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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
MICHIGAN, 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]	1857775 (A)	249232 (E)	1608543 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1715804 (B)	230157 (F)	1485647 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	1006384 (C)	226056 (G)	780328 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	25214 (D)	23697 (H)	1517 (L)

Source: Data for this table are from the MAX 2005 file for Michigan, released by CMS in 10/2008. 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 Michigan in 2005 was $970,604,024, of which $135,448,201 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]

MICHIGAN, 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	**1,006,384**	**122,388**	**171,199**	**213,633**	**497,969**	**1,195**	**6,100,689**	**1,228,979**	**1,543,350**	**858,734**	**2,458,990**	**10,636**
Age												
5 and younger	203,612	0	4,647	0	198,965	0	961,242	0	39,764	0	921,478	0
6-14	207,883	0	10,320	0	197,563	0	1,105,587	0	84,830	0	1,020,757	0
15-20	127,242	0	8,417	21,503	97,290	32	679,581	0	68,982	106,655	503,702	242
21-44	240,868	0	62,467	173,900	3,970	531	1,283,500	0	577,155	689,356	12,606	4,383
45-64	104,266	9	85,348	18,230	47	632	841,546	25	772,619	62,723	168	6,011
65-74	49,320	49,320	0	0	0	0	510,444	510,444	0	0	0	0
75-84	41,595	41,595	0	0	0	0	423,970	423,970	0	0	0	0
85 and older	31,462	31,462	0	0	0	0	294,531	294,531	0	0	0	0
Unknown	136	2	0	0	134	0	288	9	0	0	279	0
Gender												
Female	590,322	88,151	84,625	170,924	245,427	1,195	3,604,195	895,644	775,886	716,468	1,205,561	10,636
Male	416,062	34,237	86,574	42,709	252,542	0	2,496,494	333,335	767,464	142,266	1,253,429	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	644,323	84,297	111,277	139,373	308,443	933	4,104,990	835,738	1,034,850	579,668	1,646,474	8,260
African American	276,424	27,027	51,238	58,985	138,989	185	1,486,217	279,100	431,082	212,599	561,754	1,682
Other/unknown	85,637	11,064	8,684	15,275	50,537	77	509,482	114,141	77,418	66,467	250,762	694
Use of Nursing Facilities[c]												
Entire year	25,214	22,470	2,737	5	2	0	261,007	230,789	30,161	33	24	0
Part year	19,354	16,161	3,138	51	2	2	171,539	143,334	27,860	314	7	24
None	961,816	83,757	165,324	213,577	497,965	1,193	5,668,143	854,856	1,485,329	858,387	2,458,959	10,612
Maintenance Assistance Status												
Cash	227,903	38,585	85,112	38,355	65,851	0	1,622,572	432,687	799,782	147,470	242,633	0
Medically needy	99,353	9,694	8,866	55,224	25,569	0	423,967	73,427	57,768	192,521	100,251	0
Poverty-related	432,904	40,637	47,362	45,990	297,720	1,195	2,635,879	423,710	433,731	235,221	1,532,581	10,636
Other/unknown	246,224	33,472	29,859	74,064	108,829	0	1,418,271	299,155	252,069	283,522	583,525	0
Dual Medicare Status[d]												
Full dual, all year	215,039	112,628	100,075	2,262	49	25	2,205,881	1,146,534	1,045,728	13,012	366	241
Full dual, part year	11,017	4,954	6,041	22	0	0	115,784	51,730	63,837	217	0	0
Non-dual, all year	780,328	4,806	65,083	211,349	497,920	1,170	3,779,024	30,715	433,785	845,505	2,458,624	10,395
Managed Care (MC) Status												
Fee-for-service (FFS) all year	527,920	119,591	128,374	91,613	187,166	1,176	4,510,451	1,211,079	1,355,672	481,498	1,451,695	10,507
FFS part year, with Rx claims	184,453	2,404	30,787	66,634	84,611	17	741,771	15,871	144,287	236,906	344,593	114
FFS part year, no Rx claims	294,011	393	12,038	55,386	226,192	2	848,467	2,029	43,391	140,330	662,702	15

Source: Data for this table are from the MAX 2005 file for Michigan, released by CMS in 10/2008. 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]

MICHIGAN, 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	**51.4**	**13.7**	**$830**	**$61**	**$4,181**	**19.8**	**1,006,384**
Age							
5 and younger	34.4	1.5	75	51	1,801	4.2	203,612
6-14	32.7	2.7	258	94	1,358	19.0	207,883
15-20	40.4	3.5	299	84	1,881	15.9	127,242
21-44	58.4	10.0	756	76	3,657	20.7	240,868
45-64	78.3	37.1	2,492	67	8,688	28.7	104,266
65-74	85.1	49.1	2,483	51	6,989	35.5	49,320
75-84	86.6	52.9	2,426	46	12,839	18.9	41,595
85 and older	87.4	50.2	2,004	40	20,785	9.6	31,462
Unknown	0.7	0.5	13	27	158	8.2	136
Basis of Eligibility[e]							
Aged	86.2	50.7	2,340	46	12,523	18.7	122,388
Disabled	79.8	33.8	2,629	78	9,352	28.1	171,199
Adults	51.7	3.9	163	42	2,147	7.6	213,633
Children	32.9	1.9	126	65	1,213	10.3	497,969
Unknown	81.4	17.5	1,175	67	9,523	12.3	1,195
Gender							
Female	55.0	15.6	847	54	4,395	19.3	590,322
Male	46.3	11.0	806	74	3,878	20.8	416,062
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	55.9	15.7	944	60	4,563	20.7	644,323
African American	43.1	10.5	657	62	3,683	17.8	276,424
Other/unknown	44.2	9.3	527	57	2,912	18.1	85,637
Use of Nursing Facilities[f]							
Entire year	95.5	78.0	3,457	44	40,214	8.6	25,214
Part year	94.4	56.8	2,617	46	23,288	11.2	19,354
None	49.4	11.1	725	65	2,852	25.4	961,816
Maintenance Assistance Status							
Cash	62.4	21.9	1,449	66	5,177	28.0	227,903
Medically needy	49.3	9.8	548	56	3,398	16.1	99,353
Poverty related	45.4	10.4	619	60	3,117	19.9	432,904
Other/unknown	52.6	13.6	741	55	5,445	13.6	246,224

Source: Data for this table are from the MAX 2005 file for Michigan, released by CMS in 10/2008. 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]

MICHIGAN, 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	**2.3**	**$137**	**19.8**	**48.6**	**25.1**	**6.0**	**9.9**	**7.4**	**3.0**	**$690**	**1,006,384**	**6,100,689**
Age												
5 and younger	0.3	16	4.2	65.6	30.5	2.5	1.1	0.2	0.0	381	203,612	961,242
6-14	0.5	48	19.0	67.3	23.8	3.6	3.4	1.2	0.8	255	207,883	1,105,587
15-20	0.7	56	15.9	59.6	29.3	4.9	4.3	1.3	0.7	352	127,242	679,581
21-44	1.9	142	20.7	41.6	30.4	8.7	11.1	5.6	2.6	686	240,868	1,283,500
45-64	4.6	309	28.7	21.7	15.7	9.7	23.3	20.5	9.0	1,077	104,266	841,546
65-74	4.7	240	35.5	14.9	13.5	9.7	27.1	25.9	9.0	675	49,320	510,444
75-84	5.2	238	18.9	13.4	10.8	8.5	27.5	29.6	10.1	1,260	41,595	423,970
85 and older	5.4	214	9.6	12.6	8.8	7.8	29.6	31.7	9.5	2,220	31,462	294,531
Unknown	0.2	6	8.2	99.3	0.0	0.0	0.0	0.0	0.7	75	136	288
Basis of Eligibility[e]												
Aged	5.0	233	18.7	13.8	11.4	8.8	27.8	28.7	9.5	1,247	122,388	1,228,979
Disabled	3.7	292	28.1	20.2	21.3	10.6	22.8	17.5	7.6	1,037	171,199	1,543,350
Adults	1.0	41	7.6	48.3	32.4	7.6	7.2	2.9	1.6	534	213,633	858,734
Children	0.4	25	10.3	67.1	26.6	3.1	2.2	0.6	0.4	246	497,969	2,458,990
Unknown	2.0	132	12.3	18.6	40.1	16.3	17.2	7.3	0.6	1,070	1,195	10,636
Gender												
Female	2.6	139	19.3	45.0	25.9	6.3	10.7	8.5	3.5	720	590,322	3,604,195
Male	1.8	134	20.8	53.7	23.9	5.6	8.8	5.8	2.2	646	416,062	2,496,494
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.5	148	20.7	44.1	26.4	6.3	10.9	8.6	3.6	716	644,323	4,104,990
African American	2.0	122	17.8	56.9	21.6	5.6	8.5	5.5	1.9	685	276,424	1,486,217
Other/unknown	1.6	89	18.1	55.8	25.9	5.1	7.3	4.5	1.5	490	85,637	509,482
Use of Nursing Facilities[f]												
Entire year	7.5	334	8.6	4.5	3.5	4.5	23.3	42.1	22.1	3,885	25,214	261,007
Part year	6.4	295	11.2	5.6	6.6	7.1	29.7	36.1	14.9	2,628	19,354	171,539
None	1.9	123	25.4	50.6	26.0	6.0	9.2	5.9	2.2	484	961,816	5,668,143
Maintenance Assistance Status												
Cash	3.1	204	28.0	37.6	23.1	8.0	15.4	11.4	4.5	727	227,903	1,622,572
Medically needy	2.3	128	16.1	50.7	21.3	7.4	10.7	7.0	3.0	796	99,353	423,967
Poverty related	1.7	102	19.9	54.6	27.0	4.5	6.9	5.1	1.9	512	432,904	2,635,879
Other/unknown	2.4	129	13.6	47.4	25.0	6.4	9.9	7.8	3.4	945	246,224	1,418,271

Source: Data for this table are from the MAX 2005 file for Michigan, released by CMS in 10/2008. 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]

MICHIGAN, 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	**2.3**	**$137**	**$61**	**0.8**	**$111**	**$134**	**0.1**	**$5**	**$84**	**1.4**	**$22**	**$16**
Age												
5 and younger	0.3	16	51	0.1	13	127	0.0	0	55	0.2	3	12
6-14	0.5	48	94	0.3	44	148	0.0	1	99	0.2	4	17
15-20	0.7	56	84	0.3	48	167	0.0	2	84	0.4	6	16
21-44	1.9	142	76	0.6	115	179	0.0	6	120	1.2	21	18
45-64	4.6	309	67	1.6	245	155	0.1	12	127	2.9	52	18
65-74	4.7	240	51	1.7	194	112	0.1	6	69	2.9	40	14
75-84	5.2	238	46	1.9	191	98	0.1	7	48	3.1	41	13
85 and older	5.4	214	40	1.9	164	88	0.2	9	40	3.3	41	13
Unknown	0.2	6	27	0.0	4	89	0.0	0	9	0.2	2	10
Basis of Eligibility[d]												
Aged	5.0	233	46	1.8	185	101	0.1	7	50	3.1	41	13
Disabled	3.7	292	78	1.4	237	175	0.1	11	131	2.3	43	19
Adults	1.0	41	42	0.3	30	116	0.0	2	69	0.7	9	13
Children	0.4	25	65	0.2	22	120	0.0	1	75	0.2	3	14
Unknown	2.0	132	67	0.6	114	188	0.0	2	50	1.3	16	13
Gender												
Female	2.6	139	54	0.9	110	122	0.1	5	74	1.6	24	15
Male	1.8	134	74	0.7	112	157	0.0	4	110	1.1	18	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.5	148	60	0.9	119	131	0.1	6	84	1.5	24	16
African American	2.0	122	62	0.7	101	150	0.0	3	88	1.2	18	15
Other/unknown	1.6	89	57	0.6	72	125	0.0	3	73	0.9	14	14
Use of Nursing Facilities[e]												
Entire year	7.5	334	44	2.7	256	95	0.3	13	41	4.5	65	14
Part year	6.4	295	46	2.2	225	102	0.2	12	49	3.9	58	15
None	1.9	123	65	0.7	101	145	0.0	4	107	1.2	18	16
Maintenance Assistance Status												
Cash	3.1	204	66	1.1	167	149	0.1	7	104	1.9	30	16
Medically needy	2.3	128	56	0.8	103	122	0.1	4	73	1.4	21	15
Poverty related	1.7	102	60	0.6	82	132	0.0	4	91	1.0	17	16
Other/unknown	2.4	129	55	0.9	103	118	0.1	5	61	1.4	21	15

Source: Data for this table are from the MAX 2005 file for Michigan, released by CMS in 10/2008. 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 Michigan, 0.1 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]

MICHIGAN, 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	0.3	0.1	0.0	0.2	$17	$12	$2	$3	$57	$218	$71	$14	776,035	$43,961,143	282,935	28.1	2,552,394
Biologicals	0.5	0.2	0.1	0.2	1,085	264	157	664	2055	1,206	2,329	2,747	1,340	2,754,185	288	0.0	2,539
Antineoplastic Agents	0.5	0.1	0.0	0.4	90	70	0	20	177	519	147	53	48,414	8,557,306	9,467	0.9	95,024
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.5	41	32	3	5	49	110	46	11	1,292,934	63,349,128	163,517	16.2	1,556,429
Cardiovascular Agents	1.7	0.5	0.0	1.2	55	43	0	12	32	78	24	10	3,080,175	97,907,892	177,312	17.6	1,768,462
Respiratory Agents	0.6	0.3	0.0	0.3	38	35	0	3	63	103	62	10	785,068	49,320,573	138,560	13.8	1,294,157
Gastrointestinal Agents	0.7	0.4	0.0	0.3	53	50	0	3	76	134	53	10	905,579	69,234,748	129,806	12.9	1,295,684
Genitourinary Agents	0.5	0.3	0.0	0.2	26	23	1	3	56	78	57	17	229,612	12,956,142	49,976	5.0	492,884
CNS Drugs	1.3	0.6	0.0	0.7	115	103	1	11	88	173	142	15	2,345,240	205,789,194	206,268	20.5	1,785,886
Stimulants/Anti-obesity/Anorexia	1.0	0.8	0.0	0.2	67	63	0	4	69	81	91	19	212,139	14,627,218	30,639	3.0	219,155
Miscellaneous Psychological/ Neurological Agents	0.8	0.8	0.0	0.0	137	135	0	2	166	168	107	78	186,536	30,894,975	22,189	2.2	226,063
Analgesics and Anesthetics	0.7	0.1	0.0	0.6	32	14	5	14	44	164	251	22	1,450,050	64,352,577	217,890	21.7	1,981,944
Neuromuscular Agents	1.0	0.4	0.0	0.6	73	53	3	17	75	149	84	29	1,032,030	77,797,168	114,503	11.4	1,068,185
Nutritional Products	0.5	0.0	0.0	0.4	6	0	0	5	12	15	13	12	358,981	4,216,935	83,098	8.3	750,950
Hematological Agents	0.7	0.3	0.0	0.4	96	91	1	5	131	294	50	11	423,167	55,389,011	56,639	5.6	577,346
Topical Products	0.4	0.1	0.0	0.2	16	11	0	5	42	85	57	19	607,608	25,582,888	169,625	16.9	1,621,642
Miscellaneous Products	0.4	0.2	0.0	0.2	69	53	7	8	179	296	232	47	46,656	8,354,118	12,049	1.2	121,815
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	5	0	0	0	16	0	0	0	7,094	110,622	2,043	0.2	21,483
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.	13,788,658	835,155,823	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Michigan, released by CMS in 10/2008. 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 Michigan, 0.1 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]

MICHIGAN, 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	$133,684,192	84,068	8.4	880,105	0.7	$208	$152
ANTICONVULSANT	63,715,457	83,593	8.3	874,369	0.8	94	73
ULCER DRUGS	52,886,100	125,682	12.5	1,276,555	0.5	80	41
ANTIHYPERLIPIDEMIC	45,608,503	86,054	8.6	912,836	0.7	77	50
ANTIDEPRESSANTS	44,249,446	150,320	14.9	1,497,107	0.6	48	30
MISC. HEMATOLOGICAL	39,469,571	29,816	3.0	312,538	0.6	205	126
ANTIASTHMATIC	38,761,350	168,956	16.8	1,625,083	0.4	64	24
ANALGESICS - Narcotic	36,818,402	225,890	22.4	2,141,601	0.4	38	17
ANTIDIABETIC	36,664,288	94,061	9.3	960,711	0.7	56	38
MISC PSYCHOTHERAPEUTIC AND NEUROLOGICAL	30,894,793	27,179	2.7	279,011	0.7	165	111
Total	522,752,102	1,075,619		10,759,916	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Michigan, released by CMS in 10/2008. 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.