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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
MONTANA, 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]	110457 (A)	18174 (E)	92283 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	96466 (B)	16239 (F)	80227 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	96466 (C)	16239 (G)	80227 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	3250 (D)	3089 (H)	161 (L)

Source: Data for this table are from the MAX 2007 file for Montana, released by CMS in 3/2010. This table was produced on 04/19/2011.
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 Montana in 2007 was $62,617,582, of which $7,799,337 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]
MONTANA, 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	**96,241**	**8,046**	**18,666**	**9,386**	**59,967**	**176**	**866,206**	**74,630**	**188,236**	**70,264**	**531,566**	**1,510**
Age												
5 and younger	27,538	0	698	2	26,838	0	240,752	0	7,183	3	233,566	0
6-14	23,982	1	1,272	0	22,709	0	224,039	12	13,927	0	210,100	0
15-20	12,621	0	1,235	1,069	10,312	5	106,479	0	13,087	5,886	87,491	15
21-44	13,218	2	5,509	7,563	108	36	112,658	24	56,457	55,554	409	214
45-64	9,916	19	9,117	647	0	133	98,453	223	89,388	7,581	0	1,261
65-74	3,294	2,505	713	74	0	2	31,736	23,803	7,045	868	0	20
75-84	2,785	2,657	101	27	0	0	25,732	24,452	956	324	0	0
85 and older	2,887	2,862	21	4	0	0	26,357	26,116	193	48	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	53,835	5,742	9,616	8,301	30,000	176	477,035	54,268	97,773	57,887	265,597	1,510
Male	42,406	2,304	9,050	1,085	29,967	0	389,171	20,362	90,463	12,377	265,969	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	69,743	7,194	15,205	7,263	39,913	168	620,041	66,018	151,502	53,788	347,286	1,447
African American	991	21	148	47	775	0	8,601	201	1,419	343	6,638	0
Other/unknown	25,507	831	3,313	2,076	19,279	8	237,564	8,411	35,315	16,133	177,642	63
Use of Nursing Facilities[c]												
Entire year	3,250	2,793	453	4	0	0	32,192	27,424	4,720	48	0	0
Part year	1,693	1,220	439	32	1	1	14,854	10,110	4,347	373	12	12
None	91,298	4,033	17,774	9,350	59,966	175	819,160	37,096	179,169	69,843	531,554	1,498
Maintenance Assistance Status												
Cash	34,081	1,921	14,860	1,502	15,798	0	335,377	21,047	157,198	13,580	143,552	0
Medically needy	7,432	5,121	2,291	19	1	0	59,429	43,147	16,243	27	12	0
Poverty-related	34,706	0	0	4,603	29,927	176	288,261	0	0	24,754	261,997	1,510
Other/unknown	20,022	1,004	1,515	3,262	14,241	0	183,139	10,436	14,795	31,903	126,005	0
Dual Medicare Status[d]												
Full dual, all year	16,239	7,925	7,080	1,222	10	2	159,074	73,958	70,636	14,352	104	24
Full dual, part year	0	0	0	0	0	0	0	0	0	0	0	0
Non-dual, all year	80,002	121	11,586	8,164	59,957	174	707,132	672	117,600	55,912	531,462	1,486
Managed Care (MC) Status												
Fee-for-service (FFS) all year	96,234	8,046	18,665	9,386	59,961	176	866,181	74,630	188,231	70,264	531,546	1,510
FFS part year, with Rx claims	4	0	1	0	3	0	16	0	5	0	11	0
FFS part year, no Rx claims	3	0	0	0	3	0	9	0	0	0	9	0

Source: Data for this table are from the MAX 2007 file for Montana, released by CMS in 3/2010. This table was produced on 04/19/2011.

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]
MONTANA, 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	**51.3**	**6.8**	**$570**	**$84**	**$6,141**	**9.3**	**96,241**
Age							
5 and younger	52.7	2.4	137	58	2,438	5.6	27,538
6-14	48.2	4.0	400	100	3,071	13.0	23,982
15-20	55.9	6.2	564	91	5,044	11.2	12,621
21-44	61.8	11.3	1,118	99	7,761	14.4	13,218
45-64	58.2	24.4	1,905	78	12,152	15.7	9,916
65-74	28.3	3.4	154	45	11,396	1.3	3,294
75-84	24.5	1.7	33	19	18,557	0.2	2,785
85 and older	23.8	1.6	29	18	25,728	0.1	2,887
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	25.5	2.1	56	27	19,584	0.3	8,046
Disabled	59.0	19.9	1,976	100	12,752	15.5	18,666
Adults	63.2	7.1	415	58	4,901	8.5	9,386
Children	50.5	3.2	219	68	2,451	8.9	59,967
Unknown	76.7	29.0	2,565	89	14,020	18.3	176
Gender							
Female	52.7	7.4	537	73	6,402	8.4	53,835
Male	49.5	6.0	611	101	5,810	10.5	42,406
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	55.2	7.8	659	84	6,707	9.8	69,743
African American	56.0	6.2	483	78	3,791	12.7	991
Other/unknown	40.6	3.9	327	83	4,685	7.0	25,507
Use of Nursing Facilities[f]							
Entire year	33.2	6.1	357	59	38,117	0.9	3,250
Part year	45.0	11.4	820	72	26,108	3.1	1,693
None	52.1	6.7	573	85	4,633	12.4	91,298
Maintenance Assistance Status							
Cash	52.1	11.2	1,061	95	6,369	16.7	34,081
Medically needy	30.9	4.2	240	57	22,512	1.1	7,432
Poverty related	52.7	3.1	174	57	1,968	8.8	34,706
Other/unknown	55.1	6.7	542	81	6,911	7.8	20,022

Source: Data for this table are from the MAX 2007 file for Montana, released by CMS in 3/2010. This table was produced on 04/19/2011.
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]
MONTANA, 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	**0.8**	**$63**	**9.3**	**48.7**	**39.8**	**4.4**	**4.5**	**1.9**	**0.6**	**$682**	**96,241**	**866,206**
Age												
5 and younger	0.3	16	5.6	47.3	50.4	1.6	0.6	0.0	0.0	279	27,538	240,752
6-14	0.4	43	13.0	51.8	40.5	4.0	3.3	0.4	0.0	329	23,982	224,039
15-20	0.7	67	11.2	44.1	42.5	6.5	5.9	1.0	0.1	598	12,621	106,479
21-44	1.3	131	14.4	38.2	38.7	8.9	9.6	3.9	0.8	911	13,218	112,658
45-64	2.5	192	15.7	41.8	22.8	6.8	13.1	11.0	4.5	1,224	9,916	98,453
65-74	0.4	16	1.3	71.7	23.2	2.4	1.6	1.0	0.2	1,183	3,294	31,736
75-84	0.2	4	0.2	75.5	21.9	1.9	0.6	0.1	0.0	2,008	2,785	25,732
85 and older	0.2	3	0.1	76.2	21.5	1.7	0.4	0.1	0.1	2,818	2,887	26,357
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	6	0.3	74.5	22.5	2.0	0.7	0.2	0.0	2,111	8,046	74,630
Disabled	2.0	196	15.5	41.0	27.2	7.7	13.0	8.2	2.9	1,265	18,666	188,236
Adults	1.0	56	8.5	36.8	45.7	8.9	6.6	1.9	0.2	655	9,386	70,264
Children	0.4	25	8.9	49.5	45.2	3.1	2.0	0.2	0.0	277	59,967	531,566
Unknown	3.4	299	18.3	23.3	22.2	9.7	32.4	9.7	2.8	1,634	176	1,510
Gender												
Female	0.8	61	8.4	47.3	40.5	4.7	4.5	2.2	0.8	722	53,835	477,035
Male	0.7	67	10.5	50.5	38.9	4.2	4.5	1.6	0.4	633	42,406	389,171
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	0.9	74	9.8	44.8	41.9	5.0	5.3	2.3	0.8	754	69,743	620,041
African American	0.7	56	12.7	44.0	45.3	5.0	3.9	1.2	0.5	437	991	8,601
Other/unknown	0.4	35	7.0	59.4	34.0	3.0	2.5	0.9	0.2	503	25,507	237,564
Use of Nursing Facilities[f]												
Entire year	0.6	36	0.9	66.8	24.8	3.1	2.0	2.3	1.0	3,848	3,250	32,192
Part year	1.3	93	3.1	55.0	30.8	3.2	4.1	4.1	2.8	2,976	1,693	14,854
None	0.7	64	12.4	47.9	40.5	4.5	4.6	1.9	0.5	516	91,298	819,160
Maintenance Assistance Status												
Cash	1.1	108	16.7	47.9	34.2	5.4	7.3	3.9	1.3	647	34,081	335,377
Medically needy	0.5	30	1.1	69.1	23.0	3.1	2.6	1.7	0.7	2,815	7,432	59,429
Poverty related	0.4	21	8.8	47.3	46.9	3.6	2.0	0.2	0.0	237	34,706	288,261
Other/unknown	0.7	59	7.8	44.9	43.5	4.8	4.9	1.6	0.3	756	20,022	183,139

Source: Data for this table are from the MAX 2007 file for Montana, released by CMS in 3/2010. This table was produced on 04/19/2011.
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]
MONTANA, 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	**0.8**	**$63**	**$84**	**0.2**	**$45**	**$201**	**0.0**	**$5**	**$141**	**0.5**	**$13**	**$27**
Age												
5 and younger	0.3	16	58	0.1	11	198	0.0	1	69	0.2	4	21
6-14	0.4	43	100	0.2	36	175	0.0	1	102	0.2	6	26
15-20	0.7	67	91	0.3	52	190	0.0	3	122	0.4	11	26
21-44	1.3	131	99	0.4	97	264	0.1	8	157	0.9	26	29
45-64	2.5	192	78	0.6	119	185	0.1	23	159	1.7	50	30
65-74	0.4	16	45	0.0	8	159	0.0	2	127	0.3	6	21
75-84	0.2	4	19	0.0	1	87	0.0	0	47	0.2	3	16
85 and older	0.2	3	18	0.0	1	93	0.0	0	71	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	6	27	0.0	2	124	0.0	1	98	0.2	3	17
Disabled	2.0	196	100	0.6	140	240	0.1	16	158	1.3	39	31
Adults	1.0	56	58	0.2	34	161	0.0	5	137	0.7	16	23
Children	0.4	25	68	0.1	19	146	0.0	1	91	0.2	5	23
Unknown	3.4	299	89	1.0	223	223	0.2	19	117	2.2	57	26
Gender												
Female	0.8	61	73	0.2	41	183	0.0	5	137	0.6	15	26
Male	0.7	67	101	0.2	50	222	0.0	4	146	0.4	12	30
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.9	74	84	0.3	53	198	0.0	6	140	0.6	16	27
African American	0.7	56	78	0.2	41	182	0.0	3	98	0.5	12	26
Other/unknown	0.4	35	83	0.1	25	220	0.0	2	147	0.3	8	27
Use of Nursing Facilities[e]												
Entire year	0.6	36	59	0.1	22	192	0.0	3	126	0.5	12	24
Part year	1.3	93	72	0.3	58	205	0.1	10	145	0.9	25	27
None	0.7	64	85	0.2	46	201	0.0	5	141	0.5	13	27
Maintenance Assistance Status												
Cash	1.1	108	95	0.3	78	232	0.1	8	151	0.7	22	29
Medically needy	0.5	30	57	0.1	17	189	0.0	3	140	0.4	10	24
Poverty related	0.4	21	57	0.1	15	134	0.0	1	96	0.2	5	21
Other/unknown	0.7	59	81	0.2	43	172	0.0	4	132	0.4	12	27

Source: Data for this table are from the MAX 2007 file for Montana, released by CMS in 3/2010. This table was produced on 04/19/2011.
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.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, 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	$11	$5	$1	$6	$48	$267	$96	$27	68,801	$3,282,648	28,882	30.0	296,214
Biologicals	0.3	0.3	0.0	0.0	377	377	0	0	1164	1,164	0	0	598	696,304	206	0.2	1,849
Antineoplastic Agents	0.7	0.3	0.0	0.4	191	166	2	23	290	613	922	59	2,303	666,935	327	0.3	3,498
Endocrine/Metabolic Drugs	0.6	0.2	0.0	0.4	41	31	1	10	71	160	37	26	52,866	3,737,355	8,985	9.3	90,647
Cardiovascular Agents	1.1	0.1	0.1	0.8	43	13	15	15	41	97	118	19	63,791	2,617,949	5,662	5.9	60,233
Respiratory Agents	0.4	0.2	0.0	0.2	31	25	2	4	75	116	102	22	63,702	4,788,372	14,699	15.3	154,213
Gastrointestinal Agents	0.4	0.1	0.0	0.3	44	32	5	7	105	229	261	27	20,714	2,164,629	4,729	4.9	48,978
Genitourinary Agents	0.3	0.1	0.0	0.2	19	13	1	5	61	97	68	31	7,549	460,096	2,377	2.5	23,689
CNS Drugs	1.0	0.4	0.0	0.6	107	86	4	17	109	237	121	30	137,149	15,011,933	13,471	14.0	140,836
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.1	85	80	1	4	111	126	63	36	30,839	3,421,301	3,736	3.9	40,074
Miscellaneous Psychological/ Neurological Agents	0.3	0.3	0.0	0.0	95	95	0	1	366	369	0	133	2,862	1,046,616	1,010	1.0	10,999
Analgesics and Anesthetics	0.6	0.0	0.0	0.5	34	10	8	15	59	315	371	29	73,453	4,347,928	13,085	13.6	129,368
Neuromuscular Agents	0.9	0.3	0.0	0.5	87	58	8	21	100	187	160	42	65,850	6,607,462	7,053	7.3	76,004
Nutritional Products	0.3	0.0	0.0	0.3	4	0	0	4	14	32	16	13	19,270	271,880	6,422	6.7	65,019
Hematological Agents	0.6	0.1	0.0	0.4	286	279	1	6	501	1,901	27	15	7,806	3,914,427	1,356	1.4	13,705
Topical Products	0.2	0.0	0.0	0.1	8	5	0	3	40	93	64	21	31,474	1,260,361	15,303	15.9	159,805
Miscellaneous Products	0.6	0.2	0.0	0.3	226	186	11	29	374	754	271	92	1,184	443,296	185	0.2	1,962
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	14	0	0	0	77	0	0	0	1,026	78,753	525	0.5	5,636
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.	651,237	54,818,245	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Montana, released by CMS in 3/2010. This table was produced on 04/19/2011.
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, 0.6 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.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]
MONTANA, 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	$10,658,460	5,531	5.7	60,923	0.7	$260	$175
ANTICONVULSANT	5,957,011	6,213	6.5	67,794	0.7	120	88
ANTIASTHMATIC	3,549,571	13,062	13.6	138,228	0.3	84	26
ANTIDEPRESSANTS	3,439,251	9,633	10.0	101,597	0.5	63	34
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	3,421,301	4,335	4.5	46,795	0.7	111	73
ANALGESICS - Narcotic	3,063,098	16,204	16.8	162,020	0.4	54	19
MISC. HEMATOLOGICAL	2,749,949	227	0.2	2,387	0.6	1,894	1,152
MISC. ENDOCRINE	1,591,053	700	0.7	7,735	0.6	364	206
ANTIDIABETIC	1,443,771	2,439	2.5	26,173	0.7	82	55
ULCER DRUGS	1,434,214	5,986	6.2	63,314	0.5	48	23
Total	37,307,679	64,330	n.a.	676,966	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Montana, released by CMS in 3/2010. This table was produced on 04/19/2011.
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.