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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEW MEXICO, 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]	516862 (A)	53417 (E)	463445 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	493635 (B)	39298 (F)	454337 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	312359 (C)	38860 (G)	273499 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	3806 (D)	3465 (H)	341 (L)

Source: Data for this table are from the MAX 2006 file for New Mexico, released by CMS in 9/2009. 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 Mexico in 2006 was $14,337,398, of which $67,283 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 MEXICO, 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	**312,359**	**16,850**	**35,226**	**88,730**	**171,222**	**331**	**1,712,300**	**173,397**	**328,141**	**511,655**	**696,133**	**2,974**
Age												
5 and younger	65,605	1	683	0	64,921	0	245,412	7	4,383	0	241,022	0
6-14	74,738	0	1,438	0	73,300	0	322,088	0	11,223	0	310,865	0
15-20	40,709	0	1,295	6,416	32,998	0	185,716	0	9,586	31,891	144,239	0
21-44	85,413	2	9,995	75,320	3	93	529,996	16	89,483	439,726	7	764
45-64	20,943	3	13,745	6,964	0	231	165,336	15	123,272	39,875	0	2,174
65-74	10,350	4,776	5,546	21	0	7	111,875	49,974	61,749	116	0	36
75-84	8,854	6,820	2,027	7	0	0	95,267	72,208	23,020	39	0	0
85 and older	5,747	5,248	497	2	0	0	56,610	51,177	5,425	8	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	194,197	11,498	18,766	78,249	85,353	331	1,117,948	119,225	179,505	470,016	346,228	2,974
Male	118,161	5,352	16,460	10,481	85,868	0	594,350	54,172	148,636	41,639	349,903	0
Unknown	1	0	0	0	1	0	2	0	0	0	2	0
Race												
White	67,286	6,761	11,665	20,892	27,825	143	334,139	66,138	105,489	102,386	58,862	1,264
African American	5,905	186	820	1,675	3,223	1	21,970	1,935	6,676	7,078	6,276	5
Other/unknown	239,168	9,903	22,741	66,163	140,174	187	1,356,191	105,324	215,976	402,191	630,995	1,705
Use of Nursing Facilities[c]												
Entire year	3,806	3,009	797	0	0	0	39,071	30,289	8,782	0	0	0
Part year	2,470	1,816	650	4	0	0	23,439	17,216	6,202	21	0	0
None	306,083	12,025	33,779	88,726	171,222	331	1,649,790	125,892	313,157	511,634	696,133	2,974
Maintenance Assistance Status												
Cash	115,139	9,279	30,359	30,921	44,580	0	713,355	102,659	286,134	130,884	193,678	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	114,667	211	2,049	8,490	103,586	331	464,851	2,035	14,102	36,464	409,276	2,974
Other/unknown	82,553	7,360	2,818	49,319	23,056	0	534,094	68,703	27,905	344,307	93,179	0
Dual Medicare Status[d]												
Full dual, all year	37,463	15,676	21,286	488	3	10	396,534	162,373	230,598	3,443	36	84
Full dual, part year	1,397	686	675	36	0	0	14,131	7,239	6,484	408	0	0
Non-dual, all year	273,499	488	13,265	88,206	171,219	321	1,301,635	3,785	91,059	507,804	696,097	2,890
Managed Care (MC) Status												
Fee-for-service (FFS) all year	151,762	16,699	28,047	49,196	57,492	328	1,315,901	172,421	302,333	374,876	463,312	2,959
FFS part year, with Rx claims	31,035	25	2,445	11,447	17,117	1	89,230	94	8,289	41,776	39,063	8
FFS part year, no Rx claims	129,562	126	4,734	28,087	96,613	2	307,169	882	17,519	95,003	193,758	7

Source: Data for this table are from the MAX 2006 file for New Mexico, released by CMS in 9/2009. 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 MEXICO, 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	**20.0**	**1.0**	**$46**	**$46**	**$4,112**	**1.1**	**312,359**
Age							
5 and younger	19.2	0.4	15	34	2,558	0.6	65,605
6-14	15.7	0.4	17	42	1,615	1.1	74,738
15-20	21.7	0.7	27	40	1,977	1.3	40,709
21-44	24.6	1.2	54	44	3,881	1.4	85,413
45-64	24.1	4.0	237	59	10,681	2.2	20,943
65-74	8.5	1.2	59	49	9,942	0.6	10,350
75-84	12.9	1.3	47	37	15,298	0.3	8,854
85 and older	22.3	1.9	57	30	21,237	0.3	5,747
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	16.3	1.5	53	35	15,082	0.4	16,850
Disabled	19.8	3.2	203	63	14,330	1.4	35,226
Adults	25.3	1.0	37	36	2,310	1.6	88,730
Children	17.5	0.4	14	34	1,835	0.8	171,222
Unknown	83.1	20.3	1,515	75	19,361	7.8	331
Gender							
Female	21.5	1.1	46	43	4,035	1.1	194,197
Male	17.6	0.9	45	52	4,240	1.1	118,161
Unknown	0.0	0.0	0	0	242	0.0	1
Race							
White	19.1	1.1	55	49	6,093	0.9	67,286
African American	15.4	0.6	26	42	3,612	0.7	5,905
Other/unknown	20.4	1.0	44	45	3,567	1.2	239,168
Use of Nursing Facilities[f]							
Entire year	54.8	10.7	515	48	39,719	1.3	3,806
Part year	45.2	7.5	365	49	27,940	1.3	2,470
None	19.4	0.8	37	46	3,477	1.1	306,083
Maintenance Assistance Status							
Cash	20.1	1.4	71	52	5,237	1.4	115,139
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	19.0	0.5	22	41	2,169	1.0	114,667
Other/unknown	21.2	1.1	43	39	5,242	0.8	82,553

Source: Data for this table are from the MAX 2006 file for New Mexico, released by CMS in 9/2009. 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 MEXICO, 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	**0.2**	**$8**	**1.1**	**80.0**	**16.0**	**2.1**	**1.5**	**0.4**	**0.1**	**$750**	**312,359**	**1,712,300**
Age												
5 and younger	0.1	4	0.6	80.8	16.1	2.1	0.9	0.1	0.0	684	65,605	245,412
6-14	0.1	4	1.1	84.3	13.0	1.7	0.9	0.1	0.0	375	74,738	322,088
15-20	0.1	6	1.3	78.3	18.3	2.2	1.2	0.1	0.0	433	40,709	185,716
21-44	0.2	9	1.4	75.4	19.9	2.3	1.8	0.5	0.1	625	85,413	529,996
45-64	0.5	30	2.2	75.9	12.4	3.9	4.9	2.2	0.7	1,353	20,943	165,336
65-74	0.1	6	0.6	91.5	6.3	0.8	0.9	0.4	0.1	920	10,350	111,875
75-84	0.1	4	0.3	87.1	10.1	1.2	1.1	0.4	0.1	1,422	8,854	95,267
85 and older	0.2	6	0.3	77.7	18.5	1.4	1.5	0.7	0.2	2,156	5,747	56,610
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	0.1	5	0.4	83.7	13.1	1.3	1.3	0.5	0.1	1,466	16,850	173,397
Disabled	0.3	22	1.4	80.2	11.3	2.8	3.6	1.6	0.5	1,538	35,226	328,141
Adults	0.2	6	1.6	74.7	20.9	2.2	1.7	0.4	0.1	401	88,730	511,655
Children	0.1	4	0.8	82.5	14.6	1.9	0.9	0.1	0.0	451	171,222	696,133
Unknown	2.3	169	7.8	16.9	34.4	19.6	20.5	6.9	1.5	2,155	331	2,974
Gender												
Female	0.2	8	1.1	78.5	17.4	2.1	1.5	0.4	0.1	701	194,197	1,117,948
Male	0.2	9	1.1	82.4	13.6	2.1	1.5	0.3	0.1	843	118,161	594,350
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	121	1	2
Race												
White	0.2	11	0.9	80.9	13.6	2.6	2.1	0.6	0.2	1,227	67,286	334,139
African American	0.2	7	0.7	84.6	10.2	2.8	1.8	0.5	0.1	971	5,905	21,970
Other/unknown	0.2	8	1.2	79.6	16.8	1.9	1.3	0.3	0.1	629	239,168	1,356,191
Use of Nursing Facilities[f]												
Entire year	1.0	50	1.3	45.2	39.4	4.0	4.9	4.5	2.0	3,869	3,806	39,071
Part year	0.8	39	1.3	54.8	30.0	4.2	5.7	3.9	1.4	2,944	2,470	23,439
None	0.2	7	1.1	80.6	15.6	2.1	1.4	0.3	0.0	645	306,083	1,649,790
Maintenance Assistance Status												
Cash	0.2	12	1.4	79.9	14.4	2.6	2.2	0.7	0.2	845	115,139	713,355
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.1	5	1.0	81.0	15.8	2.0	1.0	0.1	0.0	535	114,667	464,851
Other/unknown	0.2	7	0.8	78.8	18.3	1.4	1.1	0.3	0.1	810	82,553	534,094

Source: Data for this table are from the MAX 2006 file for New Mexico, released by CMS in 9/2009. 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 MEXICO, 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	**0.2**	**$8**	**$46**	**0.0**	**$5**	**$129**	**0.0**	**$1**	**$68**	**0.1**	**$2**	**$18**
Age												
5 and younger	0.1	4	34	0.0	2	141	0.0	0	39	0.1	1	14
6-14	0.1	4	42	0.0	3	109	0.0	0	44	0.1	1	16
15-20	0.1	6	40	0.0	3	120	0.0	1	61	0.1	2	17
21-44	0.2	9	44	0.0	5	118	0.0	1	67	0.1	3	20
45-64	0.5	30	59	0.1	20	159	0.0	4	85	0.3	7	20
65-74	0.1	6	49	0.0	4	124	0.0	1	74	0.1	1	16
75-84	0.1	4	37	0.0	3	99	0.0	0	86	0.1	1	13
85 and older	0.2	6	30	0.0	4	84	0.0	0	56	0.1	2	12
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.1	5	35	0.0	4	94	0.0	0	67	0.1	1	13
Disabled	0.3	22	63	0.1	15	170	0.0	2	77	0.2	4	20
Adults	0.2	6	36	0.0	3	89	0.0	1	65	0.1	3	19
Children	0.1	4	34	0.0	2	105	0.0	0	45	0.1	1	15
Unknown	2.3	169	75	0.7	120	171	0.1	18	196	1.5	31	21
Gender												
Female	0.2	8	43	0.0	5	119	0.0	1	66	0.1	2	18
Male	0.2	9	52	0.0	6	149	0.0	1	71	0.1	2	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.2	11	49	0.1	7	120	0.0	1	78	0.2	3	20
African American	0.2	7	42	0.0	5	116	0.0	1	68	0.1	2	17
Other/unknown	0.2	8	45	0.0	5	134	0.0	1	66	0.1	2	17
Use of Nursing Facilities[e]												
Entire year	1.0	50	48	0.3	36	121	0.0	3	60	0.7	11	16
Part year	0.8	39	49	0.2	26	125	0.0	2	68	0.5	10	18
None	0.2	7	46	0.0	4	131	0.0	1	68	0.1	2	18
Maintenance Assistance Status												
Cash	0.2	12	52	0.0	7	157	0.0	1	70	0.1	3	18
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.1	5	41	0.0	3	124	0.0	1	69	0.1	2	17
Other/unknown	0.2	7	39	0.0	4	90	0.0	1	60	0.1	2	19

Source: Data for this table are from the MAX 2006 file for New Mexico, released by CMS in 9/2009. 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 Mexico, 1.5 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 MEXICO, 2006

	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	$8	$3	$1	$4	$32	$149	$42	$19	38,011	$1,222,887	25,288	8.1	162,059
Biologicals	0.1	0.1	0.0	0.0	19	19	0	0	180	192	194	35	2,433	436,737	2,113	0.7	22,549
Antineoplastic Agents	0.5	0.2	0.0	0.3	93	85	0	8	204	479	353	28	1,723	350,869	408	0.1	3,774
Endocrine/Metabolic Drugs	0.5	0.1	0.1	0.3	20	11	3	6	44	86	50	23	57,560	2,537,227	16,502	5.3	127,773
Cardiovascular Agents	0.7	0.2	0.1	0.5	30	13	10	7	41	89	126	13	29,233	1,199,922	5,315	1.7	39,716
Respiratory Agents	0.4	0.1	0.0	0.2	16	11	0	4	44	102	49	17	32,323	1,431,586	16,058	5.1	91,053
Gastrointestinal Agents	0.4	0.1	0.0	0.3	23	13	4	6	60	138	203	23	13,255	800,145	4,900	1.6	35,453
Genitourinary Agents	0.3	0.1	0.0	0.2	12	6	2	4	46	85	67	25	4,085	188,286	2,350	0.8	15,902
CNS Drugs	0.6	0.2	0.0	0.4	38	29	4	5	65	169	82	13	36,033	2,330,924	8,572	2.7	61,742
Stimulants/Anti-obesity/Anorexia	0.4	0.3	0.0	0.1	39	34	2	2	88	109	171	21	2,833	249,967	1,326	0.4	6,472
Miscellaneous Psychological/ Neurological Agents	0.4	0.4	0.0	0.0	69	68	0	1	163	164	0	117	1,086	177,021	307	0.1	2,574
Analgesics and Anesthetics	0.3	0.0	0.0	0.3	8	4	1	4	25	192	60	13	36,484	912,828	16,006	5.1	110,631
Neuromuscular Agents	0.5	0.1	0.0	0.4	38	21	3	13	69	176	61	36	15,816	1,090,482	4,185	1.3	29,049
Nutritional Products	0.3	0.0	0.0	0.2	4	0	0	3	14	35	38	12	8,565	119,907	4,771	1.5	32,013
Hematological Agents	0.5	0.1	0.1	0.4	31	26	1	4	62	323	19	10	8,253	508,872	1,880	0.6	16,472
Topical Products	0.2	0.0	0.0	0.2	6	3	1	3	26	80	49	15	17,501	453,817	11,202	3.6	76,149
Miscellaneous Products	0.2	0.1	0.0	0.1	19	15	2	2	91	101	316	41	1,534	139,201	1,020	0.3	7,272
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	6	0	0	0	37	0	0	0	3,233	119,437	2,032	0.7	20,459
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.	309,961	14,270,115	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for New Mexico, released by CMS in 9/2009. 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 Mexico, 1.5 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 MEXICO, 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
CONTRACEPTIVES	$1,444,181	10,732	3.4	88,418	0.4	$41	$16
ANTIPSYCHOTICS	1,423,285	1,879	0.6	15,089	0.5	197	94
ANTIDIABETIC	972,695	4,410	1.4	37,270	0.4	70	26
ANTICONVULSANT	971,448	2,674	0.9	20,093	0.5	91	48
ANTIASTHMATIC	953,345	10,644	3.4	65,421	0.3	55	15
ANTIDEPRESSANTS	700,698	5,478	1.8	37,276	0.4	49	19
ANTIHYPERLIPIDEMIC	642,992	1,768	0.6	14,269	0.4	118	45
ULCER DRUGS	590,422	4,614	1.5	35,303	0.4	47	17
ANALGESICS - Narcotic	399,839	11,628	3.7	79,719	0.3	20	5
PASSIVE IMMUNIZING AGENTS	388,172	118	0.0	799	0.3	1,703	486
Total	8,487,077	53,945	n.a.	393,657	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for New Mexico, released by CMS in 9/2009. 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.