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

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

SUPPLEMENTAL TABLES

APPENDIX TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEVADA, 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]	245,579	(A)	35,349	(E)	210,230	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	229,718	(B)	20,976	(F)	208,742	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	167,028	(C)	20,886	(G)	146,142	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	2,299	(D)	2,024	(H)	275	(L)

Source: Data for this table are from the MAX 2003 file for Nevada, released by CMS in 04/2007. 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 Nevada in 2003 was $113,548,845, of which $1,609,579 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]

NEVADA, 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	**167,028**	**13,429**	**29,121**	**36,072**	**88,403**	**3**	**819,976**	**104,377**	**217,603**	**128,999**	**368,983**	**14**
Age												
5 and younger	42,804	1	1,285	0	41,518	0	172,495	1	8,885	0	163,609	0
6-14	39,001	0	3,171	0	35,830	0	180,043	0	24,649	0	155,394	0
15-20	16,664	6	1,934	3,696	11,027	1	78,386	34	14,844	13,593	49,908	7
21-44	39,951	30	9,833	30,073	13	2	181,034	145	73,934	106,907	41	7
45-64	14,541	120	12,127	2,287	7	0	98,801	734	89,620	8,425	22	0
65-74	5,804	5,228	563	13	0	0	45,684	41,504	4,118	62	0	0
75-84	5,303	5,152	149	2	0	0	41,433	40,290	1,136	7	0	0
85 and older	2,952	2,892	59	1	0	0	22,091	21,669	417	5	0	0
Unknown	8	0	0	0	8	9 0		0	0	0	9	0
Gender												
Female	96,925	9,614	15,226	28,284	43,798	3	475,592	75,486	115,784	102,790	181,518	14
Male	69,773	3,815	13,893	7,788	44,277	0	343,152	28,891	101,809	26,209	186,243	0
Unknown	330	0	2	0	328	0	1,232	0	10	0	1,222	0
Race												
White	88,150	8,341	18,328	20,474	41,004	3	481,920	63,344	136,428	82,725	199,409	14
African American	27,479	813	5,682	6,201	14,783	0	109,687	6,599	42,516	15,467	45,105	0
Other/unknown	51,399	4,275	5,111	9,397	32,616	0	228,369	34,434	38,659	30,807	124,469	0
Use of Nursing Facilities[c]												
Entire year	2,299	1,885	413	0	1	0	17,547	14,232	3,306	0	9	0
Part year	2,216	1,657	554	3	2	0	17,228	12,791	4,416	10	11	0
None	162,513	9,887	28,154	36,069	88,400	3	785,201	77,354	209,881	128,989	368,963	14
Maintenance Assistance Status												
Cash	110,308	7,851	25,339	25,684	51,434	0	539,595	63,144	186,829	87,970	201,652	0
Medically needy	0	0	0	0	0	0 0		0	0	0	0	0
Poverty-related	26,440	323	407	4,196	21,514	0	104,049	2,631	4,032	13,578	83,808	0
Other/unknown	30,280	5,255	3,375	6,192	15,455	3	176,332	38,602	26,742	27,451	83,523	14
Dual Medicare Status[d]												
Full dual, all year	19,603	11,928	7,471	203	1	0	152,919	92,867	59,035	1,016	1	0
Full dual, part year	1,283	676	584	23	0	0	11,756	5,935	5,630	191	0	0
Non-dual, all year	146,142	825	21,066	35,846	88,402	3	655,301	5,575	152,938	127,792	368,982	14
Managed Care (MC) Status												
Fee-for-service (FFS) all year	39,267	2,704	6,204	9,649	20,707	3	152,434	12,815	27,528	33,621	78,456	14
FFS part year, with Rx claims	67,740	9,762	19,680	12,586	25,712	0	462,488	84,210	166,356	58,362	153,560	0
FFS part year, no Rx claims	60,020	963	3,237	13,836	41,984	0	205,045	7,352	23,719	37,007	136,967	0

Source: Data for this table are from the MAX 2003 file for Nevada, released by CMS in 04/2007. 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]

NEVADA, 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	**47.4 %**	**10.3**	**$670**	**$65**	**$4,081**	**16.4 %**	**167,028**
Age							
5 and younger	36.1	1.5	145	96	1,626	8.9	42,804
6-14	35.0	2.5	197	78	1,629	12.1	39,001
15-20	41.2	3.5	294	83	3,526	8.3	16,664
21-44	51.1	9.2	721	79	4,202	17.1	39,951
45-64	74.1	37.3	2,540	68	10,629	23.9	14,541
65-74	82.6	39.9	2,036	51	8,464	24.0	5,804
75-84	86.8	42.9	2,004	47	11,981	16.7	5,303
85 and older	89.4	42.4	1,697	40	18,496	9.2	2,952
Unknown	0.0	0.0	0	0	0	0.0	8
Basis of Eligibility[e]							
Aged	85.9	41.6	1,950	47	12,138	16.1	13,429
Disabled	76.5	30.6	2,459	80	11,145	22.1	29,121
Adults	42.6	3.4	160	47	1,930	8.3	36,072
Children	34.0	1.6	95	59	1,407	6.8	88,403
Unknown	33.3	6.3	267	42	5,321	5.0	3
Gender							
Female	50.4	12.0	708	59	4,144	17.1	96,925
Male	43.4	7.9	621	79	4,005	15.5	69,773
Unknown	32.4	1.4	73	53	1,451	5.0	330
Race							
White	54.9	13.5	889	66	5,190	17.1	88,150
African American	38.2	7.1	481	67	3,210	15.0	27,479
Other/unknown	39.5	6.3	396	63	2,643	15.0	51,399
Use of Nursing Facilities[f]							
Entire year	96.7	67.7	3,014	45	39,430	7.6	2,299
Part year	94.7	62.1	2,908	47	32,886	8.8	2,216
None	46.1	8.8	607	69	3,188	19.0	162,513
Maintenance Assistance Status							
Cash	48.2	10.8	753	70	3,419	22.0	110,308
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	34.0	1.6	76	47	1,419	5.4	26,440
Other/unknown	56.1	15.8	887	56	8,817	10.1	30,280

Source: Data for this table are from the MAX 2003 file for Nevada, released by CMS in 04/2007. 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]

NEVADA, 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	**2.1**	**$137**	**16.4 %**	**52.6 %**	**25.4 %**	**5.7 %**	**7.9 %**	**5.5 %**	**2.8 %**	**$831**	**167,028**	**819,976**
Age												
5 and younger	0.4	36	8.9	63.9	30.1	3.7	1.8	0.3	0.1	404	42,804	172,495
6-14	0.5	43	12.1	65.0	27.0	3.9	3.3	0.7	0.1	353	39,001	180,043
15-20	0.8	63	8.3	58.8	29.7	5.6	4.5	1.1	0.2	750	16,664	78,386
21-44	2.0	159	17.1	48.9	25.8	8.0	10.0	5.2	2.1	927	39,951	181,034
45-64	5.5	374	23.9	25.9	13.8	7.7	19.5	19.6	13.6	1,564	14,541	98,801
65-74	5.1	259	24.0	17.4	15.1	8.6	23.3	22.4	13.2	1,075	5,804	45,684
75-84	5.5	257	16.7	13.2	12.0	8.5	26.1	26.9	13.3	1,534	5,303	41,433
85 and older	5.7	227	9.2	10.6	10.5	9.1	28.9	28.6	12.3	2,472	2,952	22,091
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	8	9
Basis of Eligibility[e]												
Aged	5.4	251	16.1	14.1	13.0	8.6	25.7	25.5	13.1	1,562	13,429	104,377
Disabled	4.1	329	22.1	23.5	22.5	9.4	19.3	15.9	9.4	1,491	29,121	217,603
Adults	1.0	45	8.3	57.4	26.5	6.9	6.4	2.2	0.6	540	36,072	128,999
Children	0.4	23	6.8	66.0	27.8	3.6	2.1	0.3	0.0	337	88,403	368,983
Unknown	1.4	57	5.0	66.7	0.0	0.0	33.3	0.0	0.0	1,140	3	14
Gender												
Female	2.5	144	17.1	49.6	25.5	6.1	8.7	6.5	3.6	845	96,925	475,592
Male	1.6	126	15.5	56.6	25.3	5.3	6.9	4.0	1.8	814	69,773	343,152
Unknown	0.4	20	5.0	67.6	27.0	3.3	1.2	0.6	0.3	389	330	1,232
Race												
White	2.5	163	17.1	45.1	27.9	6.4	9.5	7.0	4.1	949	88,150	481,920
African American	1.8	121	15.0	61.8	20.3	5.6	6.5	4.0	1.9	804	27,479	109,687
Other/unknown	1.4	89	15.0	60.5	23.9	4.8	6.0	3.6	1.3	595	51,399	228,369
Use of Nursing Facilities[f]												
Entire year	8.9	395	7.6	3.3	3.7	4.9	23.1	35.3	29.7	5,166	2,299	17,547
Part year	8.0	374	8.8	5.3	6.2	6.6	25.8	30.5	25.6	4,230	2,216	17,228
None	1.8	126	19.0	53.9	26.0	5.7	7.5	4.7	2.2	660	162,513	785,201
Maintenance Assistance Status												
Cash	2.2	154	22.0	51.8	24.5	6.1	8.8	6.0	2.9	699	110,308	539,595
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.4	19	5.4	66.0	27.6	3.8	2.1	0.3	0.1	361	26,440	104,049
Other/unknown	2.7	152	10.1	43.9	26.9	6.1	10.0	8.0	5.1	1,514	30,280	176,332

Source: Data for this table are from the MAX 2003 file for Nevada, released by CMS in 04/2007. 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]

NEVADA, 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	**2.1**	**$137**	**$65**	**0.9**	**$104**	**$116**	**0.1**	**$3**	**$56**	**1.1**	**$29**	**$25**
Age												
5 and younger	0.4	36	96	0.1	31	242	0.0	0	41	0.2	4	17
6-14	0.5	43	78	0.3	35	126	0.0	1	70	0.3	6	25
15-20	0.8	63	83	0.4	51	140	0.0	2	103	0.4	10	26
21-44	2.0	159	79	0.8	124	147	0.1	4	73	1.1	31	28
45-64	5.5	374	68	2.3	279	121	0.1	8	63	3.0	86	28
65-74	5.1	259	51	2.3	191	84	0.1	5	39	2.7	63	24
75-84	5.5	257	47	2.4	187	77	0.1	5	34	2.9	64	22
85 and older	5.7	227	40	2.2	158	70	0.1	4	29	3.3	64	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.4	251	47	2.3	182	78	0.1	5	35	2.9	63	22
Disabled	4.1	329	80	1.8	257	144	0.1	7	71	2.2	64	29
Adults	1.0	45	47	0.3	31	92	0.0	1	43	0.6	13	21
Children	0.4	23	59	0.2	18	109	0.0	0	53	0.2	4	20
Unknown	1.4	57	42	0.6	49	76	0.0	0	0	0.7	9	12
Gender												
Female	2.5	144	59	1.0	107	103	0.1	3	50	1.3	34	25
Male	1.6	126	79	0.7	101	144	0.0	3	69	0.9	22	26
Unknown	0.4	20	53	0.1	15	119	0.0	0	40	0.2	4	18
Race												
White	2.5	163	66	1.0	124	118	0.1	4	56	1.4	35	26
African American	1.8	121	67	0.7	93	125	0.0	2	63	1.0	25	25
Other/unknown	1.4	89	63	0.7	69	106	0.0	1	51	0.7	18	25
Use of Nursing Facilities[e]												
Entire year	8.9	395	45	3.4	278	81	0.2	7	34	5.2	110	21
Part year	8.0	374	47	3.1	267	87	0.2	9	36	4.7	98	21
None	1.8	126	69	0.8	97	122	0.0	3	61	1.0	26	26
Maintenance Assistance Status												
Cash	2.2	154	70	1.0	119	123	0.1	3	61	1.2	32	27
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.4	19	47	0.2	14	92	0.0	1	50	0.2	5	19
Other/unknown	2.7	152	56	1.1	115	100	0.1	3	45	1.5	34	23

Source: Data for this table are from the MAX 2003 file for Nevada, released by CMS in 04/2007. 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 Nevada, 0.4 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]

NEVADA, 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	0.4	0.2	0.0	0.2	$30	$25	$0	$5	$79	$141	$82	$25	132,234	$10,430,694	48,952	29.3 %	345,267
Biologicals	0.2	0.2	0.0	0.0	175	143	0	31	772	711	0	1,268	2,888	2,228,990	1,530	0.9	12,764
Antineoplastic Agents	0.6	0.2	0.0	0.4	127	96	2	29	213	426	157	81	6,206	1,320,685	1,324	0.8	10,439
Endocrine/Metabolic Drugs	1.0	0.5	0.1	0.4	45	33	2	9	45	70	23	22	161,668	7,343,076	21,547	12.9	163,958
Cardiovascular Agents	1.9	0.8	0.0	1.1	74	51	1	22	39	65	37	20	312,503	12,124,318	20,720	12.4	164,936
Respiratory Agents	0.7	0.4	0.0	0.3	39	30	0	8	52	75	66	24	183,245	9,605,859	35,304	21.1	249,058
Gastrointestinal Agents	0.7	0.2	0.0	0.5	48	31	1	15	65	145	145	30	82,391	5,392,389	14,165	8.5	112,631
Genitourinary Agents	0.5	0.4	0.0	0.1	29	27	0	2	60	72	61	21	23,246	1,385,457	6,284	3.8	47,279
CNS Drugs	1.4	0.7	0.0	0.7	125	104	3	18	89	145	124	27	271,938	24,155,003	25,012	15.0	193,168
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	66	54	3	9	86	95	73	56	17,290	1,480,893	2,808	1.7	22,488
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	100	97	0	3	141	144	0	77	8,815	1,242,885	1,533	0.9	12,455
Analgesics and Anesthetics	0.9	0.2	0.0	0.7	61	42	2	18	69	201	104	27	214,695	14,819,050	32,787	19.6	241,250
Neuromuscular Agents	1.1	0.4	0.0	0.6	79	58	2	19	73	131	65	31	129,362	9,483,066	15,386	9.2	120,297
Nutritional Products	0.5	0.0	0.0	0.5	9	1	0	8	17	27	17	16	44,311	733,575	11,671	7.0	84,950
Hematological Agents	1.0	0.4	0.1	0.5	130	121	2	7	133	279	27	15	46,108	6,134,397	5,883	3.5	47,306
Topical Products	0.4	0.2	0.0	0.2	18	13	0	5	45	69	49	24	69,950	3,143,356	23,421	14.0	176,743
Miscellaneous Products	0.6	0.2	0.0	0.4	93	66	10	17	160	338	281	49	3,439	549,988	743	0.4	5,937
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	19	0	0	0	73	0	0	0	5,038	365,585	2,523	1.5	18,849
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.	1,715,327	111,939,266	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Nevada, released by CMS in 04/2007. 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 Nevada, 0.4 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]

NEVADA, 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
ANTIPSYCHOTICS	$10,858,072	8,773	5.3 %	72,530	0.8	$197	$150
ANALGESICS - Narcotic	7,946,963	28,294	16.9	220,020	0.5	70	36
ANTICONVULSANT	5,610,390	8,287	5.0	67,249	0.9	91	83
ANTIDEPRESSANTS	5,423,863	14,917	8.9	117,916	0.7	63	46
ANTIASTHMATIC	4,050,092	19,068	11.4	147,305	0.5	58	27
MISC. HEMATOLOGICAL	3,418,638	1,955	1.2	16,048	0.8	262	213
ANTIVIRAL	3,294,383	1,946	1.2	15,476	0.6	368	213
ANTIHYPERLIPIDEMIC	3,114,980	5,163	3.1	42,949	0.9	82	73
ANTIDIABETIC	2,915,644	6,933	4.2	55,832	0.9	55	52
ANTIHYPERTENSIVE	2,626,092	10,520	6.3	85,632	0.8	37	31
Total	49,259,117	105,856		840,957	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Nevada, released by CMS in 04/2007. 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.