STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2004
SOUTH DAKOTA

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
SOUTH DAKOTA, 2004

Inclusion Criteria (2004)	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]	125,995	(A)	19,202	(E)	106,793	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	120,898	(B)	14,161	(F)	106,737	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	120,898	(C)	14,161	(G)	106,737	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	4,048	(D)	3,889	(H)	159	(L)

Source: Data for this table are from the MAX 2004 file for South Dakota, released by CMS in 02/2008. This table was produced on 03/25/2008.

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 2004 (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 2004, 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 2004 was $84,619,368, of which $71,210 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 23 states in 2004 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NY, OK, OR, PA, SC, 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) 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 2004 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer04.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 pa

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 2004. 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 2004. 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, 2004

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**120,898**	**7,382**	**15,282**	**20,715**	**77,471**	**48**	**1,125,935**	**72,916**	**164,458**	**156,878**	**731,260**	**423**
Age												
5 and younger	31,216	0	676	0	30,540	0	285,835	0	6,477	0	279,358	0
6-14	34,132	0	1,304	0	32,828	0	339,833	0	14,429	0	325,404	0
15-20	17,136	0	1,085	1,962	14,089	0	152,009	0	11,722	13,862	126,425	0
21-44	22,411	0	5,081	17,298	14	18	186,325	0	55,068	131,014	73	170
45-64	6,839	1	5,371	1,437	0	30	68,814	12	56,695	11,854	0	253
65-74	2,561	1,184	1,360	17	0	0	27,669	12,049	15,474	146	0	0
75-84	2,856	2,514	341	1	0	0	29,170	25,277	3,891	2	0	0
85 and older	3,747	3,683	64	0	0	0	36,280	35,578	702	0	0	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Gender												
Female	68,311	5,387	7,943	16,833	38,100	48	630,336	53,988	86,379	129,292	360,254	423
Male	52,587	1,995	7,339	3,882	39,371	0	495,599	18,928	78,079	27,586	371,006	0
Unknown	0	0	0	0	0	0		0	0	0	0	0
Race												
White	72,088	6,863	9,999	11,386	43,803	37	666,384	67,762	107,042	82,351	408,903	326
African American	2,690	11	140	506	2,032	1	23,200	91	1,270	3,512	18,319	8
Other/unknown	46,120	508	5,143	8,823	31,636	10	436,351	5,063	56,146	71,015	304,038	89
Use of Nursing Facilities[c]												
Entire year	4,048	3,475	573	0	0	0	40,711	34,479	6,232	0	0	0
Part year	1,641	1,238	394	8	0	1	14,864	10,852	3,915	88	0	9
None	115,209	2,669	14,315	20,707	77,471	47	1,070,360	27,585	154,311	156,790	731,260	414
Maintenance Assistance Status												
Cash	42,703	2,032	12,816	10,480	17,375	0	417,953	22,195	138,851	84,487	172,420	0
Medically needy	0	0	0	0	0	0		0	0	0	0	0
Poverty-related	49,907	95	95	4,497	45,172	48	459,908	903	978	24,578	433,026	423
Other/unknown	28,288	5,255	2,371	5,738	14,924	0	248,074	49,818	24,629	47,813	125,814	0
Dual Medicare Status[d]												
Full dual, all year	13,652	6,927	6,607	113	3	2	143,727	68,486	74,263	928	31	19
Full dual, part year	509	326	171	12	0	0	5,250	3,348	1,759	143	0	0
Non-dual, all year	106,737	129	8,504	20,590	77,468	46	976,958	1,082	88,436	155,807	731,229	404
Managed Care (MC) Status												
Fee-for-service (FFS) all year	120,898	7,382	15,282	20,715	77,471	48	1,125,935	72,916	164,458	156,878	731,260	423
FFS part year, with Rx claims	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

Source: Data for this table are from the MAX 2004 file for South Dakota, released by CMS in 02/2008. This table was produced on 03/25/2008.

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 2004. 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, 2004

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	**58.6 %**	**11.1**	**$699**	**$63**	**$4,808**	**14.5 %**	**120,898**
Age							
5 and younger	59.0	3.3	152	46	2,098	7.2	31,216
6-14	49.8	3.7	274	73	1,769	15.5	34,132
15-20	51.7	4.7	313	67	3,757	8.3	17,136
21-44	60.9	11.2	898	80	6,198	14.5	22,411
45-64	70.7	36.6	2,725	75	13,922	19.6	6,839
65-74	77.0	46.5	2,677	58	12,540	21.3	2,561
75-84	89.3	60.8	3,110	51	17,050	18.2	2,856
85 and older	95.7	61.8	2,827	46	20,321	13.9	3,747
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	91.8	60.7	2,978	49	18,196	16.4	7,382
Disabled	72.7	33.3	2,710	81	16,139	16.8	15,282
Adults	57.2	5.8	320	55	2,814	11.4	20,715
Children	53.1	3.3	187	56	1,823	10.2	77,471
Unknown	66.7	22.0	1,565	71	17,502	8.9	48
Gender							
Female	61.7	13.0	767	59	4,955	15.5	68,311
Male	54.6	8.5	612	72	4,618	13.2	52,587
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	70.6	15.7	1,000	64	5,698	17.6	72,088
African American	54.3	4.0	247	62	1,836	13.4	2,690
Other/unknown	40.2	4.1	255	62	3,591	7.1	46,120
Use of Nursing Facilities[f]							
Entire year	98.0	75.4	3,966	53	30,102	13.2	4,048
Part year	94.8	58.5	3,159	54	22,828	13.8	1,641
None	56.7	8.1	550	68	3,663	15.0	115,209
Maintenance Assistance Status							
Cash	56.4	13.7	981	71	5,583	17.6	42,703
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	55.5	3.3	189	57	1,371	13.8	49,907
Other/unknown	67.6	20.6	1,174	57	9,705	12.1	28,288

Source: Data for this table are from the MAX 2004 file for South Dakota, released by CMS in 02/2008. This table was produced on 03/25/2008.

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, 2004

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**	**$75**	**14.5 %**	**41.4 %**	**41.5 %**	**5.0 %**	**6.0 %**	**4.4 %**	**1.6 %**	**$516**	**120,898**	**1,125,935**
Age												
5 and younger	0.4	17	7.2	41.0	54.8	3.1	1.0	0.1	0.0	229	31,216	285,835
6-14	0.4	28	15.5	50.2	43.3	3.7	2.5	0.3	0.0	178	34,132	339,833
15-20	0.5	35	8.3	48.3	42.5	5.2	3.3	0.7	0.1	424	17,136	152,009
21-44	1.3	108	14.5	39.1	39.5	8.1	8.4	4.0	1.0	746	22,411	186,325
45-64	3.6	271	19.6	29.3	19.5	8.0	19.2	17.0	7.2	1,384	6,839	68,814
65-74	4.3	248	21.3	23.0	15.0	7.7	21.1	23.1	10.2	1,161	2,561	27,669
75-84	6.0	305	18.2	10.7	9.3	6.9	24.3	32.9	15.9	1,669	2,856	29,170
85 and older	6.4	292	13.9	4.3	6.3	6.3	29.3	40.7	13.2	2,099	3,747	36,280
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	6.1	302	16.4	8.2	8.0	6.6	26.7	35.7	14.7	1,842	7,382	72,916
Disabled	3.1	252	16.8	27.3	24.2	9.1	18.8	15.2	5.4	1,500	15,282	164,458
Adults	0.8	42	11.4	42.8	43.2	7.3	5.2	1.3	0.2	372	20,715	156,878
Children	0.4	20	10.2	46.9	47.7	3.5	1.7	0.1	0.0	193	77,471	731,260
Unknown	2.5	178	8.9	33.3	18.8	12.5	27.1	6.3	2.1	1,986	48	423
Gender												
Female	1.4	83	15.5	38.3	42.1	5.4	6.7	5.4	2.1	537	68,311	630,336
Male	0.9	65	13.2	45.4	40.8	4.6	5.1	3.2	1.0	490	52,587	495,599
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.7	108	17.6	29.4	46.3	6.6	8.4	6.7	2.5	616	72,088	666,384
African American	0.5	29	13.4	45.7	47.1	3.6	2.8	0.7	0.1	213	2,690	23,200
Other/unknown	0.4	27	7.1	59.8	33.7	2.7	2.4	1.1	0.3	380	46,120	436,351
Use of Nursing Facilities[f]												
Entire year	7.5	394	13.2	2.0	4.3	4.8	25.1	42.8	21.0	2,993	4,048	40,711
Part year	6.5	349	13.8	5.2	8.3	7.1	28.0	36.0	15.4	2,520	1,641	14,864
None	0.9	59	15.0	43.3	43.3	5.0	5.0	2.6	0.7	394	115,209	1,070,360
Maintenance Assistance Status												
Cash	1.4	100	17.6	43.6	34.6	5.9	8.6	5.7	1.6	570	42,703	417,953
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	21	13.8	44.5	50.0	3.7	1.6	0.1	0.0	149	49,907	459,908
Other/unknown	2.4	134	12.1	32.4	37.1	6.2	9.9	10.1	4.4	1,107	28,288	248,074

Source: Data for this table are from the MAX 2004 file for South Dakota, released by CMS in 02/2008. This table was produced on 03/25/2008.

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, 2004

	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**	**$75**	**$63**	**0.5**	**$57**	**$114**	**0.1**	**$5**	**$58**	**0.6**	**$13**	**$21**
Age												
5 and younger	0.4	17	46	0.2	12	79	0.0	1	43	0.2	3	17
6-14	0.4	28	73	0.2	24	109	0.0	1	60	0.1	3	21
15-20	0.5	35	67	0.3	28	109	0.0	2	67	0.2	5	22
21-44	1.3	108	80	0.6	82	145	0.1	9	81	0.7	17	26
45-64	3.6	271	75	1.6	208	134	0.3	21	75	1.8	42	23
65-74	4.3	248	58	1.7	186	106	0.3	17	54	2.2	45	20
75-84	6.0	305	51	2.3	226	99	0.4	18	41	3.2	60	19
85 and older	6.4	292	46	2.3	209	93	0.5	18	35	3.6	64	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	6.1	302	49	2.3	221	97	0.5	18	38	3.3	61	18
Disabled	3.1	252	81	1.4	195	143	0.3	19	76	1.5	37	26
Adults	0.8	42	55	0.3	31	108	0.0	3	66	0.4	8	18
Children	0.4	20	56	0.2	16	89	0.0	1	51	0.2	3	19
Unknown	2.5	178	71	0.9	146	157	0.2	8	43	1.3	23	17
Gender												
Female	1.4	83	59	0.6	63	110	0.1	6	54	0.7	14	20
Male	0.9	65	72	0.4	50	122	0.1	4	67	0.4	10	24
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.7	108	64	0.7	83	114	0.1	7	57	0.8	18	21
African American	0.5	29	62	0.2	23	111	0.0	2	65	0.2	4	18
Other/unknown	0.4	27	62	0.2	21	115	0.0	2	63	0.2	5	20
Use of Nursing Facilities[e]												
Entire year	7.5	394	53	2.7	287	105	0.6	25	41	4.1	82	20
Part year	6.5	349	54	2.4	257	107	0.5	21	45	3.5	70	20
None	0.9	59	68	0.4	46	117	0.1	4	66	0.4	9	22
Maintenance Assistance Status												
Cash	1.4	100	71	0.6	78	128	0.1	8	73	0.7	15	21
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.4	21	57	0.2	15	88	0.0	1	51	0.2	4	25
Other/unknown	2.4	134	57	0.9	101	108	0.2	8	45	1.2	24	20

Source: Data for this table are from the MAX 2004 file for South Dakota, released by CMS in 02/2008. This table was produced on 03/25/2008.

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, 1.2 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 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, 2004

	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	0.3	0.1	0.0	0.1	$12	$8	$1	$3	$45	$78	$65	$21	134,830	$6,098,119	49,338	40.8 %	516,712
Biologicals	0.1	0.1	0.0	0.0	89	76	0	13	595	553	21	1,110	1,409	838,031	881	0.7	9,458
Antineoplastic Agents	0.6	0.1	0.0	0.5	92	67	1	24	144	502	110	48	3,506	504,767	529	0.4	5,476
Endocrine/Metabolic Drugs	0.7	0.2	0.1	0.3	33	24	4	6	49	96	28	19	121,314	5,979,048	17,278	14.3	179,017
Cardiovascular Agents	1.7	0.5	0.1	1.1	50	33	3	15	30	65	29	14	214,652	6,498,818	12,328	10.2	129,186
Respiratory Agents	0.5	0.3	0.0	0.2	27	24	0	3	60	85	48	18	134,019	8,072,367	27,737	22.9	293,994
Gastrointestinal Agents	0.7	0.3	0.0	0.3	58	47	3	9	85	139	52	30	94,032	8,001,295	13,188	10.9	137,266
Genitourinary Agents	0.5	0.3	0.0	0.1	36	30	2	3	74	91	61	29	23,789	1,770,138	4,809	4.0	49,773
CNS Drugs	1.2	0.6	0.1	0.5	107	87	8	12	91	147	98	24	208,668	18,947,713	17,288	14.3	177,830
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	71	66	1	3	94	104	71	35	36,484	3,438,067	4,617	3.8	48,756
Miscellaneous Psychological/ Neurological Agents	0.8	0.8	0.0	0.0	147	145	1	1	185	188	97	57	9,573	1,770,397	1,169	1.0	12,079
Analgesics and Anesthetics	0.6	0.2	0.0	0.3	34	26	2	6	61	132	208	17	117,727	7,218,899	20,834	17.2	212,863
Neuromuscular Agents	1.0	0.4	0.1	0.5	88	61	13	14	90	161	95	31	87,267	7,812,041	8,356	6.9	89,102
Nutritional Products	0.5	0.0	0.0	0.5	9	0	1	8	18	25	35	17	33,545	590,578	6,543	5.4	63,629
Hematological Agents	0.9	0.2	0.2	0.5	85	63	5	17	93	294	28	33	34,016	3,175,494	3,599	3.0	37,432
Topical Products	0.3	0.1	0.0	0.1	11	7	1	3	43	78	46	22	72,958	3,155,563	26,935	22.3	287,411
Miscellaneous Products	0.3	0.1	0.0	0.1	43	30	6	7	154	211	267	59	3,594	554,888	1,194	1.0	12,910
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	7	0	0	0	23	0	0	0	5,193	121,935	1,504	1.2	16,470
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.	1,336,576	84,548,158	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for South Dakota, released by CMS in 02/2008. This table was produced on 03/25/2008.

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, 1.2 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 2004.

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, 2004

		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	$11,445,385	7,626	6.3 %	81,789	0.8	$183	$140
ANTICONVULSANT	6,728,660	6,759	5.6	73,481	0.9	105	92
ANTIDEPRESSANTS	6,665,733	17,103	14.1	177,268	0.6	61	38
ULCER DRUGS	6,280,981	11,167	9.2	116,386	0.5	99	54
ANTIASTHMATIC	4,933,927	20,830	17.2	221,689	0.3	68	22
ANALGESICS - Narcotic	3,735,254	21,151	17.5	216,726	0.3	52	17
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	3,438,067	5,668	4.7	60,533	0.6	94	57
ANALGESICS - ANTI-INFLAMMATORY	2,704,004	10,978	9.1	115,135	0.3	76	23
ANTIDIABETIC	2,530,028	5,452	4.5	58,031	0.8	57	44
MISC. HEMATOLOGICAL	2,193,902	1,117	0.9	11,745	0.7	273	187
Total	50,655,941	107,851		1,132,783	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2004 file for South Dakota, released by CMS in 02/2008. This table was produced on 03/25/2008.

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 2004. 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 2004. 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.