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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006
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, 2006

Inclusion Criteria (2006)	Number of Dual and Nondual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Nondual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	159470 (A)	31698 (E)	127772 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	156971 (B)	31569 (F)	125402 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	156971 (C)	31569 (G)	125402 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2282 (D)	2199 (H)	83 (L)

Source: Data for this table are from the MAX 2006 file for Vermont, released by CMS in 10/2009. This table was produced on 02/12/2010.
a. MAX data element "Eligible Months Count" was used to determine an individual's Medicaid eligibility. All individuals who had a value greater than zero were considered as beneficiaries and counted in Cell A.
b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2006 (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 2006, 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 2006 was $115,316,270, of which $6,883,547 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 29 states in 2006 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, KY, MA, MI, MS, NC, NH, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, and WI. In addition, there were 10 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NC, NE, NY, TN, TX, UT, and WV). These lists were constructed from the CMS 2006 Medicaid Managed Care Enrollment Report and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we 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 2006. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.
g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit. Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2006. 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, 2006

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**156,971**	**18,551**	**21,906**	**49,734**	**66,651**	**129**	**1,510,989**	**191,378**	**239,334**	**425,222**	**653,968**	**1,087**
Age												
5 and younger	22,532	0	369	0	22,163	0	212,749	0	3,971	0	208,778	0
6-14	31,033	0	1,371	0	29,662	0	320,093	0	15,594	0	304,499	0
15-20	17,867	1	1,337	2,077	14,448	4	168,339	12	14,892	15,858	137,548	29
21-44	42,464	0	7,083	34,938	369	74	375,034	0	76,919	294,499	3,050	566
45-64	22,897	2	10,316	12,521	8	50	225,289	24	111,700	113,002	81	482
65-74	7,486	6,222	1,084	179	0	1	78,525	64,483	12,358	1,674	0	10
75-84	7,787	7,472	300	14	1	0	81,759	78,235	3,373	139	12	0
85 and older	4,905	4,854	46	5	0	0	49,201	48,624	527	50	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	87,630	13,023	11,169	30,502	32,807	129	854,228	135,789	123,290	271,692	322,370	1,087
Male	69,341	5,528	10,737	19,232	33,844	0	656,761	55,589	116,044	153,530	331,598	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	95,198	10,532	17,868	33,869	32,855	74	943,455	111,239	197,115	296,051	338,431	619
African American	1,719	25	174	674	846	0	16,395	244	1,788	5,813	8,550	0
Other/unknown	60,054	7,994	3,864	15,191	32,950	55	551,139	79,895	40,431	123,358	306,987	468
Use of Nursing Facilities[c]												
Entire year	2,282	2,105	175	2	0	0	22,053	20,231	1,819	3	0	0
Part year	1,215	941	261	13	0	0	12,133	9,265	2,742	126	0	0
None	153,474	15,505	21,470	49,719	66,651	129	1,476,803	161,882	234,773	425,093	653,968	1,087
Maintenance Assistance Status												
Cash	27,329	1,370	13,655	3,922	8,382	0	293,726	15,276	154,917	38,216	85,317	0
Medically needy	15,853	3,490	3,886	6,003	2,474	0	151,544	37,313	39,769	54,283	20,179	0
Poverty-related	49,272	0	0	2,681	46,462	129	470,540	0	0	19,304	450,149	1,087
Other/unknown	64,517	13,691	4,365	37,128	9,333	0	595,179	138,789	44,648	313,419	98,323	0
Dual Medicare Status[d]												
Full dual, all year	31,569	18,298	12,587	674	7	3	331,562	188,963	136,127	6,364	74	34
Full dual, part year	0	0	0	0	0	0	0	0	0	0	0	0
Non-dual, all year	125,402	253	9,319	49,060	66,644	126	1,179,427	2,415	103,207	418,858	653,894	1,053
Managed Care (MC) Status												
Fee-for-service (FFS) all year	156,971	18,551	21,906	49,734	66,651	129	1,510,989	191,378	239,334	425,222	653,968	1,087
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 2006 file for Vermont, released by CMS in 10/2009. This table was produced on 02/12/2010.

a. Table 2 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.
b. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services. The total includes some beneficiaries with unknown basis of eligibility and some whose age categories are not consistent with basis of eligibility.
c. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.
d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2006. 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, 2006

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	**70.2**	**11.8**	**$691**	**$58**	**$5,124**	**13.5**	**156,971**
Age							
5 and younger	66.0	3.2	170	53	2,167	7.8	22,532
6-14	60.4	4.6	373	82	3,805	9.8	31,033
15-20	65.6	6.6	495	76	5,313	9.3	17,867
21-44	71.7	12.3	814	66	4,782	17.0	42,464
45-64	79.0	24.6	1,587	64	7,100	22.3	22,897
65-74	80.5	22.4	755	34	5,474	13.8	7,486
75-84	81.9	23.3	669	29	8,187	8.2	7,787
85 and older	79.1	18.8	493	26	14,704	3.4	4,905
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	81.0	22.5	649	29	8,770	7.4	18,551
Disabled	81.0	26.1	1,854	71	14,321	12.9	21,906
Adults	71.7	12.1	767	63	3,025	25.4	49,734
Children	62.5	4.0	263	65	2,650	9.9	66,651
Unknown	69.8	11.5	877	77	6,935	12.6	129
Gender							
Female	74.5	13.6	738	54	5,104	14.5	87,630
Male	64.8	9.6	631	66	5,150	12.3	69,341
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	74.6	14.1	844	60	6,164	13.7	95,198
African American	62.2	6.6	550	83	3,518	15.6	1,719
Other/unknown	63.5	8.5	452	53	3,521	12.8	60,054
Use of Nursing Facilities[f]							
Entire year	69.4	12.0	479	40	41,333	1.2	2,282
Part year	80.9	22.1	1,005	46	27,825	3.6	1,215
None	70.1	11.8	691	59	4,406	15.7	153,474
Maintenance Assistance Status							
Cash	77.2	18.5	1,350	73	10,067	13.4	27,329
Medically needy	70.7	11.4	674	59	3,869	17.4	15,853
Poverty related	60.5	3.4	208	61	1,815	11.5	49,272
Other/unknown	74.5	15.6	784	50	5,866	13.4	64,517

Source: Data for this table are from the MAX 2006 file for Vermont, released by CMS in 10/2009. This table was produced on 02/12/2010.
a. Table 3 includes beneficiaries represented by Cell C of Table 1.
b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.
c. In ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

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	**1.2**	**$72**	**13.5**	**29.8**	**47.1**	**8.6**	**10.1**	**3.8**	**0.7**	**$532**	**156,971**	**1,510,989**
Age												
5 and younger	0.3	18	7.8	34.0	62.7	2.4	0.8	0.0	0.0	230	22,532	212,749
6-14	0.4	36	9.8	39.6	52.6	4.3	3.2	0.3	0.0	369	31,033	320,093
15-20	0.7	53	9.3	34.4	52.8	6.8	5.0	0.9	0.1	564	17,867	168,339
21-44	1.4	92	17.0	28.3	45.2	11.2	11.3	3.5	0.6	541	42,464	375,034
45-64	2.5	161	22.3	21.0	33.1	13.0	20.2	10.1	2.6	722	22,897	225,289
65-74	2.1	72	13.8	19.5	35.2	13.4	21.0	9.5	1.3	522	7,486	78,525
75-84	2.2	64	8.2	18.1	34.5	13.7	22.4	10.3	1.0	780	7,787	81,759
85 and older	1.9	49	3.4	20.9	37.9	12.6	20.3	7.4	0.9	1,466	4,905	49,201
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Basis of Eligibility[e]												
Aged	2.2	63	7.4	19.0	34.4	13.4	22.3	9.7	1.1	850	18,551	191,378
Disabled	2.4	170	12.9	19.0	37.8	12.7	17.9	9.5	3.0	1,311	21,906	239,334
Adults	1.4	90	25.4	28.3	43.3	11.5	12.7	3.8	0.4	354	49,734	425,222
Children	0.4	27	9.9	37.5	56.4	3.8	2.1	0.2	0.0	270	66,651	653,968
Unknown	1.4	104	12.6	30.2	43.4	7.0	15.5	3.9	0.0	823	129	1,087
Gender												
Female	1.4	76	14.5	25.5	48.3	9.6	11.3	4.5	0.9	524	87,630	854,228
Male	1.0	67	12.3	35.2	45.5	7.4	8.5	2.9	0.5	544	69,341	656,761
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.4	85	13.7	25.4	47.8	9.8	11.5	4.6	0.9	622	95,198	943,455
African American	0.7	58	15.6	37.8	49.4	5.4	5.6	1.5	0.2	369	1,719	16,395
Other/unknown	0.9	49	12.8	36.5	45.8	6.8	8.0	2.5	0.3	384	60,054	551,139
Use of Nursing Facilities[f]												
Entire year	1.2	50	1.2	30.6	43.9	10.4	9.4	3.5	2.2	4,277	2,282	22,053
Part year	2.2	101	3.6	19.1	44.1	13.2	13.1	6.7	3.8	2,786	1,215	12,133
None	1.2	72	15.7	29.9	47.1	8.5	10.1	3.7	0.6	458	153,474	1,476,803
Maintenance Assistance Status												
Cash	1.7	126	13.4	22.8	47.7	9.8	12.0	5.8	1.9	937	27,329	293,726
Medically needy	1.2	71	17.4	29.3	47.6	10.3	9.3	3.1	0.5	405	15,853	151,544
Poverty related	0.4	22	11.5	39.5	55.4	3.4	1.6	0.1	0.0	190	49,272	470,540
Other/unknown	1.7	85	13.4	25.5	40.3	11.7	15.9	5.9	0.7	636	64,517	595,179

Source: Data for this table are from the MAX 2006 file for Vermont, released by CMS in 10/2009. This table was produced on 02/12/2010.
a. Table 4 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.
b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.
c. In ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

	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	**1.2**	**$72**	**$58**	**0.4**	**$52**	**$125**	**0.1**	**$6**	**$103**	**0.8**	**$14**	**$19**
Age												
5 and younger	0.3	18	53	0.1	13	145	0.0	1	46	0.2	4	17
6-14	0.4	36	82	0.2	30	140	0.0	1	81	0.2	5	23
15-20	0.7	53	76	0.3	41	151	0.0	2	104	0.4	9	22
21-44	1.4	92	66	0.4	67	154	0.0	6	122	0.9	19	21
45-64	2.5	161	64	0.8	113	140	0.1	16	132	1.6	33	21
65-74	2.1	72	34	0.7	48	66	0.1	9	76	1.3	15	12
75-84	2.2	64	29	0.8	42	55	0.1	7	64	1.3	14	11
85 and older	1.9	49	26	0.6	33	53	0.1	5	51	1.2	12	10
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	2.2	63	29	0.7	42	56	0.1	7	62	1.3	14	11
Disabled	2.4	170	71	0.8	126	153	0.1	14	122	1.4	30	21
Adults	1.4	90	63	0.4	63	146	0.1	7	132	0.9	20	21
Children	0.4	27	65	0.2	21	132	0.0	1	71	0.2	5	20
Unknown	1.4	104	77	0.4	78	186	0.1	8	121	0.9	18	21
Gender												
Female	1.4	76	54	0.5	54	118	0.1	6	100	0.9	16	18
Male	1.0	67	66	0.4	50	137	0.0	5	109	0.6	12	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.4	85	60	0.5	62	132	0.1	6	109	0.9	17	19
African American	0.7	58	83	0.2	43	198	0.0	4	171	0.5	10	23
Other/unknown	0.9	49	53	0.3	36	108	0.0	4	87	0.5	9	17
Use of Nursing Facilities[e]												
Entire year	1.2	50	40	0.3	33	107	0.0	3	78	0.9	13	15
Part year	2.2	101	46	0.7	70	103	0.1	8	79	1.4	23	16
None	1.2	72	59	0.4	52	126	0.1	6	104	0.8	14	19
Maintenance Assistance Status												
Cash	1.7	126	73	0.6	94	161	0.1	9	124	1.1	23	21
Medically needy	1.2	71	59	0.4	48	136	0.1	6	122	0.8	16	20
Poverty related	0.4	22	61	0.1	17	126	0.0	1	74	0.2	4	19
Other/unknown	1.7	85	50	0.6	61	105	0.1	7	93	1.0	17	17

Source: Data for this table are from the MAX 2006 file for Vermont, released by CMS in 10/2009. This table was produced on 02/12/2010.

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

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

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In 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.medi-span.com/master-drug-database.aspx

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

or blindness. The children's group includes children receiving foster care and adoptive services.
e. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.
CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 6

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

VERMONT, 2006

	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
Therapeutic Category	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.2	0.0	0.0	0.2	$12	$7	$1	$4	$53	$210	$62	$22	139,532	$7,363,318	56,991	36.3	606,446
Biologicals	0.2	0.2	0.0	0.0	119	117	1	0	631	635	2,111	56	1,894	1,194,898	969	0.6	10,058
Antineoplastic Agents	0.5	0.2	0.0	0.3	93	83	1	10	189	482	252	30	5,850	1,108,385	1,122	0.7	11,905
Endocrine/Metabolic Drugs	0.6	0.2	0.0	0.3	26	18	1	7	47	93	42	21	178,833	8,472,131	30,733	19.6	322,691
Cardiovascular Agents	1.1	0.3	0.1	0.7	38	19	12	8	35	61	113	11	332,421	11,507,454	28,585	18.2	302,177
Respiratory Agents	0.4	0.3	0.0	0.2	29	26	0	3	66	101	71	18	150,759	10,013,008	31,930	20.3	342,351
Gastrointestinal Agents	0.5	0.3	0.0	0.2	41	37	2	3	87	125	303	15	102,577	8,961,262	20,331	13.0	217,141
Genitourinary Agents	0.3	0.1	0.0	0.1	14	9	3	2	46	63	83	19	23,821	1,105,435	7,499	4.8	80,457
CNS Drugs	0.9	0.3	0.0	0.5	61	45	5	11	69	153	106	20	351,339	24,173,103	37,979	24.2	396,114
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	81	77	1	4	105	126	105	26	53,809	5,662,113	6,418	4.1	69,526
Miscellaneous Psychological/ Neurological Agents	0.3	0.2	0.0	0.1	68	64	0	5	259	333	137	65	9,468	2,450,511	3,408	2.2	35,815
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	27	15	2	10	46	149	251	21	231,082	10,733,918	38,246	24.4	397,108
Neuromuscular Agents	0.6	0.2	0.0	0.4	45	33	2	10	69	164	92	22	126,623	8,697,975	18,443	11.7	195,112
Nutritional Products	0.2	0.0	0.0	0.2	3	0	0	2	12	41	16	11	30,452	368,269	11,930	7.6	128,563
Hematological Agents	0.5	0.1	0.0	0.4	39	32	1	6	71	253	34	16	35,926	2,552,989	6,144	3.9	65,344
Topical Products	0.2	0.1	0.0	0.1	9	6	0	2	43	91	63	18	77,749	3,310,476	34,204	21.8	367,303
Miscellaneous Products	0.1	0.1	0.0	0.0	15	12	1	2	102	106	224	61	6,839	694,397	4,338	2.8	47,682
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	10	0	0	0	65	0	0	0	977	63,081	579	0.4	6,313
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.	1,859,951	108,432,723	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Vermont, released by CMS in 10/2009. This table was produced on 02/12/2010.

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

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

c. For information about these therapeutic categories, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In 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.medi-span.com/master-drug-database.aspx.

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2006.

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, 2006

		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	$12,488,313	11,083	7.1	120,768	0.6	$183	$103
ANTIDEPRESSANTS	9,290,620	35,702	22.7	375,424	0.5	51	25
ANTICONVULSANT	7,927,477	14,324	9.1	154,505	0.6	82	51
ULCER DRUGS	7,628,046	19,667	12.5	211,522	0.4	81	36
ANTIASTHMATIC	7,580,679	32,762	20.9	353,810	0.3	73	21
ANALGESICS - Narcotic	6,471,819	42,086	26.8	442,620	0.4	40	15
ANTIHYPERLIPIDEMIC	6,288,551	14,061	9.0	152,872	0.5	79	41
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	5,662,354	7,301	4.7	79,827	0.7	105	71
ANTIDIABETIC	4,021,018	10,970	7.0	117,705	0.6	61	34
ANTIVIRAL	3,411,364	2,796	1.8	29,798	0.3	332	114
Total	70,770,241	190,752	n.a.	2,038,851	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Vermont, released by CMS in 10/2009. This table was produced on 02/12/2010.

a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2006. 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 2006. For information about these drug groups, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.

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