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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
DELAWARE, 2005

Inclusion Criteria (2005)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Non-dual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	179935 (A)	22528 (E)	157407 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	163037 (B)	12596 (F)	150441 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	114979 (C)	11275 (G)	103704 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	2124 (D)	2009 (H)	115 (L)

Source: Data for this table are from the MAX 2005 file for Delaware, released by CMS in 10/2008. This table was produced on 04/23/2009.

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

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

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

d. The total Medicaid pharmacy reimbursement for Delaware in 2005 was $121,251,725, of which $232,612 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

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

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

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

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

TABLE 2
CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY[a, b]
DELAWARE, 2005

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**114,979**	**5,721**	**14,500**	**47,757**	**46,968**	**33**	**1,135,426**	**57,515**	**160,260**	**428,962**	**488,389**	**300**
Age												
5 and younger	22,394	0	643	1	21,750	0	229,442	0	7,141	6	222,295	0
6-14	20,385	0	2,231	1	18,153	0	220,019	0	25,679	9	194,331	0
15-20	11,888	0	1,421	3,408	7,058	1	118,799	0	16,295	30,800	71,698	6
21-44	38,723	3	4,385	34,325	5	5	358,583	7	48,090	310,407	46	33
45-64	15,361	2	5,625	9,708	1	25	146,013	6	60,913	84,842	7	245
65-74	2,270	1,809	195	264	0	2	23,420	18,846	2,142	2,416	0	16
75-84	2,103	2,064	0	39	0	0	21,524	21,157	0	367	0	0
85 and older	1,855	1,843	0	11	1	0	17,626	17,499	0	115	12	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	72,575	4,325	7,558	36,691	23,968	33	711,227	43,820	83,723	333,989	249,395	300
Male	42,404	1,396	6,942	11,066	23,000	0	424,199	13,695	76,537	94,973	238,994	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	53,082	3,396	7,315	23,933	18,412	26	514,074	33,268	80,429	212,724	187,423	230
African American	48,192	1,746	6,078	19,570	20,792	6	485,657	18,174	67,580	177,902	221,934	67
Other/unknown	13,705	579	1,107	4,254	7,764	1	135,695	6,073	12,251	38,336	79,032	3
Use of Nursing Facilities[c]												
Entire year	2,124	1,891	232	1	0	0	21,483	18,862	2,611	10	0	0
Part year	995	793	193	8	1	0	8,421	6,490	1,840	79	12	0
None	111,860	3,037	14,075	47,748	46,967	33	1,105,522	32,163	155,809	428,873	488,377	300
Maintenance Assistance Status												
Cash	58,713	2,523	11,405	15,984	28,801	0	615,040	28,034	128,886	158,444	299,676	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	4,336	193	545	315	3,250	33	35,386	1,052	3,072	1,886	29,076	300
Other/unknown	51,930	3,005	2,550	31,458	14,917	0	485,000	28,429	28,302	268,632	159,637	0
Dual Medicare Status[d]												
Full dual, all year	10,084	5,101	4,103	875	3	2	108,821	53,442	46,933	8,394	36	16
Full dual, part year	1,191	444	681	66	0	0	6,156	2,234	3,614	308	0	0
Non-dual, all year	103,704	176	9,716	46,816	46,965	31	1,020,449	1,839	109,713	420,260	488,353	284
Managed Care (MC) Status												
Fee-for-service (FFS) all year	3,250	12	19	3,144	75	0	24,488	69	180	23,725	514	0
FFS part year, with Rx claims	4,871	363	596	3,833	77	2	20,498	1,712	2,974	15,478	322	12
FFS part year, no Rx claims	1,544	86	106	1,286	65	1	7,986	514	568	6,594	308	2

Source: Data for this table are from the MAX 2005 file for Delaware, released by CMS in 10/2008. This table was produced on 04/23/2009.

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

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

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

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

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

TABLE 3

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

DELAWARE, 2005

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**95.4**	**16.1**	**$1,053**	**$66**	**$1,233**	**85.4**	**114,979**
Age							
5 and younger	98.1	6.0	308	52	308	100.0	22,394
6-14	99.0	8.3	603	73	603	100.0	20,385
15-20	96.7	8.7	566	65	704	80.5	11,888
21-44	91.3	14.7	991	67	1,263	78.5	38,723
45-64	95.0	34.7	2,579	74	2,810	91.8	15,361
65-74	97.9	51.6	2,989	58	3,529	84.7	2,270
75-84	98.0	56.7	2,790	49	3,712	75.1	2,103
85 and older	99.1	55.2	2,403	44	3,424	70.2	1,855
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	98.2	55.9	2,790	50	3,673	76.0	5,721
Disabled	98.9	38.1	3,398	89	3,626	93.7	14,500
Adults	91.2	14.2	818	58	1,070	76.4	47,757
Children	98.3	6.4	354	56	362	97.9	46,968
Unknown	97.0	22.2	2,850	128	2,974	95.8	33
Gender							
Female	93.5	17.1	1,015	60	1,265	80.2	72,575
Male	98.8	14.4	1,117	78	1,179	94.7	42,404
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	95.9	20.3	1,331	65	1,539	86.5	53,082
African American	95.1	12.9	856	66	1,026	83.4	48,192
Other/unknown	94.9	10.6	664	63	779	85.3	13,705
Use of Nursing Facilities[f]							
Entire year	99.9	77.2	3,631	47	3,699	98.2	2,124
Part year	95.3	51.6	2,618	51	7,648	34.2	995
None	95.3	14.6	990	68	1,129	87.6	111,860
Maintenance Assistance Status							
Cash	98.5	16.1	1,087	67	1,147	94.8	58,713
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	95.4	8.1	490	61	1,091	44.9	4,336
Other/unknown	91.9	16.7	1,061	64	1,343	79.0	51,930

Source: Data for this table are from the MAX 2005 file for Delaware, released by CMS in 10/2008. This table was produced on 04/23/2009.

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

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

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

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

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

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

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

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

TABLE 4

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

DELAWARE, 2005

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	**1.6**	**$107**	**85.4**	**4.6**	**64.7**	**10.5**	**12.3**	**5.9**	**2.0**	**$125**	**114,979**	**1,135,426**
Age												
5 and younger	0.6	30	100.0	1.9	90.3	5.7	1.9	0.2	0.0	30	22,394	229,442
6-14	0.8	56	100.0	1.0	84.3	8.4	5.6	0.7	0.0	56	20,385	220,019
15-20	0.9	57	80.5	3.3	79.2	9.4	6.5	1.2	0.4	70	11,888	118,799
21-44	1.6	107	78.5	8.7	57.7	12.9	13.9	5.0	1.8	136	38,723	358,583
45-64	3.6	271	91.8	5.0	28.2	15.2	29.2	17.2	5.1	296	15,361	146,013
65-74	5.0	290	84.7	2.1	17.5	12.4	30.9	26.2	10.9	342	2,270	23,420
75-84	5.5	273	75.1	2.0	13.5	10.7	30.9	30.5	12.5	363	2,103	21,524
85 and older	5.8	253	70.2	0.9	9.9	9.9	32.1	34.3	12.9	360	1,855	17,626
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	5.6	278	76.0	1.8	12.4	10.9	31.1	31.0	12.7	365	5,721	57,515
Disabled	3.4	308	93.7	1.1	35.0	14.3	27.2	17.0	5.4	328	14,500	160,260
Adults	1.6	91	76.4	8.8	56.4	13.3	14.8	5.1	1.6	119	47,757	428,962
Children	0.6	34	97.9	1.7	88.6	6.5	2.9	0.2	0.0	35	46,968	488,389
Unknown	2.4	314	95.8	3.0	51.5	21.2	12.1	6.1	6.1	327	33	300
Gender												
Female	1.7	104	80.2	6.5	61.2	10.5	12.6	6.6	2.5	129	72,575	711,227
Male	1.4	112	94.7	1.2	70.6	10.6	11.9	4.7	1.1	118	42,404	424,199
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.1	138	86.5	4.1	57.0	12.0	15.5	8.3	3.0	159	53,082	514,074
African American	1.3	85	83.4	4.9	70.1	9.6	10.0	4.1	1.2	102	48,192	485,657
Other/unknown	1.1	67	85.3	5.1	74.9	8.3	7.9	3.0	0.8	79	13,705	135,695
Use of Nursing Facilities[f]												
Entire year	7.6	359	98.2	0.1	4.4	5.6	26.1	41.6	22.3	366	2,124	21,483
Part year	6.1	309	34.2	4.7	10.3	7.3	29.1	31.8	16.8	904	995	8,421
None	1.5	100	87.6	4.7	66.3	10.7	11.9	5.0	1.5	114	111,860	1,105,522
Maintenance Assistance Status												
Cash	1.5	104	94.8	1.5	70.1	10.1	11.6	5.4	1.3	110	58,713	615,040
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	60	44.9	4.6	76.5	7.9	5.1	2.2	3.7	134	4,336	35,386
Other/unknown	1.8	114	79.0	8.1	57.6	11.2	13.7	6.8	2.6	144	51,930	485,000

Source: Data for this table are from the MAX 2005 file for Delaware, released by CMS in 10/2008. This table was produced on 04/23/2009.

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

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

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

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

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

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

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

TABLE 5

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

DELAWARE, 2005

	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	**1.6**	**$107**	**$66**	**0.6**	**$79**	**$123**	**0.1**	**$5**	**$78**	**0.9**	**$23**	**$25**
Age												
5 and younger	0.6	30	52	0.2	23	117	0.0	1	58	0.4	7	18
6-14	0.8	56	73	0.4	47	112	0.0	2	82	0.3	7	22
15-20	0.9	57	65	0.4	44	115	0.0	3	64	0.4	10	22
21-44	1.6	107	67	0.6	77	134	0.1	6	82	0.9	24	26
45-64	3.6	271	74	1.4	199	138	0.1	13	103	2.1	59	29
65-74	5.0	290	58	2.0	214	105	0.2	12	65	2.8	64	23
75-84	5.5	273	49	2.2	199	91	0.2	11	44	3.1	63	20
85 and older	5.8	253	44	2.1	179	84	0.3	12	38	3.4	62	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.6	278	50	2.2	202	93	0.3	12	47	3.1	64	20
Disabled	3.4	308	89	1.5	241	165	0.1	13	98	1.9	54	29
Adults	1.6	91	58	0.6	62	110	0.1	5	83	0.9	24	25
Children	0.6	34	56	0.3	26	100	0.0	1	65	0.3	6	20
Unknown	2.4	314	128	1.2	271	229	0.0	1	124	1.3	42	33
Gender												
Female	1.7	104	60	0.7	75	112	0.1	5	71	1.0	24	24
Male	1.4	112	78	0.6	87	142	0.0	5	95	0.8	21	26
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.1	138	65	0.8	100	120	0.1	7	80	1.2	31	26
African American	1.3	85	66	0.5	65	129	0.0	4	77	0.7	16	22
Other/unknown	1.1	67	63	0.4	51	120	0.0	2	65	0.6	14	22
Use of Nursing Facilities[e]												
Entire year	7.6	359	47	2.8	256	93	0.4	18	40	4.4	86	19
Part year	6.1	309	51	2.2	222	99	0.3	14	47	3.5	73	21
None	1.5	100	68	0.6	75	126	0.1	5	85	0.8	21	25
Maintenance Assistance Status												
Cash	1.5	104	67	0.6	77	126	0.1	5	82	0.9	22	25
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	1.0	60	61	0.4	44	113	0.0	3	84	0.6	13	23
Other/unknown	1.8	114	64	0.7	84	120	0.1	6	74	1.0	24	24

Source: Data for this table are from the MAX 2005 file for Delaware, released by CMS in 10/2008. This table was produced on 04/23/2009.

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

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

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

other than the original patent holder. In Delaware, 0.2 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions

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

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

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

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

TABLE 6

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

DELAWARE, 2005

	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	0.2	$26	$20	$2	$4	$96	$224	$85	$24	192,778	$18,424,266	69,231	60.2	719,608
Biologicals	0.3	0.2	0.0	0.0	242	231	10	1	905	940	7,316	28	1,871	1,693,184	725	0.6	6,998
Antineoplastic Agents	0.5	0.1	0.0	0.3	119	98	0	21	262	679	206	67	4,832	1,266,607	1,040	0.9	10,649
Endocrine/Metabolic Drugs	0.5	0.2	0.0	0.3	27	18	3	6	54	94	58	23	175,259	9,393,336	34,539	30.0	353,637
Cardiovascular Agents	1.2	0.5	0.0	0.7	54	41	0	12	44	81	45	18	282,881	12,560,520	23,077	20.1	232,937
Respiratory Agents	0.4	0.2	0.0	0.2	24	20	1	3	56	86	62	17	235,152	13,265,408	52,045	45.3	544,752
Gastrointestinal Agents	0.5	0.2	0.0	0.3	30	24	0	5	64	130	57	20	86,769	5,593,617	18,230	15.9	188,572
Genitourinary Agents	0.3	0.2	0.0	0.1	16	12	1	2	57	75	59	26	25,915	1,481,699	9,068	7.9	94,376
CNS Drugs	0.9	0.4	0.0	0.4	70	58	1	11	78	131	109	25	272,369	21,176,474	29,923	26.0	302,208
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.1	57	52	0	4	87	96	115	41	44,141	3,843,801	6,216	5.4	67,561
Miscellaneous Psychological/ Neurological Agents	0.5	0.5	0.0	0.0	157	153	0	3	318	337	108	93	5,600	1,781,369	1,113	1.0	11,376
Analgesics and Anesthetics	0.5	0.0	0.0	0.4	23	7	3	14	46	166	149	31	223,031	10,331,247	43,449	37.8	441,114
Neuromuscular Agents	0.6	0.2	0.0	0.4	49	31	3	16	76	141	90	40	121,041	9,259,439	18,467	16.1	189,302
Nutritional Products	0.3	0.1	0.0	0.2	6	2	0	4	19	35	20	15	29,457	559,288	9,585	8.3	97,967
Hematological Agents	0.6	0.3	0.1	0.3	88	82	1	4	139	295	19	16	35,383	4,933,544	5,490	4.8	55,926
Topical Products	0.2	0.1	0.0	0.1	11	7	0	3	44	79	53	22	105,150	4,588,423	40,308	35.1	426,809
Miscellaneous Products	0.2	0.1	0.0	0.1	27	23	1	3	141	182	272	51	5,922	834,274	2,855	2.5	30,506
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	7	0	0	0	43	0	0	0	760	32,617	424	0.4	4,583
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.	1,848,311	121,019,113	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Delaware, released by CMS in 10/2008. This table was produced on 04/23/2009.

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

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

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

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

the original patent holder. In Delaware, 0.2 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined.

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

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

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

TABLE 7

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

DELAWARE, 2005

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$11,160,726	10,577	9.2	110,647	0.6	$183	$101
ANTIVIRAL	11,019,610	4,786	4.2	50,687	0.5	481	217
ANTIDEPRESSANTS	7,228,739	25,080	21.8	253,492	0.5	60	29
ANTIASTHMATIC	7,039,141	37,266	32.4	394,768	0.3	67	18
ANTICONVULSANT	7,027,095	11,107	9.7	116,574	0.6	98	60
ANALGESICS - Narcotic	5,922,076	43,093	37.5	443,300	0.3	44	13
ANTIHYPERLIPIDEMIC	5,319,672	10,419	9.1	109,098	0.5	96	49
ANTIDIABETIC	4,239,652	10,534	9.2	107,066	0.6	68	40
ULCER DRUGS	4,170,145	15,297	13.3	159,536	0.4	72	26
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	3,532,370	6,795	5.9	74,414	0.5	87	47
Total	66,659,226	174,954		1,819,582	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Delaware, released by CMS in 10/2008. This table was produced on 04/23/2009.

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

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

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

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