# MaineCare for Childless Adults Waiver
# Year 7 Annual Report
## October 1, 2008 – September 30, 2009

A report prepared by the
Cutler Institute of Health & Social Policy,
Muskie School of Public Service,
University of Southern Maine

Prepared for the
Maine Department of
Health and Human Services by:

Nathaniel Anderson
Tina Gressani

February 23, 2010

## About the Study

This report was prepared under a cooperative agreement between the Maine Department of Health and Human Services and the Muskie School of Public Service at the University of Southern Maine. We would like to thank Aimee Campell-O'Connor, Dr. Rod Prior, and Kim Fox for their helpful comments on earlier drafts of this report. The views expressed are those of the authors and do not necessarily represent the views of either the Department or the School. For more information contact Nathaniel Anderson, Research Associate, Muskie School of Public Service, 207-228-8187 or nanderso@usm.maine.edu

# Table of Contents

## Executive Summary

In early 2002, the Maine Department of Health and Human Services (Maine DHHS) successfully applied for and received a Section 1115 Demonstration Waiver to cover childless adults living below 125% of the Federal Poverty Level (FPL) under MaineCare, the state's Medicaid and SCHIP program. Maine chose to phase in the waiver and has limited eligibility to childless adults below 100 percent of the FPL. The initial Waiver authorization covered the five year period from October 2002 through September 2007, and the Childless Adults (CA) Waiver was extended at that time through September 2010. Funding for the Waiver comes from an unspent portion of disproportionate share hospital (DSH) payments for acute hospitals, capped at $90 million per year under the terms of the Waiver extension.

The Childless Adults Waiver provides a comprehensive set of benefits to members, including inpatient and outpatient hospital services, physician care, prescription drugs, mental health and substance abuse treatment services, lab and x-rays, and medical transportation. There is no monthly premium and co-pays are nominal. The health care service delivery system for CA Waiver members is the same as for all other MaineCare members.

This report provides ongoing monitoring of the MaineCare Childless Adults Waiver by describing enrollment and expenditures over the first seven years of operation: October 1, 2002 through September 30, 2009. Key findings include:

- In the sixth year of operation, October 2007 through September 2008, the MaineCare CA Waiver provided services to 18,510 members at a cost of $90.3 million[1]. During the first nine months of Year 7 (October 2008 through June 2009), $52.5 million was expended for 11,946 participants. Adjusting for member months results in a total per member month (PMPM) expenditures of $458.11 in Year 6 and $534.30 in the first part of Year 7, 17% higher than in Year 6. Monthly enrollment was closed and declining throughout most of Years 6 and 7, with the exception of July 2008 and April 2009 when DHHS enrolled groups of more than 1,500 new members from a wait list. Year 7 ended with a monthly caseload of 10,800 members, down from over 20,000 at the beginning of Year 6, and with a wait list of over 15,000 eligible individuals.
- The primary cost drivers for the CA Waiver have remained consistent over time. Hospital inpatient and outpatient services accounted for almost 50% of expenditures in Years 4 through 7. Prescription drugs accounted for about 20% of expenditures, and were the benefit most widely used by Waiver members. Also notable is the fact that outpatient psychiatric, mental health agency and substance abuse services make up between 9 and 10% of total expenditures for CA Waiver members each year.

[1] Expenditures data included in this report reflect claims expenditures and do not reflect any off claim settlements or adjustments. As a result, these expenditure figures may vary from numbers reported elsewhere.

- As documented in past years, expenditures for the MaineCare CA Waiver are not uniform across members. Most Waiver members generate few—if any—MaineCare expenditures. Among members who were ever enrolled in Year 6 (October 2007 – September 2008), fifty percent had $892 or less in paid claims, and as a group contributed only 3% of total expenditures. On the other hand, the top 5% of members (those with more than $15,814 in expenditures) accounted for 44% of total expenditures, and the top 10% (those more than $9,675) accounted for 60% of all expenditures for the CA Waiver in Year 6.
- Examining the diagnoses submitted on claims for Years 6 and 7 provides some insight into the conditions driving service use. Claims that included a diagnosis of nondependent tobacco use disorder totaled $9.8 million in Year 6; this was more than any other single diagnosis. This suggests that smoking is a contributing factor in the health problems and utilization for many members. Increasing support for smoking cessation, such as encouraging MaineCare providers to counsel patients or providing referrals to the Maine Tobacco Helpline, may be warranted.
- Mental health and substance abuse codes are also frequently noted on claims--accounting for 4 of the top 10, and 9 of the top 20 most costly diagnoses. Chronic conditions, including high blood pressure, high cholesterol, diabetes and heart disease are also among the most costly conditions among CA Waiver members.
- Previous work has shown that there is a considerable amount of turnover in members enrolled in the Waiver. Over the first six years of operation, nearly half of all members who ever enrolled were enrolled for less than one year, and three fourths were enrolled for less than 2 years.[2] High cost users in Year 6 (defined as those with more than $10,000 in total paid claims) were more likely to be enrolled for all 12 months of Year 6 (68 percent) than CA Waiver members (42 percent). In the period up to and including Year 6, high cost users were enrolled for an average of 33 months. These results indicate that the majority of high cost members were <u>not</u> new to the CA Waiver, and that most were long-term members.
- We also investigated use of care management services provided by Schaller Anderson (SA) to determine how many CA Waiver members enrolled during Year 6 received those services. Overall, 1,115 CA Waiver members received services from Schaller Anderson, representing 5% of all CA Waiver members. High cost users with more than $10,000 in expenditures were more likely to have contact with SA, at 20 percent. And contact with SA was more frequent for high cost users with more than $15,814 (the top 5% in expenditures), at 24 percent. Comparing CA Waiver members who received care management services with those who had not, we found that Schaller Anderson participants had longer average periods of enrollment in the CA Waiver (34.8 versus 26.1) and higher expenditures ($13,515 versus $3,333). PMPM expenditures for SA participants were also more than three times higher than non-participants ($1,408 versus $403).[3] Those who received services from SA represented only 5% of all members but generated 17% of the total Year 6 expenditures. These results suggest that Schaller Anderson has been successful in targeting the highest cost CA Waiver members.
- The CA Waiver has a demonstrable impact on the uninsured rate among poor adults with no children in Maine. Using CPS data and eligibility data from Maine DHHS, we estimated that

[2] Anderson, N., McGuire, C., and Gressani, T. MaineCare for Childless Adults Waiver Year 5 and 6 Annual Report.
[3] Member month and expenditure information used to calculate PMPM expenditures is from MMDSS. (Member months and expenditures for those who received care management from SA are not necessarily limited to months when the member was enrolled in care management.)

during the first six years of the CA Waiver, for every ten thousand individuals enrolled in the Waiver, the uninsured rate among the target population of adults without children living below poverty was reduced by 3.7 percent.

- We assessed the quality of care being delivered to CA Waiver members using several HEDIS measures, and constructed measures for seven overlapping time periods between October 2006 and March 2009. The MaineCare CA Waiver HEDIS scores meet or exceed the national Medicaid HMO benchmarks on three of the six measures, including documented preventive care visits for 20 to 44 year olds (76%), preventive care visits for 45 to 64 year olds (84%), and HbA1c testing for diabetic members (82%). Condition-specific screening rates were generally less prevalent among CA waiver members compared with Medicaid participants nationally. Fifty six percent of eligible women in the CA Waiver received a recommended Pap test, versus 65 percent of women in Medicaid programs nationally. Eye exams for diabetic members (31%) and colorectal screening rates (36%) were both substantially lower than national benchmarks.
- Most of the HEDIS measures we examined showed significant improvement over the seven measurement periods. For example, access scores for younger adults (20 to 44 year olds) improved from 72 to 76 percent. HbA1c testing scores also rose substantially, from 72 to 81 percent. Several of the measures that lag behind the national benchmarks as of March 2009 have been improving over the past several quarters. For example, cervical cancer screening rates among eligible CA Waiver members increased from 46 percent in September 2007 to 56 percent in March 2009, and colorectal cancer screening showed moderate improvement of 32 to 36 percent over the same period.
- Overall, quality of care for CA Waiver members compares favorably to national Medicaid benchmarks, but the comparatively low rates of cancer screening received by MaineCare Childless Adult Waiver members are cause for concern. In the absence of sufficient screening, cases of cervical and colorectal cancer among Waiver members may go undetected in the early stages, when they are treatable. These risks can be mitigated through continued increases in cancer screening rates.

## Introduction

In early 2002, the Maine Department of Health and Human Services (Maine DHHS) successfully applied for and received a Section 1115 Waiver to cover childless adults living below 125% of the Federal Poverty Level (FPL) under MaineCare, the state's Medicaid and SCHIP program. Maine chose to phase in the waiver and has limited eligibility to childless adults below 100 percent of the FPL. The initial Waiver authorization covered the five year period from October 2002 through September 2007, and the Childless Adults (CA) Waiver was extended at that time through September 2010. Funding for the Waiver comes from an unspent portion of disproportionate share hospital (DSH) payments for acute hospitals, capped at $90 million per year under the terms of the Waiver extension.

The Childless Adults Waiver provides a comprehensive set of benefits to members, including inpatient and outpatient hospital services, physician care, prescription drugs, mental health and substance abuse treatment services, lab and x-rays, and medical transportation. There is no monthly premium and co-pays are nominal. The health care service delivery system for CA Waiver members is the same as for all other MaineCare members. CA Waiver members are required to enroll in MaineCare's Primary Care Case Management (PCCM) program.[4] PCCM provides each member with a designated primary care provider (PCP) who is responsible for managing the health and health services of their patient. Exceptions to PCCM participation are allowed for members with a chronic illness, for those who are homeless, and for those without a participating PCCM provider in their area.

The goals of the MaineCare Childless Adults Waiver[5] are to extend MaineCare coverage to a group of individuals who would otherwise be ineligible, and to reduce the uninsurance rate among poor adults without children.[6] Enrollment in the Childless Adults Waiver began on October 1, 2002, at an opportune time to provide a public safety net of health care coverage for this population. In the period leading up to 2002, an estimated 40 percent of all poor childless adults in Maine were

[4] Maine Department of Health and Human Services. Non-Categorical Waiver Quarterly Report to CMS for the Period October 1, 2006 – December 31, 2006. [Downloaded from www.cms.hhs.gov on 11/15/07]
[5] The Childless Adults Waiver is also known as the "Non-Categorical Waiver", because childless adults do not fit into one of the traditional Medicaid coverage categories of children, parents, elderly or disabled.
[6] For complete context and background see Anderson, N., Kilbreth, E., & Ziller, E., (2005 January). MaineCare Non-Categorical Waiver Annual Report: Year 1: October 1, 2002 – September 30, 2003. Portland, ME: University of Southern Maine, Muskie School of Public Service, Institute for Health Policy.

uninsured, representing 19,300 individuals.[7] Their prospects for obtaining private coverage were dim as a result of a faltering Maine economy, rising premium costs, reductions in employer-based coverage, and the contraction of the individual insurance market.

This report provides ongoing monitoring of the MaineCare Childless Adults Waiver by describing enrollment and expenditures over the first seven years of operation: October 1, 2002 through September 30, 2009. We use claims and eligibility data from Maine DHHS to examine annual expenditures, the health status of Waiver members, patterns of enrollment, and the relationship between length of enrollment and expenditures. To assess the impact of the CA Waiver on the number and proportion of poor, childless adults who are uninsured, we use the Current Population Survey (CPS) data for Maine respondents; we track the uninsurance rate over time and assess the relationship between enrollment in the Waiver and the rate of uninsured individuals. We also use the CPS data to examine whether employers or individuals may have dropped private coverage in response to the availability of the Waiver – often referred to as "crowd-out" – to see if there have been shifts in the type of insurance coverage (employer-sponsored, individual, Medicaid, Medicare, and other coverage) held by members of the target population. Finally, we examine access to primary care services and the quality of care delivered to Waiver members using several Health Plan Employer Data and Information Set (HEDIS) measures.

## Data Sources

Data for Childless Adults Waiver members were drawn from the MaineCare Decision Support System (MMDSS), an information system that combines various administrative data systems operated by the Department of Health and Human Services. **Note that expenditure data included in MMDSS reflect claims expenditures and do not reflect any off claim settlements or adjustments. As a result, these expenditure figures may vary from numbers reported elsewhere.** Hospital inpatient and outpatient costs have been estimated using the method developed by DHHS. Monthly eligibility information was also drawn from MMDSS to track caseloads and assess enrollment patterns in the CA Waiver. Members receiving care management services were identified using information provided by Schaller Anderson. Using MaineCare claims submitted by

[7] Muskie School calculations using 2001 and 2002 Current Population Survey March Supplement Data (representing the period from 2000 to 2001). These weighted estimates are based on a sample of adults ages 19-64 living in households with no children under age 18.

providers in MMDSS and the algorithms specified in the 2007 HEDIS Technical Specifications[8], we constructed measures of adult access to primary care, cervical cancer screening, diabetic care, and colorectal cancer screening. As a point of comparison, we present benchmark results for these HEDIS measures from Medicaid programs nationwide.[9]

To track the number and percentage of people who are uninsured in Maine, we use data from the Current Population Survey Annual Social and Economic Supplement (CPS ASEC), administered every March by the Census Bureau. The CPS collects information on the insurance status of each respondent, including the type of insurance coverage. The series of health insurance questions is designed to capture whether or not the respondent had any employment-based coverage, a direct-purchase plan (individual coverage), Medicare, Medicaid or SCHIP, military coverage, or any other coverage. The time frame for the insurance questions is the previous calendar year. As a result, the insurance type categories are not mutually exclusive--an individual could switch from one type of coverage to another during the course of the year, or they could have more than one type of coverage at the same time. The CPS defines a person as uninsured if he or she did not have any type of insurance coverage for the entire previous calendar year.[10]

Researchers have noted that sample sizes for individual states are not sufficient to detect year to year changes in uninsurance rates, particularly among sub-state populations.[11] To increase the reliability of uninsurance estimates for the Maine population of poor adults without children, we pool CPS data from consecutive years and use two-year average rates to examine the trend. We limit the CPS sample to individuals in the target population for the MaineCare Childless Adults Waiver, namely those who are age 21 to 64 and living in households below 100% of the Federal Poverty Level with no children under age 18 in the household.

In addition to descriptive charts highlighting trends in CA Waiver enrollment and the uninsured rate, we also constructed measures of two year average enrollment based on MMDSS to use in a regression model predicting the uninsured rate among poor childless adults in Maine.

---

[8] National Committee for Quality Assurance. HEDIS 2007 Technical Specifications for Physician Measurement. [Available at http://www.ncqa.org/tabid/78/Default.aspx#HEDISMD]

[9] National Committee for Quality Assurance. HEDIS 2006 Audit Means, Percentiles and Ratios for Medicaid Population.[http://www.ncqa.org/tabid/334/Default.aspx]

[10] For more information on the Census Bureau health insurance definitions and coding for the CPS ASEC, see: http://www.census.gov/hhes/www/hlthins/hlthinshelp.html

[11] State Health Access Data Assistance Center, July 2001. *State Health Insurance Coverage Estimates: Why State-Survey Estimates Differ from CPS.* Issue Brief 3. <www.shadac.umn.edu>

## Monthly Enrollment and Operational Changes

Monthly enrollment in the MaineCare Childless Adults Waiver rose rapidly in the first two years, reaching 24,000 members by February 2005 (Chart 1, page 13). Because expenditures on the Waiver exceeded federal financing limits in the third year, Maine's Department of Health and Human Services took a number of steps to reduce Waiver expenditures. First, enrollment was closed on March 1, 2005 and a waiting list was established. Second, Maine DHHS submitted Section 1115 Waiver amendments to the Centers for Medicare and Medicaid Services (CMS) to allow a reduction in the services available to CA Waiver members[12], and to eliminate retroactive coverage. CMS approved these changes on July 7, 2005, and the reduction in the benefits package was implemented on December 5, 2005.

Measures implemented by DHHS were successful in reducing both enrollment and expenditures in the Childless Adults Waiver. The monthly caseload dropped quickly after new enrollment closed in March 2005. There had been a good deal of underlying instability in the caseload before the enrollment closure was implemented, with more than 1,700 members coming in and more than 1,000 leaving the CA Waiver each month. After closing enrollment, the monthly caseload dropped as high rates of disenrollment continued while new enrollment ceased.[13] Enrollment continued to decline until it fell below 11,000 in July 2006. At that time, the Department determined that expenditures had decreased sufficiently to re-open enrollment, and began enrolling people from the waiting list. Department financial projections showed that the Waiver could serve 20,000 people without exceeding federal financing limits, so when the caseload reached 20,000 in December 2006, a waiting list was reinstituted and total monthly enrollment was capped and maintained at approximately 20,000 through December 2007.[14]

Maine DHHS received approval from CMS to extend the Childless Adults Waiver for three more years, from October 2007 through September 2010. Under the terms of Waiver extension, Maine is no longer authorized to offer coverage to adults living between 100% and 125% FPL. Total disproportionate hospital share (DSH) payments for acute hospitals--used to fund the Waiver-

[12] The new rules limited coverage for outpatient mental health services to 16 visits per calendar year, and eliminated coverage for a number of services including: private non-medical institution (PNMI) services (except for substance abuse), laboratory and imaging services, community support services, residential services for people with mental illness, medical supplies, and durable medical equipment. The benefit reductions were in effect through September 30, 2007.
[13] Anderson, N. and McGuire, C. (2007 January). Non-Categorical Waiver Annual Report: Year 3
[14] Maine Department of Health and Human Services. Non-Categorical Waiver Quarterly Report to CMS for the Period October 1, 2006 – December 31, 2006. [Downloaded from www.cms.hhs.gov on 11/15/07]

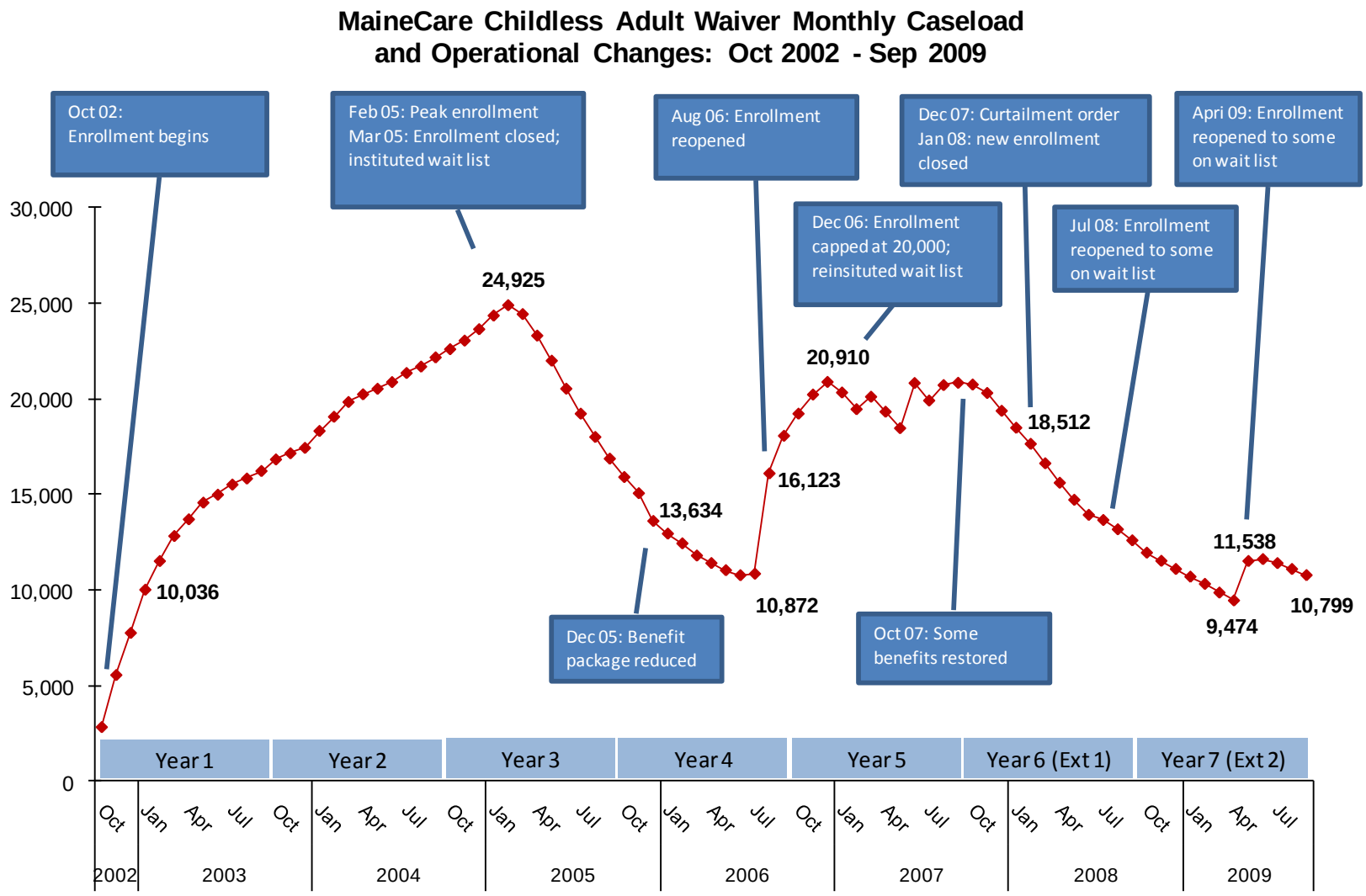
-are capped at $90 million per year, and monthly enrollment is capped at 20,000 individuals.[15] DHHS is permitted to maintain a waiting list and add members from the list as slots become available. And some of the covered benefits that were eliminated in December 2005 were restored when the Waiver extension went into effect in October 2007.[16]

In December 2007, revised economic forecasts revealed a $95 million deficit in the Maine State budget for the 2007-2008 biennium, and Governor Baldacci issued a curtailment order that again forced DHHS to close the CA Waiver to new members effective January 1, 2008. As was the case when new enrollment was closed in the period from March 2005 through July 2006, the monthly caseload for the Waiver dropped rapidly in 2008, falling below 14,000 in June. DHHS determined that enrollment could be open again effective July 1st and enrollment packets were sent to individuals who had been on the waiting list the longest. As a result, DHHS enrolled about 1,500 new Waiver members from July through September 2008. The monthly caseload continued to decline as the number of disenrollees outpaced new enrollment. By March 2009, the caseload had fallen to 9,474 and DHHS again opened enrollment to a limited number of individuals from the waiting list, adding more than 2,000 members in May 2009. Funding limitations prevented any further opening of enrollment through the end of September 2009. There remains considerable demand for the CA Waiver that is not being met due to the lack of available resources; as of October 2009, more than 15,000 eligible individuals were on the wait list.

[15] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Special Terms and Conditions for the MaineCare Childless Adults Section 1115 Demonstration, Number 11-W-00158/1. Received September 28, 2007. Available at: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/

[16] Services that were restored on October 1, 2007 included: laboratory and imaging services, oxygen and insulin pumps (medical supplies), podiatry, and ambulance services.

## CHART 1




*Source: DHHS Administrative Data from ACES – Monthly Caseload Report*

## MaineCare Childless Adult Waiver Expenditures for Years 4 through 7

During the fourth year of Waiver operations (October 2005 – September 2006), $73 million was expended for services for 18,350 participants (Table 1). (**Note: expenditures data reflect claims expenditures only, and do not reflect any off claim settlements or adjustments. As a result, these expenditure figures may vary from numbers reported elsewhere.**) Waiver expenditures were curtailed significantly relative to years two and three, when expenditures exceeded $100 million each year, due to the closure of enrollment and reduction in benefits that were in effect during most of Year 4. During the fifth year, after enrollment was re-opened, $103.5 million was expended for 24,069 Waiver participants. During the sixth year, when enrollment was closed and declining, services were provided to 18,519 members at a cost of $90.3 million. And during the first nine months of Year 7, $52.5 million was expended for 11,946 participants. As shown in Table 1, adjusting for member months results in a total per member month (PMPM) expenditures of $456.30 in Year 4, $430.27 in Year 5, and $458.11 in Year 6. In the first part of year 7, PMPM expenditures grew to $534.30, 17% higher than in Year 6. Across all years, about one fourth of CA Waiver members incurred no costs to the MaineCare program.

**TABLE 1: MAINECARE EXPENDITURES AND UTILIZATION FOR CHILDLESS ADULTS WAIVER 10/1/2005 – 6/30/2009**

| Waiver Year | FFY | Dates | Total Ever Enrolled [1] | Service Users [2] | % Service Users | Member Months | Total Expenditures | PMPM |
|---|---|---|---|---|---|---|---|---|
| 4 | 2006 | 10/1/2005 - 9/30/2006 | 25,003 | 18,350 | 73.4% | 160,281 | **$ 73,135,570** | $ 456.30 |
| 5 | 2007 | 10/1/2006 - 9/30/2007 | 31,597 | 24,069 | 76.2% | 240,619 | **$103,531,271** | $ 430.27 |
| 6 | 2008 | 10/1/2007 - 9/30/2008 | 23,656 | 18,519 | 78.3% | 197,166 | **$ 90,322,934** | $ 458.11 |
| 7 | 2009* | 10/1/2008 - 6/30/2009 | 15,136 | 11,946 | 78.9% | 98,240 | **$ 52,490,080** | $ 534.30 |

Data Source: MMDSS - Office of MaineCare Services. Claims are included based on date of service.

Management fees for Primary Care Case Management participants are excluded for the purposes of this analysis.

[1] Number of individuals with at least one month of enrollment during the waiver year. Enrollment data source: DHHS Administrative Data provided by Mike. St. John at the Office of Information Technology

[2] Service users include individuals who had one or more paid claims during the waiver year.

* Note: Only the first 9 months of Year 7 (FFY 2009) are included to allow time for claim submission.

Table 2 displays expenditures for the MaineCare CA Waiver by service category. Hospital inpatient and outpatient services accounted for almost 50% of expenditures in each year. Prescription drugs accounted for about 20% of expenditures, and were the benefit most widely used by Waiver members. Also notable is the fact that outpatient psychiatric, mental health agency and substance abuse services make up between 9 and 10% of total expenditures for CA Waiver members each year.

# TABLE 2: MAINECARE EXPENDITURES
# FOR CHILDLESS ADULTS WAIVER BY SERVICE CATEGORY
# 10/1/2006 – 6/30/2009

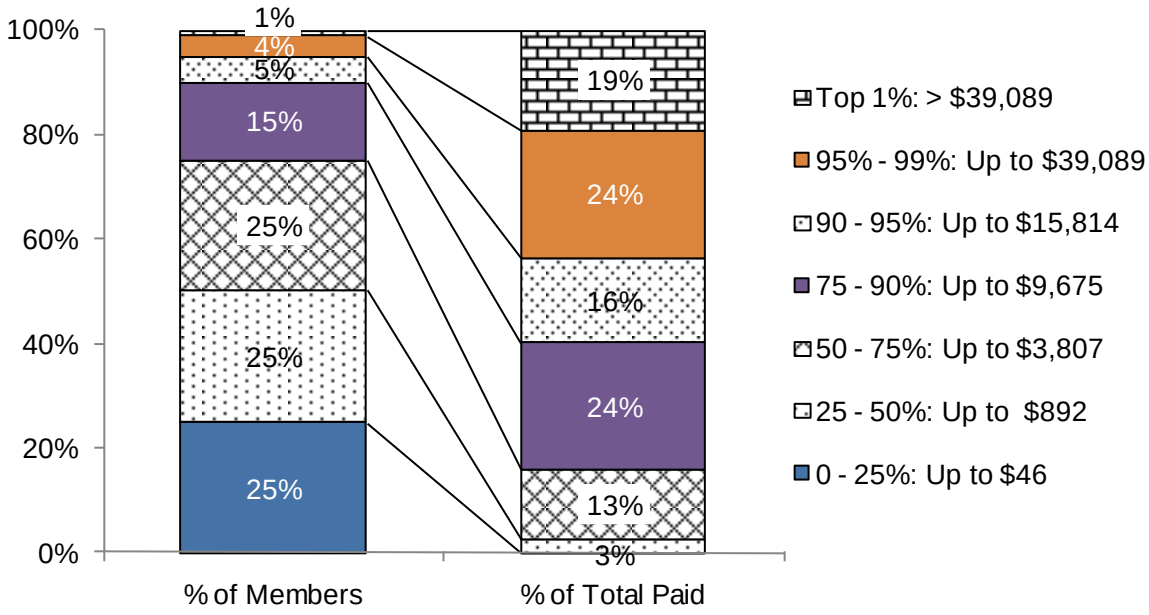
Note: Sorted by Year 6 Total Paid Amount

| | Waiver Year 4 (FFY 2006) 10/01/2005 - 09/30/2006 | | | Waiver Year 5 (FFY 2007) 10/01/2006 - 09/30/2007 | | | Waiver Year 6 (FFY 2008) 10/01/2007 - 09/30/2008 | | | Waiver Year 7* 10/01/2008 - 06/30/2009 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | # Distinct Members | Total Paid Amount | Percent of all Paid | # Distinct Members | Total Paid Amount | Percent of all Paid | # Distinct Members | Total Paid Amount | Percent of all Paid | # Distinct Members | Total Paid Amount | Percent of all Paid |
| General outpatient | 13,155 | $ 16,824,408 | 23.0% | 18,523 | $ 25,625,799 | 24.8% | 14,385 | $ 22,251,861 | 24.6% | 9,078 | $ 12,989,821 | 24.7% |
| General inpatient | 1,549 | $ 19,692,638 | 26.9% | 2,111 | $ 27,642,579 | 26.7% | 1,479 | $ 21,544,442 | 23.9% | 856 | $ 12,587,360 | 24.0% |
| Pharmacy | 15,275 | $ 15,972,777 | 21.8% | 20,356 | $ 19,902,315 | 19.2% | 16,059 | $ 18,479,628 | 20.5% | 10,349 | $ 10,859,556 | 20.7% |
| Physician | 11,434 | $ 5,063,415 | 6.9% | 15,744 | $ 6,829,367 | 6.6% | 12,856 | $ 5,534,192 | 6.1% | 8,126 | $ 3,306,212 | 6.3% |
| Outpatient psych | 516 | $ 1,588,162 | 2.2% | 779 | $ 3,699,910 | 3.6% | 675 | $ 3,411,171 | 3.8% | 433 | $ 1,436,363 | 2.7% |
| Mental health agency | 2,841 | $ 3,011,486 | 4.1% | 3,881 | $ 4,489,896 | 4.3% | 3,009 | $ 3,295,674 | 3.6% | 1,867 | $ 1,764,342 | 3.4% |
| Federally Qualified Health Center | 3,559 | $ 1,952,856 | 2.7% | 5,570 | $ 3,452,558 | 3.3% | 4,542 | $ 2,913,677 | 3.2% | 2,899 | $ 1,686,107 | 3.2% |
| Private non-medical institution | 484 | $ 2,421,267 | 3.3% | 693 | $ 3,871,636 | 3.7% | 462 | $ 2,768,883 | 3.1% | 248 | $ 1,475,983 | 2.8% |
| Substance abuse services | 1,386 | $ 1,809,702 | 2.5% | 2,088 | $ 2,650,709 | 2.6% | 1,807 | $ 2,757,484 | 3.1% | 1,089 | $ 1,743,700 | 3.3% |
| Full service transportation | 2,166 | $ 1,408,947 | 1.9% | 3,249 | $ 1,973,704 | 1.9% | 2,967 | $ 2,527,448 | 2.8% | 1,985 | $ 1,693,572 | 3.2% |
| Rural Health Center | 1,825 | $ 610,241 | 0.8% | 2,548 | $ 977,833 | 0.9% | 2,038 | $ 822,552 | 0.9% | 1,248 | $ 477,152 | 0.9% |
| Dentist | 1,595 | $ 572,208 | 0.8% | 2,662 | $ 1,027,168 | 1.0% | 2,031 | $ 810,537 | 0.9% | 1,191 | $ 512,959 | 1.0% |
| All other services | | $ 2,207,464 | 3.0% | | $ 1,387,798 | 1.3% | | $ 3,205,385 | 3.5% | | $ 1,956,953 | 3.7% |
| **Total:** | **18,350** | **$ 73,135,570** | | **24,069** | **$103,531,271** | | **18,519** | **$ 90,322,934** | | | **$ 52,490,080** | |

Data Source: MMDSS - Office of MaineCare Services. Claims are included based on date of service.
Management fees for Primary Care Case Management participants are excluded for the purposes of this analysis.
* Note: Only the first 9 months of Year 7 (FFY 2009) are included to allow time for claim submission.

It is important to note that expenditures for the MaineCare CA Waiver are not uniform across members. Most Waiver members generate few--if any--MaineCare expenditures, indicating that the majority of the population is fairly healthy (Chart 2). In fact, fifty percent of individuals who were enrolled in Year 6 had $892 or less in paid claims that year, and contributed only 3% of total expenditures. Seventy five percent of members had $3,807 or less in paid claims and as a group contributed only 16% of total expenditures. However, the top 1% of CA Waiver members, a relatively small group of 236 individuals, had more than $39,089 in expenditures and accounted for 19% of total expenditures. The top 5% (those with more than $15,814 in expenditures) accounted for 44% of total expenditures, and the top 10% (more than $9,675) accounted for 60% of all expenditures for the CA Waiver in Year 6.

**CHART 2**
**MAINECARE CHILDLESS ADULTS WAIVER**
**DISTRIBUTION OF MEMBERS AND ANNUAL EXPENDITURES**
**FOR YEAR 6 (10/1/2007 – 9/30/2008)**




This concentrated distribution of Waiver expenditures is a pattern that has persisted across all years of CA Waiver operation. Looking across our results from Years 1, 2, 4, 5 and 6, we found that individuals with $10,000 or more in annual expenditures represented between 7 and 8 percent

of members, and generated between 53 and 57 percent of expenditures each year.[17] The concentration of medical expenditures among a small group of high cost members is typical of Medicaid programs nationwide, and of private insurance markets as well. For example, in FFY 2001, the 7.6 percent of Medicaid enrollees with spending that exceeded $10,000 accounted for 65.3% of all Medicaid expenditures in the United States.[18]

Examining the diagnoses submitted on claims provides some insight into the conditions driving service use. Table 3 presents the top 10 diagnoses based on expenditures for Year 6 high cost users (defined as individuals with total expenditures that exceeded $10,000), and for all CA Waiver members. All diagnoses submitted on the claims are used in the analysis, so costs and client counts are not additive, as one claim may contain numerous diagnoses. Also prescription drug claims do not contain diagnoses so are excluded from this analysis. Claims that included a diagnosis of nondependent tobacco use disorder totaled $9.8 million in Year 6; this was more than any other single diagnosis.[19] This suggests that smoking is a contributing factor in the health problems and utilization for many members. Increasing support for smoking cessation, such as encouraging MaineCare providers to counsel patients or providing referrals to the Maine Tobacco Helpline, may be warranted.

Mental health and substance abuse codes are also frequently noted--accounting for 4 of the top 10, and 9 of the top 20 most costly diagnoses. Chronic conditions, including high blood pressure, high cholesterol, diabetes and heart disease are also among the most costly conditions among CA Waiver members.

[17] Anderson, N., McGuire, C. and Gressani, T. (2009 June). MaineCare for Childless Adults Waiver Year 5 and 6 Annual Report: October 1, 2006 – September 30, 2008. Portland, ME: University of Southern Maine, Muskie School of Public Service, Cutler Institute of Health and Social Policy.

[18] For more information, see: Sommers, A., Cohen, M. March 2006. *Medicaid's High Cost Enrollees: How much do they drive program spending?* Kaiser Commission on Medicaid and the Uninsured: Washington, D.C.; and Stanton MW, Rutherford MK. *The high concentration of U.S. health care expenditures*. Rockville (MD): Agency for Healthcare Research and Quality; 2005. Research in Action Issue 19. AHRQ Pub. No.06-0060.

[19] Appendix B includes tables outlining the top 20 diagnosis codes for all Waiver members and for high cost users for Years 5, 6 and 7.

## TABLE 3

**Top 10 Diagnoses Based on Expenditures for All Users and High Cost Users (>$10,000)**
**Waiver Year 6 (FFY 2008)**
**10/01/2007 - 09/30/2008**

| Rank | ICD-9 | Description | Waiver Members | Claims | Total Adjusted Amount | Paid per Member |
|---|---|---|---|---|---|---|
| **ALL SERVICE USERS** | | | | | | |
| 1 | 3051 | Nondependent tobacco use disorder | 4,373 | 9,462 | $9,847,771 | $2,252 |
| 2 | 4019 | Unspecified essential hypertension | 2,829 | 8,564 | $7,092,338 | $2,507 |
| 3 | 30400 | Opioid type dependence unspecified use | 1,654 | 33,601 | $5,013,370 | $3,031 |
| 4 | 311 | Depressive disorder not elsewhere classified | 3,181 | 9,515 | $4,663,705 | $1,466 |
| 5 | 53081 | Esophageal reflux | 1,662 | 3,452 | $3,791,965 | $2,282 |
| 6 | | No diagnosis code noted | 15,795 | 144,606 | $3,657,784 | $232 |
| 7 | 2724 | Hyperlipidemia, not elsewhere classified | 2,242 | 5,253 | $2,830,296 | $1,262 |
| 8 | 51881 | Acute respiratory failure | 68 | 241 | $2,665,822 | $39,203 |
| 9 | 25000 | Diabetes mellitus | 1,447 | 7,508 | $2,453,272 | $1,695 |
| 10 | 30000 | Anxiety state unspecified | 2,321 | 6,208 | $2,423,714 | $1,044 |
| **HIGH COST USERS** | | | | | | |
| 1 | 3051 | Nondependent tobacco use disorder | 1,155 | 3,581 | $7,558,507 | $6,544 |
| 2 | 4019 | Unspecified essential hypertension | 733 | 2,978 | $5,800,675 | $7,914 |
| 3 | 311 | Depressive disorder not elsewhere classified | 967 | 3,772 | $3,550,359 | $3,672 |
| 4 | 53081 | Esophageal reflux | 574 | 1,476 | $3,156,437 | $5,499 |
| 5 | 30400 | Opioid type dependence unspecified use | 595 | 14,222 | $3,044,164 | $5,116 |
| 6 | 51881 | Acute respiratory failure | 62 | 234 | $2,659,245 | $42,891 |
| 7 | 2724 | Hyperlipidemia, not elsewhere classified | 480 | 1,387 | $2,397,617 | $4,995 |
| 8 | 41401 | Coronary atherosclerosis of native coronary artery | 144 | 564 | $2,173,509 | $15,094 |
| 9 | 25000 | Diabetes mellitus | 311 | 2,403 | $1,882,487 | $6,053 |
| 10 | 29181 | Alcohol withdrawal | 176 | 511 | $1,870,291 | $10,627 |

*More than one diagnosis may be present on a claim and a client may have more than one of these conditions – therefore claims and clients are duplicated in this table and should not be totaled. Prescription drug claims do not contain diagnosis and are not included.*

*Expenditures data reflect claims expenditures only, and do not reflect any off claim settlements or adjustments. As a result, these expenditure figures may vary from numbers reported elsewhere.*

## Enrollment Patterns, Expenditures, and Care Management Participation

Previous work has shown that there is a considerable amount of turnover in members enrolled in the Waiver. Over the first six years of operation, nearly half of all members who ever enrolled were enrolled for less than one year, and three fourths were enrolled for less than 2 years.[20] And as noted above, CA Waiver expenditures tend to be concentrated among a relatively small group of high cost users. A question raised by these findings is whether high cost users are enrolled in the Waiver for longer periods relative to other members. The answer has important implications for designing and targeting interventions. If high cost users tend to be long-term members, then targeted case management services could be employed to facilitate management of chronic conditions and avoid costly inpatient stays. If, however, high cost users tend to be enrolled in MaineCare for only a short period of time, this would indicate that MaineCare is serving a safety net function for these individuals and covering health care services during episodes of acute illness or traumatic injury that are not amenable to case management.

To assess the relationship between CA Waiver member expenditures and length of enrollment we constructed a file of 23,656 individuals who were enrolled for at least one month during Year 6 (10/1/2007 - 9/30/2008) according to MaineCare eligibility records. We computed total expenditures paid under the CA Waiver for each individual, and then compared the demographic characteristics and enrollment experience of high cost users against all members. [21] We defined "high cost users" in two ways for this analysis. One definition treats those with $10,000 or more in annual expenditures as high cost, and the second definition treats those in the top 5% of annual expenditures (i.e. those with more than $15,814 in annual expenditures) as high cost. Because the results for these two groups are similar, the discussion that follows focuses primarily on the results from the first definition.

There are few demographic differences between high cost and all other CA Waiver members (Table 4). The most notable difference is that only 11% of high cost users are young adults (age 21 to 24) versus 20% of all CA Waiver members.

High cost users in Year 6 were more likely to be enrolled for all 12 months of that year at 68 percent versus 42% of all CA Waiver members. Given that a longer period of enrollment gives

[20] Anderson, N., McGuire, C., and Gressani, T. MaineCare for Childless Adults Waiver Year 5 and 6 Annual Report.
[21] There were 137 individuals who had claims paid under the CA Waiver (totaling $121,000) noted in the claims file, but no matching record in the eligibility file. Because both claims and eligibility information was needed for this analysis, these individuals were excluded.

more time to utilize services, this is not surprising. Of more interest are the significant differences we found between high cost users and other members in the length of enrollment prior to Year 6. We looked back at the number of months each CA Waiver member was enrolled between July 2003 and September 2007, representing the period of four years and three months before Year 6 began. We found that forty three percent of high cost users had been enrolled in the CA Waiver for two years or longer, and 65% had been enrolled for at least one year. By comparison, only 33% of all members had been enrolled for 2 or more years, and 53% had been enrolled for a year or more at the beginning of Year 6. Looking across the period up to and including Year 6, high cost users were enrolled for an average of 33 months and a median of 26 months. Only 7% of high cost users had no prior enrollment in the CA Waiver. These results indicate that the majority of high cost members were not new to the CA Waiver, and that most were long-term members. There may be an opportunity for MaineCare providers to help some of the long term, high cost members with chronic conditions to better manage their illness, thereby improving health outcomes and reducing costs.

Recognizing this opportunity, MaineCare has contracted with Schaller Anderson Medical Administrators, Inc. to provide care management to chronically ill MaineCare members since 2007. Initially rolled out to a pilot group of 300 members, Schaller Anderson (SA) care management services were rolled out more broadly to MaineCare members, including those in the CA Waiver, in 2008. The care management benefit provided by Schaller Anderson includes: high-risk care management; discharge planning; coordination of needed services between primary care providers, specialists, community-based agencies, and others; and member education. Patients targeted for care management include those with multiple chronic conditions, poly-pharmacy, those with multiple emergency department visits or inpatient admissions, and those who need coordination of multiple services for their medical needs. Schaller Anderson uses predictive risk modeling to identify members at risk based on the characteristics noted above. The expected outcomes of the program include a reduction in avoidable hospitalizations, fewer emergency room visits, and increased chronic and preventive care visits.[22]

We used information provided by Schaller Anderson to determine how many CA Waiver members who were ever enrolled during Year 6 received care management services[23] (Table 4).

[22] *MaineCare Managed Care Benefit Presentation, September 27, 2007*. Presentation to the State Uniform Billing Committee, Maine Chapter of the American Association of Healthcare Administrative Management. Office of MaineCare Services and Schaller Anderson Medical Administrators, Inc. Downloaded from http://www.aahamme.org/

[23] Members receiving care management services were defined as those who, according to Schaller Anderson records, were enrolled in care management for one or more months between October 2007 and September 2008.

Overall, we found 1,115 CA Waiver members received services from Schaller Anderson, representing 5% of all CA Waiver members. High cost users who had more than $10,000 in expenditures were more likely to have contact with SA, at 20 percent. And contact with SA was more frequent for high cost users in the top 5%, at 24 percent.

**TABLE 4**

**Comparison of CA Waiver Year 6 High-Cost Users to All Users**
**By Demographics, Enrollment Characteristics and Schaller Anderson Participation**

| | All Users | HC User > $10,000 | HC User Top 5% (>$15,814) |
|---|---|---|---|
| **Count** | 23,656 | 2,286 | 1,183 |
| **Percent of all users** | 100.0 | 9.7 | 5.0 |
| | | | |
| **Age** | | | |
| 21 - 24 | 20.2 | 10.7 | 8.4 |
| 25 - 34 | 24.1 | 25.9 | 23.9 |
| 35 - 54 | 42.4 | 50.4 | 52.9 |
| 55 - 64 | 13.4 | 13.0 | 14.8 |
| | | | |
| **Gender** | | | |
| Female | 43.1 | 45.6 | 43.1 |
| Male | 56.9 | 54.4 | 56.9 |
| | | | |
| **Months Enrolled During Year 6** | | | |
| 1 - 11 months | 57.6 | 32.2 | 31.7 |
| 12 months (enrolled all year) | 42.4 | 67.8 | 68.3 |
| | | | |
| **Months Enrolled Prior to Year 6** | | | |
| None | 10.9 | 7.3 | 5.9 |
| 1 - 11 | 35.7 | 27.7 | 26.3 |
| 12 - 23 | 21.2 | 22.5 | 23.0 |
| 24 or more | 32.2 | 42.6 | 44.8 |
| | | | |
| **Average Number of Months Enrolled in CA Waiver, 7/03 - 9/08** | 26.6 | 33.2 | 34.1 |
| **Median** | 22 | 26 | 27 |
| | | | |
| **Percent Served by Schaller-Anderson during Year 6** | 4.7 | 19.5 | 24.0 |

Data Sources: MMDSS – Office of MaineCare Services and Schaller Anderson
Notes:

- Year 6 eligibility months include Oct 2007 – Sep 2008. Period before Year 6 includes July 2003 – Sep 2007.
- "Served by Schaller Anderson" means the member was enrolled in SA care management for one or more months between October 2007 and September 2008.

We used the same analytic file to compare the enrollment characteristics and expenditures of CA Waiver members from Year 6 who had received care management services from Schaller Anderson against those who had not (Table 5). The results show that Schaller Anderson participants have longer average periods of enrollment in the CA Waiver (34.8 versus 26.1) and higher expenditures ($13,515 versus $3,333). PMPM expenditures for SA participants were also more than three times higher than non-participants ($1,408 versus $403). Overall, those who received services from SA represented only 5% of all members but generated 17% of the total Year 6 expenditures. These results suggest that Schaller Anderson has been successful in targeting the highest cost CA Waiver members.

**TABLE 5**

**Comparison of CA Waiver Year 6 Members who Received Care Management Services from Schaller Anderson by Enrollment Characteristics and Expenditures**

| | No Care Management | Received Care Management from SA | All Members |
|---|---|---|---|
| **Count** | 22,541 | 1,115 | 23,656 |
| **Percent of all users** | 95% | 5% | 100% |
| **Total Months Enrolled in CA Waiver, 7/03 - 9/08** | | | |
| Mean | 26.1 | 34.8 | 26.6 |
| Median | 21 | 32 | 22 |
| **Total Paid by CA Waiver in Year 6** | | | |
| Total | $75,132,806 | $15,068,954 | $90,201,760 |
| Percent of Total | 83% | 17% | 100% |
| Mean | $3,333 | $13,515 | $3,813 |
| Median | $781 | $7,581 | $892 |
| **Per Member Per Month Expenditures** | | | |
| Total Member Months in FFY08 | 186,460 | 10,706 | 197,166 |
| PMPM Expenditures | $403 | $1,408 | $457 |
| **Percent High Cost Users, > $10,000** | 8.2% | 39.9% | 9.7% |
| **Percent High Cost Users, Top 5%** | 4.0% | 25.5% | 5.0% |

Data Sources: MMDSS – Office of MaineCare Services and Schaller Anderson
Notes:

- "Received Care Management from SA" means the member was enrolled in SA care management for one or more months between October 2007 and September 2008.
- Member month and expenditure information is from MMDSS for the period October 2007 through September 2008. (Member months and expenditures for those who received care management from SA are not limited to months with SA enrollment.)

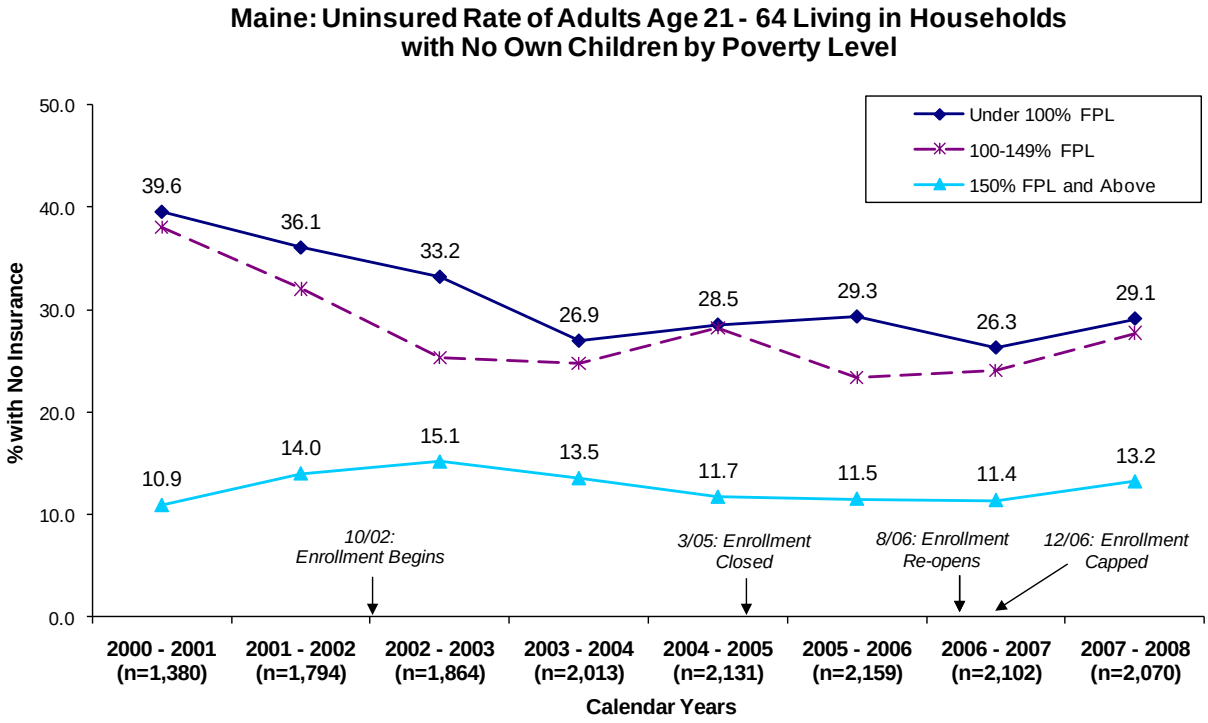
## Effects on Uninsurance Rate and Numbers of Uninsured

We use the Current Population Survey to track the number and proportion of people who are potentially eligible for the MaineCare Childless Adults Waiver who are uninsured over time (Charts 3 and 4). Both the number and proportion of low-income childless adults in Maine who were uninsured declined in the CPS results from 2000 to 2004[24]. In 2000 and 2001, an estimated 19,300 childless adults in Maine living below 100% of the Federal Poverty Level were uninsured—40 percent of all individuals in this group. The number of uninsured adults fell to 13,900 by 2003-2004, and the percentage dropped to 27 percent. These declines in the number and percent of childless adults who were uninsured coincided with the implementation and rapid growth of the MaineCare CA Waiver over that period. However, these observed declines cease after enrollment in the Waiver was closed in March 2005. In fact, the estimated number and proportion of poor childless adults who are uninsured rose for the first time in four years in 2004-2005. And in 2005-2006, which includes a few months after August 2006 when individuals were removed from the waiting list and enrolled in the CA Waiver, the proportion of uninsured adults in the target population rose slightly, and the estimated number declined by about 1,000 individuals. The 2006-2007 CPS results indicate the uninsured rate dropped to its lowest level of the entire period, at just over 26 percent. Enrollment was capped again at the end of 2006, and was followed by a rise in the number and percent of uninsured poor childless adults in the 2007-2008 CPS.

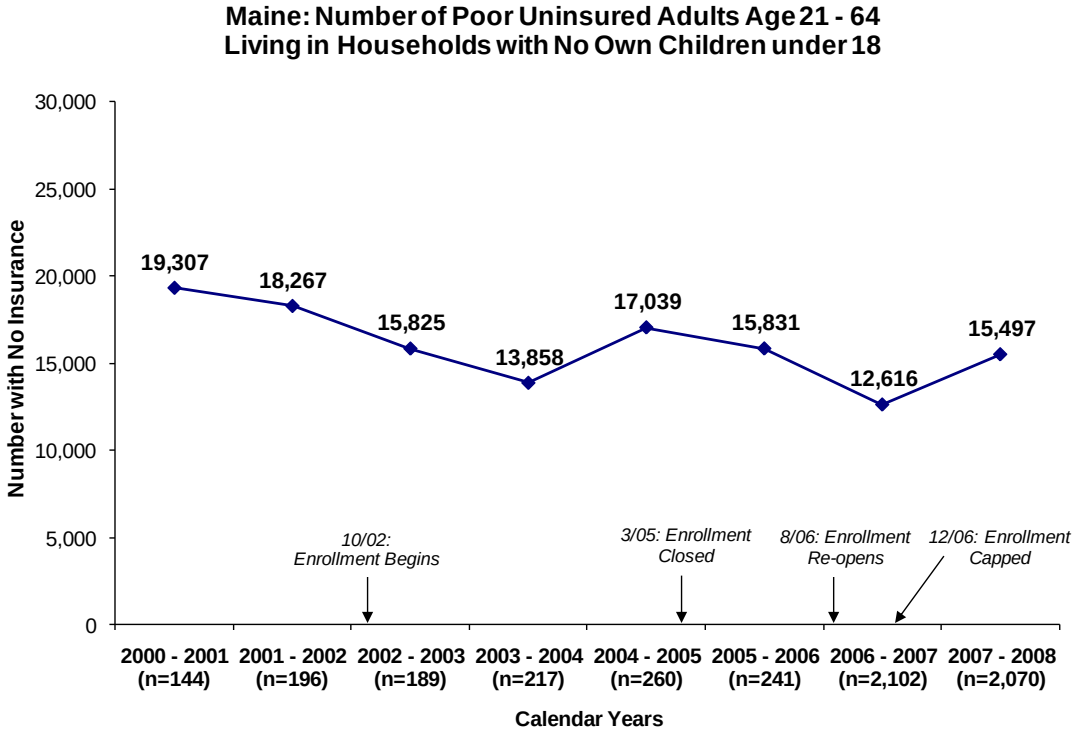
To more rigorously test the association between enrollment in the Childless Adults Waiver and the uninsured rate among poor adults without children, we ran a regression model predicting the uninsured rate in the CPS using a measure of Waiver enrollment that was designed to be comparable. Because our CPS measure is a two-year average, we determined the number of Waiver members in each calendar year from 2002 through 2008, and then computed a two-year average Waiver enrollment. Chart 5 plots the two-year average CPS uninsured rate for the seven time periods from 2000 through 2007 (2000-2001, 2001-2002, etc.) against the two-year average enrollment in the Childless Adults Waiver, in thousands of members.

[24] Because the CPS insurance questions ask about coverage in the previous calendar year, the results from calendar year 2000 are drawn from data collected in the 2001 CPS survey, 2001 results are from the 2002 CPS survey, and so on.

## CHART 3



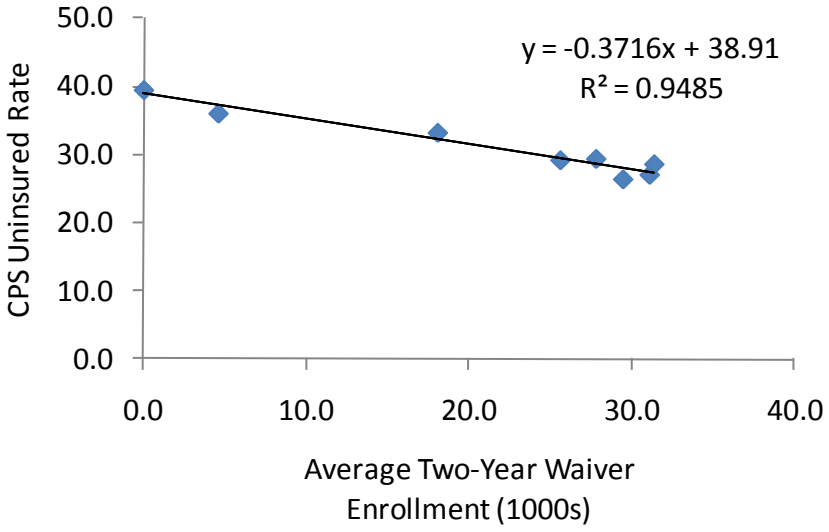

## CHART 4




*Source: Muskie School Analysis of Current Population Survey Annual Social and Economic Supplement (ASEC)*

Both the plot and the results of the regression model confirm there is a strong negative association between the uninsured rate and Waiver enrollment (Chart 5). In fact, the model indicates that 95 percent of the variation in the uninsured rate among poor childless adults in this period can be explained by changes in CA Waiver enrollment ($R^2 = 0.95$). And on average, for every thousand individuals enrolled in the Waiver, the uninsured rate among the target population was reduced by 0.37 percent, or for every ten thousand individuals enrolled, the uninsured rate was reduced by 3.7 percent.[25]

**CHART 5**
**REGRESSION MODEL RESULTS: USING WAIVER ENROLLMENT TO PREDICT CPS UNINSURED RATE, CALENDAR YEAR 2000 - 2008**




[25] We also ran a regression model using the change in two-year average Waiver enrollment as the independent variable, and change in two-year average uninsured rate from the CPS, and confirmed our findings. The resulting model ( $y = -0.38x - 0.12$ , $R^2 = 0.68$) indicated that for every 1,000 net enrollees added to the CA Waiver, the uninsured rate was reduced by 0.38 percent.

## Monitoring Types of Insurance Coverage Among Low-Income Childless Adults

Of interest to policymakers is the question whether this growth in public coverage led to a contraction of private coverage – due to employers ceasing to provide coverage to employees or individuals dropping private plans in favor of enrolling in public insurance. If the MaineCare CA Waiver was "crowding-out" private coverage, we would expect to see the number and percentage of poor, childless adults with employer-sponsored and individual coverage fall as public coverage replaced private.

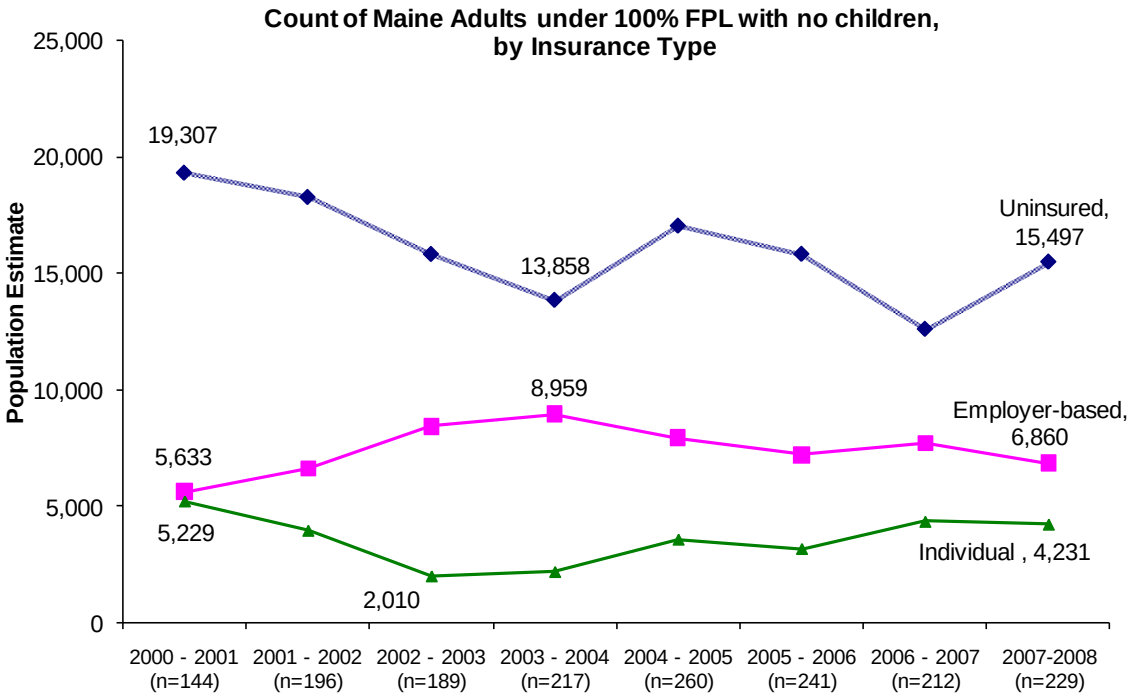
As in previous reports, there continues to be no evidence of crowd-out in our results (Charts 6 and 7). Employer-based coverage among poor adults without children in Maine actually increased in both absolute and percentage terms[26] from 2000-2001 to 2003-2004, rising from 5,600 to 9,000, and from 11.5 to 17.4 percent (Charts 6 and 7), during the period when enrollment in the MaineCare CA Waiver went from zero to more than 20,000 (see Chart 1). Individual coverage purchased directly from an insurer did decline initially[27], but then rebounded even as CA Waiver enrollment was increasing. Moreover, the decline in the individual insurance market pre-dated the start up of the CA Waiver by several years, due to a series of high premium hikes followed by falling enrollment.[28] So while some adults living in poverty may have dropped individual plans in order to enroll in the CA Waiver, it is likely that most would have been forced to drop their individual plans even in the absence of the Waiver as premiums continued to rise beyond affordable levels.

[26] Regression results indicate that there was a significant ($p < .05$) positive linear trend in the estimated number of poor, childless adults with employer-based coverage over the first four observed time periods: 2000-2001 through 2003-2004. There was a marginally significant ($p < .10$) trend in the percentage with employer-based coverage over the same period.

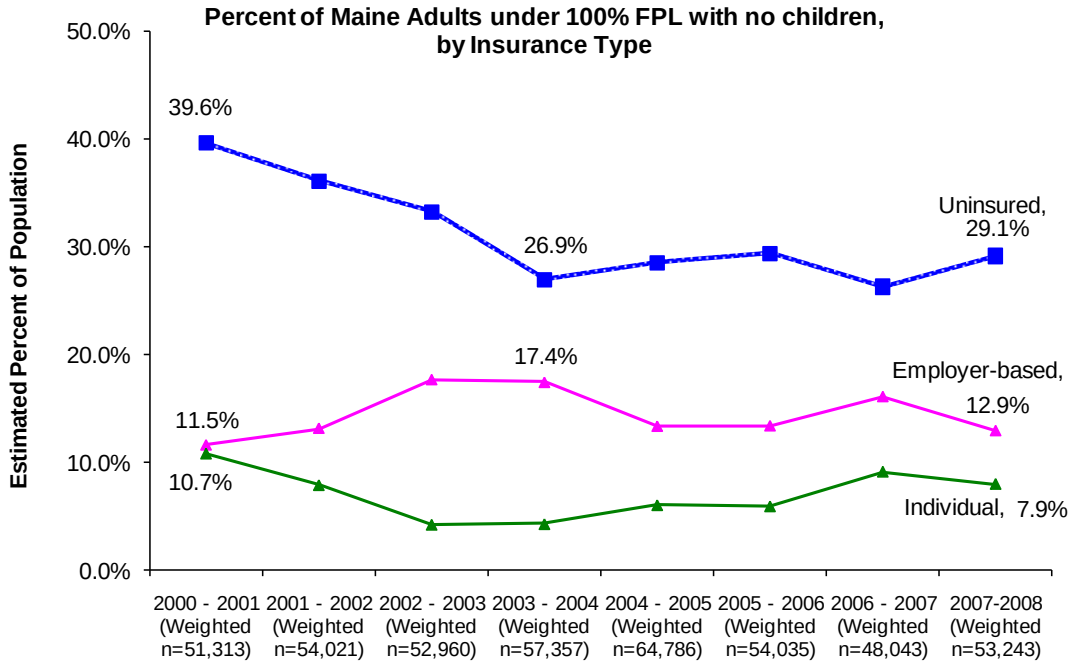
[27] There was a marginally significant negative linear trend ($p<.10$) in the proportion and number of poor childless adults with individual (direct-pay) coverage from 2000-2001 through 2003-2004.

[28] Maine Bureau of Insurance. White Paper: Maine's Individual Health Insurance Market. Updated January 22, 2001. http://www.state.me.us/pfr/120_Legis/reports/ins_Indiv_health_2001.htm

## CHART 6




## CHART 7



## Quality Measures

MaineCare members enrolled through the Childless Adults Waiver are eligible for a comprehensive set of preventive services, including physicals and preventive screenings. (These services were not affected by the change in benefits that was implemented in December 2005.) To assess the quality of care received by Waiver members, we constructed HEDIS measures of access to preventive care, cervical cancer screening, eye care exams and HbA1c testing for members with diabetes, and colorectal cancer screening. HEDIS measures are widely used by both public and private purchasers, and are based on clinical evidence demonstrating improved outcomes for patients.[29] For example, survival rates for both colorectal and cervical cancer increase dramatically if the cancer is identified in an early stage through screening. And for adults with diabetes, the risk of developing eye disease, nerve disease or kidney disease can be reduced significantly with good control of blood sugar levels – facilitated by regular HbA1c testing.[30]

HEDIS measures are constructed using a 12 month measurement period. We constructed separate measures for five time periods. The first was the period beginning October 1, 2006 and ending September 30, 2007. We also constructed measures for the 12 month periods ending the last day of December 2007, March 2008, June 2008, September 2008, December 2008, and March 2009. Only members enrolled in the CA Waiver for at least 11 out of the 12 months of the measurement period were included. Rates are calculated using claims data submitted by MaineCare providers, so the accuracy of our results is dependent upon the accuracy of providers' coding. More details on the construction of each measure are included in Appendix A.

We also include national HEDIS means reported by Medicaid HMO plans for each measure as a point of comparison. Note that the national measures are not strictly comparable to the CA Waiver measures. National rates are generally computed based on a combination of claims and chart review. And for the diabetic care and colorectal cancer screening measures, patients older than age 65 are included in the national HEDIS rates, whereas the CA Waiver population is limited to members under age 65.

The MaineCare CA Waiver HEDIS scores meet or exceed the national Medicaid HMO benchmarks on three of the six measures (Table 4, page 31). For the period ending March 2009, seventy six percent of 20 to 44 year olds had a documented preventive care visit, versus 77 percent

[29] National Committee on Quality Assurance, 2008. *Desireable Attributes of HEDIS.* http://www.ncqa.org/tabid/415/Default.aspx

[30] National Committee for Quality Assurance. *The State of Health Care Quality 2007*. Washington, DC. Downloaded from: www.ncqa.org, February 24, 2007.

of Medicaid patients nationally. CA waiver members between 45 and 64 years of age were more likely to have had a preventive care visit than younger members at 84 percent, and exceeded that national benchmark of 82 percent. HbA1c testing among diabetic CA waiver members was also higher than the national average, at 82 versus 77 percent.

Condition-specific screening rates were generally less prevalent among CA waiver members compared with Medicaid participants nationally. For the period ending March 2009, fifty six percent of eligible women in the CA Waiver received a recommended Pap test, versus 65 percent of women in Medicaid programs nationally. We identified 774 eligible patients with diabetes in the eligible sample of Waiver members for the period ending in March 2009. Among this group, more than 80 percent had an HbA1c test, but only 31 percent received an eye exam. This is substantially lower than the national benchmark of 50 percent nationally. [31] Finally, we found that screening for colorectal cancer was completed for only 36 percent of older CA Waiver members (ages 51 to 64). The national Medicaid average screening rate for colorectal cancer (for patients ages 51 to 80) was 43 percent.[32]

Most of the HEDIS measures we examined showed significant improvement over the seven measurement periods (Chart 8, page 30). Access to preventive care increased by 3 percent from September 2007 to March 2009 for CA Waiver members in the 45 to 64 age group. Access scores for younger adults (20 to 44 year olds) improved from 72 to 76 percent. HbA1c testing scores also rose substantially, from 72 to 81 percent. Several of the measures that lag behind the national benchmarks as of March 2009 have been trending in the right direction. Cervical cancer screening rates among eligible CA Waiver members increased from 46 percent in September 2007 to 56 percent in March 2009. And colorectal cancer screening has shown a moderate improvement of 32 to 36 percent over the same period. The only measure that has remained unchanged across the seven measurement periods is diabetic eye care exams.

Overall, quality of care for CA Waiver members compares favorably to national Medicaid benchmarks. The comparatively low rates of cancer screening received by MaineCare Childless Adult Waiver members are cause for concern. In the absence of sufficient screening, cases of

[31] The eye exam screening rates shown here may be understated for several reasons: 1) The HEDIS measure requires that the eye exam be performed by an "eye care professional" (i.e. an ophthalmologist or optometrist). Some primary care physicians may be performing these exams themselves—particularly in areas underserved by eye care specialists. 2) For adults, MaineCare only pays for a "routine eye exam" every two years, with no special allowance for diabetics. It is possible that patients are receiving the service but MaineCare is not received claims for those services.

[32] The national mean rate for colorectal cancer screening is not exactly comparable to our CA Waiver measure because it is based on the commercial population served by preferred provider organizations (PPOs) and includes members age 51 to 80.

cervical and colorectal cancer among Waiver members may go undetected in the early stages, when they are treatable. These risks can be mitigated through continued increases in cancer screening rates .

**CHART 8**
**HEDIS QUALITY MEASURES FOR**
**PERIODS ENDING SEPTEMBER 2007 – MARCH 2009**

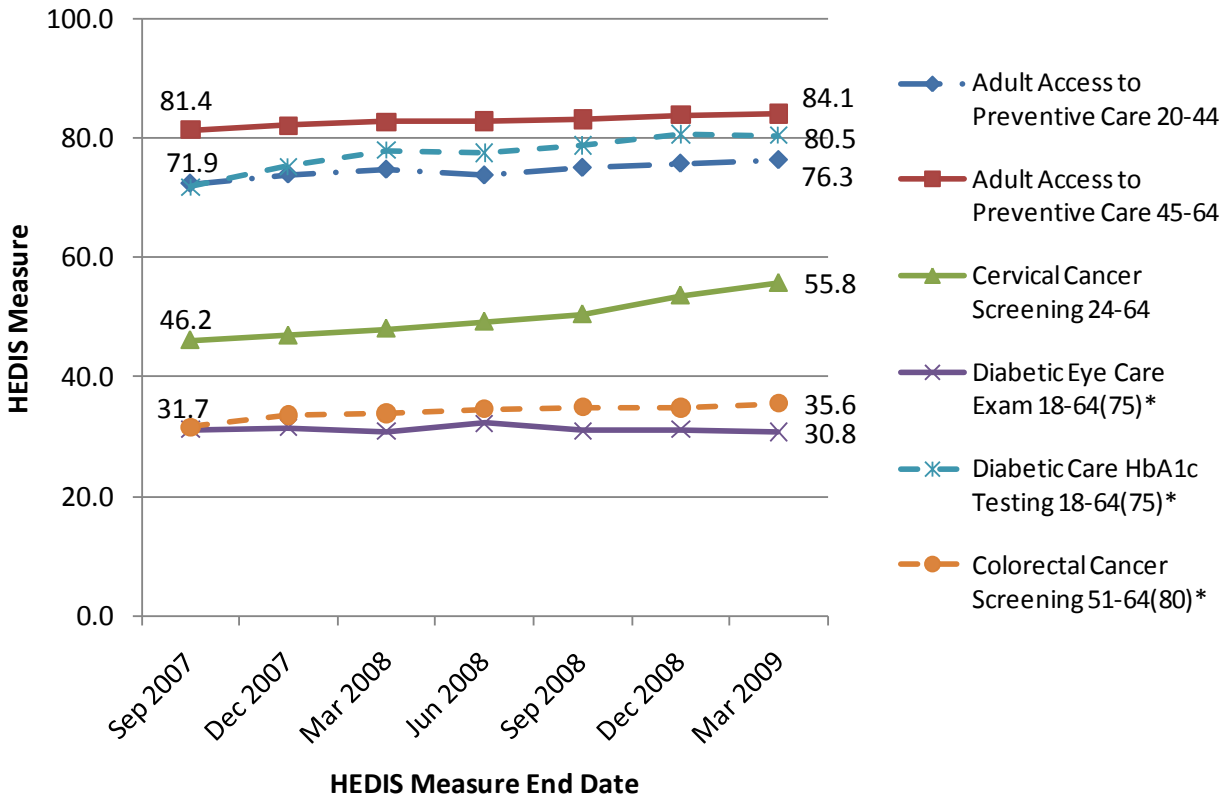


**TABLE 6. HEDIS Quality Measures**

| | | Childless Adult Waiver Measure Score for Period Ending: | | | | | | | National Medicaid |
|---|---|---|---|---|---|---|---|---|---|
| **Quality Measure** | **Age Range** | **Sep 2007** | **Dec 2007** | **Mar 2008** | **Jun 2008** | **Sep 2008** | **Dec 2008** | **Mar 2009** | **Mean(2008)** |
| Eligible sample size | | 12,427 | 11,196 | 10,581 | 11,395 | 10,644 | 10,000 | 9,021 | |
| Adult Access to Preventive Care | 20-44 | 72.4 | 73.9 | 74.7 | 73.8 | 75.0 | 75.7 | 76.3 | 76.8 |
| Adult Access to Preventive Care | 45-64 | 81.4 | 82.2 | 82.8 | 82.9 | 83.3 | 83.9 | 84.1 | 82.4 |
| Cervical Cancer Screening | 24-64 | 46.2 | 46.9 | 48.1 | 49.3 | 50.5 | 53.7 | 55.8 | 64.8 |
| Diabetic Eye Care Exam | 18-64(75)* | 31.2 | 31.5 | 30.9 | 32.2 | 31.0 | 31.2 | 30.8 | 50.1 |
| Diabetic Care HbA1c Testing | 18-64(75)* | 71.9 | 75.4 | 78.0 | 77.6 | 78.8 | 80.8 | 80.5 | 77.4 |
| Colorectal Cancer Screening | 51-64(80)* | 31.7 | 33.6 | 33.9 | 34.7 | 35.0 | 34.8 | 35.6 | 42.5 |

NOTES:

Eligible sample includes members enrolled in MaineCare under the Childless Adults Waiver for at least eleven months as of the end of the

National Comparison Source: National Committee for Quality Assurance. HEDIS 2007 Audit Means, Percentiles and Ratios for Medicaid HMO Population. http://www.ncqa.org/tabid/334/Default.aspx

* Note that the standard HEDIS measures for diabetic eye care exams and HbA1c testing include patients who are age 18 to 75 years old, and the colorectal cancer screening measure includes individuals ages 51 to 80. Because eligibility for the Childless Adults Waiver is limited to individuals under age 65, the HEDIS measures are not strictly comparable to the national averages for these three items. Further, the colorectal cancer screening measure is not applied to the Medicaid HMO population in the HEDIS 2008 data. National average figures for colorectal cancer screening are from the commercial PPO population.

# APPENDIX A: HEDIS 2007 Quality Measure Specifications

| Quality Measure | Numerator | Denominator |
|---|---|---|
| Adult Access to Preventive Care (AAP) | One or more ambulatory or preventive care visits in the measurement year. | All adults in the specified age range who were enrolled in the MaineCare CA Waiver for at least 11 months in the measurement year. |
| Cervical Cancer Screening (CCS) | One or more Pap tests in the measurement year, or in the two years prior to the beginning of the measurement year. | All women ages 24-64 who were enrolled in the MaineCare CA Waiver for at least 11 months in the measurement year. |
| Diabetic Eye Care Exam (CDC-Eye) | Received a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, OR had a negative retinal exam by an eye care professional in the year prior to the start of the measurement year. | All adults ages 21-64 with diabetes (type 1 and type 2) who were enrolled in the MaineCare CA Waiver for at least 11 months in the measurement year. Members are identified as having diabetes using either claims (diabetes diagnosis or treatment code) or pharmacy data (received insulin or oral hypoglycemics/ anti-hyperglycemics) (National comparison measure includes adults ages 18-75) |
| Diabetic Care HbA1c Testing (CDC-HbA1c) | An HbA1c test was performed in the measurement year. | Same as above |
| Colorectal Cancer Screening | One or more of the following four criteria: 1) Fecal occult blood test (FOBT) during the measurement year; 2) Flexible sigmoidoscopy during the measurement year or four years prior ; 3) Double contrast barium enema (DCBE) during the measurement year or four years prior; or 4) Colonoscopy during the measurement year or the nine years prior to the measurement year. | All adults ages 51 to 64 years who were enrolled in the MaineCare CA Waiver for at least 11 months in the measurement year. (Note: National comparison measure includes adults ages 51 – 80). |

Source: National Committee for Quality Assurance. HEDIS 2007 Technical Specifications for Physician Measurement. Available at http://www.ncqa.org/tabid/78/Default.aspx#HEDISMD

## APPENDIX B: Additional Tables

**TABLE B-1**

**Top 20 Diagnoses Based on Expenditures**
**Waiver Year 5 (FFY 2007)**
**10/01/2006 - 09/30/2007**

| Rank | ICD-9 | Description | Waiver Members | Claims | Total Adjusted Amount | Paid per Member |
|---|---|---|---|---|---|---|
| 1 | 3051 | Nondependent tobacco use disorder | 5,417 | 10,871 | $11,541,516 | $2,131 |
| 2 | 4019 | Unspecified essential hypertension | 3,270 | 9,078 | $8,124,905 | $2,485 |
| 3 | 311 | Depressive disorder not elsewhere classified | 4,101 | 11,645 | $6,006,440 | $1,465 |
| 4 | 30400 | Opioid type dependence unspecified use | 1,629 | 29,202 | $4,883,277 | $2,998 |
| 5 | 53081 | Esophageal reflux | 1,850 | 3,600 | $3,685,601 | $1,992 |
| 6 | | No diagnosis code noted | 22,601 | 183,639 | $3,418,972 | $151 |
| 7 | 2724 | Hyperlipidemia, not elsewhere classified | 2,396 | 5,154 | $3,383,100 | $1,412 |
| 8 | 30390 | Other and unspecified alcohol dependence | 1,267 | 6,946 | $3,245,319 | $2,561 |
| 9 | 25000 | Diabetes mellitus | 1,747 | 7,823 | $3,110,867 | $1,781 |
| 10 | 41401 | Coronary atherosclerosis of native coronary artery | 355 | 949 | $2,986,545 | $8,413 |
| 11 | 29181 | Alcohol withdrawl | 345 | 776 | $2,827,587 | $8,196 |
| 12 | 30391 | Other and unspecified alcohol dependence continuous drinking behavior | 475 | 1,166 | $2,769,000 | $5,829 |
| 13 | 78650 | Unspecified chest pain | 1,995 | 5,052 | $2,288,185 | $1,147 |
| 14 | 30000 | Anxiety state unspecified | 2,650 | 6,540 | $2,269,585 | $856 |
| 15 | 496 | Chronic airway obstruction not elsewhere classified | 792 | 2,035 | $2,174,439 | $2,746 |
| 16 | 49390 | Asthma unspecified | 1,517 | 3,178 | $2,169,055 | $1,430 |
| 17 | 30500 | Nondependent alcohol abuse | 1,193 | 2,838 | $2,138,780 | $1,793 |
| 18 | 51881 | Acute respiratory failure | 95 | 304 | $2,086,221 | $21,960 |
| 19 | 30981 | Prolonged posttraumatic stress disorder | 1,160 | 5,725 | $2,015,305 | $1,737 |
| 20 | 7242 | Lumbago (low back pain) | 2,935 | 8,574 | $1,884,315 | $642 |

*More than one diagnosis may be present on a claim and a client may have more than one of these conditions – therefore claims and clients are duplicated in this table and should not be totaled. Prescription drug claims do not contain diagnosis and are not included.*

*Expenditures data reflect claims expenditures only, and do not reflect any off claim settlements or adjustments. As a result, these expenditure figures may vary from numbers reported elsewhere.*

## TABLE B-2

**Top 20 Diagnoses Based on Expenditures**
**Waiver Year 6 (FFY 2008)**
**10/01/2007 - 09/30/2008**

| Rank | ICD-9 | Description | Waiver Members | Claims | Total Adjusted Amount | Paid per Member |
|---|---|---|---|---|---|---|
| 1 | 3051 | Nondependent tobacco use disorder | 4,373 | 9,462 | $9,847,771 | $2,252 |
| 2 | 4019 | Unspecified essential hypertension | 2,829 | 8,564 | $7,092,338 | $2,507 |
| 3 | 30400 | Opioid type dependence unspecified use | 1,654 | 33,601 | $5,013,370 | $3,031 |
| 4 | 311 | Depressive disorder not elsewhere classified | 3,181 | 9,515 | $4,663,705 | $1,466 |
| 5 | 53081 | Esophageal reflux | 1,662 | 3,452 | $3,791,965 | $2,282 |
| 6 | | No diagnosis code noted | 15,795 | 144,606 | $3,657,784 | $232 |
| 7 | 2724 | Hyperlipidemia, not elsewhere classified | 2,242 | 5,253 | $2,830,296 | $1,262 |
| 8 | 51881 | Acute respiratory failure | 68 | 241 | $2,665,822 | $39,203 |
| 9 | 25000 | Diabetes mellitus | 1,447 | 7,508 | $2,453,272 | $1,695 |
| 10 | 30000 | Anxiety state unspecified | 2,321 | 6,208 | $2,423,714 | $1,044 |
| 11 | 41401 | Coronary atherosclerosis of native coronary artery | 298 | 904 | $2,278,407 | $7,646 |
| 12 | 29181 | Alcohol withdrawl | 269 | 637 | $2,111,440 | $7,849 |
| 13 | 49390 | Asthma unspecified | 1,285 | 2,877 | $2,074,779 | $1,615 |
| 14 | 30390 | Other and unspecified alcohol dependence | 868 | 4,664 | $1,823,859 | $2,101 |
| 15 | 30391 | Other and unspecified alcohol dependence continuous drinking behavior | 357 | 800 | $1,794,080 | $5,025 |
| 16 | 7242 | Lumbago (low back pain) | 2,444 | 7,527 | $1,713,149 | $701 |
| 17 | 30981 | Prolonged posttraumatic stress disorder | 949 | 4,571 | $1,685,191 | $1,776 |
| 18 | 78650 | Unspecified chest pain | 1,595 | 4,270 | $1,643,937 | $1,031 |
| 19 | 30500 | Nondependent alcohol abuse | 888 | 2,233 | $1,524,110 | $1,716 |
| 20 | 2720 | Pure hypercholesterolemia | 1,392 | 2,965 | $1,523,959 | $1,095 |

*More than one diagnosis may be present on a claim and a client may have more than one of these conditions – therefore claims and clients are duplicated in this table and should not be totaled. Prescription drug claims do not contain diagnosis and are not included.*

*Expenditures data reflect claims expenditures only, and do not reflect any off claim settlements or adjustments. As a result, these expenditure figures may vary from numbers reported elsewhere.*

## TABLE B-3

**Top 20 Diagnoses Based on Expenditures**
**Waiver Year 7 (FFY 2009, first nine months only)**
**10/01/2008 - 06/30/2009**

| Rank | ICD-9 | Description | Waiver Members | Claims | Total Adjusted Amount | Paid per Member |
|---|---|---|---|---|---|---|
| 1 | 3051 | Nondependent tobacco use disorder | 2,785 | 5,878 | $5,964,571 | $2,142 |
| 2 | 4019 | Unspecified essential hypertension | 1,902 | 5,442 | $5,393,356 | $2,836 |
| 3 | 30400 | Opioid type dependence unspecified use | 1,334 | 25,944 | $3,412,944 | $2,558 |
| 4 | 311 | Depressive disorder not elsewhere classified | 1,873 | 5,426 | $2,693,220 | $1,438 |
| 5 | 53081 | Esophageal reflux | 1,098 | 2,278 | $2,454,802 | $2,236 |
| 6 | 2724 | Hyperlipidemia, not elsewhere classified | 1,577 | 3,509 | $2,188,569 | $1,388 |
| 7 | 30000 | Anxiety state unspecified | 1,443 | 4,040 | $1,741,505 | $1,207 |
| 8 | 25000 | Diabetes mellitus | 1,037 | 4,358 | $1,617,051 | $1,559 |
| 9 | 41401 | Coronary atherosclerosis of native coronary artery | 209 | 548 | $1,520,669 | $7,276 |
| 10 | 496 | Chronic airway obstruction, not elsewhere classified | 496 | 1,446 | $1,294,316 | $2,610 |
| 11 | 3004 | Neurotic depression | 618 | 1,691 | $1,251,346 | $2,025 |
| 12 | 29181 | Alcohol withdrawl | 152 | 401 | $1,203,495 | $7,918 |
| 13 | 49390 | Asthma unspecified | 750 | 1,536 | $1,123,155 | $1,498 |
| 14 | 30391 | Other and unspecified alcohol dependence continuous drinking behavior | 203 | 522 | $1,119,266 | $5,514 |
| 15 | 7242 | Lumbago (low back pain) | 1,480 | 4,315 | $1,076,424 | $727 |
| 16 | 78650 | Unspecified chest pain | 919 | 2,332 | $1,065,994 | $1,160 |
| 17 | 30390 | Other and unspecified alcohol dependence | 519 | 3,935 | $1,045,998 | $2,015 |
| 18 | 30981 | Prolonged posttraumatic stress disorder | 607 | 3,051 | $884,015 | $1,456 |
| 19 | 2720 | Pure hypercholesterolemia | 863 | 1,668 | $877,029 | $1,016 |
| 20 | 33829 | Other chronic pain | 678 | 1,339 | $846,447 | $1,248 |

*More than one diagnosis may be present on a claim and a client may have more than one of these conditions – therefore claims and clients are duplicated in this table and should not be totaled. Prescription drug claims do not contain diagnosis and are not included.*

*Expenditures data reflect claims expenditures only, and do not reflect any off claim settlements or adjustments. As a result, these expenditure figures may vary from numbers reported elsewhere.*

**TABLE B-4**
**Top 20 Diagnoses Based on Expenditures for High Cost Users Only**
**Waiver Year 5 (FFY 2007)**
**10/01/2006 - 09/30/2007**

| Rank | ICD-9 | Description | Waiver Members | Claims | Total Adjusted Amount | Paid per Member |
|---|---|---|---|---|---|---|
| 1 | 3051 | Nondependent tobacco use disorder | 1,284 | 3,581 | $8,590,164 | $6,690 |
| 2 | 4019 | Unspecified essential hypertension | 782 | 3,043 | $6,706,032 | $8,575 |
| 3 | 311 | Depressive disorder not elsewhere classified | 1,055 | 4,268 | $4,396,527 | $4,167 |
| 4 | 2724 | Hyperlipidemia, not elsewhere classified | 509 | 1,362 | $2,913,293 | $5,724 |
| 5 | 30400 | Opioid type dependence unspecified use | 527 | 11,797 | $2,886,045 | $5,476 |
| 6 | 53081 | Esophageal reflux | 545 | 1,353 | $2,879,459 | $5,283 |
| 7 | 41401 | Coronary atherosclerosis of native coronary artery | 194 | 662 | $2,850,252 | $14,692 |
| 8 | 30390 | Other and unspecified alcohol dependence | 449 | 3,328 | $2,515,262 | $5,602 |
| 9 | 29181 | Alcohol withdrawl | 211 | 565 | $2,428,534 | $11,510 |
| 10 | 25000 | Diabetes mellitus | 372 | 2,411 | $2,423,145 | $6,514 |
| 11 | 30391 | Other and unspecified alcohol dependence continuous drinking behavior | 276 | 782 | $2,353,360 | $8,527 |
| 12 | 51881 | Acute respiratory failure | 80 | 268 | $2,013,278 | $25,166 |
| 13 | 496 | Chronic airway obstruction not elsewhere classified | 260 | 882 | $1,892,555 | $7,279 |
| 14 | 486 | Pneumonia, organism unspecified | 147 | 513 | $1,673,311 | $11,383 |
| 15 | 30500 | Nondependent alcohol abuse | 388 | 1,093 | $1,581,009 | $4,075 |
| 16 | 78650 | Unspecified chest pain | 574 | 2,051 | $1,576,654 | $2,747 |
| 17 | 49390 | Asthma unspecified | 376 | 1,091 | $1,549,091 | $4,120 |
| 18 | 5849 | Acute renal failure | 84 | 245 | $1,538,692 | $18,318 |
| 19 | 30000 | Anxiety state | 705 | 2,243 | $1,483,686 | $2,105 |
| 20 | 42731 | Atrial fibrillation | 63 | 443 | $1,460,449 | $23,182 |

*More than one diagnosis may be present on a claim and a client may have more than one of these conditions – therefore claims and clients are duplicated in this table and should not be totaled. Prescription drug claims do not contain diagnosis and are not included.*

*Expenditures data reflect claims expenditures only, and do not reflect any off claim settlements or adjustments. As a result, these expenditure figures may vary from numbers reported elsewhere.*

## TABLE B-5

**Top 20 Diagnoses Based on Expenditures for High Cost Users Only**
**Waiver Year 6 (FFY 2008)**
**10/01/2007 - 09/30/2008**

| Rank | ICD-9 | Description | Waiver Members | Claims | Total Adjusted Amount | Paid per Member |
|---|---|---|---|---|---|---|
| 1 | 3051 | Nondependent tobacco use disorder | 1,155 | 3,581 | $7,558,507 | $6,544 |
| 2 | 4019 | Unspecified essential hypertension | 733 | 2,978 | $5,800,675 | $7,914 |
| 3 | 311 | Depressive disorder not elsewhere classified | 967 | 3,772 | $3,550,359 | $3,672 |
| 4 | 53081 | Esophageal reflux | 574 | 1,476 | $3,156,437 | $5,499 |
| 5 | 30400 | Opioid type dependence unspecified use | 595 | 14,222 | $3,044,164 | $5,116 |
| 6 | 51881 | Acute respiratory failure | 62 | 234 | $2,659,245 | $42,891 |
| 7 | 2724 | Hyperlipidemia, not elsewhere classified | 480 | 1,387 | $2,397,617 | $4,995 |
| 8 | 41401 | Coronary atherosclerosis of native coronary artery | 144 | 564 | $2,173,509 | $15,094 |
| 9 | 25000 | Diabetes mellitus | 311 | 2,403 | $1,882,487 | $6,053 |
| 10 | 29181 | Alcohol withdrawal | 176 | 511 | $1,870,291 | $10,627 |
| 11 | 30000 | Anxiety state | 671 | 2,140 | $1,753,109 | $2,613 |
| 12 | 49390 | Asthma unspecified | 372 | 1,064 | $1,525,397 | $4,101 |
| 13 | 30391 | Other and unspecified alcohol dependence continuous drinking behavior | 204 | 534 | $1,482,145 | $7,265 |
| 14 | 30390 | Other and unspecified alcohol dependence | 315 | 2,195 | $1,342,317 | $4,261 |
| 15 | 0389 | Unspecified septicemia | 31 | 74 | $1,330,972 | $42,935 |
| 16 | 2761 | Hyposmolality (sodium deficiency) | 71 | 143 | $1,322,697 | $18,630 |
| 17 | 2720 | Pure hypercholesterolemia | 349 | 816 | $1,267,926 | $3,633 |
| 18 | 496 | Chronic airway obstruction not elsewhere classified | 248 | 897 | $1,238,645 | $4,995 |
| 19 | 30981 | Posttraumatic stress disorder | 333 | 1,933 | $1,192,898 | $3,582 |
| 20 | 3004 | Neurotic depression | 346 | 846 | $1,162,589 | $3,360 |

*More than one diagnosis may be present on a claim and a client may have more than one of these conditions – therefore claims and clients are duplicated in this table and should not be totaled. Prescription drug claims do not contain diagnosis and are not included.*

*Expenditures data reflect claims expenditures only, and do not reflect any off claim settlements or adjustments. As a result, these expenditure figures may vary from numbers reported elsewhere.*

## TABLE B-6

**Top 20 Diagnoses Based on Expenditures for High Cost Users Only**
**Waiver Year 7 (FFY 2009, first 9 months only)**
**10/01/2008 - 06/30/2009**

| Rank | ICD-9 | Description | Waiver Members | Claims | Total Adjusted Amount | Paid per Member |
|---|---|---|---|---|---|---|
| 1 | 4019 | Unspecified essential hypertension | 431 | 1,838 | $4,582,881 | $10,633 |
| 2 | 3051 | Nondependent tobacco use disorder | 663 | 2,020 | $4,427,458 | $6,678 |
| 3 | 311 | Depressive disorder not elsewhere classified | 486 | 1,766 | $1,956,159 | $4,025 |
| 4 | 53081 | Esophageal reflux | 303 | 753 | $1,894,896 | $6,254 |
| 5 | 2724 | Hyperlipidemia, not elsewhere classified | 300 | 807 | $1,849,604 | $6,165 |
| 6 | 30400 | Opioid type dependence unspecified use | 375 | 8,808 | $1,719,722 | $4,586 |
| 7 | 41401 | Coronary atherosclerosis of native coronary artery | 94 | 308 | $1,427,921 | $15,191 |
| 8 | 30000 | Anxiety state | 411 | 1,371 | $1,318,176 | $3,207 |
| 9 | 25000 | Diabetes mellitus | 180 | 1,124 | $1,187,131 | $6,595 |
| 10 | | No diagnosis code noted | 1,035 | 15,972 | $1,127,125 | $1,089 |
| 11 | 496 | Chronic airway obstruction not elsewhere classified | 163 | 614 | $1,086,020 | $6,663 |
| 12 | 29181 | Alcohol withdrawal | 105 | 333 | $1,062,558 | $10,120 |
| 13 | 3004 | Neurotic depression | 208 | 559 | $1,031,413 | $4,959 |
| 14 | 30391 | Other and unspecified alcohol dependence continuous drinking behavior | 121 | 363 | $995,152 | $8,224 |
| 15 | 49390 | Asthma unspecified | 174 | 457 | $800,723 | $4,602 |
| 16 | 30390 | Other and unspecified alcohol dependence | 202 | 2,314 | $777,379 | $3,848 |
| 17 | 78650 | Chest pain | 285 | 1,018 | $734,521 | $2,577 |
| 18 | 486 | Pneumonia, organism unspecified | 74 | 240 | $708,948 | $9,580 |
| 19 | 2720 | Pure hypercholesterolemia | 164 | 346 | $678,619 | $4,138 |
| 20 | 2851 | Acute posthemorrhagic anemia | 22 | 43 | $676,847 | $30,766 |

*More than one diagnosis may be present on a claim and a client may have more than one of these conditions – therefore claims and clients are duplicated in this table and should not be totaled. Prescription drug claims do not contain diagnosis and are not included.*

*Expenditures data reflect claims expenditures only, and do not reflect any off claim settlements or adjustments. As a result, these expenditure figures may vary from numbers reported elsewhere.*