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

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
DELAWARE, 2004

Inclusion Criteria (2004)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)		Number of Dual Eligible Beneficiaries (Cell)[g]		Number of Non-dual Eligible Beneficiaries (Cell)	
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	168,732	(A)	20,961	(E)	147,771	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	154,147	(B)	12,486	(F)	141,661	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	109,624	(C)	11,256	(G)	98,368	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	2,173	(D)	2,054	(H)	119	(L)

Source: Data for this table are from the MAX 2004 file for Delaware, released by CMS in 02/2008. This table was produced on 03/06/2008.

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

b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2004 (based on MAX data element "Eligible Restricted Benefits Flag").

c. Cell C represents the study population for Tables 2 through 7. Cell C was obtained by excluding from Cell B beneficiaries who were in managed care (MC) plans that included prescription drugs in their capitated benefit package during all months of Medicaid eligibility in 2004, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.

d. The total Medicaid pharmacy reimbursement for Delaware in 2004 was $121,211,670, of which $212,949 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

e. Enrollees in prepaid health plans (PHP) or managed care (MC) plans that did not provide a pharmacy benefit are treated as having fee-for-service pharmacy benefit coverage. There were 23 states in 2004 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NY, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 7 states in which MC plans did not provide a pharmacy benefit (DE, IA, NE, NY, TX, UT, and WV) and one state (NV) in which MC plans provided a pharmacy benefit for nonduals but not for duals. These lists were constructed from the CMS 2004 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer04.pdf and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit pa

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2004. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.

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

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2004. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

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

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

TABLE 2

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

DELAWARE, 2004

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**109,624**	**5,736**	**14,370**	**44,869**	**44,616**	**33**	**1,088,330**	**57,769**	**157,817**	**405,164**	**467,255**	**325**
Age												
5 and younger	21,211	0	656	0	20,555	0	219,097	0	7,407	0	211,690	0
6-14	19,700	0	2,302	0	17,398	0	214,244	0	26,257	0	187,987	0
15-20	11,198	0	1,354	3,181	6,663	0	112,202	0	15,353	29,271	67,578	0
21-44	37,245	0	4,463	32,772	0	10	345,802	0	48,230	297,501	0	71
45-64	14,108	0	5,422	8,663	0	23	134,952	0	58,656	76,042	0	254
65-74	2,215	1,835	173	207	0	0	22,817	18,998	1,914	1,905	0	0
75-84	2,101	2,067	0	34	0	0	21,430	21,105	0	325	0	0
85 and older	1,846	1,834	0	12	0	0	17,786	17,666	0	120	0	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Gender												
Female	69,532	4,329	7,487	34,850	22,833	33	683,140	43,926	82,677	316,961	239,251	325
Male	40,092	1,407	6,883	10,019	21,783	0	0 405,190	13,843	75,140	88,203	228,004	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	50,811	3,426	7,312	22,301	17,748	24	495,064	33,361	79,745	199,023	182,701	234
African American	46,533	1,783	5,948	18,728	20,065	9	0 471,215	18,704	65,843	171,509	215,068	91
Other/unknown	12,280	527	1,110	3,840	6,803	0	122,051	5,704	12,229	34,632	69,486	0
Use of Nursing Facilities[c]												
Entire year	2,173	1,944	229	0	0	0	22,053	19,540	2,513	0	0	0
Part year	954	770	180	4	0	0	8,054	6,283	1,736	35	0	0
None	106,497	3,022	13,961	44,865	44,616	33	1,058,223	31,946	153,568	405,129	467,255	325
Maintenance Assistance Status												
Cash	56,932	2,478	11,213	15,487	27,754	0	600,628	27,417	126,058	154,121	293,032	0
Medically needy	0	0	0	0	0	0		0	0	0	0	0
Poverty-related	4,342	192	641	267	3,209	33	35,811	1,161	3,715	1,586	29,024	325
Other/unknown	48,350	3,066	2,516	29,115	13,653	0	451,891	29,191	28,044	249,457	145,199	0
Dual Medicare Status[d]						0						
Full dual, all year	9,914	5,065	4,000	847	0	2	106,372	53,458	45,413	7,481	0	20
Full dual, part year	1,342	497	760	85	0	0	7,096	2,534	4,200	362	0	0
Non-dual, all year	98,368	174	9,610	43,937	44,616	31	974,862	1,777	108,204	397,321	467,255	305
Managed Care (MC) Status												
Fee-for-service (FFS) all year	3,131	1	15	3,041	74	0	24,478	4	171	23,806	497	0
FFS part year, with Rx claims	5,539	423	698	4,290	125	3	22,186	2,072	3,646	16,103	345	20
FFS part year, no Rx claims	1,637	76	83	1,388	90	0	8,103	468	489	6,758	388	0
MC all year, with FFS Rx claims	99,317	5,236	13,574	36,150	44,327	30	1,033,563	55,225	153,511	358,497	466,025	305

Source: Data for this table are from the MAX 2004 file for Delaware, released by CMS in 02/2008. This table was produced on 03/06/2008.

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

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

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

d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2004. The “Full dual, part year” group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.

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

TABLE 3

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

DELAWARE, 2004

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**95.2 %**	**17.0**	**$1,104**	**$65**	**$1,282**	**86.1 %**	**109,624**
Age							
5 and younger	97.8	5.9	301	51	301	100.0	21,211
6-14	98.9	8.2	575	70	575	100.0	19,700
15-20	96.4	8.8	567	64	695	81.5	11,198
21-44	90.9	16.0	1,109	69	1,369	81.0	37,245
45-64	95.2	37.9	2,742	72	2,972	92.3	14,108
65-74	97.5	53.5	3,000	56	3,474	86.3	2,215
75-84	98.9	58.4	2,782	48	3,641	76.4	2,101
85 and older	99.1	57.4	2,425	42	3,650	66.4	1,846
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	98.5	57.6	2,783	48	3,669	75.9	5,736
Disabled	99.1	40.2	3,534	88	3,726	94.8	14,370
Adults	90.7	15.0	878	59	1,129	77.8	44,869
Children	98.1	6.3	331	53	340	97.4	44,616
Unknown	100.0	27.2	2,618	96	3,465	75.5	33
Gender							
Female	93.2	18.1	1,073	59	1,325	81.0	69,532
Male	98.7	15.1	1,157	76	1,207	95.9	40,092
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	95.6	21.3	1,389	65	1,606	86.5	50,811
African American	95.0	13.8	902	65	1,055	85.4	46,533
Other/unknown	94.6	11.1	690	62	799	86.4	12,280
Use of Nursing Facilities[f]							
Entire year	100.0	78.3	3,597	46	3,643	98.7	2,173
Part year	97.0	57.7	2,713	47	7,606	35.7	954
None	95.1	15.4	1,039	68	1,177	88.2	106,497
Maintenance Assistance Status							
Cash	98.5	17.0	1,148	68	1,207	95.1	56,932
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	95.4	8.4	574	68	1,162	49.4	4,342
Other/unknown	91.4	17.8	1,099	62	1,380	79.6	48,350

Source: Data for this table are from the MAX 2004 file for Delaware, released by CMS in 02/2008. This table was produced on 03/06/2008.

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

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

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

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

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

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

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

TABLE 4

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

DELAWARE, 2004

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Number Beneficiaries	Benefit Months
All	**1.7**	**$111**	**86.1 %**	**4.8 %**	**63.3 %**	**10.5 %**	**12.4 %**	**6.5 %**	**2.5 %**	**$129**	**109,624**	**1,088,330**
Age												
5 and younger	0.6	29	100.0	2.2	90.1	5.6	2.0	0.2	0.0	29	21,211	219,097
6-14	0.8	53	100.0	1.1	84.3	8.6	5.4	0.6	0.1	53	19,700	214,244
15-20	0.9	57	81.5	3.6	78.5	9.4	6.7	1.3	0.5	69	11,198	112,202
21-44	1.7	119	81.0	9.1	54.8	13.0	14.7	6.0	2.4	148	37,245	345,802
45-64	4.0	287	92.3	4.8	25.8	14.4	28.6	19.6	6.8	311	14,108	134,952
65-74	5.2	291	86.3	2.5	16.0	13.5	30.4	26.3	11.3	337	2,215	22,817
75-84	5.7	273	76.4	1.1	13.0	10.2	30.7	31.3	13.7	357	2,101	21,430
85 and older	6.0	252	66.4	0.9	9.0	9.4	31.9	34.6	14.1	379	1,846	17,786
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	5.7	276	75.9	1.5	11.8	10.8	31.2	31.3	13.4	364	5,736	57,769
Disabled	3.7	322	94.8	0.9	33.8	14.1	26.6	18.2	6.3	339	14,370	157,817
Adults	1.7	97	77.8	9.3	54.1	13.3	15.1	5.9	2.3	125	44,869	405,164
Children	0.6	32	97.4	1.9	88.6	6.5	2.7	0.2	0.0	32	44,616	467,255
Unknown	2.8	266	75.5	0.0	48.5	15.2	21.2	15.2	0.0	352	33	325
Gender												
Female	1.8	109	81.0	6.8	59.6	10.5	12.7	7.3	3.1	135	69,532	683,140
Male	1.5	115	95.9	1.3	69.6	10.5	12.1	5.1	1.4	119	40,092	405,190
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	143	86.5	4.4	55.8	11.8	15.4	9.0	3.6	165	50,811	495,064
African American	1.4	89	85.4	5.0	68.8	9.5	10.3	4.7	1.7	104	46,533	471,215
Other/unknown	1.1	69	86.4	5.4	73.2	8.7	8.3	3.4	1.0	80	12,280	122,051
Use of Nursing Facilities[f]												
Entire year	7.7	354	98.7	0.0	3.9	5.3	26.3	42.3	22.2	359	2,173	22,053
Part year	6.8	321	35.7	3.0	7.3	9.0	26.3	33.0	21.3	901	954	8,054
None	1.5	105	88.2	4.9	65.0	10.6	12.0	5.6	1.9	118	106,497	1,058,223
Maintenance Assistance Status												
Cash	1.6	109	95.1	1.5	69.1	10.2	11.6	5.9	1.7	114	56,932	600,628
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	70	49.4	4.6	75.9	7.9	5.6	2.9	3.1	141	4,342	35,811
Other/unknown	1.9	118	79.6	8.6	55.3	11.1	14.1	7.6	3.4	148	48,350	451,891

Source: Data for this table are from the MAX 2004 file for Delaware, released by CMS in 02/2008. This table was produced on 03/06/2008.

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

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

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

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

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

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

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

TABLE 5

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

DELAWARE, 2004

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.7**	**$111**	**$65**	**0.7**	**$84**	**$116**	**0.1**	**$7**	**$69**	**0.9**	**$21**	**$23**
Age												
5 and younger	0.6	29	51	0.2	22	112	0.1	2	39	0.3	5	15
6-14	0.8	53	70	0.4	45	105	0.0	2	61	0.3	6	21
15-20	0.9	57	64	0.4	45	106	0.0	3	63	0.4	9	22
21-44	1.7	119	69	0.7	88	129	0.1	8	82	0.9	24	25
45-64	4.0	287	72	1.7	213	126	0.2	19	90	2.1	54	26
65-74	5.2	291	56	2.2	212	96	0.3	19	63	2.7	60	22
75-84	5.7	273	48	2.3	199	85	0.4	16	41	3.0	58	19
85 and older	6.0	252	42	2.3	182	78	0.4	15	34	3.2	54	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.7	276	48	2.3	201	86	0.4	17	44	3.0	58	20
Disabled	3.7	322	88	1.6	254	156	0.2	20	91	1.8	48	27
Adults	1.7	97	59	0.7	68	103	0.1	7	76	0.9	22	24
Children	0.6	32	53	0.3	25	90	0.0	2	45	0.3	5	18
Unknown	2.8	266	96	1.1	217	196	0.1	5	90	1.6	44	28
Gender												
Female	1.8	109	59	0.8	80	106	0.1	7	63	1.0	22	23
Male	1.5	115	76	0.7	89	134	0.1	7	84	0.8	18	24
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.2	143	65	0.9	105	114	0.1	10	74	1.1	28	25
African American	1.4	89	65	0.6	69	119	0.1	5	64	0.7	15	21
Other/unknown	1.1	69	62	0.5	53	111	0.1	4	59	0.6	13	22
Use of Nursing Facilities[e]												
Entire year	7.7	354	46	2.9	259	88	0.6	23	38	4.1	71	17
Part year	6.8	321	47	2.6	223	88	0.5	25	50	3.8	73	20
None	1.5	105	68	0.7	79	119	0.1	7	75	0.8	19	24
Maintenance Assistance Status												
Cash	1.6	109	68	0.7	82	120	0.1	7	72	0.8	20	24
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	1.0	70	68	0.4	53	130	0.1	5	71	0.5	12	22
Other/unknown	1.9	118	62	0.8	88	110	0.1	8	66	1.0	22	23

Source: Data for this table are from the MAX 2004 file for Delaware, released by CMS in 02/2008. This table was produced on 03/06/2008.

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

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

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Delaware, 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 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, 2004

	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	0.3	0.1	0.0	0.1	$27	$22	$2	$4	$97	$182	$92	$25	186,242	$18,144,319	64,949	59.2 %	677,237
Biologicals	0.2	0.2	0.0	0.0	197	196	0	1	799	876	111	31	1,821	1,454,134	746	0.7	7,381
Antineoplastic Agents	0.5	0.1	0.0	0.3	110	88	1	21	240	694	111	65	4,648	1,115,861	1,010	0.9	10,121
Endocrine/Metabolic Drugs	0.5	0.2	0.1	0.2	27	19	3	5	52	87	33	24	171,816	8,906,847	32,317	29.5	332,186
Cardiovascular Agents	1.3	0.6	0.0	0.7	57	44	2	11	44	76	47	17	288,376	12,766,207	22,183	20.2	223,884
Respiratory Agents	0.5	0.3	0.0	0.2	25	22	0	3	54	77	46	18	247,119	13,398,595	50,695	46.2	531,908
Gastrointestinal Agents	0.4	0.1	0.0	0.3	20	9	2	9	45	114	50	27	76,880	3,474,223	17,038	15.5	175,513
Genitourinary Agents	0.3	0.2	0.0	0.1	16	13	1	2	57	73	43	24	26,891	1,533,297	9,187	8.4	95,257
CNS Drugs	0.9	0.5	0.0	0.4	76	61	4	11	82	135	92	26	277,282	22,636,035	29,365	26.8	296,395
Stimulants/Anti-obesity/Anorexia	0.6	0.5	0.0	0.1	52	47	0	5	84	92	95	45	42,549	3,563,029	6,275	5.7	68,033
Miscellaneous Psychological/ Neurological Agents	0.4	0.4	0.0	0.0	154	148	2	4	368	411	107	94	4,505	1,656,000	1,071	1.0	10,787
Analgesics and Anesthetics	0.5	0.1	0.0	0.4	26	14	1	11	49	142	239	25	226,095	11,123,994	41,988	38.3	425,934
Neuromuscular Agents	0.7	0.2	0.1	0.3	52	30	13	10	78	131	122	29	121,705	9,540,170	17,954	16.4	183,208
Nutritional Products	0.3	0.0	0.0	0.3	6	1	0	4	18	28	21	16	30,985	555,599	9,790	8.9	100,934
Hematological Agents	0.7	0.3	0.1	0.3	103	96	2	5	149	352	25	16	36,013	5,364,205	5,094	4.6	51,945
Topical Products	0.3	0.1	0.0	0.1	11	7	1	3	43	74	50	21	110,457	4,701,646	40,449	36.9	428,069
Miscellaneous Products	0.2	0.1	0.0	0.1	31	25	2	4	153	203	246	57	6,162	941,490	2,816	2.6	30,132
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	11	0	0	0	44	0	0	0	2,829	123,070	1,075	1.0	11,341
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.	1,862,375	120,998,721	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Delaware, released by CMS in 02/2008. This table was produced on 03/06/2008.

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

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

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

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Delaware, 0.3 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2004.

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

TABLE 7

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

DELAWARE, 2004

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$10,643,937	10,246	9.3 %	107,949	0.5	$181	$99
ANTIVIRAL	10,333,285	4,618	4.2	48,516	0.5	459	213
ANTIDEPRESSANTS	8,471,101	24,809	22.6	250,995	0.5	68	34
ANTICONVULSANT	7,181,882	10,915	10.0	114,181	0.6	99	63
ANTIASTHMATIC	6,812,804	34,966	31.9	372,619	0.3	63	18
ANALGESICS - Narcotic	5,781,411	40,284	36.7	415,840	0.3	45	14
ANTIHYPERLIPIDEMIC	4,966,726	9,374	8.6	98,248	0.5	95	51
ANTIDIABETIC	4,174,531	9,852	9.0	100,950	0.6	67	41
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	3,309,858	7,046	6.4	77,278	0.5	84	43
ANTIHYPERTENSIVE	3,168,933	13,955	12.7	143,629	0.6	39	22
Total	64,844,468	166,065		1,730,205	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for Delaware, released by CMS in 02/2008. This table was produced on 03/06/2008.

a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2004. A beneficiary who used drugs from two or more groups was counted as a user for each group. Therefore, the sum of users across drug groups may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

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

c. The top 10 drug groups were determined based on total Medicaid reimbursement in the state for 2004. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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