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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2005
INDIANA

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
INDIANA, 2005

Inclusion Criteria (2005)	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]	1028626 (A)	149719 (E)	878907 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	979665 (B)	124701 (F)	854964 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	709120 (C)	124346 (G)	584774 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	22030 (D)	20431 (H)	1599 (L)

Source: Data for this table are from the MAX 2005 file for Indiana, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 2005 (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 2005, 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 2005 was $744,872,363, of which $8,915,998 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 26 states in 2005 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NH, NV, NY, OH, 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, 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 2005 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer05.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 2005. 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 N+B18D.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 2005. 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, 2005

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**709,120**	**68,850**	**129,314**	**132,973**	**377,754**	**229**	**4,278,039**	**684,178**	**1,311,766**	**484,645**	**1,795,441**	**2,009**
Age												
5 and younger	148,482	0	1,926	1	146,555	0	657,687	0	12,490	3	645,194	0
6-14	169,320	0	5,444	21	163,855	0	845,791	0	39,649	83	806,059	0
15-20	85,901	0	4,308	14,598	66,995	0	441,244	0	37,330	61,166	342,748	0
21-44	162,301	1	49,415	112,503	341	41	912,861	12	507,657	403,512	1,384	296
45-64	73,847	45	67,781	5,835	2	184	733,108	189	711,412	19,812	15	1,680
65-74	25,946	25,489	440	10	3	4	268,952	265,622	3,228	50	19	33
75-84	23,834	23,829	0	3	2	0	237,564	237,534	0	10	20	0
85 and older	19,489	19,486	0	2	1	0	180,832	180,821	0	9	2	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	421,371	50,255	68,800	115,812	186,275	229	2,527,061	506,765	704,125	431,833	882,329	2,009
Male	287,749	18,595	60,514	17,161	191,479	0	1,750,978	177,413	607,641	52,812	913,112	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	533,899	57,393	105,019	99,240	272,056	191	3,413,859	567,156	1,081,355	390,365	1,373,315	1,668
African American	123,091	8,307	20,580	26,598	67,580	26	620,518	84,774	194,739	71,140	269,632	233
Other/unknown	52,130	3,150	3,715	7,135	38,118	12	243,662	32,248	35,672	23,140	152,494	108
Use of Nursing Facilities[c]												
Entire year	22,030	18,968	3,036	0	26	0	223,072	189,166	33,598	0	308	0
Part year	15,956	12,523	3,392	25	15	1	152,833	117,442	35,115	146	120	10
None	671,134	37,359	122,886	132,948	377,713	228	3,902,134	377,570	1,243,053	484,499	1,795,013	1,999
Maintenance Assistance Status												
Cash	258,795	14,845	64,079	81,680	98,191	0	1,500,044	161,048	639,027	288,539	411,430	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	246,116	3,997	4,743	21,215	215,932	229	1,232,119	42,478	50,824	81,671	1,055,137	2,009
Other/unknown	204,209	50,008	60,492	30,078	63,631	0	1,545,876	480,652	621,915	114,435	328,874	0
Dual Medicare Status[d]												
Full dual, all year	106,730	58,215	47,841	624	35	15	1,107,757	572,832	531,519	2,991	273	142
Full dual, part year	17,616	8,432	9,154	30	0	0	191,481	89,959	101,271	251	0	0
Non-dual, all year	584,774	2,203	72,319	132,319	377,719	214	2,978,801	21,387	678,976	481,403	1,795,168	1,867
Managed Care (MC) Status												
Fee-for-service (FFS) all year	292,687	68,824	118,113	32,833	72,689	228	2,496,799	684,002	1,255,048	113,889	441,853	2,007
FFS part year, with Rx claims	201,967	23	8,104	57,109	136,731	0	1,040,487	148	45,931	245,565	748,843	0
FFS part year, no Rx claims	214,466	3	3,097	43,031	168,334	1	740,753	28	10,787	125,191	604,745	2

Source: Data for this table are from the MAX 2005 file for Indiana, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 2005. 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, 2005

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	**56.5**	**15.4**	**$1,038**	**$67**	**$5,953**	**17.4**	**709,120**
Age							
5 and younger	42.9	1.8	86	47	1,707	5.0	148,482
6-14	43.3	3.0	244	82	1,804	13.5	169,320
15-20	48.3	4.2	437	104	2,882	15.2	85,901
21-44	61.3	12.9	1,121	87	6,720	16.7	162,301
45-64	83.0	49.4	3,534	72	14,973	23.6	73,847
65-74	84.6	54.4	3,002	55	12,036	24.9	25,946
75-84	89.0	60.4	3,027	50	18,168	16.7	23,834
85 and older	93.3	60.4	2,646	44	24,270	10.9	19,489
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	88.6	58.2	2,911	50	17,628	16.5	68,850
Disabled	83.3	42.8	3,546	83	16,225	21.9	129,314
Adults	51.6	3.5	132	38	2,309	5.7	132,973
Children	43.2	2.4	156	65	1,585	9.9	377,754
Unknown	84.7	27.6	1,802	65	15,037	12.0	229
Gender							
Female	58.6	17.2	1,022	59	5,866	17.4	421,371
Male	53.5	12.7	1,061	84	6,079	17.5	287,749
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	62.3	17.8	1,194	67	6,598	18.1	533,899
African American	40.8	9.1	654	72	4,517	14.5	123,091
Other/unknown	33.9	5.3	349	66	2,736	12.7	52,130
Use of Nursing Facilities[f]							
Entire year	98.5	87.3	4,444	51	39,055	11.4	22,030
Part year	97.8	71.8	3,783	53	27,501	13.8	15,956
None	54.1	11.7	861	74	4,354	19.8	671,134
Maintenance Assistance Status							
Cash	57.7	15.6	1,087	70	5,697	19.1	258,795
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	44.9	2.8	181	65	1,473	12.3	246,116
Other/unknown	68.9	30.3	2,009	66	11,675	17.2	204,209

Source: Data for this table are from the MAX 2005 file for Indiana, released by CMS in 10/2008. This table was produced on 04/23/2009.

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, 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 eight states (DE, IA, IL, 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, 2005

				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	**2.6**	**$172**	**17.4**	**43.5**	**29.1**	**7.1**	**10.2**	**7.4**	**2.8**	**$987**	**709,120**	**4,278,039**
Age												
5 and younger	0.4	19	5.0	57.1	36.6	4.2	1.9	0.2	0.0	385	148,482	657,687
6-14	0.6	49	13.5	56.7	33.3	5.2	4.0	0.6	0.1	361	169,320	845,791
15-20	0.8	85	15.2	51.7	34.9	6.9	5.3	1.1	0.2	561	85,901	441,244
21-44	2.3	199	16.7	38.7	29.3	10.2	13.8	6.4	1.6	1,195	162,301	912,861
45-64	5.0	356	23.6	17.0	14.8	9.7	24.7	23.8	10.0	1,508	73,847	733,108
65-74	5.2	290	24.9	15.4	13.4	8.6	24.3	26.0	12.3	1,161	25,946	268,952
75-84	6.1	304	16.7	11.0	9.8	7.2	24.4	32.2	15.5	1,823	23,834	237,564
85 and older	6.5	285	10.9	6.7	6.3	6.9	26.5	38.5	15.0	2,616	19,489	180,832
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	5.9	293	16.5	11.4	10.2	7.6	24.9	31.7	14.2	1,774	68,850	684,178
Disabled	4.2	350	21.9	16.7	20.0	11.1	24.9	19.8	7.5	1,600	129,314	1,311,766
Adults	1.0	36	5.7	48.4	31.6	8.8	8.3	2.5	0.4	634	132,973	484,645
Children	0.5	33	9.9	56.8	34.7	4.9	3.1	0.4	0.1	334	377,754	1,795,441
Unknown	3.1	205	12.0	15.3	24.5	16.2	28.4	14.0	1.7	1,714	229	2,009
Gender												
Female	2.9	170	17.4	41.4	28.8	7.2	10.7	8.5	3.4	978	421,371	2,527,061
Male	2.1	174	17.5	46.5	29.5	6.9	9.4	5.7	2.0	999	287,749	1,750,978
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.8	187	18.1	37.7	31.3	7.7	11.3	8.6	3.5	1,032	533,899	3,413,859
African American	1.8	130	14.5	59.2	22.0	5.8	7.6	4.3	1.2	896	123,091	620,518
Other/unknown	1.1	75	12.7	66.1	22.8	3.9	4.6	2.1	0.6	585	52,130	243,662
Use of Nursing Facilities[f]												
Entire year	8.6	439	11.4	1.5	2.7	3.6	20.3	43.0	29.0	3,857	22,030	223,072
Part year	7.5	395	13.8	2.2	4.6	6.2	25.9	40.1	20.9	2,871	15,956	152,833
None	2.0	148	19.8	45.9	30.5	7.2	9.5	5.4	1.6	749	671,134	3,902,134
Maintenance Assistance Status												
Cash	2.7	188	19.1	42.3	27.3	8.2	12.0	7.6	2.7	983	258,795	1,500,044
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.6	36	12.3	55.1	35.8	5.1	3.5	0.5	0.1	294	246,116	1,232,119
Other/unknown	4.0	265	17.2	31.1	23.3	8.0	16.0	15.2	6.4	1,542	204,209	1,545,876

Source: Data for this table are from the MAX 2005 file for Indiana, released by CMS in 10/2008. This table was produced on 04/23/2009.

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, 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 eight states (DE, IA, IL, 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, 2005

	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	**2.6**	**$172**	**$67**	**1.0**	**$136**	**$142**	**0.1**	**$7**	**$87**	**1.5**	**$29**	**$19**
Age												
5 and younger	0.4	19	47	0.1	15	109	0.0	0	49	0.3	4	16
6-14	0.6	49	82	0.3	42	137	0.0	2	78	0.3	5	20
15-20	0.8	85	104	0.4	75	211	0.0	3	71	0.4	8	19
21-44	2.3	199	87	0.8	161	194	0.1	9	111	1.4	29	21
45-64	5.0	356	72	1.9	276	149	0.1	17	111	3.0	63	21
65-74	5.2	290	55	2.0	225	114	0.1	10	69	3.1	54	18
75-84	6.1	304	50	2.3	235	103	0.2	9	51	3.6	59	17
85 and older	6.5	285	44	2.3	211	92	0.2	10	46	4.0	64	16
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.9	293	50	2.2	225	104	0.2	10	55	3.5	59	17
Disabled	4.2	350	83	1.6	280	174	0.1	15	113	2.5	54	22
Adults	1.0	36	38	0.2	25	104	0.0	2	70	0.7	9	14
Children	0.5	33	65	0.2	27	121	0.0	1	69	0.3	5	18
Unknown	3.1	205	65	1.2	172	143	0.1	4	66	1.9	30	16
Gender												
Female	2.9	170	59	1.0	132	126	0.1	7	77	1.7	32	18
Male	2.1	174	84	0.8	143	171	0.1	7	106	1.2	25	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.8	187	67	1.1	147	140	0.1	8	87	1.6	32	19
African American	1.8	130	72	0.7	106	160	0.0	4	88	1.1	20	18
Other/unknown	1.1	75	66	0.4	61	138	0.0	3	84	0.7	11	17
Use of Nursing Facilities[e]												
Entire year	8.6	439	51	3.1	331	107	0.3	14	52	5.2	93	18
Part year	7.5	395	53	2.6	297	112	0.2	15	60	4.6	83	18
None	2.0	148	74	0.8	119	154	0.1	6	100	1.2	23	20
Maintenance Assistance Status												
Cash	2.7	188	70	1.0	148	152	0.1	8	98	1.6	32	19
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.6	36	65	0.2	30	127	0.0	1	70	0.3	5	18
Other/unknown	4.0	265	66	1.5	210	137	0.1	10	82	2.3	45	19

Source: Data for this table are from the MAX 2005 file for Indiana, released by CMS in 10/2008. This table was produced on 04/23/2009.

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, 0.2 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)

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, 2005

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per 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	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	$21	$15	$2	$4	$60	$163	$67	$18	725,038	$43,842,176	248,288	35.0	2,039,783
Biologicals	0.1	0.1	0.0	0.0	39	27	3	10	331	365	3,592	221	9,784	3,238,778	7,495	1.1	82,969
Antineoplastic Agents	0.5	0.1	0.0	0.4	99	78	0	21	197	625	229	55	35,073	6,892,738	6,923	1.0	69,666
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.4	45	35	4	7	54	106	51	16	982,857	53,273,138	124,464	17.6	1,172,018
Cardiovascular Agents	1.6	0.6	0.0	1.0	59	48	0	11	37	78	25	11	2,060,177	75,523,880	123,402	17.4	1,276,249
Respiratory Agents	0.6	0.3	0.0	0.3	31	26	1	4	54	99	57	14	852,762	45,737,999	174,254	24.6	1,468,506
Gastrointestinal Agents	0.7	0.3	0.0	0.4	47	37	0	9	66	147	49	20	692,948	45,795,983	96,679	13.6	978,805
Genitourinary Agents	0.5	0.3	0.0	0.2	30	26	0	4	61	86	55	21	168,709	10,331,007	34,615	4.9	344,487
CNS Drugs	1.3	0.7	0.0	0.6	129	115	3	11	100	175	140	18	1,924,274	192,352,859	156,005	22.0	1,494,786
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.1	73	68	1	5	98	113	98	33	171,586	16,733,634	30,217	4.3	227,696
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	132	129	0	3	178	182	114	93	149,846	26,649,264	19,545	2.8	201,972
Analgesics and Anesthetics	0.8	0.1	0.0	0.7	38	15	7	17	49	159	234	25	1,200,738	58,740,691	171,238	24.1	1,534,351
Neuromuscular Agents	0.9	0.3	0.0	0.6	72	50	3	20	80	166	86	35	800,623	64,202,077	87,922	12.4	885,875
Nutritional Products	0.6	0.0	0.0	0.5	9	1	0	7	15	25	27	15	273,370	4,217,776	53,328	7.5	490,843
Hematological Agents	0.8	0.3	0.0	0.4	136	130	1	5	175	422	34	12	334,835	58,555,875	41,236	5.8	430,116
Topical Products	0.4	0.1	0.0	0.2	17	12	1	5	44	85	46	20	478,079	20,851,428	136,657	19.3	1,225,495
Miscellaneous Products	0.4	0.2	0.0	0.2	105	90	5	9	236	445	239	43	35,785	8,455,803	7,720	1.1	80,620
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	8	0	0	0	30	0	0	0	18,910	561,259	6,732	0.9	69,096
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.	10,915,394	735,956,365	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Indiana, released by CMS in 10/2008. This table was produced on 04/23/2009.

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, 0.2 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 2005.

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, 2005

Top 10 Drug Groups	Total Medicaid Rx $	Users: Number	Users: As a Percentage of All Beneficiaries	Number of Benefit Months	Among Users: Number of Rx per Benefit Month	Among Users: $ per Rx	Among Users: Rx $ per Benefit Month
ANTIPSYCHOTICS	$129,837,850	78,849	11.1	823,563	0.7	$224	$158
ANTICONVULSANT	56,305,368	75,313	10.6	785,852	0.7	101	72
ANTIDEPRESSANTS	50,046,099	146,510	20.7	1,463,889	0.6	59	34
MISC. HEMATOLOGICAL	42,019,826	18,615	2.6	201,324	0.6	345	209
ANTIHYPERLIPIDEMIC	36,301,238	60,618	8.5	674,326	0.6	94	54
ANALGESICS - Narcotic	34,546,378	191,953	27.1	1,814,157	0.5	42	19
ANTIDIABETIC	32,861,309	70,676	10.0	758,721	0.7	66	43
ULCER DRUGS	32,331,448	95,764	13.5	996,439	0.5	62	32
ANTIASTHMATIC	31,144,420	135,339	19.1	1,256,562	0.4	66	25
MISC PSYCHOTHERAPEUTIC AND NEUROLOGICAL	26,871,766	24,947	3.5	259,278	0.6	175	104
Total	472,265,702	898,584		9,034,111	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Indiana, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 2005. 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 2005. 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.