STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
NORTH DAKOTA

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

SUPPLEMENTAL TABLES

APPENDIX TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NORTH DAKOTA, 2003

Inclusion Criteria (2003)	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]	76,454	(A)	15,311	(E)	61,143	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	74,706	(B)	13,626	(F)	61,080	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	74,083	(C)	13,625	(G)	60,458	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	3,959	(D)	3,823	(H)	136	(L)

Source: Data for this table are from the MAX 2003 file for North Dakota, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003 (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 2003, 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 North Dakota in 2003 was $55,909,373, of which $284,671 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 19 states in 2003 that had PHPs that did not include a pharmacy benefit: AL, AR, CA, CO, FL, GA, IA, KY, MA, MI, NY, OR, PA, SD, TN, TX, UT, WA, and WI. In addition, there were 7 states in which MC plans did not provide a pharmacy benefit: DE, IA, NE, NY, TX, UT, and WV. These lists were constructed from the CMS 2003 Medicaid Managed Care Enrollment Report [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer02.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 2003. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.

g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the benficiary had a fee-for-service pharmacy benefit.

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2003. 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]

NORTH DAKOTA, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**74,083**	**8,771**	**9,646**	**18,749**	**36,917**	**0**	**641,639**	**84,237**	**99,233**	**141,780**	**316,389**	**0**
Age												
5 and younger	15,481	0	186	0	15,295	0	129,595	0	1,895	0	127,700	0
6-14	15,669	0	509	0	15,160	0	142,342	0	5,361	0	136,981	0
15-20	8,004	0	443	1,383	6,178	0	65,491	0	4,566	10,512	50,413	0
21-44	20,025	0	3,815	15,926	284	0	162,177	0	40,080	120,802	1,295	0
45-64	6,048	1	4,610	1,437	0	0	57,033	12	46,580	10,441	0	0
65-74	2,340	2,254	83	3	0	0	22,877	22,101	751	25	0	0
75-84	2,959	2,959	0	0	0	0	28,891	28,891	0	0	0	0
85 and older	3,557	3,557	0	0	0	0	33,233	33,233	0	0	0	0
Unknown	0	0	0	0	0	0	0		0	0	0	0
Gender												
Female	43,560	6,191	4,924	14,325	18,120	0	379,048	60,606	51,378	112,255	154,809	0
Male	30,521	2,580	4,722	4,424	18,795	0	262,589	23,631	47,855	29,525	161,578	0
Unknown	2	0	0	0	2	2	0	0	0	0	2	0
Race												
White	54,782	8,221	8,018	13,416	25,127	0	472,923	78,674	82,799	99,827	211,623	0
African American	1,474	22	121	369	962	0	12,056	197	1,085	2,693	8,081	0
Other/unknown	17,827	528	1,507	4,964	10,828	0	156,660	5,366	15,349	39,260	96,685	0
Use of Nursing Facilities[c]												
Entire year	3,959	3,628	330	1	0	0	38,197	34,778	3,414	5	0	0
Part year	1,308	1,078	223	3	4	0	12,138	9,855	2,226	26	31	0
None	68,816	4,065	9,093	18,745	36,913	0	591,304	39,604	93,593	141,749	316,358	0
Maintenance Assistance Status												
Cash	30,610	1,942	6,279	8,402	13,987	0	270,078	21,822	68,118	60,832	119,306	0
Medically needy	13,256	6,372	3,072	1,606	2,206	0	110,397	58,345	28,499	8,159	15,394	0
Poverty-related	9,334	457	295	834	7,748	0	73,993	4,070	2,616	4,789	62,518	0
Other/unknown	20,883	0	0	7,907	12,976	0	187,171	0	0	68,000	119,171	0
Dual Medicare Status[d]												
Full dual, all year	12,912	8,034	4,793	82	3	0	128,168	77,214	50,393	532	29	0
Full dual, part year	713	434	278	1	0	0	6,661	4,024	2,631	6	0	0
Non-dual, all year	60,458	303	4,575	18,666	36,914	0	506,810	2,999	46,209	141,242	316,360	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	73,255	8,771	9,643	18,413	36,428	0	638,868	84,237	99,219	140,745	314,667	0
FFS part year, with Rx claims	439	0	2	207	230	0	1,651	0	13	688	950	0
FFS part year, no Rx claims	389	0	1	129	259	0	1,120	0	1	347	772	0

Source: Data for this table are from the MAX 2003 file for North Dakota, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003. 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]

NORTH DAKOTA, 2003

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	**64.2 %**	**14.3**	**$751**	**$53**	**$6,049**	**12.4 %**	**74,083**
Age							
5 and younger	60.2	3.1	104	34	1,673	6.2	15,481
6-14	53.6	4.3	231	54	1,823	12.7	15,669
15-20	57.5	5.9	344	58	3,405	10.1	8,004
21-44	65.4	11.3	700	62	5,282	13.3	20,025
45-64	74.0	35.5	2,260	64	14,432	15.7	6,048
65-74	76.5	44.1	2,216	50	13,714	16.2	2,340
75-84	86.3	53.8	2,426	45	18,576	13.1	2,959
85 and older	93.8	53.7	2,133	40	24,265	8.8	3,557
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	86.8	51.3	2,249	44	19,600	11.5	8,771
Disabled	78.8	34.7	2,459	71	18,281	13.5	9,646
Adults	62.3	7.2	316	44	2,007	15.7	18,749
Children	56.0	3.7	170	46	1,687	10.1	36,917
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	67.9	16.4	810	49	6,090	13.3	43,560
Male	58.9	11.2	666	60	5,991	11.1	30,521
Unknown	0.0	0.0	0	0	1,238	0.0	2
Race							
White	68.4	17.1	904	53	7,057	12.8	54,782
African American	61.7	6.1	292	48	1,984	14.7	1,474
Other/unknown	51.6	6.3	318	50	3,290	9.7	17,827
Use of Nursing Facilities[f]							
Entire year	97.8	66.1	3,033	46	35,947	8.4	3,959
Part year	96.6	57.5	2,658	46	24,032	11.1	1,308
None	61.7	10.5	583	56	3,987	14.6	68,816
Maintenance Assistance Status							
Cash	63.6	14.0	806	58	4,873	16.5	30,610
Medically needy	73.7	36.2	1,823	50	18,666	9.8	13,256
Poverty related	52.0	3.2	136	43	1,021	13.3	9,334
Other/unknown	64.6	5.7	264	46	2,012	13.1	20,883

Source: Data for this table are from the MAX 2003 file for North Dakota, released by CMS in 05/2007. This table was produced on 11/01/2007.

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

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

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

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

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; OTC = over-the-counter; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 4

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

NORTH DAKOTA, 2003

				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	**1.6**	**$87**	**12.4 %**	**35.8 %**	**40.0 %**	**6.5 %**	**9.3 %**	**6.5 %**	**1.9 %**	**$698**	**74,083**	**641,639**
Age												
5 and younger	0.4	12	6.2	39.8	56.4	2.9	0.8	0.1	0.0	200	15,481	129,595
6-14	0.5	25	12.7	46.4	45.3	4.4	3.5	0.4	0.0	201	15,669	142,342
15-20	0.7	42	10.1	42.5	44.3	6.7	5.7	0.7	0.1	416	8,004	65,491
21-44	1.4	86	13.3	34.6	41.2	9.8	9.9	3.8	0.6	652	20,025	162,177
45-64	3.8	240	15.7	26.0	18.8	9.0	22.7	18.2	5.3	1,530	6,048	57,033
65-74	4.5	227	16.2	23.5	13.8	8.2	22.5	22.6	9.4	1,403	2,340	22,877
75-84	5.5	249	13.1	13.7	9.1	6.7	26.9	31.4	12.2	1,903	2,959	28,891
85 and older	5.7	228	8.8	6.2	6.6	7.8	30.7	39.0	9.6	2,597	3,557	33,233
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	5.3	234	11.5	13.2	9.3	7.5	27.4	32.3	10.4	2,041	8,771	84,237
Disabled	3.4	239	13.5	21.2	22.6	11.0	24.0	16.9	4.2	1,777	9,646	99,233
Adults	1.0	42	15.7	37.7	44.5	8.9	7.0	1.6	0.3	265	18,749	141,780
Children	0.4	20	10.1	44.0	49.5	3.9	2.3	0.2	0.0	197	36,917	316,389
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.9	93	13.3	32.1	40.4	7.2	10.2	7.9	2.2	700	43,560	379,048
Male	1.3	77	11.1	41.1	39.3	5.6	8.0	4.7	1.3	696	30,521	262,589
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	1,238	2	2
Race												
White	2.0	105	12.8	31.6	39.5	7.2	11.1	8.2	2.4	817	54,782	472,923
African American	0.7	36	14.7	38.3	49.2	6.2	4.3	1.8	0.3	243	1,474	12,056
Other/unknown	0.7	36	9.7	48.4	40.5	4.5	4.3	1.9	0.4	374	17,827	156,660
Use of Nursing Facilities[f]												
Entire year	6.9	314	8.4	2.2	4.7	6.2	27.8	42.3	16.8	3,726	3,959	38,197
Part year	6.2	286	11.1	3.4	7.9	7.6	29.4	38.7	13.0	2,590	1,308	12,138
None	1.2	68	14.6	38.3	42.6	6.5	7.9	3.9	0.8	464	68,816	591,304
Maintenance Assistance Status												
Cash	1.6	91	16.5	36.4	39.7	6.9	9.9	5.8	1.3	552	30,610	270,078
Medically needy	4.3	219	9.8	26.3	16.3	7.7	20.6	21.9	7.1	2,241	13,256	110,397
Poverty related	0.4	17	13.3	48.0	46.3	3.7	1.7	0.3	0.0	129	9,334	73,993
Other/unknown	0.6	30	13.1	35.4	52.6	6.6	4.6	0.7	0.1	225	20,883	187,171

Source: Data for this table are from the MAX 2003 file for North Dakota, released by CMS in 05/2007. This table was produced on 11/01/2007.

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

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

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

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

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

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

TABLE 5

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

NORTH DAKOTA, 2003

	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	**1.6**	**$87**	**$53**	**0.7**	**$68**	**$92**	**0.1**	**$3**	**$43**	**0.8**	**$16**	**$19**
Age												
5 and younger	0.4	12	34	0.2	9	56	0.0	1	42	0.2	3	15
6-14	0.5	25	54	0.3	21	80	0.0	1	57	0.2	4	19
15-20	0.7	42	58	0.4	34	91	0.0	1	50	0.3	7	21
21-44	1.4	86	62	0.6	69	109	0.1	4	55	0.7	14	20
45-64	3.8	240	64	1.7	187	109	0.2	12	67	1.9	41	22
65-74	4.5	227	50	2.0	176	89	0.2	6	33	2.3	45	19
75-84	5.5	249	45	2.3	191	82	0.3	6	24	2.9	50	17
85 and older	5.7	228	40	2.2	171	76	0.3	6	19	3.2	51	16
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.3	234	44	2.2	179	81	0.3	6	23	2.9	49	17
Disabled	3.4	239	71	1.6	190	120	0.2	12	69	1.6	37	23
Adults	1.0	42	44	0.4	32	77	0.0	1	32	0.5	9	17
Children	0.4	20	46	0.2	16	72	0.0	1	50	0.2	3	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.9	93	49	0.8	72	87	0.1	3	36	1.0	18	18
Male	1.3	77	60	0.6	61	102	0.1	3	58	0.6	13	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.0	105	53	0.9	82	93	0.1	4	41	1.0	19	19
African American	0.7	36	48	0.3	29	86	0.0	1	42	0.4	6	15
Other/unknown	0.7	36	50	0.3	27	92	0.0	1	59	0.4	8	19
Use of Nursing Facilities[e]												
Entire year	6.9	314	46	2.8	240	86	0.4	9	24	3.7	65	18
Part year	6.2	286	46	2.6	221	86	0.3	8	25	3.3	58	17
None	1.2	68	56	0.6	53	95	0.1	3	53	0.6	12	19
Maintenance Assistance Status												
Cash	1.6	91	58	0.7	71	101	0.1	4	57	0.8	16	20
Medically needy	4.3	219	50	1.9	170	91	0.2	8	33	2.2	41	18
Poverty related	0.4	17	43	0.2	13	69	0.0	1	45	0.2	3	16
Other/unknown	0.6	30	46	0.3	24	75	0.0	1	37	0.3	5	17

Source: Data for this table are from the MAX 2003 file for North Dakota, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 North Dakota, 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 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]

NORTH DAKOTA, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	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			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.1	$12	$8	$0	$3	$43	$71	$72	$20	87,299	$3,776,565	32,066	43.3 %	328,360
Biologicals	0.1	0.1	0.0	0.0	38	28	0	9	330	292	152	593	328	108,078	247	0.3	2,832
Antineoplastic Agents	0.6	0.2	0.0	0.3	117	98	3	16	197	453	82	46	3,212	632,091	534	0.7	5,409
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.3	29	21	2	5	38	63	20	17	108,676	4,128,383	14,044	19.0	144,285
Cardiovascular Agents	1.6	0.5	0.1	1.1	44	29	1	14	27	57	14	14	200,495	5,443,047	11,974	16.2	123,276
Respiratory Agents	0.4	0.3	0.0	0.2	22	18	0	3	49	71	50	18	84,833	4,153,304	18,239	24.6	189,328
Gastrointestinal Agents	0.6	0.3	0.0	0.3	43	33	1	9	67	112	121	27	59,513	3,974,448	8,889	12.0	91,919
Genitourinary Agents	0.4	0.4	0.0	0.1	27	26	0	2	61	71	36	20	19,796	1,213,761	4,245	5.7	44,395
CNS Drugs	1.1	0.7	0.0	0.5	92	78	4	10	80	119	134	22	188,497	15,165,436	16,057	21.7	164,447
Stimulants/Anti-obesity/Anorexia	0.7	0.4	0.0	0.2	43	35	1	6	66	79	53	34	21,097	1,384,690	3,065	4.1	32,425
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	85	84	0	1	141	147	0	40	5,394	760,331	863	1.2	8,949
Analgesics and Anesthetics	0.6	0.2	0.0	0.3	30	23	1	5	53	111	63	16	92,158	4,901,646	16,340	22.1	165,488
Neuromuscular Agents	0.9	0.4	0.1	0.4	68	54	3	11	78	123	49	29	73,703	5,722,495	7,933	10.7	83,579
Nutritional Products	0.6	0.0	0.0	0.6	11	1	0	10	19	77	17	18	28,616	532,570	4,808	6.5	48,731
Hematological Agents	0.8	0.2	0.1	0.5	49	40	2	7	58	201	18	13	28,085	1,629,348	3,259	4.4	33,475
Topical Products	0.3	0.1	0.0	0.2	10	7	0	3	35	57	46	18	50,024	1,742,680	16,868	22.8	176,878
Miscellaneous Products	0.3	0.1	0.0	0.1	40	27	5	8	136	182	238	65	1,680	228,913	551	0.7	5,673
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	9	0	0	0	44	0	0	0	2,877	126,916	1,404	1.9	14,872
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.	1,056,283	55,624,702	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for North Dakota, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 North Dakota, 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.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 2003.

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]

NORTH DAKOTA, 2003

		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	$8,662,632	6,185	8.3 %	66,460	0.8	$167	$130
ANTIDEPRESSANTS	5,650,561	16,454	22.2	170,255	0.6	55	33
ANTICONVULSANT	4,904,252	5,999	8.1	64,802	0.8	91	76
ULCER DRUGS	3,231,698	8,301	11.2	86,567	0.5	74	37
ANTIASTHMATIC	2,544,254	12,299	16.6	127,730	0.3	57	20
ANALGESICS - Narcotic	2,406,686	17,325	23.4	178,679	0.3	43	13
ANTIDIABETIC	2,066,854	5,090	6.9	53,482	0.8	50	39
ANALGESICS - ANTI-INFLAMMATORY	1,961,458	8,842	11.9	92,753	0.3	69	21
ANTIHYPERLIPIDEMIC	1,661,966	3,265	4.4	35,156	0.7	70	47
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	1,381,571	3,818	5.2	41,057	0.5	66	34
Total	34,471,932	87,578		916,941	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for North Dakota, released by CMS in 05/2007. This table was produced on 11/01/2007.

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 2003. 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 2003. 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.