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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006
INDIANA

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
INDIANA, 2006

Inclusion Criteria (2006)	Number of Dual and Nondual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Nondual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	1049760 (A)	153514 (E)	896246 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	988724 (B)	117383 (F)	871341 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	563859 (C)	116866 (G)	446993 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	21434 (D)	19890 (H)	1544 (L)

Source: Data for this table are from the MAX 2006 file for Indiana, released by CMS in 4/2009. This table was produced on 02/11/2010.
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 2006 (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 2006, 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 2006 was $281,432,700, of which $612,950 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 29 states in 2006 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, KY, MA, MI, MS, NC, NH, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, and WI. In addition, there were 10 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NC, NE, NY, TN, TX, UT, and WV). These lists were constructed from the CMS 2006 Medicaid Managed Care Enrollment Report 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 2006. 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 2006. 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, 2006

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**563,859**	**63,601**	**122,565**	**113,335**	**264,078**	**280**	**3,153,345**	**638,750**	**1,260,203**	**308,959**	**943,033**	**2,400**
Age												
5 and younger	105,845	0	1,476	0	104,369	0	332,400	0	9,267	0	323,133	0
6-14	115,873	0	4,413	10	111,450	0	445,719	0	31,400	37	414,282	0
15-20	64,653	0	3,896	12,795	47,961	1	280,379	0	33,687	42,172	204,508	12
21-44	142,249	2	46,392	95,524	296	35	736,077	13	480,168	254,517	1,099	280
45-64	71,277	26	66,029	4,991	0	231	717,032	147	702,684	12,166	0	2,035
65-74	23,493	23,107	359	13	1	13	248,225	245,098	2,997	49	8	73
75-84	21,615	21,612	0	2	1	0	216,664	216,643	0	18	3	0
85 and older	18,854	18,854	0	0	0	0	176,849	176,849	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	340,301	46,288	64,698	98,616	130,419	280	1,882,940	470,684	671,503	276,095	462,258	2,400
Male	223,558	17,313	57,867	14,719	133,659	0	1,270,405	168,066	588,700	32,864	480,775	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	400,382	52,733	98,764	80,604	168,045	236	2,385,012	526,165	1,031,596	224,031	601,231	1,989
African American	116,031	7,739	20,075	25,967	62,219	31	575,793	79,979	192,672	65,717	237,145	280
Other/unknown	47,446	3,129	3,726	6,764	33,814	13	192,540	32,606	35,935	19,211	104,657	131
Use of Nursing Facilities[c]												
Entire year	21,434	18,361	3,048	0	25	0	219,082	185,179	33,605	0	298	0
Part year	15,751	12,355	3,368	10	16	2	152,582	117,535	34,826	53	147	21
None	526,674	32,885	116,149	113,325	264,037	278	2,781,681	336,036	1,191,772	308,906	942,588	2,379
Maintenance Assistance Status												
Cash	213,232	13,884	58,759	69,534	71,055	0	1,133,311	151,013	593,350	179,213	209,735	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	178,220	5,483	7,964	21,330	143,163	280	725,668	60,816	89,185	74,034	499,233	2,400
Other/unknown	172,407	44,234	55,842	22,471	49,860	0	1,294,366	426,921	577,668	55,712	234,065	0
Dual Medicare Status[d]												
Full dual, all year	94,742	51,895	42,331	474	26	16	986,951	512,584	472,325	1,712	217	113
Full dual, part year	22,124	9,594	12,505	25	0	0	246,570	105,006	141,355	209	0	0
Non-dual, all year	446,993	2,112	67,729	112,836	264,052	264	1,919,824	21,160	646,523	307,038	942,816	2,287
Managed Care (MC) Status												
Fee-for-service (FFS) all year	254,833	63,573	114,000	23,097	53,884	279	2,270,665	638,566	1,224,930	66,615	338,158	2,396
FFS part year, with Rx claims	104,480	19	5,312	43,832	55,316	1	324,315	130	25,050	123,068	176,063	4
FFS part year, no Rx claims	204,546	9	3,253	46,406	154,878	0	558,365	54	10,223	119,276	428,812	0

Source: Data for this table are from the MAX 2006 file for Indiana, released by CMS in 4/2009. This table was produced on 02/11/2010.

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 2006. 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, 2006

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	**39.8**	**6.7**	**$498**	**$75**	**$6,572**	**7.6**	**563,859**
Age							
5 and younger	25.1	1.0	57	59	2,001	2.8	105,845
6-14	28.1	2.2	227	102	2,146	10.6	115,873
15-20	37.7	3.7	373	101	3,432	10.9	64,653
21-44	49.4	7.3	682	93	7,178	9.5	142,249
45-64	62.7	25.8	1,664	65	14,017	11.9	71,277
65-74	38.9	6.0	246	41	10,221	2.4	23,493
75-84	39.9	3.8	94	25	16,129	0.6	21,615
85 and older	43.8	3.2	58	18	21,984	0.3	18,854
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	40.6	4.4	133	31	15,693	0.8	63,601
Disabled	63.8	23.5	1,909	81	15,680	12.2	122,565
Adults	42.6	1.7	58	33	2,620	2.2	113,335
Children	27.3	1.5	119	78	1,836	6.5	264,078
Unknown	83.6	24.7	1,582	64	14,231	11.1	280
Gender							
Female	41.6	6.9	424	62	6,304	6.7	340,301
Male	37.1	6.4	611	96	6,981	8.7	223,558
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	43.8	7.8	581	74	7,527	7.7	400,382
African American	32.7	4.3	333	78	4,722	7.1	116,031
Other/unknown	24.0	2.6	200	78	3,040	6.6	47,446
Use of Nursing Facilities[f]							
Entire year	53.9	12.4	561	45	35,200	1.6	21,434
Part year	62.7	14.3	794	55	25,260	3.1	15,751
None	38.6	6.2	487	78	4,848	10.0	526,674
Maintenance Assistance Status							
Cash	45.1	9.8	737	76	6,205	11.9	213,232
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	27.4	1.4	110	80	1,696	6.5	178,220
Other/unknown	46.1	8.3	604	73	12,068	5.0	172,407

Source: Data for this table are from the MAX 2006 file for Indiana, released by CMS in 4/2009. This table was produced on 02/11/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

				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	**1.2**	**$89**	**7.6**	**60.2**	**24.2**	**5.5**	**6.2**	**3.0**	**0.9**	**$1,175**	**563,859**	**3,153,345**
Age												
5 and younger	0.3	18	2.8	74.9	20.0	3.2	1.7	0.2	0.0	637	105,845	332,400
6-14	0.6	59	10.6	71.9	19.7	4.1	3.5	0.7	0.1	558	115,873	445,719
15-20	0.8	86	10.9	62.3	25.7	5.4	5.0	1.4	0.2	792	64,653	280,379
21-44	1.4	132	9.5	50.6	26.3	7.9	10.1	4.2	0.9	1,387	142,249	736,077
45-64	2.6	165	11.9	37.3	24.0	7.6	14.6	11.9	4.6	1,393	71,277	717,032
65-74	0.6	23	2.4	61.1	29.5	3.9	3.2	1.7	0.6	967	23,493	248,225
75-84	0.4	9	0.6	60.1	33.5	3.8	1.9	0.5	0.2	1,609	21,615	216,664
85 and older	0.3	6	0.3	56.2	38.0	3.9	1.5	0.3	0.1	2,344	18,854	176,849
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	0.4	13	0.8	59.4	33.5	3.8	2.2	0.8	0.3	1,563	63,601	638,750
Disabled	2.3	186	12.2	36.2	26.7	8.3	14.9	10.3	3.5	1,525	122,565	1,260,203
Adults	0.6	21	2.2	57.4	25.1	7.2	7.5	2.3	0.5	961	113,335	308,959
Children	0.4	33	6.5	72.7	20.4	3.8	2.6	0.4	0.1	514	264,078	943,033
Unknown	2.9	185	11.1	16.4	28.6	17.1	25.4	10.7	1.8	1,660	280	2,400
Gender												
Female	1.2	77	6.7	58.4	25.5	5.5	6.3	3.2	1.1	1,139	340,301	1,882,940
Male	1.1	108	8.7	62.9	22.3	5.4	6.1	2.6	0.7	1,229	223,558	1,270,405
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.3	98	7.7	56.2	25.9	6.0	7.1	3.6	1.1	1,264	400,382	2,385,012
African American	0.9	67	7.1	67.3	21.4	4.6	4.6	1.7	0.4	952	116,031	575,793
Other/unknown	0.6	49	6.6	76.0	16.8	3.0	2.9	1.0	0.2	749	47,446	192,540
Use of Nursing Facilities[f]												
Entire year	1.2	55	1.6	46.1	38.1	6.1	3.6	2.9	3.1	3,444	21,434	219,082
Part year	1.5	82	3.1	37.3	44.1	5.5	4.9	4.6	3.5	2,608	15,751	152,582
None	1.2	92	10.0	61.4	23.1	5.4	6.4	3.0	0.7	918	526,674	2,781,681
Maintenance Assistance Status												
Cash	1.8	139	11.9	54.9	23.2	6.6	8.7	5.0	1.7	1,167	213,232	1,133,311
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.3	27	6.5	72.6	21.3	3.4	2.3	0.4	0.1	417	178,220	725,668
Other/unknown	1.1	80	5.0	53.9	28.5	6.2	7.3	3.2	0.8	1,607	172,407	1,294,366

Source: Data for this table are from the MAX 2006 file for Indiana, released by CMS in 4/2009. This table was produced on 02/11/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

	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	**1.2**	**$89**	**$75**	**0.4**	**$70**	**$184**	**0.0**	**$5**	**$116**	**0.8**	**$14**	**$18**
Age												
5 and younger	0.3	18	59	0.1	14	164	0.0	1	53	0.2	4	17
6-14	0.6	59	102	0.3	51	179	0.0	2	80	0.3	7	24
15-20	0.8	86	101	0.4	73	204	0.0	3	95	0.5	9	21
21-44	1.4	132	93	0.4	108	249	0.1	6	123	0.9	17	19
45-64	2.6	165	65	0.8	122	153	0.1	12	128	1.7	32	19
65-74	0.6	23	41	0.1	16	120	0.0	2	94	0.4	6	13
75-84	0.4	9	25	0.1	6	94	0.0	1	71	0.3	3	10
85 and older	0.3	6	18	0.0	3	74	0.0	0	49	0.3	3	10
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.4	13	31	0.1	8	107	0.0	1	81	0.3	4	12
Disabled	2.3	186	81	0.7	147	197	0.1	10	123	1.4	28	19
Adults	0.6	21	33	0.1	13	117	0.0	2	129	0.5	7	13
Children	0.4	33	78	0.2	27	149	0.0	1	78	0.2	5	21
Unknown	2.9	185	64	0.9	136	147	0.1	20	205	1.9	28	15
Gender												
Female	1.2	77	62	0.4	57	154	0.0	5	115	0.8	14	17
Male	1.1	108	96	0.4	89	224	0.0	5	119	0.7	14	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.3	98	74	0.4	76	181	0.0	6	117	0.8	16	19
African American	0.9	67	78	0.3	54	199	0.0	3	109	0.6	10	18
Other/unknown	0.6	49	78	0.2	40	186	0.0	2	113	0.4	7	18
Use of Nursing Facilities[e]												
Entire year	1.2	55	45	0.3	37	136	0.0	4	83	0.9	14	16
Part year	1.5	82	55	0.4	58	160	0.1	6	104	1.1	18	17
None	1.2	92	78	0.4	73	188	0.0	5	120	0.7	14	19
Maintenance Assistance Status												
Cash	1.8	139	76	0.6	108	189	0.1	8	121	1.2	22	19
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.3	27	80	0.1	22	175	0.0	1	102	0.2	4	18
Other/unknown	1.1	80	73	0.4	63	179	0.0	4	112	0.7	13	18

Source: Data for this table are from the MAX 2006 file for Indiana, released by CMS in 4/2009. This table was produced on 02/11/2010.
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.medi-span.com/master-drug-database.aspx
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, 2006

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	0.3	$24	$18	$0	$6	$69	$267	$62	$21	247,499	$17,005,260	96,870	17.2	696,761
Biologicals	0.1	0.1	0.0	0.0	83	82	0	2	582	708	0	55	2,057	1,197,415	1,350	0.2	14,418
Antineoplastic Agents	0.4	0.1	0.0	0.3	141	124	0	16	324	866	377	56	11,433	3,707,741	2,689	0.5	26,322
Endocrine/Metabolic Drugs	0.7	0.3	0.0	0.4	43	34	1	8	61	127	57	20	288,865	17,534,022	47,609	8.4	404,546
Cardiovascular Agents	1.3	0.4	0.0	0.8	51	35	5	11	41	80	97	15	535,628	21,876,691	43,394	7.7	426,949
Respiratory Agents	0.5	0.2	0.0	0.3	30	23	1	6	57	116	60	18	323,881	18,484,376	75,302	13.4	621,148
Gastrointestinal Agents	0.6	0.2	0.0	0.4	44	35	3	6	71	145	222	17	198,966	14,073,586	33,079	5.9	318,274
Genitourinary Agents	0.4	0.1	0.1	0.2	23	13	6	4	57	90	97	20	39,519	2,261,353	11,668	2.1	100,065
CNS Drugs	1.0	0.4	0.1	0.6	93	79	6	9	92	211	108	15	851,123	77,967,650	90,116	16.0	834,130
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.1	78	74	0	4	103	121	78	30	91,494	9,462,227	17,012	3.0	120,968
Miscellaneous Psychological/ Neurological Agents	0.3	0.3	0.0	0.1	115	107	0	8	337	385	98	121	17,068	5,754,442	4,877	0.9	50,220
Analgesics and Anesthetics	0.8	0.1	0.0	0.7	35	14	7	13	46	192	285	20	457,128	20,943,337	76,584	13.6	597,496
Neuromuscular Agents	0.8	0.3	0.0	0.5	65	52	1	12	79	180	81	23	354,274	28,028,372	44,732	7.9	429,652
Nutritional Products	0.5	0.0	0.0	0.4	7	1	0	6	16	26	18	15	86,040	1,392,260	23,818	4.2	189,095
Hematological Agents	0.6	0.1	0.0	0.4	164	156	0	7	274	1,045	28	17	120,564	33,035,708	19,395	3.4	201,862
Topical Products	0.3	0.1	0.0	0.2	13	9	1	4	43	110	65	18	118,824	5,094,256	46,544	8.3	381,492
Miscellaneous Products	0.4	0.2	0.0	0.2	99	84	4	11	233	519	240	44	12,273	2,854,887	2,805	0.5	28,811
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	11	0	0	0	50	0	0	0	2,940	146,167	1,346	0.2	13,581
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.	3,759,576	280,819,750	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Indiana, released by CMS in 4/2009. This table was produced on 02/11/2010.

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.medi-span.com/master-drug-database.aspx.

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.medi-span.com/master-drug-database.aspx.

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2006.

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, 2006

		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	$53,808,270	33,382	5.9	340,205	0.6	$248	$158
MISC. HEMATOLOGICAL	26,750,975	4,957	0.9	54,041	0.5	991	495
ANTICONVULSANT	25,445,659	38,824	6.9	393,862	0.7	97	65
ANTIDEPRESSANTS	17,359,480	60,660	10.8	572,197	0.5	60	30
ANTIASTHMATIC	12,290,076	51,916	9.2	463,590	0.4	72	27
ANALGESICS - Narcotic	12,194,752	83,097	14.7	714,050	0.4	38	17
ULCER DRUGS	11,249,491	40,182	7.1	410,876	0.5	56	27
ANTIHYPERLIPIDEMIC	11,115,427	21,340	3.8	234,343	0.5	95	47
ANTIDIABETIC	10,771,769	25,467	4.5	265,118	0.6	73	41
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	9,248,258	17,960	3.2	136,291	0.7	104	68
Total	190,234,157	377,785	n.a.	3,584,573	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Indiana, released by CMS in 4/2009. This table was produced on 02/11/2010.

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 2006. 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 2006. For information about these drug groups, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.

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.