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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2007
IDAHO

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
IDAHO, 2007

Inclusion Criteria (2007)	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]	229478 (A)	31775 (E)	197703 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	221070 (B)	23384 (F)	197686 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	221070 (C)	23384 (G)	197686 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2717 (D)	2559 (H)	158 (L)

Source: Data for this table are from the MAX 2007 file for Idaho, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 2007 (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 2007, 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 2007 was $101,873,308, of which $71,059 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 27 states in 2007 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, MA, MI, NC, NH, NM, NV, NY, 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, TN, TX, and WV). These lists were constructed from the CMS 2007 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 reviewed prescription drug expenditures by type of managed care plan to determine whether enrollees in comprehensive MC plans had significant prescription drug expenditures during the year, since that would indicate that at least some prescription drugs were not included in the capitated benefit and were being provided on a fee-for-service basis. There were some states in which most, but not all, prescription drugs were included in the MC capitated benefit package. Mental health drugs, for example, may have been excluded. In those states, we excluded all the MC enrollees from the study population, but some of their drugs would have been included, potentially resulting in higher reported per-beneficiary use of those drugs than would have been the case if we had been able to exclude those drugs.
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 2007. 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 2007. 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, 2007

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**221,070**	**11,969**	**32,778**	**29,186**	**147,137**	**0**	**2,063,864**	**118,372**	**350,180**	**196,814**	**1,398,498**	**0**
Age												
5 and younger	64,007	0	1,672	20	62,315	0	584,659	0	17,155	66	567,438	0
6-14	65,642	0	4,549	14	61,079	0	660,421	0	50,784	80	609,557	0
15-20	29,425	0	2,963	2,750	23,712	0	271,707	0	32,218	18,061	221,428	0
21-44	35,998	1	11,098	24,869	30	0	286,084	11	119,317	166,684	72	0
45-64	14,016	81	12,421	1,513	1	0	142,773	871	130,062	11,837	3	0
65-74	4,615	4,536	64	15	0	0	47,665	47,052	541	72	0	0
75-84	3,843	3,831	9	3	0	0	38,046	37,935	99	12	0	0
85 and older	3,524	3,520	2	2	0	0	32,509	32,503	4	2	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	123,616	8,377	16,715	25,831	72,693	0	1,126,457	83,362	178,589	173,701	690,805	0
Male	97,454	3,592	16,063	3,355	74,444	0	937,407	35,010	171,591	23,113	707,693	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	210,044	11,541	31,400	26,681	140,422	0	1,969,918	113,942	335,423	185,389	1,335,164	0
African American	2,784	38	311	408	2,027	0	25,759	363	3,245	2,760	19,391	0
Other/unknown	8,242	390	1,067	2,097	4,688	0	68,187	4,067	11,512	8,665	43,943	0
Use of Nursing Facilities[c]												
Entire year	2,717	2,351	366	0	0	0	26,078	22,246	3,832	0	0	0
Part year	1,800	1,350	444	4	2	0	17,661	12,912	4,684	41	24	0
None	216,553	8,268	31,968	29,182	147,135	0	2,020,125	83,214	341,664	196,773	1,398,474	0
Maintenance Assistance Status												
Cash	46,041	2,263	30,166	11,473	2,139	0	449,294	25,075	322,295	90,533	11,391	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	153,216	204	445	12,177	140,390	0	1,419,729	2,181	4,754	64,253	1,348,541	0
Other/unknown	21,813	9,502	2,167	5,536	4,608	0	194,841	91,116	23,131	42,028	38,566	0
Dual Medicare Status[d]												
Full dual, all year	22,095	11,031	10,902	161	1	0	227,246	108,778	116,971	1,491	6	0
Full dual, part year	1,289	556	726	7	0	0	13,662	5,731	7,857	74	0	0
Non-dual, all year	197,686	382	21,150	29,018	147,136	0	1,822,956	3,863	225,352	195,249	1,398,492	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	219,829	11,379	32,127	29,186	147,137	0	2,056,944	115,230	346,402	196,814	1,398,498	0
FFS part year, with Rx claims	363	143	220	0	0	0	2,149	818	1,331	0	0	0
FFS part year, no Rx claims	878	447	431	0	0	0	4,771	2,324	2,447	0	0	0

Source: Data for this table are from the MAX 2007 file for Idaho, released by CMS in 4/2010. This table was produced on 10/06/2010.

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 2007. 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, 2007

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	**55.8**	**6.7**	**$461**	**$69**	**$5,228**	**8.8**	**221,070**
Age							
5 and younger	57.9	2.5	115	46	2,246	5.1	64,007
6-14	52.1	3.6	283	78	2,546	11.1	65,642
15-20	59.2	5.8	427	74	3,814	11.2	29,425
21-44	62.0	12.6	927	74	8,490	10.9	35,998
45-64	63.2	29.9	2,030	68	15,903	12.8	14,016
65-74	33.6	5.8	261	45	12,046	2.2	4,615
75-84	28.4	2.5	55	22	17,547	0.3	3,843
85 and older	26.8	2.0	29	15	23,011	0.1	3,524
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	30.2	3.9	143	37	17,114	0.8	11,969
Disabled	66.1	23.7	1,972	83	17,738	11.1	32,778
Adults	61.8	8.1	406	50	3,880	10.5	29,186
Children	54.5	2.9	161	56	1,742	9.2	147,137
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	57.3	7.6	477	62	5,282	9.0	123,616
Male	54.0	5.5	440	80	5,160	8.5	97,454
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	56.3	6.8	467	69	5,272	8.8	210,044
African American	53.2	5.3	415	78	3,534	11.7	2,784
Other/unknown	45.7	5.4	323	59	4,676	6.9	8,242
Use of Nursing Facilities[f]							
Entire year	37.2	9.2	521	57	46,478	1.1	2,717
Part year	50.2	16.3	930	57	33,937	2.7	1,800
None	56.1	6.6	456	69	4,472	10.2	216,553
Maintenance Assistance Status							
Cash	63.5	19.9	1,552	78	13,284	11.7	46,041
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	54.5	2.8	147	53	1,897	7.7	153,216
Other/unknown	49.0	6.3	359	57	11,622	3.1	21,813

Source: Data for this table are from the MAX 2007 file for Idaho, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, 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, TN, TX, 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, 2007

				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**	**$49**	**8.8**	**44.2**	**45.4**	**4.1**	**3.9**	**1.8**	**0.7**	**$560**	**221,070**	**2,063,864**
Age												
5 and younger	0.3	13	5.1	42.1	55.8	1.6	0.5	0.0	0.0	246	64,007	584,659
6-14	0.4	28	11.1	47.9	46.2	3.1	2.4	0.3	0.0	253	65,642	660,421
15-20	0.6	46	11.2	40.8	48.3	5.6	4.4	0.8	0.1	413	29,425	271,707
21-44	1.6	117	10.9	38.0	38.1	8.3	9.5	4.6	1.4	1,068	35,998	286,084
45-64	2.9	199	12.8	36.8	24.0	6.8	13.5	12.3	6.7	1,561	14,016	142,773
65-74	0.6	25	2.2	66.4	25.1	3.3	3.0	1.5	0.8	1,166	4,615	47,665
75-84	0.3	6	0.3	71.6	24.2	2.3	1.4	0.5	0.0	1,772	3,843	38,046
85 and older	0.2	3	0.1	73.2	23.6	2.3	0.8	0.1	0.0	2,494	3,524	32,509
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	0.4	15	0.8	69.8	24.3	2.7	1.9	0.9	0.4	1,730	11,969	118,372
Disabled	2.2	185	11.1	33.9	31.1	8.4	13.8	8.8	4.0	1,660	32,778	350,180
Adults	1.2	60	10.5	38.2	42.8	8.1	7.5	2.7	0.6	575	29,186	196,814
Children	0.3	17	9.2	45.5	50.8	2.4	1.2	0.1	0.0	183	147,137	1,398,498
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	0.8	52	9.0	42.7	45.4	4.4	4.3	2.2	1.0	580	123,616	1,126,457
Male	0.6	46	8.5	46.0	45.4	3.6	3.5	1.3	0.3	536	97,454	937,407
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	0.7	50	8.8	43.7	45.7	4.1	4.0	1.8	0.7	562	210,044	1,969,918
African American	0.6	45	11.7	46.8	44.5	3.4	3.7	1.3	0.3	382	2,784	25,759
Other/unknown	0.7	39	6.9	54.3	37.1	3.2	3.3	1.6	0.5	565	8,242	68,187
Use of Nursing Facilities[f]												
Entire year	1.0	54	1.1	62.8	26.2	3.8	2.5	1.9	2.8	4,843	2,717	26,078
Part year	1.7	95	2.7	49.8	33.3	3.3	4.3	4.6	4.6	3,459	1,800	17,661
None	0.7	49	10.2	43.9	45.7	4.1	4.0	1.8	0.6	479	216,553	2,020,125
Maintenance Assistance Status												
Cash	2.0	159	11.7	36.5	32.5	8.2	12.2	7.5	3.1	1,361	46,041	449,294
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	16	7.7	45.5	50.7	2.5	1.2	0.1	0.0	205	153,216	1,419,729
Other/unknown	0.7	40	3.1	51.0	35.0	6.2	6.0	1.5	0.3	1,301	21,813	194,841

Source: Data for this table are from the MAX 2007 file for Idaho, released by CMS in 4/2010. This table was produced on 10/06/2010.

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 eight states (DE, IA, IL, NE, NY, TN, TX, 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, TN, TX, 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, 2007

	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**	**$49**	**$69**	**0.2**	**$38**	**$165**	**0.0**	**$3**	**$108**	**0.5**	**$9**	**$19**
Age												
5 and younger	0.3	13	46	0.1	8	152	0.0	1	70	0.2	4	18
6-14	0.4	28	78	0.2	23	140	0.0	1	100	0.2	4	22
15-20	0.6	46	74	0.2	36	160	0.0	3	130	0.4	7	20
21-44	1.6	117	74	0.5	91	190	0.1	6	121	1.0	19	18
45-64	2.9	199	68	0.9	151	167	0.1	12	111	1.9	36	19
65-74	0.6	25	45	0.1	18	146	0.0	2	80	0.4	6	14
75-84	0.3	6	22	0.0	3	115	0.0	0	67	0.2	2	10
85 and older	0.2	3	15	0.0	1	76	0.0	0	70	0.2	2	9
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.4	15	37	0.1	10	137	0.0	1	77	0.3	4	12
Disabled	2.2	185	83	0.8	147	186	0.1	11	122	1.3	26	20
Adults	1.2	60	50	0.3	42	145	0.0	4	105	0.9	14	16
Children	0.3	17	56	0.1	12	131	0.0	1	87	0.2	4	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	0.8	52	62	0.2	39	159	0.0	3	107	0.6	10	18
Male	0.6	46	80	0.2	36	174	0.0	3	110	0.3	7	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.7	50	69	0.2	38	165	0.0	3	109	0.5	9	19
African American	0.6	45	78	0.2	36	181	0.0	2	114	0.4	7	19
Other/unknown	0.7	39	59	0.2	29	162	0.0	2	91	0.5	8	18
Use of Nursing Facilities[e]												
Entire year	1.0	54	57	0.2	40	185	0.0	3	109	0.7	11	15
Part year	1.7	95	57	0.4	66	166	0.1	7	122	1.2	21	18
None	0.7	49	69	0.2	37	165	0.0	3	108	0.5	8	19
Maintenance Assistance Status												
Cash	2.0	159	78	0.7	125	183	0.1	9	120	1.3	24	19
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.3	16	53	0.1	11	130	0.0	1	88	0.2	4	19
Other/unknown	0.7	40	57	0.2	31	135	0.0	2	94	0.5	7	16

Source: Data for this table are from the MAX 2007 file for Idaho, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 Idaho, 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]
IDAHO, 2007

	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	0.0	0.0	0.2	$8	$3	$1	$4	$38	$235	$98	$22	177,286	$6,762,265	76,620	34.7	804,733
Biologicals	0.3	0.3	0.0	0.0	255	255	0	0	985	985	0	0	1,795	1,767,402	679	0.3	6,934
Antineoplastic Agents	0.6	0.2	0.0	0.4	198	186	0	13	332	798	31	35	3,207	1,064,918	503	0.2	5,372
Endocrine/Metabolic Drugs	0.5	0.2	0.0	0.3	31	23	1	8	59	123	54	23	126,530	7,428,129	22,871	10.3	236,878
Cardiovascular Agents	1.1	0.2	0.1	0.7	38	22	5	11	36	97	63	15	124,752	4,513,681	11,070	5.0	118,226
Respiratory Agents	0.4	0.2	0.0	0.2	21	17	1	3	61	101	73	19	160,060	9,702,355	42,360	19.2	451,789
Gastrointestinal Agents	0.5	0.2	0.0	0.2	42	36	2	4	90	148	185	18	68,850	6,175,826	13,874	6.3	145,706
Genitourinary Agents	0.3	0.1	0.0	0.2	14	8	1	5	53	96	103	30	17,391	919,020	6,263	2.8	63,952
CNS Drugs	1.0	0.4	0.0	0.6	105	90	5	10	101	208	108	18	313,572	31,761,703	28,825	13.0	302,603
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	73	70	1	2	101	116	48	21	61,489	6,206,318	7,693	3.5	85,364
Miscellaneous Psychological/ Neurological Agents	0.5	0.5	0.0	0.0	276	276	0	0	544	549	0	49	2,693	1,466,134	481	0.2	5,309
Analgesics and Anesthetics	0.5	0.0	0.0	0.4	17	9	1	7	37	282	400	17	170,270	6,235,759	35,280	16.0	359,227
Neuromuscular Agents	0.8	0.3	0.0	0.4	73	56	9	8	91	180	182	19	124,614	11,334,858	14,444	6.5	156,067
Nutritional Products	0.2	0.0	0.0	0.2	3	0	0	3	13	17	10	12	29,107	366,185	11,968	5.4	121,024
Hematological Agents	0.6	0.1	0.0	0.5	92	86	0	6	145	689	45	11	16,980	2,464,895	2,504	1.1	26,796
Topical Products	0.2	0.0	0.0	0.1	6	4	0	2	34	89	61	15	79,064	2,714,434	40,835	18.5	435,002
Miscellaneous Products	0.6	0.3	0.0	0.3	180	148	6	26	302	480	330	96	2,142	646,863	334	0.2	3,595
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	23	0	0	0	104	0	0	0	2,614	271,504	1,096	0.5	12,021
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.	1,482,416	101,802,249	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Idaho, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 Idaho, 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 2007.
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, 2007

		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	$21,862,785	12,564	5.7	139,371	0.6	$245	$157
ANTICONVULSANT	10,619,596	11,882	5.4	130,787	0.7	115	81
ANTIDEPRESSANTS	8,008,709	25,041	11.3	265,949	0.5	57	30
ANTIASTHMATIC	6,753,498	28,384	12.8	306,165	0.3	76	22
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	6,206,318	8,951	4.0	99,793	0.6	101	62
ULCER DRUGS	5,085,257	13,184	6.0	139,899	0.4	89	36
ANTIDIABETIC	3,746,873	6,785	3.1	73,031	0.6	80	51
ANALGESICS - Narcotic	3,568,479	40,812	18.5	420,314	0.3	29	8
ANTIHYPERLIPIDEMIC	1,981,867	3,959	1.8	43,955	0.6	73	45
MISC. ENDOCRINE	1,843,619	1,399	0.6	15,810	0.5	242	117
Total	69,677,001	152,961	n.a.	1,635,074	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Idaho, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 2007. 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 2007. 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.