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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEBRASKA, 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]	262014 (A)	41341 (E)	220673 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	259146 (B)	38505 (F)	220641 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	224979 (C)	31955 (G)	193024 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	7107 (D)	6623 (H)	484 (L)

Source: Data for this table are from the MAX 2006 file for Nebraska, released by CMS in 3/2010. This table was produced on 02/12/2010.
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 Nebraska in 2006 was $134,288,808, of which $603,640 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]

NEBRASKA, 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	**224,979**	**18,742**	**29,140**	**42,819**	**133,888**	**390**	**1,512,838**	**172,087**	**272,774**	**171,599**	**893,779**	**2,599**
Age												
5 and younger	59,551	0	889	92	58,570	0	392,010	0	7,880	280	383,850	0
6-14	54,009	0	1,609	10	52,390	0	371,022	0	15,888	90	355,044	0
15-20	25,521	0	1,404	2,121	21,966	30	173,018	0	13,131	7,698	152,084	105
21-44	38,364	0	10,544	27,588	34	198	219,264	0	99,303	118,714	212	1,035
45-64	17,238	0	14,401	2,680	0	157	147,220	0	133,740	12,063	0	1,417
65-74	5,784	5,485	293	1	0	5	52,703	49,817	2,832	12	0	42
75-84	6,460	6,459	0	1	0	0	59,825	59,824	0	1	0	0
85 and older	6,798	6,798	0	0	0	0	62,446	62,446	0	0	0	0
Unknown	11,254	0	0	10,326	928	0	35,330	0	0	32,741	2,589	0
Gender												
Female	126,328	13,961	15,760	29,841	66,376	390	858,503	131,377	150,314	131,603	442,610	2,599
Male	95,168	4,781	13,379	9,600	67,408	0	647,217	40,710	122,448	33,206	450,853	0
Unknown	3,483	0	1	3,378	104	0	7,118	0	12	6,790	316	0
Race												
White	145,036	16,155	22,389	25,737	80,431	324	1,005,627	147,999	212,098	101,643	541,740	2,147
African American	28,296	1,003	3,590	6,732	16,958	13	201,125	9,771	33,136	33,021	125,118	79
Other/unknown	51,647	1,584	3,161	10,350	36,499	53	306,086	14,317	27,540	36,935	226,921	373
Use of Nursing Facilities[c]												
Entire year	7,107	6,011	1,091	1	4	0	70,986	59,057	11,894	1	34	0
Part year	3,892	2,941	923	16	9	3	32,256	24,585	7,533	67	39	32
None	213,980	9,790	27,126	42,802	133,875	387	1,409,596	88,445	253,347	171,531	893,706	2,567
Maintenance Assistance Status												
Cash	54,708	3,306	17,362	13,190	20,850	0	395,566	33,358	170,114	52,063	140,031	0
Medically needy	23,730	10,172	2,390	10,863	305	0	159,381	92,878	21,687	43,847	969	0
Poverty-related	119,375	5,256	9,042	10,108	94,579	390	749,180	45,776	77,295	32,289	591,221	2,599
Other/unknown	27,166	8	346	8,658	18,154	0	208,711	75	3,678	43,400	161,558	0
Dual Medicare Status[d]												
Full dual, all year	30,886	17,033	13,714	121	4	14	291,674	156,710	133,998	775	42	149
Full dual, part year	1,069	508	561	0	0	0	6,790	3,429	3,361	0	0	0
Non-dual, all year	193,024	1,201	14,865	42,698	133,884	376	1,214,374	11,948	135,415	170,824	893,737	2,450
Managed Care (MC) Status												
Fee-for-service (FFS) all year	31,431	11,317	8,029	7,069	4,631	385	218,018	105,688	79,285	14,972	15,491	2,582
FFS part year, with Rx claims	65,475	1,579	4,571	18,114	41,207	4	133,382	6,463	13,877	34,469	78,557	16
FFS part year, no Rx claims	26,086	921	1,316	5,633	18,215	1	53,857	2,787	3,796	10,646	36,627	1

Source: Data for this table are from the MAX 2006 file for Nebraska, released by CMS in 3/2010. This table was produced on 02/12/2010.

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]
NEBRASKA, 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	**76.8**	**8.9**	**$594**	**$67**	**$4,538**	**13.1**	**224,979**
Age							
5 and younger	84.9	5.9	228	38	1,659	13.7	59,551
6-14	78.7	6.2	499	81	1,185	42.1	54,009
15-20	82.3	8.8	866	98	2,368	36.6	25,521
21-44	77.5	13.0	938	72	6,328	14.8	38,364
45-64	73.6	24.5	1,664	68	12,501	13.3	17,238
65-74	57.8	11.0	558	51	11,528	4.8	5,784
75-84	51.0	6.0	202	33	15,375	1.3	6,460
85 and older	45.1	3.7	83	22	21,470	0.4	6,798
Unknown	58.9	3.2	117	36	2,445	4.8	11,254
Basis of Eligibility[e]							
Aged	50.6	6.3	237	37	16,412	1.4	18,742
Disabled	76.4	23.7	1,906	81	15,003	12.7	29,140
Adults	73.6	8.4	453	54	2,306	19.7	42,819
Children	81.6	6.1	403	66	1,298	31.0	133,888
Unknown	67.4	13.0	889	68	9,283	9.6	390
Gender							
Female	77.8	9.6	575	60	4,681	12.3	126,328
Male	76.9	8.1	640	79	4,476	14.3	95,168
Unknown	40.1	1.5	57	39	1,019	5.6	3,483
Race							
White	76.6	9.9	697	70	5,733	12.2	145,036
African American	79.1	8.1	501	62	2,722	18.4	28,296
Other/unknown	76.0	6.4	356	56	2,178	16.3	51,647
Use of Nursing Facilities[f]							
Entire year	51.7	10.7	516	48	35,970	1.4	7,107
Part year	61.0	15.0	843	56	27,923	3.0	3,892
None	77.9	8.7	592	68	3,069	19.3	213,980
Maintenance Assistance Status							
Cash	79.0	15.1	1,119	74	5,826	19.2	54,708
Medically needy	59.9	8.0	583	73	17,274	3.4	23,730
Poverty related	76.3	5.8	317	55	1,992	15.9	119,375
Other/unknown	89.4	10.5	764	73	2,007	38.1	27,166

Source: Data for this table are from the MAX 2006 file for Nebraska, released by CMS in 3/2010. This table was produced on 02/12/2010.
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]
NEBRASKA, 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	**1.3**	**$88**	**13.1**	**23.2**	**46.3**	**9.5**	**10.9**	**5.7**	**4.4**	**$675**	**224,979**	**1,512,838**
Age												
5 and younger	0.9	35	13.7	15.1	55.8	10.1	10.4	5.3	3.3	252	59,551	392,010
6-14	0.9	73	42.1	21.3	54.7	8.8	9.1	3.5	2.6	173	54,009	371,022
15-20	1.3	128	36.6	17.7	50.2	10.7	12.2	5.3	4.0	349	25,521	173,018
21-44	2.3	164	14.8	22.5	32.9	11.4	15.4	9.2	8.6	1,107	38,364	219,264
45-64	2.9	195	13.3	26.4	30.3	8.3	13.8	11.1	10.0	1,464	17,238	147,220
65-74	1.2	61	4.8	42.2	38.1	5.8	6.8	4.3	2.8	1,265	5,784	52,703
75-84	0.7	22	1.3	49.0	39.3	5.0	3.7	2.0	1.0	1,660	6,460	59,825
85 and older	0.4	9	0.4	54.9	38.4	3.5	1.8	1.1	0.3	2,337	6,798	62,446
Unknown	1.0	37	4.8	41.1	29.2	10.6	12.1	4.9	2.1	779	11,254	35,330
Basis of Eligibility[e]												
Aged	0.7	26	1.4	49.4	38.7	4.7	3.8	2.2	1.2	1,787	18,742	172,087
Disabled	2.5	204	12.7	23.6	35.1	9.0	14.3	10.0	8.0	1,603	29,140	272,774
Adults	2.1	113	19.7	26.4	30.7	11.8	15.1	8.2	7.7	575	42,819	171,599
Children	0.9	60	31.0	18.4	54.8	9.6	9.8	4.4	3.0	195	133,888	893,779
Unknown	2.0	133	9.6	32.6	32.6	13.3	15.6	5.6	0.3	1,393	390	2,599
Gender												
Female	1.4	85	12.3	22.2	45.6	9.6	11.3	6.1	5.1	689	126,328	858,503
Male	1.2	94	14.3	23.1	48.0	9.4	10.6	5.2	3.6	658	95,168	647,217
Unknown	0.7	28	5.6	59.9	21.0	8.5	7.3	2.5	0.7	499	3,483	7,118
Race												
White	1.4	101	12.2	23.4	44.9	9.7	11.1	6.0	4.9	827	145,036	1,005,627
African American	1.1	71	18.4	20.9	51.2	8.9	9.9	5.4	3.7	383	28,296	201,125
Other/unknown	1.1	60	16.3	24.0	47.4	9.5	10.9	5.0	3.2	368	51,647	306,086
Use of Nursing Facilities[f]												
Entire year	1.1	52	1.4	48.3	38.0	5.1	2.6	3.3	2.8	3,601	7,107	70,986
Part year	1.8	102	3.0	39.0	38.4	5.9	5.5	4.5	6.7	3,369	3,892	32,256
None	1.3	90	19.3	22.1	46.7	9.7	11.3	5.8	4.4	466	213,980	1,409,596
Maintenance Assistance Status												
Cash	2.1	155	19.2	21.0	40.8	9.7	13.8	8.4	6.3	806	54,708	395,566
Medically needy	1.2	87	3.4	40.1	32.5	8.3	9.3	5.0	4.9	2,572	23,730	159,381
Poverty related	0.9	51	15.9	23.7	49.7	9.2	9.5	4.6	3.3	317	119,375	749,180
Other/unknown	1.4	100	38.1	10.6	54.1	11.7	12.9	5.8	4.9	261	27,166	208,711

Source: Data for this table are from the MAX 2006 file for Nebraska, released by CMS in 3/2010. This table was produced on 02/12/2010.
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]

NEBRASKA, 2006

Beneficiary Characteristics	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
	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	**1.3**	**$88**	**$67**	**0.4**	**$67**	**$149**	**0.1**	**$5**	**$91**	**0.8**	**$17**	**$20**
Age												
5 and younger	0.9	35	38	0.2	20	91	0.0	3	56	0.6	12	19
6-14	0.9	73	81	0.4	60	138	0.0	2	60	0.4	11	25
15-20	1.3	128	98	0.5	107	196	0.1	5	86	0.7	16	23
21-44	2.3	164	72	0.7	123	167	0.1	12	117	1.4	29	21
45-64	2.9	195	68	0.9	144	153	0.1	13	115	1.8	38	21
65-74	1.2	61	51	0.3	45	128	0.0	4	79	0.8	13	16
75-84	0.7	22	33	0.1	14	105	0.0	1	61	0.5	6	13
85 and older	0.4	9	22	0.1	5	93	0.0	0	40	0.3	4	10
Unknown	1.0	37	36	0.1	13	90	0.1	13	224	0.8	12	14
Basis of Eligibility[d]												
Aged	0.7	26	37	0.2	17	114	0.0	1	65	0.5	7	14
Disabled	2.5	204	81	0.9	157	175	0.1	12	113	1.5	34	23
Adults	2.1	113	54	0.6	76	128	0.1	12	127	1.4	25	18
Children	0.9	60	66	0.3	46	137	0.0	3	63	0.5	11	21
Unknown	2.0	133	68	0.7	102	153	0.1	8	106	1.2	23	19
Gender												
Female	1.4	85	60	0.4	61	136	0.1	6	94	0.9	18	20
Male	1.2	94	79	0.4	75	166	0.1	4	85	0.7	15	22
Unknown	0.7	28	39	0.1	9	89	0.0	11	267	0.6	8	14
Race												
White	1.4	101	70	0.5	77	152	0.1	6	91	0.9	18	21
African American	1.1	71	62	0.4	51	143	0.0	5	109	0.7	15	20
Other/unknown	1.1	60	56	0.3	42	134	0.0	4	81	0.7	14	19
Use of Nursing Facilities[e]												
Entire year	1.1	52	48	0.2	36	146	0.0	3	67	0.8	13	17
Part year	1.8	102	56	0.5	72	151	0.1	6	93	1.3	24	19
None	1.3	90	68	0.5	68	149	0.1	6	92	0.8	17	21
Maintenance Assistance Status												
Cash	2.1	155	74	0.7	117	161	0.1	10	108	1.3	28	22
Medically needy	1.2	87	73	0.3	69	220	0.0	5	98	0.8	14	17
Poverty related	0.9	51	55	0.3	36	122	0.0	3	77	0.6	12	20
Other/unknown	1.4	100	73	0.6	80	140	0.1	5	79	0.7	15	21

Source: Data for this table are from the MAX 2006 file for Nebraska, released by CMS in 3/2010. This table was produced on 02/12/2010.
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 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.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]

NEBRASKA, 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	$16	$8	$1	$7	$46	$129	$55	$24	289,433	$13,222,288	109,834	48.8	820,335
Biologicals	0.3	0.2	0.0	0.0	167	164	3	1	638	701	202	42	99	63,147	37	0.0	377
Antineoplastic Agents	0.6	0.2	0.0	0.4	140	121	1	19	219	659	77	41	3,592	787,330	629	0.3	5,606
Endocrine/Metabolic Drugs	0.6	0.2	0.0	0.3	32	22	2	9	56	106	47	27	151,273	8,475,441	34,930	15.5	262,449
Cardiovascular Agents	1.2	0.5	0.0	0.7	51	38	4	10	43	83	80	14	153,850	6,654,683	16,206	7.2	131,233
Respiratory Agents	0.5	0.2	0.0	0.3	25	19	1	5	54	107	41	20	313,182	16,930,884	84,896	37.7	667,207
Gastrointestinal Agents	0.4	0.1	0.0	0.3	29	14	10	5	65	123	281	17	72,278	4,684,317	21,442	9.5	163,485
Genitourinary Agents	0.4	0.1	0.1	0.2	21	11	6	5	57	90	93	24	25,154	1,434,333	9,998	4.4	67,272
CNS Drugs	1.1	0.5	0.1	0.5	106	91	6	9	100	195	97	16	346,297	34,461,764	39,475	17.5	324,555
Stimulants/Anti-obesity/Anorexia	0.9	0.8	0.0	0.1	106	102	1	3	119	130	124	29	83,329	9,892,527	10,881	4.8	93,586
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	251	251	0	0	392	396	0	19	4,043	1,583,919	759	0.3	6,306
Analgesics and Anesthetics	0.5	0.1	0.0	0.5	21	10	2	9	40	177	347	20	200,156	8,066,436	51,965	23.1	375,803
Neuromuscular Agents	0.9	0.4	0.0	0.5	80	66	2	13	92	176	119	26	134,174	12,278,010	18,372	8.2	153,108
Nutritional Products	0.4	0.0	0.0	0.3	4	0	0	4	11	13	20	10	47,077	500,651	20,521	9.1	132,797
Hematological Agents	0.7	0.1	0.0	0.5	175	167	1	8	261	1,250	26	16	29,076	7,576,423	5,007	2.2	43,186
Topical Products	0.3	0.1	0.0	0.2	12	8	0	3	44	90	67	19	139,055	6,113,898	62,441	27.8	493,528
Miscellaneous Products	0.5	0.3	0.0	0.2	124	100	6	18	235	392	170	75	3,952	927,097	862	0.4	7,491
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	12	0	0	0	56	0	0	0	575	32,020	326	0.1	2,658
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.	1,996,595	133,685,168	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Nebraska, released by CMS in 3/2010. This table was produced on 02/12/2010.

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 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.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]
NEBRASKA, 2006

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	$18,882,892	12,574	5.6	111,347	0.7	$239	$170
ANTICONVULSANT	9,280,208	12,409	5.5	111,236	0.8	104	83
ANTIASTHMATIC	8,456,069	38,720	17.2	304,943	0.4	78	28
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	7,922,191	10,418	4.6	89,347	0.8	117	89
ANTIDEPRESSANTS	6,335,702	21,779	9.7	164,504	0.6	63	39
MISC. HEMATOLOGICAL	6,033,152	701	0.3	5,735	0.6	1,646	1,052
DERMATOLOGICAL	3,213,571	52,925	23.5	438,492	0.2	37	7
ANTIDIABETIC	2,808,639	6,392	2.8	51,111	0.7	74	55
ULCER DRUGS	2,760,207	21,735	9.7	181,938	0.5	30	15
COUGH/COLD/ALLERGY	2,575,473	80,594	35.8	664,010	0.2	19	4
Total	68,268,104	258,247	n.a.	2,122,663	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Nebraska, released by CMS in 3/2010. This table was produced on 02/12/2010.
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.