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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
MICHIGAN, 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]	1938399 (A)	256740 (E)	1681659 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1791101 (B)	234431 (F)	1556670 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	1073611 (C)	230528 (G)	843083 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	24358 (D)	22941 (H)	1417 (L)

Source: Data for this table are from the MAX 2006 file for Michigan, 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 Michigan in 2006 was $385,120,426, of which $141,590,737 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]

MICHIGAN, 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	**1,073,611**	**120,771**	**178,648**	**252,051**	**520,816**	**1,325**	**6,482,093**	**1,229,420**	**1,632,168**	**1,037,812**	**2,570,878**	**11,815**
Age												
5 and younger	207,121	0	4,891	0	202,230	0	925,422	0	41,453	0	883,969	0
6-14	217,047	0	10,514	1	206,532	0	1,186,245	0	88,319	5	1,097,921	0
15-20	144,484	0	8,967	27,842	107,655	20	784,803	0	75,585	134,552	574,504	162
21-44	272,408	1	63,346	204,285	4,259	517	1,448,767	1	597,440	833,053	14,125	4,148
45-64	111,307	14	90,690	19,786	48	769	905,689	44	828,680	69,431	136	7,398
65-74	49,709	49,325	240	123	2	19	517,609	516,122	691	683	6	107
75-84	40,529	40,517	0	12	0	0	418,185	418,105	0	80	0	0
85 and older	30,916	30,912	0	2	2	0	295,145	295,129	0	8	8	0
Unknown	90	2	0	0	88	0	228	19	0	0	209	0
Gender												
Female	638,164	86,546	88,168	205,892	256,233	1,325	3,865,427	890,771	820,839	881,554	1,260,448	11,815
Male	435,447	34,225	90,480	46,159	264,583	0	2,616,666	338,649	811,329	156,258	1,310,430	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	691,375	83,051	115,478	168,704	323,119	1,023	4,355,110	836,688	1,086,317	710,824	1,712,238	9,043
African American	292,682	26,915	54,321	66,046	145,195	205	1,596,398	280,416	465,325	250,753	597,957	1,947
Other/unknown	89,554	10,805	8,849	17,301	52,502	97	530,585	112,316	80,526	76,235	260,683	825
Use of Nursing Facilities[c]												
Entire year	24,358	21,694	2,659	4	1	0	255,067	225,590	29,458	18	1	0
Part year	19,414	16,031	3,340	38	4	1	176,039	145,852	29,956	194	25	12
None	1,029,839	83,046	172,649	252,009	520,811	1,324	6,050,987	857,978	1,572,754	1,037,600	2,570,852	11,803
Maintenance Assistance Status												
Cash	252,196	38,187	87,667	50,122	76,220	0	1,737,739	429,506	835,621	196,114	276,498	0
Medically needy	92,972	8,996	8,779	53,056	22,141	0	393,289	69,075	53,323	185,841	85,050	0
Poverty-related	461,354	41,917	52,814	47,220	318,078	1,325	2,814,018	437,978	486,370	243,884	1,633,971	11,815
Other/unknown	267,089	31,671	29,388	101,653	104,377	0	1,537,047	292,861	256,854	411,973	575,359	0
Dual Medicare Status[d]												
Full dual, all year	218,947	111,780	104,674	2,397	62	34	2,268,014	1,149,052	1,104,272	13,945	473	272
Full dual, part year	11,581	5,202	6,358	21	0	0	123,669	55,586	67,867	216	0	0
Non-dual, all year	843,083	3,789	67,616	249,633	520,754	1,291	4,090,410	24,782	460,029	1,023,651	2,570,405	11,543
Managed Care (MC) Status												
Fee-for-service (FFS) all year	569,659	118,178	138,250	122,274	189,644	1,313	4,775,812	1,214,310	1,456,290	618,108	1,475,356	11,748
FFS part year, with Rx claims	190,756	1,590	27,754	72,128	89,274	10	769,723	9,521	126,409	265,499	368,232	62
FFS part year, no Rx claims	313,196	1,003	12,644	57,649	241,898	2	936,558	5,589	49,469	154,205	727,290	5

Source: Data for this table are from the MAX 2006 file for Michigan, 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]

MICHIGAN, 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	**38.0**	**3.5**	**$227**	**$65**	**$3,529**	**6.4**	**1,073,611**
Age							
5 and younger	32.8	1.4	79	56	1,880	4.2	207,121
6-14	32.4	2.7	268	100	1,400	19.1	217,047
15-20	38.4	3.3	295	89	1,848	16.0	144,484
21-44	46.3	4.3	244	57	2,856	8.5	272,408
45-64	49.4	9.0	499	56	6,596	7.6	111,307
65-74	28.1	2.4	61	25	4,869	1.2	49,709
75-84	25.7	1.8	22	12	11,039	0.2	40,529
85 and older	27.5	1.6	16	10	20,271	0.1	30,916
Unknown	0.0	0.0	0	0	9	0.0	90
Basis of Eligibility[e]							
Aged	27.1	2.0	36	18	10,887	0.3	120,771
Disabled	49.1	9.1	730	80	7,258	10.1	178,648
Adults	47.7	3.6	153	43	2,034	7.5	252,051
Children	31.9	1.9	131	71	1,248	10.5	520,816
Unknown	81.7	19.2	1,468	76	10,849	13.5	1,325
Gender							
Female	40.2	3.6	188	52	3,625	5.2	638,164
Male	34.7	3.3	283	85	3,389	8.4	435,447
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	41.2	4.0	244	61	3,775	6.5	691,375
African American	31.8	2.6	208	80	3,254	6.4	292,682
Other/unknown	33.2	2.5	156	62	2,529	6.2	89,554
Use of Nursing Facilities[f]							
Entire year	37.7	7.9	326	41	39,470	0.8	24,358
Part year	44.7	7.3	332	46	22,458	1.5	19,414
None	37.9	3.3	223	67	2,322	9.6	1,029,839
Maintenance Assistance Status							
Cash	41.5	5.7	436	77	4,002	10.9	252,196
Medically needy	42.4	3.9	215	55	3,234	6.6	92,972
Poverty related	34.7	2.3	133	57	2,645	5.0	461,354
Other/unknown	38.8	3.4	196	58	4,711	4.2	267,089

Source: Data for this table are from the MAX 2006 file for Michigan, 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]

MICHIGAN, 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**	**$38**	**6.4**	**62.0**	**27.1**	**4.2**	**3.9**	**1.7**	**1.1**	**$585**	**1,073,611**	**6,482,093**
Age												
5 and younger	0.3	18	4.2	67.2	28.9	2.5	1.2	0.2	0.0	421	207,121	925,422
6-14	0.5	49	19.1	67.6	23.7	3.4	3.2	1.2	0.8	256	217,047	1,186,245
15-20	0.6	54	16.0	61.6	28.1	4.6	3.8	1.2	0.6	340	144,484	784,803
21-44	0.8	46	8.5	53.7	29.1	6.4	6.4	2.7	1.8	537	272,408	1,448,767
45-64	1.1	61	7.6	50.6	27.1	6.0	7.9	5.1	3.5	811	111,307	905,689
65-74	0.2	6	1.2	71.9	24.3	1.9	1.1	0.5	0.2	468	49,709	517,609
75-84	0.2	2	0.2	74.3	23.7	1.4	0.5	0.1	0.0	1,070	40,529	418,185
85 and older	0.2	2	0.1	72.5	25.4	1.5	0.5	0.0	0.0	2,123	30,916	295,145
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	3	90	228
Basis of Eligibility[e]												
Aged	0.2	4	0.3	72.9	24.4	1.6	0.7	0.2	0.1	1,070	120,771	1,229,420
Disabled	1.0	80	10.1	50.9	28.5	5.8	7.3	4.3	3.1	794	178,648	1,632,168
Adults	0.9	37	7.5	52.3	30.2	6.8	6.6	2.6	1.6	494	252,051	1,037,812
Children	0.4	27	10.5	68.1	25.7	3.0	2.1	0.6	0.4	253	520,816	2,570,878
Unknown	2.2	165	13.5	18.3	35.4	15.3	23.8	6.6	0.6	1,217	1,325	11,815
Gender												
Female	0.6	31	5.2	59.8	28.9	4.4	4.0	1.7	1.1	598	638,164	3,865,427
Male	0.6	47	8.4	65.3	24.5	3.9	3.8	1.6	1.0	564	435,447	2,616,666
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	0.6	39	6.5	58.8	29.0	4.6	4.4	1.9	1.3	599	691,375	4,355,110
African American	0.5	38	6.4	68.2	23.1	3.7	3.0	1.2	0.8	597	292,682	1,596,398
Other/unknown	0.4	26	6.2	66.8	25.8	3.2	2.7	1.0	0.5	427	89,554	530,585
Use of Nursing Facilities[f]												
Entire year	0.8	31	0.8	62.3	28.8	3.1	1.9	2.1	1.8	3,769	24,358	255,067
Part year	0.8	37	1.5	55.3	34.2	2.8	2.5	2.8	2.5	2,477	19,414	176,039
None	0.6	38	9.6	62.1	26.9	4.3	4.0	1.6	1.0	395	1,029,839	6,050,987
Maintenance Assistance Status												
Cash	0.8	63	10.9	58.5	26.5	5.0	5.3	2.8	2.0	581	252,196	1,737,739
Medically needy	0.9	51	6.6	57.6	23.5	6.7	7.5	3.0	1.7	765	92,972	393,289
Poverty related	0.4	22	5.0	65.3	28.3	3.0	2.1	0.8	0.5	434	461,354	2,814,018
Other/unknown	0.6	34	4.2	61.2	27.0	4.7	4.4	1.7	1.0	819	267,089	1,537,047

Source: Data for this table are from the MAX 2006 file for Michigan, 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]

MICHIGAN, 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**	**$38**	**$65**	**0.2**	**$30**	**$168**	**0.0**	**$2**	**$98**	**0.4**	**$5**	**$14**
Age												
5 and younger	0.3	18	56	0.1	14	151	0.0	1	56	0.2	3	14
6-14	0.5	49	100	0.3	44	164	0.0	1	90	0.2	4	19
15-20	0.6	54	89	0.2	46	187	0.0	2	107	0.3	6	17
21-44	0.8	46	57	0.2	35	170	0.0	3	109	0.6	8	14
45-64	1.1	61	56	0.3	47	167	0.0	3	108	0.8	12	15
65-74	0.2	6	25	0.0	4	126	0.0	0	58	0.2	2	8
75-84	0.2	2	12	0.0	1	89	0.0	0	32	0.2	1	6
85 and older	0.2	2	10	0.0	1	76	0.0	0	28	0.2	1	5
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.2	4	18	0.0	2	112	0.0	0	46	0.2	1	7
Disabled	1.0	80	80	0.3	66	213	0.0	3	111	0.7	10	16
Adults	0.9	37	43	0.2	26	129	0.0	3	111	0.6	8	13
Children	0.4	27	71	0.2	23	136	0.0	1	71	0.2	3	16
Unknown	2.2	165	76	0.7	134	203	0.1	10	153	1.4	21	15
Gender												
Female	0.6	31	52	0.2	24	146	0.0	2	102	0.4	6	13
Male	0.6	47	85	0.2	41	193	0.0	1	91	0.3	5	16
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.6	39	61	0.2	31	153	0.0	2	100	0.4	6	14
African American	0.5	38	80	0.1	32	231	0.0	1	89	0.3	5	14
Other/unknown	0.4	26	62	0.1	21	163	0.0	1	99	0.3	4	14
Use of Nursing Facilities[e]												
Entire year	0.8	31	41	0.2	23	135	0.0	2	65	0.6	7	13
Part year	0.8	37	46	0.2	26	155	0.0	2	70	0.6	9	14
None	0.6	38	67	0.2	31	170	0.0	2	101	0.4	5	14
Maintenance Assistance Status												
Cash	0.8	63	77	0.3	52	203	0.0	3	111	0.5	8	16
Medically needy	0.9	51	55	0.3	39	154	0.0	3	95	0.6	9	14
Poverty related	0.4	22	57	0.1	18	146	0.0	1	93	0.3	3	13
Other/unknown	0.6	34	58	0.2	27	145	0.0	2	86	0.4	5	14

Source: Data for this table are from the MAX 2006 file for Michigan, 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 Michigan, 0.2 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]

MICHIGAN, 2006

	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	0.0	0.0	0.2	$14	$10	$1	$4	$51	$273	$47	$16	365,296	$18,529,491	172,274	16.0	1,311,768
Biologicals	0.5	0.5	0.0	0.0	794	776	7	11	1493	1,485	973	6,002	2,034	3,037,219	481	0.0	3,824
Antineoplastic Agents	0.5	0.2	0.0	0.3	123	109	0	13	238	644	108	39	10,827	2,576,305	2,386	0.2	20,932
Endocrine/Metabolic Drugs	0.5	0.2	0.0	0.3	32	24	1	6	70	155	83	22	241,356	16,867,311	71,465	6.7	533,140
Cardiovascular Agents	0.9	0.2	0.0	0.6	31	21	2	8	35	91	100	12	280,235	9,862,703	44,212	4.1	319,220
Respiratory Agents	0.5	0.3	0.0	0.2	34	31	0	3	72	114	53	17	281,918	20,359,805	76,073	7.1	592,849
Gastrointestinal Agents	0.5	0.2	0.0	0.2	41	32	6	3	87	138	306	14	155,532	13,536,777	41,592	3.9	326,465
Genitourinary Agents	0.3	0.1	0.0	0.2	11	7	1	3	42	83	66	18	40,049	1,671,241	19,165	1.8	149,905
CNS Drugs	0.9	0.3	0.0	0.6	59	49	4	6	64	184	83	10	1,005,569	63,883,009	143,386	13.4	1,085,933
Stimulants/Anti-obesity/Anorexia	1.0	0.8	0.0	0.2	72	69	1	3	72	83	286	16	205,234	14,835,011	29,706	2.8	204,982
Miscellaneous Psychological/ Neurological Agents	0.4	0.3	0.0	0.1	128	121	0	7	356	422	70	95	8,965	3,189,123	3,164	0.3	24,851
Analgesics and Anesthetics	0.5	0.0	0.0	0.4	15	7	1	7	31	170	375	16	373,991	11,663,542	110,644	10.3	779,487
Neuromuscular Agents	0.8	0.3	0.0	0.5	59	49	2	8	69	148	116	16	376,839	26,173,485	59,880	5.6	444,991
Nutritional Products	0.3	0.0	0.0	0.3	3	0	0	3	10	16	16	9	128,287	1,265,641	49,035	4.6	381,972
Hematological Agents	0.5	0.1	0.0	0.4	136	132	0	4	264	1,758	54	10	98,878	26,084,807	20,480	1.9	191,139
Topical Products	0.2	0.0	0.0	0.2	8	4	0	3	32	89	61	16	160,257	5,132,877	85,189	7.9	665,540
Miscellaneous Products	0.4	0.3	0.0	0.1	83	71	7	6	204	279	202	50	23,385	4,776,662	5,973	0.6	57,233
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	11	0	0	0	47	0	0	0	1,819	84,680	982	0.1	7,804
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.	3,760,471	243,529,689	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Michigan, 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 Michigan, 0.2 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]
MICHIGAN, 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	$27,904,662	25,184	2.3	221,506	0.6	$213	$126
MISC. HEMATOLOGICAL	20,669,846	3,594	0.3	27,684	0.5	1,618	747
ANTICONVULSANT	19,463,428	37,254	3.5	351,824	0.7	83	55
ANTIASTHMATIC	14,296,164	85,056	7.9	694,616	0.3	69	21
ANTIDEPRESSANTS	11,021,870	53,301	5.0	425,081	0.5	53	26
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	10,864,730	21,827	2.0	202,946	0.7	82	54
ULCER DRUGS	8,714,957	43,062	4.0	345,529	0.4	69	25
MISC. ENDOCRINE	7,737,367	4,308	0.4	41,347	0.5	393	187
ANTIDIABETIC	6,464,434	21,190	2.0	156,513	0.6	74	41
ANALGESICS - Narcotic	6,217,033	99,408	9.3	720,986	0.3	26	9
Total	133,354,491	394,184	n.a.	3,188,032	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Michigan, 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.