Medicare-Medicaid Enrollee State Profile

Tennessee

Centers for Medicare & Medicaid Services

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Introduction

This State Profile provides an overview of persons who are dually eligible for Medicare and Medicaid benefits in Tennessee, referred to as *Medicare-Medicaid enrollees*. Medicare-Medicaid enrollees are low-income seniors and people with disabilities.

Medicare-Medicaid enrollees can be categorized into 3 groups, based on the level of benefit they receive from Medicaid:

- ***Full Benefit*** enrollees receive the full array of Medicaid benefits available in the state
- *Qualified Medicare Beneficiaries (QMBs)* are ***Partial Benefit*** enrollees who receive assistance from Medicaid to pay their Medicare premiums and cost-sharing obligations
- *Specified Low Income Medicare* Beneficiaries (SLMBs), *Qualified Individuals (QIs)* and *Qualified Disabled and Working Individuals (QDWIs)* are ***Partial Benefit*** enrollees who receive assistance from Medicaid to pay Medicare premiums only.

The primary data source for the Medicare-Medicaid Enrollee State Profile is an analytic file developed by the Centers for Medicare & Medicaid Services (CMS) that contains linked calendar year 2007 Medicare and Medicaid administrative and claims data for persons age 18 and older. Other data sources are noted herein. Because of data limitations, some charts were excluded from some State Profiles. Exclusions are noted where applicable. For more information about the 2007 linked analytic file, refer to **Data Source and Limitations** at the end of the State Profile.

At a Glance

TABLE 1. MEDICARE, MEDICAID, AND MEDICARE-MEDICAID ENROLLMENT AS PERCENT OF POPULATION: TENNESSEE COMPARED TO THE UNITED STATES, 2007

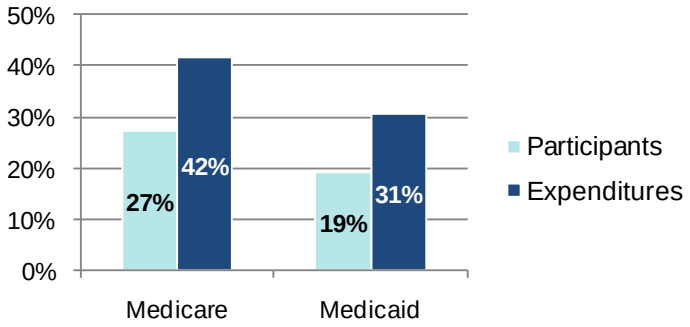
Population Type	Population Count	Percent of State Population	U.S. Percent
State	6,175,727	100%	N/A
Medicare	1,034,374	17%	15%
Medicaid	1,467,595	24%	20%
Medicare-Medicaid enrollees (Full and Partial Benefit)	283,420	5%	3%

Source: State population, U.S. Census, Intercensal Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico (September 2011 release); Medicaid, Mathematica Policy Research, Medicaid Analytic Extract State Anomaly Tables, Table 1; Medicare and Medicare-Medicaid enrollees, CMS 2007 linked analytic file.

Note: The Medicare, Medicaid, and Medicare-Medicaid population counts reflect beneficiaries "ever enrolled" during CY 2007.

There were about 283,000 Medicare-Medicaid enrollees in Tennessee and about 9 million nationally. Medicare-Medicaid enrollees represented 5% of the State's population, compared to 3% for the United States. They represented 27% of the State's Medicare population and 19% of its Medicaid population, compared to 20% and 15% for the United States, respectively (not shown).

FIGURE 1. MEDICARE-MEDICAID ENROLLEES (FULL AND PARTIAL BENEFIT) AS SHARE OF PROGRAM PARTICIPANTS VS. SHARE OF EXPENDITURES: TENNESSEE, 2007



Total Expenditures in Tennessee:

Medicare: $9.6B **Medicaid: $5.7B**
Medicare-Medicaid Enrollee MEDICARE: $4.0B **Medicare-Medicaid Enrollee MEDICAID: $1.7B**

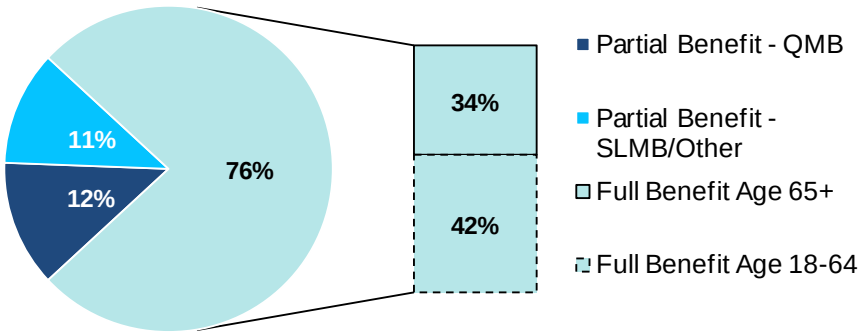
Source: Total Medicaid expenditures and participants are based on *Medicaid Analytic Extract State Anomaly Tables*, Table 1. The remaining figures are based on the CMS 2007 linked analytic file.

Note: Medicaid and Medicare expenditures include managed care and fee-for-service. Medicaid expenditures include both the State and Federal Share; they do not include payments made outside of the claims processing system.

Medicare-Medicaid enrollees have, on average, greater health and long-term services and supports (LTSS) needs than beneficiaries who have only Medicare or Medicaid coverage. As shown in Figure 1, Medicare-Medicaid enrollees accounted for a disproportionate share of total spending in both programs.

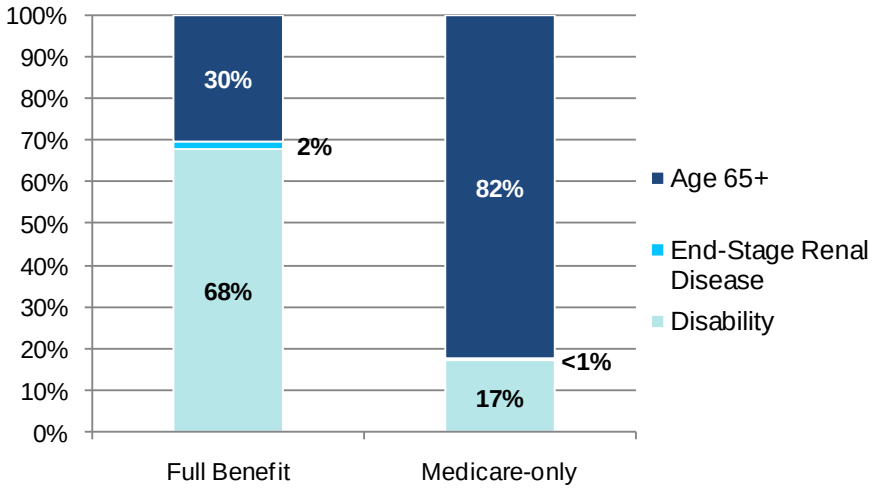
Eligibility

FIGURE 2. MEDICARE-MEDICAID ENROLLEES BY MEDICAID BENEFIT LEVEL AND FULL BENEFIT MEDICARE-MEDICAID ENROLLEES BY ELIGIBILITY CATEGORY: TENNESSEE, 2007



In Tennessee, 76% of Medicare-Medicaid enrollees had full Medicaid benefits: 34% were ages 65 and older and 42% were ages 18 to 64. The remaining enrollees got Medicaid help with Medicare premium payments, and, in the case of QMBs, Medicare cost-sharing.

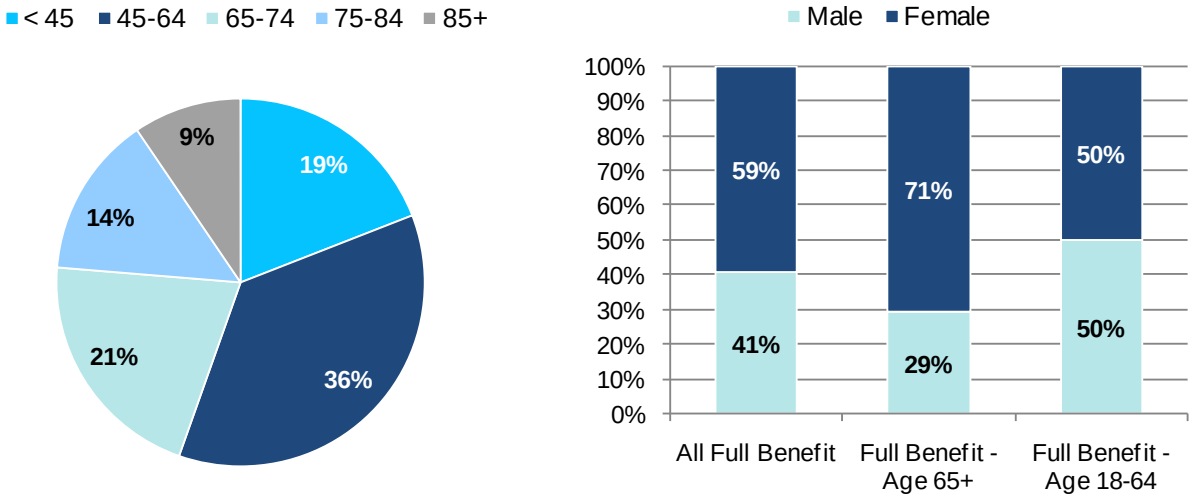
FIGURE 3. ORIGINAL REASON FOR MEDICARE ELIGIBILITY BY ENROLLMENT GROUP: TENNESSEE, 2007



At least twice as many Full Benefit Medicare-Medicaid enrollees originally became eligible for Medicare because of a disability compared to the Medicare-only (Medicare with no Medicaid coverage) population.

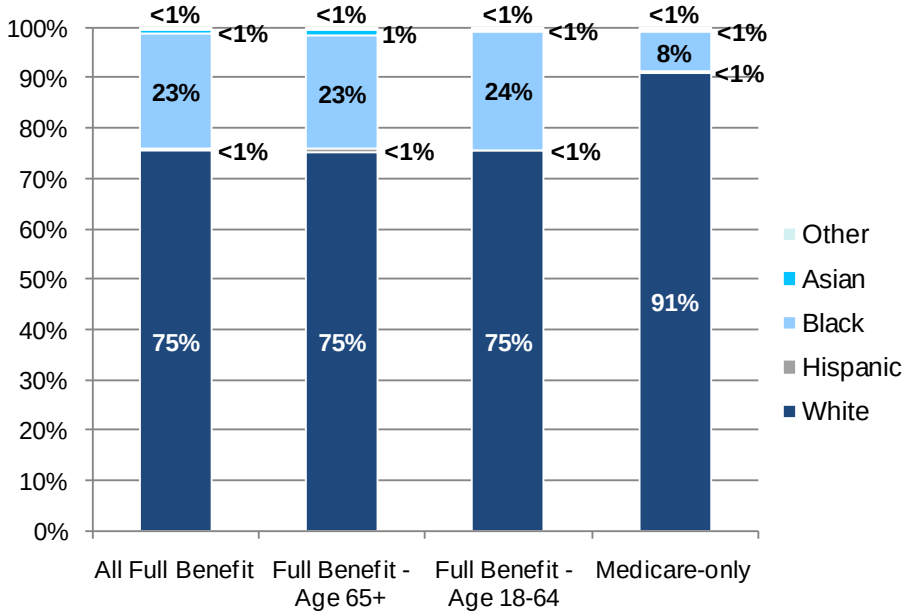
Demographics

FIGURE 4. FULL BENEFIT MEDICARE-MEDICAID ENROLLEES BY AGE GROUP AND GENDER: TENNESSEE, 2007



A total of 45% of Full Benefit enrollees in Tennessee were age 65 and older; people age 85 and older comprised 21% of this group. The majority of Full Benefit enrollees in Tennessee were female; this share was higher among those age 65 and older.

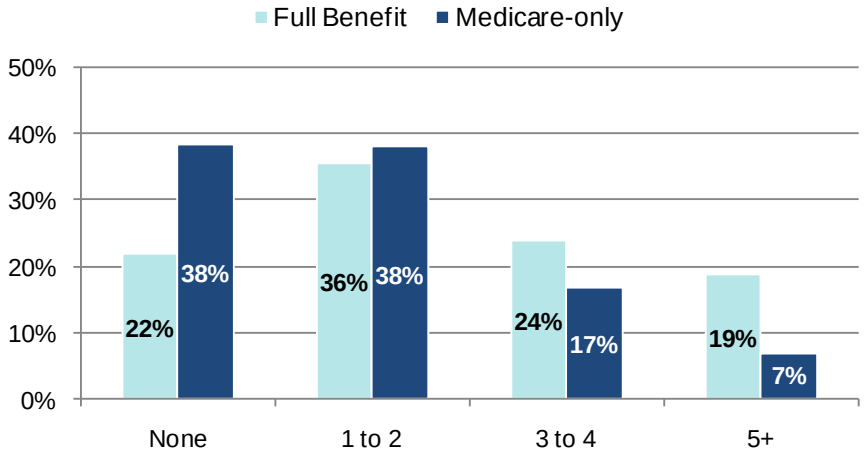
FIGURE 5. RACIAL DISTRIBUTION BY ENROLLMENT GROUP: TENNESSEE, 2007



A higher share of Full Benefit enrollees was non-white compared to the Medicare-only population. The share of Full Benefit enrollees that was non-white did not vary by age group (age 65+ vs. age 18-64).

Chronic Conditions

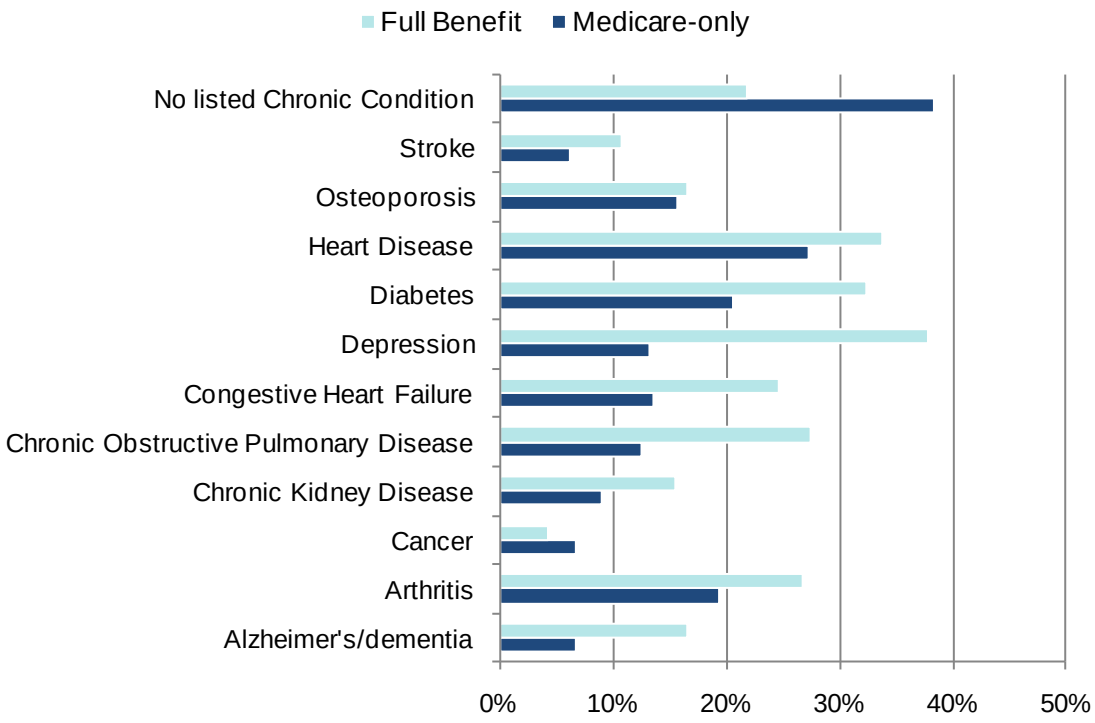
FIGURE 6. NUMBER OF CHRONIC CONDITIONS BY ENROLLMENT GROUP: TENNESSEE, 2007



Note: Findings related to chronic conditions were not age-adjusted. At the time the Profiles were developed, the data source did not capture the range of mental health or developmental conditions, which disproportionately affect the age 18 - 64 Medicare-Medicaid enrollee population.

Full Benefit enrollees were over 2 and a half times more likely than Medicare-only beneficiaries to have had 5 or more chronic conditions.

FIGURE 7. PREVALENCE OF SELECT CHRONIC CONDITIONS BY ENROLLMENT GROUP: TENNESSEE, 2007

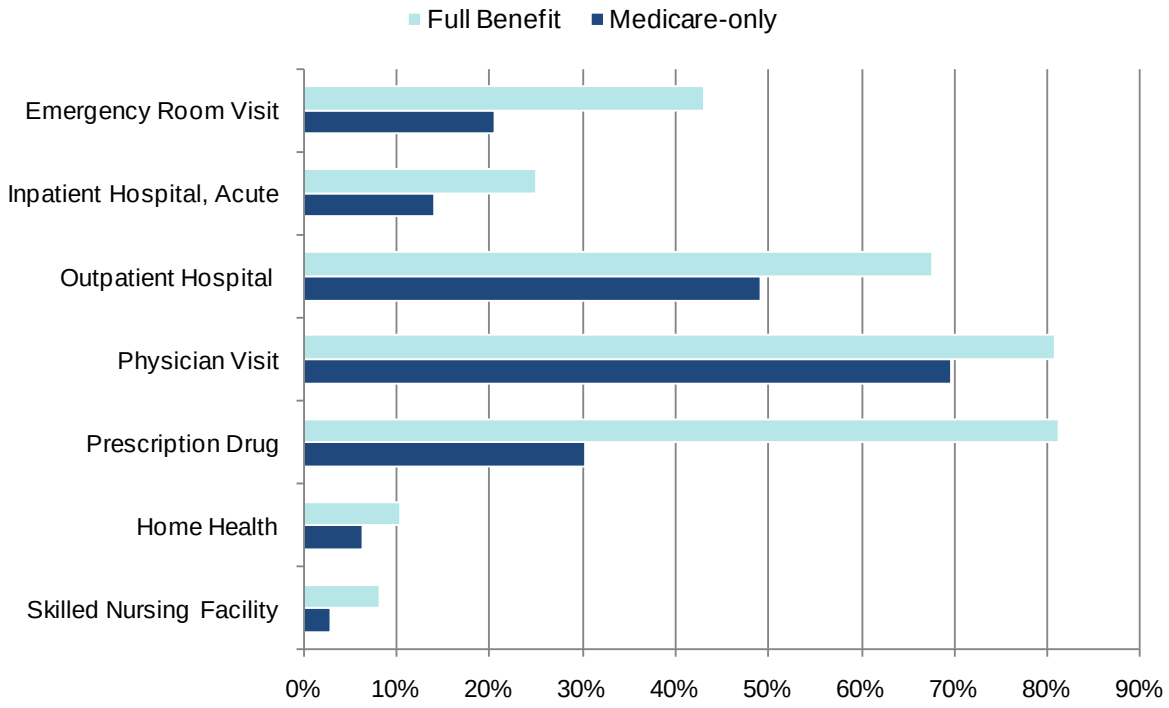


Note: This is a subset of the 20 chronic conditions reported in the CMS Chronic Condition Warehouse. The following conditions were not included in this analysis: pelvic/hip fracture, glaucoma, atrial fibrillation, cataract, and acute myocardial infarction. Five cancer conditions were combined as one category. Findings related to chronic conditions were not age-adjusted. At the time the Profiles were developed, the data source did not capture the range of mental health or developmental conditions, which disproportionately affect the age 18 - 64 Medicare-Medicaid enrollee population.

Full Benefit enrollees typically had a greater prevalence of chronic conditions compared to Medicare-only beneficiaries.

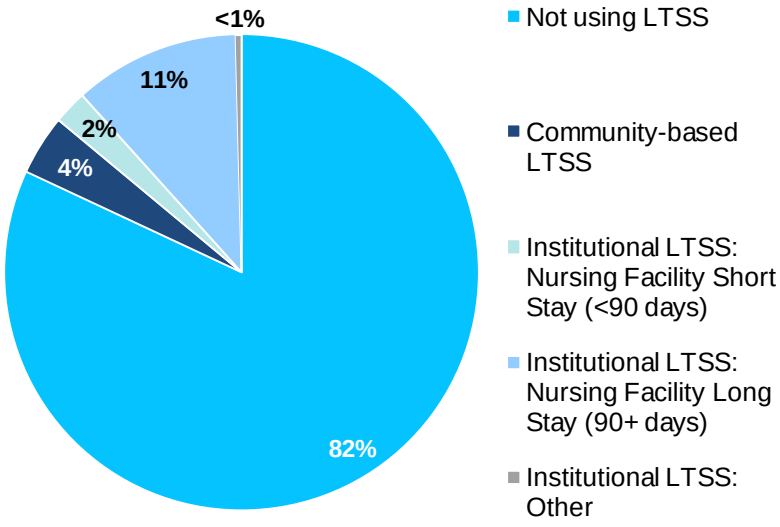
Utilization

FIGURE 8. PERCENTAGE OF FEE-FOR-SERVICE BENEFICIARIES USING SELECT MEDICARE HEALTH AND POST-ACUTE SERVICES BY ENROLLMENT GROUP: TENNESSEE, 2007



Full Benefit enrollees tended to use select Medicare services at higher rates than Medicare-only beneficiaries. Utilization was measured by the percentage of people using the service.

FIGURE 9. FULL BENEFIT MEDICARE-MEDICAID ENROLLEES' USE OF FEE-FOR-SERVICE MEDICAID-FUNDED LTSS: TENNESSEE, 2007

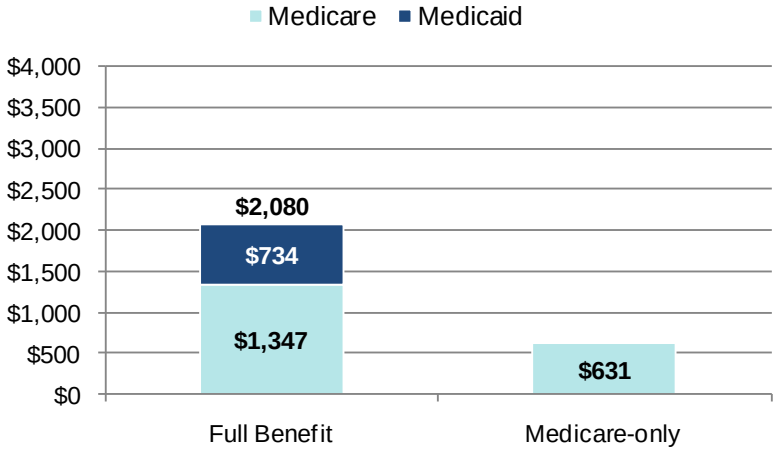


Note: these categories are mutually exclusive in that persons using more than one type of LTSS were assigned to only one category. Beneficiaries with Medicaid fee-for-service payments greater than $0 for any type of LTSS were assigned to an LTSS category. Assignments to LTSS categories were made in a hierarchical manner with institutional LTSS being the first category assigned. Thus, beneficiaries with Medicaid payments for both institutional and community-based LTSS were assigned to the institutional LTSS category. **This analysis is based on fee-for-service claims. Full Benefit enrollees' participation in Medicaid managed care was greater than 20% in 2007, which impacts Medicaid findings for this group.**

The majority of Full Benefit enrollees in Tennessee did not use Medicaid-funded LTSS. Of those that did, 77% used institutional LTSS and the remainder used community-based LTSS.

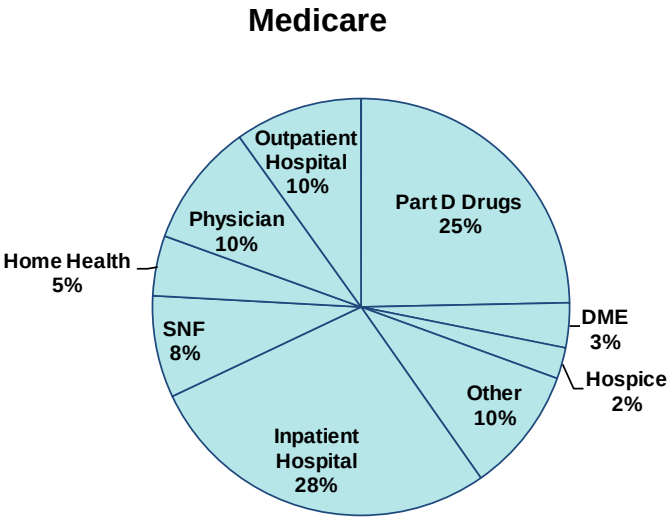
Spending

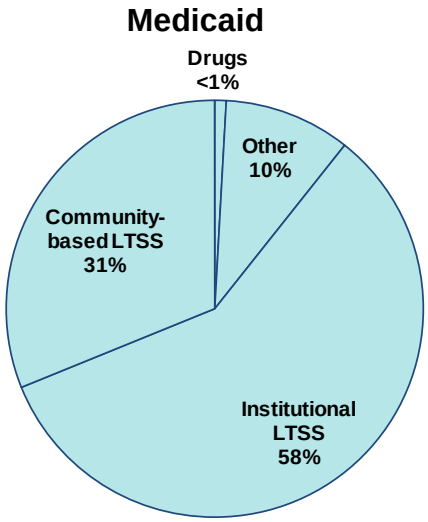
FIGURE 10. AVERAGE MONTHLY SPENDING PER PERSON BY ENROLLMENT STATUS: TENNESSEE, 2007



Full Benefit enrollees had significantly higher average monthly spending per person compared to Medicare-only beneficiaries, including higher average Medicare costs. Total costs included managed care and fee-for-service (FFS) payments.

FIGURE 11. DISTRIBUTION OF FEE-FOR-SERVICE SPENDING: FULL BENEFIT ENROLLEES: TENNESSEE, 2007





Medicare FFS Spending: $ 2.7B **Medicaid FFS Spending: $ 1.3B**

Note: Institutional LTSS includes nursing facility, intermediate care facility for the mentally retarded, inpatient psychiatric facility for the under-21, and mental hospital for the aged. Community-based LTSS includes State Plan Services such as Home Health and Personal Care and HCBS waivers which allow states to provide a broader array of LTSS to persons living in the community than those covered in the State Plan. This analysis is based on fee-for-service claims. Full Benefit enrollees' participation in Medicaid managed care was greater than 20% in 2007, which impacts Medicaid findings for this group.

The largest share of Full Benefit enrollees' FFS Medicare spending went toward Inpatient Hospital care, whereas the largest share of FFS Medicaid spending went toward Institutional LTSS.

Service Delivery

Medicaid Delivery System, 2010

In 2010, all of Tennessee's Medicaid enrollees were in the State's mandatory managed care program, TennCare II. Full Benefit Medicare-Medicaid enrollees were required to enroll in TennCare managed care organizations to receive Medicaid-covered services. Full Benefit Medicare-Medicaid enrollees under the age of 21 were required to enroll in pharmacy benefit manager and dental benefit manager plans. In August 2010, the State implemented a managed LTSS program, CHOICES. All Medicaid beneficiaries, including Medicare-Medicaid enrollees, must participate in CHOICES for Medicaid-covered LTSS. Prior to this, Medicare-Medicaid enrollees in Middle Tennessee received LTSS through managed care and those in East and West Tennessee received them through the fee-for-service system. Tennessee had 1 PACE program in 2010.

Source: Kaiser Family Foundation statehealthfacts.org Medicaid managed care enrollment reports as of July and October 2010; CMS Medicaid managed care enrollment reports as of July 2010; and CMS National Summary of State Medicaid Managed Care Programs as of June 30, 2010.

Medicare Advantage Dual Eligible Special Needs Plans, 2011

As of January 2011, there were 8 Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) in Tennessee with total enrollment of 38,699. The D-SNP enrollment represented 29% of Tennessee's Full Benefit Medicare-Medicaid enrollee population during the same time period.

Integrated Medicare and Medicaid Programs, 2011

For the purposes of this analysis, integrated Medicare-Medicaid programs are defined as those designed by states or counties, outside of PACE, to enable Medicare-Medicaid enrollees to receive most or all of their Medicare and Medicaid services through a single entity that is accountable for the quality and cost of those services. Further, these programs promote integration by requiring participating plans to offer a companion Medicare Advantage product.

There are other programs and circumstances in which a health plan offers both Medicare and Medicaid products within the same market. Those are not identified as integrated Medicare and Medicaid programs because they are not required to be offered as part of an integrated program contract.

Tennessee did not have an integrated Medicare and Medicaid Program in 2011.

Data Source and Limitations

Unless otherwise noted, the data source for the Medicare-Medicaid Enrollee State Profile is an analytic file developed by the Centers for Medicare & Medicaid Services (CMS) that contains linked calendar year 2007 Medicare and Medicaid administrative and claims data for persons ages 18 and older from the CMS Chronic Condition Data Warehouse (CCW) and Medicaid Analytic eXtract (MAX) files. As the Medicare claims data do not include Medicare spending on managed care, payments to Medicare Advantage plans were added to the linked file. The MAX files include Medicaid managed care capitation payments. The spending information does not include Medicaid Buy-In payments for Medicare Part B premiums nor any Medicare or Medicaid payments made outside of the claims processing system (with the exception of the payments to Medicare Advantage plans). All Medicaid expenditure amounts presented in the State Profiles include both the State and Federal share.

A significant limitation of the linked analytic file is that it does not contain Medicare or Medicaid managed care encounter records. These records document utilization of, and sometimes spending on, services provided through managed care programs. Accordingly, for states with significant Medicare and/or Medicaid managed care enrollment, findings that are based solely on fee-for-service claims experience must be interpreted with caution as they may not be representative of the entire beneficiary population. State Profiles were notated if Full Benefit Medicare-Medicaid enrollees' participation in Medicare or Medicaid managed care was 20% to 34%. If the participation rate was 35% or higher, the charts affected by managed care enrollment were excluded and the Profile was noted accordingly.

Another limitation relates to the types of chronic conditions available in the CCW at the time the Profiles were developed as they did not include a range of mental health or developmental conditions. Newly proposed mental health, substance abuse, HIV/AIDS, and developmental conditions are under development to be added to the CCW. The addition of these conditions, which disproportionately affect Medicare-Medicaid enrollees under age 65, will make age-adjusted analyses of the prevalence of chronic conditions more robust.

For more information, the *Medicare-Medicaid Linked Analytic File Methodological Summary* available at http://www.integratedcareresourcecenter.com/icmstateprofiles.aspx provides a detailed description of the methodology used to produce the linked analytic file, the criteria used to define populations, data caveats, and limitations. This includes the understanding developed as a result of this analytic effort of some limitations of using MSIS data to identify dual eligible beneficiaries. In future analytical efforts this limitation can be addressed by shifting to State MMA file reported dual status.