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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2005
ARKANSAS

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
ARKANSAS, 2005

Inclusion Criteria (2005)	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]	746506 (A)	102364 (E)	644142 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	714090 (B)	71366 (F)	642724 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	714090 (C)	71366 (G)	642724 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	4255 (D)	3949 (H)	306 (L)

Source: Data for this table are from the MAX 2005 file for Arkansas, released by CMS in 2/2009. This table was produced on 04/23/2009.

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 2005 (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 2005, 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 2005 was $456,316,481, of which $12,052,603 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 26 states in 2005 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, 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 2005 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer05.pdf and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit package.

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2005. 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 N+B18D.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 beneficiary 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 2005. 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, 2005

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**714,090**	**44,891**	**97,494**	**172,529**	**398,675**	**501**	**7,124,052**	**469,011**	**1,019,863**	**1,556,654**	**4,074,757**	**3,767**
Age												
5 and younger	156,590	0	6,101	57	150,432	0	1,537,990	0	64,989	569	1,472,432	0
6-14	194,270	0	12,427	82	181,761	0	2,069,879	0	138,039	758	1,931,082	0
15-20	108,356	0	8,386	33,527	66,440	3	1,057,243	0	91,056	295,265	670,898	24
21-44	164,829	0	32,014	132,615	41	159	1,546,440	0	338,378	1,206,651	343	1,068
45-64	44,818	0	38,265	6,216	1	336	440,984	0	385,067	53,256	2	2,659
65-74	14,599	14,268	301	27	0	3	154,953	152,480	2,334	123	0	16
75-84	15,732	15,728	0	4	0	0	166,027	166,005	0	22	0	0
85 and older	14,896	14,895	0	1	0	0	150,536	150,526	0	10	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	442,458	33,494	49,550	160,756	198,157	501	4,379,050	354,497	525,075	1,462,849	2,032,862	3,767
Male	269,765	11,344	47,880	11,591	198,950	0	2,728,162	114,057	494,362	92,487	2,027,256	0
Unknown	1,867	53	64	182	1,568	0	16,840	457	426	1,318	14,639	0
Race												
White	432,082	29,533	51,764	109,778	240,624	383	4,292,030	302,114	535,784	990,730	2,460,521	2,881
African American	207,932	11,365	27,112	52,734	116,619	102	2,103,090	122,940	286,207	491,377	1,201,806	760
Other/unknown	74,076	3,993	18,618	10,017	41,432	16	728,932	43,957	197,872	74,547	412,430	126
Use of Nursing Facilities[c]												
Entire year	4,255	3,768	486	1	0	0	28,706	25,136	3,569	1	0	0
Part year	14,046	12,066	1,977	3	0	0	153,323	131,174	22,125	24	0	0
None	695,789	29,057	95,031	172,525	398,675	501	6,942,023	312,701	994,169	1,556,629	4,074,757	3,767
Maintenance Assistance Status												
Cash	155,984	23,112	84,305	21,648	26,919	0	1,614,236	260,104	899,436	185,940	268,756	0
Medically needy	10,722	476	3,276	5,266	1,704	0	68,576	1,789	14,336	36,122	16,329	0
Poverty-related	300,619	187	662	37,834	261,435	501	2,950,171	1,843	6,144	287,438	2,650,979	3,767
Other/unknown	246,765	21,116	9,251	107,781	108,617	0	2,491,069	205,275	99,947	1,047,154	1,138,693	0
Dual Medicare Status[d]												
Full dual, all year	69,161	39,976	28,004	1,146	8	27	724,962	417,379	297,033	10,253	70	227
Full dual, part year	2,205	1,129	1,016	60	0	0	22,595	12,126	9,815	654	0	0
Non-dual, all year	642,724	3,786	68,474	171,323	398,667	474	6,376,495	39,506	713,015	1,545,747	4,074,687	3,540
Managed Care (MC) Status												
Fee-for-service (FFS) all year	714,090	44,891	97,494	172,529	398,675	501	7,124,052	469,011	1,019,863	1,556,654	4,074,757	3,767
FFS part year, with Rx claims	0	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

Source: Data for this table are from the MAX 2005 file for Arkansas, released by CMS in 2/2009. This table was produced on 04/23/2009.

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 2005. 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, 2005

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	**62.8**	**9.3**	**$622**	**$67**	**$3,705**	**16.8**	**714,090**
Age							
5 and younger	73.7	5.3	236	44	2,561	9.2	156,590
6-14	63.5	5.1	383	75	1,821	21.0	194,270
15-20	56.8	5.0	370	74	2,464	15.0	108,356
21-44	44.5	6.3	512	81	2,905	17.6	164,829
45-64	78.4	27.8	2,114	76	9,824	21.5	44,818
65-74	86.2	39.4	2,448	62	11,773	20.8	14,599
75-84	89.0	46.7	2,716	58	15,944	17.0	15,732
85 and older	86.4	45.4	2,367	52	18,942	12.5	14,896
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	87.4	44.1	2,522	57	15,634	16.1	44,891
Disabled	81.9	23.2	2,160	93	11,420	18.9	97,494
Adults	39.0	3.2	150	46	1,073	14.0	172,529
Children	65.6	4.6	236	51	1,602	14.7	398,675
Unknown	89.8	15.3	1,321	86	13,243	10.0	501
Gender							
Female	59.9	9.7	593	61	3,446	17.2	442,458
Male	67.6	8.7	672	78	4,142	16.2	269,765
Unknown	53.0	4.8	257	54	2,008	12.8	1,867
Race							
White	64.8	10.4	695	67	3,940	17.6	432,082
African American	58.9	7.3	449	62	3,069	14.6	207,932
Other/unknown	61.8	8.5	683	81	4,117	16.6	74,076
Use of Nursing Facilities[f]							
Entire year	94.6	52.1	3,022	58	25,584	11.8	4,255
Part year	98.4	74.6	4,424	59	34,185	12.9	14,046
None	61.9	7.7	531	69	2,956	18.0	695,789
Maintenance Assistance Status							
Cash	77.6	19.2	1,521	79	6,962	21.9	155,984
Medically needy	67.7	8.4	632	75	4,904	12.9	10,722
Poverty related	67.2	4.7	226	48	1,768	12.8	300,619
Other/unknown	47.9	8.7	535	62	3,953	13.5	246,765

Source: Data for this table are from the MAX 2005 file for Arkansas, released by CMS in 2/2009. This table was produced on 04/23/2009.

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 eight states (DE, IA, IL, 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 eight states (DE, IA, IL, 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, 2005

				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	**0.9**	**$62**	**16.8**	**37.2**	**45.7**	**6.2**	**7.7**	**2.7**	**0.5**	**$371**	**714,090**	**7,124,052**
Age												
5 and younger	0.5	24	9.2	26.3	65.9	5.8	1.9	0.2	0.0	261	156,590	1,537,990
6-14	0.5	36	21.0	36.5	55.4	4.8	2.9	0.3	0.0	171	194,270	2,069,879
15-20	0.5	38	15.0	43.2	48.2	5.0	3.1	0.5	0.0	253	108,356	1,057,243
21-44	0.7	55	17.6	55.5	30.5	5.9	6.9	1.2	0.0	310	164,829	1,546,440
45-64	2.8	215	21.5	21.6	18.0	13.2	34.1	12.0	1.1	998	44,818	440,984
65-74	3.7	231	20.8	13.8	13.8	11.5	38.4	18.5	3.9	1,109	14,599	154,953
75-84	4.4	257	17.0	11.0	10.5	10.4	37.1	24.5	6.6	1,511	15,732	166,027
85 and older	4.5	234	12.5	13.6	8.6	9.4	34.5	27.4	6.5	1,874	14,896	150,536
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	4.2	241	16.1	12.6	10.9	10.4	36.7	23.6	5.7	1,496	44,891	469,011
Disabled	2.2	207	18.9	18.1	31.6	14.2	27.3	8.1	0.7	1,092	97,494	1,019,863
Adults	0.4	17	14.0	61.0	32.4	3.9	2.6	0.2	0.0	119	172,529	1,556,654
Children	0.5	23	14.7	34.4	58.9	4.7	1.9	0.1	0.0	157	398,675	4,074,757
Unknown	2.0	176	10.0	10.2	32.7	27.9	27.3	1.8	0.0	1,761	501	3,767
Gender												
Female	1.0	60	17.2	40.1	42.3	5.8	8.2	3.2	0.5	348	442,458	4,379,050
Male	0.9	67	16.2	32.4	51.4	6.9	7.1	2.0	0.3	410	269,765	2,728,162
Unknown	0.5	29	12.8	47.0	44.2	4.0	2.9	1.7	0.2	223	1,867	16,840
Race												
White	1.1	70	17.6	35.2	45.8	6.6	8.5	3.4	0.6	397	432,082	4,292,030
African American	0.7	44	14.6	41.1	45.5	5.5	6.2	1.5	0.2	303	207,932	2,103,090
Other/unknown	0.9	69	16.6	38.2	45.8	5.8	7.8	2.2	0.1	418	74,076	728,932
Use of Nursing Facilities[f]												
Entire year	7.7	448	11.8	5.4	3.6	4.4	24.0	42.3	20.4	3,792	4,255	28,706
Part year	6.8	405	12.9	1.6	5.2	5.9	29.4	42.0	16.0	3,132	14,046	153,323
None	0.8	53	18.0	38.1	46.8	6.2	7.2	1.7	0.0	296	695,789	6,942,023
Maintenance Assistance Status												
Cash	1.9	147	21.9	22.4	35.8	12.4	22.8	6.3	0.2	673	155,984	1,614,236
Medically needy	1.3	99	12.9	32.3	32.2	14.3	18.8	2.4	0.0	767	10,722	68,576
Poverty related	0.5	23	12.8	32.8	59.9	5.1	2.0	0.1	0.0	180	300,619	2,950,171
Other/unknown	0.9	53	13.5	52.1	35.3	3.2	4.7	3.6	1.2	392	246,765	2,491,069

Source: Data for this table are from the MAX 2005 file for Arkansas, released by CMS in 2/2009. This table was produced on 04/23/2009.

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 eight states (DE, IA, IL, 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 eight states (DE, IA, IL, 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, 2005

	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	**0.9**	**$62**	**$67**	**0.4**	**$47**	**$128**	**0.0**	**$3**	**$64**	**0.5**	**$13**	**$24**
Age												
5 and younger	0.5	24	44	0.2	17	92	0.0	1	41	0.3	6	18
6-14	0.5	36	75	0.2	29	128	0.0	2	66	0.2	5	23
15-20	0.5	38	74	0.2	30	150	0.0	2	60	0.3	6	22
21-44	0.7	55	81	0.3	41	163	0.0	3	82	0.4	11	27
45-64	2.8	215	76	1.1	158	142	0.1	9	92	1.6	48	30
65-74	3.7	231	62	1.5	170	114	0.1	8	62	2.1	52	25
75-84	4.4	257	58	1.8	191	109	0.2	8	51	2.5	58	23
85 and older	4.5	234	52	1.6	167	103	0.2	9	47	2.7	58	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	4.2	241	57	1.6	177	108	0.2	8	52	2.4	56	23
Disabled	2.2	207	93	0.9	162	177	0.1	8	92	1.2	36	30
Adults	0.4	17	46	0.1	11	89	0.0	1	56	0.2	5	21
Children	0.5	23	51	0.2	17	95	0.0	2	51	0.2	5	19
Unknown	2.0	176	86	0.8	137	173	0.1	4	77	1.2	35	29
Gender												
Female	1.0	60	61	0.4	44	117	0.0	3	60	0.6	13	24
Male	0.9	67	78	0.4	52	147	0.0	3	71	0.5	11	25
Unknown	0.5	29	54	0.2	20	98	0.0	2	69	0.3	7	23
Race												
White	1.1	70	67	0.4	52	125	0.1	3	66	0.6	15	25
African American	0.7	44	62	0.3	33	123	0.0	2	56	0.4	9	22
Other/unknown	0.9	69	81	0.3	55	160	0.0	3	67	0.5	11	24
Use of Nursing Facilities[e]												
Entire year	7.7	448	58	2.9	328	114	0.3	16	56	4.5	104	23
Part year	6.8	405	59	2.5	297	118	0.3	14	56	4.0	94	23
None	0.8	53	69	0.3	40	130	0.0	3	65	0.4	10	25
Maintenance Assistance Status												
Cash	1.9	147	79	0.7	113	152	0.1	6	78	1.0	28	27
Medically needy	1.3	99	75	0.5	72	153	0.0	5	95	0.8	22	28
Poverty related	0.5	23	48	0.2	16	93	0.0	2	49	0.3	5	19
Other/unknown	0.9	53	62	0.3	39	114	0.0	2	59	0.5	11	24

Source: Data for this table are from the MAX 2005 file for Arkansas, released by CMS in 2/2009. This table was produced on 04/23/2009.

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 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)

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, 2005

	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	0.1	$12	$6	$2	$3	$48	$100	$67	$22	815,238	$39,467,559	308,821	43.2	3,367,542
Biologicals	0.4	0.3	0.0	0.0	451	362	14	75	1257	1,169	1,259	1,969	4,924	6,190,874	1,448	0.2	13,724
Antineoplastic Agents	0.5	0.1	0.0	0.4	90	61	0	29	170	617	113	67	27,911	4,750,577	5,156	0.7	52,671
Endocrine/Metabolic Drugs	0.5	0.2	0.1	0.2	28	19	3	5	58	98	52	24	631,256	36,517,812	120,596	16.9	1,309,504
Cardiovascular Agents	1.2	0.5	0.0	0.7	53	39	1	14	43	80	22	19	1,065,826	45,858,134	80,229	11.2	859,141
Respiratory Agents	0.3	0.2	0.0	0.2	18	14	1	3	52	92	28	16	785,637	40,729,966	211,399	29.6	2,315,256
Gastrointestinal Agents	0.5	0.2	0.0	0.3	37	31	0	6	77	149	59	21	357,060	27,567,623	69,751	9.8	749,250
Genitourinary Agents	0.3	0.2	0.0	0.1	21	17	1	3	66	87	71	28	95,010	6,278,572	27,790	3.9	296,204
CNS Drugs	0.7	0.4	0.0	0.4	78	68	0	10	104	180	65	27	890,281	93,019,089	110,369	15.5	1,187,883
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	60	56	0	3	102	111	58	42	207,369	21,086,609	31,696	4.4	354,055
Miscellaneous Psychological/ Neurological Agents	0.8	0.8	0.0	0.0	133	130	0	3	167	172	81	73	73,551	12,310,919	8,787	1.2	92,545
Analgesics and Anesthetics	0.4	0.0	0.0	0.3	16	6	2	8	46	161	201	26	605,412	27,842,780	156,990	22.0	1,688,544
Neuromuscular Agents	0.7	0.2	0.0	0.4	59	40	3	16	89	172	77	41	401,561	35,894,113	56,593	7.9	613,319
Nutritional Products	0.4	0.0	0.0	0.4	7	0	0	6	17	12	17	18	149,971	2,587,300	36,783	5.2	382,192
Hematological Agents	0.7	0.3	0.0	0.4	110	103	1	7	161	354	57	18	143,756	23,172,753	19,866	2.8	210,553
Topical Products	0.2	0.1	0.0	0.1	10	7	0	3	48	83	50	25	362,218	17,334,053	157,507	22.1	1,731,309
Miscellaneous Products	0.1	0.1	0.0	0.0	20	16	1	4	142	155	300	97	23,065	3,267,706	14,873	2.1	161,960
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	7	0	0	0	37	0	0	0	10,531	387,439	4,993	0.7	55,750
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.	6,650,577	444,263,878	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Arkansas, released by CMS in 2/2009. This table was produced on 04/23/2009.

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 2005.

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, 2005

		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	$60,340,618	41,037	5.7	452,235	0.5	$243	$133
ANTICONVULSANT	30,036,990	39,968	5.6	439,342	0.6	110	68
ANTIASTHMATIC	26,909,851	124,587	17.4	1,378,761	0.3	74	20
ANTIDEPRESSANTS	25,894,986	79,967	11.2	865,122	0.5	64	30
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	21,086,609	38,117	5.3	428,687	0.5	102	49
ULCER DRUGS	20,698,472	59,273	8.3	640,743	0.4	81	32
MISC. HEMATOLOGICAL	17,835,296	9,545	1.3	102,576	0.6	272	174
ANTIHYPERLIPIDEMIC	15,980,052	23,639	3.3	262,440	0.6	111	61
ANALGESICS - Narcotic	15,412,963	162,666	22.8	1,753,716	0.2	38	9
ANTIDIABETIC	15,271,631	32,798	4.6	357,987	0.6	70	43
Total	249,467,468	611,597		6,681,609	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Arkansas, released by CMS in 2/2009. This table was produced on 04/23/2009.

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 2005. 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 2005. 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.