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

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEBRASKA, 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]	263,200	(A)	39,529	(E)	223,671	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	261,068	(B)	37,415	(F)	59,940	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	231,124	(C)	37,360	(G)	193,764	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	7,578	(D)	7,067	(H)	511	(L)

Source: Data for this table are from the MAX 2004 file for Nebraska, released by CMS in 11/2007. This table was produced on 03/25/2008.

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 Nebraska in 2004 was $231,623,820, of which $1,183,980 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]

NEBRASKA, 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	**231,124**	**21,916**	**30,846**	**47,070**	**130,943**	**349**	**1,608,048**	**221,264**	**305,159**	**201,580**	**878,207**	**1,838**
Age												
5 and younger	56,956	0	790	295	55,871	0	379,694	0	6,675	694	372,325	0
6-14	53,908	0	1,562	15	52,331	0	376,758	0	15,802	42	360,914	0
15-20	25,489	0	1,376	2,332	21,735	46	164,176	0	12,451	9,371	142,200	154
21-44	43,660	0	11,931	31,114	408	207	266,562	0	120,236	144,466	979	881
45-64	17,916	2	14,860	2,963	1	90	161,474	13	146,734	13,975	1	751
65-74	7,153	6,811	326	10	0	6	74,529	71,178	3,251	48	0	52
75-84	7,796	7,795	0	1	0	0	79,847	79,845	0	2	0	0
85 and older	7,310	7,308	1	1	0	0	70,239	70,228	10	1	0	0
Unknown	10,936	0	0	10,339	597	0	34,769	0	0	32,981	1,788	0
Gender												
Female	130,885	16,180	16,475	33,013	64,868	349	924,886	165,166	164,756	157,603	435,523	1,838
Male	96,141	5,736	14,371	10,114	65,920	0	674,651	56,098	140,403	35,945	442,205	0
Unknown	4,098	0	0	3,943	155	0	8,511	0	0	8,032	479	0
Race												
White	154,392	18,950	24,011	29,279	81,868	284	1,106,694	190,799	240,002	123,550	550,858	1,485
African American	28,111	1,197	3,798	6,991	16,114	11	211,092	12,809	37,076	37,904	123,253	50
Other/unknown	48,621	1,769	3,037	10,800	32,961	54	290,262	17,656	28,081	40,126	204,096	303
Use of Nursing Facilities[c]												
Entire year	7,578	6,552	1,021	2	3	0	74,448	63,585	10,836	2	25	0
Part year	3,580	2,709	825	31	15	0	33,309	25,563	7,453	163	130	0
None	219,966	12,655	29,000	47,037	130,925	349	1,500,291	132,116	286,870	201,415	878,052	1,838
Maintenance Assistance Status												
Cash	60,851	4,264	18,375	15,214	22,998	0	451,712	46,258	184,000	64,833	156,621	0
Medically needy	24,306	10,191	2,256	11,025	834	0	168,278	95,296	21,319	48,193	3,470	0
Poverty-related	116,363	7,440	9,747	10,311	88,516	349	772,373	79,476	94,808	32,807	563,444	1,838
Other/unknown	29,604	21	468	10,520	18,595	0	215,685	234	5,032	55,747	154,672	0
Dual Medicare Status[d]												
Full dual, all year	36,582	20,317	16,026	225	7	7	376,222	204,954	169,760	1,407	46	55
Full dual, part year	778	431	346	1	0	0	7,914	4,389	3,515	10	0	0
Non-dual, all year	193,764	1,168	14,474	46,844	130,936	342	1,223,912	11,921	131,884	200,163	878,161	1,783
Managed Care (MC) Status												
Fee-for-service (FFS) all year	53,653	20,947	18,321	6,543	7,513	329	463,966	211,826	194,121	13,976	42,290	1,753
FFS part year, with Rx claims	61,703	235	3,788	18,727	38,935	18	124,059	1,195	14,814	34,324	73,649	77
FFS part year, no Rx claims	23,926	30	432	5,784	17,678	2	46,167	111	1,359	10,468	34,221	8
MC all year, with FFS Rx claims	91,842	704	8,305	16,016	66,817	0	973,856	8,132	94,865	142,812	728,047	0

Source: Data for this table are from the MAX 2004 file for Nebraska, released by CMS in 11/2007. This table was produced on 03/25/2008.

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]

NEBRASKA, 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	**82.3 %**	**16.7**	**$997**	**$60**	**$4,250**	**23.5 %**	**231,124**
Age							
5 and younger	84.2	5.7	194	34	1,274	15.3	56,956
6-14	78.1	6.1	471	77	1,150	41.0	53,908
15-20	80.5	8.2	528	64	2,040	25.9	25,489
21-44	83.1	17.7	1,305	74	4,635	28.2	43,660
45-64	89.7	49.6	3,423	69	11,873	28.8	17,916
65-74	90.1	56.0	2,998	54	11,488	26.1	7,153
75-84	93.6	59.4	2,822	48	15,097	18.7	7,796
85 and older	95.5	58.6	2,409	41	21,409	11.3	7,310
Unknown	60.3	3.3	107	33	2,216	4.8	10,936
Basis of Eligibility[e]							
Aged	93.1	58.0	2,730	47	16,050	17.0	21,916
Disabled	91.1	45.4	3,513	77	12,591	27.9	30,846
Adults	76.3	8.5	409	48	1,910	21.4	47,070
Children	80.7	5.9	327	55	1,145	28.6	130,943
Unknown	47.9	7.6	493	65	6,365	7.8	349
Gender							
Female	85.1	19.6	1,087	56	4,543	23.9	130,885
Male	80.4	13.4	916	68	3,993	22.9	96,141
Unknown	39.2	1.3	50	40	908	5.5	4,098
Race							
White	84.0	20.2	1,233	61	5,255	23.5	154,392
African American	82.8	12.1	695	58	2,706	25.7	28,111
Other/unknown	76.8	8.1	423	53	1,949	21.7	48,621
Use of Nursing Facilities[f]							
Entire year	97.7	74.8	3,729	50	35,655	10.5	7,578
Part year	96.0	68.2	3,458	51	26,810	12.9	3,580
None	81.6	13.8	863	62	2,800	30.8	219,966
Maintenance Assistance Status							
Cash	83.4	20.7	1,412	68	4,616	30.6	60,851
Medically needy	85.1	39.1	1,947	50	16,669	11.7	24,306
Poverty related	79.7	11.6	683	59	2,053	33.2	116,363
Other/unknown	88.0	9.9	600	60	1,932	31.1	29,604

Source: Data for this table are from the MAX 2004 file for Nebraska, released by CMS in 11/2007. This table was produced on 03/25/2008.

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]

NEBRASKA, 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	**2.4**	**$143**	**23.5 %**	**17.7 %**	**41.7 %**	**9.9 %**	**14.5 %**	**10.2 %**	**5.9 %**	**$611**	**231,124**	**1,608,048**
Age												
5 and younger	0.9	29	15.3	15.8	56.8	9.5	9.9	5.1	2.9	191	56,956	379,694
6-14	0.9	67	41.0	21.9	54.9	8.4	8.9	3.4	2.6	165	53,908	376,758
15-20	1.3	82	25.9	19.5	47.8	11.2	12.0	5.1	4.3	317	25,489	164,176
21-44	2.9	214	28.2	16.9	32.4	12.5	18.3	11.5	8.4	759	43,660	266,562
45-64	5.5	380	28.8	10.3	15.0	9.6	25.3	24.3	15.6	1,317	17,916	161,474
65-74	5.4	288	26.1	9.9	13.8	9.5	24.8	29.4	12.7	1,103	7,153	74,529
75-84	5.8	276	18.7	6.4	9.7	8.1	28.3	33.9	13.5	1,474	7,796	79,847
85 and older	6.1	251	11.3	4.5	6.5	7.1	30.4	39.7	11.8	2,228	7,310	70,239
Unknown	1.0	34	4.8	39.7	30.5	10.5	12.0	5.4	2.0	697	10,936	34,769
Basis of Eligibility[e]												
Aged	5.7	270	17.0	6.9	10.0	8.2	28.0	34.3	12.6	1,590	21,916	221,264
Disabled	4.6	355	27.9	8.9	21.4	10.9	25.2	21.7	11.9	1,273	30,846	305,159
Adults	2.0	95	21.4	23.7	33.6	12.2	15.1	8.1	7.2	446	47,070	201,580
Children	0.9	49	28.6	19.3	54.8	9.2	9.5	4.3	2.9	171	130,943	878,207
Unknown	1.4	94	7.8	52.1	22.3	10.0	12.9	2.3	0.3	1,209	349	1,838
Gender												
Female	2.8	154	23.9	14.9	40.0	10.2	15.7	12.0	7.1	643	130,885	924,886
Male	1.9	131	22.9	19.6	44.9	9.6	13.2	8.2	4.5	569	96,141	674,651
Unknown	0.6	24	5.5	60.8	22.4	8.1	6.5	1.9	0.3	437	4,098	8,511
Race												
White	2.8	172	23.5	16.0	39.0	10.1	15.8	12.1	7.0	733	154,392	1,106,694
African American	1.6	93	25.7	17.2	49.6	9.5	12.2	7.5	4.1	360	28,111	211,092
Other/unknown	1.3	71	21.7	23.2	46.1	9.7	11.7	6.0	3.4	327	48,621	290,262
Use of Nursing Facilities[f]												
Entire year	7.6	380	10.5	2.3	3.3	4.7	24.1	43.6	22.1	3,629	7,578	74,448
Part year	7.3	372	12.9	4.0	4.6	5.4	25.9	39.1	20.9	2,882	3,580	33,309
None	2.0	127	30.8	18.4	43.7	10.2	14.0	8.6	5.1	411	219,966	1,500,291
Maintenance Assistance Status												
Cash	2.8	190	30.6	16.6	37.3	10.6	16.9	11.6	6.9	622	60,851	451,712
Medically needy	5.6	281	11.7	14.9	17.7	8.5	20.1	24.5	14.3	2,408	24,306	168,278
Poverty related	1.7	103	33.2	20.3	46.4	9.4	12.4	7.7	3.9	309	116,363	772,373
Other/unknown	1.4	82	31.1	12.0	52.2	12.0	13.2	5.8	4.8	265	29,604	215,685

Source: Data for this table are from the MAX 2004 file for Nebraska, released by CMS in 11/2007. This table was produced on 03/25/2008.

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]

NEBRASKA, 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	**2.4**	**$143**	**$60**	**0.9**	**$110**	**$118**	**0.1**	**$9**	**$62**	**1.3**	**$24**	**$19**
Age												
5 and younger	0.9	29	34	0.3	18	72	0.1	3	43	0.5	8	15
6-14	0.9	67	77	0.5	58	124	0.0	2	56	0.4	7	20
15-20	1.3	82	64	0.6	65	109	0.1	4	64	0.6	13	21
21-44	2.9	214	74	1.1	167	147	0.2	14	81	1.6	32	20
45-64	5.5	380	69	2.1	287	135	0.3	29	84	3.0	63	21
65-74	5.4	288	54	2.1	219	103	0.3	17	55	2.9	52	18
75-84	5.8	276	48	2.2	205	94	0.4	17	46	3.2	53	17
85 and older	6.1	251	41	2.0	179	89	0.4	15	36	3.6	56	16
Unknown	1.0	34	33	0.2	22	99	0.0	2	39	0.8	10	14
Basis of Eligibility[d]												
Aged	5.7	270	47	2.1	200	95	0.4	17	45	3.3	54	17
Disabled	4.6	355	77	1.8	276	150	0.3	26	86	2.4	53	22
Adults	2.0	95	48	0.7	71	103	0.1	6	59	1.2	19	16
Children	0.9	49	55	0.4	38	102	0.1	3	49	0.5	8	18
Unknown	1.4	94	65	0.5	72	143	0.1	3	52	0.9	18	21
Gender												
Female	2.8	154	56	1.0	116	111	0.2	10	59	1.5	28	18
Male	1.9	131	68	0.8	103	131	0.1	8	69	1.0	20	20
Unknown	0.6	24	40	0.1	17	120	0.0	1	39	0.4	6	14
Race												
White	2.8	172	61	1.1	132	119	0.2	11	62	1.5	29	19
African American	1.6	93	58	0.6	70	119	0.1	6	70	0.9	17	18
Other/unknown	1.3	71	53	0.5	53	112	0.1	5	57	0.8	14	17
Use of Nursing Facilities[e]												
Entire year	7.6	380	50	2.6	277	106	0.6	25	45	4.4	77	17
Part year	7.3	372	51	2.6	271	104	0.5	26	53	4.2	74	18
None	2.0	127	62	0.8	98	121	0.1	8	67	1.1	21	19
Maintenance Assistance Status												
Cash	2.8	190	68	1.1	147	134	0.2	13	76	1.5	30	20
Medically needy	5.6	281	50	2.0	207	104	0.4	18	48	3.2	56	17
Poverty related	1.7	103	59	0.7	78	115	0.1	7	63	1.0	18	18
Other/unknown	1.4	82	60	0.6	67	105	0.1	4	53	0.7	12	18

Source: Data for this table are from the MAX 2004 file for Nebraska, released by CMS in 11/2007. This table was produced on 03/25/2008.

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 Nebraska, 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]

NEBRASKA, 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	0.4	0.1	0.0	0.2	$18	$12	$2	$4	$50	$93	$64	$21	364,870	$18,267,492	128,709	55.7 %	1,038,569
Biologicals	0.2	0.1	0.0	0.1	163	41	0	122	863	328	0	1,892	149	128,654	85	0.0	791
Antineoplastic Agents	0.6	0.1	0.0	0.5	94	72	2	19	154	570	136	41	9,861	1,520,959	1,693	0.7	16,266
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.4	39	30	2	6	49	87	25	18	358,275	17,406,197	52,030	22.5	445,204
Cardiovascular Agents	1.7	0.6	0.1	1.0	64	48	3	13	37	75	30	13	637,147	23,502,689	38,160	16.5	369,233
Respiratory Agents	0.5	0.2	0.0	0.3	26	21	1	5	49	90	34	16	410,829	20,197,915	92,794	40.1	764,702
Gastrointestinal Agents	0.6	0.1	0.1	0.5	31	19	3	9	49	173	53	19	204,002	9,978,876	35,849	15.5	324,889
Genitourinary Agents	0.5	0.3	0.0	0.1	34	28	3	4	68	86	61	27	72,976	4,962,269	17,136	7.4	145,357
CNS Drugs	1.3	0.7	0.1	0.6	129	110	6	14	96	158	86	23	627,331	60,258,502	52,922	22.9	465,911
Stimulants/Anti-obesity/Anorexia	0.9	0.7	0.0	0.1	85	78	1	5	97	107	83	42	86,797	8,412,386	11,417	4.9	99,515
Miscellaneous Psychological/ Neurological Agents	0.8	0.8	0.0	0.0	166	166	0	0	215	219	0	24	24,701	5,306,092	3,224	1.4	31,901
Analgesics and Anesthetics	0.7	0.1	0.0	0.5	33	23	2	8	49	154	237	16	398,291	19,521,638	71,936	31.1	593,707
Neuromuscular Agents	1.0	0.4	0.2	0.5	83	53	17	12	85	148	112	27	247,321	21,137,551	27,530	11.9	255,939
Nutritional Products	0.5	0.0	0.0	0.5	7	0	0	7	15	22	19	14	99,451	1,453,660	27,584	11.9	207,380
Hematological Agents	0.8	0.2	0.1	0.5	82	73	3	6	98	324	39	12	84,273	8,293,871	10,386	4.5	101,648
Topical Products	0.3	0.1	0.0	0.2	14	9	1	4	43	74	53	20	214,888	9,139,406	78,043	33.8	665,016
Miscellaneous Products	0.4	0.1	0.0	0.2	60	37	9	13	153	306	225	58	5,323	814,617	1,451	0.6	13,594
Unknown Therapeutic Category	0.5	0.0	0.0	0.0	8	0	0	0	16	0	0	0	8,736	137,066	1,742	0.8	17,773
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.	3,855,221	230,439,840	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Nebraska, released by CMS in 11/2007. This table was produced on 03/25/2008.

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 Nebraska, 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]

NEBRASKA, 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	$35,533,470	23,919	10.3 %	234,788	0.8	$200	$151
ANTICONVULSANT	16,401,031	19,802	8.6	195,554	0.8	102	84
ANTIDEPRESSANTS	15,624,991	43,716	18.9	392,522	0.7	59	40
ANTIASTHMATIC	11,594,759	50,898	22.0	442,281	0.4	66	26
ANALGESICS - Narcotic	8,862,376	58,570	25.3	494,129	0.4	43	18
ANTIHYPERLIPIDEMIC	8,461,555	13,921	6.0	144,115	0.7	89	59
ANTIDIABETIC	8,413,271	18,023	7.8	179,600	0.8	61	47
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	6,887,007	11,485	5.0	99,570	0.7	96	69
MISC. HEMATOLOGICAL	5,784,949	3,449	1.5	35,676	0.7	244	162
ANALGESICS - ANTI-INFLAMMATORY	5,406,863	36,834	15.9	315,069	0.3	49	17
Total	122,970,272	280,617		2,533,304	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Nebraska, released by CMS in 11/2007. This table was produced on 03/25/2008.

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.