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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006
COLORADO

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
COLORADO, 2006

Inclusion Criteria (2006)	Number of Dual and Nondual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Nondual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	571704 (A)	80461 (E)	491243 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	543680 (B)	66755 (F)	476925 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	521189 (C)	63050 (G)	458139 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	8974 (D)	8225 (H)	749 (L)

Source: Data for this table are from the MAX 2006 file for Colorado, released by CMS in 9/2009. This table was produced on 03/22/2010.
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 2006 (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 2006, 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 Colorado in 2006 was $205,457,672, of which $1,906,237 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 29 states in 2006 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, KY, MA, MI, MS, NC, NH, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, and WI. In addition, there were 10 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NC, NE, NY, TN, TX, UT, and WV). These lists were constructed from the CMS 2006 Medicaid Managed Care Enrollment Report 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 2006. 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 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 2006. 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]

COLORADO, 2006

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**521,189**	**41,528**	**65,714**	**92,139**	**321,541**	**267**	**4,012,722**	**391,423**	**589,353**	**621,374**	**2,408,265**	**2,307**
Age												
5 and younger	153,419	0	2,696	0	150,723	0	1,134,455	0	23,716	0	1,110,739	0
6-14	124,050	0	5,812	1	118,237	0	964,804	0	53,031	4	911,769	0
15-20	56,238	0	4,875	1	51,362	0	421,697	0	42,122	3	379,572	0
21-44	107,838	0	22,340	84,262	1,210	26	775,959	0	199,251	570,343	6,135	230
45-64	37,384	0	29,331	7,817	2	234	318,835	0	266,102	50,682	9	2,042
65-74	16,405	15,818	546	34	0	7	152,852	148,639	3,979	199	0	35
75-84	14,727	14,619	100	8	0	0	141,282	140,224	1,009	49	0	0
85 and older	11,107	11,091	14	2	0	0	102,717	102,560	143	14	0	0
Unknown	21	0	0	14	7	0	121	0	0	80	41	0
Gender												
Female	302,755	29,162	34,214	75,959	163,153	267	2,330,221	278,284	306,962	523,743	1,218,925	2,307
Male	218,432	12,366	31,499	16,180	158,387	0	1,682,477	113,139	282,379	97,631	1,189,328	0
Unknown	2	0	1	0	1	0	24	0	12	0	12	0
Race												
White	163,836	17,632	26,795	22,428	96,923	58	1,345,852	174,529	257,638	150,170	762,978	537
African American	32,232	989	2,946	3,969	24,328	0	242,159	8,703	23,742	25,814	183,900	0
Other/unknown	325,121	22,907	35,973	65,742	200,290	209	2,424,711	208,191	307,973	445,390	1,461,387	1,770
Use of Nursing Facilities[c]												
Entire year	8,974	7,530	1,444	0	0	0	86,797	72,183	14,614	0	0	0
Part year	5,441	4,315	1,123	2	0	1	50,336	39,783	10,527	20	0	6
None	506,774	29,683	63,147	92,137	321,541	266	3,875,589	279,457	564,212	621,354	2,408,265	2,301
Maintenance Assistance Status												
Cash	262,673	29,329	54,362	65,870	113,112	0	2,068,916	282,199	480,426	442,744	863,547	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	181,681	574	537	12,175	168,128	267	1,271,652	6,022	5,444	68,743	1,189,136	2,307
Other/unknown	76,835	11,625	10,815	14,094	40,301	0	672,154	103,202	103,483	109,887	355,582	0
Dual Medicare Status[d]												
Full dual, all year	60,766	36,550	23,638	564	8	6	579,222	347,542	228,110	3,438	71	61
Full dual, part year	2,284	1,178	1,035	71	0	0	23,272	12,036	10,538	698	0	0
Non-dual, all year	458,139	3,800	41,041	91,504	321,533	261	3,410,228	31,845	350,705	617,238	2,408,194	2,246
Managed Care (MC) Status												
Fee-for-service (FFS) all year	394,190	33,686	48,971	72,120	239,146	267	3,270,140	339,050	491,409	503,635	1,933,739	2,307
FFS part year, with Rx claims	50,609	2,049	9,215	11,262	28,083	0	327,162	15,209	55,337	72,628	183,988	0
FFS part year, no Rx claims	76,390	5,793	7,528	8,757	54,312	0	415,420	37,164	42,607	45,111	290,538	0

Source: Data for this table are from the MAX 2006 file for Colorado, released by CMS in 9/2009. This table was produced on 03/22/2010.

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 2006. 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]
COLORADO, 2006

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	**44.1**	**5.2**	**$391**	**$75**	**$4,517**	**8.6**	**521,189**
Age							
5 and younger	42.4	2.0	127	62	1,807	7.0	153,419
6-14	38.8	2.9	260	90	1,861	14.0	124,050
15-20	48.8	4.8	442	91	3,629	12.2	56,238
21-44	52.9	7.8	586	75	5,118	11.4	107,838
45-64	53.7	19.6	1,467	75	12,390	11.8	37,384
65-74	30.7	6.0	330	55	9,012	3.7	16,405
75-84	26.4	3.9	171	44	14,780	1.2	14,727
85 and older	25.7	2.5	92	38	23,553	0.4	11,107
Unknown	23.8	0.8	24	30	731	3.3	21
Basis of Eligibility[e]							
Aged	28.0	4.3	210	49	15,023	1.4	41,528
Disabled	56.0	18.1	1,690	93	14,490	11.7	65,714
Adults	52.6	6.1	324	53	2,513	12.9	92,139
Children	41.2	2.4	166	69	1,685	9.9	321,541
Unknown	84.3	22.0	1,844	84	18,336	10.1	267
Gender							
Female	46.4	5.7	387	68	4,598	8.4	302,755
Male	40.8	4.4	396	89	4,405	9.0	218,432
Unknown	50.0	0.5	5	9	2,117	0.2	2
Race							
White	47.2	6.3	508	80	6,066	8.4	163,836
African American	40.2	3.9	328	83	3,248	10.1	32,232
Other/unknown	42.9	4.7	338	71	3,863	8.7	325,121
Use of Nursing Facilities[f]							
Entire year	40.0	10.5	702	67	43,862	1.6	8,974
Part year	46.4	12.2	763	63	30,480	2.5	5,441
None	44.1	5.0	381	76	3,542	10.8	506,774
Maintenance Assistance Status							
Cash	46.2	6.9	524	76	4,899	10.7	262,673
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	39.0	1.9	118	61	1,556	7.6	181,681
Other/unknown	48.7	7.0	580	83	10,215	5.7	76,835

Source: Data for this table are from the MAX 2006 file for Colorado, released by CMS in 9/2009. This table was produced on 03/22/2010.
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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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]

COLORADO, 2006

				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	**0.7**	**$51**	**8.6**	**55.9**	**33.8**	**4.1**	**3.9**	**1.7**	**0.5**	**$587**	**521,189**	**4,012,722**
Age												
5 and younger	0.3	17	7.0	57.6	39.3	2.1	0.9	0.1	0.0	244	153,419	1,134,455
6-14	0.4	33	14.0	61.2	32.9	3.0	2.4	0.4	0.0	239	124,050	964,804
15-20	0.6	59	12.2	51.2	38.4	5.1	4.2	1.0	0.1	484	56,238	421,697
21-44	1.1	81	11.4	47.1	35.1	7.0	7.0	3.0	0.7	711	107,838	775,959
45-64	2.3	172	11.8	46.3	19.6	6.8	12.5	10.3	4.5	1,453	37,384	318,835
65-74	0.6	35	3.7	69.3	19.0	3.6	5.0	2.5	0.6	967	16,405	152,852
75-84	0.4	18	1.2	73.6	19.2	2.4	2.9	1.5	0.4	1,541	14,727	141,282
85 and older	0.3	10	0.4	74.3	21.2	2.0	1.5	0.8	0.2	2,547	11,107	102,717
Unknown	0.1	4	3.3	76.2	23.8	0.0	0.0	0.0	0.0	127	21	121
Basis of Eligibility[e]												
Aged	0.5	22	1.4	72.0	19.9	2.8	3.3	1.6	0.4	1,594	41,528	391,423
Disabled	2.0	189	11.7	44.0	23.4	7.5	12.8	8.8	3.4	1,616	65,714	589,353
Adults	0.9	48	12.9	47.4	37.2	7.0	6.0	2.0	0.4	373	92,139	621,374
Children	0.3	22	9.9	58.8	36.8	2.7	1.5	0.2	0.0	225	321,541	2,408,265
Unknown	2.5	213	10.1	15.7	31.1	17.2	23.6	9.7	2.6	2,122	267	2,307
Gender												
Female	0.7	50	8.4	53.6	35.1	4.4	4.2	2.0	0.7	597	302,755	2,330,221
Male	0.6	51	9.0	59.2	32.1	3.5	3.4	1.4	0.4	572	218,432	1,682,477
Unknown	0.0	0	0.2	50.0	50.0	0.0	0.0	0.0	0.0	176	2	24
Race												
White	0.8	62	8.4	52.8	35.0	4.7	4.8	2.1	0.7	738	163,836	1,345,852
African American	0.5	44	10.1	59.8	31.9	3.5	3.3	1.2	0.2	432	32,232	242,159
Other/unknown	0.6	45	8.7	57.1	33.4	3.8	3.5	1.6	0.5	518	325,121	2,424,711
Use of Nursing Facilities[f]												
Entire year	1.1	73	1.6	60.0	26.4	3.5	3.4	3.4	3.2	4,535	8,974	86,797
Part year	1.3	82	2.5	53.6	30.1	3.5	4.2	4.6	4.1	3,295	5,441	50,336
None	0.7	50	10.8	55.9	34.0	4.1	3.9	1.7	0.5	463	506,774	3,875,589
Maintenance Assistance Status												
Cash	0.9	67	10.7	53.8	32.4	4.9	5.4	2.7	0.9	622	262,673	2,068,916
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.3	17	7.6	61.0	35.3	2.4	1.2	0.1	0.0	222	181,681	1,271,652
Other/unknown	0.8	66	5.7	51.3	35.4	5.2	5.3	2.1	0.7	1,168	76,835	672,154

Source: Data for this table are from the MAX 2006 file for Colorado, released by CMS in 9/2009. This table was produced on 03/22/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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]

COLORADO, 2006

	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	**0.7**	**$51**	**$75**	**0.2**	**$37**	**$176**	**0.0**	**$3**	**$102**	**0.4**	**$11**	**$25**
Age												
5 and younger	0.3	17	62	0.1	13	193	0.0	1	47	0.2	4	18
6-14	0.4	33	90	0.2	28	167	0.0	1	81	0.2	5	24
15-20	0.6	59	91	0.2	47	194	0.0	3	117	0.4	9	25
21-44	1.1	81	75	0.3	57	186	0.0	5	127	0.7	19	26
45-64	2.3	172	75	0.7	118	171	0.1	8	114	1.5	45	30
65-74	0.6	35	55	0.2	24	120	0.0	2	89	0.4	10	23
75-84	0.4	18	44	0.1	12	100	0.0	1	75	0.3	5	20
85 and older	0.3	10	38	0.1	6	100	0.0	1	59	0.2	3	17
Unknown	0.1	4	30	0.0	2	46	0.0	1	70	0.1	2	19
Basis of Eligibility[d]												
Aged	0.5	22	49	0.1	15	111	0.0	1	79	0.3	6	21
Disabled	2.0	189	93	0.7	142	206	0.1	8	112	1.3	39	31
Adults	0.9	48	53	0.2	29	135	0.0	4	129	0.7	15	22
Children	0.3	22	69	0.1	17	162	0.0	1	74	0.2	4	20
Unknown	2.5	213	84	0.8	154	195	0.1	18	171	1.7	42	26
Gender												
Female	0.7	50	68	0.2	35	162	0.0	3	109	0.5	12	24
Male	0.6	51	89	0.2	40	195	0.0	2	90	0.3	9	27
Unknown	0.0	0	9	0.0	0	0	0.0	0	0	0.0	0	9
Race												
White	0.8	62	80	0.3	46	173	0.0	3	101	0.5	13	27
African American	0.5	44	83	0.2	34	190	0.0	2	96	0.3	8	24
Other/unknown	0.6	45	71	0.2	33	176	0.0	2	104	0.4	10	24
Use of Nursing Facilities[e]												
Entire year	1.1	73	67	0.3	51	163	0.0	3	83	0.7	19	25
Part year	1.3	82	63	0.4	56	152	0.0	4	94	0.9	23	25
None	0.7	50	76	0.2	37	176	0.0	3	103	0.4	11	25
Maintenance Assistance Status												
Cash	0.9	67	76	0.3	48	178	0.0	3	108	0.6	15	26
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.3	17	61	0.1	12	164	0.0	1	90	0.2	4	19
Other/unknown	0.8	66	83	0.3	51	174	0.0	3	93	0.5	12	26

Source: Data for this table are from the MAX 2006 file for Colorado, released by CMS in 9/2009. This table was produced on 03/22/2010.

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 Colorado, 0.1 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.medi-span.com/master-drug-database.aspx

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]

COLORADO, 2006

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	0.0	0.0	0.2	$13	$8	$1	$5	$51	$217	$51	$23	324,655	$16,573,008	132,748	25.5	1,244,185
Biologicals	0.6	0.6	0.0	0.0	867	860	5	2	1411	1,413	1,099	1,835	4,845	6,836,041	911	0.2	7,885
Antineoplastic Agents	0.6	0.2	0.0	0.4	172	151	0	21	289	765	204	53	6,456	1,867,015	1,151	0.2	10,829
Endocrine/Metabolic Drugs	0.5	0.2	0.0	0.3	31	22	1	8	58	129	45	23	244,013	14,262,471	48,906	9.4	455,975
Cardiovascular Agents	1.0	0.3	0.0	0.7	47	32	2	13	46	99	92	19	262,485	12,062,974	27,509	5.3	256,433
Respiratory Agents	0.4	0.2	0.0	0.2	28	23	0	5	63	108	57	21	327,556	20,648,144	77,736	14.9	737,929
Gastrointestinal Agents	0.5	0.2	0.0	0.3	38	25	8	6	82	147	352	21	128,434	10,593,782	29,331	5.6	277,215
Genitourinary Agents	0.3	0.1	0.0	0.2	16	8	4	4	56	94	88	25	38,040	2,113,468	14,086	2.7	132,880
CNS Drugs	0.9	0.4	0.1	0.5	101	80	7	14	107	214	109	27	478,390	51,008,064	53,728	10.3	507,387
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	81	75	1	6	107	129	121	33	69,812	7,473,083	9,549	1.8	91,778
Miscellaneous Psychological/ Neurological Agents	0.5	0.5	0.0	0.0	266	265	0	1	529	536	127	80	8,079	4,276,923	1,646	0.3	16,103
Analgesics and Anesthetics	0.5	0.0	0.0	0.5	25	10	1	14	46	208	175	28	344,529	15,946,530	68,889	13.2	632,510
Neuromuscular Agents	0.8	0.3	0.0	0.5	79	59	2	18	97	187	103	38	216,663	21,103,393	27,956	5.4	267,436
Nutritional Products	0.4	0.1	0.0	0.3	10	3	0	7	25	43	25	21	53,341	1,330,191	14,207	2.7	126,993
Hematological Agents	0.7	0.2	0.0	0.5	210	196	0	14	302	953	41	28	28,590	8,646,179	4,296	0.8	41,218
Topical Products	0.2	0.1	0.0	0.2	10	6	0	4	41	106	62	20	157,083	6,436,864	67,014	12.9	640,920
Miscellaneous Products	0.7	0.3	0.0	0.4	210	174	13	23	293	581	321	60	7,432	2,177,589	1,079	0.2	10,388
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	10	0	0	0	54	0	0	0	3,613	195,716	2,009	0.4	20,318
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.	2,704,016	203,551,435	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Colorado, released by CMS in 9/2009. This table was produced on 03/22/2010.

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.medi-span.com/master-drug-database.aspx.

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 Colorado, 0.1 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.medi-span.com/master-drug-database.aspx.

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2006.

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]

COLORADO, 2006

		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	$35,074,668	20,272	3.9	196,354	0.7	$249	$179
ANTICONVULSANT	18,560,903	21,030	4.0	206,673	0.7	121	90
ANTIASTHMATIC	13,020,213	59,981	11.5	567,540	0.3	73	23
ANTIDEPRESSANTS	11,837,306	38,331	7.4	358,676	0.5	64	33
ANALGESICS - Narcotic	9,227,614	78,191	15.0	735,613	0.3	37	13
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	7,444,521	10,720	2.1	104,541	0.7	107	71
PASSIVE IMMUNIZING AGENTS	6,815,413	900	0.2	7,791	0.6	1,416	875
ANTIDIABETIC	5,954,970	13,671	2.6	126,090	0.6	73	47
ULCER DRUGS	5,606,988	25,913	5.0	247,080	0.4	64	23
ANTIVIRAL	5,564,032	6,867	1.3	66,352	0.3	305	84
Total	119,106,628	275,876	n.a.	2,616,710	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Colorado, released by CMS in 9/2009. This table was produced on 03/22/2010.

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 2006. 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 2006. For information about these drug groups, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.

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.