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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2005
IDAHO

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
IDAHO, 2005

Inclusion Criteria (2005)	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]	231270 (A)	29348 (E)	201922 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	224556 (B)	22649 (F)	201907 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	224556 (C)	22649 (G)	201907 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2811 (D)	2644 (H)	167 (L)

Source: Data for this table are from the MAX 2005 file for Idaho, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 2005 (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 2005, 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 2005 was $177,098,048, of which $121,971 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 26 states in 2005 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, 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 2005 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer05.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 2005. 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 N+B18D.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 beneficiary 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 2005. 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, 2005

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**224,556**	**12,195**	**30,430**	**34,391**	**147,540**	**0**	**2,089,941**	**122,068**	**324,165**	**247,160**	**1,396,548**	**0**
Age												
5 and younger	64,328	0	1,573	0	62,755	0	589,999	0	16,141	0	573,858	0
6-14	65,669	0	3,996	0	61,673	0	655,976	0	44,416	0	611,560	0
15-20	28,790	0	2,615	3,124	23,051	0	261,008	0	28,076	21,979	210,953	0
21-44	40,348	1	10,862	29,431	54	0	327,601	11	116,741	210,694	155	0
45-64	13,395	282	11,299	1,811	3	0	135,624	3,167	118,010	14,439	8	0
65-74	4,334	4,244	77	13	0	0	44,985	44,252	701	32	0	0
75-84	4,086	4,068	7	11	0	0	40,807	40,715	77	15	0	0
85 and older	3,605	3,600	1	1	3	0	33,939	33,923	3	1	12	0
Unknown	1	0	0	0	1	0	2	0	0	0	2	0
Gender												
Female	126,343	8,575	15,500	29,434	72,834	0	1,154,987	86,895	165,442	211,880	690,770	0
Male	98,213	3,620	14,930	4,957	74,706	0	934,954	35,173	158,723	35,280	705,778	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	211,756	11,740	29,080	31,857	139,079	0	1,980,271	117,314	309,745	233,893	1,319,319	0
African American	2,483	37	253	377	1,816	0	23,356	367	2,518	3,011	17,460	0
Other/unknown	10,317	418	1,097	2,157	6,645	0	86,314	4,387	11,902	10,256	59,769	0
Use of Nursing Facilities[c]												
Entire year	2,811	2,457	354	0	0	0	26,831	23,214	3,617	0	0	0
Part year	1,843	1,368	469	5	1	0	17,659	12,852	4,749	55	3	0
None	219,902	8,370	29,607	34,386	147,539	0	2,045,451	86,002	315,799	247,105	1,396,545	0
Maintenance Assistance Status												
Cash	56,986	1,800	28,333	9,842	17,011	0	564,789	20,116	302,032	79,378	163,263	0
Medically needy	4	0	0	0	4	0	15	0	0	0	15	0
Poverty-related	127,317	308	369	12,509	114,131	0	1,148,092	2,326	3,501	68,817	1,073,448	0
Other/unknown	40,249	10,087	1,728	12,040	16,394	0	377,045	99,626	18,632	98,965	159,822	0
Dual Medicare Status[d]												
Full dual, all year	21,604	11,214	10,236	149	5	0	227,273	112,713	113,270	1,264	26	0
Full dual, part year	1,045	520	520	5	0	0	9,637	4,450	5,133	54	0	0
Non-dual, all year	201,907	461	19,674	34,237	147,535	0	1,853,031	4,905	205,762	245,842	1,396,522	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	224,556	12,195	30,430	34,391	147,540	0	2,089,941	122,068	324,165	247,160	1,396,548	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 2005 file for Idaho, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 2005. 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, 2005

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**	**12.5**	**$788**	**$63**	**$4,688**	**16.8**	**224,556**
Age							
5 and younger	63.3	3.0	130	43	1,801	7.2	64,328
6-14	55.4	3.9	264	68	2,133	12.4	65,669
15-20	60.6	6.0	404	68	3,196	12.6	28,790
21-44	71.0	17.5	1,277	73	7,138	17.9	40,348
45-64	86.1	57.3	3,936	69	15,471	25.4	13,395
65-74	87.0	59.5	3,284	55	13,051	25.2	4,334
75-84	88.2	60.1	2,987	50	17,805	16.8	4,086
85 and older	92.5	56.7	2,497	44	22,272	11.2	3,605
Unknown	0.0	0.0	0	0	0	0.0	1
Basis of Eligibility[e]							
Aged	89.3	59.5	2,991	50	17,511	17.1	12,195
Disabled	84.3	42.6	3,326	78	16,857	19.7	30,430
Adults	65.6	8.9	441	50	3,187	13.8	34,391
Children	58.5	3.2	164	51	1,469	11.1	147,540
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	67.0	14.7	859	59	4,778	18.0	126,343
Male	61.9	9.7	697	72	4,573	15.2	98,213
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	65.4	12.8	809	63	4,763	17.0	211,756
African American	58.6	7.3	539	73	2,977	18.1	2,483
Other/unknown	53.4	7.7	426	56	3,570	11.9	10,317
Use of Nursing Facilities[f]							
Entire year	94.4	73.8	3,911	53	42,983	9.1	2,811
Part year	95.0	75.3	4,095	54	32,043	12.8	1,843
None	64.1	11.2	721	65	3,970	18.2	219,902
Maintenance Assistance Status							
Cash	75.5	27.5	2,016	73	9,979	20.2	56,986
Medically needy	50.0	12.5	513	41	3,803	13.5	4
Poverty related	57.7	3.2	149	47	1,574	9.5	127,317
Other/unknown	71.9	20.7	1,070	52	7,050	15.2	40,249

Source: Data for this table are from the MAX 2005 file for Idaho, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 eight states (DE, IA, IL, 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 eight states (DE, IA, IL, 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, 2005

				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**	**$85**	**16.8**	**35.2**	**46.6**	**5.1**	**6.4**	**4.6**	**2.1**	**$504**	**224,556**	**2,089,941**
Age												
5 and younger	0.3	14	7.2	36.7	60.5	2.1	0.6	0.1	0.0	196	64,328	589,999
6-14	0.4	26	12.4	44.6	49.1	3.4	2.5	0.3	0.0	214	65,669	655,976
15-20	0.7	45	12.6	39.4	49.1	6.1	4.4	0.9	0.1	353	28,790	261,008
21-44	2.2	157	17.9	29.0	39.9	10.1	12.1	6.7	2.3	879	40,348	327,601
45-64	5.7	389	25.4	13.9	14.9	9.1	23.4	24.0	14.7	1,528	13,395	135,624
65-74	5.7	316	25.2	13.0	12.5	7.9	23.4	28.1	15.2	1,257	4,334	44,985
75-84	6.0	299	16.8	11.8	10.0	6.7	23.5	32.1	16.0	1,783	4,086	40,807
85 and older	6.0	265	11.2	7.5	7.2	7.7	27.7	36.9	13.1	2,366	3,605	33,939
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	1	2
Basis of Eligibility[e]												
Aged	5.9	299	17.1	10.7	10.0	7.5	24.7	32.1	15.0	1,749	12,195	122,068
Disabled	4.0	312	19.7	15.7	25.8	10.8	21.7	17.1	8.8	1,582	30,430	324,165
Adults	1.2	61	13.8	34.4	45.0	9.3	7.9	2.8	0.6	444	34,391	247,160
Children	0.3	17	11.1	41.5	54.3	2.8	1.3	0.1	0.0	155	147,540	1,396,548
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	94	18.0	33.0	46.1	5.6	7.0	5.6	2.8	523	126,343	1,154,987
Male	1.0	73	15.2	38.1	47.2	4.6	5.6	3.3	1.2	480	98,213	934,954
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	87	17.0	34.6	46.8	5.2	6.5	4.7	2.2	509	211,756	1,980,271
African American	0.8	57	18.1	41.4	46.6	4.6	4.7	2.1	0.6	317	2,483	23,356
Other/unknown	0.9	51	11.9	46.6	41.9	3.6	4.2	2.8	0.8	427	10,317	86,314
Use of Nursing Facilities[f]												
Entire year	7.7	410	9.1	5.6	4.4	4.4	21.1	38.2	26.3	4,503	2,811	26,831
Part year	7.9	427	12.8	5.0	5.4	5.4	22.0	36.5	25.7	3,344	1,843	17,659
None	1.2	78	18.2	35.9	47.5	5.1	6.0	3.9	1.6	427	219,902	2,045,451
Maintenance Assistance Status												
Cash	2.8	203	20.2	24.5	36.2	8.5	14.6	10.9	5.2	1,007	56,986	564,789
Medically needy	3.3	137	13.5	50.0	0.0	0.0	50.0	0.0	0.0	1,014	4	15
Poverty related	0.4	17	9.5	42.3	53.0	3.1	1.4	0.2	0.0	175	127,317	1,148,092
Other/unknown	2.2	114	15.2	28.1	40.8	7.0	10.4	9.4	4.2	753	40,249	377,045

Source: Data for this table are from the MAX 2005 file for Idaho, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 eight states (DE, IA, IL, 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 eight states (DE, IA, IL, 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, 2005

	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**	**$85**	**$63**	**0.5**	**$65**	**$127**	**0.0**	**$3**	**$68**	**0.8**	**$17**	**$21**
Age												
5 and younger	0.3	14	43	0.1	10	102	0.0	1	51	0.2	4	17
6-14	0.4	26	68	0.2	22	114	0.0	1	79	0.2	4	20
15-20	0.7	45	68	0.3	36	133	0.0	2	63	0.4	7	20
21-44	2.2	157	73	0.8	124	153	0.1	5	82	1.3	28	22
45-64	5.7	389	69	2.2	298	136	0.1	12	82	3.3	78	24
65-74	5.7	316	55	2.2	238	108	0.2	11	58	3.3	68	20
75-84	6.0	299	50	2.2	217	99	0.2	12	47	3.6	70	20
85 and older	6.0	265	44	2.0	185	93	0.3	13	45	3.7	67	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.9	299	50	2.2	218	101	0.2	12	50	3.5	69	19
Disabled	4.0	312	78	1.7	250	150	0.1	9	88	2.2	53	24
Adults	1.2	61	50	0.4	44	118	0.0	2	59	0.8	15	19
Children	0.3	17	51	0.1	13	102	0.0	1	63	0.2	4	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.6	94	59	0.6	71	121	0.1	3	63	1.0	20	20
Male	1.0	73	72	0.4	58	139	0.0	2	77	0.6	13	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.4	87	63	0.5	67	127	0.0	3	68	0.8	17	21
African American	0.8	57	73	0.3	47	147	0.0	1	67	0.4	9	21
Other/unknown	0.9	51	56	0.3	38	124	0.0	2	63	0.6	11	19
Use of Nursing Facilities[e]												
Entire year	7.7	410	53	2.6	295	113	0.4	19	50	4.7	96	20
Part year	7.9	427	54	2.7	305	113	0.3	19	61	4.8	103	21
None	1.2	78	65	0.5	60	129	0.0	3	71	0.7	15	21
Maintenance Assistance Status												
Cash	2.8	203	73	1.1	161	144	0.1	6	81	1.6	36	23
Medically needy	3.3	137	41	1.2	108	90	0.2	2	8	1.9	27	14
Poverty related	0.4	17	47	0.1	12	99	0.0	1	66	0.2	4	18
Other/unknown	2.2	114	52	0.8	84	106	0.1	4	52	1.3	26	19

Source: Data for this table are from the MAX 2005 file for Idaho, released by CMS in 10/2008. This table was produced on 04/23/2009.

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, 0.9 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, 2005

	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	0.2	0.1	0.0	0.2	$12	$6	$2	$4	$47	$116	$66	$23	261,082	$12,282,052	98,355	43.8	1,046,752
Biologicals	0.1	0.1	0.0	0.0	83	76	6	2	573	632	1,712	84	2,313	1,324,473	1,465	0.7	15,869
Antineoplastic Agents	0.6	0.2	0.0	0.4	117	100	0	17	189	544	217	38	6,664	1,261,423	1,020	0.5	10,763
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.4	39	28	4	7	51	97	51	18	280,214	14,352,064	35,237	15.7	370,600
Cardiovascular Agents	1.6	0.6	0.0	1.0	58	45	0	13	36	75	15	13	398,330	14,531,940	23,263	10.4	248,523
Respiratory Agents	0.4	0.2	0.0	0.2	23	19	0	3	57	98	52	16	262,781	14,900,871	59,706	26.6	642,084
Gastrointestinal Agents	0.6	0.3	0.0	0.3	48	42	0	5	76	137	41	16	158,179	11,957,342	23,459	10.4	249,975
Genitourinary Agents	0.4	0.2	0.0	0.2	23	18	1	4	59	85	64	25	42,424	2,514,084	10,336	4.6	108,453
CNS Drugs	1.3	0.7	0.0	0.6	123	108	0	15	96	159	91	25	526,882	50,501,950	38,955	17.3	410,724
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	63	59	0	4	89	100	114	34	64,454	5,744,767	8,204	3.7	90,672
Miscellaneous Psychological/ Neurological Agents	0.8	0.7	0.0	0.0	195	193	0	1	258	270	0	37	16,016	4,124,766	1,976	0.9	21,199
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	28	14	2	12	46	166	195	23	323,418	14,937,098	51,343	22.9	532,441
Neuromuscular Agents	0.9	0.3	0.0	0.5	72	51	3	19	81	147	88	36	208,655	16,855,877	21,536	9.6	233,139
Nutritional Products	0.3	0.0	0.0	0.3	5	0	0	5	14	21	21	14	66,607	965,432	18,782	8.4	190,525
Hematological Agents	0.9	0.2	0.1	0.5	79	69	3	7	92	305	31	12	51,913	4,785,100	5,763	2.6	60,754
Topical Products	0.2	0.1	0.0	0.1	8	5	0	3	37	76	45	19	122,252	4,543,568	52,432	23.3	565,408
Miscellaneous Products	0.7	0.3	0.0	0.3	161	124	8	29	235	372	300	90	5,382	1,262,652	730	0.3	7,854
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	8	0	0	0	30	0	0	0	4,366	130,618	1,453	0.6	15,878
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.	2,801,932	176,976,077	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Idaho, released by CMS in 10/2008. This table was produced on 04/23/2009.

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, 0.9 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 2005.

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, 2005

		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	$31,476,355	19,279	8.6	212,220	0.7	$203	$148
ANTIDEPRESSANTS	15,898,671	41,776	18.6	447,119	0.6	59	36
ANTICONVULSANT	14,504,876	16,253	7.2	179,197	0.8	105	81
ANTIASTHMATIC	10,294,859	41,257	18.4	448,563	0.3	71	23
ULCER DRUGS	9,430,477	22,732	10.1	244,627	0.5	76	39
ANALGESICS - Narcotic	8,239,808	60,156	26.8	630,598	0.4	37	13
ANTIDIABETIC	7,675,556	14,410	6.4	156,315	0.7	66	49
ANTIHYPERLIPIDEMIC	6,164,349	9,135	4.1	101,257	0.7	86	61
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	5,744,767	9,653	4.3	107,298	0.6	89	54
ANALGESICS - ANTI-INFLAMMATORY	4,460,339	21,895	9.8	230,334	0.3	61	19
Total	113,890,057	256,546		2,757,528	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Idaho, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 2005. 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 2005. 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.