STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
TENNESSEE

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
TENNESSEE, 2003

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries	(Cell)	Number of Dual Eligible Beneficiaries	(Cell)[g]	Number of Non-dual Eligible Beneficiaries	(Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	1,582,929	(A)	292,266	(E)	1,290,663	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	1,575,459	(B)	284,854	(F)	1,290,605	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	1,575,459	(C)	284,854	(G)	1,290,605	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	23,088	(D)	21,529	(H)	1,559	(L)

Source: Data for this table are from the MAX 2003 file for Tennessee, released by CMS in 07/2007. This table was produced on 11/01/2007.

a. MAX data element "Eligible Months Count" was used to determine an individual's Medicaid eligibility. All individuals who had a value greater than zero were considered as beneficiaries and counted in Cell A.

b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2003 (based on MAX data element "Eligible Restricted Benefits Flag").

c. Cell C represents the study population for Tables 2 through 7. Cell C was obtained by excluding from Cell B beneficiaries who were in managed care (MC) plans that included prescription drugs in their capitated benefit package during all months of Medicaid eligibility in 2003, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.

d. The total Medicaid pharmacy reimbursement for Tennessee in 2003 was $1,941,336,316, of which $3,772,536 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

e. Enrollees in prepaid health plans (PHP) or managed care (MC) plans that did not provide a pharmacy benefit are treated as having fee-for-service pharmacy benefit coverage. There were 19 states in 2003 that had PHPs that did not include a pharmacy benefit: AL, AR, CA, CO, FL, GA, IA, KY, MA, MI, NY, OR, PA, SD, TN, TX, UT, WA, and WI. In addition, there were 7 states in which MC plans did not provide a pharmacy benefit: DE, IA, NE, NY, TX, UT, and WV. These lists were constructed from the CMS 2003 Medicaid Managed Care Enrollment Report [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer02.pdf] and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit package.

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2003. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.

g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the benficiary had a fee-for-service pharmacy benefit.

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2003. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

Characteristics of non-dual eligible beneficiaries represented by Cell J are shown in Appendix Table A.1 and characteristics of non-dual eligible beneficiaries and their benefit months included in Cell J but excluded from Cell K are shown in Appendix Table A.2. Characteristics of dual eligible beneficiaries represented by Cell F are shown in Appendix Table A.3, and characteristics of dual eligible beneficiaries and their benefit months included in Cell F but excluded from Cell G are shown in Appendix Table A.4.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; HMO = health maintenance organization; MAX = Medicaid Analytic Extract; MC = managed care; PCCM = primary care case management; PHP = prepaid health plan.

TABLE 2

CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY[a, b]

TENNESSEE, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**1,575,459**	**121,894**	**318,557**	**435,638**	**699,370**	**0**	**16,200,163**	**1,280,387**	**3,613,917**	**4,320,933**	**6,984,926**	**0**
Age												
5 and younger	252,262	0	6,318	1	245,943	0	2,441,945	0	70,782	2	2,371,161	0
6-14	310,879	0	18,153	5	292,721	0	3,241,515	0	211,117	9	3,030,389	0
15-20	174,600	1	15,239	832	158,528	0	1,753,664	12	177,178	2,603	1,573,871	0
21-44	418,577	8	97,787	318,604	2,178	0	4,194,894	91	1,112,074	3,073,224	9,505	0
45-64	259,434	916	142,728	115,790	0	0	2,854,310	9,362	1,603,517	1,241,431	0	0
65-74	85,506	56,779	28,372	355	0	0	938,882	608,418	327,177	3,287	0	0
75-84	47,546	39,342	8,160	44	0	0	509,141	416,294	92,505	342	0	0
85 and older	26,653	24,846	1,800	7	0	0	265,804	246,202	19,567	35	0	0
Unknown	2	2	0	0	0	8 0		8	0	0	0	0
Gender												
Female	912,935	83,330	162,417	314,289	352,899	0	9,398,390	885,364	1,851,067	3,135,322	3,526,637	0
Male	662,523	38,564	156,139	121,349	346,471	0	6,801,765	395,023	1,762,842	1,185,611	3,458,289	0
Unknown	1	0	1	0	0	8 0		0	8	0	0	0
Race												
White	1,032,988	93,787	200,777	316,709	421,715	0	10,556,263	977,963	2,261,666	3,158,094	4,158,540	0
African American	436,230	20,740	74,435	105,661	235,394	0	4,581,548	220,339	853,919	1,065,529	2,441,761	0
Other/unknown	106,241	7,367	43,345	13,268	42,261	0	1,062,352	82,085	498,332	97,310	384,625	0
Use of Nursing Facilities[c]												
Entire year	23,088	18,990	4,096	2	0	0	230,852	187,955	42,895	2	0	0
Part year	12,874	9,666	3,150	54	4	0	128,037	94,436	33,047	515	39	0
None	1,539,497	93,238	311,311	435,582	699,366	0	15,841,274	997,996	3,537,975	4,320,416	6,984,887	0
Maintenance Assistance Status												
Cash	555,775	28,277	265,006	75,034	187,458	0	6,172,899	319,378	3,074,317	770,651	2,008,553	0
Medically needy	217,519	29,894	21,367	77,743	88,515	0	2,054,471	305,591	194,949	698,444	855,487	0
Poverty-related	265,114	3,090	1,299	22,542	238,183	0	2,420,588	34,711	14,310	153,421	2,218,146	0
Other/unknown	537,051	60,633	30,885	260,319	185,214	0	5,552,205	620,707	330,341	2,698,417	1,902,740	0
Dual Medicare Status[d]												
Full dual, all year	273,649	110,365	153,917	9,329	38	0	3,025,984	1,155,364	1,770,190	100,063	367	0
Full dual, part year	11,205	8,205	2,827	173	0	0	125,978	92,524	31,532	1,922	0	0
Non-dual, all year	1,290,605	3,324	161,813	426,136	699,332	0	13,048,201	32,499	1,812,195	4,218,948	6,984,559	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	1,575,459	121,894	318,557	435,638	699,370	0	16,200,163	1,280,387	3,613,917	4,320,933	6,984,926	0
FFS part year, with Rx claims	0	0	0	0	0	0 0		0	0	0	0	0
FFS part year, no Rx claims	0	0	0	0	0	0 0		0	0	0	0	0

Source: Data for this table are from the MAX 2003 file for Tennessee, released by CMS in 07/2007. This table was produced on 11/01/2007.

a. Table 2 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services. The total includes some beneficiaries with unknown basis of eligibility and some whose age categories are not consistent with basis of eligibility.

c. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2003. The “Full dual, part year” group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service pharmacy benefit; MAX = Medicaid Analytic Extract; MC = managed care; Rx = pharmacy benefit.

TABLE 3

ANNUAL MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFICIARY, BY BENEFICIARY CHARACTERISTIC[a, b]

TENNESSEE, 2003

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**72.8 %**	**23.0**	**$1,230**	**$54**	**$3,905**	**31.5 %**	**1,575,459**
Age							
5 and younger	65.9	4.3	182	43	1,510	12.0	252,262
6-14	59.6	4.3	234	54	1,358	17.2	310,879
15-20	64.2	6.4	303	47	2,410	12.6	174,600
21-44	75.4	21.1	1,241	59	4,003	31.0	418,577
45-64	86.6	54.8	3,093	57	7,334	42.2	259,434
65-74	89.1	60.9	2,949	49	5,754	51.3	85,506
75-84	88.9	61.1	2,733	45	9,383	29.1	47,546
85 and older	89.8	56.7	2,332	41	15,461	15.1	26,653
Unknown	0.0	0.0	0	0	6,165	0.0	2
Basis of Eligibility[e]							
Aged	89.0	57.3	2,649	46	9,016	29.4	121,894
Disabled	81.3	51.4	3,109	61	8,271	37.6	318,557
Adults	78.3	22.4	1,133	51	3,292	34.4	435,638
Children	62.6	4.4	187	42	1,409	13.3	699,370
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	76.7	26.4	1,331	50	4,146	32.1	912,935
Male	67.4	18.2	1,091	60	3,574	30.5	662,523
Unknown	100.0	12.0	214	18	756	28.3	1
Race							
White	77.4	27.1	1,457	54	4,343	33.5	1,032,988
African American	63.5	12.8	645	50	2,804	23.0	436,230
Other/unknown	65.8	24.8	1,426	57	4,175	34.2	106,241
Use of Nursing Facilities[f]							
Entire year	95.7	79.5	3,605	45	32,583	11.1	23,088
Part year	96.1	71.9	3,310	46	21,894	15.1	12,874
None	72.2	21.7	1,177	54	3,325	35.4	1,539,497
Maintenance Assistance Status							
Cash	75.4	30.3	1,697	56	4,752	35.7	555,775
Medically needy	72.9	22.4	1,176	53	2,833	41.5	217,519
Poverty related	62.9	4.7	192	41	1,391	13.8	265,114
Other/unknown	74.8	24.6	1,281	52	4,705	27.2	537,051

Source: Data for this table are from the MAX 2003 file for Tennessee, released by CMS in 07/2007. This table was produced on 11/01/2007.

a. Table 3 includes beneficiaries represented by Cell C of Table 1.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. In seven states (DE, IA, NE, NY, TX, UT, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.

d. In seven states (DE, IA, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; OTC = over-the-counter; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 4

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT *PER BENEFIT MONTH*, BY BENEFICIARY CHARACTERISTIC[a, b]

TENNESSEE, 2003

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Number: Beneficiaries	Benefit Months
All	**2.2**	**$120**	**31.5 %**	**27.2 %**	**39.9 %**	**7.6 %**	**12.0 %**	**9.4 %**	**3.8 %**	**$380**	**1,575,459**	**16,200,163**
Age												
5 and younger	0.4	19	12.0	34.1	60.5	3.9	1.4	0.1	0.0	156	252,262	2,441,945
6-14	0.4	22	17.2	40.4	53.3	3.9	2.2	0.2	0.0	130	310,879	3,241,515
15-20	0.6	30	12.6	35.8	52.6	7.0	4.0	0.6	0.1	240	174,600	1,753,664
21-44	2.1	124	31.0	24.6	38.9	11.6	15.0	7.6	2.3	400	418,577	4,194,894
45-64	5.0	281	42.2	13.4	15.3	9.6	25.8	24.5	11.4	667	259,434	2,854,310
65-74	5.5	269	51.3	10.9	11.0	8.1	26.9	30.4	12.7	524	85,506	938,882
75-84	5.7	255	29.1	11.1	9.2	7.1	26.0	33.2	13.4	876	47,546	509,141
85 and older	5.7	234	15.1	10.2	8.2	7.3	27.3	34.5	12.5	1,550	26,653	265,804
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	1,541	2	8
Basis of Eligibility[e]												
Aged	5.5	252	29.4	11.0	10.5	8.1	27.4	31.2	11.7	858	121,894	1,280,387
Disabled	4.5	274	37.6	18.7	18.4	8.1	20.8	22.4	11.6	729	318,557	3,613,917
Adults	2.3	114	34.4	21.7	37.8	12.3	17.6	8.7	2.0	332	435,638	4,320,933
Children	0.4	19	13.3	37.4	56.2	4.3	1.9	0.2	0.0	141	699,370	6,984,926
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.6	129	32.1	23.3	39.6	8.4	13.2	10.9	4.7	403	912,935	9,398,390
Male	1.8	106	30.5	32.6	40.4	6.5	10.5	7.4	2.6	348	662,523	6,801,765
Unknown	1.5	27	28.3	0.0	0.0	100.0	0.0	0.0	0.0	95	1	8
Race												
White	2.7	143	33.5	22.6	39.0	8.4	13.9	11.3	4.8	425	1,032,988	10,556,263
African American	1.2	62	23.0	36.5	43.5	6.0	7.9	4.8	1.2	267	436,230	4,581,548
Other/unknown	2.5	143	34.2	34.2	34.2	5.9	10.7	10.0	4.9	418	106,241	1,062,352
Use of Nursing Facilities[f]												
Entire year	8.0	361	11.1	4.3	4.4	4.1	21.0	39.5	26.8	3,259	23,088	230,852
Part year	7.2	333	15.1	3.9	6.4	5.9	24.8	38.8	20.2	2,201	12,874	128,037
None	2.1	114	35.4	27.8	40.7	7.7	11.8	8.7	3.3	323	1,539,497	15,841,274
Maintenance Assistance Status												
Cash	2.7	153	35.7	24.6	36.4	7.4	13.4	12.4	5.9	428	555,775	6,172,899
Medically needy	2.4	125	41.5	27.1	38.6	8.3	12.2	9.7	4.0	300	217,519	2,054,471
Poverty related	0.5	21	13.8	37.1	55.1	5.1	2.4	0.3	0.1	152	265,114	2,420,588
Other/unknown	2.4	124	27.2	25.2	36.6	8.8	15.3	10.6	3.4	455	537,051	5,552,205

Source: Data for this table are from the MAX 2003 file for Tennessee, released by CMS in 07/2007. This table was produced on 11/01/2007.

a. Table 4 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. In seven states (DE, IA, NE, NY, TX, UT, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.

d. In seven states (DE, IA, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 5

AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC[a, b, c]

TENNESSEE, 2003

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**2.2**	**$120**	**$54**	**1.0**	**$94**	**$97**	**0.1**	**$3**	**$39**	**1.2**	**$22**	**$19**
Age												
5 and younger	0.4	19	43	0.2	15	83	0.0	1	46	0.2	3	14
6-14	0.4	22	54	0.2	18	91	0.0	1	61	0.2	4	17
15-20	0.6	30	47	0.2	23	95	0.0	1	46	0.4	6	16
21-44	2.1	124	59	0.9	98	114	0.1	3	48	1.2	22	19
45-64	5.0	281	57	2.3	223	99	0.2	7	42	2.5	51	20
65-74	5.5	269	49	2.5	210	85	0.2	7	30	2.8	51	18
75-84	5.7	255	45	2.4	196	82	0.3	7	26	3.0	52	17
85 and older	5.7	234	41	2.1	173	81	0.3	8	25	3.2	52	16
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.5	252	46	2.4	196	83	0.3	7	27	2.8	49	17
Disabled	4.5	274	61	2.0	217	111	0.2	7	48	2.4	49	20
Adults	2.3	114	51	1.0	91	92	0.1	2	34	1.2	21	18
Children	0.4	19	42	0.2	14	78	0.0	1	47	0.2	4	15
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.6	129	50	1.1	101	92	0.1	3	34	1.4	25	18
Male	1.8	106	60	0.8	85	109	0.1	3	52	0.9	18	20
Unknown	1.5	27	18	0.4	18	47	0.0	0	0	1.1	9	8
Race												
White	2.7	143	54	1.2	112	97	0.1	4	39	1.4	26	19
African American	1.2	62	50	0.5	48	98	0.0	2	41	0.7	12	17
Other/unknown	2.5	143	57	1.1	113	105	0.1	4	43	1.3	26	19
Use of Nursing Facilities[e]												
Entire year	8.0	361	45	3.0	272	90	0.4	12	28	4.5	76	17
Part year	7.2	333	46	2.9	256	89	0.4	10	27	4.0	66	17
None	2.1	114	54	0.9	90	98	0.1	3	41	1.1	21	19
Maintenance Assistance Status												
Cash	2.7	153	56	1.1	120	105	0.1	4	44	1.5	29	19
Medically needy	2.4	125	53	1.0	98	96	0.1	3	37	1.2	23	19
Poverty related	0.5	21	41	0.2	16	79	0.0	1	41	0.3	4	15
Other/unknown	2.4	124	52	1.1	99	91	0.1	3	34	1.2	22	18

Source: Data for this table are from the MAX 2003 file for Tennessee, released by CMS in 07/2007. This table was produced on 11/01/2007.

a. Table 5 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Tennessee, 0.5 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]

TENNESSEE, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.2	$18	$14	$0	$4	$61	$110	$68	$23	2,786,407	$170,681,426	827,887	52.5 %	9,251,950
Biologicals	0.2	0.2	0.0	0.0	216	193	4	20	912	853	2,269	2,011	12,768	11,642,177	5,144	0.3	53,781
Antineoplastic Agents	0.5	0.2	0.0	0.3	123	100	2	21	231	488	154	66	109,211	25,245,381	18,974	1.2	204,715
Endocrine/Metabolic Drugs	0.7	0.4	0.1	0.3	30	24	2	4	40	67	20	15	3,626,716	145,682,157	434,404	27.6	4,879,576
Cardiovascular Agents	1.7	0.8	0.0	0.9	66	51	1	14	38	66	26	15	7,422,870	281,730,476	380,054	24.1	4,279,103
Respiratory Agents	0.6	0.3	0.0	0.2	29	24	1	4	51	71	61	18	3,561,872	180,770,879	559,790	35.5	6,306,589
Gastrointestinal Agents	0.7	0.4	0.0	0.3	54	43	1	10	78	119	120	31	2,720,556	211,431,020	348,314	22.1	3,935,126
Genitourinary Agents	0.3	0.2	0.0	0.1	15	13	0	2	50	68	37	19	408,791	20,534,884	118,945	7.5	1,346,410
CNS Drugs	1.1	0.6	0.0	0.6	80	68	1	10	70	122	97	18	5,550,904	389,047,019	433,509	27.5	4,867,447
Stimulants/Anti-obesity/Anorexia	0.4	0.3	0.0	0.1	38	33	1	4	87	100	71	43	171,020	14,874,994	34,611	2.2	395,753
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.1	99	97	0	1	154	170	50	17	110,710	17,020,747	15,857	1.0	172,619
Analgesics and Anesthetics	0.7	0.2	0.0	0.5	29	20	1	8	43	130	99	15	4,755,800	204,295,805	636,616	40.4	7,136,228
Neuromuscular Agents	0.7	0.2	0.0	0.4	39	28	1	10	60	124	39	26	2,034,393	121,173,023	273,405	17.4	3,108,539
Nutritional Products	0.5	0.0	0.0	0.4	7	0	0	6	15	24	19	14	777,561	11,347,934	146,177	9.3	1,610,422
Hematological Agents	0.7	0.3	0.1	0.3	65	57	3	5	88	185	25	16	772,504	67,775,691	93,250	5.9	1,042,201
Topical Products	0.3	0.1	0.0	0.2	9	6	0	3	36	69	42	17	1,190,016	42,719,108	405,078	25.7	4,584,052
Miscellaneous Products	0.4	0.2	0.1	0.1	91	63	16	13	246	351	266	97	66,119	16,274,661	15,819	1.0	178,085
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	7	0	0	0	42	0	0	0	125,770	5,316,398	68,104	4.3	773,997
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.	36,203,988	1,937,563,780	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Tennessee, released by CMS in 07/2007. This table was produced on 11/01/2007.

a. Table 6 includes the beneficiaries represented by Cell C of Table 1. A beneficiary who used drugs from two or more categories was counted as a user for each category. Therefore, the sum of users across categories may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. For information about these therapeutic categories, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Tennessee, 0.5 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2003.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; CNS = Central Nervous System; MAX = Medicaid Analytic Extract; n.a. = not applicable; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 7

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY TOP 10 DRUG GROUP[a, b, c]

TENNESSEE, 2003

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ULCER DRUGS	$180,085,835	379,820	24.1 %	4,325,429	0.5	$85	$42
ANTIPSYCHOTICS	179,740,681	147,511	9.4	1,676,175	0.6	179	107
ANTIDEPRESSANTS	161,901,251	433,689	27.5	4,911,830	0.5	61	33
ANTIHYPERLIPIDEMIC	121,908,934	188,082	11.9	2,171,303	0.6	90	56
ANTIASTHMATIC	105,084,253	427,505	27.1	4,857,780	0.4	60	22
ANALGESICS - Narcotic	100,483,677	761,979	48.4	8,622,989	0.3	35	12
ANTICONVULSANT	91,807,279	168,842	10.7	1,931,622	0.6	81	48
ANTIDIABETIC	88,737,123	212,449	13.5	2,422,232	0.7	54	37
ANALGESICS - ANTI-INFLAMMATORY	80,775,601	468,331	29.7	5,338,108	0.3	54	15
ANTIHYPERTENSIVE	75,942,314	285,735	18.1	3,249,215	0.7	36	23
Total	1,186,466,948	3,473,943		39,506,683	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Tennessee, released by CMS in 07/2007. This table was produced on 11/01/2007.

a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2003. A beneficiary who used drugs from two or more groups was counted as a user for each group. Therefore, the sum of users across drug groups may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. The top 10 drug groups were determined based on total Medicaid reimbursement in the state for 2003. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.