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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEW MEXICO, 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]	521,318	(A)	49,360	(E)	471,958	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	507,489	(B)	37,308	(F)	470,181	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	298,939	(C)	36,989	(G)	261,950	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	4,262	(D)	3,887	(H)	375	(L)

Source: Data for this table are from the MAX 2004 file for New Mexico, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 Mexico in 2004 was $99,486,545, of which $203,125 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 MEXICO, 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	**298,939**	**16,492**	**34,013**	**91,708**	**156,413**	**313**	**1,733,951**	**168,374**	**295,614**	**603,550**	**663,773**	**2,640**
Age												
5 and younger	59,845	7	643	0	59,195	0	226,656	41	3,935	0	222,680	0
6-14	68,959	1	1,453	0	67,505	0	314,936	1	10,343	0	304,592	0
15-20	37,554	0	1,361	6,495	29,692	6	177,801	0	8,504	32,778	136,471	48
21-44	88,850	3	9,972	78,711	16	148	613,319	16	82,802	529,271	23	1,207
45-64	19,681	2	13,049	6,473	1	156	151,781	7	109,032	41,382	1	1,359
65-74	10,109	4,839	5,244	23	0	3	105,296	49,782	55,391	97	0	26
75-84	8,380	6,591	1,784	5	0	0	88,506	68,463	20,023	20	0	0
85 and older	5,558	5,049	507	1	1	0	55,651	50,064	5,584	2	1	0
Unknown	3	0	0	0	3	0		0	0	0	5	0
Gender												
Female	187,604	11,329	17,933	80,114	77,915	313	1,167,545	117,304	161,341	558,705	327,555	2,640
Male	111,322	5,163	16,079	11,593	78,487	0	5 566,374	51,070	134,272	44,840	336,192	0
Unknown	13	0	1	1	11	0	32	0	1	5	26	0
Race												
White	68,938	6,930	11,658	23,476	26,734	140	357,160	68,383	97,777	135,733	54,120	1,147
African American	5,641	189	811	1,699	2,940	2	21,215	2,013	6,048	7,884	5,246	24
Other/unknown	224,360	9,373	21,544	66,533	126,739	171	1,355,576	97,978	191,789	459,933	604,407	1,469
Use of Nursing Facilities[c]												
Entire year	4,262	3,437	825	0	0	0	42,509	33,797	8,712	0	0	0
Part year	2,311	1,664	640	6	0	1	22,102	15,935	6,106	52	0	9
None	292,366	11,391	32,548	91,702	156,413	312	1,669,340	118,642	280,796	603,498	663,773	2,631
Maintenance Assistance Status												
Cash	117,123	9,402	29,922	33,251	44,548	0	695,528	101,100	261,128	140,515	192,785	0
Medically needy	0	0	0	0	0	0		0	0	0	0	0
Poverty-related	99,334	201	1,628	8,058	89,134	313	422,174	1,940	10,591	37,165	369,838	2,640
Other/unknown	82,482	6,889	2,463	50,399	22,731	0	616,249	65,334	23,895	425,870	101,150	0
Dual Medicare Status[d]							0					
Full dual, all year	35,875	15,548	19,790	525	5	7	370,559	159,599	207,057	3,822	22	59
Full dual, part year	1,114	543	529	42	0	0	10,894	5,575	4,901	418	0	0
Non-dual, all year	261,950	401	13,694	91,141	156,408	306	1,352,498	3,200	83,656	599,310	663,751	2,581
Managed Care (MC) Status												
Fee-for-service (FFS) all year	152,198	15,850	25,869	53,582	56,590	307	1,380,830	165,163	266,426	479,266	467,373	2,602
FFS part year, with Rx claims	33,258	200	3,802	12,591	16,660	5	103,241	1,591	16,007	46,038	39,569	36
FFS part year, no Rx claims	113,483	442	4,342	25,535	83,163	1	249,880	1,620	13,181	78,246	156,831	2

Source: Data for this table are from the MAX 2004 file for New Mexico, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 MEXICO, 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	**33.6 %**	**6.1**	**$332**	**$55**	**$4,286**	**7.7 %**	**298,939**
Age							
5 and younger	24.6	0.7	25	35	2,294	1.1	59,845
6-14	20.7	0.7	32	45	1,452	2.2	68,959
15-20	28.3	1.1	57	50	2,635	2.2	37,554
21-44	33.9	3.5	233	66	3,557	6.5	88,850
45-64	55.4	21.6	1,383	64	11,070	12.5	19,681
65-74	77.2	35.7	1,778	50	12,772	13.9	10,109
75-84	84.6	41.7	2,043	49	17,780	11.5	8,380
85 and older	87.6	41.2	1,882	46	23,881	7.9	5,558
Unknown	0.0	0.0	0	0	1,057	0.0	3
Basis of Eligibility[e]							
Aged	80.9	37.6	1,815	48	17,444	10.4	16,492
Disabled	69.8	27.6	1,763	64	15,498	11.4	34,013
Adults	29.9	1.5	54	37	1,966	2.7	91,708
Children	22.8	0.7	26	37	1,802	1.5	156,413
Unknown	75.1	15.3	926	61	13,036	7.1	313
Gender							
Female	35.1	6.6	341	52	4,159	8.2	187,604
Male	31.0	5.2	317	61	4,499	7.0	111,322
Unknown	46.2	1.2	39	34	1,234	3.2	13
Race							
White	36.1	10.7	619	58	6,398	9.7	68,938
African American	26.6	5.8	323	56	4,003	8.1	5,641
Other/unknown	33.0	4.6	244	53	3,644	6.7	224,360
Use of Nursing Facilities[f]							
Entire year	96.5	70.4	3,623	52	40,741	8.9	4,262
Part year	93.5	51.2	2,689	53	29,517	9.1	2,311
None	32.2	4.8	266	56	3,555	7.5	292,366
Maintenance Assistance Status							
Cash	42.2	9.8	552	57	5,414	10.2	117,123
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	25.0	1.0	52	50	2,145	2.4	99,334
Other/unknown	31.6	6.9	358	52	5,262	6.8	82,482

Source: Data for this table are from the MAX 2004 file for New Mexico, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 MEXICO, 2004

				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	**1.0**	**$57**	**7.7 %**	**66.4 %**	**21.3 %**	**3.7 %**	**5.0 %**	**2.9 %**	**0.7 %**	**$739**	**298,939**	**1,733,951**
Age												
5 and younger	0.2	7	1.1	75.4	20.9	2.5	1.2	0.1	0.0	606	59,845	226,656
6-14	0.2	7	2.2	79.3	17.5	1.9	1.2	0.1	0.0	318	68,959	314,936
15-20	0.2	12	2.2	71.7	23.3	2.9	1.8	0.3	0.0	557	37,554	177,801
21-44	0.5	34	6.5	66.1	25.3	3.4	3.5	1.4	0.3	515	88,850	613,319
45-64	2.8	179	12.5	44.6	17.2	8.1	15.4	11.0	3.6	1,435	19,681	151,781
65-74	3.4	171	13.9	22.8	21.2	10.5	24.0	16.8	4.8	1,226	10,109	105,296
75-84	3.9	194	11.5	15.4	17.5	10.8	28.7	22.4	5.2	1,684	8,380	88,506
85 and older	4.1	188	7.9	12.4	15.1	10.5	33.0	24.3	4.8	2,385	5,558	55,651
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	634	3	5
Basis of Eligibility[e]												
Aged	3.7	178	10.4	19.1	17.9	10.3	27.6	20.4	4.8	1,709	16,492	168,374
Disabled	3.2	203	11.4	30.2	22.6	10.0	19.9	13.5	3.8	1,783	34,013	295,614
Adults	0.2	8	2.7	70.1	24.8	2.7	1.9	0.5	0.1	299	91,708	603,550
Children	0.2	6	1.5	77.2	19.3	2.3	1.2	0.1	0.0	425	156,413	663,773
Unknown	1.8	110	7.1	24.9	42.5	11.8	15.3	5.1	0.3	1,546	313	2,640
Gender												
Female	1.1	55	8.2	64.9	22.4	3.6	5.1	3.1	0.8	668	187,604	1,167,545
Male	1.0	62	7.0	69.0	19.5	3.8	4.8	2.4	0.6	884	111,322	566,374
Unknown	0.5	16	3.2	53.8	23.1	15.4	7.7	0.0	0.0	501	13	32
Race												
White	2.1	120	9.7	63.9	15.6	4.7	8.1	5.9	1.8	1,235	68,938	357,160
African American	1.5	86	8.1	73.4	12.5	4.9	5.3	3.3	0.7	1,064	5,641	21,215
Other/unknown	0.8	40	6.7	67.0	23.2	3.4	4.1	1.9	0.4	603	224,360	1,355,576
Use of Nursing Facilities[f]												
Entire year	7.1	363	8.9	3.5	5.8	6.4	30.2	38.1	16.0	4,085	4,262	42,509
Part year	5.4	281	9.1	6.5	11.7	9.4	32.0	29.9	10.5	3,086	2,311	22,102
None	0.8	47	7.5	67.8	21.6	3.6	4.4	2.1	0.4	623	292,366	1,669,340
Maintenance Assistance Status												
Cash	1.6	93	10.2	57.8	22.1	5.8	8.7	4.6	1.0	912	117,123	695,528
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	12	2.4	75.0	20.7	2.5	1.5	0.2	0.0	505	99,334	422,174
Other/unknown	0.9	48	6.8	68.4	20.8	2.2	4.0	3.5	1.1	704	82,482	616,249

Source: Data for this table are from the MAX 2004 file for New Mexico, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 MEXICO, 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	**1.0**	**$57**	**$55**	**0.4**	**$42**	**$112**	**0.1**	**$4**	**$54**	**0.6**	**$11**	**$19**
Age												
5 and younger	0.2	7	35	0.0	4	114	0.0	0	32	0.1	2	13
6-14	0.2	7	45	0.1	5	94	0.0	0	41	0.1	1	16
15-20	0.2	12	50	0.1	8	115	0.0	1	52	0.1	3	18
21-44	0.5	34	66	0.2	24	144	0.0	3	68	0.3	7	22
45-64	2.8	179	64	1.0	132	131	0.2	15	67	1.6	33	21
65-74	3.4	171	50	1.3	125	98	0.2	11	49	1.9	34	18
75-84	3.9	194	49	1.5	144	94	0.3	12	42	2.1	38	18
85 and older	4.1	188	46	1.5	137	92	0.3	11	37	2.3	39	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	3.7	178	48	1.4	132	94	0.3	11	41	2.0	35	18
Disabled	3.2	203	64	1.2	151	129	0.2	16	65	1.8	36	21
Adults	0.2	8	37	0.1	4	78	0.0	1	46	0.1	3	19
Children	0.2	6	37	0.0	4	94	0.0	0	37	0.1	2	14
Unknown	1.8	110	61	0.5	78	144	0.1	6	61	1.2	26	22
Gender												
Female	1.1	55	52	0.4	40	105	0.1	4	52	0.6	11	19
Male	1.0	62	61	0.4	46	127	0.1	4	59	0.6	11	20
Unknown	0.5	16	34	0.2	13	69	0.0	0	0	0.3	3	11
Race												
White	2.1	120	58	0.8	88	113	0.1	9	60	1.1	23	20
African American	1.5	86	56	0.5	64	116	0.1	6	63	0.9	16	18
Other/unknown	0.8	40	53	0.3	29	111	0.1	3	50	0.4	8	18
Use of Nursing Facilities[e]												
Entire year	7.1	363	52	2.7	277	101	0.6	23	36	3.6	62	17
Part year	5.4	281	53	2.0	206	104	0.4	20	46	2.9	55	19
None	0.8	47	56	0.3	34	115	0.1	4	59	0.5	9	20
Maintenance Assistance Status												
Cash	1.6	93	57	0.6	68	116	0.1	7	59	0.9	18	19
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.2	12	50	0.1	9	119	0.0	1	52	0.2	2	16
Other/unknown	0.9	48	52	0.3	35	103	0.1	4	46	0.5	10	19

Source: Data for this table are from the MAX 2004 file for New Mexico, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 Mexico, 1.0 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, 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	0.3	0.1	0.0	0.2	$14	$9	$1	$3	$52	$120	$72	$20	107,786	$5,617,634	47,264	15.8 %	415,720
Biologicals	0.1	0.1	0.0	0.0	28	18	0	9	256	195	141	770	3,066	784,682	2,583	0.9	28,413
Antineoplastic Agents	0.5	0.1	0.0	0.4	72	49	2	21	138	497	141	51	7,183	991,875	1,364	0.5	13,837
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.4	32	22	3	7	42	80	28	18	254,558	10,652,913	35,023	11.7	337,329
Cardiovascular Agents	1.4	0.5	0.1	0.9	48	34	2	12	33	74	31	13	364,138	12,063,748	24,432	8.2	251,543
Respiratory Agents	0.5	0.3	0.0	0.2	25	22	0	3	51	80	26	16	140,536	7,150,211	32,941	11.0	281,200
Gastrointestinal Agents	0.6	0.3	0.0	0.4	53	39	1	13	83	143	74	37	125,855	10,424,294	19,439	6.5	196,602
Genitourinary Agents	0.4	0.2	0.0	0.1	24	20	2	3	58	80	54	22	31,142	1,804,234	7,448	2.5	73,787
CNS Drugs	1.1	0.5	0.1	0.5	87	70	5	12	80	143	84	22	253,281	20,200,934	25,145	8.4	232,965
Stimulants/Anti-obesity/Anorexia	0.5	0.4	0.0	0.2	42	35	1	6	76	98	54	34	7,538	575,425	2,191	0.7	13,719
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	122	120	0	1	169	172	105	71	15,700	2,648,102	2,094	0.7	21,664
Analgesics and Anesthetics	0.5	0.1	0.0	0.4	26	19	1	6	49	132	57	15	200,208	9,740,608	40,106	13.4	376,985
Neuromuscular Agents	0.8	0.2	0.2	0.4	57	28	18	11	69	137	91	26	109,616	7,560,318	13,686	4.6	132,234
Nutritional Products	0.5	0.0	0.0	0.4	7	0	0	6	14	19	20	14	46,769	667,967	11,323	3.8	100,088
Hematological Agents	0.7	0.2	0.1	0.4	64	55	4	5	90	258	30	14	47,142	4,223,316	6,413	2.1	65,925
Topical Products	0.3	0.1	0.0	0.2	11	7	1	4	37	73	52	19	76,129	2,846,155	26,371	8.8	251,168
Miscellaneous Products	0.3	0.2	0.0	0.1	51	39	5	7	186	232	233	83	5,631	1,049,310	2,204	0.7	20,650
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	7	0	0	0	20	0	0	0	14,009	281,694	4,057	1.4	43,286
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.	1,810,287	99,283,420	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for New Mexico, released by CMS in 00/2007. This table was produced on 04/10/2008.

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 Mexico, 1.0 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 MEXICO, 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	$12,037,049	9,802	3.3 %	95,564	0.7	$173	$126
ULCER DRUGS	8,610,554	18,932	6.3	194,928	0.5	89	44
ANTIDEPRESSANTS	6,791,618	21,869	7.3	205,814	0.6	57	33
ANTICONVULSANT	6,147,670	10,042	3.4	99,459	0.7	83	62
ANTIDIABETIC	5,511,963	16,774	5.6	176,444	0.6	52	31
ANTIHYPERLIPIDEMIC	4,904,228	9,253	3.1	100,210	0.6	85	49
ANALGESICS - ANTI-INFLAMMATORY	4,636,431	29,846	10.0	296,222	0.3	56	16
ANALGESICS - Narcotic	4,101,288	32,751	11.0	317,807	0.3	40	13
ANTIASTHMATIC	4,053,980	23,147	7.7	209,230	0.3	57	19
ANTIHYPERTENSIVE	2,983,804	17,317	5.8	183,893	0.6	27	16
Total	59,778,585	189,733		1,879,571	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for New Mexico, released by CMS in 00/2007. This table was produced on 04/10/2008.

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.