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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2007
SOUTH DAKOTA

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
SOUTH DAKOTA, 2007

Inclusion Criteria (2007)	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]	131924 (A)	20509 (E)	111415 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	125458 (B)	14216 (F)	111242 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	125458 (C)	14216 (G)	111242 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	3876 (D)	3747 (H)	129 (L)

Source: Data for this table are from the MAX 2007 file for South Dakota, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 2007 (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 2007, 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 2007 was $48,647,457, of which $29,206 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 27 states in 2007 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, MA, MI, NC, NH, NM, NV, NY, 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, TN, TX, and WV). These lists were constructed from the CMS 2007 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 reviewed prescription drug expenditures by type of managed care plan to determine whether enrollees in comprehensive MC plans had significant prescription drug expenditures during the year, since that would indicate that at least some prescription drugs were not included in the capitated benefit and were being provided on a fee-for-service basis. There were some states in which most, but not all, prescription drugs were included in the MC capitated benefit package. Mental health drugs, for example, may have been excluded. In those states, we excluded all the MC enrollees from the study population, but some of their drugs would have been included, potentially resulting in higher reported per-beneficiary use of those drugs than would have been the case if we had been able to exclude those drugs.
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 2007. 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 2007. 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, 2007

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**125,458**	**7,158**	**15,978**	**20,659**	**81,562**	**101**	**1,176,514**	**70,786**	**173,983**	**158,051**	**772,771**	**923**
Age												
5 and younger	34,045	0	726	0	33,319	0	313,045	0	7,466	0	305,579	0
6-14	34,710	0	1,505	0	33,205	0	347,926	0	16,831	0	331,095	0
15-20	18,132	1	1,208	1,962	14,961	0	162,469	12	13,002	13,980	135,475	0
21-44	22,151	40	4,890	17,117	75	29	185,851	447	54,009	130,523	618	254
45-64	7,590	165	5,795	1,563	1	66	77,545	1,811	61,722	13,406	3	603
65-74	2,488	1,113	1,355	15	0	5	26,978	11,417	15,377	129	0	55
75-84	2,775	2,344	429	1	0	1	28,566	23,681	4,862	12	0	11
85 and older	3,565	3,495	70	0	0	0	34,132	33,418	714	0	0	0
Unknown	2	0	0	1	1	0	2	0	0	1	1	0
Gender												
Female	70,763	5,128	8,168	17,129	40,237	101	655,054	51,448	89,262	132,158	381,263	923
Male	54,695	2,030	7,810	3,530	41,325	0	521,460	19,338	84,721	25,893	391,508	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	71,311	6,607	10,337	10,562	43,721	84	663,458	65,230	111,877	76,092	409,461	798
African American	3,324	13	168	594	2,549	0	29,096	107	1,614	4,110	23,265	0
Other/unknown	50,823	538	5,473	9,503	35,292	17	483,960	5,449	60,492	77,849	340,045	125
Use of Nursing Facilities[c]												
Entire year	3,876	3,239	637	0	0	0	38,664	31,639	7,025	0	0	0
Part year	1,656	1,217	434	5	0	0	15,747	11,348	4,370	29	0	0
None	119,926	2,702	14,907	20,654	81,562	101	1,122,103	27,799	162,588	158,022	772,771	923
Maintenance Assistance Status												
Cash	40,427	1,921	13,194	9,645	15,667	0	404,235	21,220	144,430	79,802	158,783	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	53,906	91	153	4,549	49,012	101	501,146	916	1,567	25,660	472,080	923
Other/unknown	31,125	5,146	2,631	6,465	16,883	0	271,133	48,650	27,986	52,589	141,908	0
Dual Medicare Status[d]												
Full dual, all year	13,663	6,708	6,823	120	2	10	144,444	66,170	77,082	1,053	24	115
Full dual, part year	553	317	222	14	0	0	5,834	3,348	2,339	147	0	0
Non-dual, all year	111,242	133	8,933	20,525	81,560	91	1,026,236	1,268	94,562	156,851	772,747	808
Managed Care (MC) Status												
Fee-for-service (FFS) all year	125,458	7,158	15,978	20,659	81,562	101	1,176,514	70,786	173,983	158,051	772,771	923
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 2007 file for South Dakota, released by CMS in 4/2010. This table was produced on 10/06/2010.

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 2007. 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, 2007

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	**53.6**	**5.5**	**$388**	**$71**	**$5,044**	**7.7**	**125,458**
Age							
5 and younger	59.0	3.2	178	56	2,329	7.6	34,045
6-14	52.9	4.0	341	86	2,052	16.6	34,710
15-20	53.3	4.8	350	72	4,226	8.3	18,132
21-44	57.2	8.5	601	71	6,707	9.0	22,151
45-64	52.1	19.0	1,399	74	14,699	9.5	7,590
65-74	25.6	2.9	95	33	11,347	0.8	2,488
75-84	28.1	2.4	37	16	16,017	0.2	2,775
85 and older	29.5	2.1	27	13	20,440	0.1	3,565
Unknown	0.0	0.0	0	0	1,735	0.0	2
Basis of Eligibility[e]							
Aged	30.1	3.1	115	37	17,742	0.6	7,158
Disabled	50.8	15.5	1,387	90	16,567	8.4	15,978
Adults	59.2	6.8	365	54	3,347	10.9	20,659
Children	54.8	3.4	220	65	2,089	10.5	81,562
Unknown	69.3	22.1	1,389	63	15,598	8.9	101
Gender							
Female	55.4	5.9	381	65	5,137	7.4	70,763
Male	51.2	4.9	396	81	4,924	8.0	54,695
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	62.3	7.0	507	73	5,965	8.5	71,311
African American	53.1	3.7	260	71	2,154	12.1	3,324
Other/unknown	41.4	3.5	228	65	3,941	5.8	50,823
Use of Nursing Facilities[f]							
Entire year	38.3	5.9	236	40	30,043	0.8	3,876
Part year	42.6	8.4	491	59	25,780	1.9	1,656
None	54.2	5.4	391	72	3,950	9.9	119,926
Maintenance Assistance Status							
Cash	47.8	8.4	661	79	6,152	10.7	40,427
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	57.9	3.5	213	61	1,503	14.1	53,906
Other/unknown	53.7	5.2	336	65	9,738	3.4	31,125

Source: Data for this table are from the MAX 2007 file for South Dakota, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, 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, TN, TX, 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, 2007

				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**	**$41**	**7.7**	**46.4**	**44.0**	**4.5**	**3.5**	**1.2**	**0.3**	**$538**	**125,458**	**1,176,514**
Age												
5 and younger	0.3	19	7.6	41.0	55.2	2.7	1.1	0.1	0.0	253	34,045	313,045
6-14	0.4	34	16.6	47.1	46.0	4.0	2.5	0.3	0.1	205	34,710	347,926
15-20	0.5	39	8.3	46.7	43.3	5.3	3.9	0.7	0.0	472	18,132	162,469
21-44	1.0	72	9.0	42.8	38.9	7.9	7.2	2.7	0.6	799	22,151	185,851
45-64	1.9	137	9.5	47.9	24.0	6.2	10.3	8.2	3.4	1,439	7,590	77,545
65-74	0.3	9	0.8	74.4	22.1	1.8	1.0	0.4	0.2	1,047	2,488	26,978
75-84	0.2	4	0.2	71.9	24.6	2.9	0.5	0.0	0.1	1,556	2,775	28,566
85 and older	0.2	3	0.1	70.5	26.9	1.9	0.6	0.1	0.0	2,135	3,565	34,132
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	1,735	2	2
Basis of Eligibility[e]												
Aged	0.3	12	0.6	69.9	26.1	2.4	0.8	0.5	0.3	1,794	7,158	70,786
Disabled	1.4	127	8.4	49.2	26.6	6.5	9.8	5.8	2.1	1,521	15,978	173,983
Adults	0.9	48	10.9	40.8	42.6	8.1	6.3	1.9	0.3	438	20,659	158,051
Children	0.4	23	10.5	45.2	49.4	3.4	1.8	0.2	0.0	221	81,562	772,771
Unknown	2.4	152	8.9	30.7	23.8	11.9	24.8	5.0	4.0	1,707	101	923
Gender												
Female	0.6	41	7.4	44.6	45.0	4.8	3.7	1.4	0.4	555	70,763	655,054
Male	0.5	42	8.0	48.8	42.7	4.2	3.2	1.0	0.2	517	54,695	521,460
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	55	8.5	37.7	49.7	6.0	4.5	1.6	0.5	641	71,311	663,458
African American	0.4	30	12.1	46.9	46.3	3.5	2.5	0.6	0.1	246	3,324	29,096
Other/unknown	0.4	24	5.8	58.6	35.9	2.6	2.1	0.7	0.2	414	50,823	483,960
Use of Nursing Facilities[f]												
Entire year	0.6	24	0.8	61.7	31.0	3.5	1.4	1.4	1.0	3,012	3,876	38,664
Part year	0.9	52	1.9	57.4	31.1	3.6	3.1	3.1	1.7	2,711	1,656	15,747
None	0.6	42	9.9	45.8	44.6	4.6	3.6	1.2	0.3	422	119,926	1,122,103
Maintenance Assistance Status												
Cash	0.8	66	10.7	52.2	33.9	4.7	5.5	2.8	0.9	615	40,427	404,235
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	23	14.1	42.1	52.1	3.9	1.8	0.1	0.0	162	53,906	501,146
Other/unknown	0.6	39	3.4	46.3	43.2	5.5	3.8	1.0	0.2	1,118	31,125	271,133

Source: Data for this table are from the MAX 2007 file for South Dakota, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 eight states (DE, IA, IL, NE, NY, TN, TX, 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, TN, TX, 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, 2007

	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**	**$41**	**$71**	**0.2**	**$30**	**$161**	**0.0**	**$2**	**$93**	**0.4**	**$9**	**$25**
Age												
5 and younger	0.3	19	56	0.1	12	143	0.0	1	75	0.2	6	23
6-14	0.4	34	86	0.2	28	146	0.0	1	83	0.2	5	26
15-20	0.5	39	72	0.2	30	150	0.0	1	93	0.3	8	25
21-44	1.0	72	71	0.3	50	180	0.0	3	115	0.7	18	26
45-64	1.9	137	74	0.5	98	182	0.1	7	101	1.2	32	26
65-74	0.3	9	33	0.0	5	120	0.0	1	77	0.2	3	15
75-84	0.2	4	16	0.0	1	89	0.0	0	62	0.2	3	12
85 and older	0.2	3	13	0.0	1	67	0.0	0	17	0.2	2	10
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	0.3	12	37	0.0	7	174	0.0	0	79	0.3	4	15
Disabled	1.4	127	90	0.5	98	201	0.1	6	109	0.9	23	26
Adults	0.9	48	54	0.2	29	141	0.0	2	101	0.7	16	25
Children	0.4	23	65	0.1	17	132	0.0	1	76	0.2	5	24
Unknown	2.4	152	63	0.7	101	145	0.1	9	100	1.6	42	26
Gender												
Female	0.6	41	65	0.2	29	157	0.0	2	90	0.4	11	24
Male	0.5	42	81	0.2	32	165	0.0	2	98	0.3	8	25
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.7	55	73	0.2	40	161	0.0	3	95	0.5	12	25
African American	0.4	30	71	0.1	22	165	0.0	1	89	0.3	7	25
Other/unknown	0.4	24	65	0.1	17	160	0.0	1	87	0.3	6	24
Use of Nursing Facilities[e]												
Entire year	0.6	24	40	0.1	14	150	0.0	1	86	0.5	9	18
Part year	0.9	52	59	0.2	34	190	0.0	2	101	0.7	15	23
None	0.6	42	72	0.2	31	160	0.0	2	93	0.4	9	25
Maintenance Assistance Status												
Cash	0.8	66	79	0.3	49	182	0.0	3	106	0.5	14	26
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.4	23	61	0.1	16	127	0.0	1	77	0.2	6	25
Other/unknown	0.6	39	65	0.2	28	156	0.0	2	85	0.4	9	22

Source: Data for this table are from the MAX 2007 file for South Dakota, released by CMS in 4/2010. This table was produced on 10/06/2010.
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, 1.8 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, 2007

Therapeutic Category	Number of Rx per Benefit Month Among Users: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	$ per Benefit Month Among Users: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	$ per Rx: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Users[e]: 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	$40	$187	$90	$25	114,448	$4,594,322	45,392	36.2	472,019
Biologicals	0.2	0.2	0.0	0.0	176	176	0	0	877	877	0	0	1,525	1,337,969	718	0.6	7,602
Antineoplastic Agents	0.6	0.1	0.0	0.4	113	97	0	16	195	692	70	36	1,352	263,569	220	0.2	2,337
Endocrine/Metabolic Drugs	0.4	0.1	0.0	0.3	30	22	1	7	73	173	32	27	54,211	3,951,256	12,907	10.3	131,465
Cardiovascular Agents	0.9	0.2	0.1	0.7	34	19	4	12	36	101	65	17	47,730	1,733,728	4,977	4.0	51,469
Respiratory Agents	0.4	0.2	0.0	0.1	25	20	2	4	70	104	74	24	91,203	6,340,209	23,579	18.8	249,432
Gastrointestinal Agents	0.4	0.1	0.0	0.2	35	21	3	11	89	143	146	50	34,233	3,034,549	8,540	6.8	86,511
Genitourinary Agents	0.3	0.1	0.0	0.2	17	11	0	5	65	116	68	33	7,749	503,885	3,032	2.4	29,879
CNS Drugs	0.8	0.3	0.0	0.5	71	59	2	11	86	194	136	21	111,116	9,610,423	13,187	10.5	135,121
Stimulants/Anti-obesity/Anorexia	0.8	0.7	0.0	0.1	97	94	1	2	125	136	82	33	40,336	5,061,114	4,900	3.9	52,149
Miscellaneous Psychological/ Neurological Agents	0.2	0.2	0.0	0.0	64	64	0	0	268	272	164	63	2,507	670,819	1,036	0.8	10,470
Analgesics and Anesthetics	0.4	0.0	0.0	0.4	17	7	1	9	42	229	394	24	64,319	2,700,129	15,710	12.5	157,199
Neuromuscular Agents	0.8	0.3	0.0	0.4	76	59	6	12	98	195	176	26	49,804	4,897,661	6,044	4.8	64,040
Nutritional Products	0.3	0.0	0.0	0.3	5	1	0	4	17	54	17	14	9,326	160,154	3,560	2.8	32,832
Hematological Agents	0.6	0.1	0.0	0.5	84	78	0	6	146	788	28	12	9,165	1,334,664	1,551	1.2	15,863
Topical Products	0.2	0.1	0.0	0.1	8	5	0	3	45	103	60	22	45,070	2,022,884	22,478	17.9	238,174
Miscellaneous Products	0.2	0.2	0.0	0.0	29	24	2	3	145	161	189	71	2,223	322,684	1,010	0.8	10,992
Unknown Therapeutic Category	0.1	0.0	0.0	0.0	10	0	0	0	68	0	0	0	1,153	78,232	742	0.6	8,103
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.	687,470	48,618,251	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for South Dakota, released by CMS in 4/2010. This table was produced on 10/06/2010.
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, 1.8 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 2007.
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, 2007

		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	$6,422,812	4,097	3.3	44,060	0.6	$229	$146
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	5,061,114	5,883	4.7	63,303	0.6	125	80
ANTIASTHMATIC	4,378,577	19,106	15.2	202,231	0.3	83	22
ANTICONVULSANT	4,349,282	4,849	3.9	52,460	0.7	114	83
ANTIDEPRESSANTS	2,424,631	10,069	8.0	102,573	0.5	50	24
ULCER DRUGS	2,051,128	7,196	5.7	73,539	0.4	74	28
MISC. ENDOCRINE	1,737,017	709	0.6	7,807	0.5	429	222
ANALGESICS - Narcotic	1,588,879	17,496	13.9	175,739	0.3	34	9
DERMATOLOGICAL	1,385,518	17,214	13.7	185,017	0.1	53	7
PASSIVE IMMUNIZING AGENTS	1,307,321	241	0.2	2,203	0.4	1,329	593
Total	30,706,279	86,860	n.a.	908,932	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2007 file for South Dakota, released by CMS in 4/2010. This table was produced on 10/06/2010.
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 2007. 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 2007. 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.