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

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
ARIZONA, 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]	1,422,960	(A)	128,314	(E)	1,294,646	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1,273,536	(B)	109,333	(F)	1,164,203	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	326,299	(C)	53,222	(G)	273,077	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	455	(D)	338	(H)	117	(L)

Source: Data for this table are from the MAX 2004 file for Arizona, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 Arizona in 2004 was $4,171,898, of which $108,528 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]

ARIZONA, 2004

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**326,299**	**29,022**	**62,027**	**136,307**	**98,943**	**0**	**1,797,113**	**232,466**	**418,070**	**587,697**	**558,880**	**0**
Age												
5 and younger	26,440	0	3,357	0	23,083	0	197,534	0	32,185	0	165,349	0
6-14	42,707	0	6,081	0	36,626	0	305,111	0	60,860	0	244,251	0
15-20	62,821	0	5,759	17,831	39,231	0	252,715	0	35,526	67,914	149,275	0
21-44	113,136	2	17,961	95,170	3	0	511,158	4	105,519	405,630	5	0
45-64	44,186	11	21,452	22,723	0	0	243,571	34	131,943	111,594	0	0
65-74	13,146	7,604	5,090	452	0	0	95,650	57,219	36,411	2,020	0	0
75-84	13,591	11,602	1,881	108	0	0	104,739	91,920	12,349	470	0	0
85 and older	10,271	9,802	446	23	0	0	86,623	83,277	3,277	69	0	0
Unknown	1	1	0	0	0	0	12	12	0	0	0	0
Gender												
Female	194,521	20,749	33,094	90,844	49,834	0	1,027,720	167,932	205,270	373,050	281,468	0
Male	131,778	8,273	28,933	45,463	49,109	0	769,393	64,534	212,800	214,647	277,412	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	86,899	16,345	27,192	29,955	13,407	0	390,732	134,136	174,480	56,521	25,595	0
African American	16,844	962	4,503	7,381	3,998	0	48,261	7,564	18,417	14,366	7,914	0
Other/unknown	222,556	11,715	30,332	98,971	81,538	0	1,358,120	90,766	225,173	516,810	525,371	0
Use of Nursing Facilities[c]												
Entire year	455	315	138	1	1	0	4,141	2,808	1,330	1	2	0
Part year	631	302	300	25	4	0	6,503	3,034	3,156	281	32	0
None	325,213	28,405	61,589	136,281	98,938	0	1,786,469	226,624	413,584	587,415	558,846	0
Maintenance Assistance Status												
Cash	165,121	7,214	43,331	70,134	44,442	0	913,353	52,984	266,941	304,017	289,411	0
Medically needy	0	0	0	0	0	0		0	0	0	0	0
Poverty-related	53,239	2,205	2,531	5,051	43,452	0	252,014	10,596	8,811	17,532	215,075	0
Other/unknown	107,939	19,603	16,165	61,122	11,049	0	631,746	168,886	142,318	266,148	54,394	0
Dual Medicare Status[d]						0						
Full dual, all year	52,682	27,179	23,049	2,451	3	0	381,517	220,199	152,539	8,762	17	0
Full dual, part year	540	289	230	21	0	0	2,524	1,581	887	56	0	0
Non-dual, all year	273,077	1,554	38,748	133,835	98,940	0	1,413,072	10,686	264,644	578,879	558,863	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	154,175	22,558	30,385	50,624	50,608	0	1,409,466	214,143	340,111	404,333	450,879	0
FFS part year, with Rx claims	896	43	153	305	395	0	4,978	247	1,063	1,694	1,974	0
FFS part year, no Rx claims	171,228	6,421	31,489	85,378	47,940	0	382,669	18,076	76,896	181,670	106,027	0

Source: Data for this table are from the MAX 2004 file for Arizona, released by CMS in 00/2007. This table was produced on 04/10/2008.

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]

ARIZONA, 2004

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	**2.2 %**	**0.2**	**$13**	**$55**	**$6,752**	**0.2 %**	**326,299**
Age							
5 and younger	4.5	0.1	7	62	7,106	0.1	26,440
6-14	2.3	0.1	5	62	5,478	0.1	42,707
15-20	1.2	0.1	6	112	3,889	0.2	62,821
21-44	1.6	0.1	10	73	4,507	0.2	113,136
45-64	2.5	0.4	21	50	8,887	0.2	44,186
65-74	4.9	1.0	43	44	13,740	0.3	13,146
75-84	3.7	0.8	30	38	17,205	0.2	13,591
85 and older	3.1	0.6	21	33	21,422	0.1	10,271
Unknown	0.0	0.0	0	0	1,110	0.0	1
Basis of Eligibility[e]							
Aged	3.3	0.8	31	40	18,845	0.2	29,022
Disabled	3.2	0.6	40	69	17,898	0.2	62,027
Adults	1.3	0.1	3	42	2,165	0.1	136,307
Children	2.6	0.1	3	41	2,538	0.1	98,943
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	2.3	0.2	10	46	6,809	0.1	194,521
Male	2.2	0.2	16	66	6,668	0.2	131,778
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	0.2	0.0	0	43	11,140	0.0	86,899
African American	0.2	0.0	0	25	5,888	0.0	16,844
Other/unknown	3.2	0.3	18	55	5,105	0.4	222,556
Use of Nursing Facilities[f]							
Entire year	76.0	41.6	1,793	43	53,905	3.3	455
Part year	81.5	22.7	969	43	60,731	1.6	631
None	2.0	0.1	8	64	6,582	0.1	325,213
Maintenance Assistance Status							
Cash	3.0	0.3	17	59	6,737	0.3	165,121
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	1.9	0.1	4	58	2,322	0.2	53,239
Other/unknown	1.2	0.2	9	44	8,961	0.1	107,939

Source: Data for this table are from the MAX 2004 file for Arizona, released by CMS in 00/2007. This table was produced on 04/10/2008.

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]

ARIZONA, 2004

Beneficiary Characteristics	Mean Number of Rx	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	**0.0**	**$2**	**0.2 %**	**97.8 %**	**1.8 %**	**0.2 %**	**0.2 %**	**0.1 %**	**0.0 %**	**$1,226**	**326,299**	**1,797,113**
Age												
5 and younger	0.0	1	0.1	95.5	4.4	0.1	0.0	0.0	0.0	951	26,440	197,534
6-14	0.0	1	0.1	97.7	2.1	0.1	0.0	0.0	0.0	767	42,707	305,111
15-20	0.0	2	0.2	98.8	1.1	0.1	0.0	0.0	0.0	967	62,821	252,715
21-44	0.0	2	0.2	98.4	1.4	0.1	0.1	0.0	0.0	998	113,136	511,158
45-64	0.1	4	0.2	97.5	1.8	0.2	0.4	0.1	0.0	1,612	44,186	243,571
65-74	0.1	6	0.3	95.1	2.9	0.6	1.0	0.3	0.1	1,888	13,146	95,650
75-84	0.1	4	0.2	96.3	2.1	0.5	0.7	0.4	0.1	2,233	13,591	104,739
85 and older	0.1	2	0.1	96.9	1.5	0.5	0.9	0.3	0.0	2,540	10,271	86,623
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	93	1	12
Basis of Eligibility[e]												
Aged	0.1	4	0.2	96.7	1.6	0.5	0.8	0.4	0.1	2,353	29,022	232,466
Disabled	0.1	6	0.2	96.8	2.2	0.3	0.4	0.2	0.0	2,655	62,027	418,070
Adults	0.0	1	0.1	98.7	1.2	0.1	0.0	0.0	0.0	502	136,307	587,697
Children	0.0	1	0.1	97.4	2.5	0.1	0.0	0.0	0.0	449	98,943	558,880
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	0.1	97.7	1.9	0.2	0.2	0.1	0.0	1,289	194,521	1,027,720
Male	0.0	3	0.2	97.8	1.7	0.2	0.2	0.1	0.0	1,142	131,778	769,393
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	0	0.0	99.8	0.1	0.0	0.0	0.0	0.0	2,478	86,899	390,732
African American	0.0	0	0.0	99.8	0.1	0.0	0.0	0.0	0.0	2,055	16,844	48,261
Other/unknown	0.1	3	0.4	96.8	2.6	0.2	0.3	0.1	0.0	837	222,556	1,358,120
Use of Nursing Facilities[f]												
Entire year	4.6	197	3.3	24.0	6.2	8.4	31.0	24.2	6.4	5,923	455	4,141
Part year	2.2	94	1.6	18.5	37.6	12.0	20.0	9.5	2.4	5,893	631	6,503
None	0.0	2	0.1	98.0	1.7	0.1	0.1	0.0	0.0	1,198	325,213	1,786,469
Maintenance Assistance Status												
Cash	0.1	3	0.3	97.0	2.5	0.2	0.2	0.1	0.0	1,218	165,121	913,353
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	0.2	98.1	1.8	0.1	0.1	0.0	0.0	491	53,239	252,014
Other/unknown	0.0	2	0.1	98.8	0.8	0.1	0.2	0.1	0.0	1,531	107,939	631,746

Source: Data for this table are from the MAX 2004 file for Arizona, released by CMS in 00/2007. This table was produced on 04/10/2008.

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]

ARIZONA, 2004

	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**	**$2**	**$55**	**0.0**	**$2**	**$174**	**0.0**	**$0**	**$62**	**0.0**	**$1**	**$17**
Age												
5 and younger	0.0	1	62	0.0	1	279	0.0	0	43	0.0	0	12
6-14	0.0	1	62	0.0	1	154	0.0	0	86	0.0	0	20
15-20	0.0	2	112	0.0	1	329	0.0	0	120	0.0	0	22
21-44	0.0	2	73	0.0	2	288	0.0	0	92	0.0	0	17
45-64	0.1	4	50	0.0	3	152	0.0	0	74	0.1	1	19
65-74	0.1	6	44	0.0	4	131	0.0	0	48	0.1	2	16
75-84	0.1	4	38	0.0	3	101	0.0	0	38	0.1	1	15
85 and older	0.1	2	33	0.0	2	90	0.0	0	29	0.1	1	14
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.1	4	40	0.0	3	112	0.0	0	40	0.1	1	15
Disabled	0.1	6	69	0.0	5	226	0.0	0	78	0.1	1	19
Adults	0.0	1	42	0.0	0	187	0.0	0	67	0.0	0	15
Children	0.0	1	41	0.0	0	117	0.0	0	74	0.0	0	15
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	0.0	2	46	0.0	1	144	0.0	0	58	0.0	1	16
Male	0.0	3	66	0.0	2	209	0.0	0	68	0.0	1	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.0	0	43	0.0	0	116	0.0	0	44	0.0	0	20
African American	0.0	0	25	0.0	0	79	0.0	0	79	0.0	0	16
Other/unknown	0.1	3	55	0.0	2	174	0.0	0	62	0.0	1	17
Use of Nursing Facilities[e]												
Entire year	4.6	197	43	1.1	126	116	0.3	14	54	3.2	57	18
Part year	2.2	94	43	0.5	59	124	0.1	6	58	1.6	29	18
None	0.0	2	64	0.0	1	217	0.0	0	70	0.0	0	16
Maintenance Assistance Status												
Cash	0.1	3	59	0.0	2	204	0.0	0	68	0.0	1	17
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.0	1	58	0.0	1	149	0.0	0	85	0.0	0	17
Other/unknown	0.0	2	44	0.0	1	124	0.0	0	48	0.0	0	17

Source: Data for this table are from the MAX 2004 file for Arizona, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 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, 2004

	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
Therapeutic Category	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.2	0.1	0.0	0.2	$14	$9	$1	$4	$62	$145	$132	$25	8,582	$531,948	3,766	1.2 %	39,097
Biologicals	0.2	0.1	0.0	0.1	154	70	24	60	918	1,256	1,723	610	24	22,033	16	0.0	143
Antineoplastic Agents	0.4	0.1	0.0	0.3	89	71	1	18	224	699	188	60	252	56,354	63	0.0	631
Endocrine/Metabolic Drugs	0.5	0.1	0.1	0.3	20	14	1	5	40	115	16	16	7,930	315,820	1,477	0.5	15,561
Cardiovascular Agents	0.8	0.1	0.0	0.7	19	10	0	9	24	72	20	14	12,925	304,832	1,515	0.5	16,120
Respiratory Agents	0.3	0.1	0.0	0.2	10	7	0	2	35	86	31	12	4,863	169,042	1,707	0.5	17,563
Gastrointestinal Agents	0.4	0.1	0.0	0.3	24	20	0	4	66	234	73	13	4,008	264,435	1,025	0.3	10,975
Genitourinary Agents	0.3	0.1	0.0	0.2	13	9	0	3	44	82	37	19	1,440	63,860	463	0.1	5,006
CNS Drugs	0.6	0.2	0.0	0.4	43	33	2	8	70	155	74	21	8,295	580,338	1,274	0.4	13,618
Stimulants/Anti-obesity/Anorexia	0.5	0.3	0.0	0.2	30	23	0	6	64	89	123	30	463	29,460	92	0.0	992
Miscellaneous Psychological/ Neurological Agents	0.6	0.5	0.0	0.0	113	112	0	1	202	204	0	103	267	54,002	49	0.0	480
Analgesics and Anesthetics	0.3	0.0	0.0	0.3	11	8	0	3	34	223	199	12	11,299	382,879	3,155	1.0	33,503
Neuromuscular Agents	0.6	0.1	0.1	0.3	36	17	10	9	64	127	78	30	4,913	312,874	815	0.2	8,643
Nutritional Products	0.4	0.0	0.0	0.4	8	1	0	7	18	70	5	17	2,890	51,956	643	0.2	6,578
Hematological Agents	0.5	0.2	0.0	0.2	155	152	1	3	339	836	20	12	2,006	679,095	421	0.1	4,368
Topical Products	0.2	0.0	0.0	0.1	7	4	0	2	36	119	64	17	3,471	125,419	1,735	0.5	18,476
Miscellaneous Products	0.4	0.3	0.0	0.1	126	118	2	6	302	383	342	56	368	111,171	88	0.0	885
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	4	0	0	0	16	0	0	0	504	7,852	161	0.0	1,794
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.	74,500	4,063,370	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Arizona, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 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 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]

ARIZONA, 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
MISC. HEMATOLOGICAL	$481,194	81	0.0 %	881	0.5	$1,089	$546
ANTIPSYCHOTICS	399,777	560	0.2	6,105	0.4	157	65
ANTICONVULSANT	256,094	601	0.2	6,571	0.5	74	39
ANTIDIABETIC	227,041	1,254	0.4	13,877	0.4	39	16
ANALGESICS - Narcotic	181,863	2,280	0.7	24,406	0.3	25	7
ANALGESICS - ANTI-INFLAMMATORY	174,363	2,145	0.7	23,391	0.2	44	7
MISC. GI	161,218	374	0.1	3,927	0.4	116	41
ANTIDEPRESSANTS	160,732	887	0.3	9,609	0.4	41	17
HEMATOPOIETIC AGENTS	155,260	355	0.1	3,701	0.2	171	42
ANTIASTHMATIC	132,737	1,435	0.4	14,773	0.2	39	9
Total	2,330,279	9,972		107,241	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Arizona, released by CMS in 00/2007. This table was produced on 04/10/2008.

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.