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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
VERMONT, 2007

Inclusion Criteria (2007)	Number of Dual and Nondual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Nondual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	159205 (A)	31839 (E)	127366 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	155530 (B)	31410 (F)	124120 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	155528 (C)	31408 (G)	124120 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2206 (D)	2131 (H)	75 (L)

Source: Data for this table are from the MAX 2007 file for Vermont, released by CMS in 4/2010. This table was produced on 10/06/2010.
a. MAX data element "Eligible Months Count" was used to determine an individual's Medicaid eligibility. All individuals who had a value greater than zero were considered as beneficiaries and counted in Cell A.
b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2007 (based on MAX data element "Eligible Restricted Benefits Flag").
c. Cell C represents the study population for Tables 2 through 7. Cell C was obtained by excluding from Cell B beneficiaries who were in managed care (MC) plans that included prescription drugs in their capitated benefit package during all months of Medicaid eligibility in 2007, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.
d. The total Medicaid pharmacy reimbursement for Vermont in 2007 was $105,577,195, of which $5,849,893 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.
e. Enrollees in prepaid health plans (PHP) or managed care (MC) plans that did not provide a pharmacy benefit are treated as having fee-for-service pharmacy benefit coverage. There were 27 states in 2007 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, MA, MI, NC, NH, NM, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NE, NY, TN, TX, and WV). These lists were constructed from the CMS 2007 Medicaid Managed Care Enrollment Report and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we reviewed prescription drug expenditures by type of managed care plan to determine whether enrollees in comprehensive MC plans had significant prescription drug expenditures during the year, since that would indicate that at least some prescription drugs were not included in the capitated benefit and were being provided on a fee-for-service basis. There were some states in which most, but not all, prescription drugs were included in the MC capitated benefit package. Mental health drugs, for example, may have been excluded. In those states, we excluded all the MC enrollees from the study population, but some of their drugs would have been included, potentially resulting in higher reported per-beneficiary use of those drugs than would have been the case if we had been able to exclude those drugs.
f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2007. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.
g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

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

TABLE 2

CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY[a, b]
VERMONT, 2007

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**155,528**	**18,021**	**22,718**	**49,495**	**65,152**	**142**	**1,506,830**	**188,513**	**249,734**	**428,078**	**639,202**	**1,303**
Age												
5 and younger	22,304	0	358	0	21,946	0	210,924	0	3,885	0	207,039	0
6-14	30,084	0	1,402	0	28,682	0	310,622	0	16,091	0	294,531	0
15-20	17,522	2	1,403	2,048	14,066	3	165,430	12	15,688	16,001	133,694	35
21-44	42,089	0	7,309	34,248	448	84	376,984	0	80,238	292,195	3,835	716
45-64	23,852	3	10,767	13,020	8	54	236,057	25	117,028	118,370	89	545
65-74	7,369	6,092	1,118	158	0	1	77,735	63,674	12,765	1,289	0	7
75-84	7,520	7,188	314	17	1	0	80,073	76,356	3,527	178	12	0
85 and older	4,787	4,736	47	4	0	0	49,003	48,446	512	45	0	0
Unknown	1	0	0	0	1	0	2	0	0	0	2	0
Gender												
Female	86,779	12,629	11,702	30,228	32,078	142	850,743	133,240	129,794	270,923	315,483	1,303
Male	68,749	5,392	11,016	19,267	33,074	0	656,087	55,273	119,940	157,155	323,719	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	100,110	10,819	18,935	34,970	35,303	83	988,839	115,026	209,529	307,103	356,413	768
African American	1,858	28	195	689	946	0	17,726	282	2,000	5,924	9,520	0
Other/unknown	53,560	7,174	3,588	13,836	28,903	59	500,265	73,205	38,205	115,051	273,269	535
Use of Nursing Facilities[c]												
Entire year	2,206	2,035	171	0	0	0	21,142	19,358	1,784	0	0	0
Part year	1,248	975	250	20	3	0	12,484	9,627	2,613	208	36	0
None	152,074	15,011	22,297	49,475	65,149	142	1,473,204	159,528	245,337	427,870	639,166	1,303
Maintenance Assistance Status												
Cash	27,902	1,290	14,024	3,982	8,606	0	300,838	14,466	160,275	38,739	87,358	0
Medically needy	15,991	3,310	4,174	5,950	2,557	0	152,210	35,317	42,623	53,301	20,969	0
Poverty-related	48,205	139	182	2,641	45,101	142	459,849	1,151	1,510	18,627	437,258	1,303
Other/unknown	63,430	13,282	4,338	36,922	8,888	0	593,933	137,579	45,326	317,411	93,617	0
Dual Medicare Status[d]												
Full dual, all year	30,919	17,553	12,827	529	9	1	329,109	184,294	140,058	4,653	97	7
Full dual, part year	489	240	249	0	0	0	3,998	1,920	2,078	0	0	0
Non-dual, all year	124,120	228	9,642	48,966	65,143	141	1,173,723	2,299	107,598	423,425	639,105	1,296
Managed Care (MC) Status												
Fee-for-service (FFS) all year	155,509	18,006	22,714	49,495	65,152	142	1,506,717	188,432	249,702	428,078	639,202	1,303
FFS part year, with Rx claims	13	10	3	0	0	0	84	61	23	0	0	0
FFS part year, no Rx claims	6	5	1	0	0	0	29	20	9	0	0	0

Source: Data for this table are from the MAX 2007 file for Vermont, released by CMS in 4/2010. This table was produced on 10/06/2010.

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

d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2007. The “Full dual, part year” group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.
Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service pharmacy benefit; MAX = Medicaid Analytic Extract; MC = managed care; Rx = pharmacy benefit.

TABLE 3

ANNUAL MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFICIARY, BY BENEFICIARY CHARACTERISTIC[a, b]
VERMONT, 2007

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**66.7**	**11.5**	**$641**	**$56**	**$5,367**	**11.9**	**155,528**
Age							
5 and younger	65.1	3.1	166	54	2,243	7.4	22,304
6-14	59.7	4.5	409	90	3,959	10.3	30,084
15-20	65.5	6.6	523	79	5,465	9.6	17,522
21-44	70.4	12.3	819	67	5,116	16.0	42,089
45-64	73.2	23.5	1,425	61	7,227	19.7	23,852
65-74	65.5	19.7	381	19	5,636	6.8	7,369
75-84	66.7	21.2	304	14	8,477	3.6	7,520
85 and older	60.7	16.7	210	13	16,066	1.3	4,787
Unknown	0.0	0.0	0	0	1,841	0.0	1
Basis of Eligibility[e]							
Aged	65.9	20.6	304	15	9,304	3.3	18,021
Disabled	69.6	23.6	1,587	67	14,316	11.1	22,718
Adults	72.2	12.5	803	64	3,180	25.2	49,495
Children	61.8	4.0	281	71	2,817	10.0	65,152
Unknown	64.8	12.0	1,271	106	6,758	18.8	142
Gender							
Female	70.7	13.1	675	51	5,319	12.7	86,779
Male	61.8	9.4	599	64	5,429	11.0	68,749
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	69.8	13.2	769	58	6,225	12.4	100,110
African American	60.5	6.5	488	76	3,428	14.2	1,858
Other/unknown	61.2	8.4	408	49	3,832	10.6	53,560
Use of Nursing Facilities[f]							
Entire year	45.3	8.0	287	36	43,537	0.7	2,206
Part year	60.3	16.4	600	37	30,623	2.0	1,248
None	67.1	11.5	647	56	4,606	14.0	152,074
Maintenance Assistance Status							
Cash	70.9	17.5	1,283	73	10,342	12.4	27,902
Medically needy	59.8	9.3	534	57	3,868	13.8	15,991
Poverty related	59.6	3.4	225	65	1,900	11.8	48,205
Other/unknown	72.1	15.5	702	45	6,192	11.3	63,430

Source: Data for this table are from the MAX 2007 file for Vermont, released by CMS in 4/2010. This table was produced on 10/06/2010.
a. Table 3 includes beneficiaries represented by Cell C of Table 1.
b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.
c. In eight states (DE, IA, IL, NE, NY, TN, TX, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.
d. In eight states (DE, IA, IL, NE, NY, TN, TX, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.
e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age

who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.
f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.
Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; OTC = over-the-counter; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 4

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BENEFICIARY CHARACTERISTIC[a, b]
VERMONT, 2007

				Number of Rx, Percentage with:							Number	
Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Beneficiaries	Benefit Months
All	**1.2**	**$66**	**11.9**	**33.3**	**45.0**	**7.8**	**9.5**	**3.8**	**0.7**	**$554**	**155,528**	**1,506,830**
Age												
5 and younger	0.3	18	7.4	34.9	62.2	2.2	0.7	0.0	0.0	237	22,304	210,924
6-14	0.4	40	10.3	40.3	52.0	4.3	3.1	0.3	0.0	384	30,084	310,622
15-20	0.7	55	9.6	34.5	52.3	7.4	5.0	0.7	0.1	579	17,522	165,430
21-44	1.4	92	16.0	29.6	44.0	10.9	11.4	3.5	0.6	571	42,089	376,984
45-64	2.4	144	19.7	26.8	31.3	10.9	18.7	9.9	2.4	730	23,852	236,057
65-74	1.9	36	6.8	34.5	27.7	9.8	17.8	9.3	0.9	534	7,369	77,735
75-84	2.0	29	3.6	33.3	25.7	9.9	20.1	10.0	1.0	796	7,520	80,073
85 and older	1.6	21	1.3	39.3	27.9	8.1	16.3	7.8	0.5	1,569	4,787	49,003
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	921	1	2
Basis of Eligibility[e]												
Aged	2.0	29	3.3	34.1	25.9	9.7	19.5	9.8	0.9	889	18,021	188,513
Disabled	2.1	144	11.1	30.4	33.4	9.4	15.2	8.7	2.9	1,302	22,718	249,734
Adults	1.4	93	25.2	27.8	43.2	11.5	13.1	4.0	0.4	368	49,495	428,078
Children	0.4	29	10.0	38.2	55.7	3.9	2.1	0.2	0.0	287	65,152	639,202
Unknown	1.3	139	18.8	35.2	42.3	6.3	12.7	3.5	0.0	736	142	1,303
Gender												
Female	1.3	69	12.7	29.3	46.1	8.6	10.7	4.5	0.8	543	86,779	850,743
Male	1.0	63	11.0	38.2	43.6	6.8	8.1	2.9	0.4	569	68,749	656,087
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.3	78	12.4	30.2	45.2	8.6	10.7	4.4	0.9	630	100,110	988,839
African American	0.7	51	14.2	39.5	48.0	6.4	4.1	1.6	0.4	359	1,858	17,726
Other/unknown	0.9	44	10.6	38.8	44.4	6.3	7.6	2.6	0.3	410	53,560	500,265
Use of Nursing Facilities[f]												
Entire year	0.8	30	0.7	54.7	31.6	5.8	4.3	1.9	1.8	4,543	2,206	21,142
Part year	1.6	60	2.0	39.7	36.3	6.3	9.7	5.4	2.6	3,061	1,248	12,484
None	1.2	67	14.0	32.9	45.3	7.8	9.6	3.8	0.6	476	152,074	1,473,204
Maintenance Assistance Status												
Cash	1.6	119	12.4	29.1	43.9	8.5	11.2	5.3	1.9	959	27,902	300,838
Medically needy	1.0	56	13.8	40.2	41.2	7.8	7.6	2.7	0.4	406	15,991	152,210
Poverty related	0.4	24	11.8	40.4	54.5	3.4	1.6	0.1	0.0	199	48,205	459,849
Other/unknown	1.7	75	11.3	27.9	39.2	10.8	15.3	6.1	0.7	661	63,430	593,933

Source: Data for this table are from the MAX 2007 file for Vermont, released by CMS in 4/2010. This table was produced on 10/06/2010.
a. Table 4 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.
b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.
c. In eight states (DE, IA, IL, NE, NY, TN, TX, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.
d. In eight states (DE, IA, IL, NE, NY, TN, TX, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-

term-care services, were included.
e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.
f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.
Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 5

AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC[a, b, c]
VERMONT, 2007

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.2**	**$66**	**$56**	**0.4**	**$49**	**$130**	**0.1**	**$5**	**$95**	**0.8**	**$12**	**$16**
Age												
5 and younger	0.3	18	54	0.1	12	156	0.0	2	89	0.2	4	16
6-14	0.4	40	90	0.2	33	151	0.0	2	143	0.2	4	21
15-20	0.7	55	79	0.3	44	159	0.0	3	130	0.4	8	21
21-44	1.4	92	67	0.4	68	161	0.0	6	120	0.9	17	19
45-64	2.4	144	61	0.7	102	149	0.1	13	111	1.6	29	18
65-74	1.9	36	19	0.6	24	42	0.1	3	35	1.2	9	7
75-84	2.0	29	14	0.6	19	30	0.1	2	23	1.3	8	6
85 and older	1.6	21	13	0.4	12	28	0.1	2	21	1.1	6	6
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	2.0	29	15	0.6	19	32	0.1	2	24	1.3	8	6
Disabled	2.1	144	67	0.7	108	160	0.1	12	118	1.4	24	18
Adults	1.4	93	64	0.4	67	155	0.1	7	118	1.0	19	20
Children	0.4	29	71	0.2	23	143	0.0	2	107	0.2	4	19
Unknown	1.3	139	106	0.4	117	282	0.1	6	120	0.8	15	18
Gender												
Female	1.3	69	51	0.4	50	121	0.1	5	92	0.9	14	16
Male	1.0	63	64	0.3	48	145	0.0	4	100	0.6	10	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.3	78	58	0.4	58	137	0.1	6	103	0.9	15	17
African American	0.7	51	76	0.2	38	184	0.0	5	151	0.4	8	19
Other/unknown	0.9	44	49	0.3	33	110	0.0	3	74	0.6	8	14
Use of Nursing Facilities[e]												
Entire year	0.8	30	36	0.1	19	135	0.0	2	81	0.7	9	14
Part year	1.6	60	37	0.4	40	107	0.1	6	78	1.2	14	12
None	1.2	67	56	0.4	50	130	0.1	5	95	0.8	12	16
Maintenance Assistance Status												
Cash	1.6	119	73	0.5	90	173	0.1	9	130	1.0	20	19
Medically needy	1.0	56	57	0.3	40	155	0.0	4	109	0.7	12	18
Poverty related	0.4	24	65	0.1	18	137	0.0	2	105	0.2	4	19
Other/unknown	1.7	75	45	0.5	55	104	0.1	5	75	1.1	15	14

Source: Data for this table are from the MAX 2007 file for Vermont, released by CMS in 4/2010. This table was produced on 10/06/2010.
a. Table 5 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.
b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.
c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In 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.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, 2007

	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
Therapeutic Category	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.2	0.0	0.0	0.2	$12	$7	$1	$4	$53	$267	$110	$20	128,156	$6,742,307	53,092	34.1	566,499
Biologicals	0.2	0.2	0.0	0.0	60	60	0	0	371	371	0	0	2,939	1,090,849	1,712	1.1	18,065
Antineoplastic Agents	0.5	0.2	0.0	0.3	110	102	0	8	205	501	183	24	5,316	1,092,305	925	0.6	9,937
Endocrine/Metabolic Drugs	0.6	0.2	0.0	0.4	28	21	1	7	48	96	35	19	169,591	8,073,859	27,262	17.5	286,527
Cardiovascular Agents	1.3	0.3	0.1	0.9	27	15	3	9	22	60	45	9	309,895	6,674,958	23,073	14.8	244,871
Respiratory Agents	0.5	0.3	0.0	0.1	34	29	2	2	74	96	84	19	144,198	10,682,555	29,497	19.0	317,218
Gastrointestinal Agents	0.5	0.2	0.1	0.2	43	27	13	3	83	129	114	15	93,743	7,788,544	16,783	10.8	179,653
Genitourinary Agents	0.3	0.1	0.0	0.2	13	9	2	3	42	59	106	17	22,070	924,973	6,457	4.2	69,698
CNS Drugs	0.9	0.3	0.0	0.6	59	46	3	10	63	162	131	16	344,001	21,834,919	35,466	22.8	371,012
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	93	89	1	4	117	141	85	25	55,263	6,442,227	6,368	4.1	68,941
Miscellaneous Psychological/ Neurological Agents	0.2	0.2	0.0	0.0	39	38	0	1	166	172	131	64	13,078	2,164,509	5,238	3.4	55,410
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	30	18	2	10	49	160	288	21	220,120	10,706,313	34,493	22.2	358,625
Neuromuscular Agents	0.7	0.2	0.0	0.5	50	38	5	7	70	167	184	16	134,024	9,375,531	17,609	11.3	187,000
Nutritional Products	0.2	0.0	0.0	0.2	3	0	0	2	12	58	30	10	28,361	337,953	11,036	7.1	119,630
Hematological Agents	0.6	0.2	0.0	0.4	43	38	0	5	72	227	28	11	33,638	2,413,395	5,220	3.4	55,558
Topical Products	0.2	0.1	0.0	0.1	8	5	0	3	37	86	61	17	70,382	2,619,286	30,767	19.8	331,507
Miscellaneous Products	0.1	0.1	0.0	0.0	15	13	1	2	99	113	173	45	6,745	666,393	4,079	2.6	44,983
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	16	0	0	0	64	0	0	0	1,510	96,426	556	0.4	6,094
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.	1,783,030	99,727,302	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Vermont, released by CMS in 4/2010. This table was produced on 10/06/2010.
a. Table 6 includes the beneficiaries represented by Cell C of Table 1. A beneficiary who used drugs from two or more categories was counted as a user for each category. Therefore, the sum of users across categories may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.
b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.
c. For information about these therapeutic categories, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.
d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In 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.medi-span.com/master-drug-database.aspx.
e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2007.
Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; CNS = Central Nervous System; MAX = Medicaid Analytic Extract; n.a. = not applicable; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 7

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY TOP 10 DRUG GROUP[a, b, c]
VERMONT, 2007

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$11,851,342	8,614	5.5	93,597	0.7	$186	$127
ANTICONVULSANT	8,622,066	14,029	9.0	151,258	0.7	82	57
ANTIASTHMATIC	8,149,594	30,507	19.6	330,827	0.3	81	25
ANTIDEPRESSANTS	7,674,033	31,908	20.5	335,987	0.5	44	23
ANALGESICS - Narcotic	7,616,167	39,638	25.5	418,148	0.4	47	18
ULCER DRUGS	6,760,181	16,756	10.8	180,072	0.5	75	38
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	6,442,242	7,199	4.6	78,579	0.7	117	82
ANTIDIABETIC	3,733,134	9,114	5.9	98,272	0.6	61	38
ANTIVIRAL	3,247,906	2,837	1.8	30,108	0.3	320	108
ANTIHYPERLIPIDEMIC	2,807,232	11,675	7.5	127,376	0.6	37	22
Total	66,903,897	172,277	n.a.	1,844,224	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Vermont, released by CMS in 4/2010. This table was produced on 10/06/2010.
a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2007. A beneficiary who used drugs from two or more groups was counted as a user for each group. Therefore, the sum of users across drug groups may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.
b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.
c. The top 10 drug groups were determined based on total Medicaid reimbursement in the state for 2007. For information about these drug groups, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.
Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.