	108	160	12	3,099	167,279	859	0.6	7,774
Stimulants/Anti-obesity/Anorexia	0.3	0.2	0.0	0.2	18	14	0	4	51	79	0	23	185	9,470	61	0.0	539
Miscellaneous Psychological/ Neurological Agents	0.5	0.5	0.0	0.0	109	106	0	3	204	216	0	63	48	9,777	12	0.0	90
Analgesics and Anesthetics	0.3	0.0	0.0	0.2	7	5	0	2	26	280	13	9	6,932	179,331	2,713	2.0	27,351
Neuromuscular Agents	0.4	0.2	0.1	0.2	28	21	4	3	68	124	44	22	1,726	117,557	448	0.3	4,185
Nutritional Products	0.3	0.0	0.0	0.3	4	1	0	3	15	111	8	12	1,146	17,586	462	0.3	4,152
Hematological Agents	0.4	0.2	0.1	0.1	335	332	1	1	910	1,997	21	9	776	706,233	222	0.2	2,110
Topical Products	0.2	0.0	0.0	0.1	4	3	0	1	26	83	211	11	2,028	53,017	1,275	0.9	12,486
Miscellaneous Products	0.3	0.2	0.0	0.1	74	71	0	2	243	333	0	25	307	74,449	98	0.1	1,012
Unknown Therapeutic Category	0.1	0.0	0.0	0.0	4	0	0	0	31	0	0	0	200	6,218	148	0.1	1,587
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.	39,448	2,598,112	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Arizona, released by CMS in 06/2007. This table was produced on 11/01/2007.

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.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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 Arizona, 0.6 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.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2003.

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]

ARIZONA, 2003

		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
MISC. HEMATOLOGICAL	$567,101	40	0.0 %	415	0.5	$2,864	$1,367
ANTIDIABETIC	135,627	789	0.6	8,553	0.3	49	16
HEMATOPOIETIC AGENTS	105,112	222	0.2	2,377	0.2	275	44
ANALGESICS - ANTI-INFLAMMATORY	105,021	1,726	1.3	18,137	0.2	35	6
ULCER DRUGS	103,792	593	0.4	6,352	0.2	79	16
ANTIASTHMATIC	100,153	1,078	0.8	11,013	0.2	48	9
ANTICONVULSANT	87,639	263	0.2	2,713	0.4	87	32
MISC. GI	83,224	132	0.1	1,274	0.2	296	65
MISC. ENDOCRINE	79,640	73	0.1	776	0.3	333	103
ANTIVIRAL	78,150	58	0.0	592	0.3	465	132
Total	1,445,459	4,974		52,202	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Arizona, released by CMS in 06/2007. This table was produced on 11/01/2007.

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 2003. 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 2003. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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.