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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEBRASKA, 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]	261567 (A)	41771 (E)	219796 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	258325 (B)	38563 (F)	219762 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	224883 (C)	31525 (G)	193358 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	6773 (D)	6296 (H)	477 (L)

Source: Data for this table are from the MAX 2007 file for Nebraska, 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 Nebraska in 2007 was $143,250,319, of which $847,624 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]
NEBRASKA, 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	**224,883**	**18,224**	**29,267**	**41,461**	**135,532**	**399**	**1,533,520**	**168,328**	**276,107**	**165,475**	**920,737**	**2,873**
Age												
5 and younger	65,141	0	900	4,821	59,420	0	424,016	0	7,942	21,572	394,502	0
6-14	54,817	0	1,662	7	53,148	0	385,819	0	16,701	22	369,096	0
15-20	25,505	0	1,450	1,899	22,141	15	174,316	0	13,112	6,362	154,773	69
21-44	36,753	0	10,448	26,075	30	200	212,536	0	99,033	112,210	240	1,053
45-64	17,332	0	14,524	2,629	2	177	150,278	0	136,429	12,151	3	1,695
65-74	5,785	5,486	283	8	1	7	53,532	50,514	2,890	70	2	56
75-84	6,136	6,135	0	1	0	0	57,568	57,567	0	1	0	0
85 and older	6,603	6,603	0	0	0	0	60,247	60,247	0	0	0	0
Unknown	6,811	0	0	6,021	790	0	15,208	0	0	13,087	2,121	0
Gender												
Female	125,375	13,511	15,747	28,530	67,189	398	860,972	127,286	151,185	125,886	453,744	2,871
Male	95,392	4,713	13,520	8,885	68,273	1	664,133	41,042	124,922	31,389	466,778	2
Unknown	4,116	0	0	4,046	70	0	8,415	0	0	8,200	215	0
Race												
White	142,850	15,591	22,343	24,584	79,995	337	1,005,173	144,250	213,877	99,590	545,059	2,397
African American	28,569	968	3,633	6,664	17,284	20	199,279	9,413	33,540	28,712	127,462	152
Other/unknown	53,464	1,665	3,291	10,213	38,253	42	329,068	14,665	28,690	37,173	248,216	324
Use of Nursing Facilities[c]												
Entire year	6,773	5,706	1,060	3	4	0	67,491	55,778	11,654	17	42	0
Part year	4,156	3,183	940	23	6	4	35,119	27,179	7,702	152	43	43
None	213,954	9,335	27,267	41,435	135,522	395	1,430,910	85,371	256,751	165,306	920,652	2,830
Maintenance Assistance Status												
Cash	47,928	3,200	17,369	10,308	17,051	0	357,442	32,578	171,560	36,323	116,981	0
Medically needy	22,607	10,060	2,321	9,889	337	0	154,422	91,998	21,412	40,010	1,002	0
Poverty-related	131,136	4,954	9,232	10,501	106,050	399	846,438	43,642	79,338	33,816	686,769	2,873
Other/unknown	23,212	10	345	10,763	12,094	0	175,218	110	3,797	55,326	115,985	0
Dual Medicare Status[d]												
Full dual, all year	30,466	16,506	13,761	178	5	16	289,693	152,739	135,668	1,106	42	138
Full dual, part year	1,059	529	529	1	0	0	6,879	3,588	3,290	1	0	0
Non-dual, all year	193,358	1,189	14,977	41,282	135,527	383	1,236,948	12,001	137,149	164,368	920,695	2,735
Managed Care (MC) Status												
Fee-for-service (FFS) all year	31,416	11,163	8,238	7,000	4,624	391	219,569	104,502	81,949	14,891	15,383	2,844
FFS part year, with Rx claims	65,245	1,408	4,391	17,775	41,663	8	132,811	5,931	13,451	33,658	79,742	29
FFS part year, no Rx claims	24,821	911	1,385	5,207	17,318	0	51,842	2,829	3,971	9,905	35,137	0

Source: Data for this table are from the MAX 2007 file for Nebraska, 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]
NEBRASKA, 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	**77.4**	**9.0**	**$633**	**$71**	**$4,717**	**13.4**	**224,883**
Age							
5 and younger	84.4	5.8	233	40	1,947	12.0	65,141
6-14	79.8	6.3	546	87	1,250	43.6	54,817
15-20	83.4	9.0	952	106	2,475	38.5	25,505
21-44	77.5	13.3	1,002	75	6,636	15.1	36,753
45-64	74.2	25.1	1,758	70	13,260	13.3	17,332
65-74	58.9	11.1	557	50	12,423	4.5	5,785
75-84	51.2	6.4	241	38	16,617	1.5	6,136
85 and older	43.8	3.7	80	22	22,182	0.4	6,603
Unknown	45.7	1.9	74	40	1,211	6.1	6,811
Basis of Eligibility[e]							
Aged	50.5	6.4	247	38	17,294	1.4	18,224
Disabled	76.3	24.0	2,014	84	15,655	12.9	29,267
Adults	73.6	8.6	469	55	2,382	19.7	41,461
Children	82.4	6.2	435	71	1,362	32.0	135,532
Unknown	63.2	14.6	1,205	83	10,080	12.0	399
Gender							
Female	78.5	9.7	604	62	4,809	12.6	125,375
Male	77.5	8.3	697	84	4,752	14.7	95,392
Unknown	39.2	1.4	46	33	1,094	4.2	4,116
Race							
White	77.3	10.1	756	75	6,019	12.6	142,850
African American	78.7	7.9	509	64	2,881	17.7	28,569
Other/unknown	76.8	6.4	372	58	2,219	16.8	53,464
Use of Nursing Facilities[f]							
Entire year	51.8	11.3	560	50	37,749	1.5	6,773
Part year	59.6	14.7	848	58	27,953	3.0	4,156
None	78.5	8.8	631	72	3,220	19.6	213,954
Maintenance Assistance Status							
Cash	79.7	16.6	1,310	79	6,716	19.5	47,928
Medically needy	58.8	7.9	625	79	18,555	3.4	22,607
Poverty related	77.4	5.8	333	57	2,032	16.4	131,136
Other/unknown	90.1	11.9	937	79	2,284	41.0	23,212

Source: Data for this table are from the MAX 2007 file for Nebraska, 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]
NEBRASKA, 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	**1.3**	**$93**	**13.4**	**22.6**	**47.1**	**9.5**	**10.8**	**5.7**	**4.3**	**$692**	**224,883**	**1,533,520**
Age												
5 and younger	0.9	36	12.0	15.6	55.7	9.8	10.5	5.3	3.2	299	65,141	424,016
6-14	0.9	78	43.6	20.2	55.9	8.8	9.1	3.4	2.6	178	54,817	385,819
15-20	1.3	139	38.5	16.6	50.7	11.5	12.1	5.2	3.9	362	25,505	174,316
21-44	2.3	173	15.1	22.5	32.6	11.5	15.2	9.5	8.7	1,148	36,753	212,536
45-64	2.9	203	13.3	25.8	31.1	8.0	13.7	11.2	10.2	1,529	17,332	150,278
65-74	1.2	60	4.5	41.1	40.0	6.1	6.2	3.9	2.6	1,343	5,785	53,532
75-84	0.7	26	1.5	48.8	39.8	4.6	4.0	2.0	0.8	1,771	6,136	57,568
85 and older	0.4	9	0.4	56.2	36.9	3.8	1.8	1.0	0.4	2,431	6,603	60,247
Unknown	0.8	33	6.1	54.3	21.8	9.1	10.0	3.6	1.2	542	6,811	15,208
Basis of Eligibility[e]												
Aged	0.7	27	1.4	49.5	38.9	4.8	3.7	2.1	1.1	1,872	18,224	168,328
Disabled	2.5	214	12.9	23.7	35.5	8.7	14.2	10.1	7.9	1,659	29,267	276,107
Adults	2.2	118	19.7	26.4	30.2	11.9	14.9	8.6	7.9	597	41,461	165,475
Children	0.9	64	32.0	17.6	55.9	9.5	9.8	4.3	2.9	201	135,532	920,737
Unknown	2.0	167	12.0	36.8	25.6	13.8	17.0	6.0	0.8	1,400	399	2,873
Gender												
Female	1.4	88	12.6	21.5	46.5	9.7	11.0	6.2	5.0	700	125,375	860,972
Male	1.2	100	14.7	22.5	49.0	9.3	10.6	5.1	3.6	683	95,392	664,133
Unknown	0.7	22	4.2	60.8	20.8	7.5	8.1	2.3	0.6	535	4,116	8,415
Race												
White	1.4	107	12.6	22.7	45.6	9.7	11.0	6.1	4.9	855	142,850	1,005,173
African American	1.1	73	17.7	21.3	50.5	8.8	10.5	5.3	3.7	413	28,569	199,279
Other/unknown	1.0	61	16.8	23.2	49.1	9.2	10.5	4.8	3.2	361	53,464	329,068
Use of Nursing Facilities[f]												
Entire year	1.1	56	1.5	48.2	38.1	4.8	2.7	3.0	3.1	3,788	6,773	67,491
Part year	1.7	100	3.0	40.4	38.8	4.8	5.2	4.2	6.6	3,308	4,156	35,119
None	1.3	94	19.6	21.5	47.5	9.7	11.2	5.8	4.3	481	213,954	1,430,910
Maintenance Assistance Status												
Cash	2.2	176	19.5	20.3	40.3	9.7	14.1	8.8	6.7	901	47,928	357,442
Medically needy	1.2	92	3.4	41.2	32.6	7.9	8.3	5.2	4.8	2,716	22,607	154,422
Poverty related	0.9	52	16.4	22.6	51.4	9.1	9.4	4.4	3.1	315	131,136	846,438
Other/unknown	1.6	124	41.0	9.9	50.6	12.5	14.6	6.5	5.9	303	23,212	175,218

Source: Data for this table are from the MAX 2007 file for Nebraska, 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]
NEBRASKA, 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	**1.3**	**$93**	**$71**	**0.4**	**$69**	**$170**	**0.1**	**$5**	**$88**	**0.9**	**$19**	**$23**
Age												
5 and younger	0.9	36	40	0.2	17	111	0.1	3	56	0.7	15	23
6-14	0.9	78	87	0.4	62	153	0.0	3	82	0.4	12	27
15-20	1.3	139	106	0.5	117	217	0.0	4	102	0.7	18	25
21-44	2.3	173	75	0.7	130	187	0.1	9	123	1.5	34	22
45-64	2.9	203	70	0.9	151	175	0.1	11	105	1.9	41	21
65-74	1.2	60	50	0.3	43	143	0.0	4	79	0.9	14	16
75-84	0.7	26	38	0.1	17	125	0.0	1	58	0.5	7	14
85 and older	0.4	9	22	0.0	5	101	0.0	0	43	0.3	4	10
Unknown	0.8	33	40	0.1	11	114	0.0	1	87	0.7	21	29
Basis of Eligibility[d]												
Aged	0.7	27	38	0.1	18	129	0.0	2	67	0.5	7	14
Disabled	2.5	214	84	0.8	164	198	0.1	12	116	1.6	38	23
Adults	2.2	118	55	0.6	80	145	0.1	6	99	1.5	32	21
Children	0.9	64	71	0.3	47	159	0.0	3	68	0.6	14	24
Unknown	2.0	167	83	0.6	130	203	0.1	10	101	1.3	28	21
Gender												
Female	1.4	88	62	0.4	63	154	0.1	5	90	1.0	20	21
Male	1.2	100	84	0.4	78	192	0.1	5	85	0.7	18	24
Unknown	0.7	22	33	0.1	8	87	0.0	1	98	0.6	13	23
Race												
White	1.4	107	75	0.5	81	175	0.1	5	89	0.9	21	23
African American	1.1	73	64	0.3	52	160	0.0	4	99	0.8	17	22
Other/unknown	1.0	61	58	0.3	41	154	0.0	4	77	0.7	16	22
Use of Nursing Facilities[e]												
Entire year	1.1	56	50	0.3	40	156	0.0	2	75	0.9	14	17
Part year	1.7	100	58	0.4	70	164	0.1	4	86	1.3	26	21
None	1.3	94	72	0.4	70	171	0.1	5	88	0.8	19	23
Maintenance Assistance Status												
Cash	2.2	176	79	0.7	133	184	0.1	9	107	1.4	33	23
Medically needy	1.2	92	79	0.3	74	264	0.0	3	91	0.8	15	18
Poverty related	0.9	52	57	0.2	35	140	0.0	3	70	0.6	14	23
Other/unknown	1.6	124	79	0.6	99	158	0.1	5	91	0.9	20	22

Source: Data for this table are from the MAX 2007 file for Nebraska, 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 Nebraska, 0.7 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, 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	0.3	0.0	0.0	0.3	$16	$6	$2	$8	$45	$171	$102	$28	294,317	$13,315,434	111,879	49.7	843,491
Biologicals	0.2	0.2	0.0	0.0	127	127	0	0	701	701	0	0	140	98,101	77	0.0	771
Antineoplastic Agents	0.6	0.2	0.0	0.4	168	147	1	20	268	771	162	46	3,718	995,962	696	0.3	5,943
Endocrine/Metabolic Drugs	0.6	0.2	0.0	0.3	32	22	1	9	57	117	36	26	151,184	8,691,823	35,451	15.8	270,603
Cardiovascular Agents	1.2	0.3	0.1	0.8	45	27	6	12	38	94	70	14	158,369	6,054,207	16,371	7.3	134,560
Respiratory Agents	0.5	0.2	0.0	0.2	28	22	1	5	61	113	37	22	304,681	18,470,700	83,019	36.9	662,710
Gastrointestinal Agents	0.4	0.1	0.0	0.3	28	11	4	14	65	142	130	42	72,215	4,718,275	21,918	9.7	166,920
Genitourinary Agents	0.4	0.1	0.0	0.2	23	14	1	9	59	101	69	36	25,387	1,508,796	9,814	4.4	65,975
CNS Drugs	1.1	0.5	0.0	0.6	114	100	2	11	106	221	133	19	349,794	37,035,932	39,265	17.5	325,915
Stimulants/Anti-obesity/Anorexia	0.9	0.8	0.0	0.1	111	107	1	4	123	138	56	32	86,272	10,602,075	11,047	4.9	95,137
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	258	258	0	0	388	394	0	17	4,174	1,618,220	747	0.3	6,268
Analgesics and Anesthetics	0.5	0.0	0.0	0.5	17	7	2	9	34	273	315	18	191,275	6,458,931	52,155	23.2	378,222
Neuromuscular Agents	0.9	0.4	0.1	0.5	94	72	9	13	102	185	188	26	150,855	15,327,039	19,435	8.6	162,739
Nutritional Products	0.4	0.0	0.0	0.3	4	0	0	3	11	16	17	10	46,904	494,554	20,242	9.0	133,476
Hematological Agents	0.7	0.1	0.0	0.5	215	209	1	6	312	1,392	30	12	30,227	9,436,936	5,057	2.2	43,827
Topical Products	0.3	0.1	0.0	0.2	13	8	1	4	46	100	72	20	141,062	6,504,407	63,660	28.3	507,776
Miscellaneous Products	0.5	0.3	0.0	0.2	141	118	5	18	265	466	167	73	3,760	997,861	822	0.4	7,073
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	8	0	0	0	45	0	0	0	1,649	73,442	1,120	0.5	9,245
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.	2,015,983	142,402,695	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Nebraska, 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 Nebraska, 0.7 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]
NEBRASKA, 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	$21,508,543	12,516	5.6	111,939	0.7	$263	$192
ANTICONVULSANT	11,826,679	13,770	6.1	123,178	0.8	116	96
ANTIASTHMATIC	9,588,620	39,687	17.6	314,959	0.4	86	30
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	8,487,106	10,420	4.6	89,424	0.8	122	95
MISC. HEMATOLOGICAL	7,767,464	670	0.3	5,670	0.7	2,075	1,370
ANTIDEPRESSANTS	6,077,628	21,211	9.4	161,742	0.6	60	38
DERMATOLOGICAL	3,406,123	54,344	24.2	453,713	0.2	38	8
ANTIDIABETIC	3,074,124	6,349	2.8	51,791	0.7	81	59
ULCER DRUGS	2,851,410	20,814	9.3	173,873	0.5	33	16
CEPHALOSPORINS	2,598,889	33,523	14.9	263,617	0.2	57	10
Total	77,186,586	213,304	n.a.	1,749,906	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Nebraska, 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.