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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
DELAWARE, 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]	187576 (A)	24156 (E)	163420 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	168374 (B)	12759 (F)	155615 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	113503 (C)	6769 (G)	106734 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	1179 (D)	1035 (H)	144 (L)

Source: Data for this table are from the MAX 2007 file for Delaware, released by CMS in 3/2010. 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 Delaware in 2007 was $104,202,586, of which $1,934,574 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]
DELAWARE, 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	**113,503**	**2,946**	**13,330**	**49,151**	**48,032**	**44**	**1,092,911**	**29,083**	**145,689**	**431,940**	**485,843**	**356**
Age												
5 and younger	23,078	0	681	4	22,393	0	230,039	0	7,486	21	222,532	0
6-14	20,587	4	2,252	1	18,330	0	216,298	12	25,584	3	190,699	0
15-20	12,374	0	1,506	3,598	7,270	0	121,696	0	17,047	32,342	72,307	0
21-44	38,340	8	3,538	34,769	17	8	343,406	72	38,225	304,955	122	32
45-64	15,693	6	5,222	10,420	12	33	147,610	42	55,893	91,284	92	299
65-74	1,505	1,099	127	273	3	3	14,947	10,949	1,424	2,521	28	25
75-84	1,081	1,010	2	68	1	0	10,789	10,152	11	620	6	0
85 and older	845	819	2	18	6	0	8,126	7,856	19	194	57	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	71,374	2,221	6,856	37,723	24,530	44	680,033	22,186	75,060	334,346	248,085	356
Male	42,128	725	6,474	11,428	23,501	0	412,870	6,897	70,629	97,594	237,750	0
Unknown	1	0	0	0	1	0	8	0	0	0	8	0
Race												
White	51,418	1,757	6,633	24,584	18,416	28	489,077	16,961	72,028	215,564	184,321	203
African American	46,726	896	5,655	19,807	20,353	15	454,127	9,037	62,193	174,523	208,230	144
Other/unknown	15,359	293	1,042	4,760	9,263	1	149,707	3,085	11,468	41,853	93,292	9
Use of Nursing Facilities[c]												
Entire year	1,179	919	259	0	1	0	12,286	9,432	2,845	0	9	0
Part year	703	506	178	13	6	0	6,056	4,236	1,658	111	51	0
None	111,621	1,521	12,893	49,138	48,025	44	1,074,569	15,415	141,186	431,829	485,783	356
Maintenance Assistance Status												
Cash	70,836	1,178	10,595	21,748	37,315	0	721,640	13,001	118,644	209,075	380,920	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	5,053	206	626	275	3,902	44	41,691	1,231	3,554	1,453	35,097	356
Other/unknown	37,614	1,562	2,109	27,128	6,815	0	329,580	14,851	23,491	221,412	69,826	0
Dual Medicare Status[d]												
Full dual, all year	5,474	2,330	2,424	703	14	3	59,402	24,988	27,764	6,493	129	28
Full dual, part year	1,295	461	742	90	2	0	6,991	2,478	4,061	437	15	0
Non-dual, all year	106,734	155	10,164	48,358	48,016	41	1,026,518	1,617	113,864	425,010	485,699	328
Managed Care (MC) Status												
Fee-for-service (FFS) all year	3,390	1	13	3,317	59	0	25,217	12	126	24,705	374	0
FFS part year, with Rx claims	4,573	185	475	3,846	66	1	19,231	920	2,421	15,637	244	9
FFS part year, no Rx claims	2,047	286	285	1,411	64	1	10,902	1,602	1,639	7,303	356	2

Source: Data for this table are from the MAX 2007 file for Delaware, released by CMS in 3/2010. 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]
DELAWARE, 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	**93.0**	**12.3**	**$901**	**$73**	**$1,113**	**80.9**	**113,503**
Age							
5 and younger	96.5	5.4	285	53	286	99.7	23,078
6-14	97.2	7.8	644	83	645	99.7	20,587
15-20	95.7	8.6	649	76	766	84.7	12,374
21-44	89.2	13.4	947	71	1,275	74.3	38,340
45-64	92.2	29.0	2,318	80	2,600	89.2	15,693
65-74	80.3	15.4	896	58	2,061	43.5	1,505
75-84	76.8	7.1	253	36	2,001	12.6	1,081
85 and older	80.9	5.7	130	23	2,444	5.3	845
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	76.7	7.8	328	42	2,190	15.0	2,946
Disabled	93.3	28.3	2,806	99	3,091	90.8	13,330
Adults	90.2	14.4	942	65	1,236	76.2	49,151
Children	96.6	5.9	364	62	371	98.3	48,032
Unknown	97.7	23.3	2,863	123	3,425	83.6	44
Gender							
Female	90.9	12.7	856	67	1,156	74.0	71,374
Male	96.5	11.6	977	85	1,041	93.9	42,128
Unknown	100.0	6.0	122	20	122	100.0	1
Race							
White	93.9	15.5	1,140	74	1,385	82.3	51,418
African American	91.9	10.0	746	74	953	78.3	46,726
Other/unknown	93.0	8.4	573	68	691	82.9	15,359
Use of Nursing Facilities[f]							
Entire year	98.3	18.2	918	51	1,178	77.9	1,179
Part year	74.4	14.3	721	50	7,568	9.5	703
None	93.0	12.2	902	74	1,072	84.2	111,621
Maintenance Assistance Status							
Cash	96.1	11.7	852	73	925	92.1	70,836
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	90.3	6.8	467	68	1,195	39.0	5,053
Other/unknown	87.4	14.2	1,053	74	1,457	72.2	37,614

Source: Data for this table are from the MAX 2007 file for Delaware, released by CMS in 3/2010. 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]
DELAWARE, 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	**1.3**	**$94**	**80.9**	**7.0**	**67.4**	**9.9**	**10.5**	**3.9**	**1.2**	**$116**	**113,503**	**1,092,911**
Age												
5 and younger	0.5	29	99.7	3.5	89.6	5.2	1.6	0.1	0.0	29	23,078	230,039
6-14	0.7	61	99.7	2.8	82.8	8.3	5.4	0.6	0.1	61	20,587	216,298
15-20	0.9	66	84.7	4.3	78.2	9.4	6.5	1.3	0.3	78	12,374	121,696
21-44	1.5	106	74.3	10.8	57.0	12.5	13.8	4.4	1.6	142	38,340	343,406
45-64	3.1	246	89.2	7.8	33.1	14.1	26.6	14.4	4.0	276	15,693	147,610
65-74	1.6	90	43.5	19.7	51.6	8.2	11.4	6.6	2.6	208	1,505	14,947
75-84	0.7	25	12.6	23.2	64.4	5.3	4.7	1.9	0.6	201	1,081	10,789
85 and older	0.6	14	5.3	19.1	71.5	4.3	3.0	1.8	0.5	254	845	8,126
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	0.8	33	15.0	23.3	63.2	5.2	4.5	2.7	1.2	222	2,946	29,083
Disabled	2.6	257	90.8	6.7	44.2	12.8	21.3	11.2	3.7	283	13,330	145,689
Adults	1.6	107	76.2	9.8	54.4	13.1	15.7	5.5	1.6	141	49,151	431,940
Children	0.6	36	98.3	3.4	87.5	6.2	2.7	0.2	0.0	37	48,032	485,843
Unknown	2.9	354	83.6	2.3	36.4	13.6	34.1	13.6	0.0	423	44	356
Gender												
Female	1.3	90	74.0	9.1	64.7	9.7	10.6	4.2	1.5	121	71,374	680,033
Male	1.2	100	93.9	3.5	72.1	10.3	10.4	3.2	0.5	106	42,128	412,870
Unknown	0.8	15	100.0	0.0	100.0	0.0	0.0	0.0	0.0	15	1	8
Race												
White	1.6	120	82.3	6.1	61.0	11.8	13.8	5.6	1.7	146	51,418	489,077
African American	1.0	77	78.3	8.1	71.5	8.7	8.3	2.7	0.8	98	46,726	454,127
Other/unknown	0.9	59	82.9	7.0	76.9	7.4	6.4	1.9	0.5	71	15,359	149,707
Use of Nursing Facilities[f]												
Entire year	1.7	88	77.9	1.7	76.3	6.2	5.7	5.6	4.6	113	1,179	12,286
Part year	1.7	84	9.5	25.6	52.3	5.3	6.3	6.7	3.8	879	703	6,056
None	1.3	94	84.2	7.0	67.4	10.0	10.6	3.8	1.1	111	111,621	1,074,569
Maintenance Assistance Status												
Cash	1.1	84	92.1	3.9	74.7	9.1	8.5	3.0	0.8	91	70,836	721,640
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.8	57	39.0	9.7	75.3	6.7	3.9	1.9	2.5	145	5,053	41,691
Other/unknown	1.6	120	72.2	12.6	52.7	12.0	15.3	5.7	1.6	166	37,614	329,580

Source: Data for this table are from the MAX 2007 file for Delaware, released by CMS in 3/2010. 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]
DELAWARE, 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	**1.3**	**$94**	**$73**	**0.4**	**$69**	**$157**	**0.1**	**$6**	**$103**	**0.8**	**$18**	**$24**
Age												
5 and younger	0.5	29	53	0.1	19	170	0.0	2	75	0.4	7	18
6-14	0.7	61	83	0.4	50	135	0.0	4	91	0.3	8	23
15-20	0.9	66	76	0.4	52	144	0.0	4	93	0.5	11	23
21-44	1.5	106	71	0.5	75	159	0.1	7	115	1.0	23	24
45-64	3.1	246	80	1.1	181	170	0.2	18	107	1.9	47	26
65-74	1.6	90	58	0.5	63	136	0.1	7	80	1.0	21	21
75-84	0.7	25	36	0.1	16	119	0.0	2	78	0.5	7	13
85 and older	0.6	14	23	0.1	7	99	0.0	1	55	0.5	5	11
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.8	33	42	0.2	22	133	0.0	2	71	0.6	9	15
Disabled	2.6	257	99	1.0	204	204	0.1	14	114	1.5	39	26
Adults	1.6	107	65	0.5	74	140	0.1	8	106	1.0	25	24
Children	0.6	36	62	0.2	27	128	0.0	3	84	0.3	7	20
Unknown	2.9	354	123	1.0	293	301	0.2	20	100	1.7	42	24
Gender												
Female	1.3	90	67	0.4	64	146	0.1	6	101	0.8	19	23
Male	1.2	100	85	0.4	77	176	0.1	6	107	0.7	17	25
Unknown	0.8	15	20	0.0	0	0	0.1	10	78	0.6	6	9
Race												
White	1.6	120	74	0.6	87	151	0.1	9	110	1.0	24	25
African American	1.0	77	74	0.3	59	167	0.0	4	94	0.6	14	22
Other/unknown	0.9	59	68	0.3	44	156	0.0	4	91	0.5	11	21
Use of Nursing Facilities[e]												
Entire year	1.7	88	51	0.4	61	168	0.1	7	106	1.3	21	16
Part year	1.7	84	50	0.4	59	154	0.1	4	72	1.2	20	17
None	1.3	94	74	0.4	69	157	0.1	6	103	0.8	18	24
Maintenance Assistance Status												
Cash	1.1	84	73	0.4	62	156	0.1	6	105	0.7	16	24
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.8	57	68	0.3	41	155	0.0	5	92	0.5	11	22
Other/unknown	1.6	120	74	0.6	89	158	0.1	8	101	1.0	23	24

Source: Data for this table are from the MAX 2007 file for Delaware, released by CMS in 3/2010. 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 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.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]
DELAWARE, 2007

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	0.2	0.0	0.0	0.2	$22	$15	$2	$5	$89	$417	$111	$24	159,102	$14,172,376	63,090	55.6	638,814
Biologicals	0.3	0.3	0.0	0.0	331	331	0	0	1119	1,119	0	0	1,400	1,567,283	497	0.4	4,737
Antineoplastic Agents	0.4	0.2	0.0	0.3	178	158	1	19	405	1,019	1,504	66	2,651	1,074,175	599	0.5	6,029
Endocrine/Metabolic Drugs	0.4	0.2	0.0	0.2	25	18	1	6	59	112	46	24	126,531	7,522,106	30,222	26.6	300,960
Cardiovascular Agents	1.0	0.3	0.1	0.6	46	28	7	11	48	98	70	19	162,791	7,797,524	17,369	15.3	170,153
Respiratory Agents	0.4	0.2	0.0	0.2	26	21	2	3	66	105	74	18	171,572	11,345,858	43,002	37.9	439,867
Gastrointestinal Agents	0.4	0.2	0.0	0.2	41	34	2	6	102	163	141	31	63,187	6,430,475	15,546	13.7	157,002
Genitourinary Agents	0.2	0.1	0.0	0.1	12	8	1	3	56	84	93	27	15,232	847,333	6,959	6.1	69,489
CNS Drugs	0.8	0.4	0.0	0.4	73	60	5	8	87	171	113	18	227,292	19,863,554	27,412	24.2	271,909
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	67	62	1	4	98	112	39	36	48,536	4,763,402	6,708	5.9	71,045
Miscellaneous Psychological/ Neurological Agents	0.3	0.2	0.0	0.0	112	108	0	4	401	454	0	87	2,346	940,746	834	0.7	8,419
Analgesics and Anesthetics	0.5	0.0	0.0	0.5	24	7	3	14	48	305	366	30	189,604	9,068,074	38,164	33.6	374,424
Neuromuscular Agents	0.6	0.2	0.0	0.3	50	38	3	9	83	158	149	27	106,361	8,880,516	17,625	15.5	175,905
Nutritional Products	0.2	0.1	0.0	0.1	7	4	0	2	29	53	25	15	19,150	556,956	8,249	7.3	83,432
Hematological Agents	0.4	0.2	0.0	0.2	77	74	0	3	173	386	32	12	16,815	2,907,095	3,763	3.3	37,667
Topical Products	0.2	0.1	0.0	0.1	9	6	0	3	43	100	74	19	76,576	3,301,828	35,163	31.0	363,167
Miscellaneous Products	0.2	0.1	0.0	0.0	62	59	0	4	340	405	276	94	3,475	1,181,733	1,785	1.6	18,922
Unknown Therapeutic Category	0.1	0.0	0.0	0.0	14	0	0	0	95	0	0	0	492	46,978	315	0.3	3,389
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.	1,393,113	102,268,012	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Delaware, released by CMS in 3/2010. 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 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.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]
DELAWARE, 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	$9,881,369	8,425	7.4	86,864	0.5	$223	$114
ANTIVIRAL	8,503,888	3,100	2.7	31,469	0.5	560	270
ANTIASTHMATIC	7,082,731	34,444	30.3	357,751	0.3	77	20
ANTICONVULSANT	6,746,193	10,538	9.3	108,081	0.6	112	62
ANALGESICS - Narcotic	5,764,600	39,362	34.7	391,792	0.3	47	15
ANTIDEPRESSANTS	5,700,738	19,291	17.0	190,493	0.4	68	30
ULCER DRUGS	4,911,693	11,847	10.4	120,008	0.3	119	41
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	4,331,373	6,951	6.1	74,549	0.6	98	58
ANTIDIABETIC	3,343,973	7,297	6.4	71,204	0.6	83	47
ANTIHYPERLIPIDEMIC	2,728,452	7,112	6.3	71,378	0.5	83	38
Total	58,995,010	148,367	n.a.	1,503,589	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for Delaware, released by CMS in 3/2010. 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.