STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
IDAHO

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
IDAHO, 2003

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries	(Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]		Number of Non-dual Eligible Beneficiaries	(Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	211,563	(A)	24,102	(E)	187,461	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	208,575	(B)	21,130	(F)	187,445	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	208,575	(C)	21,130	(G)	187,445	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	2,972	(D)	2,792	(H)	180	(L)

Source: Data for this table are from the MAX 2003 file for Idaho, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003 (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 2003, 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 Idaho in 2003 was $141,299,091, of which $179,196 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 19 states in 2003 that had PHPs that did not include a pharmacy benefit: AL, AR, CA, CO, FL, GA, IA, KY, MA, MI, NY, OR, PA, SD, TN, TX, UT, WA, and WI. In addition, there were 7 states in which MC plans did not provide a pharmacy benefit: DE, IA, NE, NY, TX, UT, and WV. These lists were constructed from the CMS 2003 Medicaid Managed Care Enrollment Report [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer02.pdf] 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 2003. 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 benficiary 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 2003. 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]

IDAHO, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**208,575**	**11,499**	**27,513**	**32,571**	**136,992**	**0**	**1,939,318**	**113,884**	**293,111**	**223,501**	**1,308,822**	**0**
Age												
5 and younger	60,622	0	1,422	0	59,200	0	564,029	0	14,689	0	549,340	0
6-14	60,694	0	3,324	0	57,370	0	610,419	0	36,720	0	573,699	0
15-20	25,831	0	2,226	3,318	20,287	0	232,569	0	23,977	23,160	185,432	0
21-44	38,075	0	10,225	27,722	128	0	298,680	0	109,462	188,876	342	0
45-64	11,750	0	10,230	1,513	7	0	118,967	0	107,516	11,442	9	0
65-74	4,003	3,917	76	10	0	0	41,664	40,987	662	15	0	0
75-84	4,017	4,003	9	5	0	0	39,636	39,548	83	5	0	0
85 and older	3,583	3,579	1	3	0	0	33,354	33,349	2	3	0	0
Unknown	0	0	0	0	0	0	0		0	0	0	0
Gender												
Female	117,894	8,134	14,021	27,899	67,840	0	1,072,982	81,693	150,223	192,913	648,153	0
Male	90,681	3,365	13,492	4,672	69,152	0	866,336	32,191	142,888	30,588	660,669	0
Unknown	0	0	0	0	0	0	0		0	0	0	0
Race												
White	182,019	10,569	25,442	28,995	117,013	0	1,689,053	104,023	270,699	205,425	1,108,906	0
African American	1,851	32	181	262	1,376	0	17,310	322	1,876	1,738	13,374	0
Other/unknown	24,705	898	1,890	3,314	18,603	0	232,955	9,539	20,536	16,338	186,542	0
Use of Nursing Facilities[c]												
Entire year	2,972	2,616	356	0	0	0	28,554	24,935	3,619	0	0	0
Part year	1,967	1,503	451	8	5	0	18,621	13,831	4,648	88	54	0
None	203,636	7,380	26,706	32,563	136,987	0	1,892,143	75,118	284,844	223,413	1,308,768	0
Maintenance Assistance Status												
Cash	56,846	2,115	25,800	10,537	18,394	0	557,900	23,852	274,929	83,402	175,717	0
Medically needy	0	0	0	0	0	0	0		0	0	0	0
Poverty-related	118,793	350	257	12,152	106,034	0	1,082,876	2,669	2,462	64,873	1,012,872	0
Other/unknown	32,936	9,034	1,456	9,882	12,564	0	298,542	87,363	15,720	75,226	120,233	0
Dual Medicare Status[d]												
Full dual, all year	20,250	10,720	9,404	122	4	0	210,984	106,789	103,194	972	29	0
Full dual, part year	880	502	374	4	0	0	7,973	4,231	3,700	42	0	0
Non-dual, all year	187,445	277	17,735	32,445	136,988	0	1,720,361	2,864	186,217	222,487	1,308,793	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	208,575	11,499	27,513	32,571	136,992	0	1,939,318	113,884	293,111	223,501	1,308,822	0
FFS part year, with Rx claims	0	0	0	0	0	0	0		0	0	0	0
FFS part year, no Rx claims	0	0	0	0	0	0	0		0	0	0	0

Source: Data for this table are from the MAX 2003 file for Idaho, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003. 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]

IDAHO, 2003

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	**66.0 %**	**11.8**	**$677**	**$57**	**$4,444**	**15.2 %**	**208,575**
Age							
5 and younger	66.0	3.3	135	41	1,704	7.9	60,622
6-14	57.6	3.8	227	60	1,688	13.5	60,694
15-20	61.1	5.7	344	60	2,884	11.9	25,831
21-44	69.9	15.9	1,066	67	6,792	15.7	38,075
45-64	85.1	54.1	3,407	63	15,327	22.2	11,750
65-74	87.5	55.3	2,786	50	14,207	19.6	4,003
75-84	87.3	55.8	2,553	46	17,689	14.4	4,017
85 and older	92.6	55.4	2,306	42	22,357	10.3	3,583
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	89.3	55.7	2,567	46	18,014	14.2	11,499
Disabled	84.1	40.5	2,886	71	16,228	17.8	27,513
Adults	64.7	7.9	364	46	2,907	12.5	32,571
Children	60.7	3.3	149	45	1,304	11.4	136,992
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	68.0	13.8	743	54	4,627	16.0	117,894
Male	63.5	9.2	591	64	4,207	14.0	90,681
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	66.8	12.6	726	58	4,710	15.4	182,019
African American	59.3	6.5	389	60	2,533	15.4	1,851
Other/unknown	60.5	6.5	331	51	2,632	12.6	24,705
Use of Nursing Facilities[f]							
Entire year	96.4	73.2	3,466	47	39,425	8.8	2,972
Part year	92.3	64.2	3,202	50	29,121	11.0	1,967
None	65.3	10.4	612	59	3,695	16.5	203,636
Maintenance Assistance Status							
Cash	75.4	24.6	1,625	66	8,932	18.2	56,846
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	60.0	3.3	141	43	1,478	9.5	118,793
Other/unknown	71.6	20.4	972	48	7,398	13.1	32,936

Source: Data for this table are from the MAX 2003 file for Idaho, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 seven states (DE, IA, NE, NY, 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 seven states (DE, IA, NE, NY, 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]

IDAHO, 2003

				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**	**$73**	**15.2 %**	**34.0 %**	**48.4 %**	**5.1 %**	**6.4 %**	**4.4 %**	**1.8 %**	**$478**	**208,575**	**1,939,318**
Age												
5 and younger	0.4	15	7.9	34.0	62.9	2.3	0.7	0.1	0.0	183	60,622	564,029
6-14	0.4	23	13.5	42.4	51.9	3.1	2.3	0.3	0.0	168	60,694	610,419
15-20	0.6	38	11.9	38.9	50.1	6.0	4.1	0.8	0.0	320	25,831	232,569
21-44	2.0	136	15.7	30.1	40.1	10.1	11.9	6.0	1.9	866	38,075	298,680
45-64	5.3	337	22.2	14.9	15.5	9.3	23.7	23.5	12.9	1,514	11,750	118,967
65-74	5.3	268	19.6	12.5	14.7	7.9	24.9	27.1	13.0	1,365	4,003	41,664
75-84	5.7	259	14.4	12.7	9.5	6.8	26.1	31.5	13.4	1,793	4,017	39,636
85 and older	6.0	248	10.3	7.4	7.4	6.9	29.0	37.0	12.3	2,402	3,583	33,354
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Basis of Eligibility[e]												
Aged	5.6	259	14.2	10.7	10.6	7.2	26.6	31.8	13.0	1,819	11,499	113,884
Disabled	3.8	271	17.8	15.9	26.4	11.0	22.3	16.8	7.6	1,523	27,513	293,111
Adults	1.1	53	12.5	35.3	45.5	9.0	7.5	2.2	0.5	424	32,571	223,501
Children	0.3	16	11.4	39.3	56.6	2.8	1.2	0.1	0.0	137	136,992	1,308,822
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.5	82	16.0	32.0	47.7	5.5	7.0	5.3	2.4	508	117,894	1,072,982
Male	1.0	62	14.0	36.5	49.2	4.6	5.5	3.1	1.0	440	90,681	866,336
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.4	78	15.4	33.2	47.9	5.4	6.8	4.7	2.0	508	182,019	1,689,053
African American	0.7	42	15.4	40.7	49.9	2.8	4.1	1.8	0.6	271	1,851	17,310
Other/unknown	0.7	35	12.6	39.5	51.4	3.2	3.5	1.8	0.6	279	24,705	232,955
Use of Nursing Facilities[f]												
Entire year	7.6	361	8.8	3.6	3.6	4.5	24.8	40.0	23.4	4,104	2,972	28,554
Part year	6.8	338	11.0	7.7	5.6	6.0	25.5	37.8	17.4	3,076	1,967	18,621
None	1.1	66	16.5	34.7	49.4	5.1	5.9	3.5	1.3	398	203,636	1,892,143
Maintenance Assistance Status												
Cash	2.5	166	18.2	24.6	38.7	8.6	14.1	9.8	4.1	910	56,846	557,900
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.4	15	9.5	40.0	55.5	3.0	1.3	0.2	0.1	162	118,793	1,082,876
Other/unknown	2.3	107	13.1	28.4	39.5	6.8	11.3	10.1	4.0	816	32,936	298,542

Source: Data for this table are from the MAX 2003 file for Idaho, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 seven states (DE, IA, NE, NY, 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 seven states (DE, IA, NE, NY, 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]

IDAHO, 2003

	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**	**$73**	**$57**	**0.5**	**$56**	**$103**	**0.0**	**$2**	**$40**	**0.7**	**$15**	**$22**
Age												
5 and younger	0.4	15	41	0.1	11	82	0.0	1	48	0.2	3	15
6-14	0.4	23	60	0.2	18	94	0.0	1	69	0.2	4	21
15-20	0.6	38	60	0.3	30	102	0.0	1	65	0.3	7	22
21-44	2.0	136	67	0.9	107	123	0.0	2	46	1.1	26	23
45-64	5.3	337	63	2.3	259	111	0.2	6	39	2.8	70	25
65-74	5.3	268	50	2.3	199	87	0.2	6	31	2.8	62	22
75-84	5.7	259	46	2.3	189	81	0.3	8	27	3.0	62	20
85 and older	6.0	248	42	2.2	175	78	0.3	8	25	3.4	64	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.6	259	46	2.3	189	83	0.3	7	27	3.1	63	21
Disabled	3.8	271	71	1.8	216	123	0.1	5	46	1.9	49	26
Adults	1.1	53	46	0.4	39	93	0.0	1	36	0.7	14	19
Children	0.3	16	45	0.1	12	79	0.0	0	55	0.2	3	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.5	82	54	0.6	62	97	0.1	2	35	0.8	18	21
Male	1.0	62	64	0.4	49	112	0.0	1	49	0.5	12	23
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.4	78	58	0.6	60	103	0.0	2	40	0.7	16	22
African American	0.7	42	60	0.3	33	108	0.0	1	39	0.4	8	20
Other/unknown	0.7	35	51	0.3	26	96	0.0	1	40	0.4	8	21
Use of Nursing Facilities[e]												
Entire year	7.6	361	47	3.0	262	88	0.4	10	28	4.2	87	21
Part year	6.8	338	50	2.7	249	92	0.3	8	27	3.7	80	21
None	1.1	66	59	0.5	51	104	0.0	1	43	0.6	13	22
Maintenance Assistance Status												
Cash	2.5	166	66	1.1	131	116	0.1	3	43	1.3	31	24
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.4	15	43	0.1	11	78	0.0	0	51	0.2	4	18
Other/unknown	2.3	107	48	0.9	79	86	0.1	3	31	1.2	25	20

Source: Data for this table are from the MAX 2003 file for Idaho, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 Idaho, 1.1 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.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007)

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]

IDAHO, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total 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			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.2	0.1	0.0	0.1	$11	$8	$0	$3	$47	$79	$66	$22	246,420	$11,491,254	93,877	45.0 %	1,001,099
Biologicals	0.2	0.2	0.0	0.0	154	152	0	2	735	771	0	192	2,346	1,724,663	1,050	0.5	11,200
Antineoplastic Agents	0.6	0.3	0.0	0.3	163	146	2	15	275	508	77	52	6,135	1,686,506	984	0.5	10,361
Endocrine/Metabolic Drugs	0.8	0.4	0.1	0.3	32	25	2	5	43	68	22	18	246,547	10,617,628	31,353	15.0	327,905
Cardiovascular Agents	1.6	0.6	0.0	0.9	55	37	1	17	35	62	21	18	338,201	11,950,254	20,456	9.8	216,353
Respiratory Agents	0.4	0.2	0.0	0.2	19	15	0	4	50	82	53	20	242,700	12,037,839	58,034	27.8	625,427
Gastrointestinal Agents	0.6	0.2	0.0	0.4	34	22	1	11	56	104	201	28	127,422	7,173,522	19,940	9.6	211,473
Genitourinary Agents	0.4	0.3	0.0	0.1	23	21	0	2	59	69	37	20	37,441	2,191,982	9,328	4.5	96,858
CNS Drugs	1.2	0.7	0.0	0.5	103	90	1	13	86	126	84	27	453,201	38,924,366	36,020	17.3	376,782
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.2	49	42	1	7	76	87	69	42	47,102	3,559,789	6,513	3.1	71,937
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	139	138	0	1	199	208	0	27	8,162	1,626,390	1,139	0.5	11,670
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	29	20	0	9	50	155	59	21	281,303	13,952,635	45,917	22.0	473,577
Neuromuscular Agents	0.9	0.4	0.0	0.4	69	55	2	12	78	127	47	30	188,641	14,804,425	19,964	9.6	214,513
Nutritional Products	0.3	0.0	0.0	0.3	5	0	0	5	14	26	16	14	63,977	918,254	19,377	9.3	195,313
Hematological Agents	0.8	0.2	0.2	0.4	60	49	4	7	76	246	26	16	42,768	3,232,997	5,188	2.5	53,732
Topical Products	0.2	0.1	0.0	0.1	7	4	0	2	33	57	51	18	109,881	3,602,862	48,630	23.3	526,832
Miscellaneous Products	0.6	0.3	0.1	0.3	136	95	20	21	214	373	232	72	4,999	1,069,658	747	0.4	7,846
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	5	0	0	0	29	0	0	0	19,155	554,871	11,099	5.3	122,052
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.	2,466,401	141,119,895	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Idaho, released by CMS in 05/2007. This table was produced on 11/01/2007.

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.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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 Idaho, 1.1 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.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2003.

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]

IDAHO, 2003

		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	$21,266,706	16,218	7.8 %	177,420	0.7	$167	$120
ANTIDEPRESSANTS	15,074,444	37,960	18.2	402,429	0.6	63	37
ANTICONVULSANT	12,286,211	14,706	7.1	160,754	0.8	98	76
ANALGESICS - Narcotic	8,179,760	52,772	25.3	550,611	0.3	43	15
ANTIASTHMATIC	7,325,934	35,179	16.9	381,844	0.3	60	19
ANTIDIABETIC	5,816,064	11,760	5.6	126,684	0.7	62	46
ULCER DRUGS	5,344,249	19,755	9.5	212,589	0.4	57	25
ANALGESICS - ANTI-INFLAMMATORY	3,973,611	20,691	9.9	217,132	0.3	58	18
ANTIHYPERLIPIDEMIC	3,918,398	6,563	3.1	72,454	0.7	79	54
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	3,559,789	8,159	3.9	90,999	0.5	76	39
Total	86,745,166	223,763		2,392,916	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Idaho, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003. 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 2003. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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.