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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEVADA, 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]	254747 (A)	38648 (E)	216099 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	233145 (B)	23057 (F)	210088 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	167300 (C)	22993 (G)	144307 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2461 (D)	2171 (H)	290 (L)

Source: Data for this table are from the MAX 2006 file for Nevada, 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 Nevada in 2006 was $77,609,385, of which $627,937 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]

NEVADA, 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	**167,300**	**14,528**	**30,750**	**31,757**	**90,083**	**182**	**971,685**	**146,843**	**301,392**	**118,194**	**403,844**	**1,412**
Age												
5 and younger	44,554	0	1,467	0	43,087	0	190,888	0	13,584	0	177,304	0
6-14	37,558	0	3,514	0	34,044	0	197,445	0	35,447	0	161,998	0
15-20	18,243	0	2,374	3,084	12,782	3	99,328	0	23,382	12,184	63,751	11
21-44	36,286	0	9,677	26,470	114	25	193,717	0	95,786	97,131	673	127
45-64	15,447	6	13,112	2,170	11	148	137,230	25	127,305	8,616	52	1,232
65-74	6,376	5,899	460	10	1	6	65,401	60,894	4,385	79	1	42
75-84	5,534	5,413	108	12	1	0	56,756	55,551	1,109	94	2	0
85 and older	3,259	3,210	38	11	0	0	30,857	30,373	394	90	0	0
Unknown	43	0	0	0	43	0	63	0	0	0	63	0
Gender												
Female	96,558	10,186	15,973	25,837	44,380	182	559,957	104,061	159,224	96,951	198,309	1,412
Male	70,198	4,342	14,777	5,917	45,162	0	410,385	42,782	142,168	21,234	204,201	0
Unknown	544	0	0	3	541	0	1,343	0	0	9	1,334	0
Race												
White	78,121	8,693	18,433	15,991	34,876	128	530,976	86,090	181,444	68,650	193,800	992
African American	31,236	1,027	6,791	6,377	17,028	13	155,477	10,782	66,305	17,360	60,937	93
Other/unknown	57,943	4,808	5,526	9,389	38,179	41	285,232	49,971	53,643	32,184	149,107	327
Use of Nursing Facilities[c]												
Entire year	2,461	1,949	510	1	1	0	24,073	18,859	5,201	1	12	0
Part year	2,053	1,410	631	8	4	0	19,651	13,300	6,258	55	38	0
None	162,786	11,169	29,609	31,748	90,078	182	927,961	114,684	289,933	118,138	403,794	1,412
Maintenance Assistance Status												
Cash	102,547	8,803	26,230	22,058	45,456	0	610,240	93,260	254,165	79,715	183,100	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	30,068	270	541	4,057	25,018	182	119,344	2,665	5,140	13,914	96,213	1,412
Other/unknown	34,685	5,455	3,979	5,642	19,609	0	242,101	50,918	42,087	24,565	124,531	0
Dual Medicare Status[d]												
Full dual, all year	21,403	13,434	7,720	234	7	8	218,361	136,466	80,206	1,564	57	68
Full dual, part year	1,590	758	799	33	0	0	16,023	7,846	7,862	315	0	0
Non-dual, all year	144,307	336	22,231	31,490	90,076	174	737,301	2,531	213,324	116,315	403,787	1,344
Managed Care (MC) Status												
Fee-for-service (FFS) all year	97,643	14,528	30,138	13,195	39,600	182	781,647	146,843	297,537	68,022	267,833	1,412
FFS part year, with Rx claims	16,715	0	399	7,119	9,197	0	54,769	0	2,725	21,275	30,769	0
FFS part year, no Rx claims	52,942	0	213	11,443	41,286	0	135,269	0	1,130	28,897	105,242	0

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

NEVADA, 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	**40.2**	**7.2**	**$460**	**$64**	**$5,335**	**8.6**	**167,300**
Age							
5 and younger	28.8	1.2	130	105	2,398	5.4	44,554
6-14	28.0	2.2	247	111	2,213	11.1	37,558
15-20	37.1	3.2	322	100	4,421	7.3	18,243
21-44	47.9	7.7	593	77	5,768	10.3	36,286
45-64	72.4	32.3	2,057	64	14,555	14.1	15,447
65-74	57.4	17.1	289	17	8,382	3.4	6,376
75-84	57.7	14.7	117	8	12,538	0.9	5,534
85 and older	53.4	10.8	91	8	19,922	0.5	3,259
Unknown	0.0	0.0	0	0	110	0.0	43
Basis of Eligibility[e]							
Aged	56.6	14.7	167	11	12,444	1.3	14,528
Disabled	71.6	25.3	1,986	79	14,978	13.3	30,750
Adults	40.7	2.9	128	45	2,069	6.2	31,757
Children	26.6	1.3	102	79	2,025	5.0	90,083
Unknown	77.5	18.8	1,375	73	16,511	8.3	182
Gender							
Female	42.8	8.1	439	55	5,148	8.5	96,558
Male	36.9	6.0	493	82	5,627	8.8	70,198
Unknown	8.6	0.2	6	28	744	0.8	544
Race							
White	49.5	10.2	641	63	7,161	9.0	78,121
African American	34.2	5.7	394	69	4,516	8.7	31,236
Other/unknown	31.0	3.8	252	66	3,313	7.6	57,943
Use of Nursing Facilities[f]							
Entire year	61.8	20.4	914	45	46,818	2.0	2,461
Part year	74.5	26.6	1,192	45	41,965	2.8	2,053
None	39.5	6.7	444	66	4,246	10.5	162,786
Maintenance Assistance Status							
Cash	42.9	9.0	603	67	4,465	13.5	102,547
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	26.2	1.1	57	51	1,829	3.1	30,068
Other/unknown	44.6	7.0	387	56	10,946	3.5	34,685

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

NEVADA, 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	**1.2**	**$79**	**8.6**	**59.8**	**25.3**	**5.1**	**6.3**	**2.8**	**0.7**	**$919**	**167,300**	**971,685**
Age												
5 and younger	0.3	30	5.4	71.2	25.5	2.3	1.0	0.1	0.0	560	44,554	190,888
6-14	0.4	47	11.1	72.0	22.8	2.9	2.1	0.3	0.0	421	37,558	197,445
15-20	0.6	59	7.3	62.9	29.1	4.3	3.0	0.5	0.1	812	18,243	99,328
21-44	1.4	111	10.3	52.1	28.2	7.3	8.6	3.1	0.6	1,080	36,286	193,717
45-64	3.6	232	14.1	27.6	19.1	9.6	22.3	15.9	5.4	1,638	15,447	137,230
65-74	1.7	28	3.4	42.6	23.5	9.7	16.5	6.8	1.0	817	6,376	65,401
75-84	1.4	11	0.9	42.3	26.9	9.6	14.7	5.9	0.7	1,223	5,534	56,756
85 and older	1.1	10	0.5	46.6	28.0	8.3	12.4	4.0	0.6	2,104	3,259	30,857
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	75	43	63
Basis of Eligibility[e]												
Aged	1.5	17	1.3	43.4	25.9	9.4	14.9	5.7	0.7	1,231	14,528	146,843
Disabled	2.6	203	13.3	28.4	28.5	10.1	18.7	10.9	3.3	1,528	30,750	301,392
Adults	0.8	34	6.2	59.3	28.1	5.9	5.1	1.3	0.2	556	31,757	118,194
Children	0.3	23	5.0	73.4	23.1	2.3	1.1	0.1	0.0	452	90,083	403,844
Unknown	2.4	177	8.3	22.5	26.4	18.1	24.2	7.7	1.1	2,128	182	1,412
Gender												
Female	1.4	76	8.5	57.2	26.3	5.3	7.0	3.3	0.9	888	96,558	559,957
Male	1.0	84	8.8	63.1	24.0	4.7	5.5	2.2	0.5	963	70,198	410,385
Unknown	0.1	2	0.8	91.4	7.9	0.7	0.0	0.0	0.0	302	544	1,343
Race												
White	1.5	94	9.0	50.5	29.1	6.3	8.7	4.2	1.1	1,054	78,121	530,976
African American	1.2	79	8.7	65.8	21.5	4.7	5.1	2.2	0.6	907	31,236	155,477
Other/unknown	0.8	51	7.6	69.0	22.1	3.6	3.8	1.3	0.2	673	57,943	285,232
Use of Nursing Facilities[f]												
Entire year	2.1	93	2.0	38.2	29.5	8.6	10.1	7.5	6.1	4,786	2,461	24,073
Part year	2.8	125	2.8	25.5	33.9	8.9	13.2	11.4	7.1	4,384	2,053	19,651
None	1.2	78	10.5	60.5	25.1	5.0	6.2	2.6	0.6	745	162,786	927,961
Maintenance Assistance Status												
Cash	1.5	101	13.5	57.1	24.6	5.7	7.9	3.8	0.9	750	102,547	610,240
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.3	14	3.1	73.8	22.7	2.2	1.1	0.2	0.0	461	30,068	119,344
Other/unknown	1.0	55	3.5	55.4	29.6	5.7	6.3	2.3	0.6	1,568	34,685	242,101

Source: Data for this table are from the MAX 2006 file for Nevada, 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]
NEVADA, 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	**1.2**	**$79**	**$64**	**0.4**	**$58**	**$150**	**0.0**	**$5**	**$121**	**0.8**	**$17**	**$20**
Age												
5 and younger	0.3	30	105	0.1	26	333	0.0	1	51	0.2	4	19
6-14	0.4	47	111	0.2	40	207	0.0	1	97	0.2	6	25
15-20	0.6	59	100	0.2	49	208	0.0	2	121	0.3	8	24
21-44	1.4	111	77	0.4	81	194	0.0	6	144	1.0	23	24
45-64	3.6	232	64	1.0	152	147	0.1	21	157	2.5	58	24
65-74	1.7	28	17	0.5	18	33	0.1	2	44	1.1	8	7
75-84	1.4	11	8	0.5	7	14	0.0	1	14	0.9	4	5
85 and older	1.1	10	8	0.3	5	16	0.0	0	14	0.8	4	5
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	1.5	17	11	0.5	10	21	0.0	1	24	0.9	5	6
Disabled	2.6	203	79	0.8	148	184	0.1	14	150	1.7	41	24
Adults	0.8	34	45	0.2	20	123	0.0	2	119	0.6	12	21
Children	0.3	23	79	0.1	19	181	0.0	1	71	0.2	4	20
Unknown	2.4	177	73	0.6	138	218	0.0	5	92	1.7	35	20
Gender												
Female	1.4	76	55	0.4	53	127	0.0	5	112	0.9	18	19
Male	1.0	84	82	0.3	65	188	0.0	5	139	0.7	15	23
Unknown	0.1	2	28	0.0	1	69	0.0	0	33	0.1	1	17
Race												
White	1.5	94	63	0.5	68	146	0.1	6	119	1.0	21	21
African American	1.2	79	69	0.3	57	164	0.0	6	163	0.8	17	22
Other/unknown	0.8	51	66	0.3	40	152	0.0	2	99	0.5	9	18
Use of Nursing Facilities[e]												
Entire year	2.1	93	45	0.5	62	122	0.1	5	72	1.5	26	17
Part year	2.8	125	45	0.7	82	118	0.1	8	85	2.0	35	18
None	1.2	78	66	0.4	57	152	0.0	5	125	0.8	16	21
Maintenance Assistance Status												
Cash	1.5	101	67	0.5	73	155	0.1	7	136	1.0	22	22
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.3	14	51	0.1	10	142	0.0	1	71	0.2	4	17
Other/unknown	1.0	55	56	0.3	43	131	0.0	2	67	0.6	10	16

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

NEVADA, 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	0.1	0.0	0.2	$24	$18	$1	$5	$81	$298	$118	$23	92,690	$7,509,145	36,183	21.6	315,840
Biologicals	0.3	0.3	0.0	0.0	426	426	0	0	1310	1,346	0	32	1,891	2,476,823	631	0.4	5,814
Antineoplastic Agents	0.5	0.1	0.0	0.3	90	77	0	13	194	610	127	39	3,924	760,079	834	0.5	8,411
Endocrine/Metabolic Drugs	0.6	0.2	0.0	0.4	26	20	1	6	42	83	34	15	104,919	4,376,079	17,726	10.6	169,163
Cardiovascular Agents	1.1	0.3	0.1	0.7	29	16	5	8	26	48	90	11	197,403	5,132,233	17,149	10.3	175,336
Respiratory Agents	0.5	0.2	0.0	0.3	28	23	0	5	54	95	39	18	114,701	6,240,482	24,917	14.9	223,067
Gastrointestinal Agents	0.5	0.1	0.0	0.3	26	20	2	4	53	139	184	13	58,960	3,102,445	11,931	7.1	121,149
Genitourinary Agents	0.3	0.2	0.0	0.1	15	9	3	3	44	55	68	22	15,347	675,823	4,996	3.0	45,828
CNS Drugs	1.0	0.4	0.0	0.6	87	73	3	11	87	203	89	19	214,306	18,707,231	21,516	12.9	214,967
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	68	62	1	5	108	123	126	39	18,798	2,023,807	2,849	1.7	29,608
Miscellaneous Psychological/ Neurological Agents	0.4	0.4	0.0	0.0	83	82	0	1	194	199	70	64	6,154	1,195,548	1,399	0.8	14,490
Analgesics and Anesthetics	0.7	0.1	0.0	0.6	39	13	8	18	59	225	358	31	159,295	9,461,875	26,438	15.8	241,400
Neuromuscular Agents	0.8	0.2	0.0	0.5	55	40	2	13	73	168	107	26	104,358	7,597,824	13,719	8.2	138,154
Nutritional Products	0.3	0.1	0.0	0.3	6	2	0	4	17	32	17	15	23,409	406,219	8,315	5.0	68,596
Hematological Agents	0.6	0.2	0.0	0.4	80	71	1	7	133	383	38	19	32,145	4,263,972	5,209	3.1	53,584
Topical Products	0.3	0.1	0.0	0.2	13	8	0	4	44	88	53	21	48,578	2,159,926	18,580	11.1	172,771
Miscellaneous Products	0.6	0.3	0.0	0.2	163	130	13	20	285	444	276	86	2,714	772,281	448	0.3	4,725
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	35	0	0	0	178	0	0	0	672	119,656	337	0.2	3,400
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.	1,200,264	76,981,448	n.a.	n.a.	n.a.

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

NEVADA, 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	$14,041,353	10,397	6.2	110,108	0.5	$232	$128
ANALGESICS - Narcotic	7,334,026	30,631	18.3	290,649	0.4	63	25
ANTICONVULSANT	6,467,162	10,488	6.3	109,795	0.6	98	59
ANTIASTHMATIC	4,487,506	21,678	13.0	206,265	0.3	63	22
ANTIVIRAL	3,705,127	2,059	1.2	20,200	0.5	402	183
ANTIDEPRESSANTS	2,964,985	14,944	8.9	153,687	0.5	40	19
MISC. HEMATOLOGICAL	2,893,847	2,116	1.3	22,383	0.5	268	129
PASSIVE IMMUNIZING AGENTS	2,470,809	416	0.2	3,398	0.5	1,492	727
ANTIHYPERLIPIDEMIC	2,189,720	8,413	5.0	91,295	0.4	55	24
ANTIDIABETIC	2,161,943	8,862	5.3	91,002	0.5	45	24
Total	48,716,478	110,004	n.a.	1,098,782	n.a.	n.a.	n.a.

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