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

LIST OF TABLES

OVERVIEW OF STUDY POPULATION

TABLE 1. OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION

FOR ALL MEDICAID BENEFICIARIES

TABLE 2. CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY
TABLE 3. ANNUAL MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFICIARY, BY BENEFICIARY CHARACTERISTIC
TABLE 4. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BENEFICIARY CHARACTERISTIC
TABLE 5. AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC
TABLE 6. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY
TABLE 7. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY TOP 10 DRUG GROUP

FOR ALL NONDUAL BENEFICIARIES

TABLE ND.2. CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY
TABLE ND.3. ANNUAL MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFICIARY, BY BENEFICIARY CHARACTERISTIC
TABLE ND.4. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BENEFICIARY CHARACTERISTIC
TABLE ND.5. AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC
TABLE ND.6. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY
TABLE ND.7-7D. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY TOP 10 DRUG GROUP
TABLE ND.8. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT FOR ALL-YEAR NURSING FACILITY RESIDENTS, BY BENEFICIARY CHARACTERISTIC
TABLE ND.9. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT FOR ALL-YEAR NURSING FACILITY RESIDENTS, BY BRAND STATUS AND THERAPEUTIC CATEGORY
TABLE ND.10-10D. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT FOR TOP 10 DRUG GROUPS AMONG ALL-YEAR NURSING FACILITY RESIDENTS, BY TOP 10 DRUG GROUP
TABLE ND.11. USE AND REIMBURSEMENT FOR DRUGS EXCLUDED BY STATUTE FROM MEDICARE PART D AMONG NONDUALS, BY BENEFICIARY CHARACTERISTIC
TABLE ND.12. USE AND REIMBURSEMENT FOR DRUGS EXCLUDED BY STATUTE FROM MEDICARE PART D AMONG NONDUALS PER BENEFIT MONTH, BY BENEFICIARY CHARACTERISTIC
TABLE ND.13. USE AND REIMBURSEMENT FOR DRUGS EXCLUDED BY STATUTE FROM MEDICARE PART D FOR SELECTED DRUG CATEGORIES AMONG NONDUALS

FOR DUAL ELIGIBLE BENEFICIARIES

TABLE D.2. CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY
TABLE D.3. ANNUAL MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFICIARY, BY BENEFICIARY CHARACTERISTIC
TABLE D.4. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY

BENEFICIARY CHARACTERISTIC
TABLE D.5. AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC
TABLE D.6. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY
TABLE D.7-7D. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY TOP 10 DRUG GROUP
TABLE D.8. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT FOR ALL-YEAR NURSING FACILITY RESIDENTS, BY BENEFICIARY CHARACTERISTIC
TABLE D.9. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT FOR ALL-YEAR NURSING FACILITY RESIDENTS, BY BRAND STATUS AND THERAPEUTIC CATEGORY
TABLE D.10-10D. MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT FOR TOP 10 DRUG GROUPS AMONG ALL-YEAR NURSING FACILITY RESIDENTS, BY TOP 10 DRUG GROUP
TABLE D.11. USE AND REIMBURSEMENT FOR DRUGS EXCLUDED BY STATUTE FROM MEDICARE PART D AMONG DUALS, BY BENEFICIARY CHARACTERISTIC
TABLE D.12. USE AND REIMBURSEMENT FOR DRUGS EXCLUDED BY STATUTE FROM MEDICARE PART D AMONG DUALS PER BENEFIT MONTH, BY BENEFICIARY CHARACTERISTIC
TABLE D.13. USE AND REIMBURSEMENT FOR DRUGS EXCLUDED BY STATUTE FROM MEDICARE PART D FOR SELECTED DRUG CATEGORIES AMONG DUALS

SUPPLEMENTAL TABLES
SUPPLEMENTAL TABLE 1. MEDICAID PHARMACY REIMBURSEMENT FOR DUAL ELIGIBLE BENEFICIARIES
SUPPLEMENTAL TABLE 1A. MEDICAID PHARMACY REIMBURSEMENT FOR DISABLED DUAL ELIGIBLE BENEFICIARIES UNDER AGE 65
SUPPLEMENTAL TABLE 1B. MEDICAID PHARMACY REIMBURSEMENT FOR DUAL ELIGIBLE BENEFICIARIES AGE 65 AND OLDER
SUPPLEMENTAL TABLE 1C. MEDICAID PHARMACY REIMBURSEMENT FOR DUAL ELIGIBLE BENEFICIARIES AGE 65 TO 74
SUPPLEMENTAL TABLE 1D. MEDICAID PHARMACY REIMBURSEMENT FOR DUAL ELIGIBLE BENEFICIARIES AGE 75 TO 84
SUPPLEMENTAL TABLE 1E. MEDICAID PHARMACY REIMBURSEMENT FOR DUAL ELIGIBLE BENEFICIARIES AGE 85 AND OLDER

APPENDIX TABLES
APPENDIX TABLE A.1. CHARACTERISTICS OF MEDICAID BENEFICIARIES WITH AT LEAST ONE MONTH OF PHARMACY BENEFIT COVERAGE, BY BASIS OF ELIGIBILITY, NONDUAL BENEFICIARIES
APPENDIX TABLE A.2. MEDICAID BENEFICIARIES AND THEIR BENEFIT MONTHS WITH OR WITHOUT FEE-FOR-SERVICE PHARMACY BENEFITS, NONDUAL BENEFICIARIES
APPENDIX TABLE A.3. CHARACTERISTICS OF MEDICAID BENEFICIARIES WITH AT LEAST ONE MONTH OF PHARMACY BENEFIT COVERAGE, BY BASIS OF ELIGIBILITY, DUAL ELIGIBLE BENEFICIARIES
APPENDIX TABLE A.4. MEDICAID BENEFICIARIES AND THEIR BENEFIT MONTHS WITH OR WITHOUT FEE-FOR-SERVICE PHARMACY BENEFITS, DUAL ELIGIBLE BENEFICIARIES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
CONNECTICUT, 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]	538404 (A)	101838 (E)	436566 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	517449 (B)	81173 (F)	436276 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	444794 (C)	81039 (G)	363755 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	19063 (D)	17830 (H)	1233 (L)

Source: Data for this table are from the MAX 2007 file for Connecticut, 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 Connecticut in 2007 was $210,447,858, of which $1,353,492 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.

All Medicaid Beneficiaries

TABLE 2

CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY[a, b]

CONNECTICUT, 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	**444,794**	**50,355**	**61,059**	**102,122**	**230,927**	**331**	**1,795,251**	**523,344**	**650,933**	**215,679**	**402,022**	**3,273**
Age												
5 and younger	79,983	0	0	1	79,982	0	136,171	0	0	1	136,170	0
6-14	98,288	0	1	1	98,286	0	163,983	0	12	1	163,970	0
15-20	51,874	0	985	1,977	48,908	4	107,868	0	8,990	4,983	93,877	18
21-44	111,043	0	22,301	84,921	3,730	91	417,848	0	237,896	171,205	7,954	793
45-64	52,216	6	37,007	14,953	21	229	436,286	63	396,426	37,337	51	2,409
65-74	17,066	16,088	722	249	0	7	182,732	173,551	7,139	1,989	0	53
75-84	16,586	16,528	39	19	0	0	175,376	174,796	429	151	0	0
85 and older	17,738	17,733	4	1	0	0	174,987	174,934	41	12	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	264,722	36,641	31,627	80,444	115,680	330	1,095,450	383,839	343,031	165,544	199,765	3,271
Male	180,072	13,714	29,432	21,678	115,247	1	699,801	139,505	307,902	50,135	202,257	2
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	200,411	34,743	34,552	44,859	86,004	253	974,065	355,021	371,985	95,615	148,941	2,503
African American	91,137	6,137	11,811	20,538	52,617	34	327,399	66,208	123,758	44,659	92,429	345
Other/unknown	153,246	9,475	14,696	36,725	92,306	44	493,787	102,115	155,190	75,405	160,652	425
Use of Nursing Facilities[c]												
Entire year	19,063	16,627	2,410	2	24	0	195,096	168,120	26,690	7	279	0
Part year	9,899	7,231	2,575	67	24	2	99,721	71,409	27,428	664	196	24
None	415,832	26,497	56,074	102,053	230,879	329	1,500,434	283,815	596,815	215,008	401,547	3,249
Maintenance Assistance Status												
Cash	242,833	4,902	11,376	83,471	143,084	0	601,430	55,529	129,176	178,267	238,458	0
Medically needy	21,643	8,046	10,863	779	1,955	0	195,027	79,435	107,635	2,124	5,833	0
Poverty-related	66,572	796	1,802	8,858	54,785	331	155,478	8,674	19,637	19,877	104,017	3,273
Other/unknown	113,746	36,611	37,018	9,014	31,103	0	843,316	379,706	394,485	15,411	53,714	0
Dual Medicare Status[d]												
Full dual, all year	75,039	44,418	27,364	3,200	41	16	793,422	461,896	302,339	28,706	302	179
Full dual, part year	6,000	2,371	3,476	153	0	0	66,514	26,259	38,572	1,683	0	0
Non-dual, all year	363,755	3,566	30,219	98,769	230,886	315	935,315	35,189	310,022	185,290	401,720	3,094
Managed Care (MC) Status												
Fee-for-service (FFS) all year	141,528	50,341	60,439	14,859	15,565	324	1,294,325	523,268	647,167	63,512	57,134	3,244
FFS part year, with Rx claims	18,171	11	454	8,056	9,647	3	64,225	61	2,964	28,029	33,153	18
FFS part year, no Rx claims	285,095	3	166	79,207	205,715	4	436,701	15	802	124,138	311,735	11

Source: Data for this table are from the MAX 2007 file for Connecticut, 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]

CONNECTICUT, 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	**25.0**	**8.3**	**$470**	**$57**	**$8,645**	**5.4**	**444,794**
Age							
5 and younger	4.7	0.1	7	69	2,641	0.3	79,983
6-14	3.9	0.3	31	110	2,147	1.4	98,288
15-20	9.0	0.9	98	113	3,547	2.8	51,874
21-44	24.6	6.9	546	79	7,139	7.6	111,043
45-64	65.6	31.9	2,192	69	19,119	11.5	52,216
65-74	78.6	30.7	787	26	18,402	4.3	17,066
75-84	74.4	24.3	450	19	27,379	1.6	16,586
85 and older	66.1	13.4	257	19	38,315	0.7	17,738
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	73.1	22.6	483	21	28,506	1.7	50,355
Disabled	83.2	38.2	2,783	73	25,178	11.1	61,059
Adults	11.6	1.3	72	54	2,649	2.7	102,122
Children	5.0	0.3	30	104	2,589	1.1	230,927
Unknown	79.5	20.6	1,893	92	11,851	16.0	331
Gender							
Female	26.6	9.0	471	52	8,669	5.4	264,722
Male	22.7	7.2	468	65	8,609	5.4	180,072
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	31.4	10.6	533	50	12,955	4.1	200,411
African American	21.4	6.9	459	67	6,388	7.2	91,137
Other/unknown	18.8	6.0	394	66	4,350	9.1	153,246
Use of Nursing Facilities[f]							
Entire year	65.2	11.8	844	72	60,136	1.4	19,063
Part year	78.9	29.7	1,430	48	37,403	3.8	9,899
None	21.9	7.6	430	57	5,600	7.7	415,832
Maintenance Assistance Status							
Cash	12.3	3.7	204	55	3,874	5.3	242,833
Medically needy	68.0	22.3	822	37	12,560	6.5	21,643
Poverty related	10.5	1.0	65	65	3,324	2.0	66,572
Other/unknown	52.4	19.6	1,208	62	21,197	5.7	113,746

Source: Data for this table are from the MAX 2007 file for Connecticut, 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]

CONNECTICUT, 2007

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	**2.1**	**$117**	**5.4**	**75.0**	**10.7**	**3.4**	**6.3**	**3.7**	**0.9**	**$2,142**	**444,794**	**1,795,251**
Age												
5 and younger	0.1	4	0.3	95.3	4.2	0.3	0.1	0.0	0.0	1,551	79,983	136,171
6-14	0.2	18	1.4	96.1	3.1	0.4	0.3	0.1	0.0	1,287	98,288	163,983
15-20	0.4	47	2.8	91.0	6.3	1.2	1.0	0.3	0.1	1,706	51,874	107,868
21-44	1.8	145	7.6	75.4	11.4	3.8	6.0	2.7	0.7	1,897	111,043	417,848
45-64	3.8	262	11.5	34.4	16.0	8.8	21.5	14.9	4.4	2,288	52,216	436,286
65-74	2.9	74	4.3	21.4	25.2	11.3	24.7	15.4	1.9	1,719	17,066	182,732
75-84	2.3	43	1.6	25.6	31.1	10.7	19.7	11.8	1.2	2,589	16,586	175,376
85 and older	1.4	26	0.7	33.9	41.5	7.9	10.7	5.5	0.6	3,884	17,738	174,987
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	2.2	47	1.7	26.9	33.0	9.9	18.2	10.8	1.2	2,743	50,355	523,344
Disabled	3.6	261	11.1	16.8	22.7	11.8	26.8	16.9	5.0	2,362	61,059	650,933
Adults	0.6	34	2.7	88.4	7.4	1.7	1.8	0.6	0.1	1,255	102,122	215,679
Children	0.2	17	1.1	95.0	4.0	0.5	0.4	0.1	0.0	1,487	230,927	402,022
Unknown	2.1	191	16.0	20.5	34.7	16.9	20.5	6.3	0.9	1,199	331	3,273
Gender												
Female	2.2	114	5.4	73.4	11.4	3.5	6.6	4.2	1.0	2,095	264,722	1,095,450
Male	1.9	121	5.4	77.3	9.7	3.3	5.9	3.1	0.7	2,215	180,072	699,801
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.2	110	4.1	68.6	13.3	4.2	7.9	4.8	1.2	2,665	200,411	974,065
African American	1.9	128	7.2	78.6	9.3	3.0	5.3	3.1	0.7	1,778	91,137	327,399
Other/unknown	1.9	122	9.1	81.2	8.0	2.6	4.9	2.8	0.6	1,350	153,246	493,787
Use of Nursing Facilities[f]												
Entire year	1.2	83	1.4	34.8	48.5	7.1	4.1	3.1	2.4	5,876	19,063	195,096
Part year	3.0	142	3.8	21.1	33.4	9.6	18.1	13.2	4.6	3,713	9,899	99,721
None	2.1	119	7.7	78.1	8.4	3.1	6.2	3.5	0.7	1,552	415,832	1,500,434
Maintenance Assistance Status												
Cash	1.5	83	5.3	87.7	5.7	1.6	2.9	1.7	0.4	1,564	242,833	601,430
Medically needy	2.5	91	6.5	32.0	25.2	10.1	20.4	10.6	1.7	1,394	21,643	195,027
Poverty related	0.4	28	2.0	89.5	7.6	1.3	1.2	0.3	0.0	1,423	66,572	155,478
Other/unknown	2.6	163	5.7	47.6	20.3	7.3	14.0	8.8	2.1	2,859	113,746	843,316

Source: Data for this table are from the MAX 2007 file for Connecticut, 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]
CONNECTICUT, 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	**2.1**	**$117**	**$57**	**0.7**	**$86**	**$115**	**0.1**	**$8**	**$77**	**1.2**	**$23**	**$19**
Age												
5 and younger	0.1	4	69	0.0	3	259	0.0	0	89	0.0	1	20
6-14	0.2	18	110	0.1	15	204	0.0	1	103	0.1	3	35
15-20	0.4	47	113	0.2	37	208	0.0	2	158	0.2	8	34
21-44	1.8	145	79	0.7	111	158	0.1	9	117	1.1	25	24
45-64	3.8	262	69	1.4	190	137	0.2	19	103	2.2	53	23
65-74	2.9	74	26	1.0	51	49	0.2	6	35	1.6	16	10
75-84	2.3	43	19	0.8	30	36	0.1	4	24	1.3	9	7
85 and older	1.4	26	19	0.4	18	42	0.1	2	27	0.9	6	7
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	2.2	47	21	0.8	33	42	0.1	4	29	1.3	10	8
Disabled	3.6	261	73	1.3	193	145	0.2	18	107	2.1	49	24
Adults	0.6	34	54	0.2	23	113	0.0	3	111	0.4	8	20
Children	0.2	17	104	0.1	13	206	0.0	1	117	0.1	3	32
Unknown	2.1	191	92	0.7	139	203	0.1	11	113	1.3	42	32
Gender												
Female	2.2	114	52	0.8	83	105	0.1	8	73	1.3	23	18
Male	1.9	121	65	0.7	90	131	0.1	8	86	1.1	22	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.2	110	50	0.8	77	99	0.1	9	80	1.3	23	18
African American	1.9	128	67	0.7	97	142	0.1	8	79	1.1	22	20
Other/unknown	1.9	122	66	0.7	95	131	0.1	6	70	1.0	21	20
Use of Nursing Facilities[e]												
Entire year	1.2	83	72	0.3	59	180	0.0	5	104	0.8	18	23
Part year	3.0	142	48	1.0	101	104	0.2	10	63	1.8	31	17
None	2.1	119	57	0.8	88	112	0.1	8	77	1.2	23	19
Maintenance Assistance Status												
Cash	1.5	83	55	0.6	61	108	0.1	6	76	0.9	16	18
Medically needy	2.5	91	37	0.9	62	69	0.1	9	67	1.4	20	14
Poverty related	0.4	28	65	0.2	21	127	0.0	2	83	0.2	5	21
Other/unknown	2.6	163	62	1.0	121	127	0.1	11	80	1.6	31	20

Source: Data for this table are from the MAX 2007 file for Connecticut, 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 Connecticut, 0.2 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]

CONNECTICUT, 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	0.1	0.0	0.2	$56	$49	$1	$6	$163	$433	$288	$25	157,479	$25,663,791	45,149	10.2	458,132
Biologicals	0.1	0.1	0.0	0.0	98	98	0	0	735	735	0	0	797	586,115	559	0.1	6,002
Antineoplastic Agents	0.5	0.2	0.0	0.3	96	84	2	10	214	474	1,904	38	9,943	2,126,484	2,034	0.5	22,057
Endocrine/Metabolic Drugs	0.8	0.3	0.0	0.5	32	26	1	6	39	75	32	12	349,065	13,670,350	39,492	8.9	423,277
Cardiovascular Agents	1.4	0.4	0.1	0.9	31	17	4	10	22	45	33	11	776,855	17,425,430	50,961	11.5	559,468
Respiratory Agents	0.6	0.4	0.0	0.2	31	25	2	4	50	70	51	17	235,035	11,760,866	36,552	8.2	381,351
Gastrointestinal Agents	0.6	0.3	0.1	0.2	44	35	4	6	75	103	64	30	244,600	18,385,368	37,878	8.5	414,908
Genitourinary Agents	0.4	0.3	0.0	0.2	15	12	0	3	35	45	31	17	55,885	1,931,799	11,665	2.6	127,177
CNS Drugs	1.3	0.5	0.0	0.7	88	69	2	17	69	137	73	23	815,308	56,480,778	59,850	13.5	639,642
Stimulants/Anti-obesity/Anorexia	0.6	0.4	0.0	0.2	67	62	1	5	112	142	80	31	14,095	1,581,570	2,728	0.6	23,502
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	72	72	0	0	126	126	0	23	22,437	2,830,627	3,551	0.8	39,320
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	34	11	11	12	54	198	369	22	288,541	15,568,722	44,126	9.9	460,053
Neuromuscular Agents	0.9	0.3	0.0	0.6	53	34	4	16	57	103	96	27	361,499	20,454,579	35,295	7.9	385,556
Nutritional Products	0.5	0.0	0.0	0.4	7	1	1	5	16	40	17	14	58,895	915,400	12,699	2.9	126,554
Hematological Agents	0.6	0.2	0.0	0.4	56	52	0	4	88	277	16	8	118,957	10,414,061	17,221	3.9	187,101
Topical Products	0.4	0.2	0.0	0.2	15	11	1	4	40	69	54	17	156,621	6,207,423	38,944	8.8	418,422
Miscellaneous Products	0.3	0.2	0.0	0.1	83	73	3	7	248	376	224	54	10,482	2,600,248	3,101	0.7	31,496
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	21	0	0	0	86	0	0	0	5,703	490,755	2,002	0.5	22,892
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.	3,682,197	209,094,366	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Connecticut, 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 Connecticut, 0.2 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]

CONNECTICUT, 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	$37,924,481	34,106	7.7	375,690	0.7	$141	$101
ANTIVIRAL	20,679,344	7,255	1.6	79,025	0.5	523	262
ANTICONVULSANT	18,142,141	33,691	7.6	372,150	0.7	65	49
ULCER DRUGS	14,250,964	35,237	7.9	391,149	0.5	77	36
ANALGESICS - Narcotic	11,592,047	48,691	10.9	522,975	0.4	60	22
ANTIDEPRESSANTS	10,868,176	47,225	10.6	513,265	0.6	37	21
ANTIDIABETIC	9,245,699	33,916	7.6	379,288	0.6	44	24
ANTIASTHMATIC	8,739,675	38,986	8.8	414,021	0.4	58	21
ANTIHYPERLIPIDEMIC	8,070,890	33,528	7.5	379,311	0.5	40	21
HEMATOPOIETIC AGENTS	5,852,432	14,212	3.2	153,687	0.5	78	38
Total	145,365,849	326,847	n.a.	3,580,561	n.a.	n.a.	n.a.

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