STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2004
ARKANSAS

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
ARKANSAS, 2004

Inclusion Criteria (2004)	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]	708,286	(A)	95,454	(E)	612,832	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	678,342	(B)	68,608	(F)	609,734	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	678,342	(C)	68,608	(G)	609,734	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	13,105	(D)	11,881	(H)	1,224	(L)

Source: Data for this table are from the MAX 2004 file for Arkansas, released by CMS in 11/2007. This table was produced on 02/27/2008.

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 2004 (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 2004, 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 Arkansas in 2004 was $406,334,677, of which $8,762,465 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 23 states in 2004 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NY, OK, OR, PA, SC, 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) and one state (NV) in which MC plans provided a pharmacy benefit for nonduals but not for duals. These lists were constructed from the CMS 2004 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer04.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 pa

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 2004. 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 2004. 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]

ARKANSAS, 2004

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	Inclusion Criteria (2004)	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**678,342**	**45,345**	**91,887**	**168,918**	**371,746**	**446**	**6,796,706**	**480,822**	**964,356**	**1,580,297**	**3,767,654**	**3,577**
Age												
5 and younger	148,444	0	5,397	68	142,978	1	1,443,022	0	57,361	593	1,385,057	11
6-14	181,292	0	11,353	64	169,875	0	1,910,513	0	125,797	622	1,784,094	0
15-20	98,312	0	7,689	31,758	58,864	1	969,500	0	84,020	287,222	598,250	8
21-44	162,403	0	30,814	131,432	29	128	1,571,582	0	326,913	1,243,400	253	1,016
45-64	42,404	0	36,526	5,572	0	306	420,741	0	369,915	48,351	0	2,475
65-74	14,642	14,505	108	19	0	10	156,888	156,386	350	85	0	67
75-84	16,002	16,000	0	2	0	0	171,179	171,176	0	3	0	0
85 and older	14,843	14,840	0	3	0	0	153,281	153,260	0	21	0	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Gender												
Female	424,896	34,095	46,941	158,386	185,028	446	4,249,961	365,408	499,490	1,497,194	1,884,292	3,577
Male	251,557	11,205	44,876	10,370	185,106	0	0 2,530,964	115,020	464,424	82,048	1,869,472	0
Unknown	1,889	45	70	162	1,612	0	15,781	394	442	1,055	13,890	0
Race												
White	419,603	30,365	52,596	110,625	225,679	338	4,189,836	316,091	547,454	1,034,748	2,288,807	2,736
African American	204,533	12,133	28,297	51,358	112,645	100	2,083,637	133,510	303,763	493,060	1,152,532	772
Other/unknown	54,206	2,847	10,994	6,935	33,422	8	523,233	31,221	113,139	52,489	326,315	69
Use of Nursing Facilities[c]												
Entire year	13,105	11,451	1,654	0	0	0	134,958	117,123	17,835	0	0	0
Part year	4,884	4,155	727	2	0	0	48,653	41,179	7,453	21	0	0
None	660,353	29,739	89,506	168,916	371,746	446	6,613,095	322,520	939,068	1,580,276	3,767,654	3,577
Maintenance Assistance Status												
Cash	154,584	23,897	79,447	21,506	29,734	0	1,607,750	270,959	850,705	188,537	297,549	0
Medically needy	11,055	479	3,245	5,168	2,163	0	73,334	1,782	15,049	35,605	20,898	0
Poverty-related	273,122	185	438	33,961	238,092	446	2,645,207	1,831	3,758	258,564	2,377,477	3,577
Other/unknown	239,581	20,784	8,757	108,283	101,757	0	2,470,415	206,250	94,844	1,097,591	1,071,730	0
Dual Medicare Status[d]												
Full dual, all year	66,701	39,733	25,785	1,147	5	31	703,541	421,589	271,498	10,160	55	239
Full dual, part year	1,907	1,047	823	37	0	0	19,308	11,175	7,740	393	0	0
Non-dual, all year	609,734	4,565	65,279	167,734	371,741	415	6,073,857	48,058	685,118	1,569,744	3,767,599	3,338
Managed Care (MC) Status												
Fee-for-service (FFS) all year	678,342	45,345	91,887	168,918	371,746	446	6,796,706	480,822	964,356	1,580,297	3,767,654	3,577
FFS part year, with Rx claims	0	0	0	0	0	0		0	0	0	0	0
FFS part year, no Rx claims	0	0	0	0	0	0		0	0	0	0	0

0

0

Source: Data for this table are from the MAX 2004 file for Arkansas, released by CMS in 11/2007. This table was produced on 02/27/2008.

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 2004. 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]

ARKANSAS, 2004

Beneficiary Characteristics	Inclusion Criteria (2004)	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	**61.6 %**	**9.3**	**$586**	**$63**	**$3,585**	**16.3 %**	**678,342**
Age							
5 and younger	72.6	5.3	230	43	2,423	9.5	148,444
6-14	62.6	5.1	363	71	1,720	21.1	181,292
15-20	55.5	5.0	351	71	2,342	15.0	98,312
21-44	42.2	6.0	467	78	2,634	17.7	162,403
45-64	78.9	27.5	1,977	72	9,269	21.3	42,404
65-74	86.5	38.1	2,207	58	11,237	19.6	14,642
75-84	89.6	45.4	2,445	54	15,830	15.4	16,002
85 and older	87.1	44.6	2,149	48	19,632	10.9	14,843
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	87.9	42.9	2,277	53	15,627	14.6	45,345
Disabled	81.5	23.0	2,031	88	10,737	18.9	91,887
Adults	36.7	3.1	138	45	948	14.5	168,918
Children	64.8	4.6	226	49	1,537	14.7	371,746
Unknown	88.6	14.5	1,200	83	11,553	10.4	446
Gender							
Female	58.5	9.7	557	58	3,335	16.7	424,896
Male	67.0	8.7	638	74	4,020	15.9	251,557
Unknown	52.9	5.0	256	52	1,853	13.8	1,889
Race							
White	63.6	10.4	658	63	3,868	17.0	419,603
African American	58.3	7.4	442	60	3,064	14.4	204,533
Other/unknown	58.8	7.7	572	75	3,361	17.0	54,206
Use of Nursing Facilities[f]							
Entire year	98.5	73.8	4,028	55	37,794	10.7	13,105
Part year	96.2	50.7	2,864	57	24,862	11.5	4,884
None	60.6	7.7	501	65	2,749	18.2	660,353
Maintenance Assistance Status							
Cash	77.1	18.7	1,394	74	6,304	22.1	154,584
Medically needy	67.3	8.5	636	75	4,385	14.5	11,055
Poverty related	66.0	4.7	213	46	1,674	12.7	273,122
Other/unknown	46.3	8.5	488	58	3,972	12.3	239,581

Source: Data for this table are from the MAX 2004 file for Arkansas, released by CMS in 11/2007. This table was produced on 02/27/2008.

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]

ARKANSAS, 2004

Beneficiary Characteristics	Inclusion Criteria (2004)	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: 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]	Number Beneficiaries	Benefit Months
All	**0.9**	**$59**	**16.3 %**	**38.4 %**	**44.3 %**	**6.3 %**	**7.9 %**	**2.7 %**	**0.4 %**	**$358**	**678,342**	**6,796,706**
Age												
5 and younger	0.5	24	9.5	27.4	64.3	5.9	2.1	0.2	0.0	249	148,444	1,443,022
6-14	0.5	35	21.1	37.4	54.3	4.8	3.1	0.4	0.0	163	181,292	1,910,513
15-20	0.5	36	15.0	44.5	47.2	4.8	3.0	0.5	0.1	238	98,312	969,500
21-44	0.6	48	17.7	57.8	28.9	5.8	6.5	1.0	0.0	272	162,403	1,571,582
45-64	2.8	199	21.3	21.1	18.5	14.1	33.8	11.4	1.1	934	42,404	420,741
65-74	3.6	206	19.6	13.5	14.7	12.0	39.0	17.8	3.1	1,049	14,642	156,888
75-84	4.2	229	15.4	10.4	11.1	11.2	38.3	23.3	5.7	1,480	16,002	171,179
85 and older	4.3	208	10.9	12.9	9.6	10.3	35.7	25.8	5.6	1,901	14,843	153,281
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	4.0	215	14.6	12.1	11.8	11.1	37.7	22.4	4.8	1,474	45,345	480,822
Disabled	2.2	194	18.9	18.5	31.3	14.5	27.2	7.8	0.7	1,023	91,887	964,356
Adults	0.3	15	14.5	63.3	30.4	3.7	2.4	0.1	0.0	101	168,918	1,580,297
Children	0.5	22	14.7	35.2	57.8	4.8	2.0	0.1	0.0	152	371,746	3,767,654
Unknown	1.8	150	10.4	11.4	37.0	25.6	24.7	1.3	0.0	1,441	446	3,577
Gender												
Female	1.0	56	16.7	41.5	40.7	5.9	8.3	3.1	0.5	334	424,896	4,249,961
Male	0.9	63	15.9	33.0	50.4	7.0	7.3	1.9	0.3	400	251,557	2,530,964
Unknown	0.6	31	13.8	47.1	43.2	4.6	3.9	0.9	0.3	222	1,889	15,781
Race												
White	1.0	66	17.0	36.4	44.3	6.7	8.7	3.3	0.6	387	419,603	4,189,836
African American	0.7	43	14.4	41.7	44.3	5.7	6.5	1.6	0.2	301	204,533	2,083,637
Other/unknown	0.8	59	17.0	41.2	44.2	5.5	7.1	1.9	0.1	348	54,206	523,233
Use of Nursing Facilities[f]												
Entire year	7.2	391	10.7	1.5	3.6	5.1	27.1	44.5	18.2	3,670	13,105	134,958
Part year	5.1	288	11.5	3.8	10.2	9.8	37.7	32.1	6.5	2,496	4,884	48,653
None	0.8	50	18.2	39.4	45.4	6.3	7.3	1.6	0.0	275	660,353	6,613,095
Maintenance Assistance Status												
Cash	1.8	134	22.1	22.9	36.3	12.4	22.3	5.9	0.2	606	154,584	1,607,750
Medically needy	1.3	96	14.5	32.7	32.4	14.2	18.6	2.0	0.0	661	11,055	73,334
Poverty related	0.5	22	12.7	34.0	58.6	5.2	2.1	0.1	0.0	173	273,122	2,645,207
Other/unknown	0.8	47	12.3	53.7	33.7	3.3	4.8	3.5	1.0	385	239,581	2,470,415

Source: Data for this table are from the MAX 2004 file for Arkansas, released by CMS in 11/2007. This table was produced on 02/27/2008.

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]

ARKANSAS, 2004

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Criteria (2004)	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**0.9**	**$59**	**$63**	**0.4**	**$44**	**$115**	**0.1**	**$4**	**$58**	**0.5**	**$11**	**$23**
Age												
5 and younger	0.5	24	43	0.2	17	83	0.0	2	35	0.3	5	17
6-14	0.5	35	71	0.3	28	111	0.0	1	50	0.2	5	24
15-20	0.5	36	71	0.2	27	126	0.0	2	56	0.3	7	26
21-44	0.6	48	78	0.2	36	152	0.0	3	79	0.3	9	26
45-64	2.8	199	72	1.1	144	132	0.2	15	84	1.5	41	27
65-74	3.6	206	58	1.4	148	103	0.2	13	57	1.9	45	24
75-84	4.2	229	54	1.7	164	99	0.3	14	47	2.3	50	22
85 and older	4.3	208	48	1.5	145	95	0.3	13	41	2.5	50	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	4.0	215	53	1.5	153	99	0.3	13	48	2.2	49	22
Disabled	2.2	194	88	0.9	148	162	0.1	12	85	1.1	33	29
Adults	0.3	15	45	0.1	10	83	0.0	1	54	0.2	4	20
Children	0.5	22	49	0.2	17	85	0.0	1	37	0.2	4	19
Unknown	1.8	150	83	0.7	119	175	0.1	5	67	1.1	26	25
Gender												
Female	1.0	56	58	0.4	40	106	0.1	4	55	0.5	12	23
Male	0.9	63	74	0.4	49	132	0.1	3	63	0.4	11	25
Unknown	0.6	31	52	0.3	23	90	0.0	2	45	0.3	6	20
Race												
White	1.0	66	63	0.4	49	114	0.1	4	60	0.5	13	24
African American	0.7	43	60	0.3	32	112	0.0	3	51	0.4	9	23
Other/unknown	0.8	59	75	0.3	46	139	0.1	3	58	0.4	11	26
Use of Nursing Facilities[e]												
Entire year	7.2	391	55	2.6	281	108	0.5	24	48	4.0	86	21
Part year	5.1	288	57	1.9	208	109	0.4	18	49	2.8	62	22
None	0.8	50	65	0.3	38	117	0.0	3	60	0.4	10	24
Maintenance Assistance Status												
Cash	1.8	134	74	0.7	100	137	0.1	8	72	1.0	25	27
Medically needy	1.3	96	75	0.5	71	147	0.1	7	96	0.7	18	25
Poverty related	0.5	22	46	0.2	16	82	0.0	1	36	0.3	5	18
Other/unknown	0.8	47	58	0.3	35	104	0.1	3	50	0.4	9	22

Source: Data for this table are from the MAX 2004 file for Arkansas, released by CMS in 11/2007. This table was produced on 02/27/2008.

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 Arkansas, 0.3 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all 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]

ARKANSAS, 2004

	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
Therapeutic Category	Criteria (2004)	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	0.2	0.1	0.0	0.1	$12	$8	$1	$3	$48	$87	$65	$21	727,838	$35,125,764	279,660	41.2 %	3,048,794
Biologicals	0.3	0.3	0.0	0.0	421	341	6	75	1266	1,152	1,129	2,356	4,154	5,260,927	1,320	0.2	12,484
Antineoplastic Agents	0.5	0.1	0.0	0.4	81	53	1	27	156	576	131	64	25,408	3,954,681	4,699	0.7	49,110
Endocrine/Metabolic Drugs	0.5	0.2	0.1	0.2	27	20	3	5	56	92	33	24	591,315	32,880,272	110,572	16.3	1,207,087
Cardiovascular Agents	1.2	0.5	0.1	0.7	48	32	2	14	39	70	34	19	1,034,506	40,066,128	76,986	11.3	827,864
Respiratory Agents	0.4	0.2	0.0	0.2	19	15	0	3	51	80	21	19	784,215	39,694,855	195,787	28.9	2,142,899
Gastrointestinal Agents	0.5	0.2	0.0	0.3	30	21	2	7	64	139	65	25	323,382	20,832,495	63,364	9.3	684,742
Genitourinary Agents	0.3	0.2	0.0	0.1	20	16	2	3	64	82	54	28	92,038	5,869,847	27,078	4.0	291,115
CNS Drugs	0.7	0.4	0.0	0.4	72	60	2	10	96	167	82	27	850,066	81,916,500	105,396	15.5	1,137,274
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	55	51	0	4	93	101	51	44	191,963	17,844,176	29,382	4.3	327,056
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	126	124	0	1	168	174	96	41	60,388	10,171,346	7,622	1.1	80,899
Analgesics and Anesthetics	0.4	0.1	0.0	0.3	17	11	1	6	48	160	199	20	570,465	27,600,403	146,723	21.6	1,583,804
Neuromuscular Agents	0.7	0.2	0.1	0.3	58	35	12	11	87	154	104	33	376,573	32,947,943	52,352	7.7	569,119
Nutritional Products	0.4	0.0	0.0	0.4	7	0	0	6	17	13	19	17	147,509	2,556,668	35,537	5.2	373,046
Hematological Agents	0.7	0.3	0.1	0.4	107	91	3	14	157	344	47	39	139,186	21,854,861	19,039	2.8	203,311
Topical Products	0.2	0.1	0.0	0.1	10	6	1	3	46	77	48	24	343,488	15,789,780	147,211	21.7	1,619,430
Miscellaneous Products	0.1	0.1	0.0	0.0	20	15	2	3	140	148	399	90	19,399	2,706,218	12,383	1.8	134,451
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	6	0	0	0	28	0	0	0	17,643	499,348	7,251	1.1	81,312
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.	6,299,536	397,572,212	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Arkansas, released by CMS in 11/2007. This table was produced on 02/27/2008.

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 Arkansas, 0.3 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.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 2004.

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]

ARKANSAS, 2004

		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	$50,874,562	38,657	5.7 %	426,898	0.5	$222	$119
ANTICONVULSANT	27,501,067	37,803	5.6	415,542	0.6	106	66
ANTIDEPRESSANTS	25,182,607	78,755	11.6	852,747	0.5	63	30
ANTIASTHMATIC	22,959,602	110,814	16.3	1,223,739	0.3	70	19
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	17,844,176	36,349	5.4	407,724	0.5	93	44
MISC. HEMATOLOGICAL	17,357,136	9,185	1.4	98,634	0.6	285	176
ANALGESICS - Narcotic	15,825,483	151,232	22.3	1,634,532	0.2	42	10
ULCER DRUGS	14,893,139	53,637	7.9	583,140	0.4	65	26
ANTIDIABETIC	13,776,055	30,476	4.5	332,456	0.6	67	41
ANTIHYPERTENSIVE	12,497,215	49,862	7.4	545,330	0.6	39	23
Total	218,711,042	596,770		6,520,742	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Arkansas, released by CMS in 11/2007. This table was produced on 02/27/2008.

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 2004. 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 2004. 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.