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

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
MONTANA, 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]	114,714	(A)	18,595	(E)	96,119	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	98,743	(B)	17,486	(F)	81,257	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	98,572	(C)	17,486	(G)	81,086	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	3,358	(D)	3,185	(H)	173	(L)

Source: Data for this table are from the MAX 2004 file for Montana, released by CMS in 12/2007. 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 Montana in 2004 was $97,925,893, of which $6,056,575 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]

MONTANA, 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	**98,572**	**8,971**	**18,493**	**9,023**	**62,069**	**16**	**898,964**	**84,138**	**185,652**	**69,746**	**559,331**	**97**
Age												
5 and younger	27,202	0	585	0	26,617	0	240,932	0	5,939	0	234,993	0
6-14	25,351	0	1,135	1	24,215	0	239,692	0	12,327	4	227,361	0
15-20	13,199	0	1,050	1,024	11,121	4	113,162	0	10,986	5,652	96,510	14
21-44	13,270	4	5,866	7,280	116	4	115,869	48	59,586	55,751	467	17
45-64	9,626	19	8,987	612	0	8	95,476	191	88,117	7,102	0	66
65-74	3,586	2,784	730	72	0	0	34,238	26,098	7,309	831	0	0
75-84	3,224	3,078	116	30	0	0	30,578	29,049	1,171	358	0	0
85 and older	3,114	3,086	24	4	0	0	29,017	28,752	217	48	0	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Gender												
Female	55,295	6,612	9,711	7,933	31,023	16	500,378	63,504	98,832	57,585	280,360	97
Male	43,277	2,359	8,782	1,090	31,046	0	398,586	20,634	86,820	12,161	278,971	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	72,265	8,159	15,233	7,012	41,847	14	648,804	76,077	151,246	53,255	368,142	84
African American	908	19	126	46	717	0	8,101	176	1,254	374	6,297	0
Other/unknown	25,399	793	3,134	1,965	19,505	2	242,059	7,885	33,152	16,117	184,892	13
Use of Nursing Facilities[c]												
Entire year	3,358	2,911	447	0	0	0	34,047	29,227	4,820	0	0	0
Part year	1,780	1,300	442	30	8	0	15,900	11,215	4,254	343	88	0
None	93,434	4,760	17,604	8,993	62,061	16	849,017	43,696	176,578	69,403	559,243	97
Maintenance Assistance Status												
Cash	38,240	1,908	14,182	1,854	20,296	0	375,593	20,982	148,881	17,403	188,327	0
Medically needy	8,891	5,904	2,924	12	51	0	74,812	51,496	22,924	15	377	0
Poverty-related	30,928	0	0	4,120	26,792	16	258,642	0	0	22,674	235,871	97
Other/unknown	20,513	1,159	1,387	3,037	14,930	0	189,917	11,660	13,847	29,654	134,756	0
Dual Medicare Status[d]												
Full dual, all year	17,486	8,786	7,526	1,166	6	2	171,512	82,953	74,785	13,688	66	20
Full dual, part year	0	0	0	0	0	0		0	0	0	0	0
Non-dual, all year	81,086	185	10,967	7,857	62,063	14	727,452	1,185	110,867	56,058	559,265	77
Managed Care (MC) Status												
Fee-for-service (FFS) all year	98,572	8,971	18,493	9,023	62,069	16	898,964	84,138	185,652	69,746	559,331	97
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 Montana, released by CMS in 12/2007. 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]

MONTANA, 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	**61.6 %**	**14.4**	**$932**	**$65**	**$5,519**	**16.9 %**	**98,572**
Age							
5 and younger	54.6	2.4	94	39	1,988	4.7	27,202
6-14	48.4	3.7	284	76	2,441	11.6	25,351
15-20	54.9	5.6	407	73	4,158	9.8	13,199
21-44	74.5	18.3	1,607	88	7,343	21.9	13,270
45-64	81.6	45.6	3,254	71	11,971	27.2	9,626
65-74	82.4	47.9	2,527	53	10,690	23.6	3,586
75-84	86.9	53.3	2,532	48	16,304	15.5	3,224
85 and older	92.3	52.2	2,214	42	22,358	9.9	3,114
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	87.7	51.8	2,453	47	16,991	14.4	8,971
Disabled	78.6	35.8	2,905	81	11,919	24.4	18,493
Adults	72.6	11.4	660	58	4,651	14.2	9,023
Children	51.2	3.1	164	53	2,078	7.9	62,069
Unknown	50.0	17.8	991	56	15,036	6.6	16
Gender							
Female	65.0	17.3	1,020	59	5,910	17.2	55,295
Male	57.3	10.7	820	77	5,020	16.3	43,277
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	68.2	17.5	1,131	65	6,058	18.7	72,265
African American	61.0	7.9	564	71	3,451	16.3	908
Other/unknown	43.1	5.8	379	65	4,062	9.3	25,399
Use of Nursing Facilities[f]							
Entire year	95.7	69.1	3,413	49	33,386	10.2	3,358
Part year	94.8	55.5	2,905	52	23,370	12.4	1,780
None	59.8	11.7	805	69	4,178	19.3	93,434
Maintenance Assistance Status							
Cash	60.5	15.5	1,127	73	5,206	21.7	38,240
Medically needy	88.0	53.5	3,090	58	18,354	16.8	8,891
Poverty related	53.3	2.8	125	44	1,504	8.3	30,928
Other/unknown	64.9	13.0	849	66	6,594	12.9	20,513

Source: Data for this table are from the MAX 2004 file for Montana, released by CMS in 12/2007. 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]

MONTANA, 2004

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**	**$102**	**16.9 %**	**38.4 %**	**38.8 %**	**5.5 %**	**8.7 %**	**6.3 %**	**2.3 %**	**$605**	**98,572**	**898,964**
Age												
5 and younger	0.3	11	4.7	45.4	52.5	1.7	0.5	0.0	0.0	225	27,202	240,932
6-14	0.4	30	11.6	51.6	41.3	4.0	2.8	0.3	0.0	258	25,351	239,692
15-20	0.6	47	9.8	45.1	42.7	6.5	4.9	0.7	0.1	485	13,199	113,162
21-44	2.1	184	21.9	25.5	39.9	11.1	14.4	7.0	2.1	841	13,270	115,869
45-64	4.6	328	27.2	18.4	15.9	9.0	25.1	21.6	10.0	1,207	9,626	95,476
65-74	5.0	265	23.6	17.6	12.4	8.3	24.5	26.9	10.4	1,120	3,586	34,238
75-84	5.6	267	15.5	13.1	9.1	8.0	27.1	30.9	11.9	1,719	3,224	30,578
85 and older	5.6	238	9.9	7.7	8.8	7.9	32.0	34.3	9.2	2,399	3,114	29,017
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	262	14.4	12.3	9.9	8.1	27.8	31.0	10.9	1,812	8,971	84,138
Disabled	3.6	289	24.4	21.4	23.4	9.9	22.1	16.3	6.8	1,187	18,493	185,652
Adults	1.5	85	14.2	27.4	48.0	10.5	10.1	3.5	0.5	602	9,023	69,746
Children	0.3	18	7.9	48.8	46.2	3.1	1.7	0.2	0.0	231	62,069	559,331
Unknown	2.9	164	6.6	50.0	18.8	12.5	6.3	6.3	6.3	2,480	16	97
Gender												
Female	1.9	113	17.2	35.0	38.6	5.8	9.6	7.8	3.1	653	55,295	500,378
Male	1.2	89	16.3	42.7	39.0	5.2	7.5	4.3	1.3	545	43,277	398,586
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.0	126	18.7	31.8	40.3	6.4	10.6	7.9	2.9	675	72,265	648,804
African American	0.9	63	16.3	39.0	46.8	5.4	6.2	2.1	0.6	387	908	8,101
Other/unknown	0.6	40	9.3	56.9	34.2	3.0	3.4	1.8	0.7	426	25,399	242,059
Use of Nursing Facilities[f]												
Entire year	6.8	337	10.2	4.3	5.5	6.4	28.5	38.8	16.4	3,293	3,358	34,047
Part year	6.2	325	12.4	5.2	8.7	7.5	29.7	34.9	13.9	2,616	1,780	15,900
None	1.3	89	19.3	40.2	40.5	5.5	7.6	4.6	1.6	460	93,434	849,017
Maintenance Assistance Status												
Cash	1.6	115	21.7	39.5	35.8	6.3	10.2	6.0	2.1	530	38,240	375,593
Medically needy	6.4	367	16.8	12.0	7.9	7.1	26.9	32.7	13.5	2,181	8,891	74,812
Poverty related	0.3	15	8.3	46.7	48.1	3.5	1.6	0.1	0.0	180	30,928	258,642
Other/unknown	1.4	92	12.9	35.1	43.6	6.5	8.7	4.7	1.4	712	20,513	189,917

Source: Data for this table are from the MAX 2004 file for Montana, released by CMS in 12/2007. 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]

MONTANA, 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	**1.6**	**$102**	**$65**	**0.6**	**$72**	**$127**	**0.1**	**$7**	**$67**	**0.9**	**$23**	**$26**
Age												
5 and younger	0.3	11	39	0.1	7	88	0.0	1	48	0.2	3	15
6-14	0.4	30	76	0.2	25	123	0.0	1	68	0.2	4	21
15-20	0.6	47	73	0.3	38	136	0.0	2	64	0.3	8	24
21-44	2.1	184	88	0.7	136	185	0.1	12	96	1.2	36	29
45-64	4.6	328	71	1.6	223	138	0.3	25	94	2.7	80	29
65-74	5.0	265	53	1.7	173	99	0.3	17	52	2.9	74	25
75-84	5.6	267	48	1.9	177	91	0.4	15	38	3.3	74	23
85 and older	5.6	238	42	1.7	150	87	0.5	16	32	3.3	71	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.5	262	47	1.8	171	93	0.4	16	39	3.2	74	23
Disabled	3.6	289	81	1.3	208	161	0.2	20	95	2.1	62	30
Adults	1.5	85	58	0.5	59	121	0.1	6	64	0.9	21	23
Children	0.3	18	53	0.1	14	96	0.0	1	57	0.2	4	19
Unknown	2.9	164	56	1.2	119	97	0.2	16	79	1.5	29	19
Gender												
Female	1.9	113	59	0.7	78	117	0.1	7	60	1.1	28	25
Male	1.2	89	77	0.4	65	147	0.1	6	81	0.6	18	28
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.0	126	65	0.7	89	126	0.1	8	66	1.1	29	26
African American	0.9	63	71	0.4	48	130	0.0	3	67	0.5	12	25
Other/unknown	0.6	40	65	0.2	29	136	0.0	2	76	0.4	9	24
Use of Nursing Facilities[e]												
Entire year	6.8	337	49	2.2	217	100	0.6	23	39	4.0	96	24
Part year	6.2	325	52	2.1	214	104	0.5	24	48	3.6	87	24
None	1.3	89	69	0.5	64	134	0.1	6	79	0.7	19	26
Maintenance Assistance Status												
Cash	1.6	115	73	0.6	83	144	0.1	7	83	0.9	25	27
Medically needy	6.4	367	58	2.1	248	115	0.5	25	54	3.7	93	25
Poverty related	0.3	15	44	0.1	11	87	0.0	1	53	0.2	4	17
Other/unknown	1.4	92	66	0.5	66	123	0.1	6	67	0.8	20	26

Source: Data for this table are from the MAX 2004 file for Montana, released by CMS in 12/2007. 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 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, 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	0.3	0.1	0.0	0.2	$14	$9	$1	$4	$53	$105	$68	$23	100,444	$5,306,368	37,195	37.7 %	386,957
Biologicals	0.2	0.1	0.0	0.1	119	78	22	19	656	671	3,307	329	630	413,152	347	0.4	3,467
Antineoplastic Agents	0.6	0.1	0.0	0.5	96	69	0	26	163	596	126	56	4,179	682,930	698	0.7	7,151
Endocrine/Metabolic Drugs	0.9	0.3	0.1	0.4	44	32	2	9	50	95	25	20	145,249	7,229,681	16,132	16.4	165,569
Cardiovascular Agents	1.6	0.5	0.1	1.0	54	34	2	18	34	67	26	18	240,884	8,140,758	14,524	14.7	150,042
Respiratory Agents	0.5	0.3	0.0	0.2	31	26	0	5	61	93	46	21	108,673	6,649,071	20,201	20.5	212,099
Gastrointestinal Agents	0.6	0.1	0.0	0.4	43	22	2	20	75	171	50	48	69,172	5,179,064	11,259	11.4	119,207
Genitourinary Agents	0.5	0.3	0.0	0.1	31	26	1	4	63	79	49	27	26,289	1,650,122	5,197	5.3	53,548
CNS Drugs	1.2	0.5	0.1	0.6	116	90	6	20	95	167	95	33	254,402	24,232,132	20,171	20.5	209,601
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	63	56	2	6	85	97	66	41	32,555	2,769,389	4,181	4.2	43,999
Miscellaneous Psychological/ Neurological Agents	0.7	0.6	0.0	0.0	177	173	0	4	263	274	102	102	9,678	2,547,383	1,376	1.4	14,387
Analgesics and Anesthetics	0.8	0.2	0.0	0.6	45	27	3	14	59	164	253	25	169,081	10,056,014	22,221	22.5	225,331
Neuromuscular Agents	1.0	0.3	0.2	0.5	77	45	16	16	80	146	107	32	111,645	8,891,182	10,815	11.0	115,531
Nutritional Products	0.4	0.0	0.0	0.4	7	0	0	7	17	21	20	16	48,978	814,935	11,032	11.2	111,017
Hematological Agents	0.8	0.2	0.2	0.4	94	82	6	6	114	465	25	15	32,998	3,766,188	3,952	4.0	39,992
Topical Products	0.3	0.1	0.0	0.2	11	7	1	3	41	72	51	21	57,640	2,362,248	21,269	21.6	223,802
Miscellaneous Products	0.6	0.2	0.1	0.3	137	93	18	26	243	398	263	98	4,374	1,064,664	744	0.8	7,761
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	8	0	0	0	24	0	0	0	4,760	114,037	1,370	1.4	14,629
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.	1,421,631	91,869,318	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Montana, released by CMS in 12/2007. 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 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 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]

MONTANA, 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	$15,552,499	9,822	10.0 %	106,613	0.7	$207	$146
ANTIDEPRESSANTS	7,554,149	19,531	19.8	205,395	0.6	60	37
ANTICONVULSANT	7,326,251	8,893	9.0	96,134	0.8	97	76
ANALGESICS - Narcotic	6,514,910	26,748	27.1	274,341	0.4	53	24
ANTIASTHMATIC	5,086,450	18,394	18.7	194,227	0.4	68	26
ULCER DRUGS	3,915,128	11,124	11.3	118,230	0.6	60	33
ANTIDIABETIC	3,274,315	6,810	6.9	71,394	0.8	58	46
ANALGESICS - ANTI-INFLAMMATORY	2,869,073	9,945	10.1	104,587	0.3	80	27
ANTIHYPERLIPIDEMIC	2,866,713	4,966	5.0	53,170	0.7	78	54
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	2,769,389	5,046	5.1	53,639	0.6	85	52
Total	57,728,877	121,279		1,277,730	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Montana, released by CMS in 12/2007. 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.