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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
MONTANA, 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]	112766 (A)	18331 (E)	94435 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	98138 (B)	16558 (F)	81580 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	97932 (C)	16558 (G)	81374 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	3289 (D)	3145 (H)	144 (L)

Source: Data for this table are from the MAX 2006 file for Montana, released by CMS in 9/2009. This table was produced on 02/11/2010.
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 Montana in 2006 was $55,077,342, of which $7,041,917 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]

MONTANA, 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	**97,932**	**8,336**	**18,682**	**9,804**	**61,081**	**29**	**885,213**	**76,169**	**187,029**	**75,413**	**546,396**	**206**
Age												
5 and younger	27,402	0	667	1	26,734	0	241,141	0	6,739	1	234,401	0
6-14	24,530	0	1,226	0	23,304	0	231,046	0	13,373	0	217,673	0
15-20	13,073	0	1,154	1,014	10,901	4	111,844	0	12,256	5,839	93,741	8
21-44	13,790	3	5,644	7,993	142	8	118,510	25	57,272	60,577	581	55
45-64	9,878	14	9,155	693	0	16	97,255	149	89,191	7,775	0	140
65-74	3,373	2,577	725	70	0	1	31,709	23,819	7,061	826	0	3
75-84	2,902	2,780	94	28	0	0	26,846	25,522	988	336	0	0
85 and older	2,984	2,962	17	5	0	0	26,862	26,654	149	59	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	54,766	5,996	9,678	8,572	30,491	29	488,576	55,862	97,885	62,123	272,500	206
Male	43,166	2,340	9,004	1,232	30,590	0	396,637	20,307	89,144	13,290	273,896	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	70,914	7,518	15,246	7,450	40,671	29	630,953	67,880	150,766	56,900	355,201	206
African American	973	18	142	60	753	0	8,947	195	1,416	431	6,905	0
Other/unknown	26,045	800	3,294	2,294	19,657	0	245,313	8,094	34,847	18,082	184,290	0
Use of Nursing Facilities[c]												
Entire year	3,289	2,867	421	1	0	0	33,203	28,610	4,581	12	0	0
Part year	1,744	1,250	462	30	2	0	15,075	10,206	4,508	337	24	0
None	92,899	4,219	17,799	9,773	61,079	29	836,935	37,353	177,940	75,064	546,372	206
Maintenance Assistance Status												
Cash	35,946	1,930	14,739	1,991	17,286	0	353,513	21,045	155,474	17,691	159,303	0
Medically needy	7,798	5,346	2,426	21	5	0	61,422	44,503	16,884	30	5	0
Poverty-related	33,303	0	0	4,435	28,839	29	277,392	0	0	24,799	252,387	206
Other/unknown	20,885	1,060	1,517	3,357	14,951	0	192,886	10,621	14,671	32,893	134,701	0
Dual Medicare Status[d]												
Full dual, all year	16,558	8,213	7,125	1,208	11	1	160,137	75,583	70,259	14,179	114	2
Full dual, part year	0	0	0	0	0	0	0	0	0	0	0	0
Non-dual, all year	81,374	123	11,557	8,596	61,070	28	725,076	586	116,770	61,234	546,282	204
Managed Care (MC) Status												
Fee-for-service (FFS) all year	97,931	8,336	18,681	9,804	61,081	29	885,211	76,169	187,027	75,413	546,396	206
FFS part year, with Rx claims	0	0	0	0	0	0	0	0	0	0	0	0
FFS part year, no Rx claims	1	0	1	0	0	0	2	0	2	0	0	0

Source: Data for this table are from the MAX 2006 file for Montana, released by CMS in 9/2009. This table was produced on 02/11/2010.

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]

MONTANA, 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	**51.9**	**6.4**	**$491**	**$76**	**$5,885**	**8.3**	**97,932**
Age							
5 and younger	54.4	2.4	106	45	2,310	4.6	27,402
6-14	49.4	3.9	352	91	3,011	11.7	24,530
15-20	55.9	5.8	484	84	4,781	10.1	13,073
21-44	61.5	10.8	966	90	7,328	13.2	13,790
45-64	57.1	22.8	1,649	72	11,697	14.1	9,878
65-74	27.8	3.0	115	39	10,670	1.1	3,373
75-84	23.6	1.5	30	19	17,863	0.2	2,902
85 and older	23.8	1.4	23	17	24,215	0.1	2,984
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	24.9	1.9	44	24	18,374	0.2	8,336
Disabled	58.0	19.0	1,716	91	12,118	14.2	18,682
Adults	63.6	6.8	377	56	4,946	7.6	9,804
Children	51.8	3.1	194	62	2,422	8.0	61,081
Unknown	72.4	24.5	2,224	91	13,997	15.9	29
Gender							
Female	53.6	7.0	469	67	6,164	7.6	54,766
Male	49.7	5.7	518	91	5,532	9.4	43,166
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	55.9	7.4	569	77	6,399	8.9	70,914
African American	59.0	5.7	415	73	3,873	10.7	973
Other/unknown	40.7	3.8	280	75	4,563	6.1	26,045
Use of Nursing Facilities[f]							
Entire year	33.4	5.4	263	49	36,709	0.7	3,289
Part year	41.3	11.3	821	73	25,625	3.2	1,744
None	52.7	6.4	492	77	4,423	11.1	92,899
Maintenance Assistance Status							
Cash	52.5	10.3	886	86	5,862	15.1	35,946
Medically needy	31.0	4.0	223	56	21,092	1.1	7,798
Poverty related	53.3	2.9	146	51	1,968	7.4	33,303
Other/unknown	56.3	6.4	460	72	6,493	7.1	20,885

Source: Data for this table are from the MAX 2006 file for Montana, released by CMS in 9/2009. This table was produced on 02/11/2010.

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]

MONTANA, 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**	**$54**	**8.3**	**48.1**	**40.9**	**4.3**	**4.3**	**1.8**	**0.5**	**$651**	**97,932**	**885,213**
Age												
5 and younger	0.3	12	4.6	45.6	52.2	1.6	0.5	0.1	0.0	263	27,402	241,141
6-14	0.4	37	11.7	50.6	42.1	3.9	3.1	0.3	0.0	320	24,530	231,046
15-20	0.7	57	10.1	44.1	43.7	6.2	5.0	0.9	0.1	559	13,073	111,844
21-44	1.3	112	13.2	38.5	39.6	8.6	8.8	3.7	0.8	853	13,790	118,510
45-64	2.3	168	14.1	42.9	22.6	6.7	13.5	10.5	3.9	1,188	9,878	97,255
65-74	0.3	12	1.1	72.2	23.4	2.2	1.5	0.5	0.2	1,135	3,373	31,709
75-84	0.2	3	0.2	76.4	21.5	1.7	0.4	0.0	0.0	1,931	2,902	26,846
85 and older	0.2	3	0.1	76.2	22.2	1.3	0.3	0.0	0.0	2,690	2,984	26,862
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	0.2	5	0.2	75.1	22.5	1.7	0.6	0.1	0.1	2,011	8,336	76,169
Disabled	1.9	171	14.2	42.0	26.9	7.4	13.1	7.9	2.6	1,210	18,682	187,029
Adults	0.9	49	7.6	36.4	47.2	8.7	6.0	1.6	0.1	643	9,804	75,413
Children	0.4	22	8.0	48.2	46.7	3.0	1.8	0.2	0.0	271	61,081	546,396
Unknown	3.5	313	15.9	27.6	31.0	10.3	10.3	13.8	6.9	1,970	29	206
Gender												
Female	0.8	53	7.6	46.4	41.9	4.6	4.3	2.1	0.7	691	54,766	488,576
Male	0.6	56	9.4	50.3	39.8	4.0	4.2	1.4	0.3	602	43,166	396,637
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	0.8	64	8.9	44.1	43.1	4.9	5.0	2.2	0.6	719	70,914	630,953
African American	0.6	45	10.7	41.0	48.6	4.7	4.3	0.9	0.4	421	973	8,947
Other/unknown	0.4	30	6.1	59.3	34.8	2.6	2.3	0.8	0.3	484	26,045	245,313
Use of Nursing Facilities[f]												
Entire year	0.5	26	0.7	66.6	25.8	3.2	2.0	1.8	0.6	3,636	3,289	33,203
Part year	1.3	95	3.2	58.7	27.5	3.0	3.4	4.6	2.8	2,965	1,744	15,075
None	0.7	55	11.1	47.3	41.7	4.4	4.4	1.8	0.5	491	92,899	836,935
Maintenance Assistance Status												
Cash	1.0	90	15.1	47.5	35.8	5.0	6.9	3.6	1.1	596	35,946	353,513
Medically needy	0.5	28	1.1	69.0	23.5	2.7	2.8	1.5	0.5	2,678	7,798	61,422
Poverty related	0.3	18	7.4	46.7	48.0	3.4	1.7	0.1	0.0	236	33,303	277,392
Other/unknown	0.7	50	7.1	43.7	45.1	5.2	4.3	1.5	0.3	703	20,885	192,886

Source: Data for this table are from the MAX 2006 file for Montana, released by CMS in 9/2009. This table was produced on 02/11/2010.

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]
MONTANA, 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**	**$54**	**$76**	**0.2**	**$38**	**$176**	**0.0**	**$4**	**$109**	**0.5**	**$12**	**$26**
Age												
5 and younger	0.3	12	45	0.1	8	135	0.0	1	46	0.2	4	19
6-14	0.4	37	91	0.2	32	157	0.0	1	69	0.2	5	23
15-20	0.7	57	84	0.3	45	171	0.0	3	83	0.4	9	24
21-44	1.3	112	90	0.3	81	235	0.1	9	131	0.8	23	27
45-64	2.3	168	72	0.6	103	165	0.1	18	139	1.6	46	30
65-74	0.3	12	39	0.0	5	129	0.0	1	106	0.3	6	21
75-84	0.2	3	19	0.0	1	75	0.0	0	31	0.2	3	17
85 and older	0.2	3	17	0.0	1	93	0.0	0	14	0.2	2	14
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.2	5	24	0.0	1	102	0.0	0	70	0.2	3	17
Disabled	1.9	171	91	0.6	121	211	0.1	14	137	1.2	36	30
Adults	0.9	49	56	0.2	31	154	0.0	5	103	0.6	13	21
Children	0.4	22	62	0.1	16	129	0.0	1	59	0.2	4	21
Unknown	3.5	313	91	1.1	175	166	0.2	60	287	2.2	78	36
Gender												
Female	0.8	53	67	0.2	35	161	0.0	4	108	0.5	13	25
Male	0.6	56	91	0.2	42	195	0.0	4	112	0.4	10	28
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.8	64	77	0.3	45	174	0.0	5	112	0.5	14	26
African American	0.6	45	73	0.2	35	148	0.0	2	65	0.4	8	22
Other/unknown	0.4	30	75	0.1	21	194	0.0	2	98	0.3	7	25
Use of Nursing Facilities[e]												
Entire year	0.5	26	49	0.1	14	154	0.0	3	88	0.4	9	23
Part year	1.3	95	73	0.3	57	184	0.1	10	161	0.9	28	30
None	0.7	55	77	0.2	39	176	0.0	4	108	0.4	12	26
Maintenance Assistance Status												
Cash	1.0	90	86	0.3	65	203	0.1	7	122	0.7	19	28
Medically needy	0.5	28	56	0.1	16	174	0.0	3	138	0.4	9	23
Poverty related	0.3	18	51	0.1	12	116	0.0	1	66	0.2	4	19
Other/unknown	0.7	50	72	0.2	36	149	0.0	4	101	0.4	10	25

Source: Data for this table are from the MAX 2006 file for Montana, released by CMS in 9/2009. This table was produced on 02/11/2010.

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 Montana, 0.5 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]

MONTANA, 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	0.2	0.0	0.0	0.2	$10	$5	$1	$4	$46	$196	$49	$25	69,505	$3,183,920	30,052	30.7	309,073
Biologicals	0.2	0.2	0.0	0.0	206	202	4	0	884	902	1,406	40	452	399,435	201	0.2	1,937
Antineoplastic Agents	0.6	0.2	0.0	0.4	149	129	0	20	266	833	188	50	1,463	389,561	248	0.3	2,609
Endocrine/Metabolic Drugs	0.6	0.2	0.0	0.3	34	24	1	9	61	132	45	26	50,542	3,100,821	9,020	9.2	91,270
Cardiovascular Agents	1.0	0.2	0.1	0.7	42	16	12	14	41	82	121	19	59,223	2,410,567	5,391	5.5	57,247
Respiratory Agents	0.4	0.2	0.0	0.2	25	21	0	3	64	112	51	18	62,419	4,006,157	15,439	15.8	161,980
Gastrointestinal Agents	0.4	0.2	0.0	0.3	38	27	6	5	89	170	399	20	20,295	1,805,189	4,633	4.7	47,949
Genitourinary Agents	0.3	0.1	0.0	0.2	16	11	2	4	56	88	76	28	7,420	416,135	2,528	2.6	25,366
CNS Drugs	0.9	0.4	0.1	0.5	95	75	7	14	102	211	99	28	133,292	13,650,865	13,696	14.0	143,060
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	76	72	1	4	103	116	74	36	30,343	3,122,869	3,827	3.9	40,840
Miscellaneous Psychological/ Neurological Agents	0.3	0.3	0.0	0.0	185	180	0	4	528	575	0	119	1,368	722,596	368	0.4	3,913
Analgesics and Anesthetics	0.5	0.0	0.0	0.5	31	10	6	14	57	253	340	30	73,695	4,195,596	13,647	13.9	136,227
Neuromuscular Agents	0.8	0.3	0.0	0.5	73	51	2	19	89	168	86	40	59,761	5,320,410	6,805	6.9	72,802
Nutritional Products	0.3	0.0	0.0	0.3	4	0	0	4	14	24	16	14	19,433	274,927	6,840	7.0	69,220
Hematological Agents	0.6	0.1	0.0	0.4	261	252	1	8	468	2,220	27	20	7,378	3,449,939	1,312	1.3	13,210
Topical Products	0.2	0.1	0.0	0.1	7	4	0	3	39	84	49	20	30,414	1,180,627	15,496	15.8	161,056
Miscellaneous Products	0.6	0.2	0.1	0.3	183	135	14	35	304	574	250	111	1,249	380,106	199	0.2	2,076
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	9	0	0	0	54	0	0	0	476	25,705	275	0.3	2,862
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.	628,728	48,035,425	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Montana, released by CMS in 9/2009. This table was produced on 02/11/2010.

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 Montana, 0.5 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]

MONTANA, 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	$9,384,742	5,493	5.6	60,458	0.6	$243	$155
ANTICONVULSANT	4,744,117	5,776	5.9	62,700	0.7	106	76
ANTIDEPRESSANTS	3,392,131	9,941	10.2	105,012	0.5	63	32
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	3,122,869	4,397	4.5	47,211	0.6	103	66
ANTIASTHMATIC	2,970,409	13,056	13.3	138,222	0.3	73	21
ANALGESICS - Narcotic	2,803,049	16,480	16.8	166,342	0.3	50	17
MISC. HEMATOLOGICAL	2,384,648	235	0.2	2,405	0.5	1,849	992
ULCER DRUGS	1,362,026	6,680	6.8	71,027	0.4	44	19
ANTIDIABETIC	1,266,406	2,448	2.5	25,841	0.7	74	49
MISC. ENDOCRINE	1,177,567	710	0.7	7,917	0.5	278	149
Total	32,607,964	65,216	n.a.	687,135	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Montana, released by CMS in 9/2009. This table was produced on 02/11/2010.

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.