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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2007
INDIANA

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
INDIANA, 2007

Inclusion Criteria (2007)	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]	1068809 (A)	157759 (E)	911050 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1005179 (B)	117400 (F)	887779 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	590599 (C)	116873 (G)	473726 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	21391 (D)	19841 (H)	1550 (L)

Source: Data for this table are from the MAX 2007 file for Indiana, released by CMS in 3/2010. This table was produced on 10/06/2010.
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 2007 (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 2007, 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 2007 was $291,958,910, of which $901,945 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 27 states in 2007 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, MA, MI, NC, NH, NM, NV, NY, 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, TN, TX, and WV). These lists were constructed from the CMS 2007 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 reviewed prescription drug expenditures by type of managed care plan to determine whether enrollees in comprehensive MC plans had significant prescription drug expenditures during the year, since that would indicate that at least some prescription drugs were not included in the capitated benefit and were being provided on a fee-for-service basis. There were some states in which most, but not all, prescription drugs were included in the MC capitated benefit package. Mental health drugs, for example, may have been excluded. In those states, we excluded all the MC enrollees from the study population, but some of their drugs would have been included, potentially resulting in higher reported per-beneficiary use of those drugs than would have been the case if we had been able to exclude those drugs.
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 2007. 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 2007. 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, 2007

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**590,599**	**63,504**	**123,903**	**119,866**	**283,008**	**318**	**3,186,865**	**637,713**	**1,252,058**	**313,000**	**981,136**	**2,958**
Age												
5 and younger	110,353	0	1,561	0	108,792	0	341,362	0	9,304	0	332,058	0
6-14	126,538	0	4,850	20	121,668	0	468,494	0	34,294	57	434,143	0
15-20	69,731	0	4,201	13,290	52,239	1	290,996	0	35,076	42,015	213,893	12
21-44	146,595	2	45,044	101,213	307	29	718,103	17	458,360	258,444	1,031	251
45-64	73,424	33	67,776	5,330	0	285	726,223	154	710,966	12,428	0	2,675
65-74	23,794	23,307	471	12	1	3	250,758	246,630	4,058	44	6	20
75-84	21,186	21,184	0	1	1	0	213,124	213,107	0	12	5	0
85 and older	18,978	18,978	0	0	0	0	177,805	177,805	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	355,539	46,103	64,799	104,374	139,945	318	1,893,974	468,361	661,498	280,368	480,789	2,958
Male	235,060	17,401	59,104	15,492	143,063	0	1,292,891	169,352	590,560	32,632	500,347	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	414,889	52,315	99,615	85,035	177,655	269	2,386,646	522,070	1,023,134	223,845	615,093	2,504
African American	121,255	7,772	20,481	26,766	66,203	33	584,635	80,576	192,456	65,346	245,951	306
Other/unknown	54,455	3,417	3,807	8,065	39,150	16	215,584	35,067	36,468	23,809	120,092	148
Use of Nursing Facilities[c]												
Entire year	21,391	18,292	3,072	3	24	0	217,859	184,132	33,479	3	245	0
Part year	15,534	12,139	3,368	13	13	1	150,220	114,942	35,106	60	100	12
None	553,674	33,073	117,463	119,850	282,971	317	2,818,786	338,639	1,183,473	312,937	980,791	2,946
Maintenance Assistance Status												
Cash	221,214	12,706	58,696	73,012	76,800	0	1,117,591	138,084	583,161	180,329	216,017	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	195,074	5,072	7,735	24,497	157,452	318	751,189	56,586	86,752	82,489	522,404	2,958
Other/unknown	174,311	45,726	57,472	22,357	48,756	0	1,318,085	443,043	582,145	50,182	242,715	0
Dual Medicare Status[d]												
Full dual, all year	95,882	52,259	43,100	480	28	15	996,637	517,032	477,632	1,593	229	151
Full dual, part year	20,991	8,869	12,093	29	0	0	233,716	97,253	136,203	260	0	0
Non-dual, all year	473,726	2,376	68,710	119,357	282,980	303	1,956,512	23,428	638,223	311,147	980,907	2,807
Managed Care (MC) Status												
Fee-for-service (FFS) all year	251,798	63,480	114,820	21,731	51,450	317	2,245,882	637,582	1,216,574	59,038	329,733	2,955
FFS part year, with Rx claims	109,648	18	5,354	45,558	58,717	1	327,671	105	24,200	121,951	181,412	3
FFS part year, no Rx claims	229,153	6	3,729	52,577	172,841	0	613,312	26	11,284	132,011	469,991	0

Source: Data for this table are from the MAX 2007 file for Indiana, released by CMS in 3/2010. This table was produced on 10/06/2010.

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 2007. 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, 2007

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	**37.8**	**6.4**	**$493**	**$77**	**$6,549**	**7.5**	**590,599**
Age							
5 and younger	23.7	0.9	61	67	1,890	3.2	110,353
6-14	26.9	2.1	233	109	1,996	11.7	126,538
15-20	36.4	3.5	334	95	3,245	10.3	69,731
21-44	47.0	7.0	684	98	7,047	9.7	146,595
45-64	60.7	25.2	1,676	67	14,429	11.6	73,424
65-74	36.1	5.9	243	41	11,271	2.2	23,794
75-84	37.7	3.5	77	22	17,563	0.4	21,186
85 and older	40.5	3.0	45	15	23,582	0.2	18,978
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	37.8	4.1	120	29	17,028	0.7	63,504
Disabled	62.0	23.3	1,960	84	16,325	12.0	123,903
Adults	40.4	1.6	53	32	2,396	2.2	119,866
Children	26.1	1.4	119	82	1,665	7.1	283,008
Unknown	89.0	29.9	2,054	69	17,172	12.0	318
Gender							
Female	39.4	6.5	415	64	6,289	6.6	355,539
Male	35.4	6.2	611	99	6,942	8.8	235,060
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	42.0	7.6	579	77	7,549	7.7	414,889
African American	31.0	4.1	337	82	4,771	7.1	121,255
Other/unknown	21.2	2.3	182	79	2,889	6.3	54,455
Use of Nursing Facilities[f]							
Entire year	51.9	12.0	546	45	37,574	1.5	21,391
Part year	59.8	13.5	720	53	27,197	2.6	15,534
None	36.7	5.9	484	82	4,771	10.2	553,674
Maintenance Assistance Status							
Cash	43.2	9.4	736	78	6,077	12.1	221,214
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	25.5	1.2	91	74	1,564	5.8	195,074
Other/unknown	44.9	8.2	633	77	12,727	5.0	174,311

Source: Data for this table are from the MAX 2007 file for Indiana, released by CMS in 3/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, 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, TN, TX, 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, 2007

				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**	**$91**	**7.5**	**62.2**	**22.5**	**5.4**	**6.1**	**3.0**	**0.9**	**$1,214**	**590,599**	**3,186,865**
Age												
5 and younger	0.3	20	3.2	76.3	18.8	3.0	1.7	0.2	0.0	611	110,353	341,362
6-14	0.6	63	11.7	73.1	18.4	4.2	3.5	0.7	0.1	539	126,538	468,494
15-20	0.8	80	10.3	63.6	23.9	5.7	5.1	1.4	0.2	778	69,731	290,996
21-44	1.4	140	9.7	53.0	24.0	7.8	9.9	4.4	1.0	1,439	146,595	718,103
45-64	2.5	169	11.6	39.3	23.1	7.2	14.1	11.6	4.6	1,459	73,424	726,223
65-74	0.6	23	2.2	63.9	27.0	3.8	3.1	1.7	0.5	1,070	23,794	250,758
75-84	0.3	8	0.4	62.3	32.3	3.5	1.4	0.4	0.1	1,746	21,186	213,124
85 and older	0.3	5	0.2	59.5	35.9	3.4	0.9	0.1	0.0	2,517	18,978	177,805
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	12	0.7	62.2	31.5	3.6	1.8	0.7	0.2	1,696	63,504	637,713
Disabled	2.3	194	12.0	38.0	25.5	8.1	14.5	10.3	3.6	1,616	123,903	1,252,058
Adults	0.6	20	2.2	59.6	22.7	7.1	7.5	2.6	0.5	918	119,866	313,000
Children	0.4	34	7.1	73.9	19.1	3.8	2.7	0.5	0.1	480	283,008	981,136
Unknown	3.2	221	12.0	11.0	25.8	18.2	28.6	13.8	2.5	1,846	318	2,958
Gender												
Female	1.2	78	6.6	60.6	23.6	5.4	6.1	3.2	1.1	1,181	355,539	1,893,974
Male	1.1	111	8.8	64.6	20.7	5.2	6.1	2.7	0.7	1,262	235,060	1,292,891
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	101	7.7	58.0	24.3	6.0	7.0	3.6	1.1	1,312	414,889	2,386,646
African American	0.9	70	7.1	69.0	19.9	4.5	4.6	1.7	0.4	989	121,255	584,635
Other/unknown	0.6	46	6.3	78.8	14.6	2.8	2.6	1.0	0.2	730	54,455	215,584
Use of Nursing Facilities[f]												
Entire year	1.2	54	1.5	48.1	37.4	5.8	3.0	2.7	3.1	3,689	21,391	217,859
Part year	1.4	74	2.6	40.2	43.2	4.9	3.9	4.6	3.2	2,812	15,534	150,220
None	1.2	95	10.2	63.3	21.3	5.4	6.3	3.0	0.8	937	553,674	2,818,786
Maintenance Assistance Status												
Cash	1.9	146	12.1	56.8	21.4	6.5	8.6	5.0	1.7	1,203	221,214	1,117,591
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	24	5.8	74.5	19.2	3.3	2.4	0.5	0.1	406	195,074	751,189
Other/unknown	1.1	84	5.0	55.1	27.5	6.2	7.0	3.3	0.8	1,683	174,311	1,318,085

Source: Data for this table are from the MAX 2007 file for Indiana, released by CMS in 3/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, 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, TN, TX, 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, 2007

	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**	**$91**	**$77**	**0.4**	**$71**	**$204**	**0.1**	**$7**	**$132**	**0.8**	**$13**	**$17**
Age												
5 and younger	0.3	20	67	0.1	15	212	0.0	1	62	0.2	4	19
6-14	0.6	63	109	0.3	55	194	0.0	2	90	0.3	6	23
15-20	0.8	80	95	0.3	67	193	0.0	3	106	0.5	10	21
21-44	1.4	140	98	0.4	114	276	0.1	9	153	0.9	17	17
45-64	2.5	169	67	0.7	124	174	0.1	18	137	1.7	28	16
65-74	0.6	23	41	0.1	16	137	0.0	2	87	0.4	5	13
75-84	0.3	8	22	0.0	4	100	0.0	1	68	0.3	3	9
85 and older	0.3	5	15	0.0	2	67	0.0	0	55	0.3	2	9
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.4	12	29	0.1	8	117	0.0	1	79	0.3	4	11
Disabled	2.3	194	84	0.7	152	219	0.1	16	139	1.5	26	17
Adults	0.6	20	32	0.1	12	123	0.0	1	121	0.5	6	12
Children	0.4	34	82	0.2	28	160	0.0	1	90	0.2	5	21
Unknown	3.2	221	69	0.9	169	181	0.1	17	139	2.2	34	16
Gender												
Female	1.2	78	64	0.3	58	172	0.1	7	129	0.8	13	16
Male	1.1	111	99	0.4	91	246	0.1	7	136	0.7	13	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.3	101	77	0.4	78	200	0.1	8	135	0.9	14	17
African American	0.9	70	82	0.2	56	225	0.0	4	119	0.6	10	17
Other/unknown	0.6	46	79	0.2	37	207	0.0	3	112	0.4	6	17
Use of Nursing Facilities[e]												
Entire year	1.2	54	45	0.2	36	146	0.0	4	95	0.9	13	15
Part year	1.4	74	53	0.3	51	164	0.1	7	124	1.0	16	16
None	1.2	95	82	0.4	75	208	0.1	7	135	0.8	13	17
Maintenance Assistance Status												
Cash	1.9	146	78	0.5	113	208	0.1	12	138	1.2	21	17
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.3	24	74	0.1	19	163	0.0	1	97	0.2	4	19
Other/unknown	1.1	84	77	0.3	66	206	0.0	6	127	0.7	12	16

Source: Data for this table are from the MAX 2007 file for Indiana, released by CMS in 3/2010. This table was produced on 10/06/2010.
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, 0.3 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.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, 2007

	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	0.3	$27	$20	$1	$6	$74	$349	$107	$20	240,362	$17,859,585	95,271	16.1	672,808
Biologicals	0.1	0.1	0.0	0.0	86	86	0	0	606	606	0	0	2,627	1,592,011	1,743	0.3	18,566
Antineoplastic Agents	0.5	0.2	0.0	0.3	194	180	2	13	409	1,021	646	44	10,659	4,357,879	2,256	0.4	22,419
Endocrine/Metabolic Drugs	0.7	0.3	0.0	0.4	48	39	1	8	65	144	36	18	286,639	18,721,307	46,304	7.8	389,763
Cardiovascular Agents	1.3	0.3	0.1	0.9	47	28	6	13	36	100	64	14	531,525	19,263,686	41,672	7.1	406,762
Respiratory Agents	0.5	0.2	0.0	0.3	36	29	3	5	67	121	71	18	312,041	20,969,414	71,358	12.1	578,349
Gastrointestinal Agents	0.6	0.1	0.1	0.4	45	25	12	9	72	167	129	23	185,353	13,378,107	31,150	5.3	296,378
Genitourinary Agents	0.4	0.1	0.0	0.2	23	15	1	8	56	98	77	30	39,028	2,189,862	11,471	1.9	96,083
CNS Drugs	1.1	0.4	0.0	0.7	96	84	2	10	91	221	127	15	858,266	78,094,066	88,898	15.1	813,232
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.1	84	80	1	3	110	129	56	22	96,688	10,592,750	18,239	3.1	126,301
Miscellaneous Psychological/ Neurological Agents	0.3	0.3	0.0	0.0	86	83	0	3	282	297	0	127	24,513	6,918,091	7,838	1.3	80,350
Analgesics and Anesthetics	0.8	0.0	0.0	0.7	34	9	15	10	44	302	322	14	433,282	19,271,231	74,588	12.6	563,027
Neuromuscular Agents	0.9	0.3	0.0	0.5	77	60	7	10	86	180	166	19	398,204	34,111,823	46,763	7.9	443,719
Nutritional Products	0.5	0.0	0.0	0.4	8	1	0	7	17	28	16	16	84,632	1,445,595	23,095	3.9	184,813
Hematological Agents	0.6	0.2	0.0	0.4	164	161	0	3	266	802	31	8	125,289	33,289,866	19,514	3.3	202,673
Topical Products	0.3	0.1	0.0	0.2	14	9	1	4	44	122	77	18	113,725	5,059,611	45,502	7.7	369,402
Miscellaneous Products	0.4	0.2	0.0	0.3	126	112	3	10	281	630	246	41	12,829	3,601,993	2,810	0.5	28,701
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	20	0	0	0	92	0	0	0	3,687	340,088	1,616	0.3	16,666
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.	3,759,349	291,056,965	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Indiana, released by CMS in 3/2010. This table was produced on 10/06/2010.
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, 0.3 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.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 2007.
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, 2007

		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	$56,718,058	32,804	5.6	330,602	0.7	$255	$172
ANTICONVULSANT	31,525,920	42,343	7.2	427,747	0.7	105	74
MISC. HEMATOLOGICAL	26,996,323	4,717	0.8	51,610	0.5	1,005	523
ANTIDEPRESSANTS	14,947,365	57,027	9.7	535,185	0.5	53	28
ANALGESICS - Narcotic	14,304,673	81,785	13.8	698,402	0.5	44	20
ANTIASTHMATIC	13,935,916	50,809	8.6	455,049	0.4	82	31
ULCER DRUGS	11,204,934	38,221	6.5	391,062	0.5	57	29
ANTIDIABETIC	11,168,710	24,735	4.2	258,415	0.6	77	43
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	10,289,717	19,411	3.3	145,772	0.6	110	71
ANTIVIRAL	9,368,414	4,238	0.7	40,079	0.4	549	234
Total	200,460,030	356,090	n.a.	3,333,923	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Indiana, released by CMS in 3/2010. This table was produced on 10/06/2010.
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 2007. 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 2007. 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.