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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2005
NEW MEXICO

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEW MEXICO, 2005

Inclusion Criteria (2005)	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]	527702 (A)	51253 (E)	476449 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	509704 (B)	38320 (F)	471384 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	336056 (C)	38012 (G)	298044 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	4030 (D)	3670 (H)	360 (L)

Source: Data for this table are from the MAX 2005 file for New Mexico, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 2005 (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 2005, 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 2005 was $44,023,959, of which $244,496 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 26 states in 2005 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NE, NY, 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 2005 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer05.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 2005. 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 N+B18D.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 2005. 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, 2005

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**336,056**	**16,604**	**34,828**	**97,125**	**187,212**	**287**	**1,825,585**	**171,674**	**325,501**	**602,583**	**723,206**	**2,621**
Age												
5 and younger	70,778	3	661	0	70,114	0	252,828	10	4,287	0	248,531	0
6-14	83,092	0	1,341	0	81,751	0	338,424	0	10,548	0	327,876	0
15-20	43,414	0	1,346	6,731	35,337	0	189,048	0	9,433	32,853	146,762	0
21-44	93,080	3	10,092	82,872	6	107	615,978	28	91,263	523,808	21	858
45-64	21,174	3	13,496	7,497	3	175	169,184	5	121,651	45,783	5	1,740
65-74	10,213	4,737	5,451	20	0	5	110,624	49,892	60,599	110	0	23
75-84	8,663	6,725	1,934	4	0	0	93,543	71,414	22,103	26	0	0
85 and older	5,641	5,133	507	1	0	0	55,945	50,325	5,617	3	0	0
Unknown	1	0	0	0	1	0	11	0	0	0	11	0
Gender												
Female	208,417	11,355	18,453	84,871	93,451	287	1,212,647	118,465	177,293	555,282	358,986	2,621
Male	127,632	5,249	16,375	12,253	93,755	0	612,927	53,209	148,208	47,300	364,210	0
Unknown	7	0	0	1	6	0	11	0	0	1	10	0
Race												
White	74,799	7,033	12,133	24,010	31,502	121	381,765	69,725	111,046	132,977	66,961	1,056
African American	6,770	195	844	1,894	3,836	1	24,673	1,927	6,812	8,377	7,554	3
Other/unknown	254,487	9,376	21,851	71,221	151,874	165	1,419,147	100,022	207,643	461,229	648,691	1,562
Use of Nursing Facilities[c]												
Entire year	4,030	3,228	802	0	0	0	40,869	32,055	8,814	0	0	0
Part year	2,591	1,882	706	3	0	0	24,142	17,373	6,757	12	0	0
None	329,435	11,494	33,320	97,122	187,212	287	1,760,574	122,246	309,930	602,571	723,206	2,621
Maintenance Assistance Status												
Cash	129,560	9,332	30,255	36,767	53,206	0	751,888	103,809	285,857	149,533	212,689	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	117,346	180	1,962	8,142	106,775	287	455,746	1,706	13,527	37,600	400,292	2,621
Other/unknown	89,150	7,092	2,611	52,216	27,231	0	617,951	66,159	26,117	415,450	110,225	0
Dual Medicare Status[d]												
Full dual, all year	36,731	15,552	20,608	558	4	9	391,270	161,526	225,348	4,308	35	53
Full dual, part year	1,281	602	611	68	0	0	13,052	6,362	5,973	717	0	0
Non-dual, all year	298,044	450	13,609	96,499	187,208	278	1,421,263	3,786	94,180	597,558	723,171	2,568
Managed Care (MC) Status												
Fee-for-service (FFS) all year	156,009	16,504	27,630	53,688	57,903	284	1,382,842	171,186	298,759	460,314	449,989	2,594
FFS part year, with Rx claims	37,155	21	2,851	13,312	20,968	3	108,899	69	10,152	47,242	51,409	27
FFS part year, no Rx claims	142,892	79	4,347	30,125	108,341	0	333,844	419	16,590	95,027	221,808	0

Source: Data for this table are from the MAX 2005 file for New Mexico, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 2005. 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, 2005

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	**25.5**	**2.6**	**$130**	**$51**	**$4,061**	**3.2**	**336,056**
Age							
5 and younger	22.8	0.6	21	35	2,260	0.9	70,778
6-14	19.5	0.6	25	44	1,437	1.7	83,092
15-20	24.5	0.9	41	47	2,211	1.9	43,414
21-44	28.8	1.8	88	50	3,656	2.4	93,080
45-64	32.6	7.8	478	62	10,961	4.4	21,174
65-74	27.9	10.8	556	51	11,992	4.6	10,213
75-84	36.1	17.6	881	50	18,023	4.9	8,663
85 and older	55.0	25.5	1,208	47	24,505	4.9	5,641
Unknown	100.0	1.0	12	12	1,166	1.0	1
Basis of Eligibility[e]							
Aged	41.3	19.5	962	49	17,976	5.4	16,604
Disabled	34.0	8.7	542	63	15,419	3.5	34,828
Adults	28.4	1.3	48	37	2,108	2.3	97,125
Children	21.0	0.6	21	36	1,709	1.2	187,212
Unknown	85.7	19.6	1,433	73	15,828	9.1	287
Gender							
Female	27.0	2.8	134	48	4,003	3.3	208,417
Male	23.0	2.2	124	56	4,156	3.0	127,632
Unknown	14.3	0.6	33	59	586	5.7	7
Race							
White	23.0	4.0	210	53	6,418	3.3	74,799
African American	17.3	1.3	64	50	3,555	1.8	6,770
Other/unknown	26.5	2.2	109	50	3,382	3.2	254,487
Use of Nursing Facilities[f]							
Entire year	95.4	71.0	3,763	53	44,373	8.5	4,030
Part year	79.0	37.0	1,971	53	28,792	6.8	2,591
None	24.2	1.5	71	49	3,373	2.1	329,435
Maintenance Assistance Status							
Cash	27.1	2.7	142	52	5,111	2.8	129,560
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	22.1	0.7	29	42	2,027	1.4	117,346
Other/unknown	27.8	4.8	246	51	5,213	4.7	89,150

Source: Data for this table are from the MAX 2005 file for New Mexico, released by CMS in 11/2008. This table was produced on 04/23/2009.

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

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

c. In eight states (DE, IA, IL, NE, NY, 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 eight states (DE, IA, IL, 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, 2005

				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	**0.5**	**$24**	**3.2**	**74.5**	**18.8**	**2.7**	**2.6**	**1.1**	**0.3**	**$748**	**336,056**	**1,825,585**
Age												
5 and younger	0.2	6	0.9	77.2	19.3	2.3	1.0	0.1	0.0	633	70,778	252,828
6-14	0.1	6	1.7	80.5	16.3	2.0	1.1	0.1	0.0	353	83,092	338,424
15-20	0.2	9	1.9	75.5	20.5	2.4	1.5	0.2	0.0	508	43,414	189,048
21-44	0.3	13	2.4	71.2	23.0	2.7	2.3	0.7	0.2	553	93,080	615,978
45-64	1.0	60	4.4	67.4	14.8	5.2	7.5	3.8	1.3	1,372	21,174	169,184
65-74	1.0	51	4.6	72.1	10.5	4.3	7.1	4.4	1.6	1,107	10,213	110,624
75-84	1.6	82	4.9	63.9	9.0	4.4	10.4	9.3	3.0	1,669	8,663	93,543
85 and older	2.6	122	4.9	45.0	10.1	6.6	18.6	16.0	3.7	2,471	5,641	55,945
Unknown	0.1	1	1.0	0.0	100.0	0.0	0.0	0.0	0.0	106	1	11
Basis of Eligibility[e]												
Aged	1.9	93	5.4	58.7	9.6	4.7	12.5	11.2	3.2	1,739	16,604	171,674
Disabled	0.9	58	3.5	66.0	16.2	5.3	7.6	3.7	1.2	1,650	34,828	325,501
Adults	0.2	8	2.3	71.6	23.3	2.6	2.0	0.5	0.1	340	97,125	602,583
Children	0.1	5	1.2	79.0	17.7	2.1	1.1	0.1	0.0	442	187,212	723,206
Unknown	2.1	157	9.1	14.3	43.2	15.0	18.8	7.3	1.4	1,733	287	2,621
Gender												
Female	0.5	23	3.3	73.0	20.1	2.7	2.7	1.2	0.3	688	208,417	1,212,647
Male	0.5	26	3.0	77.0	16.6	2.7	2.5	1.0	0.3	865	127,632	612,927
Unknown	0.4	21	5.7	85.7	0.0	14.3	0.0	0.0	0.0	373	7	11
Race												
White	0.8	41	3.3	77.0	13.0	3.0	3.6	2.4	0.8	1,257	74,799	381,765
African American	0.4	17	1.8	82.7	11.5	2.6	2.0	0.9	0.2	975	6,770	24,673
Other/unknown	0.4	20	3.2	73.5	20.6	2.6	2.3	0.8	0.2	606	254,487	1,419,147
Use of Nursing Facilities[f]												
Entire year	7.0	371	8.5	4.6	5.2	6.8	29.3	39.0	15.2	4,376	4,030	40,869
Part year	4.0	212	6.8	21.0	13.6	9.4	27.2	22.4	6.4	3,090	2,591	24,142
None	0.3	13	2.1	75.8	19.0	2.6	2.1	0.5	0.1	631	329,435	1,760,574
Maintenance Assistance Status												
Cash	0.5	25	2.8	72.9	18.4	3.7	3.6	1.1	0.3	881	129,560	751,888
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	8	1.4	77.9	18.5	2.1	1.2	0.1	0.0	522	117,346	455,746
Other/unknown	0.7	36	4.7	72.2	19.5	2.0	3.0	2.4	0.8	752	89,150	617,951

Source: Data for this table are from the MAX 2005 file for New Mexico, released by CMS in 11/2008. This table was produced on 04/23/2009.

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

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

c. In eight states (DE, IA, IL, NE, NY, 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 eight states (DE, IA, IL, 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, 2005

	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	**0.5**	**$24**	**$51**	**0.1**	**$17**	**$114**	**0.0**	**$2**	**$51**	**0.3**	**$6**	**$19**
Age												
5 and younger	0.2	6	35	0.0	4	118	0.0	0	37	0.1	2	13
6-14	0.1	6	44	0.0	4	98	0.0	1	63	0.1	1	16
15-20	0.2	9	47	0.1	6	124	0.0	1	50	0.1	2	18
21-44	0.3	13	50	0.1	8	122	0.0	2	60	0.2	4	21
45-64	1.0	60	62	0.3	43	145	0.1	5	56	0.6	12	21
65-74	1.0	51	51	0.3	37	110	0.1	3	40	0.6	11	19
75-84	1.6	82	50	0.6	60	102	0.1	4	39	0.9	18	19
85 and older	2.6	122	47	0.9	86	96	0.1	6	48	1.5	30	19
Unknown	0.1	1	12	0.0	0	0	0.0	0	0	0.1	1	12
Basis of Eligibility[d]												
Aged	1.9	93	49	0.7	67	99	0.1	5	45	1.1	21	20
Disabled	0.9	58	63	0.3	42	144	0.1	5	56	0.5	11	21
Adults	0.2	8	37	0.0	4	87	0.0	1	49	0.1	3	20
Children	0.1	5	36	0.0	3	96	0.0	0	47	0.1	2	15
Unknown	2.1	157	73	0.7	122	171	0.1	4	61	1.4	31	23
Gender												
Female	0.5	23	48	0.1	16	108	0.0	2	48	0.3	6	19
Male	0.5	26	56	0.1	19	125	0.0	2	56	0.3	5	19
Unknown	0.4	21	59	0.2	20	108	0.0	0	0	0.2	2	9
Race												
White	0.8	41	53	0.3	29	106	0.0	2	53	0.5	10	21
African American	0.4	17	50	0.1	12	104	0.0	1	50	0.2	4	20
Other/unknown	0.4	20	50	0.1	13	120	0.0	2	50	0.2	5	18
Use of Nursing Facilities[e]												
Entire year	7.0	371	53	2.6	273	105	0.4	18	45	4.0	79	20
Part year	4.0	212	53	1.4	153	108	0.2	10	54	2.4	49	21
None	0.3	13	49	0.1	9	123	0.0	1	53	0.2	3	19
Maintenance Assistance Status												
Cash	0.5	25	52	0.1	17	132	0.0	2	50	0.3	5	18
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.2	8	42	0.0	5	113	0.0	1	51	0.1	2	16
Other/unknown	0.7	36	51	0.2	25	103	0.0	2	51	0.4	8	21

Source: Data for this table are from the MAX 2005 file for New Mexico, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 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)

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, 2005

	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	0.0	0.0	0.2	$9	$4	$2	$3	$37	$97	$59	$18	72,394	$2,645,532	39,837	11.9	297,215
Biologicals	0.1	0.1	0.0	0.0	19	13	5	1	180	158	2,422	37	4,111	740,545	3,513	1.0	38,569
Antineoplastic Agents	0.5	0.1	0.0	0.4	80	59	1	20	162	531	121	53	3,793	615,003	820	0.2	7,735
Endocrine/Metabolic Drugs	0.6	0.2	0.1	0.3	26	16	4	6	43	86	40	19	132,490	5,705,222	25,835	7.7	221,106
Cardiovascular Agents	1.2	0.3	0.1	0.8	39	28	1	10	32	85	18	12	144,820	4,621,807	12,794	3.8	117,278
Respiratory Agents	0.4	0.1	0.0	0.2	17	13	1	3	45	92	52	14	70,069	3,121,394	26,301	7.8	182,978
Gastrointestinal Agents	0.6	0.2	0.0	0.4	40	26	0	14	71	141	52	37	51,735	3,690,397	10,349	3.1	91,382
Genitourinary Agents	0.4	0.2	0.0	0.2	23	17	1	4	55	77	52	24	15,738	869,490	4,422	1.3	38,643
CNS Drugs	1.0	0.5	0.0	0.4	77	67	1	9	79	129	55	20	114,836	9,049,238	15,016	4.5	117,467
Stimulants/Anti-obesity/Anorexia	0.5	0.4	0.0	0.1	40	36	1	3	82	100	44	26	5,450	444,716	2,167	0.6	11,188
Miscellaneous Psychological/ Neurological Agents	0.9	0.9	0.0	0.0	140	139	0	0	148	148	67	76	12,656	1,872,487	1,343	0.4	13,407
Analgesics and Anesthetics	0.4	0.0	0.0	0.3	14	6	3	5	33	117	77	16	88,540	2,940,340	26,875	8.0	214,210
Neuromuscular Agents	0.7	0.2	0.1	0.5	47	23	5	19	63	137	56	39	49,165	3,107,222	8,100	2.4	66,583
Nutritional Products	0.4	0.0	0.0	0.4	6	0	0	5	15	35	24	14	24,541	359,338	7,734	2.3	62,040
Hematological Agents	0.8	0.2	0.1	0.4	66	58	2	6	87	287	17	13	24,381	2,121,506	3,452	1.0	32,344
Topical Products	0.3	0.1	0.0	0.2	9	4	1	3	32	72	50	18	40,282	1,269,345	18,242	5.4	148,904
Miscellaneous Products	0.2	0.1	0.0	0.1	29	24	2	3	134	167	218	47	3,464	463,728	1,916	0.6	15,959
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	5	0	0	0	22	0	0	0	6,323	142,153	2,944	0.9	30,767
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.	864,788	43,779,463	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for New Mexico, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 2005.

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, 2005

		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	$5,629,038	5,744	1.7	50,068	0.7	$154	$112
ANTIDEPRESSANTS	2,966,845	12,391	3.7	100,579	0.5	54	29
ULCER DRUGS	2,752,513	9,217	2.7	82,489	0.5	71	33
ANTIDIABETIC	2,687,119	9,333	2.8	89,027	0.5	57	30
ANTICONVULSANT	2,465,681	5,325	1.6	45,412	0.7	76	54
ANTIASTHMATIC	2,069,939	18,076	5.4	136,628	0.3	53	15
CONTRACEPTIVES	2,013,765	13,968	4.2	122,051	0.4	41	16
ANTIHYPERLIPIDEMIC	1,972,141	3,974	1.2	38,585	0.5	100	51
MISC PSYCHOTHERAPEUTIC AND NEUROLOGICAL	1,877,133	1,695	0.5	16,895	0.8	147	111
ANALGESICS - Narcotic	1,454,948	19,997	6.0	162,450	0.3	30	9
Total	25,889,122	99,720		844,184	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for New Mexico, released by CMS in 11/2008. This table was produced on 04/23/2009.

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 2005. 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 2005. 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.