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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
MONTANA, 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]	115281 (A)	19177 (E)	96104 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	99599 (B)	17714 (F)	81885 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	99424 (C)	17714 (G)	81710 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	3344 (D)	3197 (H)	147 (L)

Source: Data for this table are from the MAX 2005 file for Montana, 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 Montana in 2005 was $105,241,000, of which $6,149,201 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]
MONTANA, 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	**99,424**	**9,008**	**18,961**	**9,376**	**62,067**	**12**	**906,177**	**83,309**	**190,330**	**71,717**	**560,724**	**97**
Age												
5 and younger	27,416	0	600	3	26,813	0	244,810	0	6,157	17	238,636	0
6-14	25,061	0	1,148	5	23,908	0	236,395	0	12,330	23	224,042	0
15-20	13,377	0	1,127	1,048	11,200	2	115,255	0	11,887	5,919	97,444	5
21-44	13,635	2	5,894	7,588	146	5	117,546	16	59,532	57,360	602	36
45-64	10,013	15	9,360	633	0	5	99,700	167	92,227	7,250	0	56
65-74	3,576	2,802	707	67	0	0	34,318	26,608	6,921	789	0	0
75-84	3,212	3,078	105	29	0	0	29,827	28,389	1,104	334	0	0
85 and older	3,134	3,111	20	3	0	0	28,326	28,129	172	25	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	55,690	6,580	9,863	8,249	30,986	12	502,504	62,256	100,346	59,417	280,388	97
Male	43,734	2,428	9,098	1,127	31,081	0	403,673	21,053	89,984	12,300	280,336	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	72,485	8,177	15,603	7,240	41,454	11	649,999	75,093	154,972	54,521	365,326	87
African American	939	18	131	48	742	0	8,657	197	1,326	308	6,826	0
Other/unknown	26,000	813	3,227	2,088	19,871	1	247,521	8,019	34,032	16,888	188,572	10
Use of Nursing Facilities[c]												
Entire year	3,344	2,895	449	0	0	0	33,098	28,299	4,799	0	0	0
Part year	1,876	1,369	467	36	4	0	16,517	11,467	4,593	418	39	0
None	94,204	4,744	18,045	9,340	62,063	12	856,562	43,543	180,938	71,299	560,685	97
Maintenance Assistance Status												
Cash	37,553	1,899	14,592	1,855	19,207	0	370,527	20,898	152,897	17,075	179,657	0
Medically needy	8,955	5,990	2,906	15	44	0	74,616	51,255	23,099	17	245	0
Poverty-related	32,098	0	0	4,347	27,739	12	268,143	0	0	23,883	244,163	97
Other/unknown	20,818	1,119	1,463	3,159	15,077	0	192,891	11,156	14,334	30,742	136,659	0
Dual Medicare Status[d]												
Full dual, all year	17,714	8,881	7,631	1,193	9	0	172,860	82,623	76,232	13,908	97	0
Full dual, part year	0	0	0	0	0	0	0	0	0	0	0	0
Non-dual, all year	81,710	127	11,330	8,183	62,058	12	733,317	686	114,098	57,809	560,627	97
Managed Care (MC) Status												
Fee-for-service (FFS) all year	99,424	9,008	18,961	9,376	62,067	12	906,177	83,309	190,330	71,717	560,724	97
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 Montana, 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]
MONTANA, 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	**62.5**	**14.6**	**$997**	**$68**	**$6,085**	**16.4**	**99,424**
Age							
5 and younger	56.3	2.5	97	39	2,255	4.3	27,416
6-14	50.2	3.9	303	77	2,798	10.8	25,061
15-20	55.5	5.7	433	76	4,367	9.9	13,377
21-44	73.5	18.0	1,703	95	7,647	22.3	13,635
45-64	80.7	45.7	3,437	75	13,670	25.1	10,013
65-74	82.5	49.0	2,738	56	11,890	23.0	3,576
75-84	86.5	53.5	2,664	50	17,611	15.1	3,212
85 and older	91.8	52.0	2,254	43	23,749	9.5	3,134
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	87.7	52.1	2,580	50	18,352	14.1	9,008
Disabled	77.5	35.8	3,059	85	13,204	23.2	18,961
Adults	71.9	11.4	723	64	4,838	15.0	9,376
Children	52.8	3.2	178	55	2,317	7.7	62,067
Unknown	83.3	27.9	1,641	59	11,859	13.8	12
Gender							
Female	65.5	17.5	1,084	62	6,336	17.1	55,690
Male	58.6	11.0	885	80	5,766	15.4	43,734
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	69.1	17.9	1,219	68	6,694	18.2	72,485
African American	65.8	8.4	681	81	4,062	16.8	939
Other/unknown	44.0	5.9	388	66	4,461	8.7	26,000
Use of Nursing Facilities[f]							
Entire year	96.0	69.0	3,530	51	36,159	9.8	3,344
Part year	94.0	54.8	3,041	56	25,215	12.1	1,876
None	60.7	11.9	866	73	4,637	18.7	94,204
Maintenance Assistance Status							
Cash	61.5	16.2	1,244	77	6,029	20.6	37,553
Medically needy	87.6	54.0	3,268	61	20,122	16.2	8,955
Poverty related	54.7	2.9	136	47	1,799	7.6	32,098
Other/unknown	65.5	13.0	902	69	6,757	13.3	20,818

Source: Data for this table are from the MAX 2005 file for Montana, 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]

MONTANA, 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	**1.6**	**$109**	**16.4**	**37.5**	**39.5**	**5.5**	**8.6**	**6.5**	**2.4**	**$668**	**99,424**	**906,177**
Age												
5 and younger	0.3	11	4.3	43.7	54.1	1.6	0.5	0.0	0.0	253	27,416	244,810
6-14	0.4	32	10.8	49.8	42.8	4.0	3.0	0.3	0.0	297	25,061	236,395
15-20	0.7	50	9.9	44.5	43.2	6.5	4.8	0.8	0.1	507	13,377	115,255
21-44	2.1	198	22.3	26.5	39.4	10.6	14.5	7.1	1.8	887	13,635	117,546
45-64	4.6	345	25.1	19.3	16.1	9.0	23.9	21.9	9.8	1,373	10,013	99,700
65-74	5.1	285	23.0	17.5	12.4	7.8	23.9	27.5	10.9	1,239	3,576	34,318
75-84	5.8	287	15.1	13.5	8.5	7.4	27.3	30.9	12.5	1,897	3,212	29,827
85 and older	5.8	249	9.5	8.2	8.0	8.4	30.2	35.5	9.7	2,628	3,134	28,326
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	5.6	279	14.1	12.3	9.6	7.8	27.2	31.6	11.4	1,984	9,008	83,309
Disabled	3.6	305	23.2	22.5	23.0	9.8	21.3	16.7	6.7	1,315	18,961	190,330
Adults	1.5	95	15.0	28.1	47.1	10.3	10.5	3.5	0.4	633	9,376	71,717
Children	0.4	20	7.7	47.2	47.8	3.1	1.8	0.2	0.0	257	62,067	560,724
Unknown	3.5	203	13.8	16.7	25.0	25.0	16.7	8.3	8.3	1,467	12	97
Gender												
Female	1.9	120	17.1	34.5	39.1	5.9	9.4	8.0	3.2	702	55,690	502,504
Male	1.2	96	15.4	41.4	40.1	5.0	7.7	4.6	1.3	625	43,734	403,673
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	136	18.2	30.9	41.0	6.4	10.6	8.1	3.0	747	72,485	649,999
African American	0.9	74	16.8	34.2	50.1	6.5	5.8	2.8	0.7	441	939	8,657
Other/unknown	0.6	41	8.7	56.1	35.0	3.0	3.3	2.0	0.6	469	26,000	247,521
Use of Nursing Facilities[f]												
Entire year	7.0	357	9.8	4.0	5.5	6.2	26.2	40.2	17.9	3,653	3,344	33,098
Part year	6.2	345	12.1	6.0	7.9	7.2	31.1	35.8	12.0	2,864	1,876	16,517
None	1.3	95	18.7	39.3	41.4	5.4	7.5	4.7	1.6	510	94,204	856,562
Maintenance Assistance Status												
Cash	1.6	126	20.6	38.5	36.2	6.3	10.4	6.5	2.1	611	37,553	370,527
Medically needy	6.5	392	16.2	12.4	7.5	7.0	25.9	33.2	14.1	2,415	8,955	74,616
Poverty related	0.3	16	7.6	45.3	49.4	3.5	1.7	0.1	0.0	215	32,098	268,143
Other/unknown	1.4	97	13.3	34.5	44.2	6.4	8.6	4.9	1.4	729	20,818	192,891

Source: Data for this table are from the MAX 2005 file for Montana, 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]

MONTANA, 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	**1.6**	**$109**	**$68**	**0.5**	**$77**	**$141**	**0.1**	**$6**	**$84**	**1.0**	**$26**	**$27**
Age												
5 and younger	0.3	11	39	0.1	7	90	0.0	0	52	0.2	3	16
6-14	0.4	32	77	0.2	27	126	0.0	1	76	0.2	4	22
15-20	0.7	50	76	0.3	40	147	0.0	2	63	0.4	8	23
21-44	2.1	198	95	0.7	145	210	0.1	11	112	1.3	42	32
45-64	4.6	345	75	1.5	233	154	0.2	22	118	2.9	90	31
65-74	5.1	285	56	1.7	188	111	0.2	15	65	3.2	82	26
75-84	5.8	287	50	1.8	187	101	0.3	19	55	3.6	81	23
85 and older	5.8	249	43	1.6	151	92	0.4	22	53	3.7	77	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.6	279	50	1.8	179	102	0.3	19	56	3.5	81	23
Disabled	3.6	305	85	1.2	216	177	0.2	18	119	2.2	71	32
Adults	1.5	95	64	0.5	67	145	0.1	5	66	1.0	22	24
Children	0.4	20	55	0.1	15	104	0.0	1	64	0.2	4	19
Unknown	3.5	203	59	1.4	147	107	0.1	5	76	2.0	52	26
Gender												
Female	1.9	120	62	0.6	82	131	0.1	7	78	1.2	31	25
Male	1.2	96	80	0.4	70	159	0.1	5	97	0.7	21	30
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.0	136	68	0.7	95	140	0.1	8	83	1.2	33	27
African American	0.9	74	81	0.4	56	148	0.0	4	78	0.5	15	30
Other/unknown	0.6	41	66	0.2	28	143	0.0	3	95	0.4	10	26
Use of Nursing Facilities[e]												
Entire year	7.0	357	51	2.1	224	107	0.5	29	58	4.3	103	24
Part year	6.2	345	56	1.9	221	118	0.4	26	65	3.9	98	25
None	1.3	95	73	0.5	68	148	0.1	5	96	0.8	22	28
Maintenance Assistance Status												
Cash	1.6	126	77	0.6	90	160	0.1	7	105	1.0	29	29
Medically needy	6.5	392	61	2.1	261	127	0.4	26	69	4.0	105	26
Poverty related	0.3	16	47	0.1	12	96	0.0	1	56	0.2	4	18
Other/unknown	1.4	97	69	0.5	70	136	0.1	6	83	0.8	22	27

Source: Data for this table are from the MAX 2005 file for Montana, 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 Montana, 0.6 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]

MONTANA, 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	0.3	0.1	0.0	0.2	$14	$8	$2	$4	$53	$134	$68	$24	109,248	$5,801,324	40,309	40.5	418,789
Biologicals	0.2	0.1	0.0	0.0	96	70	19	8	567	597	3,145	170	860	487,775	492	0.5	5,071
Antineoplastic Agents	0.6	0.2	0.0	0.5	126	103	0	22	204	659	79	49	4,635	947,267	737	0.7	7,542
Endocrine/Metabolic Drugs	0.9	0.3	0.1	0.5	44	31	4	10	51	101	42	20	150,170	7,610,041	16,932	17.0	173,534
Cardiovascular Agents	1.6	0.5	0.0	1.1	59	39	1	19	36	83	17	17	248,073	9,034,323	14,896	15.0	154,322
Respiratory Agents	0.5	0.3	0.0	0.2	33	29	0	4	65	105	61	17	113,339	7,414,686	21,551	21.7	225,818
Gastrointestinal Agents	0.5	0.2	0.0	0.4	38	26	0	12	70	169	53	31	62,497	4,373,304	10,882	10.9	114,615
Genitourinary Agents	0.5	0.3	0.0	0.2	31	26	1	5	62	81	59	27	27,491	1,709,603	5,331	5.4	55,056
CNS Drugs	1.2	0.6	0.0	0.7	127	104	2	21	102	178	162	33	261,754	26,591,506	20,269	20.4	209,628
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.1	71	64	1	6	94	108	79	39	34,480	3,248,838	4,283	4.3	45,618
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	190	186	0	4	258	267	98	103	11,341	2,931,191	1,489	1.5	15,423
Analgesics and Anesthetics	0.8	0.1	0.1	0.6	46	13	12	21	61	194	205	33	168,482	10,296,166	22,191	22.3	224,577
Neuromuscular Agents	1.0	0.3	0.1	0.6	81	50	5	27	85	158	81	45	117,004	9,899,853	11,451	11.5	122,212
Nutritional Products	0.4	0.0	0.0	0.4	8	0	0	7	17	22	18	17	48,608	836,332	10,770	10.8	108,914
Hematological Agents	0.8	0.2	0.2	0.4	107	91	4	12	128	466	22	26	33,618	4,314,942	3,993	4.0	40,484
Topical Products	0.2	0.1	0.0	0.2	11	7	0	4	42	78	43	22	56,897	2,415,993	21,601	21.7	227,948
Miscellaneous Products	0.6	0.3	0.1	0.3	159	117	15	28	276	453	255	105	3,999	1,102,870	659	0.7	6,921
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	9	0	0	0	28	0	0	0	2,748	75,785	832	0.8	8,637
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.	1,455,244	99,091,799	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Montana, 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 Montana, 0.6 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]

MONTANA, 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	$17,931,631	10,292	10.4	111,590	0.7	$224	$161
ANTICONVULSANT	8,260,195	9,263	9.3	100,322	0.8	103	82
ANTIDEPRESSANTS	7,495,267	19,520	19.6	204,540	0.6	59	37
ANALGESICS - Narcotic	6,833,165	27,040	27.2	277,105	0.4	55	25
ANTIASTHMATIC	5,649,769	19,950	20.1	210,623	0.4	72	27
ANTIHYPERLIPIDEMIC	3,834,457	5,776	5.8	62,619	0.7	94	61
ANTIDIABETIC	3,714,377	7,230	7.3	76,040	0.8	62	49
ULCER DRUGS	3,352,026	11,282	11.3	119,491	0.6	49	28
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	3,248,838	4,977	5.0	53,455	0.6	94	61
MISC PSYCHOTHERAPEUTIC AND NEUROLOGICAL	2,979,277	2,223	2.2	23,160	0.5	241	129
Total	63,299,002	117,553		1,238,945	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Montana, 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.