STATISTICAL COMPENDIUM: MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003 NEBRASKA

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEBRASKA, 2003

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries	(Cell)	Number of Dual Eligible Beneficiaries	(Cell)[g]	Number of Non-dual Eligible Beneficiaries	(Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	264,654	(A)	38,715	(E)	225,939	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	262,631	(B)	36,709	(F)	225,922	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	232,210	(C)	36,661	(G)	195,549	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	7,795	(D)	7,273	(H)	522	(L)

Source: Data for this table are from the MAX 2003 file for Nebraska, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003 (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 2003, 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 Nebraska in 2003 was $204,350,120, of which $1,271,602 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 19 states in 2003 that had PHPs that did not include a pharmacy benefit: AL, AR, CA, CO, FL, GA, IA, KY, MA, MI, NY, OR, PA, SD, TN, TX, UT, WA, and WI. In addition, there were 7 states in which MC plans did not provide a pharmacy benefit: DE, IA, NE, NY, TX, UT, and WV. These lists were constructed from the CMS 2003 Medicaid Managed Care Enrollment Report [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer02.pdf] 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 2003. 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 benficiary 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 2003. 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]

NEBRASKA, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**232,210**	**22,225**	**29,572**	**44,282**	**136,131**	**0**	**1,565,420**	**221,951**	**290,516**	**178,722**	**874,231**	**0**
Age												
5 and younger	56,244	2	800	105	55,337	0	361,707	6	6,759	303	354,639	0
6-14	55,046	0	1,603	9	53,434	0	375,917	0	15,921	55	359,941	0
15-20	27,189	29	1,346	895	24,919	0	166,156	85	12,309	3,010	150,752	0
21-44	44,015	112	11,730	30,534	1,639	0	256,859	415	116,090	133,759	6,595	0
45-64	16,638	62	13,816	2,758	2	0	149,203	464	136,676	12,060	3	0
65-74	7,169	6,882	277	10	0	0	74,059	71,228	2,761	70	0	0
75-84	7,790	7,790	0	0	0	0	79,439	79,439	0	0	0	0
85 and older	7,350	7,348	0	2	0	0	70,317	70,314	0	3	0	0
Unknown	10,769	0	0	9,969	800	0	31,763	0	0	29,462	2,301	0
Gender												
Female	131,811	16,505	15,803	30,855	68,648	0	902,637	166,682	157,419	138,768	439,768	0
Male	96,666	5,720	13,769	9,858	67,319	0	655,103	55,269	133,097	32,744	433,993	0
Unknown	3,733	0	0	3,569	164	0	7,680	0	0	7,210	470	0
Race												
White	156,279	19,308	22,995	27,677	86,299	0	1,089,818	192,536	228,511	110,994	557,777	0
African American	28,061	1,214	3,696	6,380	16,771	0	203,757	12,788	35,833	32,236	122,900	0
Other/unknown	47,870	1,703	2,881	10,225	33,061	0	271,845	16,627	26,172	35,492	193,554	0
Use of Nursing Facilities[c]												
Entire year	7,795	6,800	989	4	2	0	76,521	65,969	10,506	22	24	0
Part year	3,509	2,733	738	20	18	0	32,839	25,838	6,794	98	109	0
None	220,906	12,692	27,845	44,258	136,111	0	1,456,060	130,144	273,216	178,602	874,098	0
Maintenance Assistance Status												
Cash	60,503	4,303	17,742	13,707	24,751	0	445,062	46,295	175,799	57,326	165,642	0
Medically needy	26,638	10,352	2,198	9,498	4,590	0	174,529	96,465	20,717	38,512	18,835	0
Poverty-related	109,854	7,551	9,144	9,071	84,088	0	704,514	78,975	88,613	27,430	509,496	0
Other/unknown	35,215	19	488	12,006	22,702	0	241,315	216	5,387	55,454	180,258	0
Dual Medicare Status[d]												
Full dual, all year	36,168	20,538	15,377	239	14	0	370,164	206,576	162,238	1,285	65	0
Full dual, part year	493	298	195	0	0	0	4,701	2,821	1,880	0	0	0
Non-dual, all year	195,549	1,389	14,000	44,043	136,117	0	1,190,555	12,554	126,398	177,437	874,166	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	53,335	21,237	17,445	6,721	7,932	0	453,576	212,831	183,545	14,326	42,874	0
FFS part year, with Rx claims	63,949	278	3,675	17,053	42,943	0	127,522	1,226	13,925	30,558	81,813	0
FFS part year, no Rx claims	24,479	32	466	5,659	18,322	0	46,875	83	1,357	10,078	35,357	0
MC all year, with FFS Rx claims	90,447	678	7,986	14,849	66,934	0	937,447	7,811	91,689	123,760	714,187	0

Source: Data for this table are from the MAX 2003 file for Nebraska, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003. 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]

NEBRASKA, 2003

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	**82.2 %**	**15.9**	**$875**	**$55**	**$3,835**	**22.8 %**	**232,210**
Age							
5 and younger	84.9	5.7	182	32	1,277	14.3	56,244
6-14	78.9	5.9	388	66	983	39.4	55,046
15-20	79.9	7.8	480	62	1,912	25.1	27,189
21-44	83.1	16.8	1,144	68	3,792	30.2	44,015
45-64	89.4	48.9	3,071	63	10,279	29.9	16,638
65-74	90.0	54.2	2,712	50	11,041	24.6	7,169
75-84	92.9	57.8	2,624	45	15,093	17.4	7,790
85 and older	95.9	55.8	2,207	40	21,363	10.3	7,350
Unknown	52.7	2.6	80	31	1,951	4.1	10,769
Basis of Eligibility[e]							
Aged	92.6	55.6	2,491	45	15,781	15.8	22,225
Disabled	90.6	44.1	3,154	72	10,594	29.8	29,572
Adults	74.5	8.0	364	45	1,712	21.2	44,282
Children	81.1	5.8	282	49	1,107	25.4	136,131
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	85.0	18.7	964	52	4,187	23.0	131,811
Male	80.2	12.6	785	63	3,473	22.6	96,666
Unknown	35.6	1.1	34	30	803	4.2	3,733
Race							
White	83.9	19.2	1,081	56	4,698	23.0	156,279
African American	82.0	11.5	606	53	2,471	24.5	28,061
Other/unknown	76.5	7.6	357	47	1,818	19.7	47,870
Use of Nursing Facilities[f]							
Entire year	97.4	71.0	3,426	48	35,808	9.6	7,795
Part year	97.0	66.6	3,197	48	25,152	12.7	3,509
None	81.4	13.1	748	57	2,368	31.6	220,906
Maintenance Assistance Status							
Cash	84.1	20.0	1,244	62	3,818	32.6	60,503
Medically needy	83.0	34.1	1,611	47	15,126	10.6	26,638
Poverty related	79.9	11.4	613	54	1,804	34.0	109,854
Other/unknown	85.3	8.9	497	56	1,661	29.9	35,215

Source: Data for this table are from the MAX 2003 file for Nebraska, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 seven states (DE, IA, NE, NY, 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 seven states (DE, IA, NE, NY, 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]

NEBRASKA, 2003

				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	**2.4**	**$130**	**22.8 %**	**17.8 %**	**41.5 %**	**10.2 %**	**14.8 %**	**9.9 %**	**5.7 %**	**$569**	**232,210**	**1,565,420**
Age												
5 and younger	0.9	28	14.3	15.1	55.7	10.3	10.6	5.3	3.0	199	56,244	361,707
6-14	0.9	57	39.4	21.1	55.2	8.7	9.2	3.3	2.5	144	55,046	375,917
15-20	1.3	79	25.1	20.1	46.8	10.7	12.4	5.6	4.5	313	27,189	166,156
21-44	2.9	196	30.2	16.9	32.3	13.1	18.5	10.7	8.6	650	44,015	256,859
45-64	5.4	342	29.9	10.6	14.9	9.6	25.3	24.7	14.7	1,146	16,638	149,203
65-74	5.3	263	24.6	10.0	14.2	9.1	26.1	28.5	12.0	1,069	7,169	74,059
75-84	5.7	257	17.4	7.1	9.9	8.8	28.2	33.2	12.8	1,480	7,790	79,439
85 and older	5.8	231	10.3	4.1	7.2	7.6	32.3	38.3	10.5	2,233	7,350	70,317
Unknown	0.9	27	4.1	47.3	26.7	9.4	11.0	4.1	1.5	662	10,769	31,763
Basis of Eligibility[e]												
Aged	5.6	250	15.8	7.4	10.5	8.5	28.8	33.1	11.6	1,580	22,225	221,951
Disabled	4.5	321	29.8	9.4	21.5	11.1	25.2	21.1	11.6	1,078	29,572	290,516
Adults	2.0	90	21.2	25.5	32.5	12.2	15.0	7.5	7.1	424	44,282	178,722
Children	0.9	44	25.4	18.9	53.8	9.7	10.2	4.5	3.0	172	136,131	874,231
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.7	141	23.0	15.0	39.9	10.6	15.9	11.6	6.9	611	131,811	902,637
Male	1.9	116	22.6	19.8	44.5	9.9	13.6	7.9	4.2	513	96,666	655,103
Unknown	0.6	17	4.2	64.4	20.1	7.3	6.2	1.6	0.5	390	3,733	7,680
Race												
White	2.7	155	23.0	16.1	39.0	10.4	16.1	11.7	6.7	674	156,279	1,089,818
African American	1.6	83	24.5	18.0	48.6	9.6	12.5	7.1	4.2	340	28,061	203,757
Other/unknown	1.3	63	19.7	23.5	45.4	9.9	11.9	5.8	3.5	320	47,870	271,845
Use of Nursing Facilities[f]												
Entire year	7.2	349	9.6	2.6	3.9	5.2	26.4	42.8	19.1	3,648	7,795	76,521
Part year	7.1	342	12.7	3.0	5.6	6.2	25.9	40.3	18.9	2,688	3,509	32,839
None	2.0	113	31.6	18.6	43.4	10.5	14.2	8.3	5.0	359	220,906	1,456,060
Maintenance Assistance Status												
Cash	2.7	169	32.6	15.9	37.8	10.8	17.0	11.3	7.2	519	60,503	445,062
Medically needy	5.2	246	10.6	17.0	20.2	9.1	19.7	22.4	11.6	2,309	26,638	174,529
Poverty related	1.8	96	34.0	20.1	45.9	9.8	13.0	7.4	3.8	281	109,854	704,514
Other/unknown	1.3	73	29.9	14.7	50.4	11.6	12.9	5.7	4.7	242	35,215	241,315

Source: Data for this table are from the MAX 2003 file for Nebraska, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 seven states (DE, IA, NE, NY, 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 seven states (DE, IA, NE, NY, 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]

NEBRASKA, 2003

	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	**2.4**	**$130**	**$55**	**1.0**	**$104**	**$102**	**0.1**	**$4**	**$39**	**1.2**	**$22**	**$18**
Age												
5 and younger	0.9	28	32	0.3	20	60	0.0	1	40	0.5	7	15
6-14	0.9	57	66	0.5	48	104	0.0	2	58	0.4	7	20
15-20	1.3	79	62	0.6	64	101	0.0	2	63	0.6	13	21
21-44	2.9	196	68	1.3	162	128	0.1	5	51	1.5	29	19
45-64	5.4	342	63	2.4	277	117	0.2	9	44	2.9	55	19
65-74	5.3	263	50	2.3	210	92	0.2	6	30	2.7	46	17
75-84	5.7	257	45	2.4	202	85	0.2	6	25	3.0	49	16
85 and older	5.8	231	40	2.2	174	79	0.3	7	21	3.3	50	15
Unknown	0.9	27	31	0.2	18	76	0.0	1	27	0.6	8	13
Basis of Eligibility[d]												
Aged	5.6	250	45	2.3	195	85	0.3	6	24	3.0	48	16
Disabled	4.5	321	72	2.0	265	131	0.2	9	50	2.3	47	21
Adults	2.0	90	45	0.8	71	90	0.1	2	35	1.1	17	15
Children	0.9	44	49	0.4	34	84	0.0	1	49	0.4	8	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.7	141	52	1.2	112	96	0.1	4	35	1.4	25	17
Male	1.9	116	63	0.8	94	114	0.1	3	47	0.9	18	19
Unknown	0.6	17	30	0.2	11	72	0.0	0	23	0.4	5	13
Race												
White	2.7	155	56	1.2	125	103	0.1	4	38	1.4	26	18
African American	1.6	83	53	0.7	67	101	0.0	2	44	0.9	14	16
Other/unknown	1.3	63	47	0.5	49	93	0.0	2	40	0.7	12	16
Use of Nursing Facilities[e]												
Entire year	7.2	349	48	2.9	273	94	0.4	9	24	4.0	67	17
Part year	7.1	342	48	2.8	267	94	0.3	8	26	4.0	65	17
None	2.0	113	57	0.9	91	104	0.1	3	44	1.0	19	18
Maintenance Assistance Status												
Cash	2.7	169	62	1.2	137	116	0.1	5	47	1.4	27	19
Medically needy	5.2	246	47	2.1	192	91	0.2	6	26	2.9	47	17
Poverty related	1.8	96	54	0.8	76	99	0.1	3	41	0.9	16	18
Other/unknown	1.3	73	56	0.6	60	93	0.0	2	47	0.6	11	18

Source: Data for this table are from the MAX 2003 file for Nebraska, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 Nebraska, 0.8 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 combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007)

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]

NEBRASKA, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total 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			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.4	0.2	0.0	0.2	$18	$13	$1	$4	$49	$78	$69	$22	367,810	$18,175,293	130,928	56.4 %	1,027,085
Biologicals	0.1	0.1	0.0	0.0	45	9	0	36	323	84	1,905	1,200	653	210,760	529	0.2	4,656
Antineoplastic Agents	0.6	0.3	0.0	0.3	157	142	3	13	263	461	128	47	9,705	2,552,557	1,687	0.7	16,245
Endocrine/Metabolic Drugs	0.8	0.4	0.1	0.3	36	29	2	5	44	71	21	16	343,542	15,109,091	50,241	21.6	422,253
Cardiovascular Agents	1.7	0.7	0.1	1.0	58	44	1	12	34	67	18	13	589,059	19,952,373	36,139	15.6	346,812
Respiratory Agents	0.5	0.2	0.0	0.3	23	18	1	5	43	79	38	17	416,690	18,108,498	98,042	42.2	786,658
Gastrointestinal Agents	0.7	0.2	0.0	0.5	33	22	1	10	49	121	138	21	212,834	10,442,781	35,341	15.2	318,284
Genitourinary Agents	0.5	0.4	0.0	0.1	32	30	0	2	64	76	38	19	67,265	4,333,065	16,225	7.0	136,931
CNS Drugs	1.3	0.8	0.0	0.5	120	106	2	12	91	138	94	22	584,022	52,995,415	51,034	22.0	440,946
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	72	63	2	7	86	97	71	44	71,421	6,111,587	10,016	4.3	85,200
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	118	117	0	1	161	167	0	21	15,943	2,561,553	2,208	1.0	21,799
Analgesics and Anesthetics	0.7	0.2	0.0	0.5	31	23	1	7	46	137	57	14	377,801	17,421,940	70,559	30.4	570,913
Neuromuscular Agents	0.9	0.4	0.1	0.4	71	58	2	11	78	133	45	25	231,156	18,024,008	27,963	12.0	253,546
Nutritional Products	0.5	0.0	0.0	0.4	7	0	0	6	14	25	19	14	93,795	1,318,627	26,473	11.4	198,708
Hematological Agents	0.8	0.2	0.1	0.5	72	65	1	6	88	297	14	11	75,977	6,685,652	9,524	4.1	92,875
Topical Products	0.3	0.1	0.0	0.2	12	8	1	3	39	61	55	19	200,030	7,715,120	74,025	31.9	621,663
Miscellaneous Products	0.4	0.1	0.1	0.2	75	52	12	11	178	365	224	50	4,267	760,377	1,097	0.5	10,128
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	6	0	0	0	30	0	0	0	19,762	599,821	12,974	5.6	106,488
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.	3,681,732	203,078,518	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Nebraska, released by CMS in 05/2007. This table was produced on 11/01/2007.

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.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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 Nebraska, 0.8 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.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2003.

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]

NEBRASKA, 2003

		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	$29,058,557	21,992	9.5 %	213,842	0.7	$182	$136
ANTIDEPRESSANTS	15,671,604	41,485	17.9	364,881	0.7	63	43
ANTICONVULSANT	13,873,043	18,269	7.9	178,614	0.8	94	78
ANTIASTHMATIC	9,432,342	46,499	20.0	397,466	0.4	60	24
ANALGESICS - Narcotic	7,547,994	55,739	24.0	462,100	0.4	40	16
ANTIDIABETIC	6,976,927	16,798	7.2	166,572	0.8	54	42
ANTIHYPERLIPIDEMIC	6,675,274	11,318	4.9	117,014	0.7	86	57
ULCER DRUGS	5,970,378	30,070	12.9	284,313	0.5	43	21
ANALGESICS - ANTI-INFLAMMATORY	5,709,385	38,179	16.4	320,870	0.4	50	18
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	5,013,480	10,421	4.5	88,495	0.7	86	57
Total	105,928,984	290,770		2,594,167	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Nebraska, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003. 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 2003. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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.