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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEBRASKA, 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]	261372 (A)	40489 (E)	220883 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	258976 (B)	38117 (F)	220859 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	231982 (C)	38042 (G)	193940 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	7410 (D)	6894 (H)	516 (L)

Source: Data for this table are from the MAX 2005 file for Nebraska, 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 Nebraska in 2005 was $251,793,540, of which $887,425 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 ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.

g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 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]
NEBRASKA, 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	**231,982**	**22,120**	**31,762**	**43,642**	**134,079**	**379**	**1,509,425**	**174,358**	**255,693**	**175,321**	**901,760**	**2,293**
Age												
5 and younger	58,841	0	830	350	57,661	0	395,111	0	7,148	653	387,310	0
6-14	54,567	0	1,600	47	52,920	0	377,571	0	15,936	97	361,538	0
15-20	26,040	0	1,398	2,338	22,268	36	171,432	0	12,962	8,555	149,786	129
21-44	40,865	0	12,069	28,201	382	213	221,026	0	97,272	122,055	690	1,009
45-64	18,327	0	15,558	2,637	2	130	132,926	0	119,977	11,790	4	1,155
65-74	7,284	6,970	307	6	1	0	52,343	49,916	2,398	27	2	0
75-84	7,837	7,836	0	1	0	0	61,155	61,154	0	1	0	0
85 and older	7,314	7,314	0	0	0	0	63,288	63,288	0	0	0	0
Unknown	10,907	0	0	10,062	845	0	34,573	0	0	32,143	2,430	0
Gender												
Female	129,853	16,277	16,916	29,884	66,397	379	850,259	130,478	136,944	134,240	446,304	2,293
Male	97,951	5,843	14,845	9,687	67,576	0	650,724	43,880	118,747	32,942	455,155	0
Unknown	4,178	0	1	4,071	106	0	8,442	0	2	8,139	301	0
Race												
White	152,274	18,987	24,538	26,525	81,908	316	1,008,399	151,306	199,007	104,540	551,636	1,910
African American	28,808	1,238	3,987	6,816	16,757	10	201,766	8,929	31,491	34,531	126,741	74
Other/unknown	50,900	1,895	3,237	10,301	35,414	53	299,260	14,123	25,195	36,250	223,383	309
Use of Nursing Facilities[c]												
Entire year	7,410	6,335	1,069	2	4	0	73,117	61,590	11,495	3	29	0
Part year	3,910	2,962	912	24	12	0	33,417	25,617	7,572	138	90	0
None	220,662	12,823	29,781	43,616	134,063	379	1,402,891	87,151	236,626	175,180	901,641	2,293
Maintenance Assistance Status												
Cash	60,494	4,286	18,587	14,743	22,878	0	408,210	32,217	160,818	58,983	156,192	0
Medically needy	23,868	10,295	2,343	10,946	284	0	162,245	95,550	21,711	44,018	966	0
Poverty-related	120,985	7,520	10,366	10,152	92,568	379	741,273	46,486	69,286	32,106	591,102	2,293
Other/unknown	26,635	19	466	7,801	18,349	0	197,697	105	3,878	40,214	153,500	0
Dual Medicare Status[d]												
Full dual, all year	37,190	20,443	16,595	141	7	4	277,874	158,570	118,284	934	50	36
Full dual, part year	852	466	386	0	0	0	7,158	3,851	3,307	0	0	0
Non-dual, all year	193,940	1,211	14,781	43,501	134,072	375	1,224,393	11,937	134,102	174,387	901,710	2,257
Managed Care (MC) Status												
Fee-for-service (FFS) all year	33,893	12,250	8,430	7,347	5,497	369	226,154	112,548	80,087	15,196	16,067	2,256
FFS part year, with Rx claims	80,701	8,434	13,427	18,107	40,726	7	236,845	49,530	69,784	33,817	83,685	29
FFS part year, no Rx claims	25,024	662	1,084	5,715	17,560	3	55,676	3,428	4,751	10,456	37,033	8

Source: Data for this table are from the MAX 2005 file for Nebraska, 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]
NEBRASKA, 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	**82.3**	**17.2**	**$1,082**	**$63**	**$4,891**	**22.1**	**231,982**
Age							
5 and younger	84.6	5.8	211	36	1,443	14.6	58,841
6-14	79.2	6.3	510	81	1,222	41.7	54,567
15-20	81.7	8.5	591	69	2,078	28.4	26,040
21-44	81.0	18.5	1,467	79	6,495	22.6	40,865
45-64	89.1	52.2	3,810	73	14,093	27.0	18,327
65-74	89.5	56.8	3,119	55	12,711	24.5	7,284
75-84	93.0	62.1	2,977	48	16,068	18.5	7,837
85 and older	95.5	60.9	2,506	41	22,284	11.2	7,314
Unknown	59.6	3.2	109	34	2,174	5.0	10,907
Basis of Eligibility[e]							
Aged	92.7	60.0	2,851	48	17,033	16.7	22,120
Disabled	91.0	46.9	3,813	81	15,818	24.1	31,762
Adults	73.3	8.3	421	51	2,062	20.4	43,642
Children	81.6	6.1	359	59	1,208	29.7	134,079
Unknown	58.6	10.9	717	66	9,049	7.9	379
Gender							
Female	84.6	20.3	1,179	58	5,180	22.8	129,853
Male	81.2	13.9	997	72	4,677	21.3	97,951
Unknown	37.6	1.3	49	38	911	5.3	4,178
Race							
White	84.0	21.2	1,351	64	6,139	22.0	152,274
African American	81.4	12.1	751	62	3,027	24.8	28,808
Other/unknown	77.7	8.3	462	55	2,211	20.9	50,900
Use of Nursing Facilities[f]							
Entire year	97.5	79.7	4,051	51	37,204	10.9	7,410
Part year	96.3	70.4	3,568	51	28,093	12.7	3,910
None	81.6	14.2	938	66	3,395	27.6	220,662
Maintenance Assistance Status							
Cash	83.3	21.3	1,513	71	5,887	25.7	60,494
Medically needy	83.0	41.7	2,221	53	18,132	12.2	23,868
Poverty related	80.4	11.9	722	61	2,418	29.9	120,985
Other/unknown	88.3	10.6	715	67	1,995	35.8	26,635

Source: Data for this table are from the MAX 2005 file for Nebraska, 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]
NEBRASKA, 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	**2.7**	**$166**	**22.1**	**17.7**	**40.8**	**9.5**	**13.2**	**10.2**	**8.5**	**$752**	**231,982**	**1,509,425**
Age												
5 and younger	0.9	31	14.6	15.4	56.9	9.8	9.8	5.0	3.0	215	58,841	395,111
6-14	0.9	74	41.7	20.8	55.0	8.8	9.2	3.6	2.6	177	54,567	377,571
15-20	1.3	90	28.4	18.3	49.1	11.2	12.3	5.3	3.8	316	26,040	171,432
21-44	3.4	271	22.6	19.0	28.2	11.8	17.4	12.3	11.3	1,201	40,865	221,026
45-64	7.2	525	27.0	10.9	12.0	7.6	19.4	22.6	27.4	1,943	18,327	132,926
65-74	7.9	434	24.5	10.5	8.3	6.3	18.0	27.2	29.7	1,769	7,284	52,343
75-84	8.0	382	18.5	7.0	6.3	5.4	19.3	33.6	28.5	2,059	7,837	61,155
85 and older	7.0	290	11.2	4.5	4.4	5.4	25.6	41.8	18.3	2,575	7,314	63,288
Unknown	1.0	35	5.0	40.4	29.8	10.5	12.0	5.3	2.1	686	10,907	34,573
Basis of Eligibility[e]												
Aged	7.6	362	16.7	7.3	6.3	5.7	21.0	34.2	25.5	2,161	22,120	174,358
Disabled	5.8	474	24.1	9.0	18.3	9.1	20.6	20.8	22.1	1,965	31,762	255,693
Adults	2.1	105	20.4	26.7	30.7	11.9	14.9	8.3	7.5	513	43,642	175,321
Children	0.9	53	29.7	18.4	55.2	9.5	9.6	4.4	2.9	180	134,079	901,760
Unknown	1.8	119	7.9	41.4	28.5	11.3	12.9	5.5	0.3	1,496	379	2,293
Gender												
Female	3.1	180	22.8	15.4	38.8	9.6	14.0	11.8	10.4	791	129,853	850,259
Male	2.1	150	21.3	18.8	44.4	9.5	12.4	8.5	6.3	704	97,951	650,724
Unknown	0.6	24	5.3	62.4	20.7	7.3	6.9	2.1	0.6	451	4,178	8,442
Race												
White	3.2	204	22.0	16.0	37.6	9.6	14.2	12.1	10.4	927	152,274	1,008,399
African American	1.7	107	24.8	18.6	48.1	8.7	11.1	7.5	6.0	432	28,808	201,766
Other/unknown	1.4	79	20.9	22.3	46.2	9.7	11.4	6.1	4.2	376	50,900	299,260
Use of Nursing Facilities[f]												
Entire year	8.1	411	10.9	2.5	2.8	4.2	21.9	43.3	25.3	3,770	7,410	73,117
Part year	8.2	418	12.7	3.7	4.1	4.6	20.9	39.1	27.5	3,287	3,910	33,417
None	2.2	148	27.6	18.4	42.7	9.8	12.8	8.6	7.6	534	220,662	1,402,891
Maintenance Assistance Status												
Cash	3.2	224	25.7	16.7	35.7	10.1	15.5	11.6	10.4	872	60,494	408,210
Medically needy	6.1	327	12.2	17.0	15.1	8.1	18.8	25.3	15.8	2,667	23,868	162,245
Poverty related	1.9	118	29.9	19.6	45.9	9.1	11.0	7.4	7.0	395	120,985	741,273
Other/unknown	1.4	96	35.8	11.7	52.3	11.4	13.2	6.7	4.7	269	26,635	197,697

Source: Data for this table are from the MAX 2005 file for Nebraska, 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]

NEBRASKA, 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	**2.7**	**$166**	**$63**	**1.0**	**$129**	**$128**	**0.1**	**$8**	**$73**	**1.5**	**$29**	**$19**
Age												
5 and younger	0.9	31	36	0.2	20	82	0.0	2	45	0.6	9	16
6-14	0.9	74	81	0.5	63	136	0.0	3	70	0.4	8	20
15-20	1.3	90	69	0.6	73	126	0.1	4	65	0.7	13	20
21-44	3.4	271	79	1.3	217	164	0.1	15	97	2.0	40	20
45-64	7.2	525	73	2.8	407	146	0.3	29	99	4.1	89	22
65-74	7.9	434	55	3.0	336	111	0.3	18	60	4.6	80	18
75-84	8.0	382	48	2.9	286	97	0.3	17	51	4.7	79	17
85 and older	7.0	290	41	2.2	201	90	0.3	17	49	4.4	72	16
Unknown	1.0	35	34	0.2	23	116	0.0	2	43	0.8	10	13
Basis of Eligibility[d]												
Aged	7.6	362	48	2.7	268	99	0.3	17	52	4.6	76	17
Disabled	5.8	474	81	2.4	376	160	0.2	25	101	3.2	72	23
Adults	2.1	105	51	0.7	78	118	0.1	6	75	1.3	20	15
Children	0.9	53	59	0.4	42	115	0.0	2	57	0.5	9	18
Unknown	1.8	119	66	0.6	93	146	0.1	6	72	1.1	20	18
Gender												
Female	3.1	180	58	1.1	138	121	0.1	10	70	1.8	33	18
Male	2.1	150	72	0.8	120	142	0.1	7	81	1.2	24	20
Unknown	0.6	24	38	0.1	17	127	0.0	1	48	0.5	6	12
Race												
White	3.2	204	64	1.2	160	128	0.1	10	72	1.8	35	19
African American	1.7	107	62	0.6	80	130	0.1	7	104	1.0	20	19
Other/unknown	1.4	79	55	0.5	59	124	0.1	4	64	0.9	15	17
Use of Nursing Facilities[e]												
Entire year	8.1	411	51	2.7	297	110	0.4	21	56	5.0	92	19
Part year	8.2	418	51	2.8	305	108	0.3	21	62	5.1	91	18
None	2.2	148	66	0.9	116	133	0.1	7	78	1.3	24	19
Maintenance Assistance Status												
Cash	3.2	224	71	1.2	176	144	0.1	12	90	1.8	36	20
Medically needy	6.1	327	53	2.1	244	116	0.3	15	57	3.7	67	18
Poverty related	1.9	118	61	0.7	91	123	0.1	6	71	1.1	21	19
Other/unknown	1.4	96	67	0.7	80	122	0.1	4	67	0.7	13	18

Source: Data for this table are from the MAX 2005 file for Nebraska, 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 Nebraska, 0.3 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]

NEBRASKA, 2005

	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	$19	$12	$3	$5	$50	$108	$70	$20	385,095	$19,098,245	132,988	57.3	1,007,955
Biologicals	0.2	0.1	0.0	0.1	86	30	49	7	478	282	2,115	130	100	47,753	65	0.0	558
Antineoplastic Agents	0.7	0.2	0.0	0.5	129	109	1	19	176	564	126	36	10,462	1,842,002	1,753	0.8	14,316
Endocrine/Metabolic Drugs	0.9	0.3	0.1	0.5	48	34	6	8	52	98	48	18	376,291	19,443,082	53,257	23.0	406,397
Cardiovascular Agents	2.2	0.9	0.1	1.3	87	70	1	16	40	80	23	13	671,402	26,708,533	39,010	16.8	308,050
Respiratory Agents	0.6	0.3	0.0	0.3	31	26	1	4	53	101	41	15	432,602	23,125,534	96,341	41.5	746,319
Gastrointestinal Agents	0.7	0.1	0.0	0.5	33	24	1	9	48	173	55	16	195,798	9,308,209	35,132	15.1	279,459
Genitourinary Agents	0.6	0.4	0.0	0.2	41	34	2	5	69	91	74	27	76,350	5,304,340	17,321	7.5	130,526
CNS Drugs	1.6	0.9	0.0	0.7	163	148	2	13	103	170	110	19	643,987	66,137,284	52,349	22.6	405,620
Stimulants/Anti-obesity/Anorexia	0.9	0.8	0.0	0.1	102	98	1	4	110	123	102	30	90,124	9,881,837	11,804	5.1	96,484
Miscellaneous Psychological/ Neurological Agents	1.0	1.0	0.0	0.0	211	210	0	0	215	217	0	17	31,017	6,659,206	3,537	1.5	31,616
Analgesics and Anesthetics	0.8	0.1	0.0	0.6	37	15	7	14	49	154	249	23	403,987	19,624,009	72,027	31.0	531,356
Neuromuscular Agents	1.2	0.4	0.1	0.7	100	73	5	23	87	166	82	35	261,298	22,824,172	28,616	12.3	227,180
Nutritional Products	0.5	0.0	0.0	0.5	7	0	0	7	14	17	19	13	100,939	1,368,954	27,686	11.9	193,309
Hematological Agents	1.0	0.3	0.1	0.7	101	90	2	9	97	307	30	13	90,961	8,863,038	10,966	4.7	87,959
Topical Products	0.3	0.1	0.0	0.2	15	11	1	4	44	82	48	20	220,582	9,742,515	78,671	33.9	631,798
Miscellaneous Products	0.4	0.2	0.0	0.2	65	44	6	15	146	261	214	61	5,824	851,913	1,518	0.7	13,078
Unknown Therapeutic Category	0.5	0.0	0.0	0.0	8	0	0	0	17	0	0	0	4,348	75,489	981	0.4	8,927
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.	4,001,167	250,906,115	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Nebraska, 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 Nebraska, 0.3 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]

NEBRASKA, 2005

		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	$41,010,078	24,732	10.7	207,424	0.9	$219	$198
ANTICONVULSANT	17,836,459	20,646	8.9	170,176	1.0	106	105
ANTIDEPRESSANTS	14,810,679	42,905	18.5	331,554	0.8	56	45
ANTIASTHMATIC	13,860,508	54,099	23.3	422,118	0.5	73	33
ANTIHYPERLIPIDEMIC	10,386,334	16,210	7.0	124,100	0.9	94	84
ANTIDIABETIC	9,455,404	19,294	8.3	150,559	1.0	64	63
ANALGESICS - Narcotic	9,195,812	59,391	25.6	420,696	0.5	43	22
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	8,127,754	11,693	5.0	94,160	0.8	109	86
MISC PSYCHOTHERAPEUTIC AND NEUROLOGICAL	6,400,973	4,055	1.7	36,659	0.8	210	175
MISC. HEMATOLOGICAL	6,268,657	3,669	1.6	29,275	0.9	243	214
Total	137,352,658	256,694		1,986,721	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Nebraska, 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.