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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2007
NEVADA

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEVADA, 2007

Inclusion Criteria (2007)	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]	258117 (A)	39731 (E)	218386 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	235156 (B)	23316 (F)	211840 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	174587 (C)	23258 (G)	151329 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2431 (D)	2141 (H)	290 (L)

Source: Data for this table are from the MAX 2007 file for Nevada, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 2007 (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 2007, 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 2007 was $83,002,882, of which $432,776 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 27 states in 2007 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, MA, MI, NC, NH, NM, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NE, NY, TN, TX, and WV). These lists were constructed from the CMS 2007 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 reviewed prescription drug expenditures by type of managed care plan to determine whether enrollees in comprehensive MC plans had significant prescription drug expenditures during the year, since that would indicate that at least some prescription drugs were not included in the capitated benefit and were being provided on a fee-for-service basis. There were some states in which most, but not all, prescription drugs were included in the MC capitated benefit package. Mental health drugs, for example, may have been excluded. In those states, we excluded all the MC enrollees from the study population, but some of their drugs would have been included, potentially resulting in higher reported per-beneficiary use of those drugs than would have been the case if we had been able to exclude those drugs.
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 2007. 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 2007. 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, 2007

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**174,587**	**14,717**	**31,611**	**34,856**	**93,161**	**242**	**1,003,331**	**150,511**	**310,193**	**128,339**	**412,375**	**1,913**
Age												
5 and younger	46,704	0	1,596	0	45,108	0	198,470	0	14,644	0	183,826	0
6-14	38,646	0	3,609	0	35,037	0	200,368	0	36,562	0	163,806	0
15-20	18,672	0	2,598	3,186	12,876	12	102,679	0	25,789	12,705	64,118	67
21-44	38,728	0	9,560	29,068	52	48	200,988	0	94,936	105,300	470	282
45-64	16,351	7	13,623	2,536	7	178	143,588	41	132,271	9,694	46	1,536
65-74	6,488	5,982	491	11	0	4	67,136	62,343	4,682	83	0	28
75-84	5,693	5,571	98	24	0	0	58,794	57,582	960	252	0	0
85 and older	3,224	3,157	36	31	0	0	31,199	30,545	349	305	0	0
Unknown	81	0	0	0	81	0	109	0	0	0	109	0
Gender												
Female	101,016	10,275	16,255	27,994	46,250	242	577,877	106,192	162,335	103,924	203,513	1,913
Male	73,178	4,442	15,356	6,861	46,519	0	424,556	44,319	147,858	24,414	207,965	0
Unknown	393	0	0	1	392	0	898	0	0	1	897	0
Race												
White	78,306	8,624	18,812	16,916	33,778	176	530,964	86,640	184,840	71,886	186,190	1,408
African American	33,529	1,079	7,201	7,293	17,942	14	168,613	11,168	70,589	20,158	66,583	115
Other/unknown	62,752	5,014	5,598	10,647	41,441	52	303,754	52,703	54,764	36,295	159,602	390
Use of Nursing Facilities[c]												
Entire year	2,431	1,889	542	0	0	0	23,938	18,298	5,640	0	0	0
Part year	2,123	1,398	714	9	2	0	20,555	13,358	7,128	53	16	0
None	170,033	11,430	30,355	34,847	93,159	242	958,838	118,855	297,425	128,286	412,359	1,913
Maintenance Assistance Status												
Cash	116,677	8,986	26,840	28,720	52,131	0	667,420	96,046	260,280	104,827	206,267	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	31,569	298	515	4,309	26,205	242	123,049	3,058	4,855	14,985	98,238	1,913
Other/unknown	26,341	5,433	4,256	1,827	14,825	0	212,862	51,407	45,058	8,527	107,870	0
Dual Medicare Status[d]												
Full dual, all year	21,633	13,563	7,779	273	6	12	222,805	139,622	81,284	1,744	56	99
Full dual, part year	1,625	793	786	46	0	0	16,411	8,254	7,698	459	0	0
Non-dual, all year	151,329	361	23,046	34,537	93,155	230	764,115	2,635	221,211	126,136	412,319	1,814
Managed Care (MC) Status												
Fee-for-service (FFS) all year	99,253	14,715	31,049	13,577	39,673	239	796,313	150,500	306,718	70,107	267,089	1,899
FFS part year, with Rx claims	18,084	0	348	8,187	9,547	2	58,587	0	2,368	24,500	31,708	11
FFS part year, no Rx claims	57,250	2	214	13,092	43,941	1	148,431	11	1,107	33,732	113,578	3

Source: Data for this table are from the MAX 2007 file for Nevada, released by CMS in 4/2010. This table was produced on 10/06/2010.

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 2007. 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, 2007

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	**39.4**	**7.3**	**$473**	**$65**	**$5,561**	**8.5**	**174,587**
Age							
5 and younger	28.5	1.2	119	102	2,410	5.0	46,704
6-14	27.4	2.2	262	122	2,528	10.4	38,646
15-20	36.9	3.3	382	114	5,197	7.4	18,672
21-44	46.9	7.4	581	79	5,565	10.4	38,728
45-64	71.2	32.8	2,103	64	15,182	13.9	16,351
65-74	56.3	19.7	316	16	9,195	3.4	6,488
75-84	51.9	14.9	100	7	13,032	0.8	5,693
85 and older	47.1	9.3	75	8	20,436	0.4	3,224
Unknown	0.0	0.0	0	0	453	0.0	81
Basis of Eligibility[e]							
Aged	52.6	15.6	170	11	13,017	1.3	14,717
Disabled	70.6	25.9	2,056	79	15,584	13.2	31,611
Adults	40.3	2.8	132	47	2,106	6.3	34,856
Children	26.2	1.2	109	88	2,242	4.8	93,161
Unknown	74.8	20.9	1,368	65	18,092	7.6	242
Gender							
Female	41.7	8.1	446	55	5,319	8.4	101,016
Male	36.3	6.1	513	84	5,922	8.7	73,178
Unknown	2.0	0.0	2	39	459	0.4	393
Race							
White	48.5	10.6	690	65	7,606	9.1	78,306
African American	34.4	5.8	411	71	4,631	8.9	33,529
Other/unknown	30.6	3.9	235	61	3,505	6.7	62,752
Use of Nursing Facilities[f]							
Entire year	60.6	19.5	929	48	48,348	1.9	2,431
Part year	71.3	26.3	1,410	54	43,726	3.2	2,123
None	38.7	6.8	455	67	4,472	10.2	170,033
Maintenance Assistance Status							
Cash	41.2	8.7	570	65	4,362	13.1	116,677
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	26.3	1.2	60	51	1,953	3.1	31,569
Other/unknown	46.8	8.0	536	67	15,193	3.5	26,341

Source: Data for this table are from the MAX 2007 file for Nevada, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.
d. In eight states (DE, IA, IL, NE, NY, TN, TX, 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, 2007

				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	**1.3**	**$82**	**8.5**	**60.6**	**24.7**	**4.7**	**6.1**	**3.1**	**0.7**	**$968**	**174,587**	**1,003,331**
Age												
5 and younger	0.3	28	5.0	71.5	25.6	2.0	0.9	0.1	0.0	567	46,704	198,470
6-14	0.4	51	10.4	72.6	22.2	2.9	2.1	0.3	0.0	488	38,646	200,368
15-20	0.6	70	7.4	63.1	29.0	4.3	3.1	0.6	0.0	945	18,672	102,679
21-44	1.4	112	10.4	53.1	27.4	7.3	8.4	3.2	0.6	1,072	38,728	200,988
45-64	3.7	240	13.9	28.8	18.4	9.2	21.8	16.3	5.6	1,729	16,351	143,588
65-74	1.9	31	3.4	43.7	21.6	7.7	15.4	10.3	1.3	889	6,488	67,136
75-84	1.4	10	0.8	48.1	23.6	6.9	13.7	7.0	0.7	1,262	5,693	58,794
85 and older	1.0	8	0.4	52.9	27.9	6.0	8.5	4.3	0.5	2,112	3,224	31,199
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	337	81	109
Basis of Eligibility[e]												
Aged	1.5	17	1.3	47.4	23.8	7.0	13.3	7.7	0.9	1,273	14,717	150,511
Disabled	2.6	210	13.2	29.4	27.4	9.7	18.5	11.5	3.5	1,588	31,611	310,193
Adults	0.8	36	6.3	59.7	27.4	6.2	5.2	1.3	0.2	572	34,856	128,339
Children	0.3	25	4.8	73.8	23.0	2.1	1.0	0.1	0.0	506	93,161	412,375
Unknown	2.6	173	7.6	25.2	24.8	14.9	22.7	9.9	2.5	2,289	242	1,913
Gender												
Female	1.4	78	8.4	58.3	25.6	5.0	6.6	3.6	0.9	930	101,016	577,877
Male	1.1	88	8.7	63.7	23.7	4.3	5.5	2.3	0.5	1,021	73,178	424,556
Unknown	0.0	1	0.4	98.0	2.0	0.0	0.0	0.0	0.0	201	393	898
Race												
White	1.6	102	9.1	51.5	28.3	5.9	8.4	4.7	1.2	1,122	78,306	530,964
African American	1.2	82	8.9	65.6	21.7	4.5	5.3	2.3	0.5	921	33,529	168,613
Other/unknown	0.8	49	6.7	69.4	21.9	3.4	3.6	1.4	0.2	724	62,752	303,754
Use of Nursing Facilities[f]												
Entire year	2.0	94	1.9	39.4	32.8	7.4	7.0	7.1	6.3	4,910	2,431	23,938
Part year	2.7	146	3.2	28.7	34.3	7.7	11.4	10.8	7.0	4,516	2,123	20,555
None	1.2	81	10.2	61.3	24.5	4.7	6.0	2.9	0.6	793	170,033	958,838
Maintenance Assistance Status												
Cash	1.5	100	13.1	58.8	23.7	5.2	7.5	3.9	0.9	763	116,677	667,420
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	16	3.1	73.7	22.7	2.3	1.1	0.2	0.0	501	31,569	123,049
Other/unknown	1.0	66	3.5	53.2	31.6	5.5	6.1	2.8	0.8	1,880	26,341	212,862

Source: Data for this table are from the MAX 2007 file for Nevada, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.
d. In eight states (DE, IA, IL, NE, NY, TN, TX, 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, 2007

	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	**1.3**	**$82**	**$65**	**0.4**	**$60**	**$162**	**0.0**	**$5**	**$124**	**0.8**	**$17**	**$20**
Age												
5 and younger	0.3	28	102	0.1	23	371	0.0	1	71	0.2	4	21
6-14	0.4	51	122	0.2	43	222	0.0	2	132	0.2	6	27
15-20	0.6	70	114	0.2	57	246	0.0	4	178	0.4	9	25
21-44	1.4	112	79	0.4	82	205	0.0	7	168	1.0	23	23
45-64	3.7	240	64	1.0	161	162	0.1	19	157	2.6	59	22
65-74	1.9	31	16	0.6	19	33	0.1	2	29	1.2	9	7
75-84	1.4	10	7	0.5	6	12	0.1	1	9	0.9	4	4
85 and older	1.0	8	8	0.3	4	15	0.0	0	9	0.6	3	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	22	0.1	1	18	1.0	5	5
Disabled	2.6	210	79	0.8	153	197	0.1	15	159	1.8	41	23
Adults	0.8	36	47	0.2	22	140	0.0	2	125	0.6	13	21
Children	0.3	25	88	0.1	20	208	0.0	1	109	0.2	4	22
Unknown	2.6	173	65	0.6	127	216	0.1	8	105	2.0	39	20
Gender												
Female	1.4	78	55	0.4	55	137	0.0	5	106	1.0	18	19
Male	1.1	88	84	0.3	67	203	0.0	6	153	0.7	15	22
Unknown	0.0	1	39	0.0	0	25	0.0	0	173	0.0	0	21
Race												
White	1.6	102	65	0.5	73	161	0.1	7	126	1.1	22	21
African American	1.2	82	71	0.3	59	187	0.0	6	156	0.8	16	20
Other/unknown	0.8	49	61	0.3	37	147	0.0	2	91	0.5	9	17
Use of Nursing Facilities[e]												
Entire year	2.0	94	48	0.4	63	146	0.1	5	91	1.5	26	18
Part year	2.7	146	54	0.6	90	158	0.1	12	128	2.0	43	21
None	1.2	81	67	0.4	59	162	0.0	5	125	0.8	16	20
Maintenance Assistance Status												
Cash	1.5	100	65	0.4	72	162	0.1	7	131	1.0	21	20
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.3	16	51	0.1	10	145	0.0	1	103	0.2	4	19
Other/unknown	1.0	66	67	0.3	52	165	0.0	3	93	0.6	11	17

Source: Data for this table are from the MAX 2007 file for Nevada, released by CMS in 4/2010. This table was produced on 10/06/2010.
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, 0.3 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]
NEVADA, 2007

	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	$25	$18	$1	$6	$84	$374	$123	$26	93,166	$7,840,801	36,421	20.9	317,067
Biologicals	0.3	0.3	0.0	0.0	420	420	0	0	1348	1,348	0	0	2,015	2,715,431	696	0.4	6,465
Antineoplastic Agents	0.5	0.1	0.0	0.3	111	96	0	14	239	677	133	43	4,030	961,818	852	0.5	8,700
Endocrine/Metabolic Drugs	0.7	0.3	0.0	0.4	28	22	1	5	43	86	33	14	110,404	4,754,408	17,769	10.2	169,194
Cardiovascular Agents	1.2	0.3	0.1	0.9	25	13	2	9	20	52	40	10	211,324	4,319,330	16,929	9.7	171,472
Respiratory Agents	0.5	0.3	0.0	0.2	32	27	1	5	60	89	76	20	118,071	7,142,906	24,497	14.0	220,467
Gastrointestinal Agents	0.5	0.1	0.0	0.4	26	19	2	6	51	148	60	16	63,056	3,215,264	12,184	7.0	122,923
Genitourinary Agents	0.3	0.2	0.0	0.2	15	11	0	4	44	59	59	25	15,634	687,200	4,952	2.8	44,832
CNS Drugs	1.0	0.3	0.0	0.7	90	77	2	12	88	237	97	17	224,475	19,811,392	22,150	12.7	219,163
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	72	67	1	5	112	133	80	36	18,857	2,119,181	2,810	1.6	29,286
Miscellaneous Psychological/ Neurological Agents	0.4	0.4	0.0	0.0	70	69	0	1	190	193	0	70	8,088	1,534,506	2,131	1.2	22,051
Analgesics and Anesthetics	0.7	0.0	0.0	0.6	40	12	9	19	58	354	450	30	163,603	9,464,486	26,439	15.1	237,148
Neuromuscular Agents	0.8	0.3	0.0	0.5	64	45	7	12	80	169	173	24	119,763	9,527,233	14,805	8.5	147,723
Nutritional Products	0.4	0.1	0.0	0.3	8	2	0	6	24	39	21	21	24,065	567,131	8,200	4.7	66,889
Hematological Agents	0.6	0.2	0.0	0.4	77	71	1	5	120	302	35	14	33,544	4,028,472	5,059	2.9	52,018
Topical Products	0.3	0.1	0.0	0.2	14	10	0	4	49	100	62	21	51,222	2,500,348	19,214	11.0	176,249
Miscellaneous Products	0.7	0.3	0.0	0.3	210	172	12	26	322	584	420	80	3,630	1,170,432	533	0.3	5,570
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	36	0	0	0	140	0	0	0	1,495	209,767	564	0.3	5,857
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.	1,266,442	82,570,106	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Nevada, released by CMS in 4/2010. This table was produced on 10/06/2010.
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, 0.3 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 2007.
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, 2007

		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	$15,847,944	10,717	6.1	113,447	0.6	$247	$140
ANTICONVULSANT	8,565,987	12,145	7.0	126,194	0.6	109	68
ANALGESICS - Narcotic	8,173,229	32,184	18.4	302,155	0.4	66	27
ANTIASTHMATIC	5,279,943	22,172	12.7	211,983	0.4	70	25
ANTIVIRAL	4,080,759	2,177	1.2	21,453	0.4	439	190
MISC. HEMATOLOGICAL	2,711,232	1,961	1.1	20,982	0.5	241	129
PASSIVE IMMUNIZING AGENTS	2,702,588	413	0.2	3,430	0.5	1,594	788
ANTIDEPRESSANTS	2,395,534	14,607	8.4	148,296	0.5	33	16
ANTIDIABETIC	2,391,094	9,105	5.2	93,406	0.5	47	26
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	2,119,067	3,198	1.8	33,744	0.6	112	63
Total	54,267,377	108,679	n.a.	1,075,090	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Nevada, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 2007. 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 2007. 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.