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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
SOUTH 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]	122,221	(A)	18,945	(E)	103,276	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	117,327	(B)	14,103	(F)	103,224	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	117,327	(C)	14,103	(G)	103,224	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	4,132	(D)	3,970	(H)	162	(L)

Source: Data for this table are from the MAX 2003 file for South 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 South Dakota in 2003 was $73,742,170, of which $41,135 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]

SOUTH 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	**117,327**	**7,531**	**15,081**	**19,815**	**74,900**	**0**	**1,094,290**	**74,930**	**162,931**	**150,301**	**706,128**	**0**
Age												
5 and younger	30,036	0	649	0	29,387	0	273,949	0	6,559	0	267,390	0
6-14	33,308	0	1,285	1	32,022	0	331,956	0	14,206	12	317,738	0
15-20	16,492	0	1,122	1,896	13,474	0	146,464	0	11,999	13,531	120,934	0
21-44	21,644	16	5,062	16,554	12	0	180,719	92	55,045	125,526	56	0
45-64	6,588	18	5,221	1,349	0	0	66,669	159	55,403	11,107	0	0
65-74	2,548	1,196	1,337	14	1	0	27,504	12,127	15,256	118	3	0
75-84	2,915	2,569	345	1	0	0	30,005	26,192	3,806	7	0	0
85 and older	3,794	3,732	60	0	2	0	37,020	36,360	657	0	3	0
Unknown	2	0	0	0	2	4 0		0	0	0	4	0
Gender												
Female	66,338	5,523	7,883	16,067	36,865	0	612,141	55,509	86,203	123,315	347,114	0
Male	50,988	2,008	7,198	3,747	38,035	0	482,148	19,421	76,728	26,985	359,014	0
Unknown	1	0	0	1	0	1 0		0	0	1	0	0
Race												
White	70,100	6,978	9,869	10,842	42,411	0	648,783	69,392	105,825	78,565	395,001	0
African American	2,625	12	193	391	2,029	0	23,201	112	1,894	2,723	18,472	0
Other/unknown	44,602	541	5,019	8,582	30,460	0	422,306	5,426	55,212	69,013	292,655	0
Use of Nursing Facilities[c]												
Entire year	4,132	3,584	548	0	0	0	41,607	35,585	6,022	0	0	0
Part year	1,595	1,213	378	3	1	0	14,837	11,137	3,673	19	8	0
None	111,600	2,734	14,155	19,812	74,899	0	1,037,846	28,208	153,236	150,282	706,120	0
Maintenance Assistance Status												
Cash	42,807	2,080	12,775	10,420	17,532	0	421,398	22,824	138,831	84,658	175,085	0
Medically needy	0	0	0	0	0	0 0		0	0	0	0	0
Poverty-related	48,240	114	98	4,376	43,652	0	443,586	1,066	1,010	24,024	417,486	0
Other/unknown	26,280	5,337	2,208	5,019	13,716	0	229,306	51,040	23,090	41,619	113,557	0
Dual Medicare Status[d]												
Full dual, all year	13,640	7,051	6,460	124	5	0	143,954	70,230	72,639	1,051	34	0
Full dual, part year	463	288	165	9	1	0	4,824	3,021	1,719	81	3	0
Non-dual, all year	103,224	192	8,456	19,682	74,894	0	945,512	1,679	88,573	149,169	706,091	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	117,327	7,531	15,081	19,815	74,900	0	1,094,290	74,930	162,931	150,301	706,128	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 2003 file for South 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]

SOUTH 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	**60.1 %**	**10.8**	**$628**	**$58**	**$4,652**	**13.5 %**	**117,327**
Age							
5 and younger	61.6	3.6	148	41	2,005	7.4	30,036
6-14	52.7	3.6	223	62	1,671	13.4	33,308
15-20	51.9	4.6	284	62	3,632	7.8	16,492
21-44	60.5	10.9	820	76	6,000	13.7	21,644
45-64	70.4	34.3	2,356	69	13,508	17.4	6,588
65-74	78.4	44.3	2,380	54	11,903	20.0	2,548
75-84	89.1	58.2	2,807	48	16,052	17.5	2,915
85 and older	95.6	58.8	2,541	43	19,508	13.0	3,794
Unknown	0.0	0.0	0	0	14	0.0	2
Basis of Eligibility[e]							
Aged	92.0	57.6	2,662	46	17,391	15.3	7,531
Disabled	72.8	31.6	2,381	75	15,468	15.4	15,081
Adults	56.4	5.4	277	51	2,631	10.5	19,815
Children	55.4	3.4	164	48	1,727	9.5	74,900
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	62.8	12.7	695	55	4,803	14.5	66,338
Male	56.7	8.4	541	65	4,455	12.1	50,988
Unknown	0.0	0.0	0	0	5	0.0	1
Race							
White	72.8	15.4	900	58	5,465	16.5	70,100
African American	59.8	4.6	256	56	1,738	14.7	2,625
Other/unknown	40.3	3.9	223	57	3,544	6.3	44,602
Use of Nursing Facilities[f]							
Entire year	98.0	71.2	3,507	49	28,150	12.5	4,132
Part year	95.2	59.1	2,944	50	22,483	13.1	1,595
None	58.2	7.9	489	62	3,527	13.9	111,600
Maintenance Assistance Status							
Cash	56.8	13.1	872	67	5,311	16.4	42,807
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	58.1	3.4	160	47	1,262	12.7	48,240
Other/unknown	69.3	20.8	1,090	52	9,799	11.1	26,280

Source: Data for this table are from the MAX 2003 file for South 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]

SOUTH DAKOTA, 2003

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: 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]	Number: Beneficiaries	Benefit Months
All	**1.2**	**$67**	**13.5 %**	**39.9 %**	**43.2 %**	**5.0 %**	**6.0 %**	**4.4 %**	**1.5 %**	**$499**	**117,327**	**1,094,290**
Age												
5 and younger	0.4	16	7.4	38.4	57.2	3.3	1.0	0.1	0.0	220	30,036	273,949
6-14	0.4	22	13.4	47.3	46.8	3.6	2.1	0.3	0.0	168	33,308	331,956
15-20	0.5	32	7.8	48.1	42.6	5.2	3.3	0.7	0.1	409	16,492	146,464
21-44	1.3	98	13.7	39.5	39.9	7.6	8.4	3.6	1.0	719	21,644	180,719
45-64	3.4	233	17.4	29.6	20.1	8.5	18.8	16.9	6.1	1,335	6,588	66,669
65-74	4.1	221	20.0	21.6	16.7	8.5	22.7	21.0	9.5	1,103	2,548	27,504
75-84	5.7	273	17.5	10.9	9.6	7.6	24.8	32.8	14.2	1,560	2,915	30,005
85 and older	6.0	260	13.0	4.4	7.0	6.8	30.3	39.5	12.1	1,999	3,794	37,020
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	7	2	4
Basis of Eligibility[e]												
Aged	5.8	268	15.3	8.0	9.1	7.4	27.5	34.8	13.2	1,748	7,531	74,930
Disabled	2.9	220	15.4	27.2	25.2	9.4	19.0	14.4	4.8	1,432	15,081	162,931
Adults	0.7	37	10.5	43.6	43.5	6.9	4.7	1.1	0.2	347	19,815	150,301
Children	0.4	17	9.5	44.6	50.2	3.5	1.6	0.1	0.0	183	74,900	706,128
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.4	75	14.5	37.2	43.3	5.4	6.7	5.4	2.0	521	66,338	612,141
Male	0.9	57	12.1	43.3	43.2	4.6	5.0	3.0	0.9	471	50,988	482,148
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	5	1	1
Race												
White	1.7	97	16.5	27.2	48.7	6.6	8.5	6.6	2.3	591	70,100	648,783
African American	0.5	29	14.7	40.2	51.5	4.6	2.9	0.5	0.2	197	2,625	23,201
Other/unknown	0.4	24	6.3	59.7	34.2	2.7	2.2	1.0	0.2	374	44,602	422,306
Use of Nursing Facilities[f]												
Entire year	7.1	348	12.5	2.0	4.7	5.6	27.3	42.5	18.0	2,796	4,132	41,607
Part year	6.4	316	13.1	4.8	8.3	8.2	27.5	35.6	15.6	2,417	1,595	14,837
None	0.8	53	13.9	41.8	45.2	5.0	4.9	2.5	0.7	379	111,600	1,037,846
Maintenance Assistance Status												
Cash	1.3	89	16.4	43.2	35.7	5.8	8.5	5.3	1.5	540	42,807	421,398
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.4	17	12.7	41.9	52.9	3.6	1.5	0.1	0.0	137	48,240	443,586
Other/unknown	2.4	125	11.1	30.7	37.8	6.4	10.3	10.6	4.3	1,123	26,280	229,306

Source: Data for this table are from the MAX 2003 file for South 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]

SOUTH 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	**1.2**	**$67**	**$58**	**0.5**	**$54**	**$99**	**0.1**	**$3**	**$40**	**0.6**	**$11**	**$20**
Age												
5 and younger	0.4	16	41	0.2	13	65	0.0	1	46	0.2	3	16
6-14	0.4	22	62	0.2	19	89	0.0	1	70	0.1	3	20
15-20	0.5	32	62	0.3	26	96	0.0	1	68	0.2	5	21
21-44	1.3	98	76	0.6	78	127	0.1	4	57	0.6	16	26
45-64	3.4	233	69	1.6	190	119	0.2	9	46	1.6	34	21
65-74	4.1	221	54	1.8	173	95	0.2	8	35	2.0	40	19
75-84	5.7	273	48	2.4	211	88	0.4	9	24	2.9	53	18
85 and older	6.0	260	43	2.4	195	83	0.4	9	22	3.2	56	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.8	268	46	2.4	205	86	0.4	9	23	3.0	54	18
Disabled	2.9	220	75	1.4	179	127	0.2	9	53	1.3	32	24
Adults	0.7	37	51	0.3	29	93	0.0	1	36	0.4	7	18
Children	0.4	17	48	0.2	14	73	0.0	1	60	0.2	3	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.4	75	55	0.6	60	96	0.1	3	36	0.7	13	19
Male	0.9	57	65	0.4	46	106	0.0	2	49	0.4	9	23
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.7	97	58	0.8	77	100	0.1	4	39	0.8	16	20
African American	0.5	29	56	0.3	23	89	0.0	1	67	0.2	4	18
Other/unknown	0.4	24	57	0.2	19	99	0.0	1	50	0.2	4	19
Use of Nursing Facilities[e]												
Entire year	7.1	348	49	2.9	266	92	0.5	11	25	3.7	71	19
Part year	6.4	316	50	2.6	245	94	0.4	10	28	3.4	61	18
None	0.8	53	62	0.4	42	102	0.0	2	48	0.4	8	21
Maintenance Assistance Status												
Cash	1.3	89	67	0.6	71	114	0.1	4	49	0.6	14	22
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.4	17	47	0.2	14	72	0.0	1	58	0.2	3	19
Other/unknown	2.4	125	52	1.1	98	93	0.1	4	29	1.2	22	19

Source: Data for this table are from the MAX 2003 file for South 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 South Dakota, 1.0 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]

SOUTH 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	$9	$0	$3	$44	$65	$72	$21	141,691	$6,182,045	50,531	43.1 %	528,785
Biologicals	0.1	0.1	0.0	0.0	44	39	0	5	358	330	0	982	2,113	757,045	1,536	1.3	17,133
Antineoplastic Agents	0.6	0.3	0.0	0.3	147	132	2	13	247	444	120	46	3,218	795,991	515	0.4	5,405
Endocrine/Metabolic Drugs	0.7	0.3	0.1	0.2	29	22	3	4	43	72	22	17	115,862	5,002,135	16,747	14.3	174,248
Cardiovascular Agents	1.6	0.5	0.1	1.0	47	31	1	14	29	59	18	14	200,702	5,782,178	11,805	10.1	123,892
Respiratory Agents	0.4	0.2	0.0	0.2	23	19	1	3	54	79	65	18	130,548	7,023,359	28,685	24.4	303,120
Gastrointestinal Agents	0.7	0.4	0.0	0.3	54	44	1	9	81	118	125	32	85,582	6,966,866	12,294	10.5	128,112
Genitourinary Agents	0.5	0.4	0.0	0.1	32	30	0	2	69	80	40	21	22,030	1,512,825	4,576	3.9	47,366
CNS Drugs	1.1	0.7	0.0	0.4	97	84	3	10	85	126	122	22	194,374	16,605,106	16,602	14.2	171,753
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.1	56	49	2	5	80	92	60	35	28,771	2,297,968	3,876	3.3	41,279
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	110	110	0	0	152	156	0	12	6,188	940,312	823	0.7	8,550
Analgesics and Anesthetics	0.5	0.2	0.0	0.3	30	25	1	5	56	126	54	14	109,466	6,162,472	19,853	16.9	203,801
Neuromuscular Agents	0.8	0.3	0.1	0.4	61	48	3	11	80	143	47	29	85,195	6,854,125	10,411	8.9	111,555
Nutritional Products	0.5	0.0	0.0	0.5	10	0	1	8	18	24	32	17	33,226	598,311	6,418	5.5	62,030
Hematological Agents	0.9	0.2	0.2	0.5	79	58	4	17	90	289	18	37	32,344	2,905,942	3,546	3.0	36,634
Topical Products	0.3	0.1	0.0	0.1	10	7	1	3	38	64	48	19	70,717	2,712,592	26,083	22.2	278,309
Miscellaneous Products	0.3	0.1	0.0	0.1	39	28	7	5	146	200	286	46	3,140	458,410	1,087	0.9	11,626
Unknown Therapeutic Category	0.1	0.0	0.0	0.0	4	0	0	0	30	0	0	0	4,807	143,353	3,470	3.0	37,402
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.	1,269,974	73,701,035	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for South 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 South Dakota, 1.0 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]

SOUTH 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	$9,468,810	7,074	6.0 %	76,750	0.7	$169	$123
ANTIDEPRESSANTS	6,349,643	16,288	13.9	169,702	0.6	62	37
ANTICONVULSANT	5,819,587	6,366	5.4	69,477	0.9	96	84
ULCER DRUGS	5,689,453	10,462	8.9	109,399	0.5	96	52
ANTIASTHMATIC	4,024,493	19,827	16.9	209,850	0.3	59	19
ANALGESICS - Narcotic	3,151,746	19,837	16.9	203,750	0.3	47	15
ANALGESICS - ANTI-INFLAMMATORY	2,368,747	10,597	9.0	111,940	0.3	69	21
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	2,297,968	4,997	4.3	53,819	0.5	80	43
ANTIDIABETIC	2,211,863	5,148	4.4	54,920	0.7	54	40
MISC. HEMATOLOGICAL	2,029,856	1,058	0.9	11,188	0.7	278	181
Total	43,412,166	101,654		1,070,795	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for South 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.