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Outcomes of the IowaCare program For Year Ending September 30, 2010

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THE UNIVERSITY OF IOWA

August 2011

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Preface

This report is one in a continuing series of evaluations of the IowaCare program, which is designed to provide health care to low-income adults in Iowa. This evaluation was conducted at the request of the Iowa Department of Human Services (IDHS) as part of their compliance to receive a waiver from the Center for Medicare and Medicaid Services to operate the IowaCare program.

The evaluation includes a set of outcome measures adapted from the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA), in addition to locally developed utilization rates. These outcomes and rates are compared with results from previous years.

Researchers at The University of Iowa Public Policy Center conducted this study with funding provided by the IDHS and the US Department of Health and Human Services Center for Medicare and Medicaid Services (CMS).

Information and conclusions presented in this report are the responsibility of the authors and do not represent the views of the IDHS, the CMS, the IowaCare health care providers or the University of Iowa.

Introduction

The Iowa Care program was initiated in SFY 2006. This report provides information from the fourth year following implementation, thus allowing comparison to previous years and the establishment of a trend line. Recent program changes have resulted in a change to the measurement year used for outcome purposes. In the past, the measurement year has been the same as the state fiscal year; however, on October 1, 2010, the IowaCare program began assigning enrollees to Medical Homes designed to provide coordinated care. To reflect more closely the experiences of enrollees in the Medical Homes, the measurement year has shifted to the Federal Fiscal Year (FFY), October 1-September 30. For this report the measurement year is FFY 2010, October 1, 2009 through September 30, 2010.

The outcomes were either chosen from the HEDIS (Healthcare Effectiveness Data and Information Set) 2011 measures or developed by researchers at the Public Policy Center. The following measures are included in this report.

1. 10 most common diagnoses for inpatient care
2. 10 most common diagnoses for emergency room visits
3. 10 most common mental health diagnoses
4. Adults' access to preventive/ambulatory care (HEDIS)
5. Ambulatory care utilization
6. Frequency of selected procedures

Eligibility for IowaCare

The population eligible for IowaCare includes:

- Persons 19 through 64 years with a net income at or below 200% of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid
- Pregnant women (regardless of age) if their gross income is below 300% of the FPL and whose allowable family medical expenses bring their income to below 200% of the FPL
- Newborn children born to qualifying pregnant women who reduced their income to below 200% of the FPL

Though pregnant women and newborns are able to qualify for this program, they form a very small percentage of the enrollees, less than 1%. Therefore, the results within this report are for persons 19 through 64 years of age with a

net income at or below 200% of the FPL, who are not otherwise eligible for Medicaid.

Number enrolled in the program by month

The IowaCare program began on July 1, 2005. During SFY 2006, 24,288 people were enrolled in the IowaCare program for at least 1 month; in SFY 2007, 29,144 people were enrolled for at least one month; in SFY 2008, 33,117 people were enrolled for at least one month; and in SFY 2009, 43,147 were enrolled for at least one month. Figure 1 below provides a visual representation of program growth over the four-year period July 2005 through September 2010. IowaCare grew rapidly in the first year with a slight drop during the first quarter of SFY 2007 and then consistently grew over the next 3 years with over 55,000 people enrolled by September 2010.

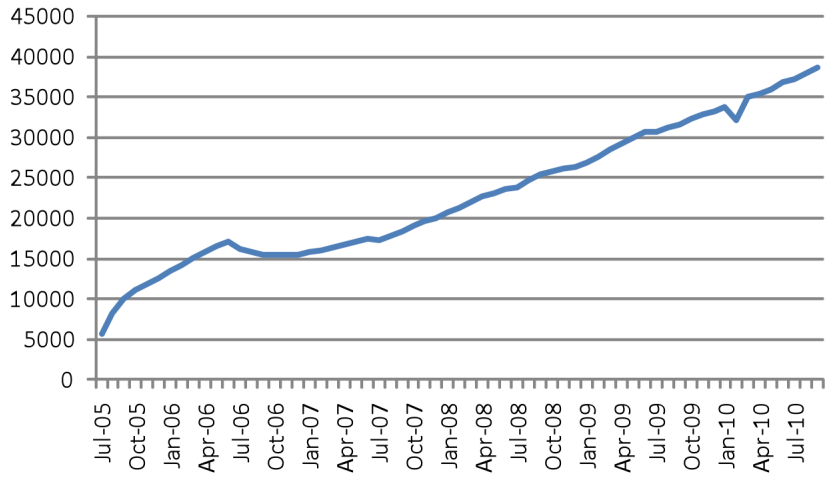

Figure 1. Number of enrollees by month for the first five years of the IowaCare program

Age, gender, and length of enrollment

Table 1 provides demographic information for IowaCare enrollees for SFYs 2006-2009 and FFY 2010. The proportion of men and women in IowaCare was essentially equal during this period and the age proportions remain static. However, the proportion of enrollees who remain enrolled for the full 12 months of the measurement year increased from 14% in SFY 2006 to 21% in SFY 2007 to 28% in SFY 2008 to 30% in SFY 2009, and has remained at this level for the most recent measurement year. Though the enrollee group continues to increase, there are no dramatic changes in demographic characteristics. The average IowaCare enrollee is as likely to be a man as a

woman, will most likely be between 22 and 50 years of age, and is increasingly likely to remain eligible for the entire year.

Table 1. Demographics of people enrolled in IowaCare for at least 1 month by state fiscal year

Demographic Characteristic	SFY2006 Number (%)	SFY2007 Number (%)	SFY2008 Number (%)	SFY2009 Number (%)	FFY2010 Number (%)
Gender					
Female	12,365 51%	14,369 49%	16,424 50%	21,166 49%	27,009 48%
Male	11,911 49%	14,766 51%	16,693 50%	21,981 51%	28,746 52%
Age					
19-21 years	1,471 6%	1,540 5%	1,185 4%	1,713 4%	2,149 4%
22-30 years	5,167 21%	5,962 21%	6,897 21%	9,361 22%	12,559 23%
31-40 years	4,983 21%	5,680 20%	6,109 18%	8,158 19%	10,771 19%
41-50 years	7,334 30%	8,877 31%	9,499 29%	11,910 28%	14,751 27%
51-60 years	4,357 18%	5,751 20%	7,502 23%	9,547 22%	12,356 22%
Over 60 years	964 4%	1,325 4%	1,919 6%	2,458 6%	3,168 6%
Length of enrollment					
1 month	1,736 7%	2,739 9%	2,556 8%	2,883 7%	4,012 7%
2 months	2,037 8%	2,791 10%	2,437 7%	3,087 7%	3,793 7%
3 months	3,843 16%	2,905 10%	2,537 8%	3,408 8%	3,990 7%
4 months	2,749 11%	2,590 9%	2,481 8%	3,359 8%	5,458 10%
5 months	1,872 8%	2,146 7%	2,158 7%	3,006 7%	2,406 4%
6 months	1,653 7%	2,051 7%	2,308 7%	2,853 7%	3,383 6%
7 months	1,402 6%	1,620 6%	1,671 5%	2,187 5%	3,362 6%
8 months	1,338 6%	1,637 6%	1,822 6%	2,314 5%	3,185 6%
9 months	1,266 5%	1,568 5%	2,003 6%	2,358 6%	3,288 6%
10 months	1,447 6%	1,497 5%	1,871 6%	2,256 5%	3,203 6%
11 months	1,477 6%	1,590 5%	2,155 7%	2,416 6%	3,453 6%
12 months	3,468 14%	6,010 21%	9,118 28%	13,020 30%	16,222 29%
Total	24,288	29,144	33,117	43,147	55,755

Research methods

This report incorporates the results from selected outcome measures during SFYs 2006-2009 and measurement year (FFY) 2010 (October 1, 2009-September 30, 2010). The outcomes are calculated from administrative claims and enrollment data housed at the University of Iowa PPC. Over 100 million claims are currently kept in the Medicaid claims database. New data is added on a monthly basis.

Limitations

Claims data has a set of limitations that must be considered when calculating population rates. Only claims actually submitted by the providers are used for outcome rate calculations; it is therefore possible that we may be missing claims, thus underestimating the rates for specific services. Since the IowaCare program does not pay for medications, we have no information regarding prescription medication use. This limits the outcome measures available. For example, we are unable to calculate the rate of adults and children with appropriate treatment for asthma because the determination of whether someone has asthma includes a protocol dependent on prescription medication use. In addition, the “appropriate treatment” is a medication protocol that we are unable to assess. Despite these limitations, using five years of data allows us to estimate the rates for specific types of utilization more accurately.

Outcome measures

IowaCare is tailored to adults, eliminating the need for outcome measures reflecting the health care needs and utilization of children. IowaCare is not designed to provide dental care other than extractions, so we did not attempt to estimate dental utilization outcome rates. We did not calculate any rates with respect to breast cancer and cervical cancer screening because women not eligible for Medicaid without other insurance are covered through the Breast and Cervical Cancer Early Detection Program or the Susan G. Komen Foundation under the Breast and Cervical Cancer Prevention and Treatment Act of 2000. As a result, it is difficult to estimate the degree to which the claims actually reflect breast and cervical cancer screening. Outcome measures that have been included are designed to provide a snapshot of the types of diseases being treated, the most common procedures being performed and the utilization of healthcare by an adult population.

Results

Ten most common diagnoses for inpatient stays

The ten most common diagnoses for inpatient stays lasting at least one day are provided in Table 2. Individuals are counted once per diagnosis, regardless of the number of times they were admitted to the hospital for that diagnosis. This prevents someone with a severe chronic disease from skewing the results. The primary diagnosis as listed on the institutional claim was used.

The top diagnosis for inpatient stays for all three years was ischemic heart disease, which includes coronary atherosclerosis and subendocardial infarction (Table 2). The primary diagnoses for admission into the hospital have remained stable over the 4 years of the program, indicating at least a subpopulation of individuals with chronic disease.

Table 2. Top ten diagnoses for inpatient stays with number of visits and rank, SFYs 2006-2009*

	Description	FFY 2010 Visits Rank	SFY 2009 Visits Rank	SFY 2008 Visits Rank	SFY 2007 Visits Rank	SFY 2006 Visits Rank
414	Ischemic heart disease	128	143 1	100 1	82 1	76 1
715	Osteoarthrosis and allied disorders	88	83 2	68 2	57 2	43 3
410	Acute myocardial infarction	50	36 5	45 4	48 3	47 2
722	Intervertebral disc disorders	39	49 3	51 3	39 4	37 5
780	General symptoms	36	34 7	35 9	36 8	30 8
998	Other complications of procedures	35	33 9	38 7	29 10	35 6
427	Cardiac dysrhythmias	34	37 4	-	-	25 10
428	Heart failure	33	33 8	33 10	38 6	40 4
577	Disease of the pancreas	33	32 10	36 8	36 7	-
996	Complications particular to certain procedures	28	35 6	42 6	39 5	33 7

*In order of rank for FFY2010
- Did not qualify as one of the top ten diagnoses

Ten most common diagnoses for emergency room visits

Primary diagnosis codes associated with an emergency room visit were used to determine the most common reasons for emergency room admission. Using ICD-9 coding allowed each primary diagnosis to be placed into one of three levels. For example, a diagnosis code of 786.5 (chest pain) may also have been classified as 786 (symptoms involving the respiratory system and other chest symptoms) or, at an even more general level, as 16.01 (symptoms). The variance within and between classifications was extraordinary, leaving little room for a rule regarding the level of classification. Therefore both the 5-digit and 3-digit codes were used to determine the most common diagnoses. Decisions on whether to use the 5-digit or 3-digit class were determined primarily by the degree to which the classification described a uniquely identifiable problem, disease, or symptom (Table 3).

The top ten diagnoses for emergency room visits reflect both acute problems and the exacerbations of chronic disease. Abdominal pain, limb pain and back pain may all be chronic, but are also seen as acute symptoms for which emergency care may be the most appropriate. However, skin infections and headaches may represent problems in which adequate primary care could eliminate the need for an emergency room.

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Table 3. Top ten diagnoses for emergency room visits, SFYs 2006-2009 and FFY 2010*

ICD-9 Code	Description	Visits FFY 2010	Visits SFY 2009	Rank SFY 2009	Visits SFY 2008	Rank SFY 2008	Visits SFY 2007	Rank SFY 2007	Visits SFY 2006	Rank SFY 2006
789.0	Abdominal pain	1,680	1,529	1	1,114	2	741	1	461	3
724	Unspecified back disorders	1,439	1,113	3	730	4	530	4	427	4
786.5	Chest pain	1,254	957	4	873	3	705	2	498	2
719.0	Other joint disorders	1,057	657	6	486	6	-	-	-	-
5.020	Neurotic, personality, and other non-psychotic mental disorders	881	633	7	502	5	415	5	569	1
12.010	Infections of skin/subcutaneous tissue	805	495	9	440	8	332	10	366	6
9.010	Disease of oral cavity, salivary glands, and jaws	781	526	8	423	9	376	6	313	9
780	General symptoms	686	745	5	-	-	362	7	-	-
729.5	Pain in limb	606	1207	2	-	-	-	-	-	-
784	Headache	533	474	10	-	-	-	-	-	-

*In order of rank for FFY 2010
- Did not qualify as one of the top ten diagnoses

Adults' access to preventive/ambulatory care

Adults included in this measure had to have been enrolled in IowaCare for at least 11 months during FFY 2010. The following codes are indicative of a preventive/ambulatory visit for adults: CPT 99385-99387, 99395-99397, 99401-99404, 99411-99412, 99420, and 99429; HCPCS G0344; and revenue codes 770, 0771, and 779. In addition, a diagnosis code of V70.0, V70.3, V70.5, V70.6, V70.8, or V70.9 indicates a well-person visit. For this measure, the adult population was separated into two groups: 20-44 years of age and 45-64 years of age. The measure consisted of the proportion of each age group that had experienced an ambulatory care visit within the measurement year.

The processing of claims during the period SFY 2006-2008 was particularly problematic for this measure as physician visits for care provided at University

of Iowa Health Care and Broadlawns were not reimbursed and, therefore, perhaps not billed. It is believed that this problem has been resolved in the last two years. Access to ambulatory health services is low for this population. Medicaid managed care enrollees experience access rates of 80% and greater, indicating that efforts to improve the rates for IowaCare enrollees are warranted. Recent programmatic changes to implement Medicaid Homes in other parts of the state may lead to improvements in access to ambulatory health services as measured by this outcome.

Table 4. Proportion of adults with access to ambulatory health services, SFYs 2006-2009 and FFY 2010

Age	FFY 2010	SFY 2009
20-44 years	56%	63%
45-64 years	69%	71%
Total	63%	68%

Ambulatory care visits

Ambulatory care visits include any visit to a health care provider that does not include an inpatient admission. These visits encompass outpatient clinics, emergency rooms, and observation room stays. The rates for these measures use a denominator of member months for the measurement year. All enrollees were included in the measure by adding the months the enrollees were eligible in each age group. Outpatient visits were defined through CPT coding and revenue codes. The CPT codes included: 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99301-99303, 99311-99313, 99321-99323, 99331-99333, 99385-99387, 99395-99397, 99401-99404, 99411-99412, 99420-99429, 99799, and 92002-92014. The revenue codes included: 510-529, 982, and 983. Emergency department visits were defined by combinations of codes as follows: revenue codes of 450-459 or 981 and institutional bill type 130-139 or CPT codes 10040-69979 and place of service 23, or CPT codes 99281-99285. Observation room stays were defined by revenue code 762 and institutional bill type 130-139 or CPT codes 99217-99220.

Ambulatory care encompasses all care provided without an inpatient hospitalization. Past HEDIS protocols have categorized ambulatory care into four types of service utilization: outpatient visits, emergency department, ambulatory surgeries, and observation room stays. Tables 5-9 provide the rates for these four categories for the 2 age groups for the first five years of the program. Older enrollees were more likely to use outpatient, ambulatory surgery, and observation room services; younger enrollees were more likely to

use emergency department services. This is most likely the result of younger enrollees having fewer chronic conditions and more acute illnesses and injuries. Figures 2 and 3 provide a visual representation of the rates of outpatient visits and emergency department visits per 1000 member months. Outpatient visits have declined steadily while emergency room visits have remained stable.

HEDIS protocols for this year eliminated the Observation Room Stays and Ambulatory Surgeries. Outpatient visits per 1,000 member months continue to fall. Emergency Department visits increased slightly over last year, however, this may be due to Observation Room Stays being lumped in with this category.

Table 5.Use of Services: Ambulatory Care, FFY 2010

	20-44 years	45-64 years	Total
Outpatient Visits	32,389	50,325	83,531
Outpatient Visits/1000 member months	153.2	244.0	198.4
Emergency Department Visits	12,900	9,289	22,320
ED visits/1000 member months	61.0	45.0	53.0

Table 6.Use of Services: Ambulatory Care, SFY 2009

	20-44 years	45-64 years	Total
Outpatient Visits	29,982	45,975	75,957
Outpatient Visits/1000 member months	185.8	285.6	235.6
Emergency Department Visits	9,975	6,707	16,682
ED visits/1000 member months	61.8	41.7	51.7
Ambulatory Surgeries	351	601	952
Amb. Surgeries/1000 member months	2.2	3.7	3.0
Observation Room Stays	395	671	1066
Obs. Room Stays/1000 member months	2.4	4.2	3.3

Table 7. Use of Services: Ambulatory Care, SFY 2008

	20-44 years	45-64 years	Total
Outpatient Visits	24,583	37,230	61,813
Outpatient Visits/1000 member months	207.1	297.3	253.4
Emergency Department Visits	7,510	5,250	12,760
ED visits/1000 member months	63.3	41.9	52.3
Ambulatory Surgeries	451	780	1,231
Amb. Surgeries/1000 member months	3.8	6.2	5.0
Observation Room Stays	224	303	527
Obs. Room Stays/1000 member months	1.9	2.4	2.2

Table 8. Use of Services: Ambulatory Care, SFY 2007

	20-44 years	45-64 years	Total
Outpatient Visits	22,025	32,402	54,427
Outpatient Visits/1000 member months	223.1	347.0	283.3
Emergency Department Visits	5,751	3,909	9,660
ED visits/1000 member months	58.2	41.9	50.3
Ambulatory Surgeries	2,155	2,817	4,972
Amb. Surgeries/1000 member months	21.8	30.2	25.9
Observation Room Stays	224	340	564
Obs. Room Stays/1000 member months	2.3	3.6	2.9

Table 9.Use of Services: Ambulatory Care, SFY 2006

	20-44 years	45-64 years	Total
Outpatient Visits	21,033	25,886	46,919
Outpatient Visits/1000 member months	255.5	380.4	312.0
Emergency Department Visits	5,306	3,168	8,474
ED visits/1000 member months	64.4	46.5	56.3
Ambulatory Surgeries	1,779	2,051	3,830
Amb. Surgeries/1000 member months	21.6	30.1	25.5
Observation Room Stays	204	305	509
Obs. Room Stays/1000 member months	2.5	4.5	3.4

Figure 2. Outpatient visits for 1000 member months, SFY 2006-FFY 2010

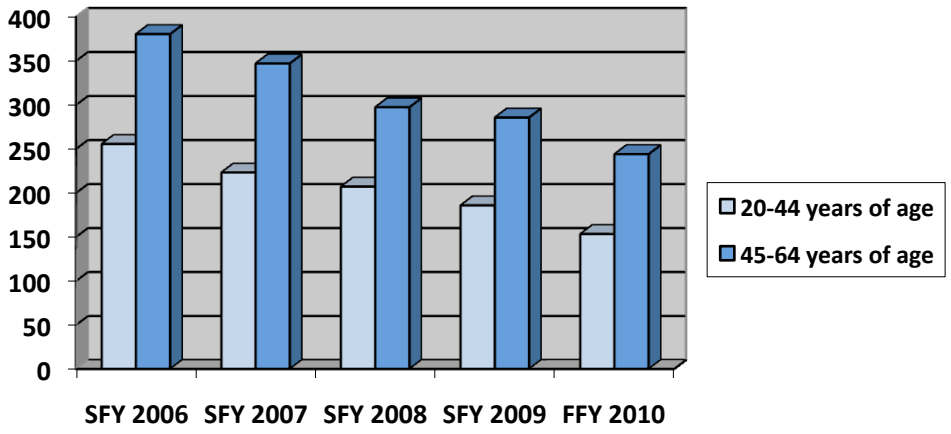
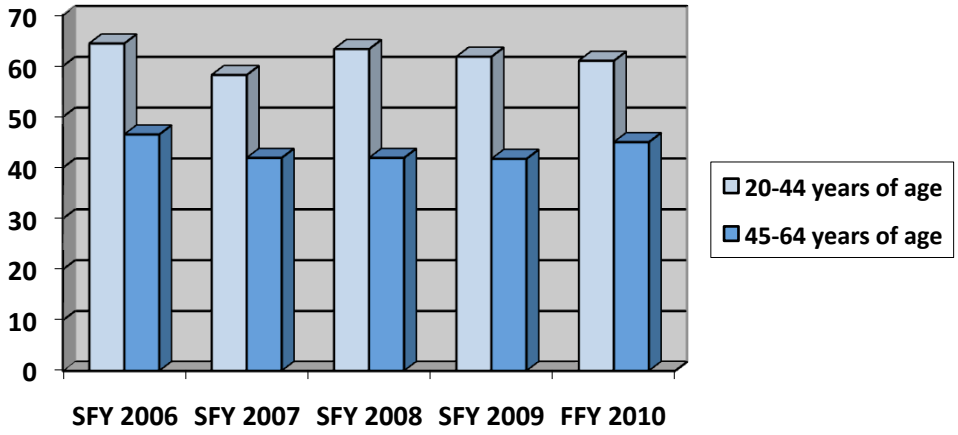


Figure 3. Emergency Department visits per 1000 member months, SFY 2006-FFY 2010



Frequency of selected procedures

The procedures that are reported for this measure help provide an understanding of the pent-up demand that might occur in a population that has been without insurance for a period of time. Since the program has been in place for five years now, there should be a leveling off of the procedure rates. Rates of selected procedures included back surgery and gall bladder surgery. All enrollees were included in the measure by adding the months the enrollees were eligible for each age group. Back surgery was defined by CPT codes

22220, 22222, 22224, 22226, 22532-22534, 22548-22585, 2290, 22595-22614, 22630, 22632, 22830, 62263-62319, 63001-63017, 63020, 63030, 63035, 63040, 63042-63048, 63050, 63051, 63055-63057, 63064, 63066, 63075-63078, 63081, 63082, 63085-63088, 63090, 63091, and 63101-63103; HCPCS codes S2348 and S2350; ICD-9-CM procedures codes 3.02, 3.09, 80.5-80.52, 80.59, 81.0, 81.3, 81.6, and 84.6; and DRG codes 496-498, 519, 520, and 546. Gall bladder surgery was identified by CPT codes 47600, 47605, 47610, 47612, 47620, 47562-47564 and ICD-9-CM procedure codes 51.21-21.24.

Table 10 indicates that the highest rate of gall bladder surgery is among women ages 20 to 44 years of age, as might be expected, while the lowest rate is among men 30 to 60 years of age. The rates increased slightly from the first to the second year, but have decreased in the third year. Though the rate of back surgery had decreased significantly in the third year of the program, the rate increased again in SFY 2009, remaining higher through FFY 2010. Back surgery rates vary across years and age/gender groups (Table 11). Rates have generally fallen since the inception of the program and rates seem to be more stable across age.

Table 10. Rates of gall bladder surgeries, FFY 2010 and SFYs 2009-2006

Age and Gender	Number of gall bladder surgeries	Gall bladder surgeries per 1,000 member months
FFY 2010		
30-64 year old Males	53	0.33
20-44 year old Females	80	0.87
45-64 year old Females	60	0.54
SFY 2009		
30-64 year old Males	37	0.30
20-44 year old Females	46	0.65
45-64 year old Females	58	0.66
SFY 2008		
30-64 year old Males	15	0.16
20-44 year old Females	17	0.32
45-64 year old Females	14	0.20
SFY 2007		
30-64 year old Males	20	0.27
20-44 year old Females	42	1.00
45-64 year old Females	24	0.45
SFY 2006		
30-64 year old Males	9	0.16
20-44 year old Females	36	0.95
45-64 year old Females	25	0.63

Table 11. Rates of back surgeries, FFY 2010 and SFYs 2009-2006

Age and Gender	Number of back surgeries	Back surgeries per 1,000 member months
FFY 2010		
20-44 year old Males	83	0.69
45-64 year old Males	81	0.85
20-44 year old Females	77	0.84
45-64 year old Females	83	0.74
SFY 2009		
20-44 year old Males	91	1.00
45-64 year old Males	97	1.32
20-44 year old Females	70	1.00
45-64 year old Females	108	1.45
SFY 2008		
20-44 year old Males	33	0.50
45-64 year old Males	42	0.76
20-44 year old Females	24	0.46
45-64 year old Females	27	0.39
SFY 2007		
20-44 year old Males	82	1.48
45-64 year old Males	32	0.78
20-44 year old Females	55	1.27
45-64 year old Females	67	1.28
SFY 2006		
20-44 year old Males	60	1.39
45-64 year old Males	40	1.34
20-44 year old Females	29	0.74
45-64 year old Females	41	1.08

Inpatient utilization

To determine inpatient utilization, we used four measures: average length of stay for general medical admissions, total number of inpatient days for general medical care, average length of stay for surgical admissions, and total number of inpatient days for surgical care. All claims for inpatient care were used except those with a principal diagnosis code (ICD-9-CM) of 290-316, or 960-979, with a secondary diagnosis V30-V39. These codes represented claims with substance abuse or mental illness. Surgical care was defined as any inpatient stay with DRG codes 1-8, 36-42, 49-63, 75-77, 103-120, 146-171, 191-201, 209-234, 257-270, 285-293, 302-315, 334-345, 353-365, 392-394,

400-402, 406-408, 415, 439-443, 461, 468, 471, 476-486, 488, 491, 493-504, 506, 507, 512-520, 525-558. Medical care was defined as any inpatient stay with DRG codes 9-35, 43-48, 64-74, 78-102, 121-145, 172-190, 202-208, 235-256, 271-284, 294-301, 316-333, 346-352, 366-369, 385-391, 395-399, 403-405, 409-414, 416-423, 444-455, 463-467, 473, 475, 487, 489, 490, 492, 505, 508-511, 524, and 559.

Average length of stay (ALOS)

The average length of stay remains higher for the older age group than the younger age group and highest among those in the older age group who had a surgical procedure.

Discharges

The discharges per 1000 member months continue to fall in all categories. The older age group had the most discharges and the discharges were primarily for medical problems and not surgeries. Discharges may have been higher in the first year due to unmet need in the years prior to enrolling, or they may have been higher in the first year because enrollees did not yet have their chronic health conditions under control (Tables 12-16). This pattern of falling rates can be seen more clearly in Figure 4.

Table 12. Inpatient discharges and length of stay, FFY 2010

Age	Discharges	Discharges/1,000 member months	Days	Days/1,000 member months	Average length of stay
19-44 years	1693	7.9	6772	31.8	4.0
45-64 years	2926	14.1	14177	68.7	4.8
Total	4619	11.0	20949	50.0	4.5
Medical					
19-44 years	987	4.6	3309	15.5	3.3
44-64 years	1727	8.8	6689	32.4	3.9
Total	2714	6.5	9998	23.9	3.7
Surgical					
19-44 years	706	3.3	3463	16.3	4.9
45-65 years	1199	5.8	7488	36.3	6.2
Total	1905	4.5	10951	26.1	5.7

Table 13. Inpatient discharges and length of stay, SFY 2009

Age	Discharges	Discharges/1,000 member months	Days	Days/1,000 member months	Average length of stay
19-44 years	1370	8.4	5533	34.1	4.0
45-64 years	2430	15.1	11746	73.0	4.8
Total	3800	11.7	17279	53.1	4.5
Medical					
19-44 years	873	5.4	2981	18.4	3.4
44-64 years	1418	8.8	5421	33.7	3.8
Total	2313	7.1	8402	25.8	3.6
Surgical					
19-44 years	497	3.1	2552	15.7	5.1
45-65 years	1012	6.3	6325	39.3	6.3
Total	1531	4.7	8877	27.3	5.8

Table 14. Inpatient discharges and length of stay, SFY 2008

Age	Discharges	Discharges/1,000 member months	Days	Days/1,000 member months	Average length of stay
19-44 years	1449	12.2	6316	53.2	4.4
45-64 years	2354	18.8	11884	94.9	5.0
Total	3803	15.6	18200	74.6	4.8
Medical					
19-44 years	975	8.2	3546	29.9	3.6
45-65 years	1465	11.7	5869	46.9	4.0
Total	2440	10.0	9415	38.6	3.9
Surgical					
19-44 years	474	4.0	2770	23.3	5.8
44-64 years	889	7.1	6015	48.0	6.8
Total	1363	5.6	8785	36.0	6.4

Table 15. Inpatient discharges and length of stay, SFY 2007

Age	Discharges	Discharges/1,000 member months	Days	Days/1,000 member months	Average length of stay
19-44 years	1275	12.9	6054	61.3	4.7
45-64 years	1992	21.3	10323	110.5	5.2
Total	32.67	17.0	16377	85.2	5.0
Medical					
19-44 years	825	8.4	3340	33.8	4.0
45-65 years	1237	13.2	5117	54.8	4.1
Total	2062	10.7	8457	44.0	4.1
Surgical					
19-44 years	450	4.6	2714	27.5	6.0
44-64 years	755	8.1	5206	55.7	6.9
Total	1205	6.3	7920	41.2	6.6

Table 16. Inpatient discharges and length of stay, SFY 2006

Age	Discharges	Discharges/1,000 member months	Days	Days/1,000 member months	Average length of stay
19-44 years	1236	15.0	5311	64.5	4.3
45-64 years	1648	24.2	8107	119.1	4.9
Total	2884	19.2	13418	89.2	4.7
Medicine					
19-44 years	815	9.9	3080	37.4	3.8
45-65 years	980	14.4	4307	63.3	4.4
Total	1795	11.9	7387	49.1	4.1
Surgical					
19-44 years	421	5.1	2231	27.1	5.3
44-64 years	668	9.8	380	55.8	5.7
Total	1089	7.2	6031	40.1	5.5

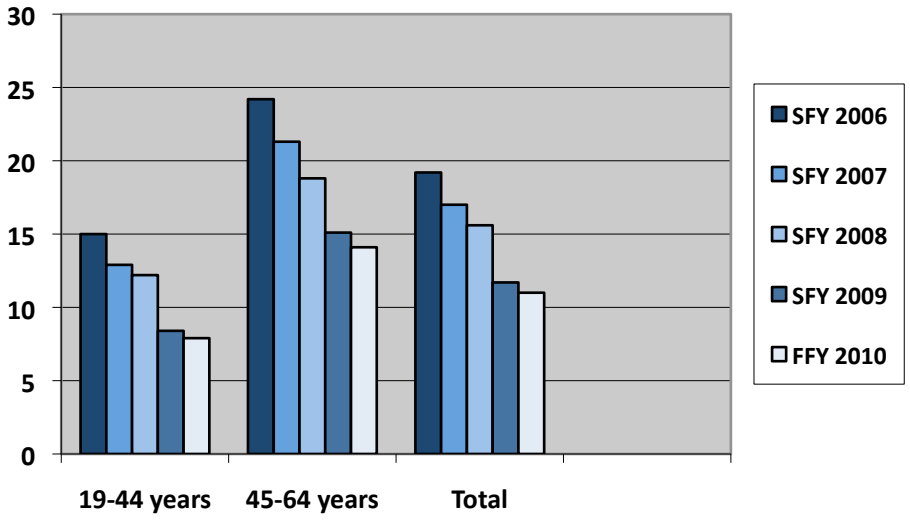



Figure 4. Discharges per 1,000 member months, SFY 2006-2009 and FFY 2010