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

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
MICHIGAN, 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]	1,793,901	(A)	238,835	(E)	1,555,066	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1,648,202	(B)	221,317	(F)	1,426,885	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	980,110	(C)	216,329	(G)	763,781	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	25,334	(D)	23,899	(H)	1,435	(L)

Source: Data for this table are from the MAX 2004 file for Michigan, released by CMS in 02/2008. This table was produced on 03/25/2008.

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 Michigan in 2004 was $868,136,765, of which $128,761,395 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]

MICHIGAN, 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	**980,110**	**94,662**	**190,690**	**198,595**	**495,301**	**862**	**5,791,987**	**935,336**	**1,715,319**	**776,599**	**2,356,836**	**7,897**
Age												
5 and younger	206,931	0	4,753	0	202,178	0	941,992	0	36,026	0	905,966	0
6-14	210,968	0	10,570	0	200,398	0	1,072,810	0	77,872	0	994,938	0
15-20	118,865	0	8,120	21,543	89,167	35	612,368	0	62,711	104,247	445,114	296
21-44	225,363	1	61,257	160,321	3,384	400	1,181,138	3	552,172	615,463	10,002	3,498
45-64	96,903	21	79,810	16,600	47	425	766,010	113	705,627	56,076	111	4,083
65-74	48,449	27,759	20,571	117	0	2	501,433	282,306	218,356	751	0	20
75-84	41,405	36,802	4,592	11	0	0	422,938	371,271	51,610	57	0	0
85 and older	31,100	30,078	1,017	3	2	0	292,602	281,640	10,945	5	12	0
Unknown	126	1	0	0	125	0	696	3	0	0	693	0
Gender												
Female	571,164	69,726	99,178	157,902	243,496	862	3,425,588	698,256	917,313	646,733	1,155,389	7,897
Male	408,946	24,936	91,512	40,693	251,805	0	2,366,399	237,080	798,006	129,866	1,201,447	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	626,752	67,659	122,841	129,371	306,208	673	3,931,833	659,627	1,139,677	529,261	1,597,127	6,141
African American	271,456	17,954	57,268	55,250	140,849	135	0 1,384,573	183,028	477,963	189,576	532,740	1,266
Other/unknown	81,902	9,049	10,581	13,974	48,244	54	475,581	92,681	97,679	57,762	226,969	490
Use of Nursing Facilities[c]												
Entire year	25,334	21,887	3,443	3	1	0	263,248	224,582	38,626	28	12	0
Part year	18,699	14,760	3,900	36	2	1	168,265	131,811	36,242	189	11	12
None	936,077	58,015	183,347	198,556	495,298	861	5,360,474	578,943	1,640,451	776,382	2,356,813	7,885
Maintenance Assistance Status												
Cash	231,396	19,744	104,803	38,139	68,710	0	1,599,176	222,623	989,966	143,825	242,762	0
Medically needy	92,616	8,501	9,740	50,781	23,594	0	378,565	64,969	55,416	171,993	86,187	0
Poverty-related	400,886	30,588	39,628	39,054	290,754	862	2,372,529	338,193	380,585	196,570	1,449,284	7,897
Other/unknown	255,212	35,829	36,519	70,621	112,243	0	1,441,717	309,551	289,352	264,211	578,603	0
Dual Medicare Status[d]												
Full dual, all year	206,541	86,147	118,355	1,972	51	16	2,113,077	866,056	1,235,383	11,090	369	179
Full dual, part year	9,788	4,547	5,219	21	1	0	96,989	46,415	50,361	205	8	0
Non-dual, all year	763,781	3,968	67,116	196,602	495,249	846	3,581,921	22,865	429,575	765,304	2,356,459	7,718
Managed Care (MC) Status												
Fee-for-service (FFS) all year	495,261	93,925	143,533	82,120	174,836	847	4,187,424	929,940	1,512,519	422,607	1,314,533	7,825
FFS part year, with Rx claims	179,147	567	33,765	60,758	84,045	12	723,818	4,404	156,700	215,899	346,748	67
FFS part year, no Rx claims	305,702	170	13,392	55,717	236,420	3	880,745	992	46,100	138,093	695,555	5

Source: Data for this table are from the MAX 2004 file for Michigan, released by CMS in 02/2008. This table was produced on 03/25/2008.

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]

MICHIGAN, 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	**49.8 %**	**13.0**	**$754**	**$58**	**$4,296**	**17.6 %**	**980,110**
Age							
5 and younger	33.3	1.3	60	45	2,047	2.9	206,931
6-14	30.3	2.4	230	95	1,390	16.6	210,968
15-20	39.7	3.4	254	75	1,985	12.8	118,865
21-44	57.4	9.9	732	74	3,955	18.5	225,363
45-64	76.5	35.0	2,265	65	8,980	25.2	96,903
65-74	85.0	47.8	2,339	49	7,159	32.7	48,449
75-84	86.7	51.2	2,248	44	12,580	17.9	41,405
85 and older	87.5	48.2	1,846	38	20,216	9.1	31,100
Unknown	0.0	0.0	0	0	1	0.0	126
Basis of Eligibility[e]							
Aged	85.1	47.6	2,056	43	13,845	14.8	94,662
Disabled	79.6	34.8	2,436	70	9,459	25.8	190,690
Adults	50.4	3.7	150	40	2,167	6.9	198,595
Children	31.2	1.7	100	58	1,328	7.5	495,301
Unknown	81.6	16.8	1,086	65	9,688	11.2	862
Gender							
Female	53.7	15.1	784	52	4,524	17.3	571,164
Male	44.3	10.1	713	71	3,979	17.9	408,946
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	54.5	15.0	863	58	4,666	18.5	626,752
African American	41.0	9.7	583	60	3,793	15.4	271,456
Other/unknown	42.5	9.1	497	54	3,133	15.9	81,902
Use of Nursing Facilities[f]							
Entire year	95.6	72.0	3,024	42	38,319	7.9	25,334
Part year	94.4	54.9	2,354	43	22,998	10.2	18,699
None	47.6	10.6	661	63	3,002	22.0	936,077
Maintenance Assistance Status							
Cash	60.6	20.7	1,334	64	5,494	24.3	231,396
Medically needy	47.9	9.0	477	53	3,386	14.1	92,616
Poverty related	42.7	9.4	530	57	2,994	17.7	400,886
Other/unknown	51.8	13.2	682	52	5,586	12.2	255,212

Source: Data for this table are from the MAX 2004 file for Michigan, released by CMS in 02/2008. This table was produced on 03/25/2008.

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]

MICHIGAN, 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	**2.2**	**$128**	**17.6 %**	**50.2 %**	**24.1 %**	**5.9 %**	**9.8 %**	**7.2 %**	**2.7 %**	**$727**	**980,110**	**5,791,987**
Age												
5 and younger	0.3	13	2.9	66.7	29.6	2.4	1.1	0.2	0.0	450	206,931	941,992
6-14	0.5	45	16.6	69.7	21.8	3.3	3.2	1.2	0.8	273	210,968	1,072,810
15-20	0.7	49	12.8	60.3	28.7	5.0	4.0	1.3	0.7	385	118,865	612,368
21-44	1.9	140	18.5	42.6	29.2	8.8	11.2	5.6	2.6	755	225,363	1,181,138
45-64	4.4	287	25.2	23.5	15.3	9.5	23.1	19.9	8.6	1,136	96,903	766,010
65-74	4.6	226	32.7	15.0	13.9	9.6	27.5	25.8	8.2	692	48,449	501,433
75-84	5.0	220	17.9	13.3	11.1	8.7	28.6	29.3	9.0	1,232	41,405	422,938
85 and older	5.1	196	9.1	12.5	9.1	8.7	30.8	31.3	7.6	2,149	31,100	292,602
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	126	696
Basis of Eligibility[e]												
Aged	4.8	208	14.8	14.9	11.7	9.0	28.2	28.0	8.1	1,401	94,662	935,336
Disabled	3.9	271	25.8	20.4	19.5	10.1	23.6	18.8	7.6	1,052	190,690	1,715,319
Adults	1.0	38	6.9	49.6	31.3	7.8	7.1	2.7	1.5	554	198,595	776,599
Children	0.4	21	7.5	68.8	25.3	2.9	2.1	0.6	0.3	279	495,301	2,356,836
Unknown	1.8	119	11.2	18.4	41.8	15.4	18.7	4.8	0.9	1,058	862	7,897
Gender												
Female	2.5	131	17.3	46.3	25.0	6.3	10.7	8.5	3.2	754	571,164	3,425,588
Male	1.7	123	17.9	55.7	22.8	5.4	8.6	5.5	2.0	688	408,946	2,366,399
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.4	138	18.5	45.5	25.7	6.3	10.8	8.4	3.4	744	626,752	3,931,833
African American	1.9	114	15.4	59.0	20.3	5.3	8.3	5.3	1.7	744	271,456	1,384,573
Other/unknown	1.6	86	15.9	57.5	24.1	4.8	7.5	4.7	1.3	540	81,902	475,581
Use of Nursing Facilities[f]												
Entire year	6.9	291	7.9	4.4	4.4	5.5	26.7	41.2	17.8	3,688	25,334	263,248
Part year	6.1	262	10.2	5.6	7.1	8.3	30.8	35.5	12.7	2,556	18,699	168,265
None	1.8	115	22.0	52.4	25.0	5.9	9.0	5.7	2.1	524	936,077	5,360,474
Maintenance Assistance Status												
Cash	3.0	193	24.3	39.4	22.3	7.7	15.2	11.0	4.3	795	231,396	1,599,176
Medically needy	2.2	117	14.1	52.1	20.3	7.3	10.4	7.0	2.8	828	92,616	378,565
Poverty related	1.6	90	17.7	57.3	26.0	4.2	6.2	4.7	1.6	506	400,886	2,372,529
Other/unknown	2.3	121	12.2	48.2	24.0	6.4	10.4	7.9	3.1	989	255,212	1,441,717

Source: Data for this table are from the MAX 2004 file for Michigan, released by CMS in 02/2008. This table was produced on 03/25/2008.

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]

MICHIGAN, 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	**2.2**	**$128**	**$58**	**0.8**	**$101**	**$124**	**0.1**	**$7**	**$74**	**1.3**	**$19**	**$15**
Age												
5 and younger	0.3	13	45	0.1	10	109	0.0	1	52	0.2	2	12
6-14	0.5	45	95	0.3	41	148	0.0	1	85	0.2	4	20
15-20	0.7	49	75	0.3	40	139	0.0	3	84	0.3	7	20
21-44	1.9	140	74	0.7	110	165	0.1	9	104	1.1	20	18
45-64	4.4	287	65	1.5	224	144	0.2	19	99	2.7	44	16
65-74	4.6	226	49	1.7	180	104	0.2	10	62	2.7	37	13
75-84	5.0	220	44	1.9	174	91	0.2	9	44	2.9	37	13
85 and older	5.1	196	38	1.9	152	82	0.3	8	30	3.0	36	12
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	4.8	208	43	1.8	164	90	0.2	9	41	2.8	35	13
Disabled	3.9	271	70	1.4	216	152	0.2	16	99	2.3	39	17
Adults	1.0	38	40	0.3	28	103	0.0	3	68	0.6	8	12
Children	0.4	21	58	0.2	18	105	0.0	1	66	0.2	3	14
Unknown	1.8	119	65	0.6	98	175	0.1	4	55	1.2	17	14
Gender												
Female	2.5	131	52	0.9	102	112	0.1	7	66	1.5	21	14
Male	1.7	123	71	0.7	100	147	0.1	6	92	1.0	17	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.4	138	58	0.9	109	120	0.1	8	75	1.4	21	15
African American	1.9	114	60	0.7	92	139	0.1	5	73	1.2	18	15
Other/unknown	1.6	86	54	0.6	69	114	0.1	4	66	0.9	13	14
Use of Nursing Facilities[e]												
Entire year	6.9	291	42	2.6	226	88	0.4	14	35	4.0	52	13
Part year	6.1	262	43	2.2	200	92	0.3	13	39	3.6	48	13
None	1.8	115	63	0.7	92	133	0.1	6	90	1.1	17	16
Maintenance Assistance Status												
Cash	3.0	193	64	1.1	155	139	0.1	10	88	1.8	28	16
Medically needy	2.2	117	53	0.8	91	113	0.1	7	66	1.3	18	14
Poverty related	1.6	90	57	0.6	71	119	0.1	5	78	0.9	14	15
Other/unknown	2.3	121	52	0.9	95	109	0.1	6	56	1.3	19	14

Source: Data for this table are from the MAX 2004 file for Michigan, released by CMS in 02/2008. This table was produced on 03/25/2008.

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 Michigan, 0.2 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all 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]

MICHIGAN, 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	0.3	0.1	0.0	0.2	$18	$14	$1	$3	$60	$140	$71	$15	689,158	$41,095,064	256,852	26.2 %	2,297,820
Biologicals	1.0	0.1	0.0	0.9	####	76	109	####	2940	1,029	4,350	3,062	772	2,269,541	92	0.0	796
Antineoplastic Agents	0.5	0.1	0.0	0.4	76	52	1	23	156	496	173	60	46,360	7,209,007	9,483	1.0	94,701
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.4	37	30	2	5	44	95	24	12	1,196,471	52,955,117	151,554	15.5	1,427,167
Cardiovascular Agents	1.7	0.5	0.0	1.2	51	37	1	13	29	72	25	11	2,861,988	84,131,786	166,429	17.0	1,654,932
Respiratory Agents	0.6	0.3	0.0	0.3	36	32	0	3	59	96	48	12	710,080	41,861,501	126,276	12.9	1,164,848
Gastrointestinal Agents	0.7	0.3	0.0	0.3	43	38	2	3	64	116	60	10	805,946	51,561,047	120,390	12.3	1,192,231
Genitourinary Agents	0.5	0.3	0.0	0.1	27	24	1	2	60	78	47	18	217,425	12,941,571	47,797	4.9	471,353
CNS Drugs	1.3	0.6	0.0	0.7	109	92	4	13	83	163	90	18	2,200,846	182,981,455	196,179	20.0	1,680,060
Stimulants/Anti-obesity/Anorexia	1.0	0.7	0.0	0.2	61	55	0	5	63	74	74	24	192,431	12,167,427	28,727	2.9	199,133
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	119	118	0	1	164	167	103	65	141,928	23,306,339	19,009	1.9	195,218
Analgesics and Anesthetics	0.7	0.2	0.0	0.6	36	27	2	7	49	147	409	14	1,370,831	67,610,789	204,797	20.9	1,854,230
Neuromuscular Agents	1.0	0.4	0.2	0.5	75	48	17	10	76	133	108	22	955,640	73,041,554	105,599	10.8	975,311
Nutritional Products	0.5	0.0	0.0	0.4	7	0	0	6	14	17	14	13	343,022	4,634,648	77,221	7.9	706,960
Hematological Agents	0.7	0.3	0.1	0.4	96	86	3	7	132	296	58	19	397,753	52,311,446	53,524	5.5	543,832
Topical Products	0.4	0.1	0.0	0.2	14	9	1	5	39	77	53	19	566,160	21,888,150	162,075	16.5	1,525,746
Miscellaneous Products	0.4	0.2	0.0	0.2	68	51	9	8	171	306	210	44	42,450	7,252,598	10,549	1.1	105,990
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	4	0	0	0	13	0	0	0	11,991	156,330	3,416	0.3	35,618
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.	12,751,252	739,375,370	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Michigan, released by CMS in 02/2008. This table was produced on 03/25/2008.

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 Michigan, 0.2 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.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]

MICHIGAN, 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	$113,298,747	79,344	8.1 %	827,237	0.7	$186	$137
ANTICONVULSANT	59,341,964	76,109	7.8	796,015	0.8	95	75
ANTIDEPRESSANTS	43,420,107	136,811	14.0	1,367,258	0.6	51	32
ULCER DRUGS	38,386,491	118,345	12.1	1,200,708	0.5	66	32
MISC. HEMATOLOGICAL	37,340,689	27,811	2.8	292,171	0.6	213	128
ANTIHYPERLIPIDEMIC	36,402,966	72,153	7.4	764,728	0.6	74	48
ANALGESICS - Narcotic	35,887,271	203,701	20.8	1,930,777	0.4	43	19
ANTIASTHMATIC	32,331,207	151,615	15.5	1,441,270	0.4	60	22
ANTIDIABETIC	31,563,202	86,724	8.8	884,648	0.7	52	36
ANALGESICS - ANTI-INFLAMMATORY	24,119,150	119,562	12.2	1,139,610	0.4	59	21
Total	452,091,794	1,072,175		10,644,422	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Michigan, released by CMS in 02/2008. This table was produced on 03/25/2008.

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.