STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2004
NEW HAMPSHIRE

LIST OF TABLES

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

Inclusion Criteria (2004)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)		Number of Dual Eligible Beneficiaries (Cell)[g]		Number of Non-dual Eligible Beneficiaries (Cell)	
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	136,228	(A)	25,149	(E)	111,079	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	133,163	(B)	22,119	(F)	111,044	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	133,163	(C)	22,119	(G)	111,044	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	4,687	(D)	4,511	(H)	176	(L)

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

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

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

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

d. The total Medicaid pharmacy reimbursement for New Hampshire in 2004 was $127,939,336, of which $99,818 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

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

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

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

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

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

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

TABLE 2

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

NEW HAMPSHIRE, 2004

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**133,163**	**12,273**	**17,631**	**19,365**	**83,894**	**0**	**1,232,097**	**120,221**	**181,714**	**149,292**	**780,870**	**0**
Age												
5 and younger	29,134	0	32	0	29,102	0	260,518	0	368	0	260,150	0
6-14	37,483	0	95	0	37,388	0	367,212	0	1,087	0	366,125	0
15-20	17,802	0	546	0	17,256	0	159,417	0	5,423	0	153,994	0
21-44	25,470	0	7,713	17,614	143	0	216,491	0	80,333	135,563	595	0
45-64	10,901	0	9,174	1,727	0	0	107,579	0	93,969	13,610	0	0
65-74	3,623	3,562	51	10	0	0	36,688	36,267	334	87	0	0
75-84	4,202	4,188	13	1	0	0	41,345	41,208	125	12	0	0
85 and older	4,530	4,523	7	0	0	0	42,821	42,746	75	0	0	0
Unknown	18	0	0	13	5	0	26	0	0	20	6	0
Gender												
Female	76,962	9,409	9,564	16,657	41,332	0	706,838	93,955	99,573	131,257	382,053	0
Male	56,201	2,864	8,067	2,708	42,562	0	525,259	26,266	82,141	18,035	398,817	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	121,225	11,723	17,033	17,488	74,981	0	1,128,222	114,838	175,926	135,709	701,749	0
African American	2,964	56	213	643	2,052	0	25,859	534	2,105	4,552	18,668	0
Other/unknown	8,974	494	385	1,234	6,861	0	78,016	4,849	3,683	9,031	60,453	0
Use of Nursing Facilities[c]												
Entire year	4,687	4,390	296	0	1	0	48,423	45,156	3,255	0	12	0
Part year	2,456	2,093	327	8	28	0	22,042	18,125	3,498	88	331	0
None	126,020	5,790	17,008	19,357	83,865	0	1,161,632	56,940	174,961	149,204	780,527	0
Maintenance Assistance Status												
Cash	26,272	1,540	6,985	5,586	12,161	0	256,424	17,347	75,952	45,248	117,877	0
Medically needy	12,336	5,067	3,201	2,583	1,485	0	109,807	46,241	30,000	19,189	14,377	0
Poverty-related	63,745	565	624	3,847	58,709	0	563,484	4,852	5,619	22,196	530,817	0
Other/unknown	30,810	5,101	6,821	7,349	11,539	0	302,382	51,781	70,143	62,659	117,799	0
Dual Medicare Status[d]												
Full dual, all year	20,109	10,548	8,589	960	12	0	206,271	104,652	92,830	8,677	112	0
Full dual, part year	2,010	853	1,091	66	0	0	18,874	7,770	10,405	699	0	0
Non-dual, all year	111,044	872	7,951	18,339	83,882	0	1,006,952	7,799	78,479	139,916	780,758	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	133,163	12,273	17,631	19,365	83,894	0	1,232,097	120,221	181,714	149,292	780,870	0
FFS part year, with Rx claims	0	0	0	0	0	0		0	0	0	0	0
FFS part year, no Rx claims	0	0	0	0	0	0		0	0	0	0	0

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

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

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

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

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

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

TABLE 3

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

NEW HAMPSHIRE, 2004

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**67.5 %**	**15.4**	**$960**	**$63**	**$6,210**	**15.5 %**	**133,163**
Age							
5 and younger	60.7	2.8	100	36	1,601	6.2	29,134
6-14	57.5	4.5	297	66	2,551	11.6	37,483
15-20	62.2	6.3	416	66	3,776	11.0	17,802
21-44	75.4	18.0	1,309	73	7,570	17.3	25,470
45-64	85.2	48.7	3,576	74	15,630	22.9	10,901
65-74	86.2	52.9	2,959	56	14,809	20.0	3,623
75-84	90.4	58.7	2,889	49	20,101	14.4	4,202
85 and older	93.5	56.6	2,477	44	25,635	9.7	4,530
Unknown	0.0	0.0	0	0	0	0.0	18
Basis of Eligibility[e]							
Aged	90.4	56.3	2,762	49	20,624	13.4	12,273
Disabled	85.6	44.1	3,483	79	18,280	19.1	17,631
Adults	71.6	11.8	628	53	2,864	21.9	19,365
Children	59.5	4.1	243	59	2,337	10.4	83,894
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	70.5	18.1	1,053	58	6,343	16.6	76,962
Male	63.5	11.6	832	72	6,027	13.8	56,201
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	68.6	16.3	1,016	63	6,592	15.4	121,225
African American	59.1	6.5	457	71	2,514	18.2	2,964
Other/unknown	55.8	6.2	371	60	2,268	16.4	8,974
Use of Nursing Facilities[f]							
Entire year	98.1	75.0	3,684	49	38,105	9.7	4,687
Part year	96.9	59.2	2,907	49	24,197	12.0	2,456
None	65.8	12.3	821	67	4,673	17.6	126,020
Maintenance Assistance Status							
Cash	74.3	18.8	1,247	66	7,807	16.0	26,272
Medically needy	82.7	39.8	2,425	61	13,767	17.6	12,336
Poverty related	57.2	3.7	203	55	1,669	12.2	63,745
Other/unknown	77.0	26.8	1,696	63	11,217	15.1	30,810

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

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

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

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

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

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

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

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

TABLE 4

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

NEW HAMPSHIRE, 2004

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Number Beneficiaries	Benefit Months
All	**1.7**	**$104**	**15.5 %**	**32.5 %**	**42.9 %**	**6.6 %**	**9.4 %**	**6.4 %**	**2.1 %**	**$671**	**133,163**	**1,232,097**
Age												
5 and younger	0.3	11	6.2	39.3	58.1	1.7	0.6	0.1	0.0	179	29,134	260,518
6-14	0.5	30	11.6	42.5	49.6	4.5	3.0	0.4	0.0	260	37,483	367,212
15-20	0.7	46	11.0	37.8	49.1	7.3	4.9	0.8	0.1	422	17,802	159,417
21-44	2.1	154	17.3	24.6	39.3	12.3	15.4	6.8	1.4	891	25,470	216,491
45-64	4.9	362	22.9	14.8	16.1	10.7	26.1	22.9	9.3	1,584	10,901	107,579
65-74	5.2	292	20.0	13.8	12.8	8.7	26.6	27.0	11.0	1,462	3,623	36,688
75-84	6.0	294	14.4	9.6	8.5	7.9	27.9	33.0	13.0	2,043	4,202	41,345
85 and older	6.0	262	9.7	6.5	7.2	7.4	30.8	36.8	11.4	2,712	4,530	42,821
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	18	26
Basis of Eligibility[e]												
Aged	5.7	282	13.4	9.6	9.3	7.9	28.6	32.7	11.8	2,105	12,273	120,221
Disabled	4.3	338	19.1	14.4	19.8	12.1	26.2	20.2	7.2	1,774	17,631	181,714
Adults	1.5	82	21.9	28.4	43.7	11.6	11.9	3.8	0.6	372	19,365	149,292
Children	0.4	26	10.4	40.5	52.6	4.1	2.5	0.3	0.0	251	83,894	780,870
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.0	115	16.6	29.5	41.9	7.2	10.6	8.0	2.7	691	76,962	706,838
Male	1.2	89	13.8	36.5	44.4	5.7	7.7	4.3	1.4	645	56,201	525,259
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.7	109	15.4	31.4	42.6	6.8	9.9	6.9	2.3	708	121,225	1,128,222
African American	0.7	52	18.2	40.9	47.3	5.4	4.3	1.8	0.4	288	2,964	25,859
Other/unknown	0.7	43	16.4	44.2	45.5	3.8	4.2	1.7	0.5	261	8,974	78,016
Use of Nursing Facilities[f]												
Entire year	7.3	357	9.7	1.9	4.4	5.0	28.3	40.5	19.9	3,688	4,687	48,423
Part year	6.6	324	12.0	3.1	6.9	7.4	28.9	38.8	14.9	2,696	2,456	22,042
None	1.3	89	17.6	34.2	45.1	6.6	8.3	4.5	1.2	507	126,020	1,161,632
Maintenance Assistance Status												
Cash	1.9	128	16.0	25.7	43.0	9.0	12.6	7.7	1.9	800	26,272	256,424
Medically needy	4.5	272	17.6	17.3	19.8	8.9	23.8	22.8	7.5	1,547	12,336	109,807
Poverty related	0.4	23	12.2	42.8	50.9	3.8	2.0	0.4	0.1	189	63,745	563,484
Other/unknown	2.7	173	15.1	23.0	35.6	9.5	16.1	11.3	4.4	1,143	30,810	302,382

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

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

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

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

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

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

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

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

TABLE 5

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

NEW HAMPSHIRE, 2004

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.7**	**$104**	**$63**	**0.7**	**$77**	**$117**	**0.1**	**$8**	**$79**	**0.9**	**$19**	**$21**
Age												
5 and younger	0.3	11	36	0.1	8	82	0.0	1	38	0.2	3	13
6-14	0.5	30	66	0.2	26	107	0.0	1	57	0.2	3	17
15-20	0.7	46	66	0.3	37	111	0.0	3	67	0.3	7	20
21-44	2.1	154	73	0.8	114	145	0.1	15	105	1.2	25	21
45-64	4.9	362	74	1.9	266	137	0.3	34	103	2.7	63	24
65-74	5.2	292	56	2.1	215	102	0.3	18	63	2.8	59	21
75-84	6.0	294	49	2.4	214	90	0.3	15	46	3.3	65	20
85 and older	6.0	262	44	2.2	183	82	0.3	12	37	3.4	67	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.7	282	49	2.2	203	91	0.3	15	47	3.2	64	20
Disabled	4.3	338	79	1.7	252	147	0.3	32	106	2.3	54	24
Adults	1.5	82	53	0.5	58	113	0.1	7	86	0.9	17	18
Children	0.4	26	59	0.2	21	104	0.0	1	56	0.2	4	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.0	115	58	0.8	85	111	0.1	8	71	1.1	22	20
Male	1.2	89	72	0.5	68	128	0.1	7	97	0.6	14	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.7	109	63	0.7	81	117	0.1	8	80	0.9	20	21
African American	0.7	52	71	0.3	41	136	0.0	4	98	0.4	8	19
Other/unknown	0.7	43	60	0.3	34	116	0.0	2	64	0.4	7	18
Use of Nursing Facilities[e]												
Entire year	7.3	357	49	2.8	248	89	0.4	18	46	4.0	90	22
Part year	6.6	324	49	2.5	228	93	0.4	18	49	3.7	77	21
None	1.3	89	67	0.5	67	125	0.1	7	89	0.7	15	20
Maintenance Assistance Status												
Cash	1.9	128	66	0.7	95	128	0.1	11	95	1.1	22	21
Medically needy	4.5	272	61	1.8	200	113	0.3	20	76	2.4	52	22
Poverty related	0.4	23	55	0.2	18	101	0.0	1	61	0.2	4	17
Other/unknown	2.7	173	63	1.1	129	117	0.2	13	76	1.5	31	21

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

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

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

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

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

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

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

TABLE 6

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

NEW HAMPSHIRE, 2004

	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
Therapeutic Category	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.2	0.1	0.0	0.2	$13	$9	$1	$3	$51	$113	$79	$20	140,036	$7,123,594	53,071	39.9 %	564,885
Biologicals	0.2	0.1	0.0	0.1	76	58	3	16	448	560	1,251	242	728	326,010	419	0.3	4,275
Antineoplastic Agents	0.6	0.1	0.0	0.4	102	77	3	22	179	590	166	52	5,889	1,051,745	997	0.7	10,308
Endocrine/Metabolic Drugs	0.7	0.2	0.1	0.3	33	24	3	6	49	98	27	19	175,278	8,635,634	25,129	18.9	263,742
Cardiovascular Agents	1.5	0.5	0.0	0.9	51	35	1	14	34	73	36	15	322,442	11,078,493	20,625	15.5	218,956
Respiratory Agents	0.5	0.3	0.0	0.2	30	26	0	3	59	82	42	18	165,852	9,801,584	30,825	23.1	329,928
Gastrointestinal Agents	0.6	0.2	0.0	0.4	46	33	2	11	71	137	64	29	119,815	8,504,233	17,451	13.1	186,476
Genitourinary Agents	0.4	0.3	0.0	0.1	24	20	1	2	58	77	42	21	29,438	1,716,716	6,841	5.1	72,979
CNS Drugs	1.3	0.6	0.1	0.6	115	90	10	16	88	145	107	26	433,580	38,129,427	31,548	23.7	330,577
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.1	57	52	1	5	83	96	68	37	51,483	4,295,606	6,946	5.2	74,959
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	104	101	0	3	167	174	105	66	20,518	3,422,570	3,097	2.3	32,777
Analgesics and Anesthetics	0.7	0.2	0.0	0.5	37	26	3	9	54	134	180	18	227,792	12,399,195	32,028	24.1	333,024
Neuromuscular Agents	0.9	0.3	0.1	0.4	71	43	16	12	79	138	116	27	155,473	12,293,281	16,187	12.2	173,278
Nutritional Products	0.3	0.0	0.0	0.3	6	1	0	4	19	108	16	15	45,065	851,890	14,127	10.6	147,613
Hematological Agents	0.8	0.2	0.1	0.5	54	45	2	7	68	221	33	13	44,601	3,018,847	5,331	4.0	55,838
Topical Products	0.3	0.1	0.0	0.2	12	8	1	3	42	78	52	20	100,216	4,181,820	33,275	25.0	359,079
Miscellaneous Products	0.5	0.2	0.1	0.3	115	86	13	16	235	500	228	60	4,103	962,944	787	0.6	8,388
Unknown Therapeutic Category	0.5	0.0	0.0	0.0	6	0	0	0	13	0	0	0	3,598	45,929	720	0.5	7,568
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.	2,045,907	127,839,518	n.a.	n.a.	n.a.

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

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

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

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

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

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

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

TABLE 7

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

NEW HAMPSHIRE, 2004

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$23,309,915	16,230	12.2 %	177,906	0.8	$172	$131
ANTIDEPRESSANTS	12,764,117	32,673	24.5	346,483	0.6	60	37
ANTICONVULSANT	10,610,575	14,158	10.6	154,055	0.8	91	69
ANALGESICS - Narcotic	7,347,072	36,796	27.6	386,231	0.4	49	19
ULCER DRUGS	6,512,690	16,321	12.3	176,079	0.5	77	37
ANTIASTHMATIC	6,464,654	29,212	21.9	314,260	0.3	63	21
ANTIHYPERLIPIDEMIC	4,937,822	8,166	6.1	90,046	0.6	87	55
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	4,295,606	8,454	6.3	92,228	0.6	83	47
ANTIDIABETIC	4,029,520	9,385	7.0	100,298	0.7	56	40
NEUROLOGICAL	3,498,837	4,063	3.1	43,271	0.5	159	81
Total	83,770,808	175,458		1,880,857	n.a.	n.a.	n.a.

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

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

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

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

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