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

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
UTAH, 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]	301,897	(A)	26,898	(E)	274,999	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	295,123	(B)	25,387	(F)	269,736	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	295,115	(C)	25,381	(G)	269,734	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	3,008	(D)	2,674	(H)	334	(L)

Source: Data for this table are from the MAX 2004 file for Utah, 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 Utah in 2004 was $197,319,842, of which $64,314 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]

UTAH, 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	**295,115**	**12,422**	**31,688**	**85,527**	**165,190**	**288**	**2,412,937**	**121,760**	**328,935**	**599,405**	**1,360,141**	**2,696**
Age												
5 and younger	93,116	0	1,304	3	91,809	0	759,869	0	12,731	11	747,127	0
6-14	57,599	0	2,205	11	55,383	0	493,685	0	23,764	46	469,875	0
15-20	25,944	0	1,690	6,252	17,995	7	198,686	0	17,398	38,101	143,120	67
21-44	80,478	1	12,534	67,811	3	129	605,699	6	131,317	473,214	19	1,143
45-64	24,774	5	13,234	11,384	0	151	225,335	40	136,170	87,648	0	1,477
65-74	5,884	5,192	630	61	0	1	59,466	52,489	6,609	359	0	9
75-84	4,549	4,468	79	2	0	0	44,721	43,877	826	18	0	0
85 and older	2,768	2,756	12	0	0	0	25,468	25,348	120	0	0	0
Unknown	3	0	0	3	0	0		0	0	8	0	0
Gender												
Female	169,029	8,806	16,315	63,177	80,443	288	1,374,145	87,825	172,608	446,405	664,611	2,696
Male	125,647	3,616	15,373	22,349	84,309	0	8 1,037,767	33,935	156,327	152,998	694,507	0
Unknown	439	0	0	1	438	0	1,025	0	0	2	1,023	0
Race												
White	218,543	9,288	26,850	69,122	113,031	252	1,794,160	89,211	279,341	494,515	928,744	2,349
African American	6,036	124	653	1,332	3,926	1	51,824	1,256	6,408	9,672	34,485	3
Other/unknown	70,536	3,010	4,185	15,073	48,233	35	566,953	31,293	43,186	95,218	396,912	344
Use of Nursing Facilities[c]												
Entire year	3,008	2,351	655	0	2	0	29,155	22,254	6,877	0	24	0
Part year	2,317	1,518	771	21	6	1	21,572	13,564	7,757	177	62	12
None	289,790	8,553	30,262	85,506	165,182	287	2,362,210	85,942	314,301	599,228	1,360,055	2,684
Maintenance Assistance Status												
Cash	97,919	3,382	15,429	27,321	51,787	0	869,895	37,773	166,093	201,412	464,617	0
Medically needy	8,709	1,409	2,545	2,040	2,715	0	60,658	10,202	21,367	10,667	18,422	0
Poverty-related	103,646	3,207	7,961	18,806	73,384	288	782,907	33,034	76,744	113,023	557,410	2,696
Other/unknown	84,841	4,424	5,753	37,360	37,304	0	699,477	40,751	64,731	274,303	319,692	0
Dual Medicare Status[d]												
Full dual, all year	24,720	10,842	13,303	559	3	13	251,694	105,650	141,499	4,381	26	138
Full dual, part year	661	301	355	5	0	0	6,439	2,931	3,457	51	0	0
Non-dual, all year	269,734	1,279	18,030	84,963	165,187	275	2,154,804	13,179	183,979	594,973	1,360,115	2,558
Managed Care (MC) Status												
Fee-for-service (FFS) all year	294,738	12,146	31,587	85,527	165,190	288	2,409,512	119,377	327,893	599,405	1,360,141	2,696
FFS part year, with Rx claims	110	87	23	0	0	0	552	409	143	0	0	0
FFS part year, no Rx claims	0	0	0	0	0	0		0	0	0	0	0
MC all year, with FFS Rx claims	267	189	78	0	0	0	2,873	1,974	899	0	0	0

Source: Data for this table are from the MAX 2004 file for Utah, 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]

UTAH, 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	**64.8 %**	**10.7**	**$668**	**$62**	**$3,487**	**19.2 %**	**295,115**
Age							
5 and younger	62.6	3.1	102	33	1,446	7.0	93,116
6-14	52.5	3.7	285	78	1,758	16.2	57,599
15-20	63.0	6.5	449	70	4,147	10.8	25,944
21-44	68.8	12.2	830	68	3,940	21.1	80,478
45-64	78.8	35.4	2,387	67	8,551	27.9	24,774
65-74	83.9	47.3	2,680	57	9,296	28.8	5,884
75-84	88.0	49.5	2,543	51	11,733	21.7	4,549
85 and older	92.3	50.2	2,333	46	17,580	13.3	2,768
Unknown	100.0	3.0	45	15	167	26.8	3
Basis of Eligibility[e]							
Aged	87.2	48.8	2,554	52	11,916	21.4	12,422
Disabled	84.3	41.8	3,407	82	15,159	22.5	31,688
Adults	66.8	8.1	365	45	1,729	21.1	85,527
Children	58.3	3.3	157	48	1,514	10.4	165,190
Unknown	84.7	22.0	1,442	66	9,877	14.6	288
Gender							
Female	68.3	12.4	701	57	3,341	21.0	169,029
Male	60.3	8.5	628	74	3,696	17.0	125,647
Unknown	2.1	0.0	1	21	145	0.6	439
Race							
White	67.2	12.4	788	64	3,947	20.0	218,543
African American	59.6	8.0	504	63	2,661	18.9	6,036
Other/unknown	57.7	5.9	311	53	2,135	14.5	70,536
Use of Nursing Facilities[f]							
Entire year	97.5	80.8	4,656	58	36,638	12.7	3,008
Part year	96.1	71.4	4,063	57	29,857	13.6	2,317
None	64.2	9.5	600	63	2,932	20.5	289,790
Maintenance Assistance Status							
Cash	67.1	12.7	823	65	3,095	26.6	97,919
Medically needy	57.3	20.3	1,488	73	5,495	27.1	8,709
Poverty related	60.8	7.0	417	60	1,831	22.8	103,646
Other/unknown	67.7	12.1	714	59	5,758	12.4	84,841

Source: Data for this table are from the MAX 2004 file for Utah, 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]

UTAH, 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	**1.3**	**$82**	**19.2 %**	**35.2 %**	**46.1 %**	**6.5 %**	**7.2 %**	**3.6 %**	**1.3 %**	**$427**	**295,115**	**2,412,937**
Age												
5 and younger	0.4	12	7.0	37.4	58.9	2.6	0.9	0.1	0.0	177	93,116	759,869
6-14	0.4	33	16.2	47.5	46.2	3.5	2.5	0.3	0.0	205	57,599	493,685
15-20	0.8	59	10.8	37.0	47.9	8.1	5.9	1.1	0.1	541	25,944	198,686
21-44	1.6	110	21.1	31.2	42.6	10.6	10.7	3.9	1.0	524	80,478	605,699
45-64	3.9	262	27.9	21.2	24.3	12.1	21.6	13.9	7.1	940	24,774	225,335
65-74	4.7	265	28.8	16.1	17.2	10.5	24.1	22.3	9.9	920	5,884	59,466
75-84	5.0	259	21.7	12.0	14.7	9.1	26.0	26.9	11.3	1,193	4,549	44,721
85 and older	5.5	254	13.3	7.7	10.9	9.8	28.4	32.6	10.6	1,911	2,768	25,468
Unknown	1.1	17	26.8	0.0	66.7	0.0	33.3	0.0	0.0	63	3	8
Basis of Eligibility[e]												
Aged	5.0	261	21.4	12.8	14.9	9.7	25.7	26.1	10.6	1,216	12,422	121,760
Disabled	4.0	328	22.5	15.7	24.4	11.3	23.2	17.8	7.7	1,460	31,688	328,935
Adults	1.2	52	21.1	33.2	44.9	10.7	9.2	1.7	0.2	247	85,527	599,405
Children	0.4	19	10.4	41.7	53.3	3.2	1.6	0.2	0.0	184	165,190	1,360,141
Unknown	2.3	154	14.6	15.3	35.1	16.0	24.7	7.3	1.7	1,055	288	2,696
Gender												
Female	1.5	86	21.0	31.7	46.7	7.4	8.2	4.3	1.7	411	169,029	1,374,145
Male	1.0	76	17.0	39.7	45.5	5.4	5.8	2.7	0.8	447	125,647	1,037,767
Unknown	0.0	0	0.6	97.9	1.6	0.2	0.2	0.0	0.0	62	439	1,025
Race												
White	1.5	96	20.0	32.8	45.8	7.3	8.1	4.3	1.7	481	218,543	1,794,160
African American	0.9	59	18.9	40.4	45.6	5.1	6.1	2.2	0.6	310	6,036	51,824
Other/unknown	0.7	39	14.5	42.3	47.1	4.5	4.2	1.6	0.3	266	70,536	566,953
Use of Nursing Facilities[f]												
Entire year	8.3	480	12.7	2.5	3.8	5.2	22.4	38.6	27.5	3,780	3,008	29,155
Part year	7.7	436	13.6	3.9	6.9	5.6	24.0	36.8	22.9	3,207	2,317	21,572
None	1.2	74	20.5	35.8	46.9	6.6	6.9	3.0	0.9	360	289,790	2,362,210
Maintenance Assistance Status												
Cash	1.4	93	26.6	32.9	46.2	6.9	8.2	4.3	1.5	348	97,919	869,895
Medically needy	2.9	214	27.1	42.7	24.7	6.8	11.6	10.0	4.2	789	8,709	60,658
Poverty related	0.9	55	22.8	39.2	48.4	5.2	4.4	2.0	0.7	242	103,646	782,907
Other/unknown	1.5	87	12.4	32.3	45.5	7.7	8.9	4.0	1.7	698	84,841	699,477

Source: Data for this table are from the MAX 2004 file for Utah, 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]

UTAH, 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**	**$82**	**$62**	**0.5**	**$58**	**$119**	**0.1**	**$6**	**$71**	**0.7**	**$18**	**$24**
Age												
5 and younger	0.4	12	33	0.1	8	74	0.0	1	44	0.2	4	15
6-14	0.4	33	78	0.2	27	139	0.0	1	65	0.2	5	22
15-20	0.8	59	70	0.3	45	131	0.0	3	68	0.5	11	24
21-44	1.6	110	68	0.6	78	137	0.1	8	86	1.0	24	25
45-64	3.9	262	67	1.5	183	123	0.2	20	85	2.2	60	28
65-74	4.7	265	57	1.9	191	99	0.3	15	55	2.5	59	24
75-84	5.0	259	51	2.0	183	92	0.3	15	46	2.7	61	22
85 and older	5.5	254	46	2.0	176	88	0.4	14	35	3.0	64	21
Unknown	1.1	17	15	0.4	6	15	0.1	2	16	0.6	9	14
Basis of Eligibility[d]												
Aged	5.0	261	52	2.0	185	93	0.3	15	47	2.7	61	23
Disabled	4.0	328	82	1.6	242	148	0.3	25	92	2.1	61	29
Adults	1.2	52	45	0.3	32	94	0.1	3	62	0.8	16	22
Children	0.4	19	48	0.1	14	98	0.0	1	50	0.2	4	18
Unknown	2.3	154	66	0.8	99	130	0.1	13	113	1.5	42	29
Gender												
Female	1.5	86	57	0.5	60	109	0.1	6	66	0.9	21	23
Male	1.0	76	74	0.4	57	137	0.1	5	83	0.6	14	26
Unknown	0.0	0	21	0.0	0	21	0.0	0	19	0.0	0	21
Race												
White	1.5	96	64	0.6	69	121	0.1	7	72	0.8	21	25
African American	0.9	59	63	0.3	44	125	0.0	3	74	0.5	12	22
Other/unknown	0.7	39	53	0.2	27	109	0.0	2	61	0.4	9	21
Use of Nursing Facilities[e]												
Entire year	8.3	480	58	3.1	336	108	0.5	28	51	4.6	116	25
Part year	7.7	436	57	2.8	303	107	0.5	30	63	4.3	103	24
None	1.2	74	63	0.4	53	121	0.1	5	74	0.7	16	24
Maintenance Assistance Status												
Cash	1.4	93	65	0.5	66	126	0.1	6	78	0.8	20	25
Medically needy	2.9	214	73	1.2	155	134	0.2	16	88	1.6	43	27
Poverty related	0.9	55	60	0.3	39	120	0.1	4	74	0.5	12	22
Other/unknown	1.5	87	59	0.6	61	109	0.1	6	59	0.8	19	24

Source: Data for this table are from the MAX 2004 file for Utah, 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 Utah, 0.3 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.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]

UTAH, 2004

	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
Therapeutic Category	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.2	$13	$8	$1	$4	$52	$108	$62	$24	297,979	$15,556,649	117,527	39.8 %	1,160,953
Biologicals	0.2	0.1	0.0	0.0	69	32	3	34	424	279	405	831	1,664	706,338	889	0.3	10,232
Antineoplastic Agents	0.6	0.1	0.0	0.4	110	84	2	24	191	603	165	56	6,870	1,313,010	1,124	0.4	11,893
Endocrine/Metabolic Drugs	0.7	0.3	0.1	0.3	31	22	2	7	46	82	26	22	302,384	13,909,090	45,371	15.4	448,850
Cardiovascular Agents	1.3	0.5	0.0	0.7	50	36	1	13	39	71	30	18	380,813	14,955,422	28,677	9.7	297,187
Respiratory Agents	0.4	0.2	0.0	0.2	18	15	0	4	50	88	37	19	255,413	12,787,625	68,686	23.3	692,803
Gastrointestinal Agents	0.5	0.3	0.0	0.2	46	35	2	9	85	122	62	41	186,163	15,785,946	34,026	11.5	344,481
Genitourinary Agents	0.3	0.1	0.0	0.1	16	11	1	3	50	75	44	23	44,962	2,233,748	14,567	4.9	143,018
CNS Drugs	1.1	0.5	0.1	0.5	100	78	5	17	92	154	94	32	596,500	54,927,931	54,954	18.6	548,704
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.1	59	52	1	6	89	99	77	48	54,874	4,880,939	7,947	2.7	82,621
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	154	151	1	1	255	264	108	74	12,280	3,137,031	1,984	0.7	20,379
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	25	15	2	9	43	130	220	19	456,012	19,753,631	80,785	27.4	792,110
Neuromuscular Agents	0.9	0.3	0.1	0.4	71	44	15	13	83	144	125	30	250,861	20,938,584	28,319	9.6	294,196
Nutritional Products	0.3	0.0	0.0	0.3	5	0	0	4	15	17	18	15	102,402	1,585,830	35,083	11.9	326,435
Hematological Agents	0.7	0.2	0.1	0.4	87	77	3	7	120	416	31	16	53,965	6,456,758	7,278	2.5	74,568
Topical Products	0.2	0.1	0.0	0.1	9	5	1	3	39	73	49	21	147,818	5,767,854	63,372	21.5	640,185
Miscellaneous Products	0.3	0.2	0.0	0.1	57	44	4	9	198	250	309	92	12,197	2,415,632	4,044	1.4	42,148
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	6	0	0	0	25	0	0	0	5,797	143,510	2,179	0.7	23,395
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.	3,168,954	197,255,528	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Utah, 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 Utah, 0.3 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.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]

UTAH, 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	$30,947,860	19,439	6.6 %	210,102	0.7	$207	$147
ANTIDEPRESSANTS	19,313,815	54,926	18.6	560,087	0.5	64	34
ANTICONVULSANT	17,582,792	21,523	7.3	230,168	0.7	105	76
ULCER DRUGS	12,913,279	31,989	10.8	327,364	0.4	90	39
ANALGESICS - Narcotic	11,481,264	85,310	28.9	846,903	0.3	39	14
ANTIASTHMATIC	7,854,681	39,667	13.4	410,085	0.3	64	19
ANTIDIABETIC	7,092,269	15,426	5.2	161,253	0.7	65	44
ANTIHYPERLIPIDEMIC	5,999,428	10,795	3.7	117,176	0.6	84	51
ANALGESICS - ANTI-INFLAMMATORY	5,696,977	50,769	17.2	511,638	0.3	44	11
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	4,875,253	9,434	3.2	99,187	0.6	89	49
Total	123,757,618	339,278		3,473,963	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Utah, 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.