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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006
NEW HAMPSHIRE

LIST OF TABLES

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

Inclusion Criteria (2006)	Number of Dual and Nondual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Nondual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	142225 (A)	27057 (E)	115168 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	137651 (B)	22523 (F)	115128 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	137651 (C)	22523 (G)	115128 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	4507 (D)	4330 (H)	177 (L)

Source: Data for this table are from the MAX 2006 file for New Hampshire, released by CMS in 10/2009. This table was produced on 02/11/2010.
a. MAX data element "Eligible Months Count" was used to determine an individual's Medicaid eligibility. All individuals who had a value greater than zero were considered as beneficiaries and counted in Cell A.
b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2006 (based on MAX data element "Eligible Restricted Benefits Flag").
c. Cell C represents the study population for Tables 2 through 7. Cell C was obtained by excluding from Cell B beneficiaries who were in managed care (MC) plans that included prescription drugs in their capitated benefit package during all months of Medicaid eligibility in 2006, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.
d. The total Medicaid pharmacy reimbursement for New Hampshire in 2006 was $88,127,444, of which $2,701 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.
e. Enrollees in prepaid health plans (PHP) or managed care (MC) plans that did not provide a pharmacy benefit are treated as having fee-for-service pharmacy benefit coverage. There were 29 states in 2006 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, KY, MA, MI, MS, NC, NH, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, and WI. In addition, there were 10 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NC, NE, NY, TN, TX, UT, and WV). These lists were constructed from the CMS 2006 Medicaid Managed Care Enrollment Report and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit package.
f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2006. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.
g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit. Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2006. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.
Characteristics of non-dual eligible beneficiaries represented by Cell J are shown in Appendix Table A.1 and characteristics of non-dual eligible beneficiaries and their benefit months included in Cell J but excluded from Cell K are shown in Appendix Table A.2. Characteristics of dual eligible beneficiaries represented by Cell F are shown in Appendix Table A.3, and characteristics of dual eligible beneficiaries and their benefit months included in Cell F but excluded from Cell G are shown in Appendix Table A.4.
Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; HMO = health maintenance organization; MAX = Medicaid Analytic Extract; MC = managed care; PCCM = primary care case management; PHP = prepaid health plan.

TABLE 2

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

NEW HAMPSHIRE, 2006

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**137,651**	**11,807**	**19,176**	**20,036**	**86,632**	**0**	**1,290,420**	**116,549**	**200,482**	**155,006**	**818,383**	**0**
Age												
5 and younger	30,070	0	44	0	30,026	0	272,673	0	475	0	272,198	0
6-14	37,745	0	73	0	37,672	0	376,284	0	860	0	375,424	0
15-20	19,344	0	569	0	18,775	0	176,032	0	5,977	0	170,055	0
21-44	26,429	0	8,164	18,107	158	0	227,264	0	86,686	139,884	694	0
45-64	12,164	0	10,235	1,928	1	0	120,806	0	105,684	15,110	12	0
65-74	3,493	3,418	74	1	0	0	35,492	34,877	603	12	0	0
75-84	3,991	3,978	13	0	0	0	39,582	39,430	152	0	0	0
85 and older	4,415	4,411	4	0	0	0	42,287	42,242	45	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	79,319	8,935	10,387	17,291	42,706	0	738,046	89,541	110,004	136,737	401,764	0
Male	58,332	2,872	8,789	2,745	43,926	0	552,374	27,008	90,478	18,269	416,619	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	125,211	11,180	18,425	18,114	77,492	0	1,176,165	110,335	192,924	140,801	732,105	0
African American	3,235	67	256	662	2,250	0	30,114	637	2,570	5,065	21,842	0
Other/unknown	9,205	560	495	1,260	6,890	0	84,141	5,577	4,988	9,140	64,436	0
Use of Nursing Facilities[c]												
Entire year	4,507	4,185	317	0	5	0	46,865	43,367	3,438	0	60	0
Part year	2,605	2,163	422	13	7	0	23,351	18,946	4,207	114	84	0
None	130,539	5,459	18,437	20,023	86,620	0	1,220,204	54,236	192,837	154,892	818,239	0
Maintenance Assistance Status												
Cash	24,490	1,488	7,306	4,878	10,818	0	240,984	16,804	80,716	38,592	104,872	0
Medically needy	12,066	4,657	3,095	2,771	1,543	0	105,863	41,742	28,663	20,573	14,885	0
Poverty-related	67,511	739	1,146	4,115	61,511	0	609,703	6,968	11,304	24,240	567,191	0
Other/unknown	33,584	4,923	7,629	8,272	12,760	0	333,870	51,035	79,799	71,601	131,435	0
Dual Medicare Status[d]												
Full dual, all year	19,607	9,820	8,824	956	7	0	201,965	97,528	95,624	8,733	80	0
Full dual, part year	2,916	1,072	1,702	142	0	0	29,404	10,532	17,349	1,523	0	0
Non-dual, all year	115,128	915	8,650	18,938	86,625	0	1,059,051	8,489	87,509	144,750	818,303	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	137,651	11,807	19,176	20,036	86,632	0	1,290,420	116,549	200,482	155,006	818,383	0
FFS part year, with Rx claims	0	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	0

Source: Data for this table are from the MAX 2006 file for New Hampshire, released by CMS in 10/2009. This table was produced on 02/11/2010.

a. Table 2 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.
b. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services. The total includes some beneficiaries with unknown basis of eligibility and some whose age categories are not consistent with basis of eligibility.
c. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.
d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2006. The “Full

dual, part year" group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.
Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service pharmacy benefit; MAX = Medicaid Analytic Extract; MC = managed care; Rx = pharmacy benefit.

TABLE 3

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

NEW HAMPSHIRE, 2006

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**59.6**	**9.9**	**$640**	**$65**	**$6,334**	**10.1**	**137,651**
Age							
5 and younger	60.5	4.0	167	42	2,033	8.2	30,070
6-14	58.3	6.3	471	75	2,894	16.3	37,745
15-20	62.4	8.5	599	71	4,399	13.6	19,344
21-44	66.5	15.5	990	64	7,678	12.9	26,429
45-64	61.6	28.2	1,996	71	14,683	13.6	12,164
65-74	41.3	10.8	551	51	13,673	4.0	3,493
75-84	38.9	6.8	249	37	19,052	1.3	3,991
85 and older	37.5	4.1	80	19	25,164	0.3	4,415
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	39.0	6.9	272	39	19,785	1.4	11,807
Disabled	60.2	25.9	1,997	77	17,518	11.4	19,176
Adults	69.9	13.9	698	50	3,136	22.3	20,036
Children	59.9	5.8	377	65	2,765	13.6	86,632
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	61.3	10.9	641	59	6,321	10.1	79,319
Male	57.3	8.4	639	76	6,353	10.1	58,332
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	60.0	10.2	660	65	6,686	9.9	125,211
African American	56.4	6.6	497	76	2,984	16.6	3,235
Other/unknown	54.8	6.5	423	66	2,726	15.5	9,205
Use of Nursing Facilities[f]							
Entire year	45.2	9.0	332	37	37,603	0.9	4,507
Part year	48.9	11.6	605	52	23,267	2.6	2,605
None	60.3	9.9	652	66	4,917	13.3	130,539
Maintenance Assistance Status							
Cash	68.0	18.7	1,292	69	8,701	14.8	24,490
Medically needy	50.5	9.9	616	62	13,520	4.6	12,066
Poverty related	56.5	4.6	275	60	1,940	14.2	67,511
Other/unknown	62.9	14.0	907	65	10,859	8.4	33,584

Source: Data for this table are from the MAX 2006 file for New Hampshire, released by CMS in 10/2009. This table was produced on 02/11/2010.

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

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

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

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

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability

or blindness. The children's group includes children receiving foster care and adoptive services.
f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.
Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; OTC = over-the-counter; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 4

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

NEW HAMPSHIRE, 2006

				Number of Rx, Percentage with:							Number	
Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Beneficiaries	Benefit Months
All	**1.1**	**$68**	**10.1**	**40.4**	**42.1**	**7.0**	**6.7**	**2.7**	**1.1**	**$676**	**137,651**	**1,290,420**
Age												
5 and younger	0.4	18	8.2	39.5	54.0	4.0	2.2	0.3	0.0	224	30,070	272,673
6-14	0.6	47	16.3	41.7	46.4	5.7	5.1	1.0	0.2	290	37,745	376,284
15-20	0.9	66	13.6	37.6	44.6	8.5	7.1	1.7	0.3	483	19,344	176,032
21-44	1.8	115	12.9	33.5	35.6	10.7	12.7	5.7	1.8	893	26,429	227,264
45-64	2.8	201	13.6	38.4	24.0	8.6	12.1	10.0	6.8	1,478	12,164	120,806
65-74	1.1	54	4.0	58.7	24.8	6.4	5.3	3.0	1.8	1,346	3,493	35,492
75-84	0.7	25	1.3	61.1	26.9	5.5	4.1	1.7	0.7	1,921	3,991	39,582
85 and older	0.4	8	0.3	62.5	29.3	5.3	2.0	0.7	0.2	2,627	4,415	42,287
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Basis of Eligibility[e]												
Aged	0.7	28	1.4	61.0	27.2	5.7	3.6	1.7	0.8	2,004	11,807	116,549
Disabled	2.5	191	11.4	39.8	24.7	8.7	12.3	8.9	5.5	1,676	19,176	200,482
Adults	1.8	90	22.3	30.1	38.5	11.5	13.0	5.5	1.4	405	20,036	155,006
Children	0.6	40	13.6	40.1	48.8	5.7	4.4	0.8	0.1	293	86,632	818,383
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.2	69	10.1	38.7	42.2	7.4	7.1	3.2	1.4	679	79,319	738,046
Male	0.9	67	10.1	42.7	42.0	6.3	6.1	2.1	0.7	671	58,332	552,374
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.1	70	9.9	40.0	42.0	7.1	6.9	2.8	1.2	712	125,211	1,176,165
African American	0.7	53	16.6	43.6	44.5	5.3	4.4	1.8	0.5	321	3,235	30,114
Other/unknown	0.7	46	15.5	45.2	43.2	5.1	4.3	1.8	0.6	298	9,205	84,141
Use of Nursing Facilities[f]												
Entire year	0.9	32	0.9	54.8	30.4	7.7	4.2	1.4	1.7	3,616	4,507	46,865
Part year	1.3	68	2.6	51.1	34.2	4.9	3.7	3.0	3.0	2,596	2,605	23,351
None	1.1	70	13.3	39.7	42.7	7.0	6.8	2.7	1.1	526	130,539	1,220,204
Maintenance Assistance Status												
Cash	1.9	131	14.8	32.0	38.5	9.1	11.0	6.1	3.3	884	24,490	240,984
Medically needy	1.1	70	4.6	49.5	31.1	7.4	7.3	3.4	1.3	1,541	12,066	105,863
Poverty related	0.5	31	14.2	43.5	47.3	5.1	3.4	0.5	0.1	215	67,511	609,703
Other/unknown	1.4	91	8.4	37.1	38.2	8.9	9.9	4.3	1.6	1,092	33,584	333,870

Source: Data for this table are from the MAX 2006 file for New Hampshire, released by CMS in 10/2009. This table was produced on 02/11/2010.

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

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

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

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

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability

or blindness. The children's group includes children receiving foster care and adoptive services.
f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.
Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 5

AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC[a, b, c]
NEW HAMPSHIRE, 2006

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.1**	**$68**	**$65**	**0.3**	**$49**	**$152**	**0.0**	**$5**	**$131**	**0.7**	**$14**	**$20**
Age												
5 and younger	0.4	18	42	0.1	12	128	0.0	1	43	0.3	5	16
6-14	0.6	47	75	0.3	39	134	0.0	1	62	0.3	7	22
15-20	0.9	66	71	0.4	52	141	0.0	3	95	0.5	12	22
21-44	1.8	115	64	0.5	80	172	0.1	10	151	1.3	25	20
45-64	2.8	201	71	0.8	135	169	0.1	26	177	1.9	40	21
65-74	1.1	54	51	0.3	38	135	0.0	6	126	0.7	11	15
75-84	0.7	25	37	0.1	16	109	0.0	3	112	0.5	6	12
85 and older	0.4	8	19	0.1	4	78	0.0	1	104	0.4	3	9
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.7	28	39	0.2	18	120	0.0	3	120	0.5	7	13
Disabled	2.5	191	77	0.7	136	183	0.1	20	165	1.6	36	22
Adults	1.8	90	50	0.4	57	141	0.1	10	156	1.3	23	17
Children	0.6	40	65	0.2	31	134	0.0	1	65	0.4	7	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.2	69	59	0.3	48	147	0.0	6	134	0.8	15	19
Male	0.9	67	76	0.3	52	158	0.0	4	125	0.5	11	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.1	70	65	0.3	51	151	0.0	6	132	0.7	14	20
African American	0.7	53	76	0.2	43	184	0.0	2	100	0.5	8	18
Other/unknown	0.7	46	66	0.2	35	162	0.0	3	107	0.5	8	18
Use of Nursing Facilities[e]												
Entire year	0.9	32	37	0.2	22	130	0.0	2	90	0.7	8	12
Part year	1.3	68	52	0.3	44	142	0.1	8	150	0.9	16	17
None	1.1	70	66	0.3	51	152	0.0	5	131	0.7	14	20
Maintenance Assistance Status												
Cash	1.9	131	69	0.6	93	165	0.1	13	153	1.3	26	21
Medically needy	1.1	70	62	0.3	48	171	0.0	8	166	0.8	15	18
Poverty related	0.5	31	60	0.2	23	130	0.0	1	69	0.3	6	19
Other/unknown	1.4	91	65	0.4	66	152	0.1	7	129	0.9	18	20

Source: Data for this table are from the MAX 2006 file for New Hampshire, released by CMS in 10/2009. This table was produced on 02/11/2010.
a. Table 5 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.
b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.
c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In New Hampshire, 0.2 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions
combined. For information about this classification method, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx

d. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.
e. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.
CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 6

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY[a, b, c, d]
NEW HAMPSHIRE, 2006

Therapeutic Category	Number of Rx per Benefit Month Among Users: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	$ per Benefit Month Among Users: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	$ per Rx: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Users[e]: Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.0	0.0	0.3	$13	$6	$1	$6	$44	$263	$59	$22	144,318	$6,280,754	45,187	32.8	480,968
Biologicals	0.4	0.4	0.0	0.0	395	390	4	0	1012	1,055	1,107	30	975	987,184	249	0.2	2,499
Antineoplastic Agents	0.7	0.2	0.0	0.5	237	210	3	25	326	849	984	52	3,015	982,228	391	0.3	4,137
Endocrine/Metabolic Drugs	0.6	0.2	0.0	0.4	39	29	1	9	64	141	46	24	109,611	7,050,340	17,191	12.5	179,131
Cardiovascular Agents	1.2	0.3	0.1	0.8	52	28	14	10	42	91	138	12	123,637	5,155,662	9,249	6.7	99,106
Respiratory Agents	0.6	0.3	0.0	0.3	37	32	0	5	66	105	59	20	127,834	8,474,581	21,119	15.3	227,765
Gastrointestinal Agents	0.6	0.3	0.0	0.3	51	43	3	5	85	159	181	17	60,264	5,128,407	9,470	6.9	100,781
Genitourinary Agents	0.3	0.1	0.0	0.2	18	12	2	4	51	92	70	22	14,182	725,539	3,915	2.8	40,870
CNS Drugs	1.2	0.4	0.0	0.7	92	71	4	17	80	191	106	23	280,831	22,459,346	23,032	16.7	243,002
Stimulants/Anti-obesity/Anorexia	1.0	0.8	0.0	0.2	95	88	0	7	98	114	80	34	72,012	7,025,077	6,852	5.0	74,038
Miscellaneous Psychological/ Neurological Agents	0.4	0.2	0.0	0.1	109	103	0	6	303	425	0	52	3,818	1,155,869	988	0.7	10,630
Analgesics and Anesthetics	0.7	0.1	0.0	0.6	33	12	12	9	47	165	257	15	164,180	7,647,701	22,798	16.6	234,992
Neuromuscular Agents	1.0	0.3	0.0	0.6	68	50	3	15	71	165	113	24	118,043	8,419,731	11,593	8.4	124,112
Nutritional Products	0.3	0.0	0.0	0.3	4	2	0	2	15	88	12	9	31,462	461,793	10,531	7.7	111,736
Hematological Agents	0.8	0.1	0.0	0.7	68	58	1	9	86	479	44	14	23,282	2,001,593	2,761	2.0	29,366
Topical Products	0.3	0.1	0.0	0.2	12	8	0	4	46	107	52	19	71,928	3,278,152	25,287	18.4	271,694
Miscellaneous Products	0.3	0.2	0.0	0.1	33	25	2	6	123	134	215	82	7,142	881,141	2,420	1.8	26,639
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	7	0	0	0	34	0	0	0	286	9,645	122	0.1	1,336
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.	1,356,820	88,124,743	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for New Hampshire, released by CMS in 10/2009. This table was produced on 02/11/2010.

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

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

c. For information about these therapeutic categories, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In New Hampshire, 0.2 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined.
For information about this classification method, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2006.

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

TABLE 7

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

NEW HAMPSHIRE, 2006

		Users		Among Users			
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$14,507,589	7,409	5.4	81,789	0.8	$213	$177
ANTICONVULSANT	7,605,494	9,702	7.0	105,781	0.9	82	72
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	7,025,077	7,897	5.7	85,949	0.8	98	82
ANTIASTHMATIC	6,365,295	22,576	16.4	244,764	0.4	72	26
ANTIDEPRESSANTS	6,094,920	17,574	12.8	185,448	0.6	52	33
ANALGESICS - Narcotic	5,046,002	27,149	19.7	282,687	0.4	43	18
ULCER DRUGS	3,703,592	8,608	6.3	92,029	0.5	81	40
MISC. ENDOCRINE	2,861,270	1,169	0.8	13,309	0.7	328	215
ANTIHYPERLIPIDEMIC	2,790,943	3,255	2.4	35,903	0.8	103	78
ANTIDIABETIC	2,493,351	3,700	2.7	39,554	0.8	77	63
Total	58,493,533	109,039	n.a.	1,167,213	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for New Hampshire, released by CMS in 10/2009. This table was produced on 02/11/2010.

a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2006. A beneficiary who used drugs from two or more groups was counted as a user for each group. Therefore, the sum of users across drug groups may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

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

c. The top 10 drug groups were determined based on total Medicaid reimbursement in the state for 2006. For information about these drug groups, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.

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