STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
VIRGINIA

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
VIRGINIA, 2003

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)		Number of Dual Eligible Beneficiaries (Cell)[g]		Number of Non-dual Eligible Beneficiaries (Cell)	
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	773,111	(A)	150,014	(E)	623,097	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	722,789	(B)	110,012	(F)	612,777	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	523,872	(C)	108,955	(G)	414,917	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	15,431	(D)	13,981	(H)	1,450	(L)

Source: Data for this table are from the MAX 2003 file for Virginia, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003 (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 2003, 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 Virginia in 2003 was $529,131,121, of which $16,431,230 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 19 states in 2003 that had PHPs that did not include a pharmacy benefit: AL, AR, CA, CO, FL, GA, IA, KY, MA, MI, NY, OR, PA, SD, TN, TX, UT, WA, and WI. In addition, there were 7 states in which MC plans did not provide a pharmacy benefit: DE, IA, NE, NY, TX, UT, and WV. These lists were constructed from the CMS 2003 Medicaid Managed Care Enrollment Report [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer02.pdf] and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit package.

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2003. 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 benficiary 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 2003. 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]

VIRGINIA, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**523,872**	**71,300**	**93,285**	**72,577**	**286,710**	**0**	**3,622,778**	**735,489**	**880,239**	**319,770**	**1,687,280**	**0**
Age												
5 and younger	121,251	0	2,226	0	119,025	0	642,282	0	14,603	0	627,679	0
6-14	130,005	0	6,601	191	123,213	0	821,228	0	49,244	1,092	770,892	0
15-20	58,782	0	5,038	9,398	44,346	0	366,906	0	38,643	40,409	287,854	0
21-44	95,128	50	35,050	59,921	107	0	604,073	418	339,825	263,082	748	0
45-64	45,599	232	42,304	3,060	3	0	434,019	2,013	416,822	15,152	32	0
65-74	27,618	25,721	1,891	6	0	0	290,545	271,133	19,378	34	0	0
75-84	27,166	27,031	135	0	0	0	284,783	283,420	1,363	0	0	0
85 and older	18,308	18,266	40	1	1	0	178,870	178,505	361	1	3	0
Unknown	15	0	0	0	15	0	72	0	0	0	72	0
Gender												
Female	313,118	52,970	49,753	67,029	143,366	0	2,162,936	550,638	476,261	293,981	842,056	0
Male	210,740	18,319	43,529	5,548	143,344	0	1,459,792	184,813	403,966	25,789	845,224	0
Unknown	14	11	3	0	0	0	50	38	12	0	0	0
Race												
White	260,686	39,033	56,797	35,781	129,075	0	2,026,135	394,908	568,307	179,009	883,911	0
African American	210,636	25,037	33,875	32,764	118,960	0	1,282,232	264,107	288,751	126,011	603,363	0
Other/unknown	52,550	7,230	2,613	4,032	38,675	0	314,411	76,474	23,181	14,750	200,006	0
Use of Nursing Facilities[c]												
Entire year	15,431	13,232	2,190	0	9	0	157,459	133,228	24,144	0	87	0
Part year	10,317	8,424	1,848	18	27	0	96,674	78,726	17,605	147	196	0
None	498,124	49,644	89,247	72,559	286,674	0	3,368,645	523,535	838,490	319,623	1,686,997	0
Maintenance Assistance Status												
Cash	113,427	35,393	73,272	4,644	118	0	1,091,421	389,797	677,562	23,375	687	0
Medically needy	965	366	570	15	14	0	8,747	3,742	4,858	69	78	0
Poverty-related	305,607	9,948	9,737	28,588	257,334	0	1,789,478	101,553	94,901	114,651	1,478,373	0
Other/unknown	103,873	25,593	9,706	39,330	29,244	0	733,132	240,397	102,918	181,675	208,142	0
Dual Medicare Status[d]												
Full dual, all year	104,587	63,094	41,092	377	24	0	1,106,548	656,728	447,286	2,286	248	0
Full dual, part year	4,368	2,676	1,678	14	0	0	46,555	28,449	17,974	132	0	0
Non-dual, all year	414,917	5,530	50,515	72,186	286,686	0	2,469,675	50,312	414,979	317,352	1,687,032	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	322,926	69,741	76,565	32,865	143,755	0	2,943,783	727,516	815,621	189,189	1,211,457	0
FFS part year, with Rx claims	77,114	1,206	10,590	21,133	44,185	0	299,894	6,713	45,457	75,304	172,420	0
FFS part year, no Rx claims	123,832	353	6,130	18,579	98,770	0	379,101	1,260	19,161	55,277	303,403	0

Source: Data for this table are from the MAX 2003 file for Virginia, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003. 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]

VIRGINIA, 2003

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	**58.4 %**	**16.1**	**$979**	**$61**	**$5,204**	**18.8 %**	**523,872**
Age							
5 and younger	45.6	2.4	114	47	1,835	6.2	121,251
6-14	44.3	3.5	247	72	1,543	16.0	130,005
15-20	49.0	4.7	351	75	2,800	12.5	58,782
21-44	63.8	14.9	1,135	76	6,641	17.1	95,128
45-64	83.2	47.8	3,189	67	13,271	24.0	45,599
65-74	87.6	50.6	2,745	54	9,557	28.7	27,618
75-84	90.4	53.5	2,693	50	12,166	22.1	27,166
85 and older	92.5	52.2	2,388	46	16,767	14.2	18,308
Unknown	26.7	1.5	35	23	982	3.5	15
Basis of Eligibility[e]							
Aged	89.9	51.9	2,623	51	12,410	21.1	71,300
Disabled	80.0	38.2	2,813	74	13,468	20.9	93,285
Adults	54.7	4.6	217	47	2,219	9.8	72,577
Children	44.5	2.9	166	58	1,478	11.2	286,710
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	61.1	18.5	1,047	57	5,240	20.0	313,118
Male	54.5	12.5	877	70	5,149	17.0	210,740
Unknown	64.3	13.6	802	59	4,329	18.5	14
Race							
White	67.8	21.5	1,303	61	6,268	20.8	260,686
African American	49.4	11.4	700	62	4,544	15.4	210,636
Other/unknown	48.2	8.1	484	60	2,567	18.9	52,550
Use of Nursing Facilities[f]							
Entire year	97.5	76.3	3,824	50	33,263	11.5	15,431
Part year	97.2	64.8	3,331	51	23,935	13.9	10,317
None	56.4	13.2	842	64	3,946	21.3	498,124
Maintenance Assistance Status							
Cash	82.9	39.9	2,591	65	9,420	27.5	113,427
Medically needy	80.3	27.3	1,973	72	12,305	16.0	965
Poverty related	46.7	4.6	248	54	1,524	16.3	305,607
Other/unknown	65.9	23.8	1,359	57	11,359	12.0	103,873

Source: Data for this table are from the MAX 2003 file for Virginia, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 seven states (DE, IA, NE, NY, TX, UT, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.

d. In seven states (DE, IA, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; OTC = over-the-counter; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 4

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT *PER BENEFIT MONTH*, BY BENEFICIARY CHARACTERISTIC[a, b]

VIRGINIA, 2003

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: 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]	Number Beneficiaries	Benefit Months
All	**2.3**	**$142**	**18.8 %**	**41.6 %**	**30.8 %**	**6.8 %**	**10.6 %**	**7.6 %**	**2.5 %**	**$753**	**523,872**	**3,622,778**
Age												
5 and younger	0.5	22	6.2	54.4	39.0	4.5	1.9	0.2	0.0	346	121,251	642,282
6-14	0.5	39	16.0	55.7	36.0	4.7	3.1	0.4	0.1	244	130,005	821,228
15-20	0.7	56	12.5	51.0	37.4	6.0	4.6	1.0	0.1	449	58,782	366,906
21-44	2.3	179	17.1	36.2	32.0	9.7	13.5	6.9	1.7	1,046	95,128	604,073
45-64	5.0	335	24.0	16.8	14.2	9.3	25.4	24.4	9.9	1,394	45,599	434,019
65-74	4.8	261	28.7	12.4	13.6	10.1	29.2	25.7	9.0	908	27,618	290,545
75-84	5.1	257	22.1	9.6	11.1	9.8	30.9	28.8	9.7	1,161	27,166	284,783
85 and older	5.3	244	14.2	7.5	9.6	9.3	31.6	32.1	9.9	1,716	18,308	178,870
Unknown	0.3	7	3.5	73.3	26.7	0.0	0.0	0.0	0.0	205	15	72
Basis of Eligibility[e]												
Aged	5.0	254	21.1	10.1	11.7	9.9	30.4	28.4	9.4	1,203	71,300	735,489
Disabled	4.0	298	20.9	20.0	20.6	10.6	23.7	18.6	6.7	1,427	93,285	880,239
Adults	1.1	49	9.8	45.3	37.2	8.3	7.0	2.0	0.3	504	72,577	319,770
Children	0.5	28	11.2	55.5	37.3	4.4	2.4	0.3	0.0	251	286,710	1,687,280
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.7	152	20.0	38.9	30.2	7.1	11.6	9.0	3.1	759	313,118	2,162,936
Male	1.8	127	17.0	45.5	31.8	6.4	9.2	5.5	1.6	743	210,740	1,459,792
Unknown	3.8	224	18.5	35.7	7.1	7.1	21.4	14.3	14.3	1,212	14	50
Race												
White	2.8	168	20.8	32.2	33.5	7.7	12.5	10.2	3.9	806	260,686	2,026,135
African American	1.9	115	15.4	50.6	27.6	5.9	9.0	5.6	1.3	747	210,636	1,282,232
Other/unknown	1.4	81	18.9	51.8	30.9	5.8	7.7	3.2	0.5	429	52,550	314,411
Use of Nursing Facilities[f]												
Entire year	7.5	375	11.5	2.5	4.1	5.3	25.6	39.9	22.6	3,260	15,431	157,459
Part year	6.9	356	13.9	2.8	6.4	7.6	28.5	35.7	18.9	2,554	10,317	96,674
None	2.0	125	21.3	43.6	32.2	6.8	9.8	6.0	1.6	584	498,124	3,368,645
Maintenance Assistance Status												
Cash	4.1	269	27.5	17.1	19.4	10.9	26.3	20.2	6.0	979	113,427	1,091,421
Medically needy	3.0	218	16.0	19.7	25.7	15.1	24.5	11.8	3.2	1,358	965	8,747
Poverty related	0.8	42	16.3	53.3	36.4	5.0	3.7	1.4	0.3	260	305,607	1,789,478
Other/unknown	3.4	193	12.0	34.1	26.9	7.6	13.8	12.2	5.3	1,609	103,873	733,132

Source: Data for this table are from the MAX 2003 file for Virginia, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 seven states (DE, IA, NE, NY, TX, UT, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.

d. In seven states (DE, IA, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 5

AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC[a, b, c]

VIRGINIA, 2003

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**2.3**	**$142**	**$61**	**1.1**	**$109**	**$103**	**0.1**	**$5**	**$48**	**1.1**	**$27**	**$24**
Age												
5 and younger	0.5	22	47	0.2	17	86	0.0	1	37	0.2	4	17
6-14	0.5	39	72	0.3	32	109	0.0	1	59	0.2	5	23
15-20	0.7	56	75	0.4	46	121	0.0	2	64	0.3	8	24
21-44	2.3	179	76	1.0	139	133	0.1	7	72	1.2	32	27
45-64	5.0	335	67	2.3	256	112	0.2	12	58	2.5	66	26
65-74	4.8	261	54	2.2	199	88	0.2	7	38	2.4	54	23
75-84	5.1	257	50	2.3	194	84	0.2	8	32	2.5	54	21
85 and older	5.3	244	46	2.2	180	81	0.3	9	29	2.8	55	20
Unknown	0.3	7	23	0.1	5	36	0.0	0	0	0.2	3	14
Basis of Eligibility[d]												
Aged	5.0	254	51	2.3	191	85	0.2	8	33	2.5	54	22
Disabled	4.0	298	74	1.9	232	124	0.2	11	66	2.0	54	27
Adults	1.1	49	47	0.4	36	88	0.0	1	35	0.6	12	19
Children	0.5	28	58	0.2	23	94	0.0	1	48	0.2	5	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.7	152	57	1.2	116	95	0.1	5	43	1.3	31	23
Male	1.8	127	70	0.8	99	118	0.1	5	59	0.9	23	26
Unknown	3.8	224	59	1.8	177	99	0.0	1	27	2.0	47	24
Race												
White	2.8	168	61	1.3	128	102	0.1	6	48	1.4	33	24
African American	1.9	115	62	0.8	90	106	0.1	3	46	0.9	22	23
Other/unknown	1.4	81	60	0.7	65	91	0.0	2	52	0.6	14	23
Use of Nursing Facilities[e]												
Entire year	7.5	375	50	3.1	280	89	0.5	14	31	3.8	78	21
Part year	6.9	356	51	3.0	269	91	0.4	13	30	3.5	71	21
None	2.0	125	64	0.9	96	106	0.1	4	55	1.0	24	25
Maintenance Assistance Status												
Cash	4.1	269	65	1.9	207	108	0.2	9	58	2.0	52	25
Medically needy	3.0	218	72	1.5	176	120	0.1	7	59	1.4	33	23
Poverty related	0.8	42	54	0.4	32	90	0.0	1	43	0.4	8	22
Other/unknown	3.4	193	57	1.5	148	100	0.2	6	36	1.7	37	22

Source: Data for this table are from the MAX 2003 file for Virginia, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 Virginia, 1.0 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 combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007)

d. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

e. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 6

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY[a, b, c, d]

VIRGINIA, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total 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			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.2	0.0	0.2	$20	$16	$0	$4	$66	$105	$74	$25	544,148	$35,660,487	186,188	35.5 %	1,768,161
Biologicals	0.3	0.3	0.0	0.0	327	268	16	43	1121	1,001	1,584	3,062	3,665	4,107,397	1,415	0.3	12,566
Antineoplastic Agents	0.5	0.2	0.0	0.3	105	78	2	26	216	422	158	89	31,020	6,696,234	6,295	1.2	63,502
Endocrine/Metabolic Drugs	0.8	0.4	0.1	0.3	36	28	2	7	47	70	22	22	704,804	32,865,160	89,316	17.0	900,673
Cardiovascular Agents	1.7	0.7	0.0	1.0	65	45	2	18	38	65	31	19	1,789,858	67,738,517	99,838	19.1	1,044,532
Respiratory Agents	0.6	0.3	0.0	0.2	30	23	1	5	51	72	48	22	893,130	45,162,300	157,015	30.0	1,514,641
Gastrointestinal Agents	0.7	0.4	0.0	0.3	65	51	1	14	89	127	115	42	631,367	56,363,431	83,132	15.9	865,371
Genitourinary Agents	0.4	0.3	0.0	0.1	24	23	0	2	59	68	38	21	124,261	7,299,314	30,536	5.8	298,332
CNS Drugs	1.2	0.6	0.0	0.6	101	82	4	15	84	134	115	27	1,286,990	107,560,050	105,292	20.1	1,065,041
Stimulants/Anti-obesity/Anorexia	0.6	0.4	0.0	0.2	50	41	2	7	79	93	74	43	93,834	7,453,929	16,460	3.1	150,502
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	86	84	0	2	140	145	39	62	54,836	7,662,743	8,482	1.6	88,655
Analgesics and Anesthetics	0.7	0.2	0.0	0.5	36	26	1	9	52	125	67	19	821,850	42,702,896	118,652	22.6	1,178,094
Neuromuscular Agents	0.9	0.4	0.1	0.4	65	49	3	13	74	127	51	29	540,702	39,765,027	58,680	11.2	607,735
Nutritional Products	0.5	0.0	0.0	0.5	9	1	1	7	16	23	17	16	224,722	3,705,822	44,790	8.5	420,194
Hematological Agents	0.8	0.3	0.2	0.3	83	74	3	6	107	252	19	19	235,894	25,131,393	29,425	5.6	302,789
Topical Products	0.3	0.2	0.0	0.2	15	10	1	4	44	66	54	22	371,910	16,468,005	112,613	21.5	1,113,869
Miscellaneous Products	0.5	0.2	0.0	0.2	121	97	11	13	260	487	255	58	16,222	4,212,931	3,425	0.7	34,848
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	9	0	0	0	39	0	0	0	55,559	2,144,255	22,688	4.3	229,035
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.	8,424,772	512,699,891	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Virginia, released by CMS in 05/2007. This table was produced on 11/01/2007.

a. Table 6 includes the beneficiaries represented by Cell C of Table 1. A beneficiary who used drugs from two or more categories was counted as a user for each category. Therefore, the sum of users across categories may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. For information about these therapeutic categories, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Virginia, 1.0 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2003.

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]

VIRGINIA, 2003

		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	$62,073,056	48,775	9.3 %	513,385	0.7	$174	$121
ULCER DRUGS	47,561,569	81,068	15.5	858,203	0.5	102	55
ANTIDEPRESSANTS	34,576,251	88,249	16.8	905,649	0.6	65	38
ANTICONVULSANT	32,519,995	46,959	9.0	493,712	0.8	87	66
ANTIASTHMATIC	24,178,146	108,640	20.7	1,080,632	0.4	62	22
ANTIHYPERLIPIDEMIC	22,544,657	36,625	7.0	405,776	0.6	86	56
ANTIDIABETIC	22,014,604	51,844	9.9	554,180	0.7	58	40
ANALGESICS - Narcotic	21,075,146	128,531	24.5	1,306,647	0.4	43	16
ANTIHYPERTENSIVE	18,832,307	70,062	13.4	749,742	0.7	38	25
ANALGESICS - ANTI-INFLAMMATORY	17,499,633	72,139	13.8	757,939	0.3	70	23
Total	302,875,364	732,892		7,625,865	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Virginia, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003. 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 2003. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.