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

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

SUPPLEMENTAL TABLES

APPENDIX TABLES

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

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)		Number of Dual Eligible Beneficiaries (Cell)[g]		Number of Non-dual Eligible Beneficiaries (Cell)	
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	160,518	(A)	30,955	(E)	129,563	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	157,676	(B)	30,920	(F)	126,756	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	157,676	(C)	30,920	(G)	126,756	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	2,332	(D)	2,246	(H)	86	(L)

Source: Data for this table are from the MAX 2003 file for Vermont, released by CMS in 06/2007. This table was produced on 11/01/2007.

a. MAX data element "Eligible Months Count" was used to determine an individual's Medicaid eligibility. All individuals who had a value greater than zero were considered as beneficiaries and counted in Cell A.

b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2003 (based on MAX data element "Eligible Restricted Benefits Flag").

c. Cell C represents the study population for Tables 2 through 7. Cell C was obtained by excluding from Cell B beneficiaries who were in managed care (MC) plans that included prescription drugs in their capitated benefit package during all months of Medicaid eligibility in 2003, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.

d. The total Medicaid pharmacy reimbursement for Vermont in 2003 was $131,726,890, of which $4,654,325 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

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

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2003. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.

g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the benficiary had a fee-for-service pharmacy benefit.

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2003. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

Characteristics of non-dual eligible beneficiaries represented by Cell J are shown in Appendix Table A.1 and characteristics of non-dual eligible beneficiaries and their benefit months included in Cell J but excluded from Cell K are shown in Appendix Table A.2. Characteristics of dual eligible beneficiaries represented by Cell F are shown in Appendix Table A.3, and characteristics of dual eligible beneficiaries and their benefit months included in Cell F but excluded from Cell G are shown in Appendix Table A.4.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; HMO = health maintenance organization; MAX = Medicaid Analytic Extract; MC = managed care; PCCM = primary care case management; PHP = prepaid health plan.

TABLE 2

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

VERMONT, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**157,676**	**19,522**	**19,940**	**49,220**	**68,994**	**0**	**1,528,684**	**202,222**	**218,966**	**432,302**	**675,194**	**0**
Age												
5 and younger	22,851	0	324	2	22,525	0	215,917	0	3,536	13	212,368	0
6-14	33,385	1	1,227	3	32,154	0	341,468	12	13,896	29	327,531	0
15-20	16,994	3	1,058	2,081	13,852	0	159,408	10	11,825	16,264	131,309	0
21-44	43,351	19	6,737	36,141	454	0	392,588	99	73,528	315,077	3,884	0
45-64	20,013	33	9,129	10,847	4	0	199,519	243	99,696	99,532	48	0
65-74	7,945	6,653	1,165	126	1	0	83,542	69,158	13,182	1,190	12	0
75-84	8,236	7,967	251	18	0	0	87,150	84,191	2,786	173	0	0
85 and older	4,897	4,846	49	2	0	0	49,050	48,509	517	24	0	0
Unknown	4	0	0	0	4	0	42	0	0	0	42	0
Gender												
Female	87,767	13,542	10,079	30,013	34,133	0	862,426	141,934	111,747	273,959	334,786	0
Male	69,909	5,980	9,861	19,207	34,861	0	666,258	60,288	107,219	158,343	340,408	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	91,812	11,036	15,972	32,886	31,918	0	920,095	116,968	177,183	296,461	329,483	0
African American	1,076	14	147	428	487	0	9,912	143	1,511	3,525	4,733	0
Other/unknown	64,788	8,472	3,821	15,906	36,589	0	598,677	85,111	40,272	132,316	340,978	0
Use of Nursing Facilities[c]												
Entire year	2,332	2,173	159	0	0	0	21,927	20,411	1,516	0	0	0
Part year	1,247	1,001	232	14	0	0	12,418	9,855	2,422	141	0	0
None	154,097	16,348	19,549	49,206	68,994	0	1,494,339	171,956	215,028	432,161	675,194	0
Maintenance Assistance Status												
Cash	28,098	1,670	12,700	4,455	9,273	0	299,921	18,771	143,835	43,167	94,148	0
Medically needy	14,225	3,294	3,302	5,317	2,312	0	137,836	35,355	34,205	49,529	18,747	0
Poverty-related	49,928	47	0	2,498	47,383	0	477,762	293	0	17,921	459,548	0
Other/unknown	65,425	14,511	3,938	36,950	10,026	0	613,165	147,803	40,926	321,685	102,751	0
Dual Medicare Status[d]												
Full dual, all year	30,920	19,091	11,288	537	4	0	326,835	198,582	123,330	4,875	48	0
Full dual, part year	0	0	0	0	0	0	0	0	0	0	0	0
Non-dual, all year	126,756	431	8,652	48,683	68,990	0	1,201,849	3,640	95,636	427,427	675,146	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	157,676	19,522	19,940	49,220	68,994	0	1,528,684	202,222	218,966	432,302	675,194	0
FFS part year, with Rx claims	0	0	0	0	0	0	0	0	0	0	0	0
FFS part year, no Rx claims	0	0	0	0	0	0	0	0	0	0	0	0

Source: Data for this table are from the MAX 2003 file for Vermont, released by CMS in 06/2007. This table was produced on 11/01/2007.

a. Table 2 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services. The total includes some beneficiaries with unknown basis of eligibility and some whose age categories are not consistent with basis of eligibility.

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

d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2003. The “Full dual, part year” group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.

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

TABLE 3

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

VERMONT, 2003

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**71.2 %**	**14.5**	**$806**	**$55**	**$4,199**	**19.2 %**	**157,676**
Age							
5 and younger	68.1	3.4	145	43	1,827	8.0	22,851
6-14	62.0	4.3	263	61	2,862	9.2	33,385
15-20	64.7	5.9	382	65	4,191	9.1	16,994
21-44	69.9	12.2	693	57	3,639	19.1	43,351
45-64	78.9	29.8	1,838	62	6,236	29.5	20,013
65-74	86.8	37.5	2,014	54	5,667	35.5	7,945
75-84	90.8	41.5	2,038	49	7,721	26.4	8,236
85 and older	92.2	42.3	1,808	43	12,732	14.2	4,897
Unknown	75.0	2.8	23	8	614	3.7	4
Basis of Eligibility[e]							
Aged	89.6	39.5	1,932	49	8,020	24.1	19,522
Disabled	88.1	39.6	2,912	74	13,097	22.2	19,940
Adults	67.3	9.3	347	37	1,919	18.1	49,220
Children	63.9	4.0	206	52	2,172	9.5	68,994
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	75.9	17.1	885	52	4,220	21.0	87,767
Male	65.3	11.3	707	62	4,172	16.9	69,909
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	76.5	18.4	1,029	56	5,248	19.6	91,812
African American	60.9	9.2	639	69	3,297	19.4	1,076
Other/unknown	63.9	9.2	492	54	2,726	18.1	64,788
Use of Nursing Facilities[f]							
Entire year	96.4	59.6	2,892	49	34,184	8.5	2,332
Part year	98.2	66.8	3,162	47	25,810	12.3	1,247
None	70.6	13.4	755	56	3,570	21.2	154,097
Maintenance Assistance Status							
Cash	81.3	24.3	1,591	66	8,284	19.2	28,098
Medically needy	79.2	25.0	1,545	62	4,128	37.4	14,225
Poverty related	62.1	3.4	168	50	1,494	11.2	49,928
Other/unknown	72.0	16.6	795	48	4,524	17.6	65,425

Source: Data for this table are from the MAX 2003 file for Vermont, released by CMS in 06/2007. This table was produced on 11/01/2007.

a. Table 3 includes beneficiaries represented by Cell C of Table 1.

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

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

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

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

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

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

TABLE 4

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

VERMONT, 2003

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Number Beneficiaries	Benefit Months
All	**1.5**	**$83**	**19.2 %**	**28.8 %**	**45.7 %**	**8.0 %**	**10.6 %**	**5.6 %**	**1.4 %**	**$433**	**157,676**	**1,528,684**
Age												
5 and younger	0.4	15	8.0	31.9	64.8	2.5	0.8	0.1	0.0	193	22,851	215,917
6-14	0.4	26	9.2	38.0	55.2	4.1	2.5	0.2	0.0	280	33,385	341,468
15-20	0.6	41	9.1	35.3	53.2	7.0	4.0	0.5	0.0	447	16,994	159,408
21-44	1.3	77	19.1	30.1	46.4	9.6	9.4	3.5	0.9	402	43,351	392,588
45-64	3.0	184	29.5	21.1	29.2	11.6	20.7	13.5	3.9	626	20,013	199,519
65-74	3.6	192	35.5	13.2	20.6	14.0	29.7	18.3	4.3	539	7,945	83,542
75-84	3.9	193	26.4	9.2	17.5	14.5	32.9	21.1	4.8	730	8,236	87,150
85 and older	4.2	181	14.2	7.8	13.9	12.8	34.8	25.6	5.0	1,271	4,897	49,050
Unknown	0.3	2	3.7	25.0	75.0	0.0	0.0	0.0	0.0	59	4	42
Basis of Eligibility[e]												
Aged	3.8	187	24.1	10.4	18.0	14.1	32.0	20.9	4.5	774	19,522	202,222
Disabled	3.6	265	22.2	11.9	24.4	13.3	27.1	18.2	5.1	1,193	19,940	218,966
Adults	1.1	40	18.1	32.7	47.7	9.2	7.8	2.1	0.5	219	49,220	432,302
Children	0.4	21	9.5	36.1	58.2	3.8	1.8	0.1	0.0	222	68,994	675,194
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.7	90	21.0	24.1	46.2	8.9	12.2	6.9	1.7	429	87,767	862,426
Male	1.2	74	16.9	34.7	44.9	6.8	8.6	4.0	1.0	438	69,909	666,258
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.8	103	19.6	23.5	45.1	9.2	12.9	7.3	2.0	524	91,812	920,095
African American	1.0	69	19.4	39.1	44.8	6.2	5.9	3.3	0.6	358	1,076	9,912
Other/unknown	1.0	53	18.1	36.1	46.5	6.2	7.4	3.3	0.5	295	64,788	598,677
Use of Nursing Facilities[f]												
Entire year	6.3	308	8.5	3.6	6.2	8.6	28.6	37.1	16.0	3,636	2,332	21,927
Part year	6.7	318	12.3	1.8	6.1	8.1	29.0	38.9	16.0	2,592	1,247	12,418
None	1.4	78	21.2	29.4	46.6	8.0	10.2	4.9	1.0	368	154,097	1,494,339
Maintenance Assistance Status												
Cash	2.3	149	19.2	18.7	41.9	10.3	16.8	9.7	2.6	776	28,098	299,921
Medically needy	2.6	160	37.4	20.8	35.9	11.0	18.4	11.5	2.5	426	14,225	137,836
Poverty related	0.4	18	11.2	37.9	57.6	3.2	1.2	0.1	0.0	156	49,928	477,762
Other/unknown	1.8	85	17.6	28.0	40.3	9.9	13.4	6.8	1.6	483	65,425	613,165

Source: Data for this table are from the MAX 2003 file for Vermont, released by CMS in 06/2007. This table was produced on 11/01/2007.

a. Table 4 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

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

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

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

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

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

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

TABLE 5

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

VERMONT, 2003

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.5**	**$83**	**$55**	**0.6**	**$66**	**$102**	**0.1**	**$3**	**$47**	**0.8**	**$14**	**$18**
Age												
5 and younger	0.4	15	43	0.1	12	94	0.0	1	39	0.2	3	13
6-14	0.4	26	61	0.2	21	94	0.0	1	82	0.2	3	19
15-20	0.6	41	65	0.3	33	103	0.0	2	81	0.3	6	22
21-44	1.3	77	57	0.5	60	110	0.0	3	61	0.7	13	18
45-64	3.0	184	62	1.3	147	115	0.1	6	56	1.6	31	19
65-74	3.6	192	54	1.6	153	96	0.1	5	34	1.8	34	18
75-84	3.9	193	49	1.7	153	90	0.2	4	26	2.0	35	17
85 and older	4.2	181	43	1.7	140	82	0.2	5	24	2.3	36	15
Unknown	0.3	2	8	0.0	1	14	0.1	1	6	0.1	1	8
Basis of Eligibility[d]												
Aged	3.8	187	49	1.6	148	90	0.2	4	27	2.0	34	17
Disabled	3.6	265	74	1.7	214	130	0.1	10	70	1.8	41	23
Adults	1.1	40	37	0.4	30	76	0.0	1	33	0.6	8	13
Children	0.4	21	52	0.2	17	89	0.0	1	61	0.2	3	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.7	90	52	0.7	71	95	0.1	3	42	0.9	16	17
Male	1.2	74	62	0.5	60	116	0.0	2	59	0.6	12	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.8	103	56	0.8	82	104	0.1	3	48	1.0	18	18
African American	1.0	69	69	0.5	57	126	0.0	2	62	0.5	9	18
Other/unknown	1.0	53	54	0.4	43	97	0.0	2	42	0.5	9	17
Use of Nursing Facilities[e]												
Entire year	6.3	308	49	2.6	245	93	0.3	7	26	3.4	56	16
Part year	6.7	318	47	2.8	251	91	0.3	7	23	3.6	58	16
None	1.4	78	56	0.6	62	103	0.0	3	49	0.7	13	18
Maintenance Assistance Status												
Cash	2.3	149	66	1.0	120	119	0.1	5	62	1.2	24	21
Medically needy	2.6	160	62	1.1	127	112	0.1	5	53	1.3	27	20
Poverty related	0.4	18	50	0.2	14	88	0.0	1	59	0.2	3	17
Other/unknown	1.8	85	48	0.7	67	90	0.1	2	34	1.0	15	16

Source: Data for this table are from the MAX 2003 file for Vermont, released by CMS in 06/2007. This table was produced on 11/01/2007.

a. Table 5 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

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

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Vermont, 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 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]

VERMONT, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.2	0.1	0.0	0.1	$12	$9	$0	$3	$50	$98	$65	$18	167,919	$8,362,988	64,768	41.1 %	698,308
Biologicals	0.2	0.2	0.0	0.0	142	121	0	21	724	689	1,785	1,009	1,702	1,231,891	826	0.5	8,670
Antineoplastic Agents	0.6	0.3	0.0	0.3	145	133	3	10	254	476	107	36	7,462	1,892,019	1,220	0.8	13,009
Endocrine/Metabolic Drugs	0.7	0.3	0.1	0.3	29	22	2	5	44	71	23	19	230,583	10,072,917	32,074	20.3	341,585
Cardiovascular Agents	1.4	0.5	0.0	0.9	54	40	1	13	38	81	26	14	455,038	17,146,626	29,668	18.8	317,628
Respiratory Agents	0.5	0.3	0.0	0.2	28	25	0	3	56	77	52	17	190,800	10,634,421	35,155	22.3	381,662
Gastrointestinal Agents	0.6	0.3	0.0	0.3	43	34	1	8	70	110	212	25	136,315	9,560,848	20,394	12.9	220,600
Genitourinary Agents	0.4	0.3	0.0	0.1	22	21	0	1	59	69	51	16	32,681	1,928,687	7,930	5.0	86,545
CNS Drugs	1.0	0.6	0.0	0.5	76	65	2	9	75	118	155	20	404,038	30,191,724	37,367	23.7	395,574
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.2	54	46	2	6	74	88	63	34	42,100	3,096,912	5,294	3.4	57,627
Miscellaneous Psychological/ Neurological Agents	0.4	0.3	0.0	0.1	58	52	0	7	157	167	72	107	10,912	1,708,933	2,726	1.7	29,265
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	28	20	1	8	44	132	80	16	269,710	11,788,015	40,018	25.4	424,952
Neuromuscular Agents	0.8	0.3	0.0	0.4	55	45	2	8	73	129	56	21	140,027	10,173,693	17,191	10.9	185,261
Nutritional Products	0.3	0.0	0.0	0.3	4	0	0	4	14	27	17	14	42,480	597,804	13,259	8.4	142,688
Hematological Agents	0.7	0.2	0.1	0.4	62	52	3	6	87	254	23	17	48,550	4,222,043	6,427	4.1	68,545
Topical Products	0.2	0.1	0.0	0.1	9	6	0	2	35	62	46	17	99,199	3,464,111	37,244	23.6	405,148
Miscellaneous Products	0.1	0.1	0.0	0.0	16	12	3	1	108	109	260	50	6,789	732,294	4,090	2.6	45,395
Unknown Therapeutic Category	0.1	0.0	0.0	0.0	6	0	0	0	40	0	0	0	6,738	266,639	4,199	2.7	45,984
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.	2,293,043	127,072,565	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Vermont, released by CMS in 06/2007. This table was produced on 11/01/2007.

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

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

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

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Vermont, 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.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; CNS = Central Nervous System; MAX = Medicaid Analytic Extract; n.a. = not applicable; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 7

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY TOP 10 DRUG GROUP[a, b, c]

VERMONT, 2003

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$15,127,750	12,095	7.7 %	132,580	0.7	$166	$114
ANTIDEPRESSANTS	12,906,615	36,133	22.9	387,962	0.6	59	33
ANTICONVULSANT	8,898,970	12,950	8.2	142,033	0.7	87	63
ANTIHYPERLIPIDEMIC	8,540,262	11,614	7.4	128,802	0.6	105	66
ULCER DRUGS	7,996,092	19,273	12.2	211,083	0.5	73	38
ANTIASTHMATIC	6,994,917	33,106	21.0	361,923	0.3	58	19
ANALGESICS - Narcotic	6,166,231	43,314	27.5	465,190	0.4	36	13
ANTIDIABETIC	5,067,271	11,610	7.4	126,293	0.7	57	40
ANALGESICS - ANTI-INFLAMMATORY	4,284,466	21,062	13.4	229,866	0.3	57	19
ANTIVIRAL	3,232,180	2,413	1.5	26,054	0.3	364	124
Total	79,214,754	203,570		2,211,786	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Vermont, released by CMS in 06/2007. This table was produced on 11/01/2007.

a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2003. A beneficiary who used drugs from two or more groups was counted as a user for each group. Therefore, the sum of users across drug groups may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

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

c. The top 10 drug groups were determined based on total Medicaid reimbursement in the state for 2003. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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