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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
MONTANA, 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]	111,457	(A)	18,347	(E)	93,110	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	96,072	(B)	17,314	(F)	78,758	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	95,906	(C)	17,314	(G)	78,592	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	3,466	(D)	3,274	(H)	192	(L)

Source: Data for this table are from the MAX 2003 file for Montana, 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 Montana in 2003 was $89,191,716, of which $5,520,071 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]

MONTANA, 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	**95,906**	**9,114**	**17,962**	**9,091**	**59,739**	**0**	**869,847**	**84,385**	**181,299**	**70,564**	**533,599**	**0**
Age												
5 and younger	26,014	0	535	1	25,478	0	230,001	0	5,354	1	224,646	0
6-14	24,762	0	1,131	2	23,629	0	231,340	0	12,197	3	219,140	0
15-20	12,518	1	1,033	998	10,486	0	105,535	1	10,767	5,503	89,264	0
21-44	13,410	13	5,859	7,392	146	0	117,679	116	59,881	57,133	549	0
45-64	9,154	20	8,542	592	0	0	91,133	184	84,268	6,681	0	0
65-74	3,502	2,714	717	71	0	0	33,519	25,359	7,319	841	0	0
75-84	3,346	3,197	120	29	0	0	31,325	29,726	1,259	340	0	0
85 and older	3,200	3,169	25	6	0	0	29,315	28,999	254	62	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	53,855	6,740	9,419	7,896	29,800	0	485,258	64,068	96,831	57,907	266,452	0
Male	42,049	2,374	8,543	1,195	29,937	0	384,587	20,317	84,468	12,657	267,145	0
Unknown	2	0	0	0	2	2	0	0	0	0	2	0
Race												
White	71,082	8,333	14,872	7,034	40,843	0	633,580	76,540	148,407	53,654	354,979	0
African American	815	16	110	40	649	0	7,100	151	1,062	291	5,596	0
Other/unknown	24,009	765	2,980	2,017	18,247	0	229,167	7,694	31,830	16,619	173,024	0
Use of Nursing Facilities[c]												
Entire year	3,466	3,015	450	1	0	0	34,452	29,632	4,808	12	0	0
Part year	1,791	1,352	412	22	5	0	15,797	11,422	4,063	252	60	0
None	90,649	4,747	17,100	9,068	59,734	0	819,598	43,331	172,428	70,300	533,539	0
Maintenance Assistance Status												
Cash	38,550	1,906	13,727	2,280	20,637	0	377,421	20,873	145,335	20,514	190,699	0
Medically needy	8,851	5,951	2,831	9	60	0	73,330	50,817	22,128	13	372	0
Poverty-related	28,427	10	0	3,744	24,673	0	234,804	48	0	20,282	214,474	0
Other/unknown	20,078	1,247	1,404	3,058	14,369	0	184,292	12,647	13,836	29,755	128,054	0
Dual Medicare Status[d]												
Full dual, all year	17,314	8,870	7,356	1,078	10	0	168,158	82,748	72,689	12,619	102	0
Full dual, part year	0	0	0	0	0	0	0	0	0	0	0	0
Non-dual, all year	78,592	244	10,606	8,013	59,729	0	701,689	1,637	108,610	57,945	533,497	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	95,906	9,114	17,962	9,091	59,739	0	869,847	84,385	181,299	70,564	533,599	0
FFS part year, with Rx claims	0	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	0

Source: Data for this table are from the MAX 2003 file for Montana, 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]

MONTANA, 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	**64.9 %**	**14.7**	**$872**	**$59**	**$5,279**	**16.5 %**	**95,906**
Age							
5 and younger	60.8	2.9	97	34	1,981	4.9	26,014
6-14	51.7	3.9	255	65	2,362	10.8	24,762
15-20	56.9	5.6	363	65	3,781	9.6	12,518
21-44	74.8	18.6	1,458	78	6,888	21.2	13,410
45-64	82.7	45.7	3,042	67	11,513	26.4	9,154
65-74	83.2	46.8	2,349	50	9,781	24.0	3,502
75-84	88.5	52.7	2,414	46	15,300	15.8	3,346
85 and older	92.9	51.1	2,056	40	20,529	10.0	3,200
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	88.7	50.7	2,290	45	15,747	14.5	9,114
Disabled	80.1	36.0	2,659	74	11,304	23.5	17,962
Adults	71.9	11.3	611	54	4,430	13.8	9,091
Children	55.6	3.4	159	47	1,999	8.0	59,739
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	67.8	17.8	966	54	5,632	17.1	53,855
Male	61.1	10.9	753	69	4,827	15.6	42,049
Unknown	0.0	0.0	0	0	0	0.0	2
Race							
White	71.4	17.8	1,057	60	5,780	18.3	71,082
African American	63.1	7.8	450	57	2,786	16.1	815
Other/unknown	45.5	6.0	339	57	3,878	8.7	24,009
Use of Nursing Facilities[f]							
Entire year	96.8	67.5	3,138	47	30,417	10.3	3,466
Part year	95.6	55.1	2,695	49	21,287	12.7	1,791
None	63.0	11.9	750	63	4,001	18.7	90,649
Maintenance Assistance Status							
Cash	63.4	15.4	1,003	65	4,750	21.1	38,550
Medically needy	89.0	52.5	2,847	54	16,727	17.0	8,851
Poverty related	57.3	3.1	124	40	1,460	8.5	28,427
Other/unknown	67.8	13.4	811	61	6,653	12.2	20,078

Source: Data for this table are from the MAX 2003 file for Montana, 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]

MONTANA, 2003

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: 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]	Number Beneficiaries	Benefit Months
All	**1.6**	**$96**	**16.5 %**	**35.1 %**	**41.3 %**	**5.8 %**	**9.0 %**	**6.4 %**	**2.3 %**	**$582**	**95,906**	**869,847**
Age												
5 and younger	0.3	11	4.9	39.2	57.9	2.1	0.7	0.0	0.0	224	26,014	230,001
6-14	0.4	27	10.8	48.3	44.5	4.1	2.9	0.3	0.0	253	24,762	231,340
15-20	0.7	43	9.6	43.1	44.7	6.4	5.1	0.7	0.1	449	12,518	105,535
21-44	2.1	166	21.2	25.2	39.9	11.5	14.2	7.2	2.1	785	13,410	117,679
45-64	4.6	306	26.4	17.3	16.4	9.4	25.6	21.6	9.7	1,156	9,154	91,133
65-74	4.9	245	24.0	16.8	13.2	8.3	25.6	25.6	10.3	1,022	3,502	33,519
75-84	5.6	258	15.8	11.5	9.4	7.4	27.2	33.0	11.5	1,634	3,346	31,325
85 and older	5.6	225	10.0	7.1	9.0	8.8	31.8	33.6	9.7	2,241	3,200	29,315
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	5.5	247	14.5	11.3	10.2	8.1	28.2	31.2	10.9	1,701	9,114	84,385
Disabled	3.6	263	23.5	19.9	24.0	10.7	22.4	16.4	6.6	1,120	17,962	181,299
Adults	1.5	79	13.8	28.1	47.8	10.5	9.8	3.3	0.5	571	9,091	70,564
Children	0.4	18	8.0	44.4	50.2	3.3	1.9	0.2	0.0	224	59,739	533,599
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.0	107	17.1	32.2	40.5	6.2	9.8	8.1	3.2	625	53,855	485,258
Male	1.2	82	15.6	38.9	42.3	5.4	7.9	4.3	1.3	528	42,049	384,587
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	2	2
Race												
White	2.0	119	18.3	28.6	42.9	6.8	10.7	8.0	3.0	649	71,082	633,580
African American	0.9	52	16.1	36.9	49.3	4.5	6.5	2.1	0.6	320	815	7,100
Other/unknown	0.6	36	8.7	54.5	36.1	3.2	3.8	1.9	0.5	406	24,009	229,167
Use of Nursing Facilities[f]												
Entire year	6.8	316	10.3	3.2	6.1	6.4	28.4	39.5	16.4	3,060	3,466	34,452
Part year	6.2	306	12.7	4.4	8.7	8.4	29.6	35.2	13.7	2,413	1,791	15,797
None	1.3	83	18.7	37.0	43.3	5.8	7.8	4.6	1.6	443	90,649	819,598
Maintenance Assistance Status												
Cash	1.6	102	21.1	36.6	38.9	6.6	10.1	5.8	2.0	485	38,550	377,421
Medically needy	6.3	344	17.0	11.0	7.9	7.5	27.6	32.7	13.3	2,019	8,851	73,330
Poverty related	0.4	15	8.5	42.7	51.8	3.8	1.6	0.1	0.0	177	28,427	234,804
Other/unknown	1.5	88	12.2	32.2	45.7	6.5	9.0	5.0	1.5	725	20,078	184,292

Source: Data for this table are from the MAX 2003 file for Montana, 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]

MONTANA, 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	**1.6**	**$96**	**$59**	**0.7**	**$73**	**$107**	**0.1**	**$3**	**$41**	**0.9**	**$21**	**$24**
Age												
5 and younger	0.3	11	34	0.1	8	64	0.0	0	43	0.2	3	14
6-14	0.4	27	65	0.2	23	101	0.0	1	65	0.2	4	21
15-20	0.7	43	65	0.3	35	108	0.0	1	56	0.3	7	22
21-44	2.1	166	78	0.9	130	149	0.1	5	66	1.2	31	26
45-64	4.6	306	67	1.9	228	119	0.2	9	57	2.5	68	27
65-74	4.9	245	50	2.0	178	87	0.2	5	25	2.6	62	24
75-84	5.6	258	46	2.3	184	82	0.3	6	21	3.1	67	22
85 and older	5.6	225	40	2.0	154	77	0.4	7	19	3.2	63	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.5	247	45	2.2	176	82	0.3	6	21	3.0	65	22
Disabled	3.6	263	74	1.5	202	134	0.1	8	63	1.9	53	28
Adults	1.5	79	54	0.6	59	103	0.1	2	33	0.8	18	22
Children	0.4	18	47	0.2	14	79	0.0	0	52	0.2	3	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.0	107	54	0.8	79	99	0.1	3	37	1.1	25	23
Male	1.2	82	69	0.5	64	124	0.0	2	52	0.6	16	26
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.0	119	60	0.8	89	107	0.1	3	41	1.1	26	24
African American	0.9	52	57	0.4	39	99	0.0	1	38	0.5	12	25
Other/unknown	0.6	36	57	0.2	27	109	0.0	1	43	0.4	8	22
Use of Nursing Facilities[e]												
Entire year	6.8	316	47	2.5	222	87	0.4	9	22	3.8	85	22
Part year	6.2	306	49	2.4	218	90	0.3	9	26	3.5	78	23
None	1.3	83	63	0.6	64	112	0.0	2	51	0.7	17	24
Maintenance Assistance Status												
Cash	1.6	102	65	0.7	78	118	0.1	3	57	0.9	21	25
Medically needy	6.3	344	54	2.5	252	100	0.3	9	29	3.5	82	24
Poverty related	0.4	15	40	0.2	11	72	0.0	0	46	0.2	3	16
Other/unknown	1.5	88	61	0.6	68	106	0.1	2	41	0.8	18	24

Source: Data for this table are from the MAX 2003 file for Montana, 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 Montana, 0.7 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 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]

MONTANA, 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	0.3	0.1	0.0	0.1	$13	$9	$0	$3	$48	$82	$69	$21	108,531	$5,215,594	40,140	41.9 %	413,970
Biologicals	0.1	0.1	0.0	0.0	98	60	34	3	651	612	4,340	72	474	308,641	314	0.3	3,163
Antineoplastic Agents	0.6	0.3	0.0	0.3	161	144	1	16	278	557	69	53	4,303	1,197,142	737	0.8	7,418
Endocrine/Metabolic Drugs	0.9	0.4	0.1	0.4	37	28	2	8	44	72	20	20	141,946	6,226,356	16,376	17.1	166,903
Cardiovascular Agents	1.6	0.5	0.1	1.0	51	33	1	17	32	61	15	18	226,774	7,365,344	14,205	14.8	145,658
Respiratory Agents	0.5	0.3	0.0	0.2	27	22	0	5	53	76	40	22	129,680	6,896,914	24,404	25.4	254,270
Gastrointestinal Agents	0.7	0.3	0.0	0.4	54	37	1	15	80	126	188	41	85,340	6,809,432	12,163	12.7	127,022
Genitourinary Agents	0.5	0.4	0.0	0.1	29	26	0	3	60	72	38	24	24,770	1,497,606	5,066	5.3	51,894
CNS Drugs	1.2	0.6	0.0	0.6	103	85	2	16	88	140	122	30	243,483	21,382,103	20,059	20.9	207,270
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.2	54	45	3	7	76	89	63	42	29,053	2,211,288	3,876	4.0	40,722
Miscellaneous Psychological/ Neurological Agents	0.5	0.5	0.0	0.1	115	110	0	5	210	222	0	96	6,156	1,294,647	1,066	1.1	11,261
Analgesics and Anesthetics	0.7	0.2	0.0	0.5	38	26	1	12	53	155	76	21	162,336	8,645,737	22,192	23.1	225,000
Neuromuscular Agents	0.9	0.4	0.1	0.5	67	50	3	14	74	133	46	30	107,232	7,937,078	11,074	11.5	117,772
Nutritional Products	0.4	0.0	0.0	0.4	7	0	0	6	17	21	17	16	45,748	758,388	10,724	11.2	107,815
Hematological Agents	0.8	0.2	0.3	0.4	72	61	6	5	89	354	20	15	30,806	2,747,936	3,800	4.0	37,954
Topical Products	0.3	0.1	0.0	0.1	9	6	0	3	36	61	53	18	58,377	2,118,769	21,786	22.7	228,575
Miscellaneous Products	0.6	0.2	0.1	0.3	124	79	23	22	213	356	265	80	4,202	896,618	697	0.7	7,238
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	7	0	0	0	37	0	0	0	4,331	162,052	2,346	2.4	24,722
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.	1,413,542	83,671,645	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Montana, 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 Montana, 0.7 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]

MONTANA, 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	$12,915,208	9,016	9.4 %	97,414	0.7	$188	$133
ANTIDEPRESSANTS	7,338,889	19,287	20.1	201,939	0.6	60	36
ANTICONVULSANT	6,389,746	8,479	8.8	91,286	0.8	89	70
ANALGESICS - Narcotic	5,628,679	26,543	27.7	272,014	0.4	48	21
ULCER DRUGS	5,356,692	11,585	12.1	122,189	0.5	82	44
ANTIASTHMATIC	4,540,462	18,729	19.5	196,048	0.4	62	23
ANTIDIABETIC	2,927,376	6,479	6.8	67,223	0.8	56	44
ANALGESICS - ANTI-INFLAMMATORY	2,412,649	9,621	10.0	101,189	0.3	69	24
ANTIHYPERLIPIDEMIC	2,322,016	4,321	4.5	45,900	0.7	76	51
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	2,211,288	4,867	5.1	51,927	0.6	76	43
Total	52,043,005	118,927		1,247,129	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Montana, 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.