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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006
DELAWARE

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
DELAWARE, 2006

Inclusion Criteria (2006)	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]	184542 (A)	23707 (E)	160835 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	165969 (B)	12751 (F)	153218 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	112462 (C)	7082 (G)	105380 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	1125 (D)	993 (H)	132 (L)

Source: Data for this table are from the MAX 2006 file for Delaware, released by CMS in 6/2009. This table was produced on 02/12/2010.
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 2006 (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 2006, 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 2006 was $95,024,456, of which $969,778 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 29 states in 2006 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, KY, MA, MI, MS, NC, NH, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, and WI. In addition, there were 10 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NC, NE, NY, TN, TX, UT, and WV). These lists were constructed from the CMS 2006 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 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 2006. 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 2006. 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, 2006

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**112,462**	**3,066**	**13,253**	**48,456**	**47,651**	**36**	**1,097,547**	**30,560**	**145,571**	**431,802**	**489,351**	**263**
Age												
5 and younger	22,623	0	663	3	21,957	0	229,499	0	7,351	27	222,121	0
6-14	20,699	1	2,236	2	18,460	0	220,674	12	25,740	13	194,909	0
15-20	12,302	1	1,473	3,618	7,210	0	121,367	8	16,727	32,491	72,141	0
21-44	38,090	6	3,642	34,415	16	11	346,478	41	39,262	307,025	119	31
45-64	15,219	2	5,113	10,075	5	24	144,567	12	55,106	89,181	39	229
65-74	1,547	1,147	126	272	1	1	15,411	11,624	1,385	2,392	7	3
75-84	1,139	1,082	0	56	1	0	11,501	10,964	0	528	9	0
85 and older	843	827	0	15	1	0	8,050	7,899	0	145	6	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	71,062	2,306	6,931	37,337	24,452	36	685,673	23,120	75,902	335,562	250,826	263
Male	41,400	760	6,322	11,119	23,199	0	411,874	7,440	69,669	96,240	238,525	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	51,127	1,817	6,657	24,167	18,462	24	492,465	17,586	72,376	215,323	186,997	183
African American	46,877	944	5,541	19,727	20,653	12	463,307	9,738	61,567	176,060	215,862	80
Other/unknown	14,458	305	1,055	4,562	8,536	0	141,775	3,236	11,628	40,419	86,492	0
Use of Nursing Facilities[c]												
Entire year	1,125	886	239	0	0	0	11,874	9,210	2,664	0	0	0
Part year	726	528	190	8	0	0	6,165	4,287	1,802	76	0	0
None	110,611	1,652	12,824	48,448	47,651	36	1,079,508	17,063	141,105	431,726	489,351	263
Maintenance Assistance Status												
Cash	65,654	1,287	10,457	19,626	34,284	0	682,841	14,324	117,760	194,584	356,173	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	5,146	197	652	289	3,972	36	44,085	1,241	3,780	1,720	37,081	263
Other/unknown	41,662	1,582	2,144	28,541	9,395	0	370,621	14,995	24,031	235,498	96,097	0
Dual Medicare Status[d]												
Full dual, all year	5,762	2,435	2,559	762	4	2	63,001	26,443	29,489	7,012	42	15
Full dual, part year	1,320	486	750	81	3	0	7,236	2,584	4,221	409	22	0
Non-dual, all year	105,380	145	9,944	47,613	47,644	34	1,027,310	1,533	111,861	424,381	489,287	248
Managed Care (MC) Status												
Fee-for-service (FFS) all year	3,018	10	22	2,928	58	0	22,702	96	236	22,041	329	0
FFS part year, with Rx claims	4,909	176	500	4,154	77	2	20,121	788	2,577	16,453	297	6
FFS part year, no Rx claims	2,073	315	257	1,436	63	2	11,024	1,781	1,507	7,436	297	3

Source: Data for this table are from the MAX 2006 file for Delaware, released by CMS in 6/2009. This table was produced on 02/12/2010.

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 2006. 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, 2006

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	**93.7**	**12.1**	**$836**	**$69**	**$1,050**	**79.7**	**112,462**
Age							
5 and younger	97.5	5.7	312	55	312	100.0	22,623
6-14	98.2	7.9	608	78	609	100.0	20,699
15-20	96.2	8.6	584	68	718	81.3	12,302
21-44	90.4	13.2	864	65	1,183	73.1	38,090
45-64	92.3	28.3	2,159	76	2,412	89.5	15,219
65-74	76.4	12.6	700	56	1,854	37.8	1,547
75-84	72.1	6.1	220	36	2,217	9.9	1,139
85 and older	80.4	5.5	123	22	2,880	4.3	843
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	73.1	6.5	245	38	2,328	10.5	3,066
Disabled	93.6	27.6	2,568	93	2,809	91.4	13,253
Adults	91.2	14.2	866	61	1,155	75.0	48,456
Children	97.6	6.1	362	59	371	97.6	47,651
Unknown	91.7	19.9	1,785	90	1,931	92.4	36
Gender							
Female	91.7	12.5	786	63	1,086	72.4	71,062
Male	97.1	11.4	923	81	989	93.4	41,400
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	94.3	15.2	1,057	70	1,323	79.9	51,127
African American	93.0	9.9	686	69	873	78.6	46,877
Other/unknown	93.6	8.5	542	64	659	82.2	14,458
Use of Nursing Facilities[f]							
Entire year	99.5	16.5	803	49	988	81.3	1,125
Part year	72.6	13.4	809	60	8,550	9.5	726
None	93.8	12.1	837	69	1,001	83.6	110,611
Maintenance Assistance Status							
Cash	96.7	11.9	819	69	884	92.6	65,654
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	91.3	6.9	433	62	1,022	42.3	5,146
Other/unknown	89.2	13.1	914	70	1,314	69.5	41,662

Source: Data for this table are from the MAX 2006 file for Delaware, released by CMS in 6/2009. This table was produced on 02/12/2010.
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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

				Number of Rx, Percentage with:							Number	
Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Beneficiaries	Benefit Months
All	**1.2**	**$86**	**79.7**	**6.3**	**68.6**	**10.0**	**10.2**	**3.7**	**1.1**	**$108**	**112,462**	**1,097,547**
Age												
5 and younger	0.6	31	100.0	2.5	90.2	5.4	1.8	0.1	0.0	31	22,623	229,499
6-14	0.7	57	100.0	1.8	84.0	8.2	5.3	0.6	0.0	57	20,699	220,674
15-20	0.9	59	81.3	3.8	78.7	9.5	6.7	1.0	0.3	73	12,302	121,367
21-44	1.5	95	73.1	9.6	58.5	12.7	13.1	4.4	1.6	130	38,090	346,478
45-64	3.0	227	89.5	7.7	34.8	13.9	25.9	13.8	3.8	254	15,219	144,567
65-74	1.3	70	37.8	23.6	51.1	7.5	10.6	4.5	2.7	186	1,547	15,411
75-84	0.6	22	9.9	27.9	61.5	4.3	4.7	1.3	0.4	220	1,139	11,501
85 and older	0.6	13	4.3	19.6	70.2	4.9	3.7	1.5	0.1	302	843	8,050
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	0.6	25	10.5	26.9	61.4	4.4	4.7	1.4	1.1	234	3,066	30,560
Disabled	2.5	234	91.4	6.4	44.9	13.1	21.2	11.0	3.4	256	13,253	145,571
Adults	1.6	97	75.0	8.8	56.2	13.1	14.9	5.3	1.6	130	48,456	431,802
Children	0.6	35	97.6	2.4	88.3	6.4	2.7	0.2	0.0	36	47,651	489,351
Unknown	2.7	244	92.4	8.3	41.7	13.9	25.0	8.3	2.8	264	36	263
Gender												
Female	1.3	81	72.4	8.3	65.8	10.0	10.3	4.1	1.5	113	71,062	685,673
Male	1.1	93	93.4	2.9	73.5	10.1	10.0	3.0	0.5	99	41,400	411,874
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.6	110	79.9	5.7	62.1	11.8	13.4	5.3	1.7	137	51,127	492,465
African American	1.0	69	78.6	7.0	73.0	8.7	7.9	2.6	0.8	88	46,877	463,307
Other/unknown	0.9	55	82.2	6.4	77.1	7.7	6.3	2.0	0.5	67	14,458	141,775
Use of Nursing Facilities[f]												
Entire year	1.6	76	81.3	0.5	77.4	6.4	6.3	5.9	3.5	94	1,125	11,874
Part year	1.6	95	9.5	27.4	49.6	4.1	9.8	5.8	3.3	1,007	726	6,165
None	1.2	86	83.6	6.2	68.6	10.1	10.3	3.7	1.1	103	110,611	1,079,508
Maintenance Assistance Status												
Cash	1.1	79	92.6	3.3	75.5	9.1	8.4	3.0	0.8	85	65,654	682,841
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	51	42.3	8.7	75.9	7.1	4.2	1.8	2.2	119	5,146	44,085
Other/unknown	1.5	103	69.5	10.8	56.9	11.9	13.9	5.0	1.5	148	41,662	370,621

Source: Data for this table are from the MAX 2006 file for Delaware, released by CMS in 6/2009. This table was produced on 02/12/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.2**	**$86**	**$69**	**0.4**	**$63**	**$141**	**0.0**	**$6**	**$111**	**0.7**	**$17**	**$23**
Age												
5 and younger	0.6	31	55	0.2	23	153	0.0	1	46	0.4	7	17
6-14	0.7	57	78	0.4	48	128	0.0	2	68	0.3	8	22
15-20	0.9	59	68	0.4	46	127	0.0	3	90	0.5	10	21
21-44	1.5	95	65	0.5	67	139	0.1	7	115	0.9	21	23
45-64	3.0	227	76	1.1	165	151	0.1	18	137	1.8	44	25
65-74	1.3	70	56	0.4	48	121	0.1	6	110	0.8	16	20
75-84	0.6	22	36	0.1	14	109	0.0	2	76	0.5	6	13
85 and older	0.6	13	22	0.1	7	86	0.0	1	53	0.5	6	11
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.6	25	38	0.1	16	116	0.0	2	84	0.5	7	15
Disabled	2.5	234	93	1.0	185	185	0.1	12	117	1.4	37	26
Adults	1.6	97	61	0.5	66	123	0.1	9	125	1.0	22	23
Children	0.6	35	59	0.2	27	120	0.0	1	59	0.3	7	20
Unknown	2.7	244	90	1.1	185	172	0.2	22	123	1.5	38	26
Gender												
Female	1.3	81	63	0.5	58	129	0.1	6	106	0.8	18	22
Male	1.1	93	81	0.4	72	160	0.0	5	121	0.7	16	24
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.6	110	70	0.6	80	137	0.1	8	115	0.9	22	24
African American	1.0	69	69	0.4	53	149	0.0	4	106	0.6	13	21
Other/unknown	0.9	55	64	0.3	41	137	0.0	4	96	0.5	11	20
Use of Nursing Facilities[e]												
Entire year	1.6	76	49	0.3	51	156	0.1	5	91	1.2	20	17
Part year	1.6	95	60	0.5	72	157	0.1	3	64	1.1	20	18
None	1.2	86	69	0.5	63	140	0.0	6	111	0.7	17	23
Maintenance Assistance Status												
Cash	1.1	79	69	0.4	58	143	0.0	5	103	0.7	16	23
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.8	51	62	0.3	37	128	0.0	4	106	0.5	10	21
Other/unknown	1.5	103	70	0.5	75	139	0.1	8	121	0.9	20	23

Source: Data for this table are from the MAX 2006 file for Delaware, released by CMS in 6/2009. This table was produced on 02/12/2010.
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, 2006

	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
Therapeutic Category	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.2	0.1	0.0	0.2	$22	$16	$2	$4	$88	$274	$131	$22	162,244	$14,357,864	63,480	56.4	651,161
Biologicals	0.3	0.3	0.0	0.0	338	338	0	0	1120	1,132	0	28	1,745	1,955,075	585	0.5	5,790
Antineoplastic Agents	0.4	0.2	0.0	0.3	145	128	0	17	329	805	0	61	2,597	853,503	575	0.5	5,894
Endocrine/Metabolic Drugs	0.4	0.2	0.0	0.2	24	17	1	6	58	103	71	26	127,212	7,341,015	30,032	26.7	301,702
Cardiovascular Agents	1.0	0.4	0.1	0.5	48	32	7	9	50	84	122	17	157,825	7,939,660	16,818	15.0	165,592
Respiratory Agents	0.4	0.2	0.0	0.2	22	18	1	3	58	102	70	17	176,783	10,203,507	44,672	39.7	461,667
Gastrointestinal Agents	0.4	0.2	0.0	0.2	36	32	1	4	92	145	229	21	60,588	5,549,841	15,231	13.5	153,907
Genitourinary Agents	0.2	0.1	0.0	0.1	12	7	1	3	55	78	80	30	15,852	864,492	7,349	6.5	74,111
CNS Drugs	0.8	0.3	0.1	0.4	63	49	6	8	80	148	101	21	216,375	17,263,489	27,323	24.3	273,614
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	62	58	0	4	91	101	222	37	46,372	4,229,741	6,311	5.6	68,286
Miscellaneous Psychological/ Neurological Agents	0.3	0.2	0.0	0.1	154	148	0	6	531	618	0	119	1,836	975,727	621	0.6	6,332
Analgesics and Anesthetics	0.5	0.0	0.0	0.4	21	7	2	12	44	215	321	27	183,779	8,010,488	38,779	34.5	385,544
Neuromuscular Agents	0.6	0.2	0.0	0.3	43	31	1	11	76	150	87	32	90,930	6,949,818	16,238	14.4	163,148
Nutritional Products	0.2	0.1	0.0	0.1	6	4	0	2	26	45	27	15	19,506	501,756	8,285	7.4	84,539
Hematological Agents	0.4	0.2	0.0	0.2	73	68	0	4	168	370	31	16	17,463	2,931,381	3,966	3.5	40,291
Topical Products	0.2	0.1	0.0	0.1	9	6	0	3	42	90	69	19	77,850	3,253,010	35,375	31.5	368,983
Miscellaneous Products	0.2	0.1	0.0	0.0	39	35	1	3	239	277	332	83	3,608	860,526	2,047	1.8	22,069
Unknown Therapeutic Category	0.1	0.0	0.0	0.0	5	0	0	0	42	0	0	0	328	13,785	249	0.2	2,625
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.	1,362,893	94,054,678	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Delaware, released by CMS in 6/2009. This table was produced on 02/12/2010.

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 2006.

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, 2006

		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
ANTIVIRAL	$8,410,223	3,530	3.1	36,547	0.4	$522	$230
ANTIPSYCHOTICS	8,123,524	7,949	7.1	82,869	0.5	203	98
ANTIASTHMATIC	5,866,210	33,625	29.9	353,070	0.3	66	17
ANTIDEPRESSANTS	5,454,564	19,729	17.5	196,234	0.4	65	28
ANTICONVULSANT	5,071,541	8,897	7.9	91,755	0.5	101	55
ANALGESICS - Narcotic	4,415,392	37,890	33.7	381,514	0.3	40	12
ULCER DRUGS	4,088,082	11,590	10.3	117,795	0.3	106	35
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	3,875,415	6,746	6.0	73,677	0.6	91	53
ANTIHYPERLIPIDEMIC	3,231,396	7,214	6.4	73,294	0.4	104	44
ANTIDIABETIC	2,951,355	7,271	6.5	71,662	0.5	75	41
Total	51,487,702	144,441	n.a.	1,478,417	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Delaware, released by CMS in 6/2009. This table was produced on 02/12/2010.
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 2006. 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 2006. 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.