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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
ARIZONA, 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]	1464622 (A)	137286 (E)	1327336 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1305503 (B)	114102 (F)	1191401 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	208008 (C)	40034 (G)	167974 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	404 (D)	307 (H)	97 (L)

Source: Data for this table are from the MAX 2006 file for Arizona, released by CMS in 9/2009. This table was produced on 02/11/2010.
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 Arizona in 2006 was $2,657,506, of which $249,094 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]

ARIZONA, 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	**208,008**	**25,485**	**42,686**	**68,929**	**70,892**	**16**	**1,528,082**	**192,800**	**387,918**	**459,050**	**488,273**	**41**
Age												
5 and younger	33,433	0	3,956	0	29,477	0	209,570	0	34,156	0	175,414	0
6-14	35,287	0	6,927	0	28,360	0	285,566	0	68,627	0	216,939	0
15-20	23,029	1	3,425	6,553	13,050	0	174,286	1	33,593	44,791	95,901	0
21-44	56,628	131	10,426	46,065	3	3	403,000	161	94,062	308,755	5	17
45-64	30,686	209	14,576	15,889	0	12	225,692	318	122,087	103,266	0	21
65-74	10,293	7,530	2,446	316	0	1	85,617	58,446	25,489	1,679	0	3
75-84	10,284	9,401	798	85	0	0	84,015	74,866	8,682	467	0	0
85 and older	8,365	8,213	132	20	0	0	60,321	59,008	1,222	91	0	0
Unknown	3	0	0	1	2	0	15	0	0	1	14	0
Gender												
Female	111,484	17,597	19,634	38,883	35,354	16	835,072	136,498	179,871	274,075	244,587	41
Male	96,524	7,888	23,052	30,046	35,538	0	693,010	56,302	208,047	184,975	243,686	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	46,147	13,283	17,506	9,467	5,886	5	269,692	93,365	151,760	15,490	9,068	9
African American	6,285	861	1,792	1,822	1,809	1	24,871	6,369	12,927	2,857	2,717	1
Other/unknown	155,576	11,341	23,388	57,640	63,197	10	1,233,519	93,066	223,231	440,703	476,488	31
Use of Nursing Facilities[c]												
Entire year	404	303	101	0	0	0	3,477	2,510	967	0	0	0
Part year	600	284	285	28	3	0	6,019	2,677	3,018	290	34	0
None	207,004	24,898	42,300	68,901	70,889	16	1,518,586	187,613	383,933	458,760	488,239	41
Maintenance Assistance Status												
Cash	88,419	5,030	25,115	29,139	29,135	0	739,691	47,581	234,269	219,631	238,210	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	37,659	3,475	2,490	2,211	29,467	16	231,258	17,034	12,420	11,959	189,804	41
Other/unknown	81,930	16,980	15,081	37,579	12,290	0	557,133	128,185	141,229	227,460	60,259	0
Dual Medicare Status[d]												
Full dual, all year	36,432	21,837	13,357	1,233	3	2	311,074	175,748	128,595	6,709	16	6
Full dual, part year	3,602	2,115	1,347	140	0	0	15,875	8,442	6,781	652	0	0
Non-dual, all year	167,974	1,533	27,982	67,556	70,889	14	1,201,133	8,610	252,542	451,689	488,257	35
Managed Care (MC) Status												
Fee-for-service (FFS) all year	155,120	21,025	31,464	52,045	50,581	5	1,382,988	176,093	346,645	416,404	443,823	23
FFS part year, with Rx claims	869	5	86	328	450	0	4,288	46	573	1,588	2,081	0
FFS part year, no Rx claims	52,019	4,455	11,136	16,556	19,861	11	140,806	16,661	40,700	41,058	42,369	18

Source: Data for this table are from the MAX 2006 file for Arizona, released by CMS in 9/2009. This table was produced on 02/11/2010.

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]
ARIZONA, 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	**2.9**	**0.2**	**$12**	**$77**	**$3,501**	**0.3**	**208,008**
Age							
5 and younger	4.1	0.1	5	42	4,529	0.1	33,433
6-14	3.2	0.1	10	94	2,462	0.4	35,287
15-20	3.8	0.2	18	106	3,674	0.5	23,029
21-44	3.2	0.2	14	83	3,720	0.4	56,628
45-64	2.7	0.3	21	66	4,636	0.5	30,686
65-74	0.7	0.1	3	59	2,702	0.1	10,293
75-84	0.2	0.0	0	43	1,591	0.0	10,284
85 and older	0.1	0.0	0	18	993	0.0	8,365
Unknown	0.0	0.0	0	0	3,593	0.0	3
Basis of Eligibility[e]							
Aged	0.1	0.0	0	32	1,340	0.0	25,485
Disabled	2.7	0.3	37	127	6,374	0.6	42,686
Adults	2.9	0.1	5	39	2,787	0.2	68,929
Children	4.2	0.1	7	49	3,244	0.2	70,892
Unknown	0.0	0.0	0	0	1,328	0.0	16
Gender							
Female	3.3	0.2	12	71	3,906	0.3	111,484
Male	2.5	0.1	11	85	3,034	0.4	96,524
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	0.3	0.0	1	40	1,368	0.0	46,147
African American	0.8	0.0	1	30	2,130	0.0	6,285
Other/unknown	3.8	0.2	15	77	4,190	0.4	155,576
Use of Nursing Facilities[f]							
Entire year	0.2	0.0	0	33	40,491	0.0	404
Part year	23.7	4.0	174	43	39,430	0.4	600
None	2.9	0.1	11	79	3,325	0.3	207,004
Maintenance Assistance Status							
Cash	4.5	0.3	22	83	5,385	0.4	88,419
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	3.3	0.1	6	53	2,594	0.2	37,659
Other/unknown	1.1	0.0	3	61	1,886	0.1	81,930

Source: Data for this table are from the MAX 2006 file for Arizona, released by CMS in 9/2009. This table was produced on 02/11/2010.
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]
ARIZONA, 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	**0.0**	**$2**	**0.3**	**97.1**	**2.6**	**0.1**	**0.1**	**0.0**	**0.0**	**$477**	**208,008**	**1,528,082**
Age												
5 and younger	0.0	1	0.1	95.9	3.9	0.1	0.1	0.0	0.0	723	33,433	209,570
6-14	0.0	1	0.4	96.8	3.0	0.1	0.1	0.0	0.0	304	35,287	285,566
15-20	0.0	2	0.5	96.2	3.5	0.2	0.1	0.0	0.0	485	23,029	174,286
21-44	0.0	2	0.4	96.8	2.9	0.2	0.1	0.0	0.0	523	56,628	403,000
45-64	0.0	3	0.5	97.3	2.0	0.3	0.3	0.1	0.0	630	30,686	225,692
65-74	0.0	0	0.1	99.3	0.6	0.1	0.0	0.0	0.0	325	10,293	85,617
75-84	0.0	0	0.0	99.8	0.2	0.0	0.0	0.0	0.0	195	10,284	84,015
85 and older	0.0	0	0.0	99.9	0.1	0.0	0.0	0.0	0.0	138	8,365	60,321
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	719	3	15
Basis of Eligibility[e]												
Aged	0.0	0	0.0	99.9	0.1	0.0	0.0	0.0	0.0	177	25,485	192,800
Disabled	0.0	4	0.6	97.3	2.1	0.2	0.3	0.1	0.0	701	42,686	387,918
Adults	0.0	1	0.2	97.1	2.6	0.1	0.1	0.0	0.0	419	68,929	459,050
Children	0.0	1	0.2	95.8	4.0	0.1	0.1	0.0	0.0	471	70,892	488,273
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	518	16	41
Gender												
Female	0.0	2	0.3	96.7	3.0	0.2	0.1	0.0	0.0	522	111,484	835,072
Male	0.0	2	0.4	97.5	2.2	0.1	0.1	0.0	0.0	423	96,524	693,010
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	99.7	0.2	0.1	0.1	0.0	0.0	234	46,147	269,692
African American	0.0	0	0.0	99.2	0.5	0.1	0.2	0.0	0.0	538	6,285	24,871
Other/unknown	0.0	2	0.4	96.2	3.5	0.2	0.1	0.0	0.0	528	155,576	1,233,519
Use of Nursing Facilities[f]												
Entire year	0.0	0	0.0	99.8	0.2	0.0	0.0	0.0	0.0	4,705	404	3,477
Part year	0.4	17	0.4	76.3	14.2	4.8	3.8	0.5	0.3	3,931	600	6,019
None	0.0	2	0.3	97.1	2.6	0.1	0.1	0.0	0.0	453	207,004	1,518,586
Maintenance Assistance Status												
Cash	0.0	3	0.4	95.5	4.0	0.2	0.2	0.0	0.0	644	88,419	739,691
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	0.2	96.7	3.0	0.1	0.1	0.0	0.0	422	37,659	231,258
Other/unknown	0.0	0	0.1	98.9	1.0	0.0	0.0	0.0	0.0	277	81,930	557,133

Source: Data for this table are from the MAX 2006 file for Arizona, released by CMS in 9/2009. This table was produced on 02/11/2010.

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]
ARIZONA, 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	**0.0**	**$2**	**$77**	**0.0**	**$1**	**$330**	**0.0**	**$0**	**$119**	**0.0**	**$0**	**$17**
Age												
5 and younger	0.0	1	42	0.0	1	202	0.0	0	51	0.0	0	12
6-14	0.0	1	94	0.0	1	377	0.0	0	136	0.0	0	18
15-20	0.0	2	106	0.0	2	355	0.0	0	591	0.0	0	16
21-44	0.0	2	83	0.0	2	452	0.0	0	57	0.0	0	17
45-64	0.0	3	66	0.0	2	255	0.0	0	68	0.0	1	18
65-74	0.0	0	59	0.0	0	204	0.0	0	14	0.0	0	15
75-84	0.0	0	43	0.0	0	204	0.0	0	0	0.0	0	11
85 and older	0.0	0	18	0.0	0	105	0.0	0	53	0.0	0	4
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.0	0	32	0.0	0	116	0.0	0	0	0.0	0	14
Disabled	0.0	4	127	0.0	4	435	0.0	0	249	0.0	1	20
Adults	0.0	1	39	0.0	1	230	0.0	0	57	0.0	0	16
Children	0.0	1	49	0.0	1	200	0.0	0	54	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	71	0.0	1	338	0.0	0	146	0.0	0	16
Male	0.0	2	85	0.0	1	320	0.0	0	75	0.0	0	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.0	0	40	0.0	0	128	0.0	0	68	0.0	0	19
African American	0.0	0	30	0.0	0	103	0.0	0	73	0.0	0	13
Other/unknown	0.0	2	77	0.0	2	334	0.0	0	121	0.0	0	17
Use of Nursing Facilities[e]												
Entire year	0.0	0	33	0.0	0	57	0.0	0	0	0.0	0	8
Part year	0.4	17	43	0.1	11	156	0.0	0	124	0.3	7	20
None	0.0	2	79	0.0	1	343	0.0	0	119	0.0	0	16
Maintenance Assistance Status												
Cash	0.0	3	83	0.0	2	360	0.0	0	152	0.0	0	17
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.0	1	53	0.0	1	185	0.0	0	54	0.0	0	17
Other/unknown	0.0	0	61	0.0	0	336	0.0	0	49	0.0	0	15

Source: Data for this table are from the MAX 2006 file for Arizona, released by CMS in 9/2009. This table was produced on 02/11/2010.

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 Arizona, 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.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]

ARIZONA, 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	0.1	$10	$6	$1	$3	$60	$291	$173	$22	5,521	$331,369	3,237	1.6	32,668
Biologicals	0.6	0.6	0.0	0.0	882	882	0	0	1445	1,445	0	0	72	104,072	13	0.0	118
Antineoplastic Agents	0.4	0.1	0.0	0.3	322	302	0	19	799	2,024	0	77	132	105,523	30	0.0	328
Endocrine/Metabolic Drugs	0.3	0.1	0.0	0.2	26	21	0	5	75	234	15	19	2,848	213,771	829	0.4	8,276
Cardiovascular Agents	0.6	0.1	0.0	0.5	27	21	0	6	48	210	20	13	3,104	148,880	529	0.3	5,519
Respiratory Agents	0.2	0.1	0.0	0.2	12	10	0	2	52	149	71	13	3,182	165,633	1,381	0.7	13,833
Gastrointestinal Agents	0.2	0.1	0.0	0.1	61	57	3	2	263	768	242	10	961	252,790	395	0.2	4,115
Genitourinary Agents	0.2	0.0	0.0	0.1	4	0	1	2	24	53	107	15	422	10,097	256	0.1	2,685
CNS Drugs	0.4	0.2	0.0	0.3	41	35	0	6	99	232	101	21	3,464	343,576	788	0.4	8,343
Stimulants/Anti-obesity/Anorexia	0.4	0.2	0.0	0.2	28	20	3	6	72	110	1,176	27	181	12,974	46	0.0	466
Miscellaneous Psychological/ Neurological Agents	0.2	0.2	0.0	0.0	25	25	0	0	139	139	0	0	4	557	2	0.0	22
Analgesics and Anesthetics	0.2	0.0	0.0	0.2	7	4	0	3	28	929	0	12	6,512	184,182	2,642	1.3	27,795
Neuromuscular Agents	0.3	0.1	0.0	0.2	21	14	0	6	67	151	46	30	1,514	100,686	456	0.2	4,749
Nutritional Products	0.3	0.0	0.0	0.3	5	2	0	3	19	224	0	11	837	15,703	314	0.2	3,128
Hematological Agents	0.2	0.1	0.0	0.2	158	155	0	3	704	2,448	35	21	423	297,597	172	0.1	1,881
Topical Products	0.2	0.0	0.0	0.1	3	1	0	2	21	72	53	15	1,985	41,798	1,281	0.6	12,944
Miscellaneous Products	0.3	0.3	0.0	0.0	91	87	0	4	274	300	0	101	282	77,221	79	0.0	849
Unknown Therapeutic Category	0.1	0.0	0.0	0.0	7	0	0	0	68	0	0	0	29	1,983	24	0.0	268
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.	31,473	2,408,412	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Arizona, released by CMS in 9/2009. This table was produced on 02/11/2010.

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 Arizona, 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.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]

ARIZONA, 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	$299,957	377	0.2	4,064	0.4	$197	$74
MISC. HEMATOLOGICAL	264,543	22	0.0	245	0.3	3,307	1,080
MISC. GI	207,428	137	0.1	1,420	0.2	656	146
ANTIVIRAL	131,705	81	0.0	894	0.3	432	147
ANALGESICS - ANTI-INFLAMMATORY	125,418	2,218	1.1	23,793	0.2	33	5
MISC. ENDOCRINE	125,393	30	0.0	339	0.4	889	370
ANTIASTHMATIC	114,481	1,070	0.5	10,564	0.2	55	11
ANTINEOPLASTICS	105,488	30	0.0	328	0.4	805	322
PASSIVE IMMUNIZING AGENTS	104,016	9	0.0	81	0.8	1,530	1,284
ANTICONVULSANT	95,164	308	0.1	3,210	0.3	93	30
Total	1,573,593	4,282	n.a.	44,938	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Arizona, released by CMS in 9/2009. This table was produced on 02/11/2010.

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.