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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006
ARKANSAS

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
ARKANSAS, 2006

Inclusion Criteria (2006)	Number of Dual and Nondual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Nondual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	758906 (A)	106164 (E)	652742 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	727101 (B)	75689 (F)	651412 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	727101 (C)	75689 (G)	651412 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	10975 (D)	10226 (H)	749 (L)

Source: Data for this table are from the MAX 2006 file for Arkansas, released by CMS in 9/2009. This table was produced on 02/09/2010.
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 2006 (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 2006, 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 2006 was $299,145,434, of which $5,863,843 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 29 states in 2006 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, KY, MA, MI, MS, NC, NH, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, and WI. In addition, there were 10 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NC, NE, NY, TN, TX, UT, and WV). These lists were constructed from the CMS 2006 Medicaid Managed Care Enrollment Report 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 2006. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.
g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the 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 2006. 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, 2006

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**727,101**	**48,377**	**100,528**	**150,856**	**426,732**	**608**	**7,217,801**	**509,363**	**1,056,333**	**1,343,120**	**4,304,102**	**4,883**
Age												
5 and younger	160,855	0	6,417	54	154,384	0	1,562,877	0	68,204	493	1,494,180	0
6-14	202,738	0	13,375	89	189,274	0	2,130,266	0	148,817	892	1,980,557	0
15-20	111,909	0	8,816	20,060	83,030	3	1,074,036	0	96,424	148,660	828,926	26
21-44	156,866	0	32,365	124,257	44	200	1,482,050	0	342,464	1,137,640	439	1,507
45-64	45,991	0	39,226	6,367	0	398	456,240	0	397,679	55,259	0	3,302
65-74	16,670	16,313	329	21	0	7	177,809	174,894	2,745	122	0	48
75-84	16,836	16,829	0	7	0	0	179,126	179,083	0	43	0	0
85 and older	15,235	15,234	0	1	0	0	155,395	155,384	0	11	0	0
Unknown	1	1	0	0	0	0	2	2	0	0	0	0
Gender												
Female	445,013	36,092	50,720	143,514	214,079	608	4,391,638	383,833	539,740	1,297,798	2,165,384	4,883
Male	281,291	12,264	49,779	7,256	211,992	0	2,819,143	125,344	516,359	44,784	2,132,656	0
Unknown	797	21	29	86	661	0	7,020	186	234	538	6,062	0
Race												
White	433,670	32,172	52,446	94,112	254,468	472	4,274,665	332,518	544,079	839,801	2,554,465	3,802
African American	210,121	12,158	27,487	46,416	123,948	112	2,118,951	132,631	292,154	427,828	1,265,459	879
Other/unknown	83,310	4,047	20,595	10,328	48,316	24	824,185	44,214	220,100	75,491	484,178	202
Use of Nursing Facilities[c]												
Entire year	10,975	9,561	1,413	0	0	1	107,949	93,460	14,487	0	0	2
Part year	7,255	6,105	1,144	5	1	0	73,802	61,801	11,956	33	12	0
None	708,871	32,711	97,971	150,851	426,731	607	7,036,050	354,102	1,029,890	1,343,087	4,304,090	4,881
Maintenance Assistance Status												
Cash	153,824	22,348	87,136	19,854	24,486	0	1,605,298	251,805	935,696	171,846	245,951	0
Medically needy	9,567	377	3,126	4,705	1,359	0	58,168	1,383	12,429	31,171	13,185	0
Poverty-related	322,503	4,578	673	29,423	287,221	608	3,157,766	50,499	5,639	186,045	2,910,700	4,883
Other/unknown	241,207	21,074	9,593	96,874	113,666	0	2,396,569	205,676	102,569	954,058	1,134,266	0
Dual Medicare Status[d]												
Full dual, all year	69,661	39,617	28,788	1,211	8	37	729,595	412,796	305,187	11,191	76	345
Full dual, part year	6,028	5,061	940	27	0	0	65,173	56,681	8,213	279	0	0
Non-dual, all year	651,412	3,699	70,800	149,618	426,724	571	6,423,033	39,886	742,933	1,331,650	4,304,026	4,538
Managed Care (MC) Status												
Fee-for-service (FFS) all year	727,101	48,377	100,528	150,856	426,732	608	7,217,801	509,363	1,056,333	1,343,120	4,304,102	4,883
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 2006 file for Arkansas, released by CMS in 9/2009. This table was produced on 02/09/2010.

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 2006. 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, 2006

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	**59.2**	**5.8**	**$403**	**$69**	**$3,751**	**10.8**	**727,101**
Age							
5 and younger	73.1	5.2	235	46	2,758	8.5	160,855
6-14	61.9	5.0	396	80	1,926	20.5	202,738
15-20	56.8	5.0	382	77	2,586	14.8	111,909
21-44	44.3	5.3	403	76	3,100	13.0	156,866
45-64	66.5	17.4	1,315	75	9,692	13.6	45,991
65-74	45.7	4.6	245	53	9,974	2.5	16,670
75-84	47.4	3.6	152	43	13,846	1.1	16,836
85 and older	50.9	3.7	145	39	17,872	0.8	15,235
Unknown	0.0	0.0	0	0	0	0.0	1
Basis of Eligibility[e]							
Aged	47.8	3.9	176	45	13,804	1.3	48,377
Disabled	72.4	16.2	1,555	96	11,386	13.7	100,528
Adults	38.3	3.2	150	48	1,103	13.6	150,856
Children	64.6	4.5	246	55	1,730	14.2	426,732
Unknown	89.5	16.2	1,562	96	16,231	9.6	608
Gender							
Female	56.6	5.6	347	62	3,489	9.9	445,013
Male	63.3	6.1	494	81	4,172	11.8	281,291
Unknown	37.0	1.8	92	53	1,303	7.1	797
Race							
White	61.2	6.3	433	69	3,971	10.9	433,670
African American	55.3	4.8	305	64	3,178	9.6	210,121
Other/unknown	58.2	6.0	499	84	4,046	12.3	83,310
Use of Nursing Facilities[f]							
Entire year	72.8	11.3	615	54	33,686	1.8	10,975
Part year	70.3	10.9	648	60	28,486	2.3	7,255
None	58.8	5.7	398	70	3,034	13.1	708,871
Maintenance Assistance Status							
Cash	66.7	12.0	1,048	87	7,070	14.8	153,824
Medically needy	61.3	7.1	505	71	5,218	9.7	9,567
Poverty related	65.7	4.5	230	51	1,938	11.8	322,503
Other/unknown	45.5	3.5	221	62	3,999	5.5	241,207

Source: Data for this table are from the MAX 2006 file for Arkansas, released by CMS in 9/2009. This table was produced on 02/09/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

				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	**0.6**	**$41**	**10.8**	**40.8**	**48.4**	**5.4**	**4.5**	**0.8**	**0.1**	**$378**	**727,101**	**7,217,801**
Age												
5 and younger	0.5	24	8.5	26.9	65.3	5.7	1.9	0.1	0.0	284	160,855	1,562,877
6-14	0.5	38	20.5	38.1	54.0	4.6	3.0	0.4	0.0	183	202,738	2,130,266
15-20	0.5	40	14.8	43.2	48.0	5.2	3.1	0.5	0.0	270	111,909	1,074,036
21-44	0.6	43	13.0	55.7	32.6	5.4	5.4	0.8	0.0	328	156,866	1,482,050
45-64	1.8	133	13.6	33.5	27.5	10.2	21.8	6.6	0.5	977	45,991	456,240
65-74	0.4	23	2.5	54.3	37.4	3.5	3.7	0.8	0.1	935	16,670	177,809
75-84	0.3	14	1.1	52.6	41.4	3.2	1.9	0.7	0.2	1,301	16,836	179,126
85 and older	0.4	14	0.8	49.1	43.7	4.1	2.3	0.6	0.2	1,752	15,235	155,395
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	1	2
Basis of Eligibility[e]												
Aged	0.4	17	1.3	52.2	40.9	3.6	2.5	0.7	0.1	1,311	48,377	509,363
Disabled	1.5	148	13.7	27.6	37.3	11.4	18.5	4.9	0.4	1,084	100,528	1,056,333
Adults	0.4	17	13.6	61.7	31.4	3.9	2.8	0.2	0.0	124	150,856	1,343,120
Children	0.4	24	14.2	35.4	57.9	4.7	1.9	0.1	0.0	172	426,732	4,304,102
Unknown	2.0	194	9.6	10.5	36.3	22.9	27.1	3.1	0.0	2,021	608	4,883
Gender												
Female	0.6	35	9.9	43.4	46.2	5.0	4.4	0.9	0.1	354	445,013	4,391,638
Male	0.6	49	11.8	36.7	51.9	5.9	4.6	0.8	0.1	416	281,291	2,819,143
Unknown	0.2	11	7.1	63.0	34.0	1.9	1.0	0.1	0.0	148	797	7,020
Race												
White	0.6	44	10.9	38.8	49.2	6.0	5.0	0.9	0.1	403	433,670	4,274,665
African American	0.5	30	9.6	44.7	47.0	4.5	3.3	0.5	0.0	315	210,121	2,118,951
Other/unknown	0.6	50	12.3	41.8	47.7	4.6	4.7	1.1	0.1	409	83,310	824,185
Use of Nursing Facilities[f]												
Entire year	1.1	63	1.8	27.2	52.0	8.4	6.5	4.0	1.8	3,425	10,975	107,949
Part year	1.1	64	2.3	29.7	53.0	6.9	5.6	3.4	1.5	2,800	7,255	73,802
None	0.6	40	13.1	41.2	48.3	5.3	4.4	0.8	0.0	306	708,871	7,036,050
Maintenance Assistance Status												
Cash	1.1	100	14.8	33.3	41.0	9.3	13.1	3.0	0.2	677	153,824	1,605,298
Medically needy	1.2	83	9.7	38.7	30.0	14.0	15.7	1.6	0.0	858	9,567	58,168
Poverty related	0.5	23	11.8	34.3	58.7	4.9	2.0	0.1	0.0	198	322,503	3,157,766
Other/unknown	0.4	22	5.5	54.5	40.1	3.2	1.8	0.3	0.1	403	241,207	2,396,569

Source: Data for this table are from the MAX 2006 file for Arkansas, released by CMS in 9/2009. This table was produced on 02/09/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

	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	**0.6**	**$41**	**$69**	**0.2**	**$30**	**$148**	**0.0**	**$2**	**$73**	**0.4**	**$8**	**$23**
Age												
5 and younger	0.5	24	46	0.2	16	105	0.0	2	38	0.3	6	19
6-14	0.5	38	80	0.2	31	146	0.0	1	60	0.2	6	24
15-20	0.5	40	77	0.2	31	168	0.0	2	81	0.3	7	22
21-44	0.6	43	76	0.2	32	170	0.0	2	102	0.4	9	24
45-64	1.8	133	75	0.6	92	157	0.1	9	112	1.1	31	28
65-74	0.4	23	53	0.1	14	125	0.0	2	104	0.3	7	22
75-84	0.3	14	43	0.1	9	111	0.0	1	89	0.2	5	19
85 and older	0.4	14	39	0.1	9	102	0.0	1	74	0.3	4	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.4	17	45	0.1	10	114	0.0	2	91	0.3	5	19
Disabled	1.5	148	96	0.6	116	199	0.1	7	104	0.9	25	28
Adults	0.4	17	48	0.1	11	97	0.0	2	97	0.2	5	21
Children	0.4	24	55	0.2	18	114	0.0	1	47	0.3	6	21
Unknown	2.0	194	96	0.7	151	216	0.1	9	133	1.3	33	27
Gender												
Female	0.6	35	62	0.2	25	133	0.0	2	78	0.4	8	23
Male	0.6	49	81	0.2	39	166	0.0	2	66	0.3	8	24
Unknown	0.2	11	53	0.1	7	111	0.0	1	44	0.1	3	25
Race												
White	0.6	44	69	0.2	32	144	0.0	2	75	0.4	9	24
African American	0.5	30	64	0.2	22	141	0.0	2	68	0.3	7	22
Other/unknown	0.6	50	84	0.2	40	180	0.0	2	75	0.4	9	24
Use of Nursing Facilities[e]												
Entire year	1.1	63	54	0.3	42	138	0.0	4	85	0.8	16	20
Part year	1.1	64	60	0.3	43	146	0.0	4	90	0.7	16	23
None	0.6	40	70	0.2	30	148	0.0	2	73	0.3	8	24
Maintenance Assistance Status												
Cash	1.1	100	87	0.4	77	188	0.1	5	100	0.7	18	27
Medically needy	1.2	83	71	0.4	60	164	0.0	5	100	0.8	19	25
Poverty related	0.5	23	51	0.2	16	109	0.0	1	49	0.3	6	20
Other/unknown	0.4	22	62	0.1	16	122	0.0	1	69	0.2	5	22

Source: Data for this table are from the MAX 2006 file for Arkansas, released by CMS in 9/2009. This table was produced on 02/09/2010.

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.medi-span.com/master-drug-database.aspx

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, 2006

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	0.2	0.0	0.0	0.2	$11	$5	$1	$4	$46	$141	$49	$25	696,463	$31,767,936	277,711	38.2	2,983,887
Biologicals	0.4	0.4	0.0	0.0	500	491	3	6	1329	1,331	1,055	1,381	4,831	6,422,255	1,427	0.2	12,854
Antineoplastic Agents	0.4	0.1	0.0	0.3	111	96	0	14	267	746	245	51	9,436	2,519,497	2,268	0.3	22,782
Endocrine/Metabolic Drugs	0.3	0.1	0.0	0.2	21	14	1	6	62	109	65	29	363,766	22,561,037	99,186	13.6	1,064,490
Cardiovascular Agents	0.7	0.2	0.1	0.4	30	13	7	10	45	70	127	24	356,807	16,136,049	50,156	6.9	533,321
Respiratory Agents	0.3	0.1	0.0	0.2	17	13	1	3	53	95	32	19	666,276	35,026,480	191,183	26.3	2,065,426
Gastrointestinal Agents	0.3	0.2	0.0	0.1	31	27	2	3	96	146	225	21	197,007	18,833,360	56,716	7.8	599,657
Genitourinary Agents	0.2	0.1	0.0	0.1	11	6	3	3	57	85	101	26	40,685	2,301,587	19,364	2.7	200,704
CNS Drugs	0.6	0.2	0.0	0.3	60	50	3	7	105	221	103	23	606,972	63,846,795	98,419	13.5	1,055,393
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	67	63	0	3	112	121	158	41	212,127	23,664,306	32,152	4.4	355,751
Miscellaneous Psychological/ Neurological Agents	0.3	0.2	0.0	0.0	73	71	0	3	272	285	81	121	10,146	2,757,324	3,599	0.5	37,658
Analgesics and Anesthetics	0.3	0.0	0.0	0.2	10	4	0	5	35	171	90	21	397,298	13,947,359	135,435	18.6	1,431,913
Neuromuscular Agents	0.5	0.2	0.0	0.3	53	41	2	10	99	185	98	33	245,696	24,240,921	42,765	5.9	459,908
Nutritional Products	0.2	0.0	0.0	0.2	3	0	0	3	14	10	12	15	63,390	895,118	26,043	3.6	261,171
Hematological Agents	0.4	0.1	0.0	0.3	109	103	0	6	246	909	52	20	52,955	13,052,389	11,461	1.6	119,422
Topical Products	0.2	0.1	0.0	0.1	8	5	0	2	44	93	50	20	277,805	12,146,704	139,906	19.2	1,515,922
Miscellaneous Products	0.1	0.1	0.0	0.0	18	16	0	2	139	152	281	72	21,531	2,987,773	15,245	2.1	164,301
Unknown Therapeutic Category	0.1	0.0	0.0	0.0	7	0	0	0	52	0	0	0	3,379	174,701	2,320	0.3	25,485
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.	4,226,570	293,281,591	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Arkansas, released by CMS in 9/2009. This table was produced on 02/09/2010.

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.medi-span.com/master-drug-database.aspx.

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.medi-span.com/master-drug-database.aspx.

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2006.

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, 2006

		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	$43,491,963	31,288	4.3	344,635	0.5	$280	$126
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	23,664,306	37,588	5.2	419,232	0.5	112	56
ANTIASTHMATIC	23,217,469	115,642	15.9	1,271,087	0.2	76	18
ANTICONVULSANT	22,383,057	31,878	4.4	348,641	0.5	119	64
ANTIDEPRESSANTS	14,781,688	57,860	8.0	618,425	0.4	65	24
ULCER DRUGS	14,668,441	45,564	6.3	482,069	0.3	104	30
MISC. HEMATOLOGICAL	10,500,207	3,902	0.5	40,858	0.4	667	257
CEPHALOSPORINS	7,969,038	110,334	15.2	1,216,616	0.1	54	7
MISC. ENDOCRINE	7,812,269	5,474	0.8	61,237	0.4	351	128
ANTIDIABETIC	6,983,565	17,978	2.5	192,279	0.5	79	36
Total	175,472,003	457,508	n.a.	4,995,079	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Arkansas, released by CMS in 9/2009. This table was produced on 02/09/2010.

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 2006. 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 2006. For information about these drug groups, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.

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.