STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2004
VERMONT

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OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
VERMONT, 2004

Inclusion Criteria (2004)	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]	163,149	(A)	31,478	(E)	131,671	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	159,733	(B)	31,441	(F)	128,292	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	159,733	(C)	31,441	(G)	128,292	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	2,391	(D)	2,305	(H)	86	(L)

Source: Data for this table are from the MAX 2004 file for Vermont, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 2004 (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 2004, 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 2004 was $173,849,836, of which $10,519,289 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 23 states in 2004 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NY, OK, OR, PA, SC, 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) and one state (NV) in which MC plans provided a pharmacy benefit for nonduals but not for duals. These lists were constructed from the CMS 2004 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer04.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 pa

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 2004. 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 2004. 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, 2004

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**159,733**	**19,467**	**20,594**	**50,926**	**68,669**	**77**	**1,527,784**	**195,845**	**225,096**	**431,959**	**674,156**	**728**
Age												
5 and younger	22,950	0	330	6	22,614	0	217,166	0	3,627	41	213,498	0
6-14	32,869	1	1,280	2	31,586	0	338,204	12	14,534	4	323,654	0
15-20	17,422	0	1,153	2,165	14,097	7	163,310	0	12,937	16,505	133,797	71
21-44	44,122	2	6,862	36,859	365	34	387,302	14	74,725	309,138	3,123	302
45-64	21,310	13	9,517	11,738	6	36	208,412	80	102,985	104,920	72	355
65-74	7,898	6,645	1,122	131	0	0	80,329	66,546	12,656	1,127	0	0
75-84	8,247	7,949	273	24	1	0	84,956	81,678	3,054	212	12	0
85 and older	4,915	4,857	57	1	0	0	48,105	47,515	578	12	0	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Gender												
Female	88,828	13,475	10,441	30,950	33,886	76	862,654	138,291	115,363	274,870	333,414	716
Male	70,905	5,992	10,153	19,976	34,783	1	0 665,130	57,554	109,733	157,089	340,742	12
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	92,013	10,923	16,443	33,753	30,857	37	909,994	113,441	181,695	295,261	319,225	372
African American	1,326	17	158	536	615	0	0 11,459	143	1,606	4,099	5,611	0
Other/unknown	66,394	8,527	3,993	16,637	37,197	40	606,331	82,261	41,795	132,599	349,320	356
Use of Nursing Facilities[c]												
Entire year	2,391	2,224	167	0	0	0	22,653	21,006	1,647	0	0	0
Part year	1,223	937	266	19	0	1	11,956	9,050	2,695	199	0	12
None	156,119	16,306	20,161	50,907	68,669	76	1,493,175	165,789	220,754	431,760	674,156	716
Maintenance Assistance Status												
Cash	27,649	1,544	13,031	4,255	8,819	0	296,243	17,141	148,017	41,482	89,603	0
Medically needy	14,414	3,410	3,395	5,346	2,263	0	138,353	36,196	35,087	49,056	18,014	0
Poverty-related	49,914	0	0	2,524	47,313	77	479,019	0	0	17,939	460,352	728
Other/unknown	67,756	14,513	4,168	38,801	10,274	0	614,169	142,508	41,992	323,482	106,187	0
Dual Medicare Status[d]												
Full dual, all year	31,441	19,093	11,746	595	5	2	325,417	192,993	126,919	5,438	51	16
Full dual, part year	0	0	0	0	0	0		0	0	0	0	0
Non-dual, all year	128,292	374	8,848	50,331	68,664	75	1,202,367	2,852	98,177	426,521	674,105	712
Managed Care (MC) Status												
Fee-for-service (FFS) all year	159,733	19,467	20,594	50,926	68,669	77	0 1,527,784	195,845	225,096	431,959	674,156	728
FFS part year, with Rx claims	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

Source: Data for this table are from the MAX 2004 file for Vermont, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 2004. 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, 2004

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	**71.3 %**	**15.9**	**$1,023**	**$64**	**$4,819**	**21.2 %**	**159,733**
Age							
5 and younger	66.6	3.3	153	46	1,930	7.9	22,950
6-14	60.2	4.4	307	70	3,285	9.3	32,869
15-20	65.3	6.4	427	67	4,735	9.0	17,422
21-44	71.0	13.2	913	69	4,253	21.5	44,122
45-64	80.6	32.4	2,362	73	7,218	32.7	21,310
65-74	87.9	42.2	2,545	60	6,686	38.1	7,898
75-84	91.2	46.0	2,525	55	8,809	28.7	8,247
85 and older	91.9	45.8	2,186	48	13,853	15.8	4,915
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	90.2	43.9	2,406	55	9,086	26.5	19,467
Disabled	88.8	42.1	3,392	81	14,511	23.4	20,594
Adults	68.8	10.6	609	57	2,513	24.2	50,926
Children	62.6	4.0	224	56	2,407	9.3	68,669
Unknown	77.9	15.1	2,769	184	10,262	27.0	77
Gender							
Female	76.1	18.7	1,127	60	4,870	23.1	88,828
Male	65.4	12.4	892	72	4,755	18.8	70,905
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	76.9	20.1	1,307	65	6,015	21.7	92,013
African American	60.5	8.1	626	78	3,468	18.0	1,326
Other/unknown	63.8	10.2	637	62	3,189	20.0	66,394
Use of Nursing Facilities[f]							
Entire year	97.2	66.7	3,470	52	36,976	9.4	2,391
Part year	97.0	66.2	3,535	53	26,966	13.1	1,223
None	70.7	14.7	965	66	4,153	23.2	156,119
Maintenance Assistance Status							
Cash	81.5	26.0	1,874	72	9,416	19.9	27,649
Medically needy	78.9	26.5	1,793	68	4,618	38.8	14,414
Poverty related	60.8	3.4	180	53	1,638	11.0	49,914
Other/unknown	73.3	18.7	1,132	61	5,330	21.2	67,756

Source: Data for this table are from the MAX 2004 file for Vermont, released by CMS in 00/2007. This table was produced on 04/10/2008.

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, 2004

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	**1.7**	**$107**	**21.2 %**	**28.7 %**	**43.0 %**	**8.3 %**	**12.0 %**	**6.4 %**	**1.5 %**	**$504**	**159,733**	**1,527,784**
Age												
5 and younger	0.3	16	7.9	33.4	63.2	2.5	0.8	0.0	0.0	204	22,950	217,166
6-14	0.4	30	9.3	39.8	52.9	4.2	2.8	0.2	0.0	319	32,869	338,204
15-20	0.7	46	9.0	34.7	52.5	7.2	4.8	0.7	0.0	505	17,422	163,310
21-44	1.5	104	21.5	29.0	43.7	10.9	11.7	3.9	0.8	485	44,122	387,302
45-64	3.3	242	32.7	19.4	25.6	12.2	23.5	15.1	4.1	738	21,310	208,412
65-74	4.1	250	38.1	12.1	16.8	13.6	30.2	21.7	5.6	657	7,898	80,329
75-84	4.5	245	28.7	8.8	13.3	12.9	34.0	25.4	5.6	855	8,247	84,956
85 and older	4.7	223	15.8	8.1	11.4	11.6	35.6	27.3	6.1	1,415	4,915	48,105
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	4.4	239	26.5	9.8	14.2	13.0	33.3	24.3	5.5	903	19,467	195,845
Disabled	3.9	310	23.4	11.2	23.3	12.7	27.5	19.3	5.9	1,328	20,594	225,096
Adults	1.3	72	24.2	31.2	43.8	10.8	10.9	2.9	0.3	296	50,926	431,959
Children	0.4	23	9.3	37.4	56.6	3.9	2.0	0.2	0.0	245	68,669	674,156
Unknown	1.6	293	27.0	22.1	44.2	16.9	11.7	3.9	1.3	1,085	77	728
Gender												
Female	1.9	116	23.1	23.9	43.4	9.2	13.6	7.9	1.9	502	88,828	862,654
Male	1.3	95	18.8	34.6	42.5	7.2	9.9	4.6	1.1	507	70,905	665,130
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.0	132	21.7	23.1	42.2	9.6	14.5	8.4	2.2	608	92,013	909,994
African American	0.9	72	18.0	39.5	45.0	6.0	6.6	2.5	0.4	401	1,326	11,459
Other/unknown	1.1	70	20.0	36.2	44.1	6.7	8.5	3.9	0.6	349	66,394	606,331
Use of Nursing Facilities[f]												
Entire year	7.0	366	9.4	2.8	5.4	6.5	25.5	39.4	20.3	3,903	2,391	22,653
Part year	6.8	362	13.1	3.0	6.1	6.2	29.9	38.3	16.4	2,758	1,223	11,956
None	1.5	101	23.2	29.3	43.9	8.4	11.6	5.7	1.1	434	156,119	1,493,175
Maintenance Assistance Status												
Cash	2.4	175	19.9	18.5	40.3	10.2	17.7	10.3	3.1	879	27,649	296,243
Medically needy	2.8	187	38.8	21.1	34.0	10.7	18.9	12.4	3.0	481	14,414	138,353
Poverty related	0.4	19	11.0	39.2	56.0	3.3	1.4	0.1	0.0	171	49,914	479,019
Other/unknown	2.1	125	21.2	26.7	36.6	10.8	15.9	8.3	1.8	588	67,756	614,169

Source: Data for this table are from the MAX 2004 file for Vermont, released by CMS in 00/2007. This table was produced on 04/10/2008.

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, 2004

	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	**1.7**	**$107**	**$64**	**0.7**	**$80**	**$121**	**0.1**	**$8**	**$83**	**0.9**	**$18**	**$21**
Age												
5 and younger	0.3	16	46	0.1	12	113	0.0	1	40	0.2	3	14
6-14	0.4	30	70	0.2	25	110	0.0	1	76	0.2	4	20
15-20	0.7	46	67	0.3	35	116	0.0	3	77	0.3	7	22
21-44	1.5	104	69	0.5	75	137	0.1	10	103	0.8	19	22
45-64	3.3	242	73	1.3	180	137	0.2	21	106	1.8	41	23
65-74	4.1	250	60	1.8	193	110	0.2	14	68	2.2	43	20
75-84	4.5	245	55	1.8	188	103	0.2	13	53	2.4	44	18
85 and older	4.7	223	48	1.8	169	94	0.3	12	46	2.6	43	16
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	4.4	239	55	1.8	183	103	0.2	13	55	2.3	43	18
Disabled	3.9	310	81	1.6	235	148	0.3	28	110	2.0	48	24
Adults	1.3	72	57	0.4	51	114	0.1	6	85	0.7	15	21
Children	0.4	23	56	0.2	18	100	0.0	1	62	0.2	4	18
Unknown	1.6	293	184	0.6	263	472	0.1	11	152	1.0	19	19
Gender												
Female	1.9	116	60	0.8	86	113	0.1	9	75	1.0	21	20
Male	1.3	95	72	0.5	73	134	0.1	7	103	0.7	15	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.0	132	65	0.8	99	123	0.1	10	87	1.1	23	21
African American	0.9	72	78	0.4	57	155	0.1	6	103	0.5	10	19
Other/unknown	1.1	70	62	0.5	53	115	0.1	5	72	0.6	12	20
Use of Nursing Facilities[e]												
Entire year	7.0	366	52	2.8	283	103	0.4	21	50	3.8	62	16
Part year	6.8	362	53	2.6	274	104	0.4	22	54	3.7	64	17
None	1.5	101	66	0.6	76	122	0.1	8	87	0.8	17	21
Maintenance Assistance Status												
Cash	2.4	175	72	1.0	133	137	0.1	14	96	1.3	28	21
Medically needy	2.8	187	68	1.1	138	126	0.2	16	97	1.5	32	22
Poverty related	0.4	19	53	0.1	14	97	0.0	1	59	0.2	3	18
Other/unknown	2.1	125	61	0.8	94	113	0.1	9	74	1.1	23	20

Source: Data for this table are from the MAX 2004 file for Vermont, released by CMS in 00/2007. This table was produced on 04/10/2008.

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, 0.4 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, 2004

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	0.2	$14	$9	$1	$3	$55	$126	$72	$20	172,407	$9,491,922	65,108	40.8 %	696,665
Biologicals	0.2	0.2	0.0	0.0	130	107	0	22	639	589	29	1,134	1,951	1,246,792	953	0.6	9,626
Antineoplastic Agents	0.6	0.2	0.0	0.4	117	96	3	19	193	618	171	42	8,636	1,662,729	1,340	0.8	14,233
Endocrine/Metabolic Drugs	0.7	0.3	0.1	0.3	35	24	3	8	50	95	31	22	248,269	12,398,275	33,666	21.1	356,104
Cardiovascular Agents	1.5	0.6	0.0	0.9	67	52	1	14	44	92	34	16	515,744	22,922,811	32,165	20.1	342,114
Respiratory Agents	0.5	0.4	0.0	0.2	35	32	0	3	66	91	43	17	209,489	13,905,848	36,759	23.0	396,156
Gastrointestinal Agents	0.6	0.3	0.0	0.3	52	43	3	7	83	132	108	24	156,399	12,995,381	23,138	14.5	248,233
Genitourinary Agents	0.4	0.3	0.0	0.1	26	23	1	2	68	84	49	21	37,461	2,535,503	8,852	5.5	95,793
CNS Drugs	1.1	0.5	0.1	0.5	89	67	9	14	84	146	105	26	450,021	37,822,898	40,536	25.4	424,630
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	66	60	1	6	89	103	80	38	50,677	4,526,874	6,271	3.9	68,336
Miscellaneous Psychological/ Neurological Agents	0.5	0.4	0.0	0.1	89	84	0	4	196	216	116	68	15,989	3,141,732	3,361	2.1	35,489
Analgesics and Anesthetics	0.7	0.2	0.0	0.5	37	26	2	9	55	147	251	19	297,462	16,449,143	42,640	26.7	447,416
Neuromuscular Agents	0.7	0.2	0.1	0.4	63	36	19	9	85	154	134	24	152,903	12,956,890	19,194	12.0	204,271
Nutritional Products	0.3	0.0	0.0	0.3	5	0	0	4	15	33	18	15	43,013	663,925	13,649	8.5	146,698
Hematological Agents	0.8	0.2	0.1	0.4	67	56	4	7	89	254	43	17	56,564	5,054,023	7,067	4.4	75,216
Topical Products	0.3	0.1	0.0	0.2	11	7	1	3	43	81	52	21	107,562	4,625,267	39,060	24.5	422,266
Miscellaneous Products	0.2	0.1	0.0	0.0	16	11	2	3	104	102	251	83	7,467	777,474	4,469	2.8	49,187
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	8	0	0	0	28	0	0	0	5,449	153,060	1,701	1.1	18,432
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.	2,537,463	163,330,547	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Vermont, released by CMS in 00/2007. This table was produced on 04/10/2008.

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, 0.4 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 2004.

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, 2004

		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	$19,173,194	13,396	8.4 %	146,164	0.7	$184	$131
ANTIDEPRESSANTS	15,897,040	40,551	25.4	430,792	0.6	65	37
ANTIHYPERLIPIDEMIC	12,024,125	14,900	9.3	164,004	0.6	115	73
ANTICONVULSANT	11,475,433	14,470	9.1	157,169	0.7	102	73
ULCER DRUGS	10,940,705	21,562	13.5	233,476	0.5	87	47
ANTIASTHMATIC	9,308,601	35,440	22.2	385,668	0.3	71	24
ANALGESICS - Narcotic	8,797,750	46,594	29.2	495,099	0.4	47	18
ANTIDIABETIC	6,551,906	12,754	8.0	138,535	0.7	66	47
ANALGESICS - ANTI-INFLAMMATORY	5,691,760	23,680	14.8	255,054	0.3	69	22
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	4,526,874	7,494	4.7	82,392	0.6	89	55
Total	104,387,388	230,841		2,488,353	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Vermont, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 2004. 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 2004. 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.