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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
SOUTH 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]	129084 (A)	19697 (E)	109387 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	123605 (B)	14267 (F)	109338 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	123605 (C)	14267 (G)	109338 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	4069 (D)	3917 (H)	152 (L)

Source: Data for this table are from the MAX 2005 file for South 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 South Dakota in 2005 was $90,177,406, of which $42,290 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]
SOUTH 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	**123,605**	**7,210**	**15,594**	**21,296**	**79,442**	**63**	**1,154,565**	**71,033**	**167,656**	**162,578**	**752,718**	**580**
Age												
5 and younger	32,290	0	655	0	31,635	0	296,770	0	6,571	0	290,199	0
6-14	34,537	0	1,321	0	33,216	0	345,312	0	14,752	0	330,560	0
15-20	17,640	0	1,126	1,945	14,569	0	157,618	0	12,053	13,764	131,801	0
21-44	22,938	0	5,093	17,804	21	20	190,920	0	54,900	135,697	157	166
45-64	7,186	0	5,612	1,532	0	42	72,660	0	59,279	12,979	0	402
65-74	2,440	1,087	1,337	14	1	1	26,509	11,279	15,091	126	1	12
75-84	2,816	2,442	373	1	0	0	28,498	24,292	4,194	12	0	0
85 and older	3,758	3,681	77	0	0	0	36,278	35,462	816	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	69,864	5,292	8,089	17,311	39,109	63	645,207	52,752	87,835	133,575	370,465	580
Male	53,741	1,918	7,505	3,985	40,333	0	509,358	18,281	79,821	29,003	382,253	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	72,609	6,718	10,223	11,493	44,121	54	672,659	65,932	109,215	83,077	413,954	481
African American	3,021	10	152	616	2,243	0	25,765	90	1,340	4,188	20,147	0
Other/unknown	47,975	482	5,219	9,187	33,078	9	456,141	5,011	57,101	75,313	318,617	99
Use of Nursing Facilities[c]												
Entire year	4,069	3,453	615	1	0	0	40,279	33,644	6,633	2	0	0
Part year	1,622	1,163	453	3	3	0	15,331	10,697	4,571	30	33	0
None	117,914	2,594	14,526	21,292	79,439	63	1,098,955	26,692	156,452	162,546	752,685	580
Maintenance Assistance Status												
Cash	42,551	1,946	12,988	10,514	17,103	0	420,195	21,385	140,447	86,834	171,529	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	51,268	107	162	4,375	46,561	63	474,021	1,089	1,683	23,582	447,087	580
Other/unknown	29,786	5,157	2,444	6,407	15,778	0	260,349	48,559	25,526	52,162	134,102	0
Dual Medicare Status[d]												
Full dual, all year	13,720	6,812	6,771	127	6	4	144,176	67,076	75,887	1,128	52	33
Full dual, part year	547	307	229	11	0	0	5,770	3,243	2,418	109	0	0
Non-dual, all year	109,338	91	8,594	21,158	79,436	59	1,004,619	714	89,351	161,341	752,666	547
Managed Care (MC) Status												
Fee-for-service (FFS) all year	123,605	7,210	15,594	21,296	79,442	63	1,154,565	71,033	167,656	162,578	752,718	580
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 2005 file for South 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]
SOUTH 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	**60.4**	**11.4**	**$729**	**$64**	**$4,999**	**14.6**	**123,605**
Age							
5 and younger	60.3	3.4	162	48	2,119	7.6	32,290
6-14	53.4	4.0	293	74	1,876	15.6	34,537
15-20	53.1	4.9	329	67	3,873	8.5	17,640
21-44	62.1	11.4	890	78	6,389	13.9	22,938
45-64	71.4	38.4	2,963	77	14,749	20.1	7,186
65-74	78.0	48.3	2,815	58	13,320	21.1	2,440
75-84	90.0	62.2	3,279	53	17,843	18.4	2,816
85 and older	95.9	63.9	2,970	47	21,578	13.8	3,758
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	92.3	62.6	3,131	50	19,340	16.2	7,210
Disabled	74.0	34.6	2,810	81	16,791	16.7	15,594
Adults	58.3	6.1	337	55	2,953	11.4	21,296
Children	55.4	3.5	208	59	1,924	10.8	79,442
Unknown	77.8	21.7	1,191	55	13,603	8.8	63
Gender							
Female	63.4	13.3	794	60	5,144	15.4	69,864
Male	56.5	8.8	645	73	4,810	13.4	53,741
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	72.7	16.3	1,053	65	5,939	17.7	72,609
African American	53.6	4.2	275	65	1,876	14.7	3,021
Other/unknown	42.3	4.3	267	62	3,773	7.1	47,975
Use of Nursing Facilities[f]							
Entire year	98.4	77.4	4,122	53	31,154	13.2	4,069
Part year	95.7	63.6	3,426	54	25,165	13.6	1,622
None	58.6	8.4	575	69	3,819	15.1	117,914
Maintenance Assistance Status							
Cash	57.3	14.2	1,047	74	5,890	17.8	42,551
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	58.2	3.6	203	56	1,369	14.8	51,268
Other/unknown	68.8	20.6	1,182	57	9,973	11.8	29,786

Source: Data for this table are from the MAX 2005 file for South 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]
SOUTH 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	**1.2**	**$78**	**14.6**	**39.6**	**42.9**	**5.2**	**6.0**	**4.5**	**1.8**	**$535**	**123,605**	**1,154,565**
Age												
5 and younger	0.4	18	7.6	39.7	56.1	3.1	1.0	0.1	0.0	231	32,290	296,770
6-14	0.4	29	15.6	46.6	46.5	4.0	2.6	0.3	0.0	188	34,537	345,312
15-20	0.6	37	8.5	46.9	42.5	6.0	3.8	0.6	0.1	434	17,640	157,618
21-44	1.4	107	13.9	37.9	40.1	8.3	8.6	4.2	1.0	768	22,938	190,920
45-64	3.8	293	20.1	28.6	18.8	7.8	18.9	17.7	8.3	1,459	7,186	72,660
65-74	4.4	259	21.1	22.0	14.8	6.8	21.9	23.6	10.9	1,226	2,440	26,509
75-84	6.1	324	18.4	10.0	9.3	6.7	23.1	32.3	18.6	1,763	2,816	28,498
85 and older	6.6	308	13.8	4.1	5.7	6.0	26.4	42.9	14.9	2,235	3,758	36,278
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	6.4	318	16.2	7.7	7.5	6.5	24.6	37.0	16.6	1,963	7,210	71,033
Disabled	3.2	261	16.7	26.0	24.0	9.0	19.2	15.7	6.1	1,562	15,594	167,656
Adults	0.8	44	11.4	41.7	43.3	7.7	5.6	1.5	0.2	387	21,296	162,578
Children	0.4	22	10.8	44.6	49.7	3.7	1.8	0.2	0.0	203	79,442	752,718
Unknown	2.4	129	8.8	22.2	34.9	9.5	23.8	9.5	0.0	1,478	63	580
Gender												
Female	1.4	86	15.4	36.6	43.3	5.7	6.6	5.6	2.3	557	69,864	645,207
Male	0.9	68	13.4	43.5	42.4	4.7	5.2	3.1	1.1	508	53,741	509,358
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.8	114	17.7	27.3	47.7	6.8	8.4	6.9	2.8	641	72,609	672,659
African American	0.5	32	14.7	46.4	46.5	3.7	2.4	0.6	0.4	220	3,021	25,765
Other/unknown	0.5	28	7.1	57.7	35.4	2.9	2.6	1.1	0.3	397	47,975	456,141
Use of Nursing Facilities[f]												
Entire year	7.8	416	13.2	1.6	3.5	4.9	22.5	43.7	23.7	3,147	4,069	40,279
Part year	6.7	362	13.6	4.3	8.7	6.3	26.4	35.6	18.6	2,662	1,622	15,331
None	0.9	62	15.1	41.4	44.7	5.2	5.2	2.7	0.8	410	117,914	1,098,955
Maintenance Assistance Status												
Cash	1.4	106	17.8	42.7	34.8	6.0	8.7	5.9	1.8	596	42,551	420,195
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	22	14.8	41.8	52.1	4.0	1.8	0.2	0.0	148	51,268	474,021
Other/unknown	2.4	135	11.8	31.2	38.7	6.1	9.3	9.9	4.8	1,141	29,786	260,349

Source: Data for this table are from the MAX 2005 file for South 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]
SOUTH 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	**1.2**	**$78**	**$64**	**0.5**	**$58**	**$121**	**0.1**	**$5**	**$66**	**0.7**	**$15**	**$23**
Age												
5 and younger	0.4	18	48	0.1	13	87	0.0	1	52	0.2	4	18
6-14	0.4	29	74	0.2	24	115	0.0	2	71	0.2	4	21
15-20	0.6	37	67	0.2	29	119	0.0	2	62	0.3	6	22
21-44	1.4	107	78	0.5	82	156	0.1	7	86	0.8	18	24
45-64	3.8	293	77	1.5	221	143	0.2	18	84	2.0	55	27
65-74	4.4	259	58	1.7	189	109	0.2	13	57	2.5	57	23
75-84	6.1	324	53	2.3	232	103	0.3	16	52	3.6	76	21
85 and older	6.6	308	47	2.2	208	95	0.4	19	45	4.0	81	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	6.4	318	50	2.2	222	99	0.4	17	48	3.7	78	21
Disabled	3.2	261	81	1.4	202	149	0.2	15	82	1.7	44	27
Adults	0.8	44	55	0.3	31	121	0.0	3	73	0.5	9	19
Children	0.4	22	59	0.2	17	100	0.0	1	62	0.2	4	20
Unknown	2.4	129	55	0.8	94	112	0.2	6	36	1.3	29	22
Gender												
Female	1.4	86	60	0.5	63	116	0.1	5	61	0.8	18	22
Male	0.9	68	73	0.4	53	130	0.1	4	76	0.5	11	24
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.8	114	65	0.7	85	121	0.1	7	65	0.9	22	23
African American	0.5	32	65	0.2	25	123	0.0	2	83	0.3	5	20
Other/unknown	0.5	28	62	0.2	21	121	0.0	2	73	0.3	6	22
Use of Nursing Facilities[e]												
Entire year	7.8	416	53	2.7	288	107	0.4	23	53	4.7	105	23
Part year	6.7	362	54	2.3	253	108	0.4	21	57	4.0	88	22
None	0.9	62	69	0.4	47	126	0.1	4	71	0.5	11	23
Maintenance Assistance Status												
Cash	1.4	106	74	0.6	81	138	0.1	7	80	0.8	19	24
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.4	22	56	0.2	17	99	0.0	2	59	0.2	4	20
Other/unknown	2.4	135	57	0.9	98	112	0.1	7	54	1.3	29	22

Source: Data for this table are from the MAX 2005 file for South 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 South Dakota, 1.1 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]
SOUTH DAKOTA, 2005

	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	0.2	$12	$6	$2	$3	$44	$90	$66	$20	147,727	$6,454,079	53,410	43.2	559,360
Biologicals	0.1	0.1	0.0	0.0	67	66	0	0	464	493	119	47	2,021	937,877	1,275	1.0	14,075
Antineoplastic Agents	0.7	0.2	0.0	0.5	113	90	0	23	165	528	119	44	3,781	623,049	531	0.4	5,502
Endocrine/Metabolic Drugs	0.7	0.2	0.1	0.3	35	23	5	7	52	105	43	20	129,922	6,697,037	18,334	14.8	189,712
Cardiovascular Agents	1.7	0.6	0.0	1.1	55	38	1	16	32	68	24	15	224,069	7,268,000	12,695	10.3	132,680
Respiratory Agents	0.4	0.3	0.0	0.2	28	24	1	3	63	90	62	19	142,723	9,053,957	29,994	24.3	317,744
Gastrointestinal Agents	0.7	0.3	0.0	0.3	57	48	1	9	85	144	49	27	98,478	8,365,059	14,003	11.3	145,974
Genitourinary Agents	0.5	0.3	0.0	0.1	36	31	1	4	75	94	66	30	25,088	1,877,322	5,054	4.1	52,378
CNS Drugs	1.2	0.6	0.0	0.5	112	96	3	14	96	156	149	26	213,243	20,393,710	17,667	14.3	181,420
Stimulants/Anti-obesity/Anorexia	0.8	0.7	0.0	0.1	79	75	1	3	103	113	83	32	39,364	4,073,448	4,898	4.0	51,786
Miscellaneous Psychological/ Neurological Agents	0.8	0.8	0.0	0.0	150	149	0	1	180	182	114	64	12,219	2,197,532	1,428	1.2	14,606
Analgesics and Anesthetics	0.5	0.1	0.0	0.4	29	12	6	12	55	138	172	28	119,866	6,551,739	22,170	17.9	226,067
Neuromuscular Agents	0.8	0.3	0.0	0.5	72	53	3	17	89	172	71	36	92,954	8,234,401	10,657	8.6	113,583
Nutritional Products	0.5	0.0	0.0	0.5	10	1	1	9	18	36	35	17	34,747	635,142	6,705	5.4	65,334
Hematological Agents	0.9	0.2	0.1	0.6	72	61	2	8	78	264	23	14	35,219	2,734,271	3,705	3.0	38,128
Topical Products	0.3	0.1	0.0	0.2	11	7	0	4	45	83	36	24	74,831	3,352,121	27,849	22.5	297,813
Miscellaneous Products	0.3	0.2	0.0	0.1	43	34	3	6	161	215	210	64	3,836	618,674	1,330	1.1	14,391
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	7	0	0	0	23	0	0	0	3,003	67,698	960	0.8	10,392
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.	1,403,091	90,135,116	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for South 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 South Dakota, 1.1 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]

SOUTH 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	$12,938,885	7,858	6.4	83,944	0.8	$198	$154
ANTICONVULSANT	6,971,352	7,090	5.7	76,575	0.9	105	91
ULCER DRUGS	6,552,368	11,884	9.6	123,883	0.6	96	53
ANTIDEPRESSANTS	6,438,007	17,124	13.9	177,540	0.6	59	36
ANTIASTHMATIC	5,721,033	22,474	18.2	238,279	0.3	74	24
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	4,073,448	5,897	4.8	62,701	0.6	103	65
ANALGESICS - Narcotic	3,631,323	23,329	18.9	239,121	0.3	46	15
ANTIDIABETIC	2,900,934	5,977	4.8	63,583	0.8	59	46
MISC. ENDOCRINE	2,483,586	2,256	1.8	24,493	0.7	151	101
ANTIHYPERLIPIDEMIC	2,460,043	3,984	3.2	43,827	0.7	81	56
Total	54,170,979	107,873		1,133,946	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for South 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.