STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2004
IDAHO

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

SUPPLEMENTAL TABLES

APPENDIX TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
IDAHO, 2004

Inclusion Criteria (2004)	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]	223,497	(A)	25,082	(E)	198,415	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	220,208	(B)	21,807	(F)	198,401	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	220,208	(C)	21,807	(G)	198,401	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	2,840	(D)	2,666	(H)	174	(L)

Source: Data for this table are from the MAX 2004 file for Idaho, released by CMS in 02/2008. This table was produced on 03/25/2008.

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 2004 (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 2004, 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 2004 was $165,293,092, of which $107,527 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 23 states in 2004 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NY, OK, OR, PA, SC, 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) and one state (NV) in which MC plans provided a pharmacy benefit for nonduals but not for duals. These lists were constructed from the CMS 2004 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer04.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 pa

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 2004. 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 2004. 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, 2004

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**220,208**	**11,772**	**28,843**	**34,550**	**145,043**	**0**	**2,057,390**	**117,791**	**308,657**	**243,375**	**1,387,567**	**0**
Age												
5 and younger	63,565	0	1,453	0	62,112	0	592,046	0	15,086	0	576,960	0
6-14	64,302	0	3,627	0	60,675	0	647,077	0	40,323	0	606,754	0
15-20	27,927	1	2,400	3,406	22,120	0	253,558	12	26,243	23,871	203,432	0
21-44	40,093	1	10,550	29,407	135	0	320,032	12	113,388	206,212	420	0
45-64	12,510	73	10,720	1,717	0	0	126,873	818	112,800	13,255	0	0
65-74	4,173	4,075	85	12	1	0	43,617	42,841	748	27	1	0
75-84	4,055	4,040	8	7	0	0	40,672	40,595	69	8	0	0
85 and older	3,583	3,582	0	1	0	0	33,515	33,513	0	2	0	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Gender												
Female	124,278	8,294	14,726	29,563	71,695	0	1,136,588	83,717	158,316	208,611	685,944	0
Male	95,930	3,478	14,117	4,987	73,348	0	920,802	34,074	150,341	34,764	701,623	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	198,970	10,947	26,966	31,600	129,457	0	1,861,047	108,686	287,971	229,018	1,235,372	0
African American	2,238	36	217	345	1,640	0	19,762	381	2,177	2,308	14,896	0
Other/unknown	19,000	789	1,660	2,605	13,946	0	176,581	8,724	18,509	12,049	137,299	0
Use of Nursing Facilities[c]												
Entire year	2,840	2,486	354	0	0	0	27,299	23,590	3,709	0	0	0
Part year	1,820	1,358	450	10	2	0	17,520	12,822	4,576	108	14	0
None	215,548	7,928	28,039	34,540	145,041	0	2,012,571	81,379	300,372	243,267	1,387,553	0
Maintenance Assistance Status												
Cash	59,451	2,181	27,039	11,039	19,192	0	591,080	24,570	289,246	90,215	187,049	0
Medically needy	0	0	0	0	0	0		0	0	0	0	0
Poverty-related	125,650	358	265	12,852	112,175	0	1,142,594	2,881	2,488	69,171	1,068,054	0
Other/unknown	35,107	9,233	1,539	10,659	13,676	0	323,716	90,340	16,923	83,989	132,464	0
Dual Medicare Status[d]												
Full dual, all year	20,891	10,909	9,827	154	1	0	218,979	109,664	108,140	1,174	1	0
Full dual, part year	916	515	397	4	0	0	8,355	4,431	3,880	44	0	0
Non-dual, all year	198,401	348	18,619	34,392	145,042	0	1,830,056	3,696	196,637	242,157	1,387,566	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	220,208	11,772	28,843	34,550	145,043	0	2,057,390	117,791	308,657	243,375	1,387,567	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 2004 file for Idaho, released by CMS in 02/2008. This table was produced on 03/25/2008.

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 2004. 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, 2004

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	**63.3 %**	**12.1**	**$750**	**$62**	**$4,581**	**16.4 %**	**220,208**
Age							
5 and younger	62.2	3.0	124	41	1,957	6.3	63,565
6-14	52.5	3.7	245	65	1,920	12.7	64,302
15-20	59.2	5.8	374	64	3,040	12.3	27,927
21-44	70.3	16.8	1,207	72	6,995	17.3	40,093
45-64	85.7	56.9	3,843	68	15,329	25.1	12,510
65-74	87.6	58.6	3,237	55	12,915	25.1	4,173
75-84	88.5	59.1	2,948	50	17,406	16.9	4,055
85 and older	93.5	57.2	2,570	45	22,109	11.6	3,583
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	89.8	58.6	2,952	50	17,345	17.0	11,772
Disabled	84.4	42.6	3,232	76	16,744	19.3	28,843
Adults	65.1	8.4	427	51	3,142	13.6	34,550
Children	56.5	3.2	155	49	1,469	10.5	145,043
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	65.7	14.2	821	58	4,733	17.4	124,278
Male	60.2	9.4	658	70	4,382	15.0	95,930
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	64.2	12.6	786	62	4,767	16.5	198,970
African American	55.1	6.7	437	66	2,809	15.6	2,238
Other/unknown	55.3	7.3	414	57	2,834	14.6	19,000
Use of Nursing Facilities[f]							
Entire year	95.5	73.2	3,801	52	40,388	9.4	2,840
Part year	94.0	72.5	4,032	56	31,221	12.9	1,820
None	62.6	10.8	682	63	3,884	17.6	215,548
Maintenance Assistance Status							
Cash	74.6	25.9	1,834	71	9,254	19.8	59,451
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	55.8	3.2	146	46	1,614	9.1	125,650
Other/unknown	70.9	20.9	1,077	52	7,283	14.8	35,107

Source: Data for this table are from the MAX 2004 file for Idaho, released by CMS in 02/2008. This table was produced on 03/25/2008.

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, 2004

				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**	**$80**	**16.4 %**	**36.7 %**	**45.5 %**	**5.1 %**	**6.3 %**	**4.5 %**	**2.0 %**	**$490**	**220,208**	**2,057,390**
Age												
5 and younger	0.3	13	6.3	37.8	59.4	2.1	0.7	0.1	0.0	210	63,565	592,046
6-14	0.4	24	12.7	47.5	46.5	3.2	2.5	0.3	0.0	191	64,302	647,077
15-20	0.6	41	12.3	40.8	48.0	6.1	4.2	0.8	0.1	335	27,927	253,558
21-44	2.1	151	17.3	29.7	39.9	10.0	12.1	6.4	2.1	876	40,093	320,032
45-64	5.6	379	25.1	14.3	14.7	9.3	23.2	24.3	14.1	1,511	12,510	126,873
65-74	5.6	310	25.1	12.4	13.2	8.2	23.7	27.7	14.8	1,236	4,173	43,617
75-84	5.9	294	16.9	11.5	10.0	6.9	23.4	33.7	14.6	1,735	4,055	40,672
85 and older	6.1	275	11.6	6.5	7.4	7.7	27.2	37.2	14.0	2,364	3,583	33,515
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	5.9	295	17.0	10.2	10.3	7.6	24.6	32.7	14.5	1,734	11,772	117,791
Disabled	4.0	302	19.3	15.6	25.7	10.9	21.9	17.4	8.5	1,565	28,843	308,657
Adults	1.2	61	13.6	34.9	45.0	9.1	7.9	2.5	0.5	446	34,550	243,375
Children	0.3	16	10.5	43.5	52.4	2.7	1.3	0.1	0.0	154	145,043	1,387,567
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.6	90	17.4	34.3	45.2	5.5	6.9	5.5	2.6	518	124,278	1,136,588
Male	1.0	69	15.0	39.8	45.8	4.5	5.5	3.2	1.2	457	95,930	920,802
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	84	16.5	35.8	45.6	5.2	6.5	4.7	2.1	510	198,970	1,861,047
African American	0.8	50	15.6	44.9	43.7	4.6	4.2	1.9	0.7	318	2,238	19,762
Other/unknown	0.8	45	14.6	44.7	44.7	3.4	4.0	2.5	0.8	305	19,000	176,581
Use of Nursing Facilities[f]												
Entire year	7.6	395	9.4	4.5	3.9	4.4	21.9	40.3	24.9	4,202	2,840	27,299
Part year	7.5	419	12.9	6.0	5.0	5.8	22.9	37.3	23.0	3,243	1,820	17,520
None	1.2	73	17.6	37.4	46.4	5.1	5.9	3.7	1.5	416	215,548	2,012,571
Maintenance Assistance Status												
Cash	2.6	184	19.8	25.4	37.3	8.4	14.0	10.3	4.6	931	59,451	591,080
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	9.1	44.2	51.2	3.0	1.4	0.2	0.1	178	125,650	1,142,594
Other/unknown	2.3	117	14.8	29.1	38.8	7.0	10.8	10.0	4.3	790	35,107	323,716

Source: Data for this table are from the MAX 2004 file for Idaho, released by CMS in 02/2008. This table was produced on 03/25/2008.

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, 2004

	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**	**$80**	**$62**	**0.5**	**$60**	**$116**	**0.1**	**$5**	**$67**	**0.7**	**$16**	**$22**
Age												
5 and younger	0.3	13	41	0.1	9	92	0.0	1	44	0.2	3	16
6-14	0.4	24	65	0.2	20	103	0.0	1	62	0.2	3	21
15-20	0.6	41	64	0.3	32	116	0.0	2	64	0.3	7	22
21-44	2.1	151	72	0.8	114	140	0.1	9	84	1.2	28	24
45-64	5.6	379	68	2.2	274	124	0.3	26	86	3.1	78	25
65-74	5.6	310	55	2.2	223	101	0.3	19	59	3.0	67	22
75-84	5.9	294	50	2.2	208	94	0.4	19	46	3.2	67	21
85 and older	6.1	275	45	2.1	189	89	0.5	18	38	3.5	66	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.9	295	50	2.2	209	95	0.4	19	47	3.2	67	21
Disabled	4.0	302	76	1.7	230	137	0.2	18	84	2.1	53	26
Adults	1.2	61	51	0.4	42	108	0.0	4	78	0.8	15	20
Children	0.3	16	49	0.1	12	91	0.0	1	50	0.2	3	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.6	90	58	0.6	65	110	0.1	6	63	0.9	19	22
Male	1.0	69	70	0.4	53	126	0.1	4	74	0.5	12	24
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.4	84	62	0.5	62	116	0.1	5	67	0.7	17	23
African American	0.8	50	66	0.3	40	122	0.0	2	55	0.4	8	21
Other/unknown	0.8	45	57	0.3	32	112	0.0	3	65	0.4	9	21
Use of Nursing Facilities[e]												
Entire year	7.6	395	52	2.6	274	104	0.6	29	46	4.3	91	21
Part year	7.5	419	56	2.8	301	108	0.5	28	54	4.2	89	21
None	1.2	73	63	0.5	55	117	0.1	4	71	0.6	14	23
Maintenance Assistance Status												
Cash	2.6	184	71	1.1	139	130	0.1	11	81	1.4	34	25
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.3	16	46	0.1	12	90	0.0	1	51	0.2	4	18
Other/unknown	2.3	117	52	0.9	84	98	0.1	7	50	1.2	26	20

Source: Data for this table are from the MAX 2004 file for Idaho, released by CMS in 02/2008. This table was produced on 03/25/2008.

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, 1.0 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, 2004

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per 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	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.2	0.1	0.0	0.2	$12	$7	$1	$4	$49	$97	$72	$25	236,354	$11,588,792	90,499	41.1 %	967,238
Biologicals	0.2	0.2	0.0	0.0	124	114	1	9	687	746	199	391	1,731	1,188,777	921	0.4	9,614
Antineoplastic Agents	0.6	0.2	0.0	0.4	122	97	2	23	202	587	141	54	5,981	1,206,648	944	0.4	9,909
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.4	37	28	2	7	49	86	26	20	262,456	12,752,270	32,915	14.9	345,859
Cardiovascular Agents	1.6	0.6	0.1	0.9	58	40	2	16	37	69	33	17	373,418	13,718,275	22,124	10.0	235,079
Respiratory Agents	0.4	0.2	0.0	0.2	23	19	0	4	55	87	40	19	253,328	13,841,514	55,637	25.3	601,505
Gastrointestinal Agents	0.6	0.3	0.0	0.3	41	32	2	7	67	125	61	23	148,497	9,974,200	22,636	10.3	240,819
Genitourinary Agents	0.4	0.2	0.0	0.1	24	19	2	3	62	81	48	26	40,883	2,514,401	10,059	4.6	104,955
CNS Drugs	1.3	0.6	0.1	0.6	114	93	5	17	91	145	83	30	508,300	46,343,035	38,542	17.5	405,186
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	58	52	0	5	83	92	74	41	59,635	4,953,136	7,777	3.5	86,121
Miscellaneous Psychological/ Neurological Agents	0.8	0.8	0.0	0.0	196	195	0	1	241	254	0	29	14,480	3,493,825	1,689	0.8	17,794
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	31	20	1	10	51	158	313	20	311,917	15,887,561	49,209	22.3	509,419
Neuromuscular Agents	0.9	0.4	0.1	0.4	76	49	14	13	82	133	115	29	204,420	16,665,337	20,274	9.2	219,258
Nutritional Products	0.3	0.0	0.0	0.3	5	0	0	5	14	26	19	14	67,268	970,517	19,628	8.9	197,892
Hematological Agents	0.8	0.2	0.1	0.5	72	60	5	7	88	290	35	15	48,164	4,235,989	5,621	2.6	58,792
Topical Products	0.2	0.1	0.0	0.1	8	5	0	3	37	70	50	21	114,794	4,302,517	49,648	22.5	536,998
Miscellaneous Products	0.7	0.3	0.1	0.3	176	124	19	32	237	375	263	96	5,090	1,205,816	652	0.3	6,866
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	10	0	0	0	28	0	0	0	12,057	342,955	3,120	1.4	34,460
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.	2,668,773	165,185,565	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Idaho, released by CMS in 02/2008. This table was produced on 03/25/2008.

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, 1.0 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 2004.

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, 2004

		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	$26,954,980	18,642	8.5 %	205,833	0.7	$181	$131
ANTIDEPRESSANTS	16,518,193	41,299	18.8	440,856	0.6	62	37
ANTICONVULSANT	14,052,346	15,948	7.2	176,079	0.8	102	80
ANALGESICS - Narcotic	9,359,239	57,452	26.1	600,556	0.4	44	16
ANTIASTHMATIC	9,030,231	37,757	17.1	411,864	0.3	67	22
ULCER DRUGS	7,865,025	22,200	10.1	239,105	0.5	69	33
ANTIDIABETIC	6,960,572	12,885	5.9	139,684	0.8	65	50
ANTIHYPERLIPIDEMIC	5,069,377	8,042	3.7	88,907	0.7	82	57
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	4,953,136	9,366	4.3	104,430	0.6	83	47
ANALGESICS - ANTI-INFLAMMATORY	4,570,897	22,788	10.3	241,200	0.3	61	19
Total	105,333,996	246,379		2,648,514	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Idaho, released by CMS in 02/2008. This table was produced on 03/25/2008.

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 2004. 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 2004. 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.