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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2005
VIRGINIA

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
VIRGINIA, 2005

Inclusion Criteria (2005)	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]	884499 (A)	162163 (E)	722336 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	827448 (B)	117811 (F)	709637 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	547081 (C)	116632 (G)	430449 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	15253 (D)	13835 (H)	1418 (L)

Source: Data for this table are from the MAX 2005 file for Virginia, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 2005 (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 2005, 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 2005 was $615,992,976, of which $18,657,331 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 26 states in 2005 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NH, NV, NY, OH, 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, TX, UT, and WV) and one state (NV) in which MC plans provided a pharmacy benefit for nonduals but not for duals. These lists were constructed from the CMS 2005 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer05.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 2005. 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 N+B18D.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 2005. 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, 2005

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**547,081**	**72,224**	**96,319**	**84,477**	**293,662**	**399**	**3,838,469**	**738,730**	**940,075**	**387,105**	**1,768,842**	**3,717**
Age												
5 and younger	125,734	0	2,013	0	123,721	0	650,132	0	14,385	0	635,747	0
6-14	125,260	0	5,877	63	119,320	0	839,115	0	49,102	380	789,633	0
15-20	65,235	0	5,343	9,416	50,475	1	430,405	0	45,387	42,484	342,528	6
21-44	104,731	4	34,815	69,724	141	47	669,057	24	348,121	319,596	898	418
45-64	51,047	17	45,419	5,266	2	343	481,470	137	453,491	24,592	5	3,245
65-74	28,545	25,835	2,697	5	0	8	297,752	269,611	28,056	37	0	48
75-84	27,820	27,706	114	0	0	0	288,589	287,400	1,189	0	0	0
85 and older	18,706	18,662	41	2	1	0	181,920	181,558	344	10	8	0
Unknown	3	0	0	1	2	0	29	0	0	6	23	0
Gender												
Female	326,964	53,123	51,375	75,743	146,324	399	2,287,149	548,151	507,247	346,792	881,242	3,717
Male	220,086	19,078	44,936	8,734	147,338	0	1,551,088	190,418	432,757	40,313	887,600	0
Unknown	31	23	8	0	0	0	232	161	71	0	0	0
Race												
White	275,072	39,005	59,340	42,551	133,943	233	2,175,311	391,898	606,077	222,288	952,885	2,163
African American	206,974	25,099	34,193	35,951	111,586	145	1,305,029	263,160	310,447	143,420	586,660	1,342
Other/unknown	65,035	8,120	2,786	5,975	48,133	21	358,129	83,672	23,551	21,397	229,297	212
Use of Nursing Facilities[c]												
Entire year	15,253	12,846	2,393	2	12	0	156,901	130,158	26,599	16	128	0
Part year	10,479	8,285	2,118	37	36	3	97,830	77,118	20,218	206	264	24
None	521,349	51,093	91,808	84,438	293,614	396	3,583,738	531,454	893,258	386,883	1,768,450	3,693
Maintenance Assistance Status												
Cash	113,698	34,678	72,161	6,822	37	0	1,102,957	376,267	691,521	34,995	174	0
Medically needy	823	184	609	10	20	0	6,904	1,836	4,881	62	125	0
Poverty-related	302,759	10,411	12,567	23,668	255,714	399	1,856,297	110,377	126,602	95,196	1,520,405	3,717
Other/unknown	129,801	26,951	10,982	53,977	37,891	0	872,311	250,250	117,071	256,852	248,138	0
Dual Medicare Status[d]												
Full dual, all year	111,803	66,099	45,037	632	21	14	1,181,773	681,334	496,014	4,104	193	128
Full dual, part year	4,829	2,800	2,004	25	0	0	51,111	29,755	21,081	275	0	0
Non-dual, all year	430,449	3,325	49,278	83,820	293,641	385	2,605,585	27,641	422,980	382,726	1,768,649	3,589
Managed Care (MC) Status												
Fee-for-service (FFS) all year	321,719	69,069	79,645	33,851	138,758	396	2,959,177	718,698	856,444	206,829	1,173,514	3,692
FFS part year, with Rx claims	87,810	2,613	11,501	26,894	46,799	3	433,811	17,213	64,836	110,594	241,143	25
FFS part year, no Rx claims	137,552	542	5,173	23,732	108,105	0	445,481	2,819	18,795	69,682	354,185	0

Source: Data for this table are from the MAX 2005 file for Virginia, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 2005. 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, 2005

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	**56.4**	**16.3**	**$1,092**	**$67**	**$5,978**	**18.3**	**547,081**
Age							
5 and younger	41.9	2.1	123	59	2,298	5.4	125,734
6-14	40.5	3.4	288	85	1,867	15.4	125,260
15-20	45.7	4.8	433	90	3,363	12.9	65,235
21-44	62.9	14.4	1,179	82	7,188	16.4	104,731
45-64	83.0	47.3	3,414	72	14,842	23.0	51,047
65-74	87.3	52.3	3,063	59	10,492	29.2	28,545
75-84	89.9	55.3	2,994	54	13,423	22.3	27,820
85 and older	91.2	53.1	2,624	49	18,450	14.2	18,706
Unknown	33.3	1.7	33	20	754	4.4	3
Basis of Eligibility[e]							
Aged	89.2	53.5	2,908	54	13,637	21.3	72,224
Disabled	82.0	40.1	3,220	80	15,544	20.7	96,319
Adults	53.9	5.0	243	49	2,812	8.6	84,477
Children	40.6	2.7	190	71	1,859	10.2	293,662
Unknown	86.0	27.6	2,083	75	12,909	16.1	399
Gender							
Female	59.3	18.7	1,155	62	5,972	19.3	326,964
Male	52.0	12.8	998	78	5,986	16.7	220,086
Unknown	77.4	45.8	2,502	55	19,547	12.8	31
Race							
White	65.7	21.6	1,421	66	7,029	20.2	275,072
African American	48.6	12.3	847	69	5,519	15.4	206,974
Other/unknown	41.7	7.0	478	68	2,999	15.9	65,035
Use of Nursing Facilities[f]							
Entire year	97.6	82.7	4,583	55	38,504	11.9	15,253
Part year	97.2	66.2	3,708	56	27,553	13.5	10,479
None	54.4	13.4	937	70	4,593	20.4	521,349
Maintenance Assistance Status							
Cash	83.3	40.5	2,870	71	10,857	26.4	113,698
Medically needy	80.4	28.5	2,460	86	18,152	13.6	823
Poverty related	43.7	5.0	314	63	1,737	18.1	302,759
Other/unknown	62.3	21.7	1,340	62	11,521	11.6	129,801

Source: Data for this table are from the MAX 2005 file for Virginia, released by CMS in 11/2008. This table was produced on 04/23/2009.

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, 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 eight states (DE, IA, IL, 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, 2005

				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	**2.3**	**$156**	**18.3**	**43.6**	**29.0**	**6.4**	**10.5**	**7.8**	**2.6**	**$852**	**547,081**	**3,838,469**
Age												
5 and younger	0.4	24	5.4	58.1	36.7	3.6	1.5	0.1	0.0	444	125,734	650,132
6-14	0.5	43	15.4	59.5	33.0	4.1	2.9	0.4	0.0	279	125,260	839,115
15-20	0.7	66	12.9	54.3	34.2	5.6	4.6	1.1	0.1	510	65,235	430,405
21-44	2.2	185	16.4	37.1	31.6	9.9	13.4	6.5	1.6	1,125	104,731	669,057
45-64	5.0	362	23.0	17.0	14.9	9.4	25.1	24.1	9.6	1,574	51,047	481,470
65-74	5.0	294	29.2	12.7	12.7	9.5	28.4	26.7	9.9	1,006	28,545	297,752
75-84	5.3	289	22.3	10.1	10.5	8.9	29.7	30.3	10.6	1,294	27,820	288,589
85 and older	5.5	270	14.2	8.8	9.0	8.4	30.8	32.4	10.8	1,897	18,706	181,920
Unknown	0.2	3	4.4	66.7	33.3	0.0	0.0	0.0	0.0	78	3	29
Basis of Eligibility[e]												
Aged	5.2	284	21.3	10.8	11.0	9.0	29.5	29.4	10.3	1,333	72,224	738,730
Disabled	4.1	330	20.7	18.0	20.7	10.8	24.2	19.4	7.0	1,593	96,319	940,075
Adults	1.1	53	8.6	46.1	35.2	8.5	7.8	2.1	0.3	614	84,477	387,105
Children	0.4	32	10.2	59.4	34.4	3.8	2.1	0.3	0.0	309	293,662	1,768,842
Unknown	3.0	224	16.1	14.0	28.8	11.8	31.3	13.3	0.8	1,386	399	3,717
Gender												
Female	2.7	165	19.3	40.7	28.6	6.7	11.5	9.2	3.2	854	326,964	2,287,149
Male	1.8	142	16.7	48.0	29.6	6.0	9.0	5.7	1.7	849	220,086	1,551,088
Unknown	6.1	334	12.8	22.6	6.5	3.2	29.0	29.0	9.7	2,612	31	232
Race												
White	2.7	180	20.2	34.3	31.7	7.5	12.4	10.2	4.0	889	275,072	2,175,311
African American	2.0	134	15.4	51.4	26.0	5.6	9.3	6.1	1.5	875	206,974	1,305,029
Other/unknown	1.3	87	15.9	58.3	27.1	4.5	6.6	3.1	0.4	545	65,035	358,129
Use of Nursing Facilities[f]												
Entire year	8.0	446	11.9	2.4	3.5	4.1	23.5	40.0	26.5	3,743	15,253	156,901
Part year	7.1	397	13.5	2.8	5.8	6.6	27.0	38.8	19.0	2,951	10,479	97,830
None	1.9	136	20.4	45.6	30.2	6.5	9.8	6.2	1.6	668	521,349	3,583,738
Maintenance Assistance Status												
Cash	4.2	296	26.4	16.7	19.4	10.8	26.2	20.7	6.2	1,119	113,698	1,102,957
Medically needy	3.4	293	13.6	19.6	24.9	13.0	24.1	13.9	4.6	2,164	823	6,904
Poverty related	0.8	51	18.1	56.3	33.6	4.4	3.8	1.6	0.3	283	302,759	1,856,297
Other/unknown	3.2	200	11.6	37.7	26.7	7.3	12.5	10.9	5.0	1,714	129,801	872,311

Source: Data for this table are from the MAX 2005 file for Virginia, released by CMS in 11/2008. This table was produced on 04/23/2009.

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, 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 eight states (DE, IA, IL, 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, 2005

	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**	**$156**	**$67**	**0.9**	**$118**	**$134**	**0.1**	**$8**	**$86**	**1.4**	**$30**	**$22**
Age												
5 and younger	0.4	24	59	0.1	18	133	0.0	1	50	0.3	5	19
6-14	0.5	43	85	0.3	36	142	0.0	2	78	0.2	6	24
15-20	0.7	66	90	0.3	54	169	0.0	3	73	0.4	9	24
21-44	2.2	185	82	0.8	139	176	0.1	11	111	1.4	35	25
45-64	5.0	362	72	1.8	269	146	0.2	20	113	3.0	73	25
65-74	5.0	294	59	2.0	225	115	0.2	11	70	2.9	58	20
75-84	5.3	289	54	2.1	221	106	0.2	11	60	3.1	57	19
85 and older	5.5	270	49	2.0	199	101	0.2	13	59	3.2	57	18
Unknown	0.2	3	20	0.0	3	74	0.0	0	0	0.1	1	7
Basis of Eligibility[d]												
Aged	5.2	284	54	2.0	216	108	0.2	11	63	3.0	57	19
Disabled	4.1	330	80	1.5	251	162	0.2	18	115	2.4	61	26
Adults	1.1	53	49	0.3	36	118	0.0	3	67	0.7	14	19
Children	0.4	32	71	0.2	25	132	0.0	1	65	0.2	5	22
Unknown	3.0	224	75	0.9	176	186	0.1	7	94	1.9	40	21
Gender												
Female	2.7	165	62	1.0	124	125	0.1	8	81	1.6	33	21
Male	1.8	142	78	0.7	110	152	0.1	6	99	1.0	25	24
Unknown	6.1	334	55	2.7	237	88	0.2	22	133	3.2	75	23
Race												
White	2.7	180	66	1.0	134	132	0.1	10	88	1.6	36	22
African American	2.0	134	69	0.7	105	141	0.1	5	84	1.1	24	21
Other/unknown	1.3	87	68	0.6	70	121	0.0	3	73	0.7	14	22
Use of Nursing Facilities[e]												
Entire year	8.0	446	55	2.9	329	112	0.4	25	67	4.7	92	20
Part year	7.1	397	56	2.6	296	114	0.3	22	71	4.2	79	19
None	1.9	136	70	0.7	104	139	0.1	6	93	1.1	26	23
Maintenance Assistance Status												
Cash	4.2	296	71	1.6	227	140	0.1	14	99	2.4	56	23
Medically needy	3.4	293	86	1.3	219	172	0.1	29	232	2.0	45	23
Poverty related	0.8	51	63	0.3	39	127	0.0	2	76	0.5	10	21
Other/unknown	3.2	200	62	1.2	150	126	0.1	10	74	1.9	39	21

Source: Data for this table are from the MAX 2005 file for Virginia, released by CMS in 11/2008. This table was produced on 04/23/2009.

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, 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.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, 2005

	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	0.1	0.0	0.2	$20	$13	$2	$5	$67	$186	$72	$23	545,428	$36,444,451	185,684	33.9	1,786,212
Biologicals	0.3	0.3	0.0	0.0	440	342	32	66	1361	1,219	4,014	1,903	4,192	5,706,132	1,519	0.3	12,954
Antineoplastic Agents	0.5	0.1	0.0	0.4	100	71	1	29	194	575	171	74	34,977	6,778,625	6,706	1.2	67,489
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.5	42	30	4	8	52	102	54	18	824,135	42,605,089	101,498	18.6	1,010,944
Cardiovascular Agents	1.8	0.6	0.0	1.1	74	57	0	17	42	88	25	15	1,998,826	83,251,405	107,879	19.7	1,124,719
Respiratory Agents	0.6	0.3	0.0	0.3	33	28	1	5	59	98	46	18	757,155	44,973,415	139,742	25.5	1,364,953
Gastrointestinal Agents	0.7	0.4	0.0	0.3	65	59	0	5	88	134	60	18	653,998	57,804,139	86,043	15.7	894,874
Genitourinary Agents	0.5	0.3	0.0	0.1	30	25	1	4	66	83	64	30	145,935	9,665,620	32,641	6.0	322,978
CNS Drugs	1.2	0.5	0.0	0.7	114	94	2	18	91	176	129	26	1,397,045	127,384,660	110,416	20.2	1,121,075
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.2	67	60	0	6	98	115	98	40	114,150	11,212,119	17,440	3.2	167,289
Miscellaneous Psychological/ Neurological Agents	0.8	0.8	0.0	0.0	144	142	0	2	177	180	118	84	98,718	17,507,424	11,636	2.1	121,342
Analgesics and Anesthetics	0.7	0.1	0.0	0.6	33	12	9	12	49	174	210	21	834,762	40,754,904	123,192	22.5	1,225,322
Neuromuscular Agents	0.9	0.3	0.1	0.6	75	48	4	23	83	165	86	40	603,734	49,833,366	63,859	11.7	664,534
Nutritional Products	0.5	0.0	0.0	0.5	9	1	0	8	16	25	17	16	231,094	3,739,161	44,978	8.2	427,913
Hematological Agents	0.8	0.3	0.1	0.4	96	88	2	7	118	266	27	16	275,149	32,530,675	32,686	6.0	338,750
Topical Products	0.3	0.1	0.0	0.2	18	12	1	5	53	88	56	27	397,862	21,164,483	116,578	21.3	1,153,010
Miscellaneous Products	0.5	0.2	0.0	0.2	143	118	7	19	297	525	254	80	19,677	5,842,409	3,909	0.7	40,845
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	6	0	0	0	22	0	0	0	6,293	137,568	1,933	0.4	21,447
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.	8,943,130	597,335,645	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Virginia, released by CMS in 11/2008. This table was produced on 04/23/2009.

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, 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.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 2005.

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, 2005

		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	$84,383,859	53,468	9.8	562,068	0.7	$207	$150
ULCER DRUGS	45,243,950	83,029	15.2	875,838	0.6	92	52
ANTICONVULSANT	42,316,443	52,400	9.6	555,264	0.8	101	76
ANTIHYPERLIPIDEMIC	38,564,607	51,090	9.3	563,179	0.6	107	68
ANTIDEPRESSANTS	35,605,152	95,644	17.5	987,417	0.6	61	36
ANTIASTHMATIC	32,178,153	115,983	21.2	1,159,958	0.4	74	28
ANTIDIABETIC	25,988,667	59,428	10.9	634,293	0.7	60	41
ANALGESICS - Narcotic	23,492,922	141,530	25.9	1,439,206	0.4	42	16
ANTIHYPERTENSIVE	18,516,053	75,941	13.9	809,311	0.7	34	23
MISC. HEMATOLOGICAL	18,165,342	13,713	2.5	146,159	0.7	185	124
Total	364,455,148	742,226		7,732,693	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Virginia, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 2005. 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 2005. 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.