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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEVADA, 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]	267880 (A)	37852 (E)	230028 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	247282 (B)	22583 (F)	224699 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	173480 (C)	22509 (G)	150971 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2505 (D)	2246 (H)	259 (L)

Source: Data for this table are from the MAX 2005 file for Nevada, 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 Nevada in 2005 was $134,420,404, of which $276,502 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]

NEVADA, 2005

	Number of Beneficiaries						Number of Benefit Months					
Beneficiary Characteristics	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**173,480**	**14,167**	**30,208**	**34,525**	**94,396**	**184**	**976,918**	**143,161**	**298,581**	**126,116**	**407,795**	**1,265**
Age												
5 and younger	47,696	0	1,411	0	46,285	0	189,995	0	13,379	0	176,616	0
6-14	38,711	0	3,453	0	35,258	0	199,599	0	34,603	0	164,996	0
15-20	18,042	0	2,271	3,045	12,720	6	100,203	0	22,670	11,670	65,837	26
21-44	38,794	0	9,795	28,945	20	34	202,808	0	97,553	104,895	137	223
45-64	15,230	5	12,611	2,460	13	141	134,289	27	123,953	9,276	36	997
65-74	6,234	5,692	494	43	2	3	63,609	58,706	4,691	179	14	19
75-84	5,498	5,352	122	24	0	0	56,226	54,936	1,219	71	0	0
85 and older	3,177	3,118	51	8	0	0	30,030	29,492	513	25	0	0
Unknown	98	0	0	0	98	0	159	0	0	0	159	0
Gender												
Female	100,119	10,001	15,726	27,702	46,506	184	563,666	102,258	158,111	102,545	199,487	1,265
Male	72,447	4,166	14,480	6,820	46,981	0	411,132	40,903	140,451	23,564	206,214	0
Unknown	914	0	2	3	909	0	2,120	0	19	7	2,094	0
Race												
White	81,623	8,261	18,028	17,657	37,557	120	534,259	81,258	178,921	73,648	199,569	863
African American	31,721	977	6,385	6,870	17,474	15	151,535	10,080	63,062	18,630	59,666	97
Other/unknown	60,136	4,929	5,795	9,998	39,365	49	291,124	51,823	56,598	33,838	148,560	305
Use of Nursing Facilities[c]												
Entire year	2,505	2,015	488	0	2	0	24,451	19,233	5,194	0	24	0
Part year	2,246	1,582	652	6	3	3	21,258	14,735	6,438	31	27	27
None	168,729	10,570	29,068	34,519	94,391	181	931,209	109,193	286,949	126,085	407,744	1,238
Maintenance Assistance Status												
Cash	107,151	8,428	25,772	23,702	49,249	0	618,323	89,498	253,098	83,834	191,893	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	29,317	302	478	3,824	24,529	184	112,524	3,164	4,596	13,391	90,108	1,265
Other/unknown	37,012	5,437	3,958	6,999	20,618	0	246,071	50,499	40,887	28,891	125,794	0
Dual Medicare Status[d]												
Full dual, all year	20,964	12,948	7,700	309	3	4	213,820	131,430	80,722	1,611	17	40
Full dual, part year	1,545	779	723	42	1	0	15,780	8,208	7,186	381	5	0
Non-dual, all year	150,971	440	21,785	34,174	94,392	180	747,318	3,523	210,673	124,124	407,773	1,225
Managed Care (MC) Status												
Fee-for-service (FFS) all year	100,811	14,166	29,623	14,298	42,541	183	779,922	143,151	294,543	71,834	269,138	1,256
FFS part year, with Rx claims	18,240	1	393	7,854	9,991	1	59,335	10	2,889	23,191	33,236	9
FFS part year, no Rx claims	54,429	0	192	12,373	41,864	0	137,661	0	1,149	31,091	105,421	0

Source: Data for this table are from the MAX 2005 file for Nevada, 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]
NEVADA, 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	**44.0**	**10.9**	**$773**	**$71**	**$5,106**	**15.1**	**173,480**
Age							
5 and younger	29.1	1.2	196	161	2,007	9.8	47,696
6-14	29.2	2.3	225	98	1,845	12.2	38,711
15-20	37.2	3.3	306	92	3,758	8.1	18,042
21-44	50.5	9.3	814	87	5,435	15.0	38,794
45-64	78.5	41.9	3,013	72	14,374	21.0	15,230
65-74	83.8	43.2	2,300	53	10,565	21.8	6,234
75-84	88.5	48.1	2,298	48	15,301	15.0	5,498
85 and older	90.0	46.5	1,930	42	22,356	8.6	3,177
Unknown	0.0	0.0	0	0	123	0.0	98
Basis of Eligibility[e]							
Aged	87.2	46.1	2,229	48	14,996	14.9	14,167
Disabled	79.0	33.4	2,935	88	14,913	19.7	30,208
Adults	41.4	2.9	137	47	1,901	7.2	34,525
Children	27.3	1.3	95	74	1,631	5.8	94,396
Unknown	71.7	16.5	1,073	65	17,569	6.1	184
Gender							
Female	47.2	12.6	792	63	5,063	15.6	100,119
Male	40.0	8.6	757	88	5,218	14.5	72,447
Unknown	11.8	0.4	15	39	951	1.6	914
Race							
White	53.7	15.5	1,085	70	6,933	15.7	81,623
African American	36.2	7.4	553	75	3,951	14.0	31,721
Other/unknown	35.0	6.4	466	73	3,235	14.4	60,136
Use of Nursing Facilities[f]							
Entire year	96.6	79.3	3,502	44	48,322	7.2	2,505
Part year	95.1	63.5	3,108	49	39,554	7.9	2,246
None	42.6	9.2	702	77	4,006	17.5	168,729
Maintenance Assistance Status							
Cash	46.2	11.9	909	76	4,286	21.2	107,151
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	27.7	1.4	75	54	1,586	4.7	29,317
Other/unknown	50.6	15.4	933	61	10,266	9.1	37,012

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

NEVADA, 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	**1.9**	**$137**	**15.1**	**56.0**	**24.3**	**5.4**	**7.7**	**4.9**	**1.7**	**$907**	**173,480**	**976,918**
Age												
5 and younger	0.3	49	9.8	70.9	25.3	2.5	1.1	0.1	0.0	504	47,696	189,995
6-14	0.4	44	12.2	70.8	23.7	2.9	2.2	0.3	0.0	358	38,711	199,599
15-20	0.6	55	8.1	62.8	29.2	4.2	3.1	0.6	0.1	677	18,042	100,203
21-44	1.8	156	15.0	49.5	28.0	8.1	9.3	4.1	0.9	1,040	38,794	202,808
45-64	4.8	342	21.0	21.5	16.4	9.7	23.6	20.0	8.7	1,630	15,230	134,289
65-74	4.2	225	21.8	16.2	17.0	10.7	27.1	22.0	7.1	1,035	6,234	63,609
75-84	4.7	225	15.0	11.5	14.3	10.9	29.4	25.3	8.6	1,496	5,498	56,226
85 and older	4.9	204	8.6	10.0	12.3	10.8	31.2	27.3	8.4	2,365	3,177	30,030
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	76	98	159
Basis of Eligibility[e]												
Aged	4.6	221	14.9	12.8	14.9	10.8	29.0	24.6	8.0	1,484	14,167	143,161
Disabled	3.4	297	19.7	21.0	26.8	10.9	20.9	14.8	5.6	1,509	30,208	298,581
Adults	0.8	38	7.2	58.6	28.1	6.3	5.2	1.5	0.2	521	34,525	126,116
Children	0.3	22	5.8	72.7	23.5	2.5	1.2	0.1	0.0	378	94,396	407,795
Unknown	2.4	156	6.1	28.3	24.5	13.0	27.7	6.0	0.5	2,556	184	1,265
Gender												
Female	2.2	141	15.6	52.8	24.8	5.7	8.7	5.9	2.1	899	100,119	563,666
Male	1.5	133	14.5	60.0	23.7	5.0	6.6	3.6	1.1	919	72,447	411,132
Unknown	0.2	7	1.6	88.2	10.7	0.7	0.3	0.1	0.0	410	914	2,120
Race												
White	2.4	166	15.7	46.3	27.3	6.4	10.1	7.2	2.7	1,059	81,623	534,259
African American	1.6	116	14.0	63.8	21.3	4.8	5.9	3.3	0.9	827	31,721	151,535
Other/unknown	1.3	96	14.4	65.0	21.8	4.3	5.5	2.8	0.6	668	60,136	291,124
Use of Nursing Facilities[f]												
Entire year	8.1	359	7.2	3.4	4.4	5.1	25.0	37.2	25.0	4,951	2,505	24,451
Part year	6.7	328	7.9	4.9	7.8	7.4	27.8	34.4	17.6	4,179	2,246	21,258
None	1.7	127	17.5	57.4	24.8	5.4	7.2	4.1	1.1	726	168,729	931,209
Maintenance Assistance Status												
Cash	2.1	158	21.2	53.8	24.0	6.1	9.1	5.4	1.6	743	107,151	618,323
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	20	4.7	72.3	23.3	2.7	1.3	0.3	0.0	413	29,317	112,524
Other/unknown	2.3	140	9.1	49.4	25.8	5.5	8.9	7.2	3.1	1,544	37,012	246,071

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

NEVADA, 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	**1.9**	**$137**	**$71**	**0.7**	**$98**	**$150**	**0.1**	**$11**	**$137**	**1.2**	**$29**	**$24**
Age												
5 and younger	0.3	49	161	0.1	45	499	0.0	0	61	0.2	4	19
6-14	0.4	44	98	0.2	37	177	0.0	2	87	0.2	5	24
15-20	0.6	55	92	0.2	45	181	0.0	3	86	0.3	8	24
21-44	1.8	156	87	0.6	109	192	0.1	15	175	1.1	31	28
45-64	4.8	342	72	1.5	220	146	0.2	37	184	3.0	85	28
65-74	4.2	225	53	1.5	159	107	0.1	13	90	2.6	54	21
75-84	4.7	225	48	1.6	159	97	0.2	11	70	2.9	55	19
85 and older	4.9	204	42	1.6	141	90	0.2	9	54	3.2	54	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	4.6	221	48	1.6	156	99	0.2	11	73	2.8	54	19
Disabled	3.4	297	88	1.1	211	185	0.1	27	179	2.1	59	28
Adults	0.8	38	47	0.2	22	116	0.0	3	101	0.6	12	22
Children	0.3	22	74	0.1	18	158	0.0	1	69	0.2	4	20
Unknown	2.4	156	65	0.6	106	169	0.1	10	114	1.7	40	24
Gender												
Female	2.2	141	63	0.7	95	130	0.1	12	127	1.4	34	24
Male	1.5	133	88	0.5	101	188	0.1	9	158	0.9	23	25
Unknown	0.2	7	39	0.0	4	151	0.0	0	56	0.1	3	18
Race												
White	2.4	166	70	0.8	116	148	0.1	13	129	1.5	37	25
African American	1.6	116	75	0.5	77	157	0.1	14	216	1.0	24	24
Other/unknown	1.3	96	73	0.5	74	152	0.0	5	110	0.8	17	22
Use of Nursing Facilities[e]												
Entire year	8.1	359	44	2.5	244	99	0.3	17	57	5.4	97	18
Part year	6.7	328	49	1.9	219	113	0.2	16	72	4.5	93	21
None	1.7	127	77	0.6	91	159	0.1	10	152	1.0	26	25
Maintenance Assistance Status												
Cash	2.1	158	76	0.7	112	159	0.1	13	159	1.3	33	26
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.4	20	54	0.1	13	137	0.0	1	83	0.3	5	20
Other/unknown	2.3	140	61	0.8	101	131	0.1	8	90	1.5	31	21

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

NEVADA, 2005

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	$26	$19	$3	$5	$82	$238	$85	$24	127,485	$10,497,784	45,296	26.1	399,121
Biologicals	0.3	0.2	0.0	0.0	285	235	4	46	1110	1,126	1,095	1,038	2,613	2,901,233	1,033	0.6	10,174
Antineoplastic Agents	0.5	0.1	0.0	0.4	95	67	0	27	185	624	96	68	7,361	1,362,097	1,461	0.8	14,397
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.5	41	30	3	8	51	101	52	18	175,739	9,029,472	22,542	13.0	217,584
Cardiovascular Agents	1.6	0.6	0.0	1.0	60	45	0	15	39	81	50	15	364,781	14,161,489	22,948	13.2	234,434
Respiratory Agents	0.6	0.3	0.1	0.3	37	27	4	6	61	101	68	22	176,284	10,780,701	32,405	18.7	290,301
Gastrointestinal Agents	0.6	0.1	0.0	0.5	34	26	1	7	56	181	77	15	96,131	5,389,912	15,425	8.9	158,198
Genitourinary Agents	0.4	0.3	0.0	0.1	28	23	1	4	65	85	69	26	27,838	1,796,615	6,875	4.0	64,610
CNS Drugs	1.2	0.5	0.0	0.7	111	94	2	14	94	193	147	21	302,177	28,292,374	25,623	14.8	254,890
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	66	59	1	5	105	117	106	48	20,345	2,129,751	3,186	1.8	32,374
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	134	133	0	1	185	188	81	63	17,013	3,144,002	2,274	1.3	23,451
Analgesics and Anesthetics	0.8	0.1	0.0	0.6	59	18	18	23	76	207	379	35	235,936	17,836,932	32,585	18.8	302,802
Neuromuscular Agents	0.9	0.2	0.0	0.6	67	40	4	23	78	165	123	39	144,980	11,328,056	16,712	9.6	168,957
Nutritional Products	0.5	0.0	0.0	0.4	8	1	0	7	18	39	21	16	42,741	772,514	10,577	6.1	91,747
Hematological Agents	0.8	0.3	0.0	0.5	123	115	1	7	149	365	35	14	62,942	9,402,534	7,388	4.3	76,337
Topical Products	0.3	0.1	0.0	0.2	20	14	1	5	56	97	60	26	79,100	4,428,457	24,092	13.9	226,664
Miscellaneous Products	0.5	0.2	0.0	0.2	100	70	12	18	209	348	307	75	4,038	842,470	831	0.5	8,419
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	10	0	0	0	49	0	0	0	977	47,509	446	0.3	4,678
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.	1,888,481	134,143,902	n.a.	n.a.	n.a.

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

NEVADA, 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	$20,121,843	13,145	7.6	138,932	0.6	$236	$145
ANALGESICS - Narcotic	13,526,952	38,837	22.4	376,504	0.5	79	36
ANTICONVULSANT	9,331,028	12,716	7.3	133,554	0.7	102	70
MISC. HEMATOLOGICAL	7,401,543	3,323	1.9	35,107	0.6	330	211
ANTIASTHMATIC	6,802,286	27,178	15.7	259,586	0.4	68	26
ANTIDEPRESSANTS	6,274,700	19,707	11.4	201,846	0.6	54	31
ANTIHYPERLIPIDEMIC	6,231,627	10,983	6.3	118,597	0.6	88	53
ANTIVIRAL	4,831,847	2,759	1.6	27,729	0.5	387	174
ANTIDIABETIC	4,755,021	12,213	7.0	126,404	0.6	58	38
ANTIHYPERTENSIVE	3,236,811	16,827	9.7	175,636	0.6	30	18
Total	82,513,658	157,688		1,593,895	n.a.	n.a.	n.a.

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