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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2005
NORTH DAKOTA

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NORTH DAKOTA, 2005

Inclusion Criteria (2005)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Non-dual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	74986 (A)	15534 (E)	59452 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	72674 (B)	13230 (F)	59444 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	72062 (C)	13230 (G)	58832 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	3794 (D)	3664 (H)	130 (L)

Source: Data for this table are from the MAX 2005 file for North Dakota, released by CMS in 12/2008. This table was produced on 04/23/2009.

a. MAX data element "Eligible Months Count" was used to determine an individual's Medicaid eligibility. All individuals who had a value greater than zero were considered as beneficiaries and counted in Cell A.

b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2005 (based on MAX data element "Eligible Restricted Benefits Flag").

c. Cell C represents the study population for Tables 2 through 7. Cell C was obtained by excluding from Cell B beneficiaries who were in managed care (MC) plans that included prescription drugs in their capitated benefit package during all months of Medicaid eligibility in 2005, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.

d. The total Medicaid pharmacy reimbursement for North Dakota in 2005 was $63,715,988, of which $331,203 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

e. Enrollees in prepaid health plans (PHP) or managed care (MC) plans that did not provide a pharmacy benefit are treated as having fee-for-service pharmacy benefit coverage. There were 26 states in 2005 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NE, NY, TX, UT, and WV) and one state (NV) in which MC plans provided a pharmacy benefit for nonduals but not for duals. These lists were constructed from the CMS 2005 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer05.pdf and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit package.

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2005. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and N+B18D.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.

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

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2005. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

Characteristics of non-dual eligible beneficiaries represented by Cell J are shown in Appendix Table A.1 and characteristics of non-dual eligible beneficiaries and their benefit months included in Cell J but excluded from Cell K are shown in Appendix Table A.2. Characteristics of dual eligible beneficiaries represented by Cell F are shown in Appendix Table A.3, and characteristics of dual eligible beneficiaries and their benefit months included in Cell F but excluded from Cell G are shown in Appendix Table A.4.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; HMO = health maintenance organization; MAX = Medicaid Analytic Extract; MC = managed care; PCCM = primary care case management; PHP = prepaid health plan.

TABLE 2

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

NORTH DAKOTA, 2005

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**72,062**	**8,145**	**9,744**	**16,458**	**37,715**	**0**	**619,564**	**79,756**	**101,534**	**118,988**	**319,286**	**0**
Age												
5 and younger	16,584	0	193	0	16,391	0	137,758	0	2,026	0	135,732	0
6-14	15,313	0	464	2	14,847	0	136,785	0	4,964	11	131,810	0
15-20	8,016	0	446	1,351	6,219	0	64,999	0	4,621	9,780	50,598	0
21-44	17,860	0	3,778	13,824	258	0	140,874	0	39,421	100,307	1,146	0
45-64	6,081	2	4,802	1,277	0	0	58,852	23	49,960	8,869	0	0
65-74	2,108	2,043	61	4	0	0	21,320	20,757	542	21	0	0
75-84	2,666	2,666	0	0	0	0	26,250	26,250	0	0	0	0
85 and older	3,434	3,434	0	0	0	0	32,726	32,726	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	42,544	5,789	4,967	13,253	18,535	0	366,141	57,674	52,481	99,372	156,614	0
Male	29,516	2,356	4,777	3,205	19,178	0	253,412	22,082	49,053	19,616	162,661	0
Unknown	2	0	0	0	2	0	11	0	0	0	11	0
Race												
White	49,114	7,563	7,886	10,631	23,034	0	422,477	73,865	82,741	74,631	191,240	0
African American	1,648	30	111	434	1,073	0	13,163	281	970	2,969	8,943	0
Other/unknown	21,300	552	1,747	5,393	13,608	0	183,924	5,610	17,823	41,388	119,103	0
Use of Nursing Facilities[c]												
Entire year	3,794	3,445	349	0	0	0	37,202	33,483	3,719	0	0	0
Part year	1,380	1,060	306	13	1	0	13,021	9,820	3,066	123	12	0
None	66,888	3,640	9,089	16,445	37,714	0	569,341	36,453	94,749	118,865	319,274	0
Maintenance Assistance Status												
Cash	30,606	1,786	6,397	8,316	14,107	0	269,659	20,095	69,226	58,468	121,870	0
Medically needy	12,742	6,070	2,750	1,565	2,357	0	110,075	56,955	26,082	8,003	19,035	0
Poverty-related	12,638	287	242	1,189	10,920	0	93,508	2,682	2,283	6,315	82,228	0
Other/unknown	16,076	2	355	5,388	10,331	0	146,322	24	3,943	46,202	96,153	0
Dual Medicare Status[d]												
Full dual, all year	12,387	7,559	4,763	62	3	0	126,047	74,097	51,419	497	34	0
Full dual, part year	843	481	360	2	0	0	8,379	4,768	3,588	23	0	0
Non-dual, all year	58,832	105	4,621	16,394	37,712	0	485,138	891	46,527	118,468	319,252	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	71,232	8,145	9,742	16,126	37,219	0	616,581	79,756	101,526	117,836	317,463	0
FFS part year, with Rx claims	450	0	2	203	245	0	1,830	0	8	768	1,054	0
FFS part year, no Rx claims	380	0	0	129	251	0	1,153	0	0	384	769	0

Source: Data for this table are from the MAX 2005 file for North Dakota, released by CMS in 12/2008. This table was produced on 04/23/2009.

a. Table 2 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services. The total includes some beneficiaries with unknown basis of eligibility and some whose age categories are not consistent with basis of eligibility.

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

d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2005. The “Full dual, part year” group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.

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

TABLE 3

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

NORTH DAKOTA, 2005

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**64.6**	**15.0**	**$880**	**$59**	**$7,442**	**11.8**	**72,062**
Age							
5 and younger	59.0	3.0	128	42	1,929	6.6	16,584
6-14	53.7	4.4	279	64	2,121	13.1	15,313
15-20	58.7	6.3	411	66	4,171	9.9	8,016
21-44	66.3	12.1	837	69	6,751	12.4	17,860
45-64	78.0	39.5	2,800	71	19,090	14.7	6,081
65-74	80.2	50.3	2,744	55	19,229	14.3	2,108
75-84	88.0	58.4	2,862	49	22,729	12.6	2,666
85 and older	94.6	57.8	2,423	42	29,296	8.3	3,434
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	88.9	56.1	2,650	47	24,635	10.8	8,145
Disabled	81.3	37.2	2,927	79	22,577	13.0	9,744
Adults	62.6	7.4	348	47	2,468	14.1	16,458
Children	56.0	3.8	200	53	1,989	10.1	37,715
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	67.8	17.2	931	54	7,490	12.4	42,544
Male	60.1	12.0	805	67	7,374	10.9	29,516
Unknown	50.0	6.5	536	83	696	77.0	2
Race							
White	69.3	19.0	1,120	59	9,282	12.1	49,114
African American	60.4	5.6	285	51	2,253	12.7	1,648
Other/unknown	54.2	6.8	370	55	3,601	10.3	21,300
Use of Nursing Facilities[f]							
Entire year	97.5	72.3	3,603	50	43,138	8.4	3,794
Part year	95.9	59.6	3,133	53	28,618	10.9	1,380
None	62.1	10.9	679	62	4,980	13.6	66,888
Maintenance Assistance Status							
Cash	63.9	14.3	928	65	5,841	15.9	30,606
Medically needy	76.5	39.2	2,145	55	23,040	9.3	12,742
Poverty related	52.5	3.0	145	48	1,146	12.7	12,638
Other/unknown	66.2	6.8	361	54	3,077	11.7	16,076

Source: Data for this table are from the MAX 2005 file for North Dakota, released by CMS in 12/2008. This table was produced on 04/23/2009.

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

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

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

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

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

or blindness. The children's group includes children receiving foster care and adoptive services.

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

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

TABLE 4

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

NORTH DAKOTA, 2005

				Number of Rx, Percentage with:							Number	
Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Beneficiaries	Benefit Months
All	**1.8**	**$102**	**11.8**	**35.4**	**39.8**	**6.5**	**9.2**	**7.0**	**2.1**	**$866**	**72,062**	**619,564**
Age												
5 and younger	0.4	15	6.6	41.0	55.2	3.0	0.8	0.1	0.0	232	16,584	137,758
6-14	0.5	31	13.1	46.3	44.9	4.6	3.8	0.4	0.0	238	15,313	136,785
15-20	0.8	51	9.9	41.3	44.9	6.7	5.9	1.2	0.1	514	8,016	64,999
21-44	1.5	106	12.4	33.7	40.8	9.9	10.3	4.3	0.9	856	17,860	140,874
45-64	4.1	289	14.7	22.0	17.9	10.1	23.5	20.0	6.5	1,973	6,081	58,852
65-74	5.0	271	14.3	19.8	12.7	7.5	23.2	26.0	10.8	1,901	2,108	21,320
75-84	5.9	291	12.6	12.0	8.6	6.3	24.9	34.6	13.5	2,308	2,666	26,250
85 and older	6.1	254	8.3	5.4	6.0	7.0	29.7	40.6	11.2	3,074	3,434	32,726
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	5.7	271	10.8	11.1	8.6	7.0	26.4	35.0	11.9	2,516	8,145	79,756
Disabled	3.6	281	13.0	18.7	22.4	11.8	24.1	17.7	5.2	2,167	9,744	101,534
Adults	1.0	48	14.1	37.4	44.3	8.9	7.2	2.0	0.4	341	16,458	118,988
Children	0.4	24	10.1	44.0	49.2	4.0	2.5	0.3	0.0	235	37,715	319,286
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.0	108	12.4	32.2	40.1	7.0	10.0	8.2	2.6	870	42,544	366,141
Male	1.4	94	10.9	39.9	39.5	5.8	8.1	5.1	1.5	859	29,516	253,412
Unknown	1.2	98	77.0	50.0	50.0	0.0	0.0	0.0	0.0	127	2	11
Race												
White	2.2	130	12.1	30.7	38.3	7.3	11.4	9.3	2.9	1,079	49,114	422,477
African American	0.7	36	12.7	39.6	50.0	4.5	4.3	1.6	0.1	282	1,648	13,163
Other/unknown	0.8	43	10.3	45.8	42.5	4.7	4.5	2.0	0.5	417	21,300	183,924
Use of Nursing Facilities[f]												
Entire year	7.4	367	8.4	2.5	3.7	5.1	24.6	44.3	19.8	4,399	3,794	37,202
Part year	6.3	332	10.9	4.1	8.0	7.8	28.1	39.1	13.0	3,033	1,380	13,021
None	1.3	80	13.6	37.9	42.5	6.6	7.9	4.2	0.9	585	66,888	569,341
Maintenance Assistance Status												
Cash	1.6	105	15.9	36.1	39.8	6.9	9.6	6.0	1.5	663	30,606	269,659
Medically needy	4.5	248	9.3	23.5	17.6	7.6	19.9	23.2	8.1	2,667	12,742	110,075
Poverty related	0.4	20	12.7	47.5	46.5	3.8	1.9	0.2	0.0	155	12,638	93,508
Other/unknown	0.7	40	11.7	33.8	52.3	7.0	5.6	1.1	0.2	338	16,076	146,322

Source: Data for this table are from the MAX 2005 file for North Dakota, released by CMS in 12/2008. This table was produced on 04/23/2009.

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

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

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

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

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

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

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

TABLE 5
AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC[a, b, c]
NORTH DAKOTA, 2005

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.8**	**$102**	**$59**	**0.6**	**$75**	**$115**	**0.1**	**$5**	**$68**	**1.0**	**$23**	**$22**
Age												
5 and younger	0.4	15	42	0.1	11	82	0.0	1	47	0.2	4	18
6-14	0.5	31	64	0.2	25	102	0.0	1	68	0.2	5	21
15-20	0.8	51	66	0.3	40	119	0.0	2	56	0.4	9	21
21-44	1.5	106	69	0.5	78	143	0.1	6	79	0.9	23	25
45-64	4.1	289	71	1.5	213	138	0.2	16	95	2.4	61	26
65-74	5.0	271	55	1.8	194	106	0.2	11	63	2.9	66	22
75-84	5.9	291	49	2.1	208	97	0.2	10	48	3.6	73	21
85 and older	6.1	254	42	1.9	172	88	0.2	12	47	3.9	71	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.7	271	47	2.0	189	95	0.2	11	51	3.5	70	20
Disabled	3.6	281	79	1.4	212	150	0.1	14	96	2.0	54	27
Adults	1.0	48	47	0.3	32	104	0.1	3	62	0.7	13	20
Children	0.4	24	53	0.2	18	93	0.0	1	56	0.2	4	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.0	108	54	0.7	77	109	0.1	5	64	1.2	26	21
Male	1.4	94	67	0.6	71	127	0.1	4	78	0.8	19	24
Unknown	1.2	98	83	1.2	98	83	0.0	0	0	0.0	0	0
Race												
White	2.2	130	59	0.8	96	116	0.1	6	67	1.3	28	22
African American	0.7	36	51	0.2	27	108	0.0	2	48	0.4	7	17
Other/unknown	0.8	43	55	0.3	30	115	0.0	3	80	0.5	11	22
Use of Nursing Facilities[e]												
Entire year	7.4	367	50	2.5	256	103	0.3	16	55	4.6	96	21
Part year	6.3	332	53	2.2	235	108	0.2	13	55	3.9	83	21
None	1.3	80	62	0.5	59	120	0.1	4	75	0.7	17	23
Maintenance Assistance Status												
Cash	1.6	105	65	0.6	78	129	0.1	5	79	1.0	22	23
Medically needy	4.5	248	55	1.6	178	109	0.2	11	63	2.7	59	22
Poverty related	0.4	20	48	0.2	14	88	0.0	1	59	0.2	4	18
Other/unknown	0.7	40	54	0.3	30	101	0.0	2	58	0.4	8	20

Source: Data for this table are from the MAX 2005 file for North Dakota, released by CMS in 12/2008. This table was produced on 04/23/2009.

a. Table 5 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

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

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies

other than the original patent holder. In North Dakota, 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.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, 2005

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	0.2	$12	$6	$2	$4	$43	$93	$62	$21	86,773	$3,752,896	31,717	44.0	321,828
Biologicals	0.2	0.2	0.0	0.0	164	155	0	9	780	824	0	414	466	363,396	207	0.3	2,211
Antineoplastic Agents	0.6	0.2	0.0	0.5	85	63	0	22	136	406	160	46	3,103	422,910	508	0.7	4,980
Endocrine/Metabolic Drugs	0.8	0.3	0.1	0.4	33	22	3	8	43	85	40	18	111,794	4,769,535	13,964	19.4	143,493
Cardiovascular Agents	1.7	0.5	0.0	1.2	53	37	0	16	31	68	18	14	218,203	6,728,538	12,066	16.7	125,785
Respiratory Agents	0.4	0.2	0.0	0.2	26	22	1	4	59	95	51	19	75,929	4,448,020	16,557	23.0	171,407
Gastrointestinal Agents	0.5	0.1	0.0	0.4	32	22	0	10	58	152	56	24	40,526	2,341,855	7,054	9.8	73,934
Genitourinary Agents	0.5	0.3	0.0	0.1	33	27	1	5	68	84	63	32	21,374	1,454,812	4,206	5.8	43,990
CNS Drugs	1.2	0.6	0.0	0.6	110	92	2	15	89	146	164	26	201,396	17,861,934	15,872	22.0	162,686
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.2	61	55	1	6	83	97	93	35	26,065	2,165,435	3,481	4.8	35,651
Miscellaneous Psychological/ Neurological Agents	0.9	0.9	0.0	0.0	168	167	0	1	189	191	104	51	11,161	2,111,624	1,211	1.7	12,570
Analgesics and Anesthetics	0.6	0.1	0.0	0.4	32	13	5	13	54	137	143	29	94,140	5,108,568	16,046	22.3	162,047
Neuromuscular Agents	0.9	0.3	0.0	0.5	75	52	3	19	86	152	77	40	79,125	6,806,490	8,637	12.0	90,984
Nutritional Products	0.6	0.0	0.0	0.6	10	0	0	9	17	24	22	17	28,474	491,562	4,807	6.7	48,440
Hematological Agents	0.9	0.2	0.0	0.6	59	50	1	8	67	227	25	13	30,377	2,049,939	3,324	4.6	34,534
Topical Products	0.3	0.1	0.0	0.2	12	8	0	4	41	74	43	22	51,179	2,110,075	16,796	23.3	175,340
Miscellaneous Products	0.3	0.1	0.0	0.2	54	39	2	13	159	294	236	66	2,192	349,038	610	0.8	6,436
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	6	0	0	0	23	0	0	0	2,124	48,158	760	1.1	8,247
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.	1,084,401	63,384,785	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for North Dakota, released by CMS in 12/2008. This table was produced on 04/23/2009.

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

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

c. For information about these therapeutic categories, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than

the original patent holder. In North Dakota, 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.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2005.

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

TABLE 7

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

NORTH DAKOTA, 2005

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$11,088,490	6,520	9.0	70,065	0.8	$191	$158
ANTICONVULSANT	5,920,286	6,292	8.7	68,117	0.8	104	87
ANTIDEPRESSANTS	5,676,990	16,102	22.3	167,121	0.6	54	34
ANTIASTHMATIC	3,412,454	12,954	18.0	134,865	0.4	71	25
ANALGESICS - Narcotic	2,784,687	18,148	25.2	185,947	0.3	45	15
ANTIDIABETIC	2,616,667	5,496	7.6	58,037	0.8	57	45
ANTIHYPERLIPIDEMIC	2,505,102	4,205	5.8	46,363	0.7	77	54
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	2,153,402	4,070	5.6	42,258	0.6	83	51
MISC PSYCHOTHERAPEUTIC AND NEUROLOGICAL	2,141,539	1,801	2.5	18,808	0.6	180	114
ULCER DRUGS	1,881,866	7,743	10.7	81,449	0.6	41	23
Total	40,181,483	83,331		873,030	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for North Dakota, released by CMS in 12/2008. This table was produced on 04/23/2009.

a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2005. A beneficiary who used drugs from two or more groups was counted as a user for each group. Therefore, the sum of users across drug groups may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

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

c. The top 10 drug groups were determined based on total Medicaid reimbursement in the state for 2005. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

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