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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
ARIZONA, 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]	1476842 (A)	139247 (E)	1337595 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1320629 (B)	117299 (F)	1203330 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	202299 (C)	40903 (G)	161396 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	489 (D)	366 (H)	123 (L)

Source: Data for this table are from the MAX 2005 file for Arizona, 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 Arizona in 2005 was $4,348,255, of which $208,988 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]
ARIZONA, 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	**202,299**	**27,114**	**39,092**	**68,150**	**67,938**	**5**	**1,572,997**	**227,730**	**374,284**	**469,151**	**501,825**	**7**
Age												
5 and younger	31,206	0	3,687	0	27,519	0	210,540	0	33,480	0	177,060	0
6-14	34,071	0	6,171	0	27,900	0	290,333	0	63,810	0	226,523	0
15-20	22,072	0	3,135	6,419	12,518	0	176,176	0	31,955	45,980	98,241	0
21-44	55,450	12	9,467	45,971	0	0	408,427	17	89,919	318,491	0	0
45-64	28,435	30	13,134	15,265	1	5	220,704	60	118,370	102,266	1	7
65-74	9,990	7,114	2,497	379	0	0	88,470	60,357	26,201	1,912	0	0
75-84	11,225	10,317	826	82	0	0	97,310	88,082	8,852	376	0	0
85 and older	9,850	9,641	175	34	0	0	81,037	79,214	1,697	126	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	108,649	19,053	18,068	37,801	33,722	5	865,640	163,068	173,930	277,124	251,511	7
Male	93,650	8,061	21,024	30,349	34,216	0	707,357	64,662	200,354	192,027	250,314	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	44,803	15,192	16,055	8,724	4,830	2	294,374	123,831	147,813	14,637	8,090	3
African American	5,926	952	1,565	1,983	1,426	0	27,101	7,699	12,009	4,469	2,924	0
Other/unknown	151,570	10,970	21,472	57,443	61,682	3	1,251,522	96,200	214,462	450,045	490,811	4
Use of Nursing Facilities[c]												
Entire year	489	372	116	1	0	0	4,275	3,164	1,110	1	0	0
Part year	676	323	321	27	5	0	6,821	3,082	3,403	295	41	0
None	201,134	26,419	38,655	68,122	67,933	5	1,561,901	221,484	369,771	468,855	501,784	7
Maintenance Assistance Status												
Cash	86,427	5,208	22,967	29,113	29,139	0	754,801	51,010	227,662	226,778	249,351	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	32,173	1,898	1,445	2,073	26,752	5	220,034	11,344	7,462	12,122	189,099	7
Other/unknown	83,699	20,008	14,680	36,964	12,047	0	598,162	165,376	139,160	230,251	63,375	0
Dual Medicare Status[d]												
Full dual, all year	39,683	25,210	13,268	1,204	1	0	351,542	215,181	129,685	6,675	1	0
Full dual, part year	1,220	745	401	74	0	0	6,438	4,372	1,748	318	0	0
Non-dual, all year	161,396	1,159	25,423	66,872	67,937	5	1,215,017	8,177	242,851	462,158	501,824	7
Managed Care (MC) Status												
Fee-for-service (FFS) all year	158,842	23,827	30,922	52,419	51,674	0	1,447,508	214,730	343,552	427,403	461,823	0
FFS part year, with Rx claims	960	40	132	361	427	0	5,057	216	837	1,947	2,057	0
FFS part year, no Rx claims	42,497	3,247	8,038	15,370	15,837	5	120,432	12,784	29,895	39,801	37,945	7

Source: Data for this table are from the MAX 2005 file for Arizona, 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]
ARIZONA, 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	**4.1**	**0.3**	**$21**	**$60**	**$8,181**	**0.3**	**202,299**
Age							
5 and younger	4.5	0.1	9	84	6,412	0.1	31,206
6-14	3.3	0.1	8	68	5,924	0.1	34,071
15-20	4.1	0.2	28	147	5,799	0.5	22,072
21-44	3.7	0.3	22	82	6,064	0.4	55,450
45-64	4.3	0.6	31	49	10,555	0.3	28,435
65-74	6.7	1.1	42	40	13,537	0.3	9,990
75-84	4.7	0.8	27	33	15,884	0.2	11,225
85 and older	3.1	0.5	16	31	17,782	0.1	9,850
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	3.6	0.7	23	35	16,511	0.1	27,114
Disabled	5.3	0.8	69	84	21,050	0.3	39,092
Adults	3.2	0.1	6	37	2,634	0.2	68,150
Children	4.4	0.1	6	48	3,016	0.2	67,938
Unknown	0.0	0.0	0	0	329	0.0	5
Gender							
Female	4.6	0.4	17	46	8,783	0.2	108,649
Male	3.4	0.3	24	79	7,483	0.3	93,650
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	0.6	0.0	1	44	14,525	0.0	44,803
African American	2.6	0.1	3	30	8,404	0.0	5,926
Other/unknown	5.2	0.4	27	60	6,297	0.4	151,570
Use of Nursing Facilities[f]							
Entire year	78.1	31.9	1,260	40	47,327	2.7	489
Part year	68.9	15.1	560	37	54,950	1.0	676
None	3.7	0.2	16	72	7,928	0.2	201,134
Maintenance Assistance Status							
Cash	6.3	0.5	36	66	8,993	0.4	86,427
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	4.0	0.1	9	64	2,603	0.3	32,173
Other/unknown	1.8	0.2	9	42	9,486	0.1	83,699

Source: Data for this table are from the MAX 2005 file for Arizona, 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]

ARIZONA, 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	**0.0**	**$3**	**0.3**	**95.9**	**3.3**	**0.3**	**0.3**	**0.1**	**0.0**	**$1,052**	**202,299**	**1,572,997**
Age												
5 and younger	0.0	1	0.1	95.5	4.3	0.1	0.0	0.0	0.0	950	31,206	210,540
6-14	0.0	1	0.1	96.7	3.2	0.1	0.0	0.0	0.0	695	34,071	290,333
15-20	0.0	4	0.5	95.9	3.8	0.2	0.1	0.0	0.0	727	22,072	176,176
21-44	0.0	3	0.4	96.3	3.2	0.3	0.2	0.1	0.0	823	55,450	408,427
45-64	0.1	4	0.3	95.7	3.0	0.5	0.6	0.1	0.1	1,360	28,435	220,704
65-74	0.1	5	0.3	93.3	4.1	0.9	1.3	0.4	0.0	1,529	9,990	88,470
75-84	0.1	3	0.2	95.3	2.6	0.7	1.0	0.3	0.1	1,832	11,225	97,310
85 and older	0.1	2	0.1	96.9	1.6	0.5	0.8	0.2	0.0	2,161	9,850	81,037
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	0.1	3	0.1	96.4	1.9	0.6	0.9	0.3	0.0	1,966	27,114	227,730
Disabled	0.1	7	0.3	94.7	3.7	0.6	0.7	0.2	0.1	2,199	39,092	374,284
Adults	0.0	1	0.2	96.8	2.8	0.2	0.1	0.0	0.0	383	68,150	469,151
Children	0.0	1	0.2	95.6	4.2	0.1	0.1	0.0	0.0	408	67,938	501,825
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	235	5	7
Gender												
Female	0.0	2	0.2	95.4	3.9	0.3	0.3	0.1	0.0	1,102	108,649	865,640
Male	0.0	3	0.3	96.6	2.7	0.3	0.3	0.1	0.0	991	93,650	707,357
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	99.4	0.3	0.1	0.1	0.0	0.0	2,211	44,803	294,374
African American	0.0	1	0.0	97.4	1.7	0.5	0.3	0.1	0.0	1,838	5,926	27,101
Other/unknown	0.1	3	0.4	94.8	4.3	0.4	0.4	0.1	0.0	763	151,570	1,251,522
Use of Nursing Facilities[f]												
Entire year	3.6	144	2.7	21.9	8.6	10.8	36.4	17.0	5.3	5,414	489	4,275
Part year	1.5	56	1.0	31.1	35.7	12.7	15.7	3.8	1.0	5,446	676	6,821
None	0.0	2	0.2	96.3	3.2	0.2	0.2	0.0	0.0	1,021	201,134	1,561,901
Maintenance Assistance Status												
Cash	0.1	4	0.4	93.7	5.2	0.5	0.5	0.1	0.0	1,030	86,427	754,801
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	0.3	96.0	3.7	0.2	0.1	0.0	0.0	381	32,173	220,034
Other/unknown	0.0	1	0.1	98.2	1.3	0.2	0.3	0.1	0.0	1,327	83,699	598,162

Source: Data for this table are from the MAX 2005 file for Arizona, 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]
ARIZONA, 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	**0.0**	**$3**	**$60**	**0.0**	**$2**	**$223**	**0.0**	**$0**	**$66**	**0.0**	**$1**	**$18**
Age												
5 and younger	0.0	1	84	0.0	1	336	0.0	0	56	0.0	0	12
6-14	0.0	1	68	0.0	1	201	0.0	0	255	0.0	0	17
15-20	0.0	4	147	0.0	3	458	0.0	0	220	0.0	0	24
21-44	0.0	3	82	0.0	2	396	0.0	0	74	0.0	1	19
45-64	0.1	4	49	0.0	3	178	0.0	0	57	0.1	1	19
65-74	0.1	5	40	0.0	3	121	0.0	0	38	0.1	2	17
75-84	0.1	3	33	0.0	2	99	0.0	0	37	0.1	1	16
85 and older	0.1	2	31	0.0	1	87	0.0	0	33	0.0	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	3	35	0.0	2	102	0.0	0	38	0.1	1	16
Disabled	0.1	7	84	0.0	6	316	0.0	0	78	0.1	1	21
Adults	0.0	1	37	0.0	1	186	0.0	0	94	0.0	0	14
Children	0.0	1	48	0.0	1	160	0.0	0	55	0.0	0	14
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	171	0.0	0	57	0.0	1	17
Male	0.0	3	79	0.0	3	281	0.0	0	79	0.0	1	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.0	0	44	0.0	0	127	0.0	0	45	0.0	0	20
African American	0.0	1	30	0.0	1	93	0.0	0	47	0.0	0	14
Other/unknown	0.1	3	60	0.0	2	226	0.0	0	66	0.0	1	18
Use of Nursing Facilities[e]												
Entire year	3.6	144	40	0.7	83	113	0.1	8	55	2.8	53	19
Part year	1.5	56	37	0.3	32	121	0.0	3	78	1.2	21	17
None	0.0	2	72	0.0	2	283	0.0	0	68	0.0	0	17
Maintenance Assistance Status												
Cash	0.1	4	66	0.0	3	269	0.0	0	63	0.0	1	18
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.0	1	64	0.0	1	199	0.0	0	59	0.0	0	16
Other/unknown	0.0	1	42	0.0	1	124	0.0	0	75	0.0	0	18

Source: Data for this table are from the MAX 2005 file for Arizona, 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 Arizona, 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]

ARIZONA, 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	0.0	0.0	0.1	$8	$4	$1	$3	$45	$139	$59	$21	8,288	$376,744	4,422	2.2	45,166
Biologicals	0.4	0.1	0.2	0.1	530	14	321	195	1463	264	1,863	1,412	42	61,430	13	0.0	116
Antineoplastic Agents	0.4	0.1	0.0	0.2	171	154	0	16	467	1,148	0	71	272	127,049	74	0.0	745
Endocrine/Metabolic Drugs	0.5	0.1	0.0	0.3	23	17	1	5	47	151	23	16	7,693	364,057	1,567	0.8	15,816
Cardiovascular Agents	0.8	0.1	0.0	0.6	21	12	0	9	27	93	9	14	12,317	338,407	1,570	0.8	15,972
Respiratory Agents	0.3	0.1	0.0	0.2	10	8	0	2	38	104	53	9	4,817	183,554	1,847	0.9	18,356
Gastrointestinal Agents	0.3	0.1	0.0	0.3	31	28	0	3	92	363	9	12	3,102	285,368	890	0.4	9,180
Genitourinary Agents	0.3	0.1	0.0	0.2	11	8	0	3	43	89	62	18	1,344	57,601	470	0.2	5,033
CNS Drugs	0.6	0.2	0.0	0.4	42	34	0	8	75	177	0	22	7,448	560,443	1,318	0.7	13,454
Stimulants/Anti-obesity/Anorexia	0.4	0.2	0.0	0.2	23	15	0	8	56	93	0	32	258	14,551	59	0.0	635
Miscellaneous Psychological/ Neurological Agents	0.4	0.4	0.0	0.0	97	96	0	0	227	227	0	82	198	44,886	49	0.0	465
Analgesics and Anesthetics	0.3	0.0	0.0	0.3	8	3	1	4	26	427	131	14	11,585	305,064	3,630	1.8	37,708
Neuromuscular Agents	0.5	0.1	0.0	0.3	33	17	2	14	67	141	48	42	4,461	297,820	880	0.4	9,084
Nutritional Products	0.3	0.0	0.0	0.3	3	0	0	3	10	36	154	10	2,097	21,815	647	0.3	6,596
Hematological Agents	0.4	0.1	0.0	0.3	197	194	0	3	498	1,422	20	11	1,816	903,877	449	0.2	4,588
Topical Products	0.2	0.0	0.0	0.2	5	2	0	3	25	70	65	17	3,092	76,840	1,648	0.8	16,972
Miscellaneous Products	0.3	0.3	0.0	0.0	100	96	0	4	323	369	0	75	357	115,349	106	0.1	1,158
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	4	0	0	0	22	0	0	0	203	4,412	95	0.0	1,016
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.	69,390	4,139,267	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Arizona, 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 Arizona, 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]

ARIZONA, 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
MISC. HEMATOLOGICAL	$796,858	107	0.1	1,051	0.4	$1,695	$758
ANTIPSYCHOTICS	430,904	583	0.3	6,174	0.4	174	70
ANTICONVULSANT	251,942	664	0.3	6,923	0.5	79	36
MISC. GI	223,947	391	0.2	4,015	0.3	191	56
ANTIDIABETIC	199,953	1,238	0.6	13,204	0.4	39	15
ANALGESICS - Narcotic	166,285	2,687	1.3	27,849	0.3	22	6
MISC. ENDOCRINE	161,593	132	0.1	1,439	0.4	316	112
ANTIASTHMATIC	151,042	1,526	0.8	14,948	0.2	45	10
ANTINEOPLASTICS	127,049	76	0.0	767	0.4	467	166
ANALGESICS - ANTI-INFLAMMATORY	116,738	2,528	1.2	27,055	0.2	26	4
Total	2,626,311	9,932		103,425	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Arizona, 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.