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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEVADA, 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]	261,213	(A)	38,298	(E)	222,915	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	240,985	(B)	22,192	(F)	218,793	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	181,517	(C)	22,132	(G)	159,385	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	2,516	(D)	2,210	(H)	306	(L)

Source: Data for this table are from the MAX 2004 file for Nevada, released by CMS in 01/2008. This table was produced on 09/23/2008.

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 Nevada in 2004 was $128,054,897, of which $353,406 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]

NEVADA, 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	**181,517**	**13,924**	**31,511**	**38,260**	**97,670**	**152**	**1,008,861**	**141,107**	**309,002**	**141,194**	**416,397**	**1,161**
Age												
5 and younger	46,977	0	1,419	0	45,558	0	193,275	0	13,049	0	180,226	0
6-14	42,550	0	3,568	0	38,982	0	208,251	0	35,788	0	172,463	0
15-20	18,606	0	2,233	3,388	12,982	3	98,520	0	22,200	12,995	63,313	12
21-44	42,776	1	10,484	32,240	21	30	221,725	2	103,343	118,081	97	202
45-64	15,798	10	13,043	2,616	16	113	138,555	71	127,493	10,030	47	914
65-74	6,112	5,532	557	16	1	6	62,654	57,397	5,135	88	1	33
75-84	5,531	5,383	148	0	0	0	56,368	54,952	1,416	0	0	0
85 and older	3,057	2,998	59	0	0	0	29,263	28,685	578	0	0	0
Unknown	110	0	0	0	110	0	250	0	0	0	250	0
Gender												
Female	104,863	9,912	16,322	30,237	48,240	152	583,655	101,562	163,121	113,194	204,617	1,161
Male	76,127	4,012	15,188	8,023	48,904	0	423,701	39,545	145,869	28,000	210,287	0
Unknown	527	0	1	0	526	0	1,505	0	12	0	1,493	0
Race												
White	89,839	8,293	19,207	20,588	41,646	105	568,130	81,925	188,311	85,090	211,993	811
African American	30,302	893	6,426	6,729	16,244	10	145,644	9,539	63,216	18,152	54,662	75
Other/unknown	61,376	4,738	5,878	10,943	39,780	37	295,087	49,643	57,475	37,952	149,742	275
Use of Nursing Facilities[c]												
Entire year	2,516	2,029	486	0	1	0	25,189	20,085	5,092	0	12	0
Part year	2,161	1,568	577	5	9	2	19,989	14,223	5,639	32	81	14
None	176,840	10,327	30,448	38,255	97,660	150	963,683	106,799	298,271	141,162	416,304	1,147
Maintenance Assistance Status												
Cash	118,118	8,286	27,209	27,432	55,191	0	667,100	87,856	265,016	99,136	215,092	0
Medically needy	0	0	0	0	0	0		0	0	0	0	0
Poverty-related	29,294	243	493	3,952	24,454	152	112,724	2,536	4,824	13,904	90,299	1,161
Other/unknown	34,105	5,395	3,809	6,876	18,025	0	229,037	50,715	39,162	28,154	111,006	0
Dual Medicare Status[d]							0					
Full dual, all year	20,650	12,471	7,919	249	3	8	209,877	126,764	81,674	1,365	17	57
Full dual, part year	1,482	757	702	23	0	0	15,124	7,844	7,057	223	0	0
Non-dual, all year	159,385	696	22,890	37,988	97,667	144	783,860	6,499	220,271	139,606	416,380	1,104
Managed Care (MC) Status												
Fee-for-service (FFS) all year	96,932	13,921	30,701	14,626	37,533	151	778,948	141,092	303,782	76,819	256,095	1,160
FFS part year, with Rx claims	21,955	1	546	9,293	12,115	0	70,047	10	3,829	27,734	38,474	0
FFS part year, no Rx claims	62,630	2	264	14,341	48,022	1	159,866	5	1,391	36,641	121,828	1

Source: Data for this table are from the MAX 2004 file for Nevada, released by CMS in 01/2008. This table was produced on 09/23/2008.

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]

NEVADA, 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	**42.8 %**	**10.1**	**$704**	**$70**	**$4,580**	**15.4 %**	**181,517**
Age							
5 and younger	29.8	1.2	198	162	2,127	9.3	46,977
6-14	27.8	2.2	203	93	1,731	11.7	42,550
15-20	36.6	3.2	321	100	3,526	9.1	18,606
21-44	49.1	8.6	728	84	4,542	16.0	42,776
45-64	73.5	38.2	2,668	70	12,245	21.8	15,798
65-74	82.2	41.9	2,149	51	9,745	22.1	6,112
75-84	86.3	45.1	2,121	47	14,298	14.8	5,531
85 and older	89.6	45.6	1,842	40	21,484	8.6	3,057
Unknown	0.0	0.0	0	0	177	0.0	110
Basis of Eligibility[e]							
Aged	85.7	44.3	2,092	47	14,104	14.8	13,924
Disabled	74.6	31.0	2,689	87	12,842	20.9	31,511
Adults	41.0	2.8	132	47	1,814	7.3	38,260
Children	27.1	1.3	88	69	1,620	5.5	97,670
Unknown	77.0	17.5	1,131	65	17,136	6.6	152
Gender							
Female	46.3	11.8	724	62	4,601	15.7	104,863
Male	38.3	7.8	679	87	4,574	14.9	76,127
Unknown	16.1	0.7	45	66	1,228	3.6	527
Race							
White	51.0	13.9	953	69	6,001	15.9	89,839
African American	36.0	7.3	540	74	3,667	14.7	30,302
Other/unknown	34.3	5.9	419	72	2,950	14.2	61,376
Use of Nursing Facilities[f]							
Entire year	97.1	77.3	3,399	44	47,418	7.2	2,516
Part year	94.4	61.1	2,882	47	36,742	7.8	2,161
None	41.4	8.5	639	75	3,577	17.9	176,840
Maintenance Assistance Status							
Cash	44.2	10.6	805	76	3,758	21.4	118,118
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	27.7	1.3	67	50	1,582	4.2	29,294
Other/unknown	51.2	15.7	898	57	10,000	9.0	34,105

Source: Data for this table are from the MAX 2004 file for Nevada, released by CMS in 01/2008. This table was produced on 09/23/2008.

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]

NEVADA, 2004

				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	**1.8**	**$127**	**15.4 %**	**57.2 %**	**24.0 %**	**5.4 %**	**7.5 %**	**4.5 %**	**1.5 %**	**$824**	**181,517**	**1,008,861**
Age												
5 and younger	0.3	48	9.3	70.2	25.9	2.6	1.2	0.2	0.0	517	46,977	193,275
6-14	0.4	42	11.7	72.2	22.1	3.1	2.3	0.3	0.0	354	42,550	208,251
15-20	0.6	61	9.1	63.4	28.1	4.5	3.3	0.6	0.1	666	18,606	98,520
21-44	1.7	141	16.0	50.9	27.8	7.7	8.9	3.8	1.0	876	42,776	221,725
45-64	4.4	304	21.8	26.5	16.2	9.6	22.1	17.9	7.6	1,396	15,798	138,555
65-74	4.1	210	22.1	17.8	17.4	11.6	25.6	20.7	6.9	951	6,112	62,654
75-84	4.4	208	14.8	13.7	14.0	10.9	30.0	24.6	6.9	1,403	5,531	56,368
85 and older	4.8	193	8.6	10.4	13.2	11.2	30.4	27.3	7.5	2,244	3,057	29,263
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	78	110	250
Basis of Eligibility[e]												
Aged	4.4	206	14.8	14.3	14.9	11.3	28.6	23.8	7.1	1,392	13,924	141,107
Disabled	3.2	274	20.9	25.4	25.8	10.5	20.0	13.3	5.0	1,310	31,511	309,002
Adults	0.8	36	7.3	59.0	27.9	6.3	5.2	1.5	0.2	492	38,260	141,194
Children	0.3	21	5.5	72.9	23.1	2.6	1.3	0.1	0.0	380	97,670	416,397
Unknown	2.3	148	6.6	23.0	32.2	15.8	19.1	9.2	0.7	2,244	152	1,161
Gender												
Female	2.1	130	15.7	53.7	24.7	5.9	8.4	5.5	1.8	827	104,863	583,655
Male	1.4	122	14.9	61.7	23.0	4.8	6.3	3.2	1.0	822	76,127	423,701
Unknown	0.2	16	3.6	83.9	13.1	1.7	1.1	0.2	0.0	430	527	1,505
Race												
White	2.2	151	15.9	49.0	26.5	6.3	9.4	6.4	2.3	949	89,839	568,130
African American	1.5	112	14.7	64.0	20.7	5.0	6.1	3.2	0.9	763	30,302	145,644
Other/unknown	1.2	87	14.2	65.7	21.8	4.3	5.3	2.5	0.5	614	61,376	295,087
Use of Nursing Facilities[f]												
Entire year	7.7	340	7.2	2.9	4.6	6.3	26.1	38.8	21.3	4,736	2,516	25,189
Part year	6.6	312	7.8	5.6	8.3	8.0	29.0	32.4	16.8	3,972	2,161	19,989
None	1.6	117	17.9	58.6	24.4	5.4	7.0	3.7	1.0	656	176,840	963,683
Maintenance Assistance Status												
Cash	1.9	143	21.4	55.8	23.7	5.9	8.4	4.7	1.4	665	118,118	667,100
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	17	4.2	72.3	23.1	2.8	1.5	0.3	0.0	411	29,294	112,724
Other/unknown	2.3	134	9.0	48.8	25.4	6.0	9.4	7.5	2.9	1,489	34,105	229,037

Source: Data for this table are from the MAX 2004 file for Nevada, released by CMS in 01/2008. This table was produced on 09/23/2008.

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]

NEVADA, 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	**1.8**	**$127**	**$70**	**0.7**	**$93**	**$136**	**0.1**	**$9**	**$110**	**1.0**	**$24**	**$23**
Age												
5 and younger	0.3	48	162	0.1	44	475	0.0	1	49	0.2	3	17
6-14	0.4	42	93	0.2	36	154	0.0	1	82	0.2	5	23
15-20	0.6	61	100	0.3	51	184	0.0	2	87	0.3	7	24
21-44	1.7	141	84	0.6	102	170	0.1	12	146	1.0	27	27
45-64	4.4	304	70	1.6	207	132	0.2	29	145	2.6	67	26
65-74	4.1	210	51	1.6	152	94	0.2	13	74	2.3	45	20
75-84	4.4	208	47	1.7	151	87	0.2	11	58	2.5	46	18
85 and older	4.8	193	40	1.7	135	81	0.2	9	46	2.9	48	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	4.4	206	47	1.7	149	89	0.2	11	62	2.5	46	18
Disabled	3.2	274	87	1.2	203	170	0.2	22	143	1.8	49	27
Adults	0.8	36	47	0.2	23	103	0.0	2	82	0.5	11	21
Children	0.3	21	69	0.1	17	134	0.0	1	60	0.2	3	19
Unknown	2.3	148	65	0.8	111	143	0.1	5	67	1.4	32	22
Gender												
Female	2.1	130	62	0.8	92	118	0.1	10	102	1.2	28	23
Male	1.4	122	87	0.6	96	173	0.1	8	127	0.8	19	24
Unknown	0.2	16	66	0.1	12	158	0.0	1	70	0.1	3	19
Race												
White	2.2	151	69	0.8	110	135	0.1	11	103	1.3	30	23
African American	1.5	112	74	0.6	78	142	0.1	12	177	0.9	22	25
Other/unknown	1.2	87	72	0.5	69	137	0.0	4	92	0.7	14	21
Use of Nursing Facilities[e]												
Entire year	7.7	340	44	2.6	234	92	0.4	22	56	4.8	84	18
Part year	6.6	312	47	2.2	215	98	0.3	20	64	4.1	77	19
None	1.6	117	75	0.6	87	144	0.1	8	122	0.9	22	24
Maintenance Assistance Status												
Cash	1.9	143	76	0.7	105	146	0.1	11	130	1.1	27	25
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.4	17	50	0.1	12	106	0.0	1	70	0.2	4	19
Other/unknown	2.3	134	57	0.9	99	114	0.1	8	71	1.4	27	20

Source: Data for this table are from the MAX 2004 file for Nevada, released by CMS in 01/2008. This table was produced on 09/23/2008.

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 Nevada, 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]

NEVADA, 2004

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per 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	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	$28	$21	$2	$5	$87	$177	$107	$25	123,266	$10,667,252	44,384	24.5 %	387,607
Biologicals	0.3	0.2	0.0	0.0	310	251	0	59	1108	1,045	45	1,508	2,259	2,502,122	846	0.5	8,063
Antineoplastic Agents	0.5	0.1	0.0	0.4	79	50	1	28	159	586	148	69	7,051	1,124,589	1,406	0.8	14,228
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.4	37	28	2	7	47	88	32	18	168,025	7,945,699	22,375	12.3	213,318
Cardiovascular Agents	1.5	0.6	0.0	0.9	57	42	1	14	38	73	45	15	347,327	13,036,530	22,267	12.3	227,212
Respiratory Agents	0.6	0.4	0.0	0.3	37	31	0	6	59	85	40	22	179,932	10,535,759	32,177	17.7	286,965
Gastrointestinal Agents	0.6	0.2	0.0	0.4	35	25	2	8	58	168	72	18	93,729	5,449,678	15,232	8.4	154,564
Genitourinary Agents	0.4	0.3	0.0	0.1	25	21	1	3	62	81	50	24	26,132	1,619,261	6,785	3.7	63,747
CNS Drugs	1.1	0.5	0.0	0.6	103	85	4	14	90	171	94	23	293,961	26,466,036	26,022	14.3	256,921
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	62	55	2	5	97	108	91	49	21,623	2,103,158	3,423	1.9	34,042
Miscellaneous Psychological/ Neurological Agents	0.7	0.6	0.0	0.0	119	118	0	1	180	184	105	61	13,387	2,410,269	1,973	1.1	20,221
Analgesics and Anesthetics	0.8	0.2	0.0	0.6	59	30	10	19	78	200	486	33	228,818	17,863,438	32,795	18.1	300,301
Neuromuscular Agents	0.9	0.2	0.1	0.5	66	37	16	14	78	150	127	29	140,741	10,975,005	16,409	9.0	165,544
Nutritional Products	0.5	0.0	0.0	0.4	7	1	0	6	15	26	15	15	43,921	677,264	10,973	6.0	93,421
Hematological Agents	0.8	0.3	0.1	0.4	140	131	3	6	177	442	42	14	55,412	9,808,949	6,795	3.7	70,150
Topical Products	0.3	0.1	0.0	0.2	17	11	1	5	50	84	58	25	76,047	3,767,799	23,886	13.2	222,416
Miscellaneous Products	0.5	0.2	0.0	0.3	82	58	11	13	152	293	272	42	4,511	684,142	826	0.5	8,357
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	7	0	0	0	31	0	0	0	2,075	64,541	859	0.5	9,201
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.	1,828,217	127,701,491	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Nevada, released by CMS in 01/2008. This table was produced on 09/23/2008.

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 Nevada, 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]

NEVADA, 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	$17,224,569	12,443	6.9 %	132,914	0.6	$216	$130
ANALGESICS - Narcotic	13,397,959	38,346	21.1	366,892	0.4	84	37
ANTICONVULSANT	9,095,076	12,537	6.9	131,485	0.7	102	69
MISC. HEMATOLOGICAL	8,199,246	3,077	1.7	32,571	0.6	396	252
ANTIDEPRESSANTS	6,906,049	21,087	11.6	212,651	0.6	58	32
ANTIASTHMATIC	6,278,602	26,418	14.6	251,011	0.4	64	25
ANTIHYPERLIPIDEMIC	5,360,040	9,702	5.3	104,756	0.6	86	51
ANTIVIRAL	4,709,904	2,777	1.5	28,080	0.5	372	168
ANTIDIABETIC	4,142,808	11,295	6.2	116,580	0.7	54	36
ANTIHYPERTENSIVE	3,186,279	16,443	9.1	172,827	0.6	31	18
Total	78,500,532	154,125		1,549,767	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Nevada, released by CMS in 01/2008. This table was produced on 09/23/2008.

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.