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

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
VERMONT, 2005

Inclusion Criteria (2005)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Non-dual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	160651 (A)	31489 (E)	129162 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	157855 (B)	31401 (F)	126454 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	157846 (C)	31392 (G)	126454 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2352 (D)	2265 (H)	87 (L)

Source: Data for this table are from the MAX 2005 file for Vermont, released by CMS in 12/2008. This table was produced on 04/23/2009.

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

b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2005 (based on MAX data element "Eligible Restricted Benefits Flag").

c. Cell C represents the study population for Tables 2 through 7. Cell C was obtained by excluding from Cell B beneficiaries who were in managed care (MC) plans that included prescription drugs in their capitated benefit package during all months of Medicaid eligibility in 2005, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.

d. The total Medicaid pharmacy reimbursement for Vermont in 2005 was $193,690,013, of which $12,599,478 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

e. Enrollees in prepaid health plans (PHP) or managed care (MC) plans that did not provide a pharmacy benefit are treated as having fee-for-service pharmacy benefit coverage. There were 26 states in 2005 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NE, NY, TX, UT, and WV) and one state (NV) in which MC plans provided a pharmacy benefit for nonduals but not for duals. These lists were constructed from the CMS 2005 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer05.pdf and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit package.

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2005. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and N+B18D.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.

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

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2005. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

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

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

TABLE 2

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

VERMONT, 2005

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**157,846**	**18,855**	**21,319**	**50,047**	**67,524**	**101**	**1,517,854**	**194,154**	**233,801**	**425,965**	**663,098**	**836**
Age												
5 and younger	22,613	0	352	0	22,261	0	214,375	0	3,881	0	210,494	0
6-14	31,854	1	1,346	1	30,506	0	328,450	12	15,381	5	313,052	0
15-20	17,680	0	1,248	2,080	14,349	3	166,319	0	14,091	15,971	136,242	15
21-44	43,115	0	6,978	35,684	401	52	378,318	0	76,202	298,482	3,226	408
45-64	22,086	6	9,936	12,094	6	44	218,079	65	107,786	109,748	72	408
65-74	7,562	6,275	1,119	166	0	2	79,268	65,021	12,685	1,557	0	5
75-84	8,014	7,705	289	19	1	0	83,905	80,503	3,221	169	12	0
85 and older	4,922	4,868	51	3	0	0	49,140	48,553	554	33	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	87,894	13,104	10,830	30,539	33,320	101	857,189	137,476	119,805	271,485	327,587	836
Male	69,952	5,751	10,489	19,508	34,204	0	660,665	56,678	113,996	154,480	335,511	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	93,452	10,610	17,207	33,621	31,962	52	927,078	111,734	190,425	294,202	330,292	425
African American	1,567	15	163	638	751	0	14,713	159	1,723	5,358	7,473	0
Other/unknown	62,827	8,230	3,949	15,788	34,811	49	576,063	82,261	41,653	126,405	325,333	411
Use of Nursing Facilities[c]												
Entire year	2,352	2,180	171	0	0	1	22,319	20,563	1,755	0	0	1
Part year	1,187	903	262	22	0	0	11,756	8,828	2,726	202	0	0
None	154,307	15,772	20,886	50,025	67,524	100	1,483,779	164,763	229,320	425,763	663,098	835
Maintenance Assistance Status												
Cash	27,255	1,433	13,325	4,044	8,453	0	293,426	15,915	151,673	39,709	86,129	0
Medically needy	15,159	3,482	3,688	5,649	2,340	0	144,707	37,031	37,953	51,223	18,500	0
Poverty-related	49,419	0	0	2,545	46,773	101	473,428	0	0	17,977	454,615	836
Other/unknown	66,013	13,940	4,306	37,809	9,958	0	606,293	141,208	44,175	317,056	103,854	0
Dual Medicare Status[d]												
Full dual, all year	31,392	18,577	12,202	604	8	1	329,992	191,607	132,476	5,833	73	3
Full dual, part year	0	0	0	0	0	0	0	0	0	0	0	0
Non-dual, all year	126,454	278	9,117	49,443	67,516	100	1,187,862	2,547	101,325	420,132	663,025	833
Managed Care (MC) Status												
Fee-for-service (FFS) all year	157,846	18,855	21,319	50,047	67,524	101	1,517,854	194,154	233,801	425,965	663,098	836
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 2005 file for Vermont, released by CMS in 12/2008. This table was produced on 04/23/2009.

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

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

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

d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2005. The “Full dual, part year” group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.

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

TABLE 3
ANNUAL MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFICIARY, BY BENEFICIARY CHARACTERISTIC[a, b]
VERMONT, 2005

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**72.5**	**17.1**	**$1,147**	**$67**	**$5,352**	**21.4**	**157,846**
Age							
5 and younger	67.7	3.3	160	49	2,051	7.8	22,613
6-14	60.8	4.5	341	77	3,580	9.5	31,854
15-20	64.5	6.4	462	72	5,096	9.1	17,680
21-44	72.3	14.2	1,033	73	4,749	21.8	43,115
45-64	82.6	35.1	2,627	75	7,983	32.9	22,086
65-74	91.0	46.2	2,904	63	7,335	39.6	7,562
75-84	92.9	49.0	2,787	57	9,982	27.9	8,014
85 and older	94.4	48.7	2,356	48	15,807	14.9	4,922
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	92.6	47.4	2,676	56	10,379	25.8	18,855
Disabled	89.3	44.8	3,662	82	15,622	23.4	21,319
Adults	70.7	11.6	719	62	2,884	24.9	50,047
Children	62.9	4.0	245	62	2,533	9.7	67,524
Unknown	74.3	11.8	712	60	7,313	9.7	101
Gender							
Female	77.0	20.0	1,247	62	5,405	23.1	87,894
Male	66.9	13.5	1,022	76	5,286	19.3	69,952
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	77.7	21.3	1,434	67	6,557	21.9	93,452
African American	66.5	8.2	636	78	3,629	17.5	1,567
Other/unknown	65.0	11.0	734	66	3,603	20.4	62,827
Use of Nursing Facilities[f]							
Entire year	97.0	69.1	3,663	53	42,111	8.7	2,352
Part year	96.9	72.8	3,983	55	31,797	12.5	1,187
None	72.0	15.9	1,087	69	4,589	23.7	154,307
Maintenance Assistance Status							
Cash	81.8	27.7	2,039	74	10,288	19.8	27,255
Medically needy	78.8	27.5	1,925	70	5,044	38.2	15,159
Poverty related	61.1	3.4	189	56	1,720	11.0	49,419
Other/unknown	75.8	20.6	1,318	64	6,105	21.6	66,013

Source: Data for this table are from the MAX 2005 file for Vermont, released by CMS in 12/2008. This table was produced on 04/23/2009.

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

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

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

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

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability

or blindness. The children's group includes children receiving foster care and adoptive services.

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

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

TABLE 4

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

VERMONT, 2005

				Number of Rx, Percentage with:							Number	
Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Beneficiaries	Benefit Months
All	**1.8**	**$119**	**21.4**	**27.5**	**42.9**	**8.3**	**12.7**	**6.9**	**1.8**	**$557**	**157,846**	**1,517,854**
Age												
5 and younger	0.3	17	7.8	32.3	64.5	2.3	0.9	0.0	0.0	216	22,613	214,375
6-14	0.4	33	9.5	39.2	53.2	4.4	2.9	0.3	0.0	347	31,854	328,450
15-20	0.7	49	9.1	35.5	51.8	6.9	5.0	0.7	0.1	542	17,680	166,319
21-44	1.6	118	21.8	27.7	43.2	11.3	12.6	4.3	0.9	541	43,115	378,318
45-64	3.6	266	32.9	17.4	25.6	11.7	24.6	16.0	4.8	808	22,086	218,079
65-74	4.4	277	39.6	9.0	15.3	13.3	32.4	23.8	6.2	700	7,562	79,268
75-84	4.7	266	27.9	7.1	12.3	12.7	35.3	26.2	6.5	953	8,014	83,905
85 and older	4.9	236	14.9	5.6	10.9	11.2	37.3	27.8	7.1	1,583	4,922	49,140
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	4.6	260	25.8	7.4	13.0	12.6	35.1	25.6	6.4	1,008	18,855	194,154
Disabled	4.1	334	23.4	10.7	23.1	12.1	27.7	19.7	6.7	1,425	21,319	233,801
Adults	1.4	85	24.9	29.3	43.6	11.2	12.2	3.5	0.3	339	50,047	425,965
Children	0.4	25	9.7	37.1	56.9	3.8	2.0	0.2	0.0	258	67,524	663,098
Unknown	1.4	86	9.7	25.7	40.6	14.9	15.8	2.0	1.0	884	101	836
Gender												
Female	2.0	128	23.1	23.0	42.9	9.3	14.3	8.3	2.2	554	87,894	857,189
Male	1.4	108	19.3	33.1	42.8	7.2	10.6	5.2	1.3	560	69,952	660,665
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.1	145	21.9	22.3	41.9	9.5	15.1	8.7	2.5	661	93,452	927,078
African American	0.9	68	17.5	33.5	52.0	5.8	5.9	2.6	0.2	387	1,567	14,713
Other/unknown	1.2	80	20.4	35.0	44.1	6.6	9.2	4.3	0.8	393	62,827	576,063
Use of Nursing Facilities[f]												
Entire year	7.3	386	8.7	3.0	4.8	5.6	25.1	39.1	22.4	4,438	2,352	22,319
Part year	7.3	402	12.5	3.1	6.8	5.7	28.8	36.7	18.8	3,211	1,187	11,756
None	1.7	113	23.7	28.0	43.7	8.4	12.3	6.2	1.3	477	154,307	1,483,779
Maintenance Assistance Status												
Cash	2.6	189	19.8	18.2	39.8	10.2	17.7	10.6	3.4	956	27,255	293,426
Medically needy	2.9	202	38.2	21.2	33.6	10.6	18.6	12.7	3.3	528	15,159	144,707
Poverty related	0.4	20	11.0	38.9	56.2	3.4	1.4	0.1	0.0	180	49,419	473,428
Other/unknown	2.2	144	21.6	24.2	36.3	10.7	17.6	9.1	2.1	665	66,013	606,293

Source: Data for this table are from the MAX 2005 file for Vermont, released by CMS in 12/2008. This table was produced on 04/23/2009.

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

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

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

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

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

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

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

TABLE 5

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

VERMONT, 2005

Beneficiary Characteristics	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
	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	**1.8**	**$119**	**$67**	**0.7**	**$90**	**$132**	**0.1**	**$6**	**$93**	**1.0**	**$24**	**$23**
Age												
5 and younger	0.3	17	49	0.1	13	119	0.0	0	33	0.2	4	15
6-14	0.4	33	77	0.2	28	124	0.0	1	87	0.2	4	22
15-20	0.7	49	72	0.3	39	132	0.0	2	71	0.4	8	23
21-44	1.6	118	73	0.6	86	150	0.1	7	115	1.0	25	25
45-64	3.6	266	75	1.3	195	146	0.1	16	123	2.1	55	26
65-74	4.4	277	63	1.7	214	122	0.1	10	74	2.5	53	21
75-84	4.7	266	57	1.8	205	114	0.2	9	54	2.7	52	19
85 and older	4.9	236	48	1.7	176	101	0.2	9	48	2.9	51	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	4.6	260	56	1.8	199	113	0.2	9	58	2.7	52	19
Disabled	4.1	334	82	1.6	251	156	0.2	20	127	2.3	62	27
Adults	1.4	85	62	0.5	60	131	0.0	4	91	0.9	20	23
Children	0.4	25	62	0.2	20	115	0.0	1	70	0.2	4	19
Unknown	1.4	86	60	0.5	71	135	0.0	2	57	0.9	13	15
Gender												
Female	2.0	128	62	0.8	95	125	0.1	6	81	1.2	26	22
Male	1.4	108	76	0.6	83	146	0.0	5	120	0.8	20	25
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.1	145	67	0.8	108	133	0.1	7	97	1.3	29	23
African American	0.9	68	78	0.3	53	156	0.0	4	145	0.5	11	22
Other/unknown	1.2	80	66	0.5	62	130	0.0	3	81	0.7	15	22
Use of Nursing Facilities[e]												
Entire year	7.3	386	53	2.6	285	110	0.3	16	58	4.4	85	19
Part year	7.3	402	55	2.6	294	111	0.2	16	66	4.4	92	21
None	1.7	113	69	0.6	85	135	0.1	6	96	1.0	22	23
Maintenance Assistance Status												
Cash	2.6	189	74	1.0	144	146	0.1	10	108	1.5	35	24
Medically needy	2.9	202	70	1.1	149	137	0.1	12	106	1.7	41	25
Poverty related	0.4	20	56	0.1	15	107	0.0	1	62	0.2	4	19
Other/unknown	2.2	144	64	0.8	108	127	0.1	6	82	1.3	29	22

Source: Data for this table are from the MAX 2005 file for Vermont, released by CMS in 12/2008. This table was produced on 04/23/2009.

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

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

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

other than the original patent holder. In Vermont, 0.3 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions

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

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

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

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

All Medicaid Beneficiaries

TABLE 6

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY[a, b, c, d]

VERMONT, 2005

Therapeutic Category	Number of Rx per Benefit Month Among Users: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	$ per Benefit Month Among Users: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	$ per Rx: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Users[e]: Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.2	$14	$9	$2	$4	$57	$171	$79	$20	179,085	$10,215,044	66,217	42.0	707,454
Biologicals	0.2	0.2	0.0	0.0	136	100	9	27	710	612	3,031	1,082	1,939	1,377,334	984	0.6	10,154
Antineoplastic Agents	0.6	0.2	0.0	0.4	125	105	1	19	199	561	169	44	9,109	1,814,723	1,379	0.9	14,460
Endocrine/Metabolic Drugs	0.7	0.3	0.1	0.4	38	26	4	8	53	105	49	21	267,520	14,092,697	34,893	22.1	368,282
Cardiovascular Agents	1.6	0.6	0.0	1.0	72	57	1	15	46	101	34	15	560,198	25,930,187	33,635	21.3	357,763
Respiratory Agents	0.5	0.3	0.0	0.2	38	33	1	3	72	108	69	16	201,259	14,589,570	36,182	22.9	388,285
Gastrointestinal Agents	0.7	0.4	0.0	0.3	63	58	1	5	95	146	88	18	169,977	16,086,842	23,888	15.1	255,846
Genitourinary Agents	0.4	0.3	0.0	0.1	28	25	1	3	68	86	65	22	41,483	2,800,721	9,147	5.8	98,895
CNS Drugs	1.1	0.5	0.0	0.6	97	78	3	16	86	156	173	26	487,518	41,806,675	41,303	26.2	432,230
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	76	69	1	6	98	114	106	38	54,011	5,303,378	6,391	4.0	69,606
Miscellaneous Psychological/ Neurological Agents	0.5	0.4	0.0	0.1	89	85	0	4	187	205	93	70	19,331	3,624,453	3,835	2.4	40,497
Analgesics and Anesthetics	0.7	0.1	0.0	0.5	38	17	6	15	56	146	251	28	310,943	17,283,126	43,351	27.5	453,700
Neuromuscular Agents	0.8	0.2	0.0	0.5	64	41	3	19	82	167	92	39	171,287	13,974,987	20,529	13.0	219,195
Nutritional Products	0.3	0.0	0.0	0.3	5	0	0	4	16	41	19	15	42,892	676,227	13,571	8.6	146,374
Hematological Agents	0.8	0.2	0.0	0.5	68	57	2	9	87	239	46	17	62,340	5,425,527	7,515	4.8	79,764
Topical Products	0.3	0.1	0.0	0.2	12	8	0	4	47	91	55	22	110,002	5,141,498	40,168	25.4	434,880
Miscellaneous Products	0.2	0.1	0.0	0.0	17	12	2	3	110	109	279	84	7,889	867,068	4,623	2.9	50,359
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	8	0	0	0	32	0	0	0	2,510	80,478	965	0.6	10,537
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.	2,699,293	181,090,535	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Vermont, released by CMS in 12/2008. This table was produced on 04/23/2009.

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

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

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

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

the original patent holder. In Vermont, 0.3 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined.

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

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2005.

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

TABLE 7

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

VERMONT, 2005

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$23,044,014	14,304	9.1	155,786	0.8	$194	$148
ANTIDEPRESSANTS	15,862,324	41,816	26.5	443,840	0.6	61	36
ANTIHYPERLIPIDEMIC	14,328,599	17,210	10.9	189,426	0.7	116	76
ULCER DRUGS	13,790,799	22,415	14.2	242,448	0.6	97	57
ANTICONVULSANT	12,264,144	15,415	9.8	167,651	0.7	98	73
ANTIASTHMATIC	11,113,499	37,829	24.0	409,560	0.3	79	27
ANALGESICS - Narcotic	10,262,385	48,998	31.0	520,472	0.4	50	20
ANTIDIABETIC	7,482,591	13,781	8.7	148,591	0.7	69	50
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	5,303,402	7,460	4.7	82,066	0.7	98	65
ANALGESICS - ANTI-INFLAMMATORY	4,721,126	21,855	13.8	234,256	0.3	64	20
Total	118,172,883	241,083		2,594,096	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Vermont, released by CMS in 12/2008. This table was produced on 04/23/2009.

a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2005. A beneficiary who used drugs from two or more groups was counted as a user for each group. Therefore, the sum of users across drug groups may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

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

c. The top 10 drug groups were determined based on total Medicaid reimbursement in the state for 2005. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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