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

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

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)		Number of Dual Eligible Beneficiaries (Cell)[g]		Number of Non-dual Eligible Beneficiaries (Cell)	
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	159,102	(A)	20,099	(E)	139,003	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	145,899	(B)	12,332	(F)	133,567	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	104,309	(C)	10,980	(G)	93,329	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	2,073	(D)	1,966	(H)	107	(L)

Source: Data for this table are from the MAX 2003 file for Delaware, released by CMS in 04/2007. This table was produced on 11/01/2007.

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

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

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

d. The total Medicaid pharmacy reimbursement for Delaware in 2003 was $111,129,088, of which $204,807 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

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

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

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

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

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

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

TABLE 2

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

DELAWARE, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**104,309**	**5,709**	**13,651**	**41,537**	**43,412**	**0**	**1,032,435**	**57,117**	**150,750**	**374,229**	**450,339**	**0**
Age												
5 and younger	20,742	0	704	0	20,038	0	213,139	0	7,782	0	205,357	0
6-14	19,326	0	2,230	0	17,096	0	207,553	0	25,500	0	182,053	0
15-20	10,487	2	1,268	2,941	6,276	0	103,807	7	14,240	26,643	62,917	0
21-44	35,008	11	4,303	30,693	1	0	324,212	48	47,146	277,012	6	0
45-64	12,667	29	4,984	7,653	1	0	122,652	213	54,258	68,175	6	0
65-74	2,193	1,826	162	205	0	0	22,429	18,645	1,824	1,960	0	0
75-84	2,116	2,077	0	39	0	0	21,678	21,297	0	381	0	0
85 and older	1,770	1,764	0	6	0	0	16,965	16,907	0	58	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	66,002	4,366	7,123	32,395	22,118	0	645,541	43,763	78,879	294,079	228,820	0
Male	38,307	1,343	6,528	9,142	21,294	0	386,894	13,354	71,871	80,150	221,519	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	48,433	3,385	7,019	20,501	17,528	0	470,310	32,699	76,913	182,689	178,009	0
African American	44,494	1,820	5,600	17,526	19,548	0	449,517	19,006	62,538	159,730	208,243	0
Other/unknown	11,382	504	1,032	3,510	6,336	0	112,608	5,412	11,299	31,810	64,087	0
Use of Nursing Facilities[c]												
Entire year	2,073	1,859	214	0	0	0	20,911	18,613	2,298	0	0	0
Part year	981	782	189	10	0	0	8,491	6,571	1,829	91	0	0
None	101,255	3,068	13,248	41,527	43,412	0	1,003,033	31,933	146,623	374,138	450,339	0
Maintenance Assistance Status												
Cash	54,323	2,463	10,678	14,532	26,650	0	567,938	27,389	120,500	142,427	277,622	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	4,607	227	471	281	3,628	0	38,973	1,244	2,575	1,831	33,323	0
Other/unknown	45,379	3,019	2,502	26,724	13,134	0	425,524	28,484	27,675	229,971	139,394	0
Dual Medicare Status[d]												
Full dual, all year	9,863	4,992	3,850	1,020	1	0	105,632	52,560	43,608	9,456	8	0
Full dual, part year	1,117	475	576	66	0	0	5,628	2,251	3,063	314	0	0
Non-dual, all year	93,329	242	9,225	40,451	43,411	0	921,175	2,306	104,079	364,459	450,331	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	2,599	0	4	2,529	66	0	20,746	0	42	20,264	440	0
FFS part year, with Rx claims	4,933	411	509	3,902	111	0	20,534	1,867	2,497	15,847	323	0
FFS part year, no Rx claims	1,748	77	95	1,497	79	0	9,216	445	601	7,852	318	0
MC all year, with FFS Rx claims	95,029	5,221	13,043	33,609	43,156	0	981,939	54,805	147,610	330,266	449,258	0

Source: Data for this table are from the MAX 2003 file for Delaware, released by CMS in 04/2007. This table was produced on 11/01/2007.

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

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

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

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

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

TABLE 3

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

DELAWARE, 2003

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**95.4 %**	**16.8**	**$1,063**	**$63**	**$1,219**	**87.2 %**	**104,309**
Age							
5 and younger	98.0	6.0	278	46	278	100.0	20,742
6-14	99.0	8.0	523	65	523	100.0	19,326
15-20	96.7	8.8	520	59	609	85.4	10,487
21-44	90.9	16.1	1,105	69	1,331	83.0	35,008
45-64	95.5	38.7	2,742	71	2,932	93.5	12,667
65-74	98.1	51.6	2,979	58	3,506	85.0	2,193
75-84	98.8	54.8	2,706	49	3,589	75.4	2,116
85 and older	98.5	52.5	2,220	42	3,301	67.2	1,770
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	98.5	53.8	2,670	50	3,533	75.6	5,709
Disabled	99.0	40.5	3,374	83	3,536	95.4	13,651
Adults	90.8	14.9	884	59	1,095	80.7	41,537
Children	98.3	6.2	297	48	304	97.8	43,412
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	93.4	17.9	1,042	58	1,258	82.9	66,002
Male	98.8	14.9	1,100	74	1,152	95.5	38,307
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	95.9	21.0	1,344	64	1,531	87.8	48,433
African American	95.0	13.7	861	63	1,001	86.0	44,494
Other/unknown	94.8	11.0	663	60	743	89.2	11,382
Use of Nursing Facilities[f]							
Entire year	100.0	71.4	3,120	44	3,164	98.6	2,073
Part year	96.4	55.1	2,737	50	7,280	37.6	981
None	95.3	15.3	1,005	66	1,120	89.7	101,255
Maintenance Assistance Status							
Cash	98.4	16.8	1,103	66	1,157	95.4	54,323
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	96.4	8.3	489	59	909	53.8	4,607
Other/unknown	91.7	17.6	1,074	61	1,325	81.1	45,379

Source: Data for this table are from the MAX 2003 file for Delaware, released by CMS in 04/2007. This table was produced on 11/01/2007.

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

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

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

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

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

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

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

TABLE 4

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

DELAWARE, 2003

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Number Beneficiaries	Benefit Months
All	**1.7**	**$107**	**87.2 %**	**4.6 %**	**64.0 %**	**10.2 %**	**12.5 %**	**6.3 %**	**2.4 %**	**$123**	**104,309**	**1,032,435**
Age												
5 and younger	0.6	27	100.0	2.0	90.3	5.3	2.1	0.2	0.0	27	20,742	213,139
6-14	0.7	49	100.0	1.0	84.8	8.0	5.4	0.7	0.0	49	19,326	207,553
15-20	0.9	53	85.4	3.3	78.4	9.9	6.7	1.3	0.4	62	10,487	103,807
21-44	1.7	119	83.0	9.1	54.9	12.9	14.8	5.9	2.4	144	35,008	324,212
45-64	4.0	283	93.5	4.5	25.8	14.3	29.3	19.4	6.7	303	12,667	122,652
65-74	5.0	291	85.0	1.9	17.1	11.4	32.0	26.4	11.1	343	2,193	22,429
75-84	5.3	264	75.4	1.2	15.4	11.9	30.6	28.3	12.6	350	2,116	21,678
85 and older	5.5	232	67.2	1.5	11.2	10.3	33.4	32.5	11.0	344	1,770	16,965
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	5.4	267	75.6	1.5	14.3	11.0	31.9	29.2	12.1	353	5,709	57,117
Disabled	3.7	306	95.4	1.0	34.1	13.8	27.2	17.3	6.5	320	13,651	150,750
Adults	1.7	98	80.7	9.2	54.4	13.3	15.2	5.8	2.1	122	41,537	374,229
Children	0.6	29	97.8	1.7	89.1	6.1	2.7	0.3	0.0	29	43,412	450,339
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.8	107	82.9	6.6	60.3	10.2	12.9	7.1	2.9	129	66,002	645,541
Male	1.5	109	95.5	1.2	70.4	10.3	11.8	5.0	1.4	114	38,307	386,894
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.2	138	87.8	4.1	56.8	11.6	15.4	8.6	3.4	158	48,433	470,310
African American	1.4	85	86.0	5.0	69.2	9.3	10.4	4.6	1.6	99	44,494	449,517
Other/unknown	1.1	67	89.2	5.2	74.3	8.2	8.3	3.1	0.9	75	11,382	112,608
Use of Nursing Facilities[f]												
Entire year	7.1	309	98.6	0.0	6.7	6.2	28.7	40.1	18.3	314	2,073	20,911
Part year	6.4	316	37.6	3.6	10.0	7.8	26.9	32.3	19.4	841	981	8,491
None	1.5	102	89.7	4.7	65.7	10.4	12.0	5.4	1.9	113	101,255	1,003,033
Maintenance Assistance Status												
Cash	1.6	106	95.4	1.6	69.7	9.8	11.5	5.7	1.7	111	54,323	567,938
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	1.0	58	53.8	3.6	79.3	6.9	4.4	1.7	4.1	108	4,607	38,973
Other/unknown	1.9	115	81.1	8.3	55.6	11.2	14.4	7.5	3.0	141	45,379	425,524

Source: Data for this table are from the MAX 2003 file for Delaware, released by CMS in 04/2007. This table was produced on 11/01/2007.

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

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

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

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

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

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

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

TABLE 5

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

DELAWARE, 2003

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.7**	**$107**	**$63**	**0.8**	**$87**	**$103**	**0.0**	**$2**	**$47**	**0.8**	**$18**	**$23**
Age												
5 and younger	0.6	27	46	0.3	22	85	0.0	1	48	0.3	4	15
6-14	0.7	49	65	0.4	41	94	0.0	1	73	0.3	6	22
15-20	0.9	53	59	0.5	42	89	0.0	1	75	0.4	9	23
21-44	1.7	119	69	0.8	97	115	0.0	2	54	0.9	20	23
45-64	4.0	283	71	2.1	232	112	0.1	4	46	1.8	46	25
65-74	5.0	291	58	2.5	230	91	0.2	6	37	2.4	55	23
75-84	5.3	264	49	2.6	206	80	0.2	4	23	2.6	53	21
85 and older	5.5	232	42	2.5	179	73	0.2	5	21	2.8	47	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.4	267	50	2.6	209	82	0.2	5	25	2.6	53	20
Disabled	3.7	306	83	1.9	256	134	0.1	7	62	1.6	43	26
Adults	1.7	98	59	0.8	78	97	0.0	1	40	0.8	18	22
Children	0.6	29	48	0.3	23	75	0.0	1	60	0.3	5	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.8	107	58	0.9	85	94	0.0	2	41	0.9	19	22
Male	1.5	109	74	0.8	91	120	0.0	2	63	0.7	16	23
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.2	138	64	1.1	111	104	0.1	3	46	1.0	24	24
African American	1.4	85	63	0.7	70	103	0.0	1	49	0.6	13	21
Other/unknown	1.1	67	60	0.6	55	98	0.0	1	42	0.5	11	21
Use of Nursing Facilities[e]												
Entire year	7.1	309	44	3.2	240	75	0.3	7	22	3.5	61	17
Part year	6.4	316	50	2.9	251	85	0.3	6	23	3.2	58	19
None	1.5	102	66	0.8	83	106	0.0	2	53	0.7	17	23
Maintenance Assistance Status												
Cash	1.6	106	66	0.8	86	107	0.0	2	54	0.8	18	23
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	1.0	58	59	0.5	47	98	0.0	1	49	0.5	9	21
Other/unknown	1.9	115	61	0.9	93	99	0.1	2	39	0.9	19	22

Source: Data for this table are from the MAX 2003 file for Delaware, released by CMS in 04/2007. This table was produced on 11/01/2007.

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

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

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Delaware, 0.8 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007)

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

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

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

TABLE 6

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

DELAWARE, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.2	0.0	0.1	$25	$22	$0	$3	$90	$142	$70	$26	177,148	$15,967,770	61,731	59.2 %	641,066
Biologicals	0.2	0.2	0.0	0.0	163	160	0	3	733	813	0	116	1,652	1,210,620	729	0.7	7,412
Antineoplastic Agents	0.4	0.2	0.0	0.2	132	114	1	17	303	582	138	73	4,282	1,298,331	978	0.9	9,851
Endocrine/Metabolic Drugs	0.5	0.3	0.1	0.2	25	19	1	4	49	68	25	24	157,990	7,712,193	30,189	28.9	309,600
Cardiovascular Agents	1.3	0.6	0.0	0.7	55	42	0	13	43	71	26	19	258,571	11,117,575	20,082	19.3	203,761
Respiratory Agents	0.5	0.3	0.0	0.2	23	19	1	4	50	72	70	19	238,913	12,055,462	49,903	47.8	520,979
Gastrointestinal Agents	0.5	0.3	0.0	0.2	41	32	1	8	79	114	172	33	91,141	7,158,573	16,952	16.3	175,230
Genitourinary Agents	0.3	0.2	0.0	0.0	14	14	0	1	53	60	38	17	23,607	1,252,361	8,434	8.1	87,081
CNS Drugs	0.9	0.5	0.0	0.4	73	62	1	9	80	120	121	24	255,270	20,339,875	27,408	26.3	278,074
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	46	38	0	7	74	82	63	49	38,917	2,866,658	5,811	5.6	62,661
Miscellaneous Psychological/ Neurological Agents	0.3	0.2	0.0	0.1	45	34	0	11	174	198	0	126	3,843	667,653	1,441	1.4	14,735
Analgesics and Anesthetics	0.5	0.2	0.0	0.4	27	20	0	7	52	129	48	18	210,038	10,868,388	39,230	37.6	398,382
Neuromuscular Agents	0.7	0.3	0.0	0.3	46	36	1	9	71	116	46	28	108,244	7,718,344	16,253	15.6	166,526
Nutritional Products	0.3	0.0	0.0	0.3	5	1	0	4	18	27	16	17	28,645	517,056	9,176	8.8	94,281
Hematological Agents	0.6	0.2	0.1	0.3	101	95	1	5	164	383	18	18	29,532	4,837,486	4,647	4.5	47,716
Topical Products	0.3	0.1	0.0	0.1	10	8	0	2	40	63	49	18	105,835	4,245,903	38,627	37.0	407,490
Miscellaneous Products	0.2	0.1	0.0	0.1	26	21	2	3	132	180	236	47	5,347	703,837	2,501	2.4	26,854
Unknown Therapeutic Category	0.1	0.0	0.0	0.0	5	0	0	0	35	0	0	0	11,161	386,196	7,579	7.3	82,542
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.	1,750,136	110,924,281	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Delaware, released by CMS in 04/2007. This table was produced on 11/01/2007.

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

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

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

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Delaware, 0.8 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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

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

TABLE 7

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

DELAWARE, 2003

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$9,726,036	9,792	9.4 %	103,479	0.5	$172	$94
ANTIVIRAL	8,650,600	4,230	4.1	45,634	0.4	423	190
ANTIDEPRESSANTS	8,038,191	23,863	22.9	242,532	0.5	69	33
ANTIASTHMATIC	6,147,405	33,392	32.0	354,798	0.3	59	17
ULCER DRUGS	5,914,868	16,044	15.4	168,962	0.4	94	35
ANTICONVULSANT	5,826,734	10,258	9.8	107,781	0.6	87	54
ANALGESICS - Narcotic	5,359,081	38,125	36.6	394,497	0.3	46	14
ANTIHYPERLIPIDEMIC	4,106,789	7,759	7.4	82,074	0.5	94	50
ANTIDIABETIC	3,727,591	9,437	9.0	97,576	0.6	64	38
ANALGESICS - ANTI-INFLAMMATORY	3,410,306	26,967	25.9	282,565	0.2	51	12
Total	60,907,601	179,867		1,879,898	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Delaware, released by CMS in 04/2007. This table was produced on 11/01/2007.

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

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

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

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