STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
NEW MEXICO

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

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries	(Cell)	Number of Dual Eligible Beneficiaries	(Cell)[g]	Number of Non-dual Eligible Beneficiaries	(Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	497,418	(A)	47,566	(E)	449,852	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	484,399	(B)	36,627	(F)	447,772	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	274,637	(C)	35,350	(G)	239,287	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	4,341	(D)	3,967	(H)	374	(L)

Source: Data for this table are from the MAX 2003 file for New Mexico, released by CMS in 05/2007. This table was produced on 11/01/2007.

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

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

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

d. The total Medicaid pharmacy reimbursement for New Mexico in 2003 was $88,444,391, of which $140,792 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

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

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

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

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

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

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

TABLE 2

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

NEW MEXICO, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**274,637**	**16,612**	**31,162**	**84,396**	**142,467**	**0**	**1,675,480**	**170,020**	**287,880**	**567,199**	**650,381**	**0**
Age												
5 and younger	55,168	1	658	0	54,509	0	223,212	3	4,099	0	219,110	0
6-14	62,479	4	1,277	0	61,198	0	312,502	28	9,779	0	302,695	0
15-20	34,170	12	1,225	6,188	26,745	0	168,551	108	8,235	31,671	128,537	0
21-44	82,285	112	9,209	72,949	15	0	586,139	949	81,685	503,466	39	0
45-64	17,142	111	11,798	5,233	0	0	138,597	931	105,730	31,936	0	0
65-74	9,622	4,793	4,810	19	0	0	103,336	49,825	53,416	95	0	0
75-84	8,147	6,468	1,673	6	0	0	86,908	67,675	19,206	27	0	0
85 and older	5,624	5,111	512	1	0	0	56,235	50,501	5,730	4	0	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Gender												
Female	172,774	11,612	16,516	73,579	71,067	0	1,126,626	120,015	156,871	527,976	321,764	0
Male	101,844	5,000	14,639	10,817	71,388	0	548,715	50,005	130,936	39,223	328,551	0
Unknown	19	0	7	0	12	0	139	0	73	0	66	0
Race												
White	64,893	7,117	11,057	21,979	24,740	0	356,492	70,310	99,349	132,890	53,943	0
African American	4,867	216	749	1,496	2,406	0	20,665	2,201	6,082	7,463	4,919	0
Other/unknown	204,877	9,279	19,356	60,921	115,321	0	1,298,323	97,509	182,449	426,846	591,519	0
Use of Nursing Facilities[c]												
Entire year	4,341	3,510	831	0	0	0	43,340	34,477	8,863	0	0	0
Part year	2,420	1,786	628	6	0	0	21,833	16,056	5,734	43	0	0
None	267,876	11,316	29,703	84,390	142,467	0	1,610,307	119,487	273,283	567,156	650,381	0
Maintenance Assistance Status												
Cash	116,215	9,168	27,452	35,597	43,998	0	718,654	101,116	256,768	153,245	207,525	0
Medically needy	0	0	0	0	0	0 0		0	0	0	0	0
Poverty-related	93,546	427	1,328	7,757	84,034	0	431,693	3,806	8,404	35,270	384,213	0
Other/unknown	64,876	7,017	2,382	41,042	14,435	0	525,133	65,098	22,708	378,684	58,643	0
Dual Medicare Status[d]												
Full dual, all year	34,325	15,455	18,445	421	4	0	362,655	159,480	199,920	3,210	45	0
Full dual, part year	1,025	588	404	33	0	0	10,302	6,116	3,862	324	0	0
Non-dual, all year	239,287	569	12,313	83,942	142,463	0	1,302,523	4,424	84,098	563,665	650,336	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	145,161	16,149	23,943	49,423	55,646	0	1,331,601	166,772	257,503	445,859	461,467	0
FFS part year, with Rx claims	33,433	315	4,006	11,997	17,115	0	109,953	2,411	18,970	46,085	42,487	0
FFS part year, no Rx claims	96,043	148	3,213	22,976	69,706	0	233,926	837	11,407	75,255	146,427	0

Source: Data for this table are from the MAX 2003 file for New Mexico, released by CMS in 05/2007. This table was produced on 11/01/2007.

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

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

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

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

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

TABLE 3

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

NEW MEXICO, 2003

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**35.7 %**	**6.4**	**$322**	**$50**	**$4,170**	**7.7 %**	**274,637**
Age							
5 and younger	27.3	0.8	23	27	2,042	1.1	55,168
6-14	23.9	0.8	34	42	1,365	2.5	62,479
15-20	29.6	1.2	54	45	2,565	2.1	34,170
21-44	34.1	3.6	225	62	3,420	6.6	82,285
45-64	58.4	23.8	1,383	58	11,648	11.9	17,142
65-74	81.0	37.4	1,692	45	11,536	14.7	9,622
75-84	86.4	41.7	1,860	45	17,059	10.9	8,147
85 and older	89.2	40.0	1,676	42	22,887	7.3	5,624
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	82.8	36.8	1,622	44	16,524	9.8	16,612
Disabled	73.1	29.6	1,721	58	15,419	11.2	31,162
Adults	29.9	1.4	48	34	1,853	2.6	84,396
Children	25.5	0.8	26	32	1,642	1.6	142,467
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	36.9	7.0	333	48	4,099	8.1	172,774
Male	33.6	5.5	302	55	4,292	7.0	101,844
Unknown	36.8	8.2	313	38	4,167	7.5	19
Race							
White	39.1	11.6	614	53	6,304	9.7	64,893
African American	30.5	6.7	344	52	4,293	8.0	4,867
Other/unknown	34.7	4.8	228	48	3,492	6.5	204,877
Use of Nursing Facilities[f]							
Entire year	96.8	68.7	3,142	46	37,373	8.4	4,341
Part year	93.8	47.3	2,280	48	27,469	8.3	2,420
None	34.2	5.1	258	51	3,422	7.5	267,876
Maintenance Assistance Status							
Cash	44.0	9.8	507	52	5,096	9.9	116,215
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	27.2	1.1	43	41	1,940	2.2	93,546
Other/unknown	33.0	8.1	391	48	5,728	6.8	64,876

Source: Data for this table are from the MAX 2003 file for New Mexico, released by CMS in 05/2007. This table was produced on 11/01/2007.

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

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

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

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

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

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

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

TABLE 4

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

NEW MEXICO, 2003

				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	**1.1**	**$53**	**7.7 %**	**64.3 %**	**22.9 %**	**3.8 %**	**5.1 %**	**3.0 %**	**0.8 %**	**$684**	**274,637**	**1,675,480**
Age												
5 and younger	0.2	6	1.1	72.7	23.3	2.7	1.2	0.1	0.0	505	55,168	223,212
6-14	0.2	7	2.5	76.1	20.4	2.2	1.2	0.2	0.0	273	62,479	312,502
15-20	0.2	11	2.1	70.4	24.4	3.0	1.9	0.3	0.0	520	34,170	168,551
21-44	0.5	32	6.6	65.9	25.6	3.3	3.4	1.4	0.4	480	82,285	586,139
45-64	2.9	171	11.9	41.6	18.8	7.7	15.7	11.9	4.3	1,441	17,142	138,597
65-74	3.5	158	14.7	19.0	23.1	10.1	25.2	17.2	5.3	1,074	9,622	103,336
75-84	3.9	174	10.9	13.6	19.4	11.1	28.5	21.5	5.8	1,599	8,147	86,908
85 and older	4.0	168	7.3	10.8	16.5	11.7	32.9	23.9	4.2	2,289	5,624	56,235
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	3.6	159	9.8	17.2	19.7	10.9	27.9	19.7	4.6	1,615	16,612	170,020
Disabled	3.2	186	11.2	26.9	24.4	9.7	20.1	14.2	4.6	1,669	31,162	287,880
Adults	0.2	7	2.6	70.1	25.2	2.4	1.7	0.4	0.1	276	84,396	567,199
Children	0.2	6	1.6	74.5	21.6	2.5	1.2	0.1	0.0	360	142,467	650,381
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.1	51	8.1	63.1	23.8	3.6	5.3	3.3	0.9	629	172,774	1,126,626
Male	1.0	56	7.0	66.4	21.5	4.1	4.9	2.5	0.6	797	101,844	548,715
Unknown	1.1	43	7.5	63.2	21.1	5.3	5.3	5.3	0.0	570	19	139
Race												
White	2.1	112	9.7	60.9	17.4	5.0	8.5	6.2	2.0	1,147	64,893	356,492
African American	1.6	81	8.0	69.5	15.3	4.9	5.7	3.6	1.0	1,011	4,867	20,665
Other/unknown	0.8	36	6.5	65.3	24.9	3.4	4.1	2.0	0.5	551	204,877	1,298,323
Use of Nursing Facilities[f]												
Entire year	6.9	315	8.4	3.2	6.7	7.9	30.9	36.0	15.4	3,743	4,341	43,340
Part year	5.2	253	8.3	6.2	12.9	10.2	32.8	29.0	9.0	3,045	2,420	21,833
None	0.8	43	7.5	65.8	23.3	3.7	4.5	2.2	0.5	569	267,876	1,610,307
Maintenance Assistance Status												
Cash	1.6	82	9.9	56.0	24.2	5.7	8.4	4.6	1.1	824	116,215	718,654
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.2	9	2.2	72.8	22.9	2.5	1.5	0.3	0.0	420	93,546	431,693
Other/unknown	1.0	48	6.8	67.0	20.7	2.1	4.6	4.1	1.4	708	64,876	525,133

Source: Data for this table are from the MAX 2003 file for New Mexico, released by CMS in 05/2007. This table was produced on 11/01/2007.

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

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

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

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

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

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

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

TABLE 5

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

NEW MEXICO, 2003

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.1**	**$53**	**$50**	**0.4**	**$41**	**$97**	**0.1**	**$2**	**$32**	**0.6**	**$10**	**$17**
Age												
5 and younger	0.2	6	27	0.0	3	74	0.0	0	23	0.1	2	13
6-14	0.2	7	42	0.1	5	89	0.0	0	30	0.1	1	15
15-20	0.2	11	45	0.1	8	90	0.0	1	44	0.1	2	16
21-44	0.5	32	62	0.2	25	123	0.0	2	46	0.3	6	20
45-64	2.9	171	58	1.2	136	112	0.2	7	36	1.6	29	19
65-74	3.5	158	45	1.4	122	84	0.2	5	27	1.8	31	17
75-84	3.9	174	45	1.6	135	83	0.2	5	24	2.0	34	17
85 and older	4.0	168	42	1.6	129	82	0.2	5	22	2.2	34	15
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	3.6	159	44	1.5	124	83	0.2	5	23	1.9	30	16
Disabled	3.2	186	58	1.3	147	112	0.2	7	38	1.7	32	19
Adults	0.2	7	34	0.1	4	61	0.0	1	33	0.1	2	18
Children	0.2	6	32	0.1	4	74	0.0	0	30	0.1	2	14
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.1	51	48	0.4	39	91	0.1	2	30	0.6	10	17
Male	1.0	56	55	0.4	44	110	0.1	2	37	0.6	10	18
Unknown	1.1	43	38	0.5	32	67	0.1	2	24	0.6	9	16
Race												
White	2.1	112	53	0.9	87	99	0.1	4	36	1.1	20	18
African American	1.6	81	52	0.6	62	102	0.1	3	43	0.9	16	18
Other/unknown	0.8	36	48	0.3	28	95	0.1	2	29	0.4	7	17
Use of Nursing Facilities[e]												
Entire year	6.9	315	46	2.9	254	87	0.5	10	21	3.5	50	15
Part year	5.2	253	48	2.1	200	94	0.3	8	26	2.8	45	16
None	0.8	43	51	0.3	33	99	0.0	2	36	0.5	8	18
Maintenance Assistance Status												
Cash	1.6	82	52	0.6	64	101	0.1	3	34	0.9	15	18
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.2	9	41	0.1	7	92	0.0	0	33	0.1	2	15
Other/unknown	1.0	48	48	0.4	38	89	0.1	2	28	0.5	9	17

Source: Data for this table are from the MAX 2003 file for New Mexico, released by CMS in 05/2007. This table was produced on 11/01/2007.

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

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

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In New Mexico, 0.7 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]

NEW MEXICO, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.2	$14	$11	$0	$3	$53	$109	$52	$19	113,891	$6,068,384	48,556	17.7 %	426,336
Biologicals	0.1	0.1	0.0	0.0	14	10	2	2	135	108	3,282	236	2,605	352,615	2,287	0.8	24,965
Antineoplastic Agents	0.5	0.2	0.0	0.3	88	70	2	16	172	375	141	51	6,693	1,153,476	1,281	0.5	13,115
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.3	29	22	3	5	37	63	21	16	253,331	9,448,884	33,148	12.1	322,046
Cardiovascular Agents	1.5	0.5	0.1	0.9	45	32	1	12	30	64	18	13	347,541	10,544,472	22,716	8.3	233,192
Respiratory Agents	0.5	0.3	0.0	0.2	23	18	1	4	46	73	55	15	145,460	6,672,923	34,705	12.6	293,975
Gastrointestinal Agents	0.7	0.3	0.0	0.4	51	37	0	13	77	131	68	36	123,237	9,515,997	18,632	6.8	186,241
Genitourinary Agents	0.4	0.3	0.0	0.1	24	21	0	3	56	73	51	19	29,812	1,664,872	6,967	2.5	69,028
CNS Drugs	1.1	0.6	0.0	0.5	81	70	2	8	72	123	92	16	251,240	18,178,708	24,112	8.8	225,570
Stimulants/Anti-obesity/Anorexia	0.5	0.3	0.0	0.2	34	25	2	6	64	89	62	31	6,136	394,364	1,771	0.6	11,752
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	89	87	0	2	146	152	0	50	10,469	1,528,088	1,659	0.6	17,224
Analgesics and Anesthetics	0.5	0.1	0.0	0.4	23	18	1	5	43	119	26	13	192,074	8,327,605	38,109	13.9	357,285
Neuromuscular Agents	0.8	0.3	0.1	0.4	50	36	4	10	60	111	41	24	108,240	6,486,097	13,525	4.9	130,975
Nutritional Products	0.5	0.0	0.0	0.4	7	0	0	6	14	20	17	13	46,704	643,489	11,200	4.1	97,480
Hematological Agents	0.7	0.2	0.2	0.3	59	51	3	5	81	226	20	13	44,836	3,638,487	5,982	2.2	61,723
Topical Products	0.3	0.1	0.0	0.2	11	7	1	3	35	62	51	17	75,992	2,631,435	25,772	9.4	245,235
Miscellaneous Products	0.3	0.2	0.0	0.1	45	33	7	5	165	194	241	69	5,621	929,229	2,200	0.8	20,877
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	4	0	0	0	24	0	0	0	5,178	124,474	3,181	1.2	30,996
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.	1,769,060	88,303,599	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for New Mexico, released by CMS in 05/2007. This table was produced on 11/01/2007.

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

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

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

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In New Mexico, 0.7 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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

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

TABLE 7

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

NEW MEXICO, 2003

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$10,500,383	9,241	3.4 %	91,203	0.7	$156	$115
ULCER DRUGS	8,019,524	18,041	6.6	183,911	0.5	87	44
ANTIDEPRESSANTS	6,451,606	21,040	7.7	198,535	0.6	56	32
ANTICONVULSANT	5,131,535	9,566	3.5	94,351	0.8	71	54
ANTIDIABETIC	4,613,808	15,174	5.5	158,822	0.6	46	29
ANALGESICS - ANTI-INFLAMMATORY	4,157,914	28,244	10.3	276,988	0.3	51	15
ANTIHYPERLIPIDEMIC	3,845,609	7,636	2.8	82,537	0.6	79	47
ANTIASTHMATIC	3,573,275	23,120	8.4	210,046	0.3	50	17
ANALGESICS - Narcotic	3,376,423	31,038	11.3	302,994	0.3	34	11
ANTIHYPERTENSIVE	2,852,778	16,080	5.9	170,029	0.6	26	17
Total	52,522,855	179,180		1,769,416	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for New Mexico, released by CMS in 05/2007. This table was produced on 11/01/2007.

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

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

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

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