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STATISTICAL COMPENDIUM: MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006 SOUTH DAKOTA

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
SOUTH DAKOTA, 2006

Inclusion Criteria (2006)	Number of Dual and Nondual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Nondual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	130651 (A)	20314 (E)	110337 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	124536 (B)	14278 (F)	110258 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	124536 (C)	14278 (G)	110258 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	3995 (D)	3854 (H)	141 (L)

Source: Data for this table are from the MAX 2006 file for South Dakota, released by CMS in 7/2009. This table was produced on 02/11/2010.
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 2006 (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 2006, 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 2006 was $44,774,368, of which $60,079 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 29 states in 2006 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, KY, MA, MI, MS, NC, NH, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, and WI. In addition, there were 10 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NC, NE, NY, TN, TX, UT, and WV). These lists were constructed from the CMS 2006 Medicaid Managed Care Enrollment Report 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 2006. 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 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 2006. 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, 2006

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**124,536**	**7,143**	**15,836**	**21,112**	**80,364**	**81**	**1,166,203**	**70,291**	**171,244**	**161,654**	**762,289**	**725**
Age												
5 and younger	32,974	0	697	1	32,276	0	302,923	0	6,999	1	295,923	0
6-14	34,571	0	1,409	0	33,162	0	346,673	0	15,588	0	331,085	0
15-20	17,915	0	1,155	1,871	14,889	0	160,718	0	12,477	13,242	134,999	0
21-44	22,730	0	5,025	17,645	36	24	189,837	0	54,455	134,891	281	210
45-64	7,391	3	5,748	1,585	0	55	75,100	10	61,158	13,436	0	496
65-74	2,474	1,130	1,334	8	0	2	27,067	11,727	15,250	71	0	19
75-84	2,781	2,378	402	1	0	0	28,464	23,867	4,585	12	0	0
85 and older	3,698	3,632	66	0	0	0	35,419	34,687	732	0	0	0
Unknown	2	0	0	1	1	0	2	0	0	1	1	0
Gender												
Female	70,271	5,176	8,131	17,307	39,576	81	649,896	51,686	88,619	133,711	375,155	725
Male	54,265	1,967	7,705	3,805	40,788	0	516,307	18,605	82,625	27,943	387,134	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	71,866	6,614	10,347	11,023	43,811	71	667,871	64,843	111,390	79,373	411,634	631
African American	3,193	11	149	634	2,399	0	27,611	90	1,417	4,477	21,627	0
Other/unknown	49,477	518	5,340	9,455	34,154	10	470,721	5,358	58,437	77,804	329,028	94
Use of Nursing Facilities[c]												
Entire year	3,995	3,354	641	0	0	0	39,815	32,778	7,037	0	0	0
Part year	1,693	1,249	440	4	0	0	15,720	11,217	4,455	48	0	0
None	118,848	2,540	14,755	21,108	80,364	81	1,110,668	26,296	159,752	161,606	762,289	725
Maintenance Assistance Status												
Cash	41,004	1,885	13,103	9,983	16,033	0	407,236	20,783	142,275	82,582	161,596	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	52,849	92	165	4,506	48,005	81	491,118	953	1,701	25,039	462,700	725
Other/unknown	30,683	5,166	2,568	6,623	16,326	0	267,849	48,555	27,268	54,033	137,993	0
Dual Medicare Status[d]												
Full dual, all year	13,758	6,795	6,846	110	2	5	144,927	66,763	77,097	988	24	55
Full dual, part year	520	282	230	8	0	0	5,458	2,975	2,401	82	0	0
Non-dual, all year	110,258	66	8,760	20,994	80,362	76	1,015,818	553	91,746	160,584	762,265	670
Managed Care (MC) Status												
Fee-for-service (FFS) all year	124,536	7,143	15,836	21,112	80,364	81	1,166,203	70,291	171,244	161,654	762,289	725
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 2006 file for South Dakota, released by CMS in 7/2009. This table was produced on 02/11/2010.

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 2006. 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, 2006

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	**53.7**	**5.3**	**$359**	**$67**	**$4,814**	**7.5**	**124,536**
Age							
5 and younger	59.6	3.3	166	50	2,230	7.4	32,974
6-14	52.2	3.9	307	79	1,934	15.9	34,571
15-20	53.2	4.7	325	69	4,140	7.9	17,915
21-44	56.6	7.9	547	69	6,216	8.8	22,730
45-64	53.1	18.0	1,330	74	13,690	9.7	7,391
65-74	30.0	3.2	107	33	11,367	0.9	2,474
75-84	32.7	2.7	55	20	15,306	0.4	2,781
85 and older	33.7	2.2	39	17	19,407	0.2	3,698
Unknown	0.0	0.0	0	0	3,609	0.0	2
Basis of Eligibility[e]							
Aged	33.3	2.5	49	20	16,896	0.3	7,143
Disabled	51.8	15.0	1,255	84	15,731	8.0	15,836
Adults	58.2	6.3	344	55	3,125	11.0	21,112
Children	54.7	3.4	212	62	2,020	10.5	80,364
Unknown	81.5	26.2	2,217	85	17,041	13.0	81
Gender							
Female	55.7	5.8	359	62	4,913	7.3	70,271
Male	51.2	4.8	360	75	4,685	7.7	54,265
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	62.9	6.8	470	70	5,655	8.3	71,866
African American	52.9	3.5	220	63	2,051	10.7	3,193
Other/unknown	40.5	3.4	207	61	3,771	5.5	49,477
Use of Nursing Facilities[f]							
Entire year	41.8	6.1	258	43	28,714	0.9	3,995
Part year	46.7	7.7	399	52	21,864	1.8	1,693
None	54.2	5.3	362	69	3,768	9.6	118,848
Maintenance Assistance Status							
Cash	47.9	7.9	603	76	5,729	10.5	41,004
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	57.7	3.5	205	59	1,456	14.1	52,849
Other/unknown	54.7	5.1	299	58	9,374	3.2	30,683

Source: Data for this table are from the MAX 2006 file for South Dakota, released by CMS in 7/2009. This table was produced on 02/11/2010.
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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

				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	**0.6**	**$38**	**7.5**	**46.3**	**44.3**	**4.6**	**3.3**	**1.1**	**0.3**	**$514**	**124,536**	**1,166,203**
Age												
5 and younger	0.4	18	7.4	40.4	55.4	3.0	1.0	0.1	0.0	243	32,974	302,923
6-14	0.4	31	15.9	47.8	45.5	4.0	2.4	0.3	0.0	193	34,571	346,673
15-20	0.5	36	7.9	46.8	43.5	5.5	3.6	0.6	0.1	462	17,915	160,718
21-44	0.9	65	8.8	43.4	39.6	7.4	6.7	2.4	0.5	744	22,730	189,837
45-64	1.8	131	9.7	46.9	25.3	6.3	10.5	7.9	3.1	1,347	7,391	75,100
65-74	0.3	10	0.9	70.0	24.9	2.9	1.4	0.6	0.1	1,039	2,474	27,067
75-84	0.3	5	0.4	67.3	28.4	3.1	0.9	0.3	0.0	1,495	2,781	28,464
85 and older	0.2	4	0.2	66.3	30.1	2.8	0.5	0.2	0.2	2,026	3,698	35,419
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	3,609	2	2
Basis of Eligibility[e]												
Aged	0.3	5	0.3	66.7	29.1	3.1	0.7	0.3	0.1	1,717	7,143	70,291
Disabled	1.4	116	8.0	48.2	27.8	6.6	9.7	5.7	2.0	1,455	15,836	171,244
Adults	0.8	45	11.0	41.8	42.8	7.7	5.8	1.6	0.2	408	21,112	161,654
Children	0.4	22	10.5	45.3	49.3	3.6	1.7	0.2	0.0	213	80,364	762,289
Unknown	2.9	248	13.0	18.5	30.9	16.0	19.8	11.1	3.7	1,904	81	725
Gender												
Female	0.6	39	7.3	44.3	45.5	5.0	3.5	1.3	0.4	531	70,271	649,896
Male	0.5	38	7.7	48.8	42.8	4.2	3.1	0.8	0.2	492	54,265	516,307
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	0.7	51	8.3	37.1	50.5	6.1	4.4	1.5	0.4	609	71,866	667,871
African American	0.4	25	10.7	47.1	46.9	3.5	2.0	0.4	0.1	237	3,193	27,611
Other/unknown	0.4	22	5.5	59.5	35.2	2.6	1.9	0.6	0.2	396	49,477	470,721
Use of Nursing Facilities[f]												
Entire year	0.6	26	0.9	58.2	32.7	4.8	2.0	1.4	1.0	2,881	3,995	39,815
Part year	0.8	43	1.8	53.3	35.6	3.6	2.9	3.2	1.4	2,355	1,693	15,720
None	0.6	39	9.6	45.8	44.8	4.7	3.4	1.1	0.3	403	118,848	1,110,668
Maintenance Assistance Status												
Cash	0.8	61	10.5	52.1	34.6	4.8	5.2	2.6	0.8	577	41,004	407,236
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	14.1	42.3	52.0	3.9	1.6	0.1	0.0	157	52,849	491,118
Other/unknown	0.6	34	3.2	45.3	44.2	5.6	3.8	0.9	0.1	1,074	30,683	267,849

Source: Data for this table are from the MAX 2006 file for South Dakota, released by CMS in 7/2009. This table was produced on 02/11/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

	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	**0.6**	**$38**	**$67**	**0.2**	**$28**	**$139**	**0.0**	**$3**	**$95**	**0.3**	**$8**	**$23**
Age												
5 and younger	0.4	18	50	0.1	12	108	0.0	1	45	0.2	5	21
6-14	0.4	31	79	0.2	25	130	0.0	1	65	0.2	4	25
15-20	0.5	36	69	0.2	27	134	0.0	3	103	0.3	7	24
21-44	0.9	65	69	0.3	44	156	0.0	7	142	0.6	14	23
45-64	1.8	131	74	0.6	93	161	0.1	9	114	1.1	29	26
65-74	0.3	10	33	0.0	5	111	0.0	1	60	0.2	4	17
75-84	0.3	5	20	0.0	2	88	0.0	0	56	0.2	3	12
85 and older	0.2	4	17	0.0	2	72	0.0	0	43	0.2	2	11
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.3	5	20	0.0	2	82	0.0	0	50	0.2	3	12
Disabled	1.4	116	84	0.5	88	170	0.1	7	109	0.8	21	26
Adults	0.8	45	55	0.2	27	127	0.0	6	150	0.6	12	21
Children	0.4	22	62	0.1	17	117	0.0	1	59	0.2	5	23
Unknown	2.9	248	85	1.0	187	179	0.2	22	126	1.7	38	22
Gender												
Female	0.6	39	62	0.2	27	135	0.0	3	103	0.4	9	23
Male	0.5	38	75	0.2	29	143	0.0	2	80	0.3	7	24
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.7	51	70	0.3	37	139	0.0	4	101	0.4	10	24
African American	0.4	25	63	0.1	18	134	0.0	2	121	0.3	5	22
Other/unknown	0.4	22	61	0.1	15	136	0.0	1	76	0.2	5	22
Use of Nursing Facilities[e]												
Entire year	0.6	26	43	0.1	15	135	0.0	2	92	0.5	9	19
Part year	0.8	43	52	0.2	27	150	0.0	3	108	0.6	13	21
None	0.6	39	69	0.2	28	139	0.0	3	95	0.3	8	24
Maintenance Assistance Status												
Cash	0.8	61	76	0.3	44	160	0.0	4	109	0.5	12	25
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.4	22	59	0.1	16	115	0.0	2	75	0.2	5	22
Other/unknown	0.6	34	58	0.2	24	124	0.0	2	90	0.4	7	21

Source: Data for this table are from the MAX 2006 file for South Dakota, released by CMS in 7/2009. This table was produced on 02/11/2010.

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, 1.6 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.medi-span.com/master-drug-database.aspx

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, 2006

	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	0.2	0.0	0.0	0.2	$10	$4	$1	$5	$41	$125	$45	$25	115,431	$4,693,942	45,285	36.4	470,771
Biologicals	0.2	0.2	0.0	0.0	109	109	0	0	661	667	0	35	1,439	951,566	824	0.7	8,764
Antineoplastic Agents	0.6	0.2	0.0	0.4	123	105	0	18	212	574	38	45	1,206	256,098	203	0.2	2,087
Endocrine/Metabolic Drugs	0.4	0.1	0.0	0.2	26	17	2	7	64	139	46	28	51,764	3,304,095	12,411	10.0	126,898
Cardiovascular Agents	0.9	0.3	0.0	0.6	33	22	2	9	38	79	72	16	44,581	1,698,433	5,031	4.0	51,804
Respiratory Agents	0.4	0.2	0.0	0.2	23	19	0	4	64	98	59	22	93,952	5,991,160	25,187	20.2	266,098
Gastrointestinal Agents	0.4	0.2	0.0	0.2	35	22	9	4	96	129	405	21	30,758	2,945,082	8,238	6.6	83,569
Genitourinary Agents	0.3	0.1	0.0	0.1	17	11	3	4	67	114	90	28	7,753	520,800	3,002	2.4	29,821
CNS Drugs	0.8	0.3	0.1	0.4	69	54	6	9	87	175	106	22	105,463	9,220,227	13,050	10.5	133,102
Stimulants/Anti-obesity/Anorexia	0.8	0.7	0.0	0.1	87	85	0	2	116	124	84	31	38,239	4,418,491	4,757	3.8	50,594
Miscellaneous Psychological/ Neurological Agents	0.3	0.2	0.0	0.0	117	115	1	2	442	486	132	72	967	427,824	356	0.3	3,653
Analgesics and Anesthetics	0.4	0.0	0.0	0.3	18	8	2	8	46	200	241	23	63,420	2,901,631	16,170	13.0	162,306
Neuromuscular Agents	0.7	0.3	0.0	0.4	67	52	2	12	91	185	98	29	45,285	4,133,044	5,846	4.7	61,696
Nutritional Products	0.3	0.0	0.0	0.2	5	1	0	4	17	50	19	14	9,508	165,898	3,677	3.0	33,961
Hematological Agents	0.5	0.1	0.0	0.4	50	43	1	6	96	486	31	15	8,802	843,678	1,632	1.3	16,823
Topical Products	0.2	0.1	0.0	0.1	8	5	0	3	43	91	43	21	44,131	1,893,545	22,088	17.7	233,802
Miscellaneous Products	0.2	0.1	0.0	0.0	32	27	2	3	167	195	253	63	1,905	317,694	932	0.7	10,048
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	9	0	0	0	59	0	0	0	529	31,081	324	0.3	3,509
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.	665,133	44,714,289	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for South Dakota, released by CMS in 7/2009. This table was produced on 02/11/2010.

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.medi-span.com/master-drug-database.aspx.

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, 1.6 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.medi-span.com/master-drug-database.aspx.

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2006.

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, 2006

		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	$5,474,117	4,000	3.2	42,380	0.6	$214	$129
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	4,418,491	5,611	4.5	60,237	0.6	116	73
ANTIASTHMATIC	3,988,258	18,765	15.1	199,520	0.3	77	20
ANTICONVULSANT	3,642,870	4,490	3.6	48,380	0.7	105	75
ANTIDEPRESSANTS	2,949,996	10,029	8.1	102,026	0.5	62	29
ULCER DRUGS	1,872,383	7,319	5.9	74,431	0.4	71	25
ANALGESICS - Narcotic	1,526,434	17,304	13.9	174,149	0.3	35	9
MISC. ENDOCRINE	1,294,777	737	0.6	8,104	0.5	323	160
DERMATOLOGICAL	1,268,558	16,447	13.2	176,208	0.1	50	7
ANTIDIABETIC	1,075,548	2,429	2.0	25,104	0.6	74	43
Total	27,511,432	87,131	n.a.	910,539	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for South Dakota, released by CMS in 7/2009. This table was produced on 02/11/2010.

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 2006. 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 2006. For information about these drug groups, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.

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.