STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2004
INDIANA

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
INDIANA, 2004

Inclusion Criteria (2004)	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]	989,501	(A)	139,839	(E)	849,662	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	948,720	(B)	120,580	(F)	828,140	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	732,302	(C)	120,351	(G)	611,951	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	22,270	(D)	20,646	(H)	1,624	(L)

Source: Data for this table are from the MAX 2004 file for Indiana, released by CMS in 11/2007. This table was produced on 03/06/2008.

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 2004 (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 2004, 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 Indiana in 2004 was $754,838,123, of which $35,711,423 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 23 states in 2004 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NY, OK, OR, PA, SC, 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) and one state (NV) in which MC plans provided a pharmacy benefit for nonduals but not for duals. These lists were constructed from the CMS 2004 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer04.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 pa

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 2004. 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 2004. 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]

INDIANA, 2004

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**732,302**	**70,367**	**122,488**	**135,441**	**403,746**	**260**	**5,473,801**	**703,723**	**1,242,369**	**697,702**	**2,828,005**	**2,002**
Age												
5 and younger	162,312	0	2,133	3	160,176	0	1,085,625	0	17,850	4	1,067,771	0
6-14	180,802	0	5,637	12	175,153	0	1,327,165	0	50,727	48	1,276,390	0
15-20	86,833	0	4,310	14,436	68,083	4	604,302	0	40,652	81,355	482,274	21
21-44	162,683	0	47,115	115,144	330	94	1,068,978	0	479,526	587,293	1,544	615
45-64	68,934	60	62,889	5,822	2	161	680,848	333	650,331	28,826	2	1,356
65-74	26,479	26,053	403	21	1	1	276,104	272,651	3,271	160	12	10
75-84	24,676	24,673	1	2	0	0	247,330	247,305	12	13	0	0
85 and older	19,583	19,581	0	1	1	0	183,449	183,434	0	3	12	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Gender												
Female	433,847	51,442	65,465	117,796	198,884	260	3,203,806	522,675	670,675	618,321	1,390,133	2,002
Male	298,455	18,925	57,023	17,645	204,862	0	0 2,269,995	181,048	571,694	79,381	1,437,872	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	557,466	58,636	99,437	102,115	297,058	220	4,475,713	583,093	1,024,364	582,998	2,283,509	1,749
African American	124,711	8,651	19,561	26,460	70,005	34	0 714,726	89,093	184,688	88,211	352,521	213
Other/unknown	50,125	3,080	3,490	6,866	36,683	6	283,362	31,537	33,317	26,493	191,975	40
Use of Nursing Facilities[c]												
Entire year	22,270	19,222	3,015	0	33	0	227,864	193,963	33,524	0	377	0
Part year	15,701	12,559	3,111	17	14	0	151,155	118,457	32,402	148	148	0
None	694,331	38,586	116,362	135,424	403,699	260	5,094,782	391,303	1,176,443	697,554	2,827,480	2,002
Maintenance Assistance Status												
Cash	287,781	18,871	79,781	83,819	105,310	0	2,146,766	208,426	829,550	428,724	680,066	0
Medically needy	0	0	0	0	0	0		0	0	0	0	0
Poverty-related	251,485	1,385	1,501	20,528	227,811	260	1,798,240	14,778	15,761	95,574	1,670,125	2,002
Other/unknown	193,036	50,111	41,206	31,094	70,625	0	1,528,795	480,519	397,058	173,404	477,814	0
Dual Medicare Status[d]						0						
Full dual, all year	113,870	64,469	48,446	902	43	10	1,176,070	644,260	524,501	6,817	400	92
Full dual, part year	6,481	3,500	2,874	107	0	0	67,073	35,399	30,515	1,159	0	0
Non-dual, all year	611,951	2,398	71,168	134,432	403,703	250	4,230,658	24,064	687,353	689,726	2,827,605	1,910
Managed Care (MC) Status												
Fee-for-service (FFS) all year	508,784	70,347	116,444	74,721	247,012	260	4,664,663	703,603	1,215,088	500,955	2,243,015	2,002
FFS part year, with Rx claims	86,513	16	3,801	30,895	51,801	0	376,791	102	19,986	115,526	241,177	0
FFS part year, no Rx claims	137,005	4	2,243	29,825	104,933	0	432,347	18	7,295	81,221	343,813	0

Source: Data for this table are from the MAX 2004 file for Indiana, released by CMS in 11/2007. This table was produced on 03/06/2008.

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 2004. 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]

INDIANA, 2004

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	**60.7 %**	**15.4**	**$982**	**$64**	**$5,161**	**19.0 %**	**732,302**
Age							
5 and younger	52.1	2.9	125	44	1,697	7.4	162,312
6-14	49.6	4.1	306	74	1,691	18.1	180,802
15-20	54.6	5.5	521	94	2,846	18.3	86,833
21-44	64.6	14.1	1,075	77	6,249	17.2	162,683
45-64	80.7	48.0	3,295	69	13,344	24.7	68,934
65-74	82.0	51.8	2,778	54	10,321	26.9	26,479
75-84	88.2	59.4	2,914	49	14,736	19.8	24,676
85 and older	93.2	59.1	2,591	44	19,288	13.4	19,583
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	87.3	56.5	2,774	49	14,359	19.3	70,367
Disabled	81.1	41.4	3,329	80	15,012	22.2	122,488
Adults	57.9	5.9	241	41	2,318	10.4	135,441
Children	50.7	3.5	206	59	1,519	13.6	403,746
Unknown	81.9	24.0	1,393	58	10,255	13.6	260
Gender							
Female	62.8	17.4	984	56	5,115	19.2	433,847
Male	57.6	12.4	979	79	5,227	18.7	298,455
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	66.7	17.7	1,125	64	5,660	19.9	557,466
African American	43.0	9.0	600	66	3,967	15.1	124,711
Other/unknown	37.2	5.4	342	63	2,581	13.2	50,125
Use of Nursing Facilities[f]							
Entire year	98.8	84.5	4,262	50	31,363	13.6	22,270
Part year	98.4	72.8	3,804	52	23,475	16.2	15,701
None	58.6	11.9	813	68	3,906	20.8	694,331
Maintenance Assistance Status							
Cash	63.6	18.8	1,316	70	6,240	21.1	287,781
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	51.2	3.6	209	59	1,378	15.1	251,485
Other/unknown	68.7	25.7	1,491	58	8,480	17.6	193,036

Source: Data for this table are from the MAX 2004 file for Indiana, released by CMS in 11/2007. This table was produced on 03/06/2008.

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]

INDIANA, 2004

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: 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]	Number Beneficiaries	Benefit Months
All	**2.1**	**$131**	**19.0 %**	**39.3 %**	**35.1 %**	**6.7 %**	**9.5 %**	**6.8 %**	**2.6 %**	**$690**	**732,302**	**5,473,801**
Age												
5 and younger	0.4	19	7.4	47.9	46.9	3.6	1.4	0.2	0.0	254	162,312	1,085,625
6-14	0.6	42	18.1	50.4	40.6	4.9	3.7	0.4	0.1	230	180,802	1,327,165
15-20	0.8	75	18.3	45.4	41.5	6.9	5.1	0.9	0.2	409	86,833	604,302
21-44	2.1	164	17.2	35.4	32.9	10.4	13.6	6.2	1.4	951	162,683	1,068,978
45-64	4.9	334	24.7	19.3	14.7	9.2	23.9	23.2	9.8	1,351	68,934	680,848
65-74	5.0	266	26.9	18.0	14.1	8.2	23.0	25.1	11.6	990	26,479	276,104
75-84	5.9	291	19.8	11.8	9.9	7.0	24.3	32.0	15.0	1,470	24,676	247,330
85 and older	6.3	277	13.4	6.8	6.9	6.8	27.5	37.9	14.2	2,059	19,583	183,449
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	5.7	277	19.3	12.7	10.6	7.4	24.7	31.1	13.5	1,436	70,367	703,723
Disabled	4.1	328	22.2	18.9	20.0	10.7	24.1	19.2	7.2	1,480	122,488	1,242,369
Adults	1.2	47	10.4	42.1	37.0	9.4	8.7	2.5	0.3	450	135,441	697,702
Children	0.5	29	13.6	49.3	43.3	4.5	2.6	0.3	0.0	217	403,746	2,828,005
Unknown	3.1	181	13.6	18.1	26.5	13.8	26.5	14.6	0.4	1,332	260	2,002
Gender												
Female	2.4	133	19.2	37.2	34.5	7.0	10.1	8.0	3.2	693	433,847	3,203,806
Male	1.6	129	18.7	42.4	35.9	6.4	8.5	5.1	1.7	687	298,455	2,269,995
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.2	140	19.9	33.3	38.0	7.3	10.5	7.8	3.1	705	557,466	4,475,713
African American	1.6	105	15.1	57.0	25.2	5.4	7.2	4.2	1.1	692	124,711	714,726
Other/unknown	1.0	61	13.2	62.8	26.8	3.5	4.2	2.2	0.5	457	50,125	283,362
Use of Nursing Facilities[f]												
Entire year	8.3	417	13.6	1.2	3.1	3.9	22.5	42.3	27.0	3,065	22,270	227,864
Part year	7.6	395	16.2	1.6	4.8	5.7	26.2	40.7	21.0	2,438	15,701	151,155
None	1.6	111	20.8	41.4	36.8	6.8	8.7	4.9	1.4	532	694,331	5,094,782
Maintenance Assistance Status												
Cash	2.5	176	21.1	36.4	31.4	8.2	12.7	8.5	2.9	837	287,781	2,146,766
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.5	29	15.1	48.8	43.6	4.5	2.7	0.3	0.0	193	251,485	1,798,240
Other/unknown	3.2	188	17.6	31.3	29.4	7.4	13.5	12.8	5.5	1,071	193,036	1,528,795

Source: Data for this table are from the MAX 2004 file for Indiana, released by CMS in 11/2007. This table was produced on 03/06/2008.

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]

INDIANA, 2004

	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	**2.1**	**$131**	**$64**	**0.8**	**$101**	**$128**	**0.1**	**$8**	**$72**	**1.2**	**$22**	**$19**
Age												
5 and younger	0.4	19	44	0.1	13	97	0.0	1	42	0.3	4	17
6-14	0.6	42	74	0.3	35	118	0.0	1	59	0.2	5	22
15-20	0.8	75	94	0.3	65	189	0.0	2	64	0.4	8	19
21-44	2.1	164	77	0.8	126	167	0.1	11	98	1.3	26	21
45-64	4.9	334	69	1.8	252	138	0.2	23	96	2.8	58	21
65-74	5.0	266	54	1.9	201	106	0.2	15	60	2.8	50	18
75-84	5.9	291	49	2.3	219	95	0.3	16	46	3.3	56	17
85 and older	6.3	277	44	2.3	201	88	0.4	16	40	3.6	59	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.7	277	49	2.1	207	97	0.3	15	48	3.2	55	17
Disabled	4.1	328	80	1.6	257	163	0.2	21	98	2.3	50	22
Adults	1.2	47	41	0.3	32	100	0.0	3	68	0.8	12	15
Children	0.5	29	59	0.2	23	105	0.0	1	51	0.3	5	19
Unknown	3.1	181	58	1.0	134	132	0.1	8	61	2.0	40	20
Gender												
Female	2.4	133	56	0.9	100	114	0.1	8	66	1.4	25	19
Male	1.6	129	79	0.7	103	155	0.1	7	87	0.9	19	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.2	140	64	0.8	108	127	0.1	9	73	1.2	24	19
African American	1.6	105	66	0.6	81	141	0.1	5	72	0.9	18	20
Other/unknown	1.0	61	63	0.4	47	128	0.0	3	69	0.5	10	18
Use of Nursing Facilities[e]												
Entire year	8.3	417	50	3.1	307	100	0.5	26	49	4.6	83	18
Part year	7.6	395	52	2.8	292	105	0.5	24	52	4.3	78	18
None	1.6	111	68	0.6	86	138	0.1	7	83	0.9	18	20
Maintenance Assistance Status												
Cash	2.5	176	70	0.9	137	146	0.1	11	86	1.5	29	20
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.5	29	59	0.2	23	105	0.0	1	52	0.3	5	19
Other/unknown	3.2	188	58	1.2	143	115	0.2	12	63	1.8	34	19

Source: Data for this table are from the MAX 2004 file for Indiana, released by CMS in 11/2007. This table was produced on 03/06/2008.

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 Indiana, 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 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]

INDIANA, 2004

	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	0.1	0.0	0.2	$17	$12	$1	$4	$58	$118	$83	$21	837,174	$48,594,905	283,876	38.8 %	2,777,318
Biologicals	0.1	0.1	0.0	0.0	60	50	0	9	440	572	209	193	7,559	3,323,590	5,118	0.7	55,695
Antineoplastic Agents	0.5	0.1	0.0	0.4	92	62	1	28	181	600	196	71	34,605	6,261,100	6,757	0.9	68,257
Endocrine/Metabolic Drugs	0.7	0.3	0.1	0.3	37	29	2	6	53	96	27	18	975,880	51,347,097	135,122	18.5	1,370,890
Cardiovascular Agents	1.6	0.5	0.0	1.0	53	39	1	13	34	73	35	13	1,976,448	67,296,461	120,521	16.5	1,271,958
Respiratory Agents	0.5	0.2	0.0	0.2	25	21	0	4	51	84	33	17	1,011,160	51,734,143	205,749	28.1	2,056,468
Gastrointestinal Agents	0.7	0.2	0.0	0.4	38	27	2	9	59	136	48	22	697,532	40,825,574	102,073	13.9	1,071,318
Genitourinary Agents	0.4	0.3	0.0	0.1	26	21	1	3	60	83	50	21	160,693	9,563,492	36,158	4.9	372,712
CNS Drugs	1.2	0.6	0.1	0.5	111	93	6	12	95	163	101	23	1,944,911	184,305,988	164,151	22.4	1,661,118
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	62	56	1	5	86	97	87	39	234,377	20,195,955	33,534	4.6	326,477
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	112	108	0	3	172	177	103	93	122,346	21,086,868	18,150	2.5	189,098
Analgesics and Anesthetics	0.7	0.1	0.0	0.5	33	22	2	9	48	155	261	17	1,282,177	61,884,820	191,399	26.1	1,876,614
Neuromuscular Agents	0.8	0.3	0.1	0.4	67	41	15	11	79	148	116	24	779,940	61,714,611	88,176	12.0	923,892
Nutritional Products	0.5	0.0	0.0	0.5	11	1	1	9	20	29	26	19	291,508	5,844,992	57,331	7.8	553,695
Hematological Agents	0.8	0.3	0.1	0.4	129	118	3	8	171	430	45	19	321,929	55,190,139	40,652	5.6	426,612
Topical Products	0.3	0.1	0.0	0.2	13	8	1	4	42	76	50	22	534,819	22,270,065	167,294	22.8	1,698,091
Miscellaneous Products	0.5	0.2	0.0	0.3	98	77	9	11	214	463	269	44	32,342	6,918,335	6,719	0.9	70,500
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	7	0	0	0	24	0	0	0	31,479	768,565	10,510	1.4	112,779
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.	11,276,879	719,126,700	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Indiana, released by CMS in 11/2007. This table was produced on 03/06/2008.

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 Indiana, 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.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 2004.

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]

INDIANA, 2004

		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	$116,628,564	79,528	10.9 %	860,531	0.7	$207	$136
ANTIDEPRESSANTS	56,098,235	153,734	21.0	1,600,983	0.5	64	35
ANTICONVULSANT	53,248,921	73,935	10.1	797,188	0.7	98	67
MISC. HEMATOLOGICAL	40,653,595	17,561	2.4	190,447	0.6	358	213
ANALGESICS - Narcotic	36,554,192	212,727	29.0	2,152,759	0.4	42	17
ANTIASTHMATIC	32,082,764	147,165	20.1	1,528,079	0.3	63	21
ANTIDIABETIC	31,377,016	65,188	8.9	706,671	0.7	67	44
ANTIHYPERLIPIDEMIC	29,540,971	51,509	7.0	577,002	0.6	90	51
ULCER DRUGS	28,036,909	100,253	13.7	1,075,077	0.5	56	26
NEUROLOGICAL	21,296,100	22,346	3.1	234,391	0.5	169	91
Total	445,517,267	923,946		9,723,128	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Indiana, released by CMS in 11/2007. This table was produced on 03/06/2008.

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 2004. 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 2004. 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.