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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
VIRGINIA, 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]	912082 (A)	169441 (E)	742641 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	847506 (B)	118274 (F)	729232 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	523638 (C)	117549 (G)	406089 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	14000 (D)	12805 (H)	1195 (L)

Source: Data for this table are from the MAX 2007 file for Virginia, released by CMS in 4/2010. 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 Virginia in 2007 was $213,132,314, of which $6,870,543 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.
e. Enrollees in prepaid health plans (PHP) or managed care (MC) plans that did not provide a pharmacy benefit are treated as having fee-for-service pharmacy benefit coverage. There were 27 states in 2007 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, MA, MI, NC, NH, NM, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NE, NY, TN, TX, and WV). These lists were constructed from the CMS 2007 Medicaid Managed Care Enrollment Report and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we reviewed prescription drug expenditures by type of managed care plan to determine whether enrollees in comprehensive MC plans had significant prescription drug expenditures during the year, since that would indicate that at least some prescription drugs were not included in the capitated benefit and were being provided on a fee-for-service basis. There were some states in which most, but not all, prescription drugs were included in the MC capitated benefit package. Mental health drugs, for example, may have been excluded. In those states, we excluded all the MC enrollees from the study population, but some of their drugs would have been included, potentially resulting in higher reported per-beneficiary use of those drugs than would have been the case if we had been able to exclude those drugs.
f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2007. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.
g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2007. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.
Characteristics of non-dual eligible beneficiaries represented by Cell J are shown in Appendix Table A.1 and characteristics of non-dual eligible beneficiaries and their benefit months included in Cell J but excluded from Cell K are shown in Appendix Table A.2. Characteristics of dual eligible beneficiaries represented by Cell F are shown in Appendix Table A.3, and characteristics of dual eligible beneficiaries and their benefit months included in Cell F but excluded from Cell G are shown in Appendix Table A.4.
Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; HMO = health maintenance organization; MAX = Medicaid Analytic Extract; MC = managed care; PCCM = primary care case management; PHP = prepaid health plan.

TABLE 2

CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY[a, b]
VIRGINIA, 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	**523,638**	**68,920**	**95,474**	**80,349**	**278,234**	**661**	**3,446,866**	**719,469**	**918,717**	**331,084**	**1,471,613**	**5,983**
Age												
5 and younger	123,246	0	2,074	0	121,172	0	534,654	0	15,013	0	519,641	0
6-14	114,605	0	5,525	94	108,986	0	689,569	0	44,939	371	644,259	0
15-20	62,352	0	5,620	8,824	47,898	10	390,304	0	46,610	36,998	306,635	61
21-44	100,940	2	33,573	67,007	176	182	609,181	24	331,910	274,688	1,074	1,485
45-64	50,030	8	45,146	4,413	1	462	467,234	67	443,807	18,969	1	4,390
65-74	27,531	24,121	3,393	10	0	7	291,739	256,646	34,989	57	0	47
75-84	26,432	26,323	109	0	0	0	280,056	278,904	1,152	0	0	0
85 and older	18,501	18,466	34	1	0	0	184,126	183,828	297	1	0	0
Unknown	1	0	0	0	1	0	3	0	0	0	3	0
Gender												
Female	314,549	50,577	50,892	73,415	139,004	661	2,069,667	532,487	495,754	300,927	734,516	5,983
Male	209,081	18,335	44,582	6,934	139,230	0	1,377,167	186,950	422,963	30,157	737,097	0
Unknown	8	8	0	0	0	0	32	32	0	0	0	0
Race												
White	254,535	37,016	58,644	39,220	119,243	412	1,958,314	377,827	591,663	189,406	795,679	3,739
African American	193,168	23,677	34,271	33,437	101,561	222	1,153,632	252,377	306,050	117,396	475,797	2,012
Other/unknown	75,935	8,227	2,559	7,692	57,430	27	334,920	89,265	21,004	24,282	200,137	232
Use of Nursing Facilities[c]												
Entire year	14,000	11,555	2,434	0	11	0	146,636	119,222	27,301	0	113	0
Part year	10,421	8,137	2,210	45	24	5	98,758	77,548	20,686	280	193	51
None	499,217	49,228	90,830	80,304	278,199	656	3,201,472	522,699	870,730	330,804	1,471,307	5,932
Maintenance Assistance Status												
Cash	109,089	32,886	70,892	5,220	91	0	1,060,670	365,579	670,849	23,686	556	0
Medically needy	739	162	554	7	16	0	5,806	1,585	4,076	34	111	0
Poverty-related	288,166	9,942	12,025	23,415	242,123	661	1,546,152	105,482	116,038	85,940	1,232,709	5,983
Other/unknown	125,644	25,930	12,003	51,707	36,004	0	834,238	246,823	127,754	221,424	238,237	0
Dual Medicare Status[d]												
Full dual, all year	112,097	64,046	47,437	585	26	3	1,193,569	672,821	516,501	3,952	266	29
Full dual, part year	5,452	2,992	2,444	16	0	0	58,605	32,203	26,232	170	0	0
Non-dual, all year	406,089	1,882	45,593	79,748	278,208	658	2,194,692	14,445	375,984	326,962	1,471,347	5,954
Managed Care (MC) Status												
Fee-for-service (FFS) all year	290,914	67,862	77,978	27,822	116,603	649	2,683,392	714,461	840,350	162,385	960,268	5,928
FFS part year, with Rx claims	79,541	495	10,708	26,967	41,364	7	324,918	2,490	52,494	98,935	170,958	41
FFS part year, no Rx claims	153,183	563	6,788	25,560	120,267	5	438,556	2,518	25,873	69,764	340,387	14

Source: Data for this table are from the MAX 2007 file for Virginia, released by CMS in 4/2010. 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]
VIRGINIA, 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	**42.7**	**5.6**	**$394**	**$70**	**$6,274**	**6.3**	**523,638**
Age							
5 and younger	35.5	1.7	129	78	2,784	4.6	123,246
6-14	36.9	3.2	297	92	2,220	13.4	114,605
15-20	45.0	5.1	514	102	4,279	12.0	62,352
21-44	52.5	7.8	546	70	7,668	7.1	100,940
45-64	58.9	19.4	1,205	62	15,310	7.9	50,030
65-74	36.5	5.1	211	41	8,797	2.4	27,531
75-84	36.5	3.2	77	24	11,703	0.7	26,432
85 and older	39.1	3.1	58	19	17,810	0.3	18,501
Unknown	0.0	0.0	0	0	0	0.0	1
Basis of Eligibility[e]							
Aged	36.8	3.6	99	28	12,233	0.8	68,920
Disabled	57.7	17.1	1,310	77	16,168	8.1	95,474
Adults	52.1	4.5	211	47	3,169	6.7	80,349
Children	36.2	2.4	202	83	2,281	8.9	278,234
Unknown	82.5	24.7	1,779	72	14,158	12.6	661
Gender							
Female	44.5	5.9	364	62	6,057	6.0	314,549
Male	40.0	5.1	438	86	6,600	6.6	209,081
Unknown	37.5	0.9	30	34	4,660	0.6	8
Race							
White	53.5	8.6	573	67	7,414	7.7	254,535
African American	35.1	3.3	272	82	6,054	4.5	193,168
Other/unknown	25.9	1.4	105	77	3,011	3.5	75,935
Use of Nursing Facilities[f]							
Entire year	55.3	13.3	647	49	39,433	1.6	14,000
Part year	62.4	11.5	611	53	28,719	2.1	10,421
None	41.9	5.3	382	73	4,876	7.8	499,217
Maintenance Assistance Status							
Cash	52.7	14.3	1,071	75	10,735	10.0	109,089
Medically needy	63.7	15.4	1,589	103	23,988	6.6	739
Poverty related	35.6	2.1	130	61	1,902	6.8	288,166
Other/unknown	50.1	5.9	405	69	12,324	3.3	125,644

Source: Data for this table are from the MAX 2007 file for Virginia, released by CMS in 4/2010. 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]

VIRGINIA, 2007

				Number of Rx, Percentage with:							Number	
Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Beneficiaries	Benefit Months
All	**0.9**	**$60**	**6.3**	**57.3**	**30.4**	**5.1**	**4.7**	**1.9**	**0.6**	**$953**	**523,638**	**3,446,866**
Age												
5 and younger	0.4	30	4.6	64.5	30.6	3.3	1.4	0.1	0.0	642	123,246	534,654
6-14	0.5	49	13.4	63.1	29.1	4.3	3.1	0.5	0.0	369	114,605	689,569
15-20	0.8	82	12.0	55.0	32.6	6.1	5.0	1.2	0.1	684	62,352	390,304
21-44	1.3	90	7.1	47.5	31.1	8.1	9.1	3.5	0.7	1,271	100,940	609,181
45-64	2.1	129	7.9	41.1	27.5	6.8	11.4	9.1	4.1	1,639	50,030	467,234
65-74	0.5	20	2.4	63.5	29.0	3.4	2.3	1.3	0.6	830	27,531	291,739
75-84	0.3	7	0.7	63.5	31.3	3.3	1.5	0.3	0.1	1,105	26,432	280,056
85 and older	0.3	6	0.3	60.9	34.1	3.4	1.4	0.2	0.0	1,790	18,501	184,126
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	1	3
Basis of Eligibility[e]												
Aged	0.3	10	0.8	63.2	31.3	3.3	1.6	0.5	0.2	1,172	68,920	719,469
Disabled	1.8	136	8.1	42.3	28.9	7.2	11.3	7.5	2.8	1,680	95,474	918,717
Adults	1.1	51	6.7	47.9	33.3	8.7	7.9	2.0	0.3	769	80,349	331,084
Children	0.5	38	8.9	63.8	29.8	3.8	2.2	0.3	0.0	431	278,234	1,471,613
Unknown	2.7	197	12.6	17.5	29.5	15.0	25.1	12.1	0.8	1,564	661	5,983
Gender												
Female	0.9	55	6.0	55.5	31.4	5.4	4.9	2.1	0.7	921	314,549	2,069,667
Male	0.8	67	6.6	60.0	28.8	4.7	4.4	1.6	0.4	1,002	209,081	1,377,167
Unknown	0.2	7	0.6	62.5	37.5	0.0	0.0	0.0	0.0	1,165	8	32
Race												
White	1.1	74	7.7	46.5	36.2	6.7	6.7	3.0	1.0	964	254,535	1,958,314
African American	0.6	46	4.5	64.9	26.3	4.0	3.3	1.1	0.3	1,014	193,168	1,153,632
Other/unknown	0.3	24	3.5	74.1	21.4	2.5	1.6	0.3	0.1	683	75,935	334,920
Use of Nursing Facilities[f]												
Entire year	1.3	62	1.6	44.7	37.1	6.7	5.5	3.1	2.8	3,765	14,000	146,636
Part year	1.2	65	2.1	37.6	44.6	6.2	5.1	3.7	2.9	3,030	10,421	98,758
None	0.8	60	7.8	58.1	29.9	5.1	4.7	1.8	0.5	760	499,217	3,201,472
Maintenance Assistance Status												
Cash	1.5	110	10.0	47.3	28.4	6.3	9.4	6.2	2.3	1,104	109,089	1,060,670
Medically needy	2.0	202	6.6	36.3	25.3	10.4	16.9	8.9	2.2	3,053	739	5,806
Poverty related	0.4	24	6.8	64.4	29.7	3.7	1.9	0.2	0.0	354	288,166	1,546,152
Other/unknown	0.9	61	3.3	49.9	33.7	7.3	6.8	1.9	0.4	1,856	125,644	834,238

Source: Data for this table are from the MAX 2007 file for Virginia, released by CMS in 4/2010. 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]
VIRGINIA, 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	**0.9**	**$60**	**$70**	**0.2**	**$43**	**$183**	**0.0**	**$4**	**$114**	**0.6**	**$12**	**$21**
Age												
5 and younger	0.4	30	78	0.1	22	231	0.0	2	78	0.3	6	22
6-14	0.5	49	92	0.2	39	161	0.0	3	108	0.3	7	28
15-20	0.8	82	102	0.3	66	210	0.0	4	118	0.5	12	27
21-44	1.3	90	70	0.3	64	195	0.0	6	127	0.9	21	22
45-64	2.1	129	62	0.5	87	174	0.1	11	124	1.5	30	20
65-74	0.5	20	41	0.1	12	147	0.0	2	102	0.4	5	14
75-84	0.3	7	24	0.0	4	112	0.0	1	74	0.3	3	10
85 and older	0.3	6	19	0.0	3	102	0.0	0	70	0.3	2	9
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.3	10	28	0.0	6	124	0.0	1	80	0.3	3	11
Disabled	1.8	136	77	0.5	99	203	0.1	10	127	1.2	27	22
Adults	1.1	51	47	0.2	32	137	0.0	3	109	0.8	17	20
Children	0.5	38	83	0.2	29	170	0.0	2	95	0.3	7	25
Unknown	2.7	197	72	0.7	135	205	0.1	18	158	2.0	44	23
Gender												
Female	0.9	55	62	0.2	38	167	0.0	4	112	0.6	13	20
Male	0.8	67	86	0.2	51	206	0.0	4	118	0.5	11	23
Unknown	0.2	7	34	0.2	5	32	0.0	2	69	0.0	0	6
Race												
White	1.1	74	67	0.3	52	172	0.1	6	116	0.8	16	21
African American	0.6	46	82	0.2	35	215	0.0	2	110	0.4	8	22
Other/unknown	0.3	24	77	0.1	18	218	0.0	1	86	0.2	5	21
Use of Nursing Facilities[e]												
Entire year	1.3	62	49	0.3	43	169	0.0	4	95	1.0	15	16
Part year	1.2	65	53	0.2	45	185	0.0	5	115	0.9	15	16
None	0.8	60	73	0.2	43	184	0.0	4	115	0.5	12	22
Maintenance Assistance Status												
Cash	1.5	110	75	0.4	80	200	0.1	8	124	1.0	22	22
Medically needy	2.0	202	103	0.5	155	338	0.1	10	147	1.4	37	26
Poverty related	0.4	24	61	0.1	17	139	0.0	2	93	0.3	6	22
Other/unknown	0.9	61	69	0.2	46	188	0.0	3	111	0.6	12	19

Source: Data for this table are from the MAX 2007 file for Virginia, released by CMS in 4/2010. 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 Virginia, 0.5 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]
VIRGINIA, 2007

	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
Therapeutic Category	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.0	0.0	0.2	$17	$8	$2	$6	$57	$294	$106	$25	255,058	$14,615,271	104,465	19.9	885,275
Biologicals	0.3	0.3	0.0	0.0	433	433	0	0	1409	1,409	0	0	4,304	6,066,052	1,658	0.3	14,005
Antineoplastic Agents	0.5	0.2	0.0	0.3	143	118	6	19	290	654	1,851	60	7,824	2,267,161	1,691	0.3	15,859
Endocrine/Metabolic Drugs	0.5	0.2	0.0	0.3	35	26	1	8	64	132	40	24	209,206	13,344,847	44,767	8.5	382,438
Cardiovascular Agents	1.2	0.2	0.1	1.0	37	18	6	14	30	92	79	14	313,047	9,546,047	28,675	5.5	256,093
Respiratory Agents	0.4	0.2	0.0	0.2	31	23	3	5	68	113	79	23	363,884	24,807,900	88,608	16.9	811,921
Gastrointestinal Agents	0.5	0.1	0.1	0.3	40	19	8	13	81	165	151	40	116,644	9,401,221	25,759	4.9	236,720
Genitourinary Agents	0.3	0.1	0.0	0.2	20	11	1	8	61	95	91	40	35,245	2,155,301	13,262	2.5	108,001
CNS Drugs	0.9	0.3	0.0	0.7	73	61	1	11	78	236	141	17	640,588	50,041,525	70,214	13.4	682,458
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	83	77	1	6	118	136	78	43	99,619	11,730,325	15,441	2.9	140,688
Miscellaneous Psychological/ Neurological Agents	0.3	0.3	0.0	0.0	71	68	0	2	246	253	164	134	11,925	2,939,504	4,101	0.8	41,660
Analgesics and Anesthetics	0.6	0.0	0.0	0.5	24	9	4	11	42	265	297	21	293,537	12,271,953	58,757	11.2	503,145
Neuromuscular Agents	0.9	0.3	0.0	0.5	80	61	8	12	92	201	176	22	282,445	25,933,957	33,681	6.4	323,100
Nutritional Products	0.4	0.1	0.0	0.3	6	2	0	5	16	28	16	14	76,819	1,237,058	22,465	4.3	191,436
Hematological Agents	0.6	0.2	0.0	0.4	79	74	0	4	129	440	38	10	81,073	10,421,072	13,257	2.5	132,203
Topical Products	0.3	0.1	0.0	0.2	14	8	1	5	52	113	80	27	133,048	6,956,088	58,417	11.2	514,221
Miscellaneous Products	0.5	0.3	0.0	0.2	181	156	5	21	330	499	251	94	7,370	2,428,549	1,346	0.3	13,424
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	11	0	0	0	56	0	0	0	1,747	97,940	857	0.2	8,795
TOTAL NO. OF RX AND RX $	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2,933,383	206,261,771	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Virginia, released by CMS in 4/2010. 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 Virginia, 0.5 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]
VIRGINIA, 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	$35,929,530	21,325	4.1	205,555	0.7	$263	$175
ANTICONVULSANT	23,054,915	29,542	5.6	293,811	0.7	107	78
ANTIASTHMATIC	17,023,622	63,608	12.1	574,927	0.3	91	30
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	11,729,033	17,854	3.4	166,625	0.6	118	70
ANTIDEPRESSANTS	10,193,421	38,022	7.3	351,408	0.5	56	29
ANALGESICS - Narcotic	7,956,006	64,480	12.3	566,140	0.4	38	14
ULCER DRUGS	7,249,696	32,533	6.2	321,397	0.4	50	23
ANTIDIABETIC	6,228,223	15,733	3.0	147,056	0.6	73	42
PASSIVE IMMUNIZING AGENTS	6,007,791	1,093	0.2	7,618	0.5	1,684	789
MISC. HEMATOLOGICAL	5,846,487	1,997	0.4	18,805	0.6	498	311
Total	131,218,724	286,187	n.a.	2,653,342	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Virginia, released by CMS in 4/2010. 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.