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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
UTAH, 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]	288419 (A)	31345 (E)	257074 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	256267 (B)	28816 (F)	227451 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	244237 (C)	28359 (G)	215878 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2897 (D)	2586 (H)	311 (L)

Source: Data for this table are from the MAX 2007 file for Utah, released by CMS in 10/2010. 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 Utah in 2007 was $136,717,377, of which $8,845,214 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.

All Medicaid Beneficiaries

TABLE 2

CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY[a, b]

UTAH, 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	**244,237**	**12,597**	**34,881**	**48,058**	**148,447**	**254**	**1,689,852**	**106,638**	**293,873**	**312,831**	**974,628**	**1,882**
Age												
5 and younger	84,054	0	1,367	0	82,687	0	542,145	0	10,295	0	531,850	0
6-14	51,893	0	2,383	10	49,500	0	356,328	0	19,874	35	336,419	0
15-20	23,255	0	1,903	5,109	16,243	0	148,246	0	15,791	26,189	106,266	0
21-44	53,628	0	13,187	40,354	16	71	377,879	0	111,342	265,960	81	496
45-64	18,046	0	15,283	2,581	1	181	152,079	0	130,085	20,612	12	1,370
65-74	6,215	5,537	673	3	0	2	52,318	46,520	5,759	23	0	16
75-84	4,462	4,387	74	1	0	0	38,399	37,745	642	12	0	0
85 and older	2,684	2,673	11	0	0	0	22,458	22,373	85	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	139,774	8,935	18,062	40,625	71,898	254	967,486	76,505	153,853	262,352	472,894	1,882
Male	104,026	3,662	16,819	7,433	76,112	0	721,316	30,133	140,020	50,479	500,684	0
Unknown	437	0	0	0	437	0	1,050	0	0	0	1,050	0
Race												
White	172,843	9,206	29,385	36,300	97,733	219	1,216,789	77,388	248,302	245,041	644,442	1,616
African American	5,966	133	772	981	4,076	4	42,188	1,111	6,148	6,791	28,119	19
Other/unknown	65,428	3,258	4,724	10,777	46,638	31	430,875	28,139	39,423	60,999	302,067	247
Use of Nursing Facilities[c]												
Entire year	2,897	2,148	748	0	1	0	28,607	20,474	8,121	0	12	0
Part year	2,335	1,463	852	5	15	0	20,405	12,473	7,760	44	128	0
None	239,005	8,986	33,281	48,053	148,431	254	1,640,840	73,691	277,992	312,787	974,488	1,882
Maintenance Assistance Status												
Cash	84,981	3,544	16,904	19,375	45,158	0	635,792	31,638	144,897	146,440	312,817	0
Medically needy	6,365	1,457	2,941	927	1,040	0	38,883	10,130	21,038	3,787	3,928	0
Poverty-related	92,331	3,399	8,542	16,716	63,420	254	572,012	28,385	67,709	79,830	394,206	1,882
Other/unknown	60,560	4,197	6,494	11,040	38,829	0	443,165	36,485	60,229	82,774	263,677	0
Dual Medicare Status[d]												
Full dual, all year	26,246	11,662	14,368	206	2	8	224,898	99,105	124,015	1,720	11	47
Full dual, part year	2,113	675	1,428	10	0	0	18,654	5,845	12,728	81	0	0
Non-dual, all year	215,878	260	19,085	47,842	148,445	246	1,446,300	1,688	157,130	311,030	974,617	1,835
Managed Care (MC) Status												
Fee-for-service (FFS) all year	102,269	5,526	8,523	38,908	49,256	56	629,174	46,869	70,682	262,183	249,178	262
FFS part year, with Rx claims	96,846	2,790	19,167	7,695	67,005	189	756,832	23,644	164,280	45,657	521,675	1,576
FFS part year, no Rx claims	45,122	4,281	7,191	1,455	32,186	9	303,846	36,125	58,911	4,991	203,775	44

Source: Data for this table are from the MAX 2007 file for Utah, released by CMS in 10/2010. 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]

UTAH, 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	**61.4**	**7.2**	**$524**	**$73**	**$4,132**	**12.7**	**244,237**
Age							
5 and younger	62.8	2.8	110	39	1,854	5.9	84,054
6-14	54.1	4.0	370	94	1,765	20.9	51,893
15-20	64.9	7.0	686	98	4,912	14.0	23,255
21-44	69.6	11.6	860	74	5,627	15.3	53,628
45-64	67.6	26.7	1,978	74	11,414	17.3	18,046
65-74	35.7	4.1	196	47	7,088	2.8	6,215
75-84	31.7	2.4	70	29	10,789	0.6	4,462
85 and older	34.2	2.6	67	25	17,779	0.4	2,684
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	33.5	2.9	106	36	10,604	1.0	12,597
Disabled	67.1	23.0	2,155	94	13,857	15.6	34,881
Adults	71.5	8.8	454	52	2,656	17.1	48,058
Children	59.2	3.3	194	60	1,754	11.1	148,447
Unknown	90.9	33.1	2,762	83	16,521	16.7	254
Gender							
Female	63.9	8.1	522	65	3,913	13.3	139,774
Male	58.4	6.0	529	88	4,443	11.9	104,026
Unknown	0.9	0.0	0	16	153	0.1	437
Race							
White	63.9	8.4	631	75	4,815	13.1	172,843
African American	59.3	6.5	500	77	3,136	15.9	5,966
Other/unknown	55.1	4.0	241	61	2,420	10.0	65,428
Use of Nursing Facilities[f]							
Entire year	54.6	18.8	1,114	59	41,837	2.7	2,897
Part year	59.4	21.1	1,341	64	33,241	4.0	2,335
None	61.5	6.9	508	74	3,391	15.0	239,005
Maintenance Assistance Status							
Cash	64.1	10.3	804	78	3,328	24.1	84,981
Medically needy	40.1	8.4	654	78	6,249	10.5	6,365
Poverty related	58.7	4.3	241	57	1,793	13.4	92,331
Other/unknown	64.2	7.1	548	77	8,604	6.4	60,560

Source: Data for this table are from the MAX 2007 file for Utah, released by CMS in 10/2010. 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]

UTAH, 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	**1.0**	**$76**	**12.7**	**38.6**	**45.6**	**6.4**	**6.0**	**2.5**	**1.0**	**$597**	**244,237**	**1,689,852**
Age												
5 and younger	0.4	17	5.9	37.2	57.0	4.0	1.6	0.2	0.0	287	84,054	542,145
6-14	0.6	54	20.9	45.9	44.5	4.5	4.0	1.0	0.1	257	51,893	356,328
15-20	1.1	108	14.0	35.1	44.6	9.1	8.4	2.5	0.4	771	23,255	148,246
21-44	1.7	122	15.3	30.4	40.7	11.1	11.8	4.6	1.3	799	53,628	377,879
45-64	3.2	235	17.3	32.4	26.1	7.6	14.5	11.5	7.9	1,354	18,046	152,079
65-74	0.5	23	2.8	64.3	27.1	3.5	3.1	1.3	0.7	842	6,215	52,318
75-84	0.3	8	0.6	68.3	26.2	2.4	2.0	0.8	0.3	1,254	4,462	38,399
85 and older	0.3	8	0.4	65.8	27.3	3.6	1.8	1.2	0.3	2,125	2,684	22,458
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	0.3	13	1.0	66.5	26.8	3.1	2.3	1.0	0.4	1,253	12,597	106,638
Disabled	2.7	256	15.6	32.9	28.1	8.1	14.3	10.7	5.9	1,645	34,881	293,873
Adults	1.4	70	17.1	28.5	45.3	12.1	11.1	2.8	0.4	408	48,058	312,831
Children	0.5	30	11.1	40.8	51.5	4.4	2.7	0.5	0.1	267	148,447	974,628
Unknown	4.5	373	16.7	9.1	21.7	13.0	27.6	20.5	8.3	2,230	254	1,882
Gender												
Female	1.2	75	13.3	36.1	46.1	7.2	6.7	2.7	1.2	565	139,774	967,486
Male	0.9	76	11.9	41.6	45.2	5.3	5.1	2.1	0.7	641	104,026	721,316
Unknown	0.0	0	0.1	99.1	0.7	0.2	0.0	0.0	0.0	64	437	1,050
Race												
White	1.2	90	13.1	36.1	45.5	7.2	7.1	3.0	1.2	684	172,843	1,216,789
African American	0.9	71	15.9	40.7	44.3	6.1	5.6	2.5	0.8	444	5,966	42,188
Other/unknown	0.6	37	10.0	44.9	46.3	4.3	3.1	1.0	0.3	368	65,428	430,875
Use of Nursing Facilities[f]												
Entire year	1.9	113	2.7	45.4	30.9	6.5	5.7	5.2	6.3	4,237	2,897	28,607
Part year	2.4	153	4.0	40.6	31.9	5.8	6.5	7.2	8.0	3,804	2,335	20,405
None	1.0	74	15.0	38.5	46.0	6.4	6.0	2.4	0.8	494	239,005	1,640,840
Maintenance Assistance Status												
Cash	1.4	107	24.1	35.9	44.3	6.7	7.6	3.7	1.8	445	84,981	635,792
Medically needy	1.4	107	10.5	59.9	22.4	4.7	7.0	4.1	1.9	1,023	6,365	38,883
Poverty related	0.7	39	13.4	41.3	46.7	6.0	4.2	1.3	0.4	290	92,331	572,012
Other/unknown	1.0	75	6.4	35.8	48.3	6.6	6.3	2.3	0.6	1,176	60,560	443,165

Source: Data for this table are from the MAX 2007 file for Utah, released by CMS in 10/2010. 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]

UTAH, 2007

Beneficiary Characteristics	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.0**	**$76**	**$73**	**0.3**	**$51**	**$173**	**0.0**	**$3**	**$112**	**0.7**	**$21**	**$30**
Age												
5 and younger	0.4	17	39	0.1	9	111	0.0	1	66	0.3	7	21
6-14	0.6	54	94	0.2	43	176	0.0	2	116	0.3	9	30
15-20	1.1	108	98	0.4	83	208	0.0	4	149	0.7	22	32
21-44	1.7	122	74	0.4	81	185	0.0	5	130	1.2	36	31
45-64	3.2	235	74	0.9	151	164	0.1	10	114	2.2	73	34
65-74	0.5	23	47	0.1	13	134	0.0	1	92	0.4	9	23
75-84	0.3	8	29	0.0	4	103	0.0	0	82	0.2	4	18
85 and older	0.3	8	25	0.0	3	86	0.0	0	71	0.3	5	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.3	13	36	0.1	6	121	0.0	1	86	0.3	6	20
Disabled	2.7	256	94	0.9	184	208	0.1	10	125	1.8	62	35
Adults	1.4	70	52	0.3	38	130	0.0	3	123	1.0	28	27
Children	0.5	30	60	0.1	20	138	0.0	1	86	0.3	8	25
Unknown	4.5	373	83	1.4	241	174	0.1	13	148	3.0	119	40
Gender												
Female	1.2	75	65	0.3	48	157	0.0	3	110	0.8	24	29
Male	0.9	76	88	0.3	55	196	0.0	3	114	0.6	18	32
Unknown	0.0	0	16	0.0	0	0	0.0	0	0	0.0	0	16
Race												
White	1.2	90	75	0.4	61	174	0.0	4	113	0.8	25	31
African American	0.9	71	77	0.3	49	171	0.0	3	131	0.6	18	30
Other/unknown	0.6	37	61	0.1	24	167	0.0	2	102	0.4	12	26
Use of Nursing Facilities[e]												
Entire year	1.9	113	59	0.5	74	160	0.0	3	83	1.4	36	25
Part year	2.4	153	64	0.6	93	166	0.0	5	97	1.8	55	31
None	1.0	74	74	0.3	50	174	0.0	3	112	0.7	21	30
Maintenance Assistance Status												
Cash	1.4	107	78	0.4	74	182	0.0	4	119	0.9	29	31
Medically needy	1.4	107	78	0.4	70	184	0.0	5	118	0.9	32	34
Poverty related	0.7	39	57	0.2	23	147	0.0	2	97	0.5	14	27
Other/unknown	1.0	75	77	0.3	53	172	0.0	3	109	0.6	19	30

Source: Data for this table are from the MAX 2007 file for Utah, released by CMS in 10/2010. 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 Utah, 0.4 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.

All Medicaid Beneficiaries

TABLE 6

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY[a, b, c, d]

UTAH, 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	0.3	0.0	0.0	0.3	$15	$7	$1	$8	$52	$287	$90	$29	211,407	$10,959,064	90,030	36.9	711,608
Biologicals	0.2	0.2	0.0	0.0	62	62	0	0	397	397	0	0	773	307,195	506	0.2	4,969
Antineoplastic Agents	0.7	0.3	0.0	0.4	237	206	5	26	331	790	573	58	4,288	1,418,476	699	0.3	5,974
Endocrine/Metabolic Drugs	0.6	0.2	0.0	0.4	36	26	1	10	62	128	54	26	135,312	8,444,220	28,218	11.6	232,655
Cardiovascular Agents	1.1	0.3	0.1	0.8	51	28	5	19	46	102	70	25	132,362	6,126,937	13,874	5.7	120,100
Respiratory Agents	0.4	0.2	0.0	0.2	27	21	1	5	64	109	75	24	159,911	10,252,781	47,073	19.3	385,737
Gastrointestinal Agents	0.5	0.2	0.0	0.3	46	30	3	13	92	137	115	50	93,371	8,546,465	22,826	9.3	187,447
Genitourinary Agents	0.3	0.1	0.0	0.2	13	7	0	6	44	88	59	27	20,571	902,883	8,817	3.6	70,945
CNS Drugs	1.1	0.4	0.0	0.7	109	84	2	23	100	224	112	33	352,993	35,247,550	37,812	15.5	323,984
Stimulants/Anti-obesity/Anorexia	0.9	0.7	0.0	0.2	103	96	1	7	116	132	64	44	49,975	5,795,888	6,745	2.8	56,037
Miscellaneous Psychological/ Neurological Agents	0.3	0.3	0.0	0.0	102	100	0	2	311	324	0	103	5,679	1,765,339	1,872	0.8	17,354
Analgesics and Anesthetics	0.6	0.0	0.0	0.5	24	6	2	16	42	205	317	29	248,367	10,327,334	53,432	21.9	433,811
Neuromuscular Agents	0.9	0.4	0.0	0.5	96	68	6	22	104	192	179	41	160,886	16,795,333	19,640	8.0	174,819
Nutritional Products	0.3	0.0	0.0	0.3	4	1	0	4	14	14	12	14	54,078	756,469	25,230	10.3	184,800
Hematological Agents	0.7	0.2	0.0	0.5	201	191	1	10	278	1,019	36	19	16,740	4,649,697	2,722	1.1	23,079
Topical Products	0.3	0.1	0.0	0.2	11	6	0	4	42	103	66	22	99,422	4,137,182	49,534	20.3	392,922
Miscellaneous Products	0.3	0.2	0.0	0.1	46	40	0	6	177	205	298	94	7,005	1,236,537	3,290	1.3	26,734
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	26	0	0	0	116	0	0	0	1,755	202,813	912	0.4	7,896
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.	1,754,895	127,872,163	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Utah, released by CMS in 10/2010. 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 Utah, 0.4 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]

UTAH, 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	$17,369,269	10,532	4.3	94,451	0.7	$273	$184
ANTICONVULSANT	12,591,229	15,378	6.3	139,881	0.7	125	90
ANTIDEPRESSANTS	8,195,409	28,389	11.6	252,063	0.5	63	33
ANALGESICS - Narcotic	6,428,186	48,453	19.8	417,535	0.4	43	15
ULCER DRUGS	5,715,073	18,644	7.6	159,820	0.4	88	36
ANTIASTHMATIC	5,349,418	25,416	10.4	214,491	0.3	79	25
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	4,495,412	6,774	2.8	57,470	0.7	116	78
ANTIDIABETIC	3,001,479	6,453	2.6	57,376	0.6	83	52
MISC. HEMATOLOGICAL	2,882,827	624	0.3	5,486	0.6	892	525
ANTIVIRAL	2,324,887	3,020	1.2	26,149	0.3	323	89
Total	68,353,189	163,683	n.a.	1,424,722	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Utah, released by CMS in 10/2010. 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.