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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2007
NEW HAMPSHIRE

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEW HAMPSHIRE, 2007

Inclusion Criteria (2007)	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]	144366 (A)	28059 (E)	116307 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	138917 (B)	22662 (F)	116255 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	138917 (C)	22662 (G)	116255 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	4352 (D)	4177 (H)	175 (L)

Source: Data for this table are from the MAX 2007 file for New Hampshire, released by CMS in 3/2010. This table was produced on 10/06/2010.
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 2007 (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 2007, 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 2007 was $70,086,729, of which $19,401 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 27 states in 2007 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, MA, MI, NC, NH, NM, NV, NY, 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, TN, TX, and WV). These lists were constructed from the CMS 2007 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 reviewed prescription drug expenditures by type of managed care plan to determine whether enrollees in comprehensive MC plans had significant prescription drug expenditures during the year, since that would indicate that at least some prescription drugs were not included in the capitated benefit and were being provided on a fee-for-service basis. There were some states in which most, but not all, prescription drugs were included in the MC capitated benefit package. Mental health drugs, for example, may have been excluded. In those states, we excluded all the MC enrollees from the study population, but some of their drugs would have been included, potentially resulting in higher reported per-beneficiary use of those drugs than would have been the case if we had been able to exclude those drugs.
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 2007. 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 2007. 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, 2007

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**138,917**	**11,755**	**20,038**	**19,726**	**87,398**	**0**	**1,301,088**	**114,616**	**206,239**	**151,748**	**828,485**	**0**
Age												
5 and younger	30,654	0	35	0	30,619	0	279,618	0	394	0	279,224	0
6-14	37,764	0	77	0	37,687	0	377,524	0	908	0	376,616	0
15-20	19,569	0	642	0	18,927	0	178,329	0	6,405	0	171,924	0
21-44	26,586	0	8,603	17,818	165	0	226,718	0	89,371	136,626	721	0
45-64	12,484	0	10,585	1,899	0	0	123,401	0	108,346	15,055	0	0
65-74	3,540	3,453	79	8	0	0	35,501	34,815	620	66	0	0
75-84	3,870	3,856	14	0	0	0	38,383	38,216	167	0	0	0
85 and older	4,449	4,446	3	0	0	0	41,613	41,585	28	0	0	0
Unknown	1	0	0	1	0	0	1	0	0	1	0	0
Gender												
Female	79,786	8,812	10,860	16,992	43,122	0	739,607	87,324	113,341	133,685	405,257	0
Male	59,131	2,943	9,178	2,734	44,276	0	561,481	27,292	92,898	18,063	423,228	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	126,548	11,124	19,203	17,917	78,304	0	1,187,021	108,210	198,037	138,390	742,384	0
African American	3,354	76	284	628	2,366	0	31,093	761	2,755	4,664	22,913	0
Other/unknown	9,015	555	551	1,181	6,728	0	82,974	5,645	5,447	8,694	63,188	0
Use of Nursing Facilities[c]												
Entire year	4,352	4,020	328	0	4	0	45,087	41,570	3,469	0	48	0
Part year	2,743	2,255	468	10	10	0	24,358	19,365	4,780	100	113	0
None	131,822	5,480	19,242	19,716	87,384	0	1,231,643	53,681	197,990	151,648	828,324	0
Maintenance Assistance Status												
Cash	22,473	1,447	7,626	3,897	9,503	0	223,094	16,325	82,846	30,740	93,183	0
Medically needy	12,022	4,772	3,178	2,629	1,443	0	104,990	42,531	29,044	19,191	14,224	0
Poverty-related	68,909	707	1,241	4,266	62,695	0	623,526	6,400	12,158	24,760	580,208	0
Other/unknown	35,513	4,829	7,993	8,934	13,757	0	349,478	49,360	82,191	77,057	140,870	0
Dual Medicare Status[d]												
Full dual, all year	19,617	9,778	8,932	890	17	0	200,848	96,087	96,365	8,230	166	0
Full dual, part year	3,045	1,031	1,901	113	0	0	30,347	9,836	19,287	1,224	0	0
Non-dual, all year	116,255	946	9,205	18,723	87,381	0	1,069,893	8,693	90,587	142,294	828,319	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	138,917	11,755	20,038	19,726	87,398	0	1,301,088	114,616	206,239	151,748	828,485	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 2007 file for New Hampshire, released by CMS in 3/2010. This table was produced on 10/06/2010.

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 2007. 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, 2007

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	**59.0**	**7.4**	**$504**	**$68**	**$6,466**	**7.8**	**138,917**
Age							
5 and younger	60.1	2.7	120	44	1,991	6.0	30,654
6-14	57.5	4.7	378	81	2,845	13.3	37,764
15-20	62.7	6.4	509	79	4,403	11.6	19,569
21-44	65.6	11.6	780	67	7,805	10.0	26,586
45-64	60.6	21.4	1,510	71	15,257	9.9	12,484
65-74	41.9	8.6	472	55	14,770	3.2	3,540
75-84	37.6	5.0	182	36	20,322	0.9	3,870
85 and older	35.3	2.9	52	18	25,773	0.2	4,449
Unknown	0.0	0.0	0	0	0	0.0	1
Basis of Eligibility[e]							
Aged	38.0	5.2	212	41	20,737	1.0	11,755
Disabled	58.5	19.3	1,538	80	17,657	8.7	20,038
Adults	69.8	10.5	549	52	3,247	16.9	19,726
Children	59.5	4.2	297	70	2,707	11.0	87,398
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	60.6	8.2	500	61	6,431	7.8	79,786
Male	56.8	6.3	511	81	6,512	7.8	59,131
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	59.4	7.6	519	68	6,805	7.6	126,548
African American	54.3	5.0	386	78	3,305	11.7	3,354
Other/unknown	55.3	5.0	341	68	2,877	11.9	9,015
Use of Nursing Facilities[f]							
Entire year	44.5	6.7	248	37	39,831	0.6	4,352
Part year	49.8	9.5	494	52	24,565	2.0	2,743
None	59.7	7.4	513	70	4,988	10.3	131,822
Maintenance Assistance Status							
Cash	67.7	14.7	1,079	73	9,362	11.5	22,473
Medically needy	48.9	7.5	468	63	14,945	3.1	12,022
Poverty related	56.3	3.4	216	64	1,970	11.0	68,909
Other/unknown	62.1	10.4	712	69	10,486	6.8	35,513

Source: Data for this table are from the MAX 2007 file for New Hampshire, released by CMS in 3/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, 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, TN, TX, 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, 2007

				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	**0.8**	**$54**	**7.8**	**41.0**	**46.1**	**5.4**	**5.2**	**1.8**	**0.5**	**$690**	**138,917**	**1,301,088**
Age												
5 and younger	0.3	13	6.0	39.9	57.7	1.6	0.7	0.1	0.0	218	30,654	279,618
6-14	0.5	38	13.3	42.5	49.3	4.6	3.2	0.3	0.1	285	37,764	377,524
15-20	0.7	56	11.6	37.3	50.2	6.7	4.9	0.8	0.1	483	19,569	178,329
21-44	1.4	91	10.0	34.4	40.6	10.0	10.8	3.5	0.6	915	26,586	226,718
45-64	2.2	153	9.9	39.4	27.9	7.6	12.9	8.9	3.4	1,544	12,484	123,401
65-74	0.9	47	3.2	58.1	29.5	4.2	4.3	2.7	1.1	1,473	3,540	35,501
75-84	0.5	18	0.9	62.4	29.8	3.2	2.9	1.3	0.4	2,049	3,870	38,383
85 and older	0.3	6	0.2	64.7	31.1	2.4	1.3	0.4	0.0	2,756	4,449	41,613
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	1	1
Basis of Eligibility[e]												
Aged	0.5	22	1.0	62.0	30.3	3.2	2.7	1.4	0.5	2,127	11,755	114,616
Disabled	1.9	149	8.7	41.5	28.5	7.7	12.1	7.6	2.7	1,716	20,038	206,239
Adults	1.4	71	16.9	30.2	44.4	10.9	11.2	3.0	0.4	422	19,726	151,748
Children	0.4	31	11.0	40.5	52.6	4.0	2.6	0.3	0.0	286	87,398	828,485
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	0.9	54	7.8	39.4	46.3	5.8	5.6	2.2	0.7	694	79,786	739,607
Male	0.7	54	7.8	43.2	45.7	4.9	4.6	1.3	0.3	686	59,131	561,481
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	0.8	55	7.6	40.6	46.0	5.6	5.3	1.9	0.5	726	126,548	1,187,021
African American	0.5	42	11.7	45.7	45.6	4.1	3.5	1.0	0.2	357	3,354	31,093
Other/unknown	0.5	37	11.9	44.7	46.8	3.8	3.5	1.1	0.2	313	9,015	82,974
Use of Nursing Facilities[f]												
Entire year	0.6	24	0.6	55.5	35.4	3.9	2.5	1.5	1.2	3,845	4,352	45,087
Part year	1.1	56	2.0	50.2	38.5	3.2	3.1	2.8	2.2	2,766	2,743	24,358
None	0.8	55	10.3	40.3	46.6	5.5	5.3	1.8	0.4	534	131,822	1,231,643
Maintenance Assistance Status												
Cash	1.5	109	11.5	32.3	43.2	7.7	10.1	5.2	1.6	943	22,473	223,094
Medically needy	0.9	54	3.1	51.1	33.9	5.7	6.3	2.5	0.5	1,711	12,022	104,990
Poverty related	0.4	24	11.0	43.7	50.8	3.5	1.8	0.2	0.0	218	68,909	623,526
Other/unknown	1.1	72	6.8	37.9	42.8	7.7	8.2	2.6	0.8	1,066	35,513	349,478

Source: Data for this table are from the MAX 2007 file for New Hampshire, released by CMS in 3/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, 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, TN, TX, 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, 2007

	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	**0.8**	**$54**	**$68**	**0.2**	**$39**	**$170**	**0.0**	**$4**	**$146**	**0.5**	**$11**	**$20**
Age												
5 and younger	0.3	13	44	0.1	8	145	0.0	1	69	0.2	4	18
6-14	0.5	38	81	0.2	31	150	0.0	1	85	0.2	6	23
15-20	0.7	56	79	0.3	44	165	0.0	3	105	0.4	9	23
21-44	1.4	91	67	0.3	64	194	0.0	8	173	1.0	20	20
45-64	2.2	153	71	0.6	105	182	0.1	17	193	1.5	31	21
65-74	0.9	47	55	0.2	34	161	0.0	4	134	0.6	9	15
75-84	0.5	18	36	0.1	12	127	0.0	1	89	0.4	5	12
85 and older	0.3	6	18	0.0	3	88	0.0	0	103	0.3	2	9
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.5	22	41	0.1	15	140	0.0	2	118	0.4	5	13
Disabled	1.9	149	80	0.5	108	203	0.1	13	184	1.3	28	22
Adults	1.4	71	52	0.3	45	160	0.0	7	172	1.0	19	18
Children	0.4	31	70	0.2	24	150	0.0	1	87	0.3	6	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	0.9	54	61	0.2	38	163	0.0	4	149	0.6	12	19
Male	0.7	54	81	0.2	41	180	0.0	3	141	0.4	9	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.8	55	68	0.2	40	169	0.0	4	148	0.5	11	20
African American	0.5	42	78	0.2	33	204	0.0	2	99	0.4	6	18
Other/unknown	0.5	37	68	0.2	29	186	0.0	2	117	0.4	7	18
Use of Nursing Facilities[e]												
Entire year	0.6	24	37	0.1	16	140	0.0	1	109	0.5	6	12
Part year	1.1	56	52	0.2	37	167	0.0	5	127	0.8	14	17
None	0.8	55	70	0.2	40	171	0.0	4	147	0.5	11	21
Maintenance Assistance Status												
Cash	1.5	109	73	0.4	78	187	0.1	10	172	1.0	21	21
Medically needy	0.9	54	63	0.2	37	184	0.0	5	179	0.6	12	19
Poverty related	0.4	24	64	0.1	18	143	0.0	1	90	0.2	5	21
Other/unknown	1.1	72	69	0.3	53	173	0.0	5	145	0.7	14	20

Source: Data for this table are from the MAX 2007 file for New Hampshire, released by CMS in 3/2010. This table was produced on 10/06/2010.
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, 2007

	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	$10	$5	$1	$5	$48	$370	$185	$23	103,464	$4,962,523	45,053	32.4	478,746
Biologicals	0.3	0.3	0.0	0.0	277	277	0	0	1094	1,094	0	0	755	825,722	287	0.2	2,978
Antineoplastic Agents	0.5	0.2	0.0	0.3	192	173	3	16	381	936	916	51	2,025	771,960	383	0.3	4,023
Endocrine/Metabolic Drugs	0.4	0.2	0.0	0.3	30	23	1	7	67	149	37	24	83,189	5,588,216	17,790	12.8	186,028
Cardiovascular Agents	0.9	0.2	0.0	0.7	29	18	2	8	31	103	80	11	95,503	2,952,616	9,490	6.8	101,910
Respiratory Agents	0.4	0.2	0.0	0.2	31	25	2	4	74	108	76	26	94,346	6,966,313	21,185	15.3	228,044
Gastrointestinal Agents	0.4	0.2	0.0	0.2	39	29	4	6	90	172	161	25	46,339	4,152,865	9,925	7.1	105,624
Genitourinary Agents	0.3	0.1	0.0	0.2	15	10	0	5	54	97	71	28	10,882	588,881	3,864	2.8	40,355
CNS Drugs	0.9	0.3	0.0	0.6	70	56	2	13	81	221	141	21	209,636	17,036,296	23,022	16.6	242,734
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.2	77	71	1	5	107	128	72	33	54,633	5,834,728	7,010	5.0	75,631
Miscellaneous Psychological/ Neurological Agents	0.2	0.2	0.0	0.0	54	52	0	2	227	255	163	53	5,391	1,222,322	2,130	1.5	22,793
Analgesics and Anesthetics	0.5	0.0	0.0	0.5	24	7	10	7	45	196	275	16	122,509	5,546,023	22,684	16.3	232,869
Neuromuscular Agents	0.7	0.3	0.0	0.5	61	45	5	11	82	177	154	24	96,110	7,875,234	12,108	8.7	129,394
Nutritional Products	0.2	0.0	0.0	0.2	4	1	0	2	18	115	61	11	24,235	428,018	10,436	7.5	110,981
Hematological Agents	0.6	0.1	0.0	0.5	67	62	0	5	115	593	48	11	16,663	1,914,715	2,710	2.0	28,394
Topical Products	0.2	0.0	0.0	0.1	9	6	0	3	46	117	63	20	53,846	2,501,140	25,783	18.6	277,422
Miscellaneous Products	0.2	0.1	0.0	0.0	34	28	2	4	185	219	252	87	4,728	875,345	2,334	1.7	25,784
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	10	0	0	0	61	0	0	0	402	24,411	223	0.2	2,412
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.	1,024,656	70,067,328	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for New Hampshire, released by CMS in 3/2010. This table was produced on 10/06/2010.
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 2007.
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, 2007

		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	$11,895,543	7,340	5.3	80,421	0.6	$231	$148
ANTICONVULSANT	7,202,593	10,476	7.5	113,941	0.7	95	63
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	5,834,728	8,205	5.9	89,260	0.6	107	65
ANTIASTHMATIC	5,277,278	22,449	16.2	243,031	0.3	81	22
ANALGESICS - Narcotic	4,145,128	27,876	20.1	288,907	0.3	45	14
ANTIDEPRESSANTS	3,919,545	17,295	12.4	182,329	0.5	45	21
ULCER DRUGS	3,063,961	8,428	6.1	90,233	0.4	92	34
ANTIVIRAL	2,194,113	1,616	1.2	17,031	0.3	427	129
ANTIDIABETIC	2,138,662	3,811	2.7	41,199	0.6	87	52
MISC. ENDOCRINE	2,079,104	1,118	0.8	12,657	0.5	335	164
Total	47,750,655	108,614	n.a.	1,159,009	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for New Hampshire, released by CMS in 3/2010. This table was produced on 10/06/2010.
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 2007. 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 2007. 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.