

MAINE STATE LEGISLATURE

The following document is provided by the
LAW AND LEGISLATIVE DIGITAL LIBRARY
at the Maine State Law and Legislative Reference Library
<http://legislature.maine.gov/lawlib>



Reproduced from electronic originals
(may include minor formatting differences from printed original)



Paul R. LePage, Governor

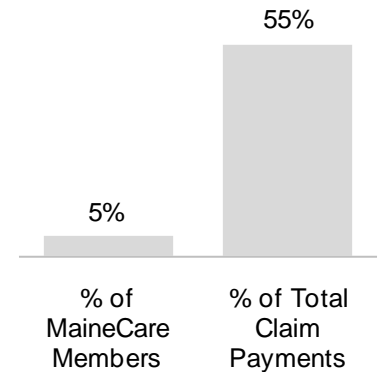
Mary C. Mayhew, Commissioner

Department of Health and Human Services
 221 State Street
 11 State House Station
 Augusta, Maine 04333-0011
 Tel. (207) 287-3707
 Fax (207) 287-3005; TTY (800) 606-0215

MaineCare SFY 2010 High-Cost Member Fact Sheet

In state fiscal year 2010, MaineCare provided coverage to 449,193 members at some point during the year. Claims payment for services totaled \$2,311,382,913¹ with 343,649 members receiving services.

The top 5% of highest cost MaineCare enrollees (17,182 members) accounted for \$1.2 billion or 55% of total claim payments.² This is consistent with findings in the literature that showed that 5% of the population accounted for almost 50% of the total health care expense.³



High Cost Member Characteristics

- Adults age 21-64 constitute 51% of high cost members and 57% of high cost claim payments.
- About one in five high cost members is 75 or older.
- Over half (61%) of the high cost members are enrolled in MaineCare due to disability and 27% are elderly (age 65+).
- High cost members average annual costs per year was \$74,215 and ranged from \$51,234 for members age 75+ to \$82,956 for members age 18 to 20.
- 46% of high cost members are dually eligible for both Medicare and MaineCare.
 - Medicare pays for most of the acute and pharmacy care, while MaineCare pays for co-pays, deductibles and services not covered by Medicare, primarily mental health and long term care services.
- With the exception of out of state residency (8%)⁴, high cost users as a proportion of all MaineCare service users are equally distributed throughout the state on a county to county basis, representing about 5% in most counties.

“Nearly half of all high-cost members are dually eligible”

¹ Costs throughout this report reflect claim payments and do not consider any off-claim settlements or adjustments. General acute hospital payments are estimated based on a proportion (cost to charge ratio) of the allowed amount on the claim.

² For this analysis, members were ranked on their total annual cost per member. The top 5% of all MaineCare members that received any services (i.e., had a paid claim for services) during sfy2010 were considered high cost members.

³ Agency for Healthcare Quality Research in Action, 2006 available at <http://www.ahrq.gov/research/ria19/expendria.pdf>

- Cumberland, Kennebec and Penobscot Counties are slightly higher at 6% and Waldo County is slightly lower at 3%.
- The largest number of high cost users (2,952) are found in Cumberland County.
- The Medicaid-only high cost users (excluding members dually eligible for Medicare) were examined separately. Member characteristics were consistent across both groups with the exception that the percentage of elderly members, which drops from 27% including the dual eligibles to 4% for Medicaid-only.

Table 1: Distribution of MaineCare Service Users and Claim Payments by Age Groups, SFY2010

Age Groups	Total					High Cost Users 5%				
	Members	Percent Members	Paid	Percent of Paid	Ave Annual Cost per Member	Members	Percent Members	Paid	Percent of Paid	Ave Annual Cost per Member
Ages 0 to 17	116,623	34%	\$518,277,018	22%	\$4,444	3,061	18%	\$237,094,517	19%	\$77,457
Ages 18 to 20	17,914	5%	\$103,942,713	4%	\$5,802	590	3%	\$48,944,243	4%	\$82,956
Ages 21 to 64	155,467	45%	\$1,297,000,210	56%	\$8,343	8,790	51%	\$726,716,853	57%	\$82,675
Ages 65 to 74	21,720	6%	\$110,726,712	5%	\$5,098	1,096	6%	\$75,658,219	6%	\$69,031
Ages 75+	31,925	9%	\$281,436,260	12%	\$8,816	3,645	21%	\$186,747,022	15%	\$51,234
Total	343,649	100%	\$2,311,382,913	100%	\$6,726	17,182	100%	\$1,275,160,854	100%	\$74,215

High Cost Member Service Use

- Long term care, which includes nursing home, all Home & Community Based waivers, ICFMRs, private duty nursing, and personal care, is the largest percentage of costs.
 - 71% of high cost members use long term care and this reflects 53% of the high cost members’ claim payments.
 - The home and community based waiver for members with developmental disabilities (MR Waiver) was the largest claims expenditure at \$294 million with an average annual cost per member of \$89,618; 19% (N=3,285) of high cost members received this service. *“71% of high-cost members use long term care”*
 - 26% of high cost members (N=4,508) used a nursing facility for a total of \$204 million in claims payments and an average annual cost per member of \$45,548.
 - Less than 2% of high cost members used any of the other home and community based waiver services.
 - 20% of the high cost members (N=3,357) received PNMI⁵ services for a total of \$173 million in claims payments and an average annual cost per member of \$51,707.

⁴ Residents residing out of state are generally receiving residential services and treatments in specialty facilities.

⁵ This includes all types of PNMI providers that are reimbursed by MaineCare.

- General hospital services, including both inpatient and outpatient services, represent 20% of high cost members’ payments⁶.
 - Combined inpatient and outpatient hospital spending is estimated at \$255 million for high cost members, approximately 44% of the total estimated payments to hospitals for all MaineCare members. *“High-cost members account for 44% of total estimated hospital payments”*
 - Over a quarter (27%) of high cost members used inpatient hospital services compared with 8% of all service users.
 - 33% of high cost members visited the ER during the year and had an average of 4 visits as compared to 30% of all full benefit MaineCare members with an average of 2 visits.
 - ED expenditures for high cost members are estimated at \$11 million for an average cost of \$530 per visit.
 - 457 of high cost members (3%) had an avoidable hospitalization⁷, accounting for \$5.6 million (3%) of high cost members’ estimated general inpatient spending.
- Mental health services were used by 42% of high cost users and accounted for 11% of their claims payments.
 - 13% (2,245) of high cost members received community support services accounting for \$23 million in claims payments. The average annual cost per high cost member for community support services was \$10,151.
 - Most (93%) of the total inpatient psychiatric hospital spending for all MaineCare members (\$33.5 million) was attributed to high cost members.
- 42% of high cost members received some level of case management and accounted for \$25 million in claims payments – an average of \$3,478 per service user.
- High cost member service use was similar whether or not members dual eligible for Medicare were excluded from the analysis, with the exception that the percentage of hospital payments out of total high cost user payments rises from 20% including duals to 36% for Medicaid-only.
- Approximately one-in-four (27%) high cost MaineCare members are enrolled in the Primary Care Case Management Program (PCCM). Average annual expenditures for those enrolled in PCCM (\$67,627) were less than members not enrolled in PCCM (\$76, 628).
 - Many of the criteria for exemptions or exclusion from the PCCM program are applicable to high cost members including dual eligibles, children in the Katie Beckett program, members in nursing homes, ICF-MRs or receiving home and community care benefits.

⁶ In SFY2010, MaineCare reimbursed hospitals on a prospective payment system with a cost settlement. These payments are not reflected in claims, so payments shown in this report are estimated based from claims payment using the OMS approved methodology.

⁷ Based on Agency for HealthCare Research and Quality (AHRQ) Quality Indicators, potentially avoidable hospitalizations for ambulatory sensitive conditions (ACSA) was calculated. Potentially avoidable hospitalizations involve admissions that evidence suggests could have been avoided, at least in part due to better access to quality outpatient care. This measure is a composite of avoidable hospitalizations for asthma, pneumonia, severe eye, nose and throat (ENT) infections, kidney urinary tract infection (UTI), Congestive Heart Failure (CHF) and gastroenteritis. Avoidable hospitalizations and the costs associated with these stays were identified.

- The top four primary diagnoses observed accounted for 55% of high cost members' claim expenditures and were all behavioral health related including:
 - Intellectual disabilities (25% of members, 27% of costs),
 - Other psychosis (37% of members, 15% of costs),
 - Neurotic, personality, & other non-psychotic mental disorders (44% of members, 10% of costs), and
 - Organic psychotic conditions (15% of members, 3% of costs).

Policy Implications for DHHS

- DHHS' strategy to achieve higher value healthcare must:
 - Address members with dual Medicare and Medicaid enrollment
 - Emphasize integration of behavioral and physical health
 - Achieve coordination with long term service providers and existing care management resources.
- The current Patient-Centered Medical Home (PCMH) Pilot and emerging Community Care Teams (CCT) are well positioned to achieve these goals, given Medicare's participation in the Pilot and the opportunity through the ACA to transition the PCMHs and CCTs to become "Health Homes" focused on providing integrated care to the highest need individuals.
- Emergency Department use and avoidable hospitalizations are a relatively small part of the picture for high cost users. However, given the high rate of ED visits for the MaineCare population as a whole and especially for the top 5% high cost users, the ED is a natural place to identify and begin care management of high cost users, which would result in cost savings and better health across all services.
- Despite the relative uniformity of the distribution of high cost users at a county level across the state, exploring the data at zip code, census tract, and street levels reveals important information that DHHS should utilize for:
 - MaineCare to target sites for ED collaborative care management project priority and PCMH/Health Homes expansion.
 - Community Care Teams to target specific communities where there is a large proportion of high cost users and/or scarce health resources.