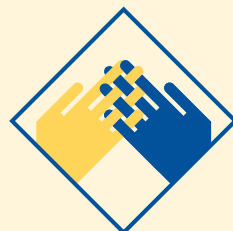


Opportunities and Challenges: Improving Access and Health Outcomes through the CarePartners Program



**A Report on a Study Conducted by the
Institute for Health Policy at the Muskie School,
University of Southern Maine
In Collaboration with MaineHealth**

February 2006



CarePartners
Your Maine Access to Healthcare

MaineHealth[®]
465 Congress Street, Suite 600
Portland, Maine 04101
(207) 775-7001
www.mainehealth.org

FACTS AT-A-GLANCE*

CarePartners Goals

- Increase access to healthcare and existing community resources for low income, uninsured adults.
- Support healthy behaviors, appropriate utilization of healthcare services, and improved health status outcomes for enrollees.

Since June 2001

- Over \$17 million dollars of medical care has been donated by 7 hospitals and a volunteer network of 854 primary care providers and specialists.
- Over \$6.5 million in donated pharmaceuticals via patient assistance programs.
- 4,174 individuals have been enrolled.
- 1,456 CarePartners members transitioned to federal, state or private insurance program.
- Total number of individuals screened for eligibility = 12,352
- MaineCare referrals = 2,820
- DirigoChoice referrals = 224

Members Profile

- Over 75% are employed.
- Average household monthly income in 2004 = \$1,308



**Statistics are current as of June 2006.*

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February 2006

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Supported by Grant No. 2003A-0113 from the MaineHealth Foundation

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a limited number of copies of the full report are available from the same source.

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Acknowledgements

We would like to thank the dedicated staff of CarePartners who provided much of the information and data that form the basis of this report. We appreciate their tireless responses to our many questions and we value their good cheer and admire their dedication to their jobs. We are grateful for the leadership of Deborah Deatrick and Carol Zechman, Vice President for Community Health and Director of the CarePartners Program, respectively, at MaineHealth, which guided the project at every stage. We are thankful for the insights of enrollees and key informants who shared their experiences and perspectives with us through interviews and discussions. The acknowledgements would not be complete without citing the leadership and commitment of Phebe Conrey King, who oversaw the development and implementation of CarePartners from 1999 until her untimely death in 2004.

Our thanks also go to Christine Torraca and Jeff Guevin of Martin's Point Informatics for sharing their expertise and providing claims data reports essential to this review.

Most importantly, we are grateful for the generous support of the Maine Health Access Foundation which provided funding for this project.

We would particularly like to thank Wendy Wolf, MD, MPH, Executive Director of the Foundation, for her dedication to expanding access to health care in Maine.

The views and options expressed in this report are the authors' and should not be attributed to collaborating organizations or funders.



Funders and Partners

Anthem Blue Cross Blue Shield in Maine, and their subsidiary, Machigonne Benefits Administrator

The Bingham Program

Jessie B. Cox Foundation

The Dana Foundation

The Davis Family Foundation

Health Resources & Services Administration (HRSA)

Inland Hospital

Maine Health

Maine Health Access Foundation (MeHAF)

Maine Medical Center

MaineGeneral Medical Center

Martin's Point Informatics

Mercy Hospital

Miles Memorial Hospital

The Robert Wood Johnson Foundation

St. Andrews Hospital

EXECUTIVE SUMMARY

CarePartners, an enhanced uncompensated care safety net program, has been **servicing approximately 1,000 Mainers per year** in the MaineHealth service area since 2001. The program was originally designed for those who fall between public and private coverage programs until a more comprehensive or universal program became accessible to people with incomes below 175% of the federal poverty level.

Using enrollee and provider survey results, interview findings, claims, and other data analyses, this report provides profiles of enrollees, providers, and program performance for the past four years. Key findings in this report that may be of interest to organizations considering developing a managed uncompensated care program, include:

- Costs and service utilization rapidly decrease for those who remained in the program more than one year and continued to decline over 18 months. We attribute this to access to care management, pharmacy benefits, and the assignment of a regular primary care provider.
- Engaging primary and specialty providers to donate their services relies heavily on their good will and proves challenging at a time when providers feel squeezed by low reimbursements from public programs competing for their good will. Being sensitive to their concerns and attracting new providers is essential to sustain a donated care program.
- A six month enrollment period allows for review for more appropriate public or private coverage for enrollees, but generates ‘churning,’ adds administration and costs, and limits overall program performance analyses.
- Pharmacy benefits require considerable resources which CarePartners has been able to sustain by aggressively pursuing free pharmacy programs offered by pharmaceutical companies.
- Tracking the value of donated care by multiple organizations and providers is vital to measuring program performance and providing information to make timely programmatic decisions. However, evidence shows inconsistent reporting of the value of donated services, a task that falls on the provider who is donating services.
- A number of conditions and economic factors influence the breadth and success of a donated care program: supply of providers, demand of potential enrollees, competing programs, political will, and diversity of funding streams.
- Small safety net programs, sandwiched between large public and private programs, require a flexible program design that can be adjusted quickly to be responsive to external changes.

I. Background and Design

In 1999, a group of health care stakeholders set out to re-design uncompensated care to be delivered in a **more coherent, accessible, and effective manner for both patients and providers**. The group, associated with MaineHealth, a broad-based integrated health care system, recruited public and private stakeholders and began the task of defining the nature of the problem and potential solutions.

Based on this vision and their reviews of existing models, the group, which ultimately became the CarePartners Steering Committee, designed a program model and articulated the following program goals:

1. increase access to existing resources for under insured and uninsured adults,
2. support healthy behaviors of enrollees,
3. provide comprehensive services based on primary care, rather than emergency care, and
4. assure financial stability of the program.

Program Design

Eligibility

Age: People between the ages of 18 and 65 are eligible to apply for CarePartners.

Asset limit: The CarePartners program has a maximum asset limit of \$10,000 for an individual and \$12,000 for a family. Excluded from the asset test is one house and one car for each driver in the household. Assets are reviewed at the initial enrollment and at each subsequent re-enrollment.

Enrollment length: Program eligibility is reviewed every 6 months. There is no maximum enrollment limit.

Income limits/other program eligibility: Applicants are eligible for CarePartners if their income is less than 175% of the federal poverty level (FPL). Applicants must show evidence of their income by providing intake staff with pay records or tax forms.

Applicants do not qualify for CarePartners if they are eligible for federal or state health benefits including Medicare, Veteran's Administration benefits, or Maine's Medicaid program, MaineCare.

Private health insurance availability: Recognizing that the costs of private health insurance premiums are prohibitive for persons with low incomes, applicants are now eligible for CarePartners if the premium and deductible of the private insurance for which they are eligible is in excess of 5% of their gross income.

Residency requirements: The CarePartners program is open to residents of Lincoln, Kennebec counties and the Greater Portland region. Six months of residency is required. Greater Portland includes towns as far west as Steep Falls, as far south as Scarborough, and north to Freeport.

Services and Providers

CarePartners differs from many free care programs by providing care management services, pharmacy benefit services, and by matching each patient to a primary care provider to ensure each enrollee has a medical home.

All providers donate their time and services when they participate in CarePartners. Inpatient and outpatient services are provided by seven hospitals participating in the CarePartners network. In principle, all health care services are available to enrollees through the CarePartners network of 854 PCPs and specialists.

Enrollee Responsibilities

Enrollees pay a \$10 co-pay for each provider visit. Enrollees are discouraged from seeking care inappropriately from emergency departments rather than from their PCP.

Enrollees also pay \$5, \$15, or \$25 co-payments for medications, depending upon the drug and whether it is generic or name brand. Enrollees are required to work with the CarePartners staff to enroll in the prescription assistance programs through which pharmaceutical companies provide free medications.

Service Areas and Administration

CarePartners is administered by MaineHealth and by the lead MaineHealth member or affiliate hospital in each region: MaineGeneral Medical Center in Augusta and Waterville in Kennebec County; Miles Memorial Hospital (in collaboration with St. Andrews Hospital in Boothbay Harbor) in Lincoln County; and Maine Medical Center in Portland. MaineHealth provides overall systems support for claims reporting, staff training, resource development, marketing, and systems support through a director, assistant director, and database manager.

The Greater Portland site includes Maine’s most populous city and a region in southern Maine of approximately 70,000 people. The population of Kennebec County, which includes the state capitol city of Augusta, is 120,600. Lincoln County, located in mid-coast Maine, is the most rural of the three regions and has a population of 35,200.

Staffing of the sites varies according to need. In addition to a local project coordinator, each site has different staffing based on their needs, see Table 1 below.

Program Funding

Services donated by hospitals and providers to CarePartners represent approximately \$4M annually (CY 04). In addition to donated services, the cost of operating the program falls into two categories, administration and pharmacy. Total FY06 budget was \$1.4 million. Administrative costs include salaries and expenses associated with program staff, care managers, intake coordinators, and pharmacy technicians.

CarePartners has been able to underwrite these program costs through both core institutional funds from the MaineHealth system, member and affiliate lead hospitals, and from grant support. It has benefited from several important grant awards which have provided targeted program support and complemented institutional funds. Grant funding from the Robert Wood Johnson Foundation, the Maine Health Access Foundation, the Health Services Research Administration (HRSA), the Bingham Program, the Cox Charitable Trusts, and the Dana Foundation have provided support for all facets of the program from initial design to current operating support. In addition to external grant support and providers’ donated services, in-kind contributions are also donated to the program. Anthem donates enrollee cards and medical claims processing. Martin’s Point Informatics donates analytic support. This diversification of funding support, real and in-kind, is essential to the continued financial viability of the program.

Table 1. Full Time Equivalent (FTE) Staffing of CarePartners Program

Region	Care Managers	Pharmacy Technicians	Intake Coordinators	TOTAL
Kennebec 500 enrollees	2.0 FTE	2.0 FTE	2.0 FTE	6.0 FTE
Lincoln 80 enrollees	0.3 FTE	0.6 FTE pharmacy technician/intake		0.9 FTE
Portland 460 enrollees	1.9 FTE	1.5 FTE	1.9 FTE	5.3 FTE
Total	4.2 FTE	4.1 FTE	3.9 FTE	12.2 FTE

II. Methods and Data Sources

We used data collected and maintained by CarePartners and other organizations and developed a **variety of analyses to provide a comprehensive picture** of the program's experience over four years. Data and methods used for this report include the following:

CarePartners internal data – CarePartners maintains various databases on enrollee enrollment, disenrollment, referral information, provider capacity, and donated pharmacy benefits.

Claims data analyses – These are *proxy* claims submitted by all providers – hospitals, practice-based, and ancillary service providers – for the purpose of tracking donated care provided to CarePartners enrollees. Machigonne Benefit Administrators (Anthem Blue Cross/Blue Shield of Maine) donate claims processing to the program and Martin's Point Informatics donate 20 hours per month for data warehousing and reporting.

Using data from the four years of program experience, we designed, and Martin's Point Informatics produced, claims data reports specifically for this paper. They include per member per month cost analyses, selected HEDIS (Health Plan Employer Data Information Set) analyses, value of donated services, and costs for extended enrollment (18 months) in the program.

Enrollee and provider satisfaction surveys – CarePartners staff conduct these surveys annually of all current enrollees and all providers who are in the CarePartners network. For this report, we compared results from these surveys for the last two years to identify variations.

Exit survey data – In the spring of 2005, we designed, tested, and implemented a rolling survey of former enrollees to determine current insurance status three months after exiting the program. The survey was conducted by CarePartners staff and will continue beyond this project to provide ongoing information about program disenrollees.

Health Assessment data – Enrollees complete a health assessment upon entry into the CarePartners program for the initial six month enrollment period. To determine eligibility for each continuing six month enrollment period, additional assessments are completed. CarePartners staff capture and maintain this information on their internal information system. It includes self-reported health status, smoking status, household, and income information.

Hospital financial reports – In order to understand the levels of uncompensated care and payer mix of the hospitals in the regions served by the CarePartners program, we collected data from annual audited financial statements submitted to the Maine Health Data Organization (MHDO) by all Maine hospitals. We compared CarePartners' network hospital payer mix to state averages.

Interviews – We conducted interviews with 12 key informants for this report; these individuals represented a wide spectrum of providers, hospital administrators, and advocates. In addition, we conducted interviews with enrollees and care managers at each of the four local sites to better understand the needs of enrollees and the services provided to them by care managers.

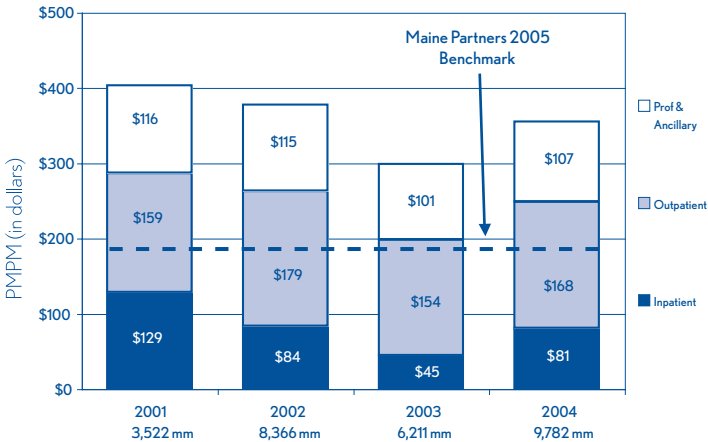
Michigan Survey – This survey of 300 enrollees was conducted at the start of the CarePartners program and repeated twice at six month intervals. Conducted under the auspices of the Robert Wood Johnson *Communities in Charge* initiative, it was designed and administered by the survey research center at the University of Michigan. Catherine McLaughlin PhD, of the University of Michigan, presented these results to stakeholders in the spring of 2003 and 2004 and they were recently published.

III. CarePartners Program Performance

The following graph shows the per member per month (PMPM) cost for the entire program. Included are all medical expenses (pharmacy per member per month costs are displayed separately). Professional services include physician practices and ancillary services such as laboratory and diagnostic services. The Maine Partners per member per month rates are used as benchmarks in these graphs to show the relationship between CarePartners per member per month rates and those of a commercially insured population.

The two populations have significant differences. Maine Partners, a product offered by Anthem Blue Cross Blue Shield, covers approximately 26,000 lives in Maine and represents 334,000 member months. The Maine Partners medical services rate is \$196.56 per member per month and the pharmacy rate is \$34.26 per month. The CarePartners population is distinguished by its low income, previously uninsured status, and lower health status with more than half with at least one chronic condition. Nationally, chronic conditions account for 76% of all hospital admissions, 88% of all filled prescriptions, and 72% of all physician visits, so it is not surprising that utilization for the CarePartners population is higher than a general commercial plan.¹

Figure 1. Average Per Member Per Month (PMPM) CarePartners Costs by Service Category and Year
CY 2001-2004, All Sites

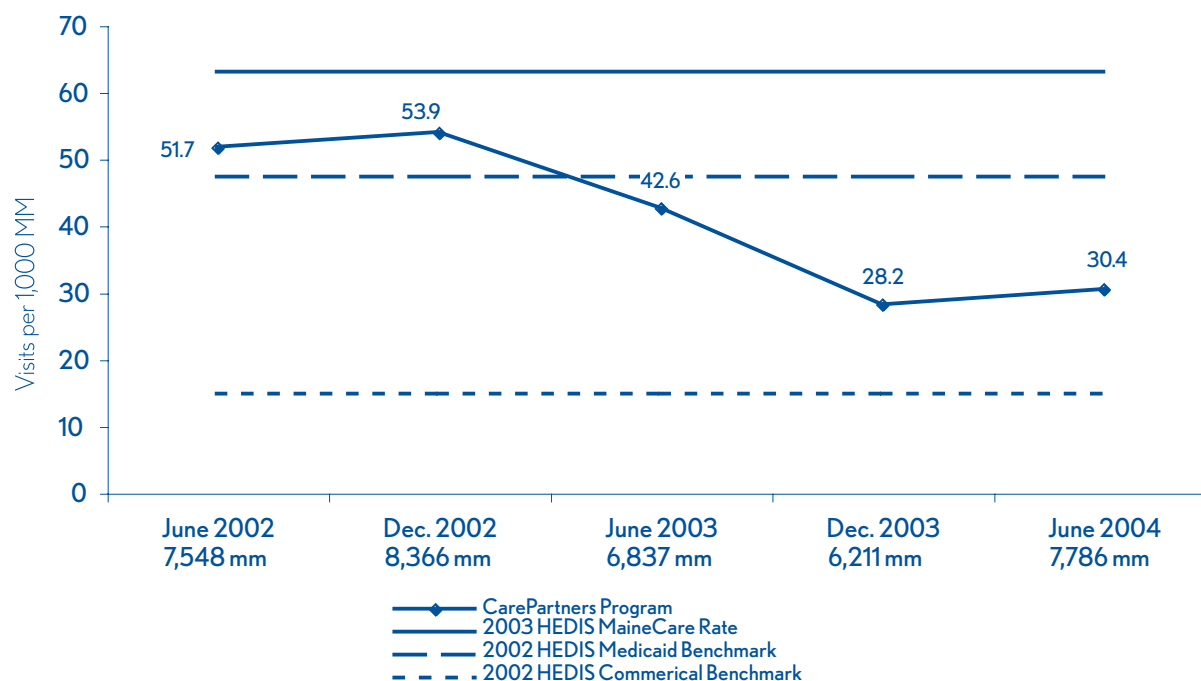


- The most dramatic change over the four years is the decrease in inpatient costs from \$129 pmpm in 2001, at the start of the program, to \$81 pmpm in 2004.

¹ Johns Hopkins University. *Chronic Conditions: Making the Case for Ongoing Care*. Partnership for Solutions. December 2002.

Figure 2. Emergency Room Visits per 1,000 Member Months (MM)

All Sites – Twelve Month Rolling Average



HEDIS Measures

We selected three measures from the Health Plan Employer Data and Information Set (HEDIS) based on availability of data and appropriateness for the CarePartners population. We chose utilization measures (emergency room use, hospital discharge rates, and length of hospital stay) which we could analyze using CarePartners claims data.

HEDIS provides measures that are consistent over time and can be compared to other populations including national HEDIS benchmarks for both commercial and Medicaid populations. The benchmarks developed by the National HEDIS Benchmarking Project² (NHBP) represent the national average of all plans reporting on a particular measure.

2 Lee, Meredith, The American Public Human Services Association (APHSA) Medicaid HEDIS Database Project, Report for 2002, the Fifth Project Year, September 2003; www.nasmd.org.

Each of the three measures shows reduced utilization over time. We attribute this outcome to improved health status resulting from critical program services including access to medications, to regular primary care, and to the services of a care manager. Certainly, reduced emergency room use has a direct relationship to access to a regular source of care. However, without clinical data showing health outcomes for hospital discharges and reduced length of hospital stay, we cannot state for certain the reasons for reductions in these measures.

- This measure in Figure 2 is defined as ER visits that did not result in an admission.
- This rate compares favorably to the national HEDIS benchmark for the Medicaid population which was 47.2 per 1,000 member months in 2002. The ER rate for the MaineCare managed care benefit, including 96,978 MaineCare children and adults, was 63 visits in 2003. The national HEDIS commercial rate, traditionally much lower, is 14.7 visits.

Figure 3. Hospital Discharges per 1,000 Member
All Sites – 12-Month Rolling Average

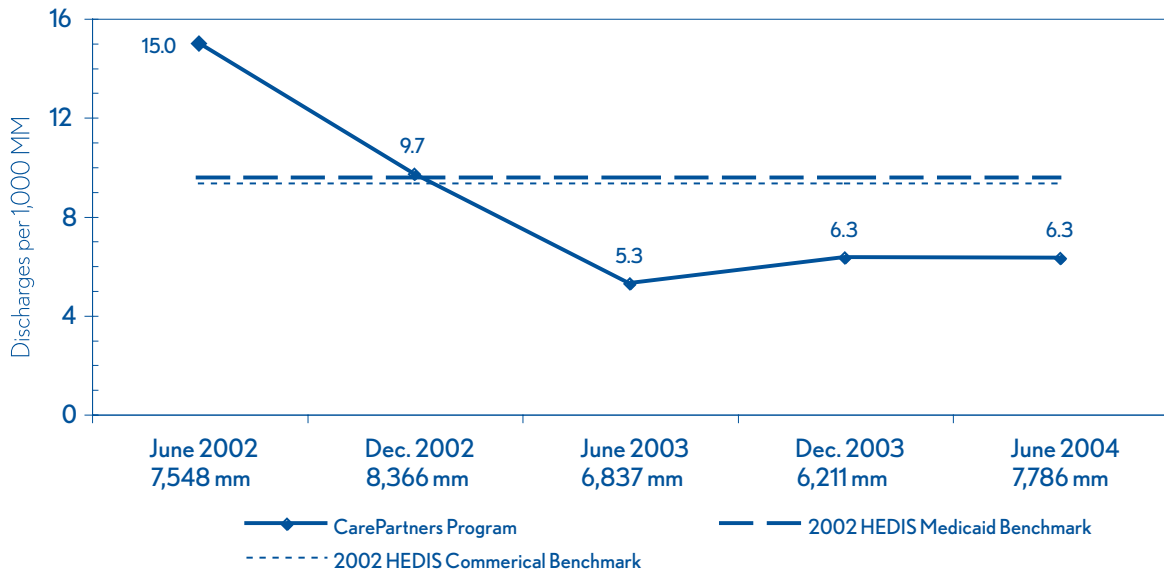


Figure 4. Average Inpatient Length of Stay (ALOS) per 1,000 Member Months
All Sites – 12-Month Rolling Average

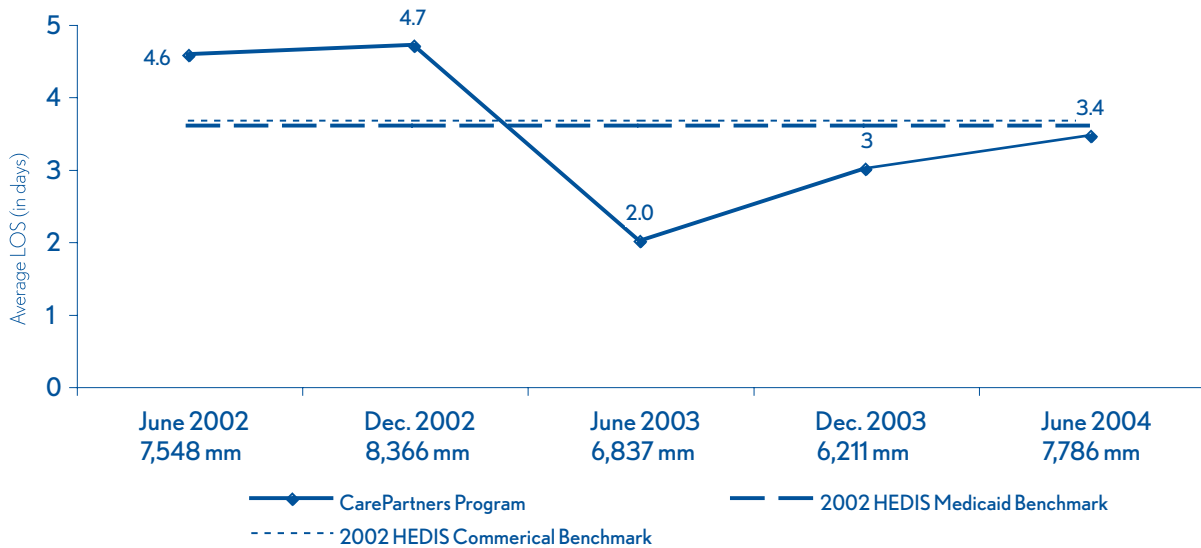
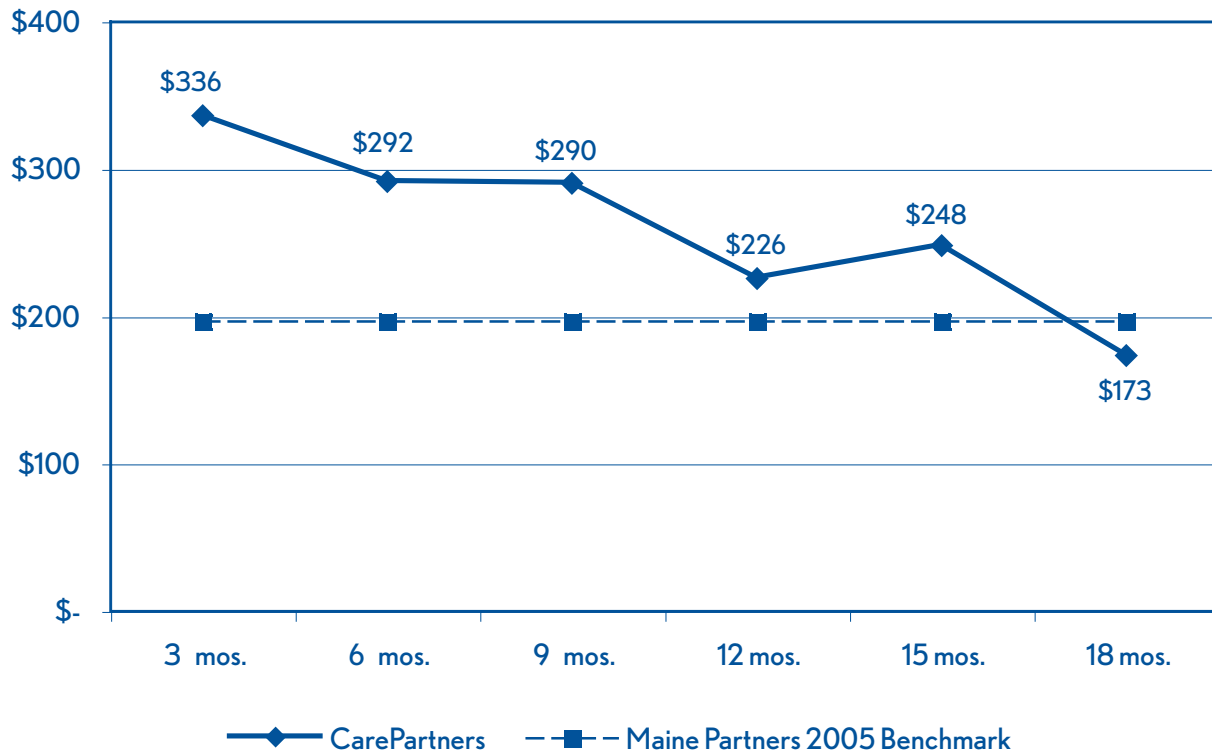


Figure 5. PMPM Medical Costs for CarePartners Enrollees Enrolled for at least 18 months (Submitted Claims) N=396



What Happens to Costs When Enrollees Stay in the Program?

The high enrollment/disenrollment turnover, or churning of the CarePartners population limits our ability to study long term trends. However, we were able to identify a small cohort of 396 enrollees who had remained in the program for 18 continuous months.³

The results of this study show relatively high medical costs for the first nine months as seen in the graph above. After that time, the per member per month cost dips to, and subsequently below, a Maine commercial benchmark (Maine Partners benchmark of \$197).

Program Pharmacy Benefit

The pharmacy benefit has been a cornerstone of CarePartners since the program’s inception and sets the program apart from other safety net programs (see figure 6). Success at sustaining this costly benefit has resulted largely from aggressively accessing free medication programs of pharmaceutical companies. The CarePartners program provides program-supported prescriptions to enrollees after they enter the program and before free medications are available through the Patient Assistance Programs (PAP). Not all medications are available through PAPs.

Free medications through PAPs are available to the general public; however, the application processes are too impenetrable for all but the most tenacious and astute patients.

The values in Figure 6 below are taken from pharmacy claim costs paid by the CarePartners program. This data has been updated from the original report to include 2005 – 2006 data.

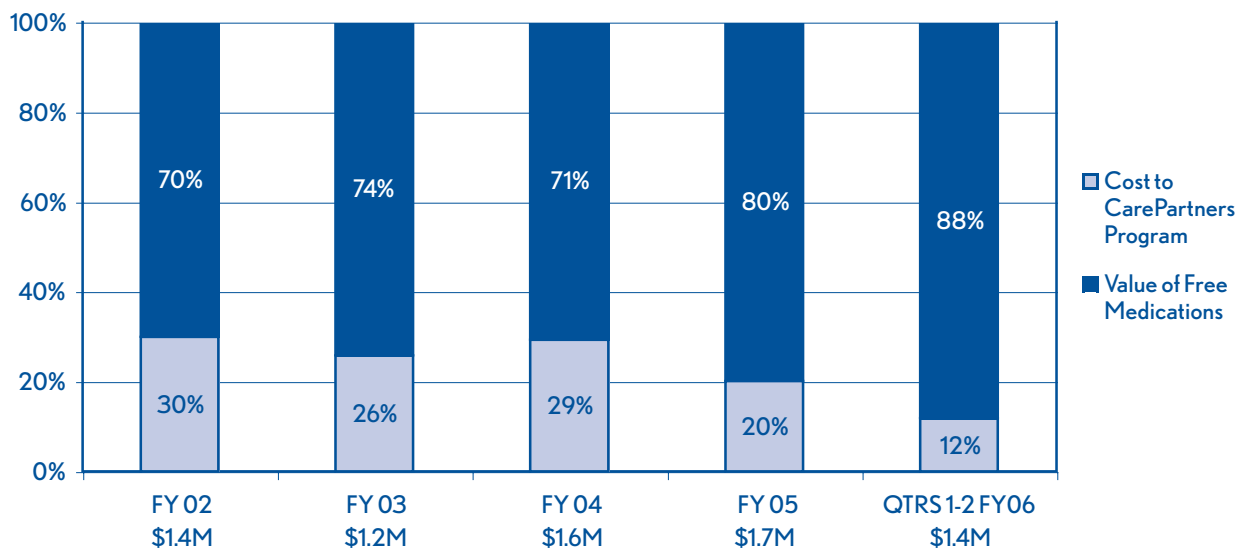
Due to the efficient use of free medications from the PAP programs of pharmaceutical companies, the average per member per month pharmacy cost is much lower for this population than it would have been had all pharmacy (free and subsidized) been included.



- To do this, we captured enrollees' costs regardless of entry date. For example, we included observations for any single 18 month period of an enrollee beginning any time after June 2001 and ending any time before April 2005. If enrollees were enrolled for longer periods, we captured only the first 18 months.

»» *“CarePartners is the best and most effective medical help I have had in my life. The assistance of the program and staff have helped solve most of my health care problems and have followed through to overcome the obstacles and achieve the goals that are possible in dealing with my conditions.”*
“CarePartners has been an exceptional service when I needed it the most.”
 — From the CarePartners' Member Satisfaction Survey, June 2003

Figure 6. Pharmacy: Value of Free Medications vs. Real Costs FY02-FY06
 Source: CarePartners Pharmacy Data



IV. CarePartners Enrollee Profile

Demographics

The following table shows descriptive characteristics of this population.

Demographic Characteristic	2001	2002	2003	2004
Unduplicated enrollment				2,186
Enrollment	891	1,174	968	1,274
Female	69%	61%	67%	63%
Average Age	47	42	42	42
Average Household size	1	1	2	2
Widowed/Divorced/Single	76%	86%	67%	65%
Employment	n/a	n/a	83%	73%
Self-employed	3%	6%	4%	4%
Enrollees receiving unemployment income	4%	5%	2%	5%
Enrollees receiving SSI/SS/SSDI income	2%	1%	4%	10%
Enrollees reporting no source of income	10%	8%	10%	12%
Average Total Household Assets	\$1,258	\$2,335	\$1,996	\$2,254
Average Total Household Monthly Income	\$1,016	\$1,077	\$1,246	\$1,308

Where Do Enrollees Come From?

More than a quarter of applicant referrals to CarePartners originated from Maine’s Department of Health and Human Services. Approximately 20% are referred from free clinics, emergency rooms, hospital-based social workers, and other offices where care was provided and 15% found out about the program through friends or family members. Fifteen percent of applicants were referred to the program by their physicians.

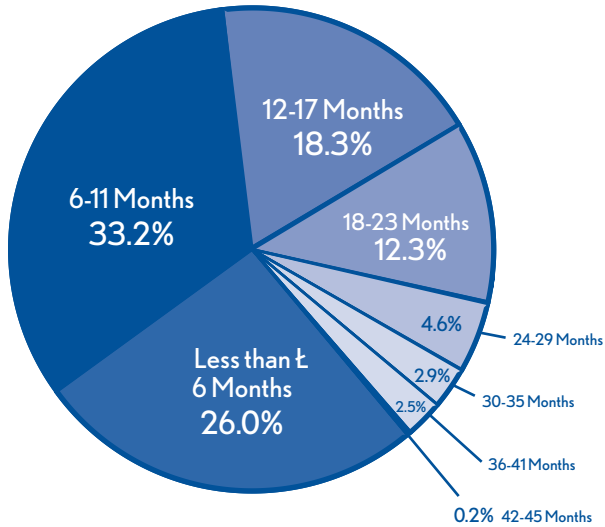
How Long Do Enrollees Stay?

CarePartners enrolls participants for an initial six month periods; after that time enrollees must re-apply to be re-enrolled for another six months. The recertification process includes a review of current income, assets, and eligibility options for other programs including state, federal or employer-sponsored insurance. Figure 7, on page 15 shows the length of time CarePartners enrollees stay in the program.

Approximately one quarter of enrollees exit the program after six months and do not re-enroll. One third exit after two enrollment periods and another 18% exit after three periods.

Figure 7. Enrollment Length of CarePartners Enrollees

CY 01-04, N=2,186



What are Enrollees' Unmet Needs?

Uninsured adults are more likely to delay accessing health care, even for serious conditions.⁴ To assess the unmet needs of enrollees, CarePartners staff capture self-assessment reports upon entrance to the program and at the time of each re-enrollment. Approximately half of CarePartners

enrollees report having no limiting conditions upon entering the program; 22% report having one condition and the remainder, 28%, report having two or more conditions.

The most prevalent conditions that enrollees report upon entering the program are:

- Musculoskeletal conditions
- Depression
- Hypertension
- Mental health conditions other than depression
- Gastrointestinal conditions
- Diabetes

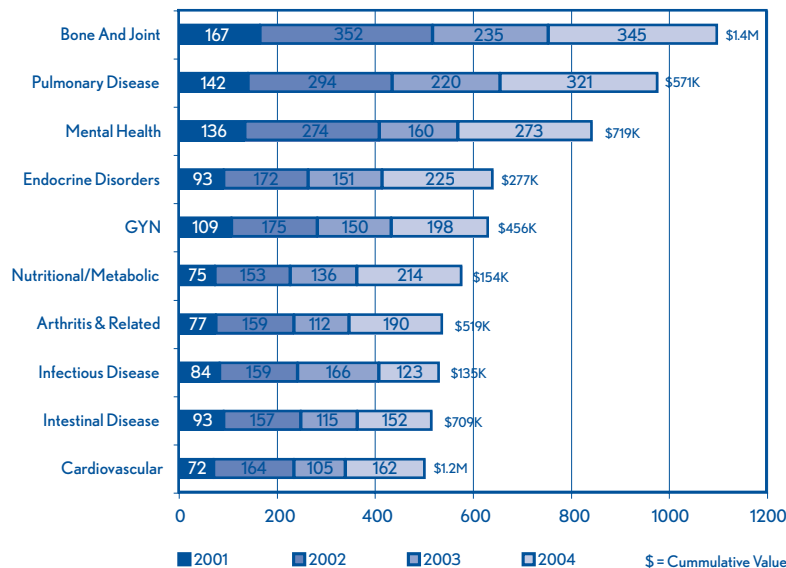
These self-reports are confirmed in analyses of claims data that show the number and cost of enrollees treated each year for conditions most frequently diagnosed.

Hip and knee replacements top the list of most frequently reported unmet needs and most delivered services. These conditions limit functional ability including employment and reduce quality of life, though they are generally not life-threatening and, thus, generally not delivered by hospital free care programs. That these types of services are delivered through this program is a commentary on the level of comprehensive services provided by CarePartners.

4 Institute of Medicine. *Coverage Matters, Insurance and Health Care*. National Academies Press. 2001.

Figure 8. Most Prevalent Diagnoses of CarePartners Enrollees CY 2001-2004

Includes multiple diagnoses for enrollees. Number of enrollees with diagnosis each year and cumulative value of services.



Do New Applicants Have a Regular Source of Care?

A quarter of enrollees did not have any PCP or medical home upon entering the program in 2003 and 2004. Not having a medical home and a usual source of care is correlated with high emergency room use and delay in obtaining needed health care services.

Why Do Enrollees Need Care Management?

Care management is an integral component of the CarePartners program. Designers of the program recognized that new enrollees would need assistance navigating the health care system and support services available to them.

As with other aspects of the program, each site has adapted the care management service to accommodate its needs and environment. For example, in Portland, the care managers are located in the administrative program site which is convenient to other social service agencies frequented by its enrollees. In the Lincoln and Kennebec sites, care managers are located in physician practices or hospital sites; these care managers reported greater efficiency due to direct access to enrollees before or after their medical appointments, access to providers and to electronic medical records. Access to electronic medical records was reported to be extremely useful in identifying enrollees' providers, making appointments, and assisting enrollees with managing their medications.

Care managers report case loads of between 200 and 250 enrollees each. At any given time between a quarter to a third of their enrollees have high needs and are in frequent, sometimes daily contact with them, requiring referral follow up, social services, explanations of benefits or education. Another third have intermediate care management needs with contact several times a month, and another third of the population requires only minimal contact.

Deborah

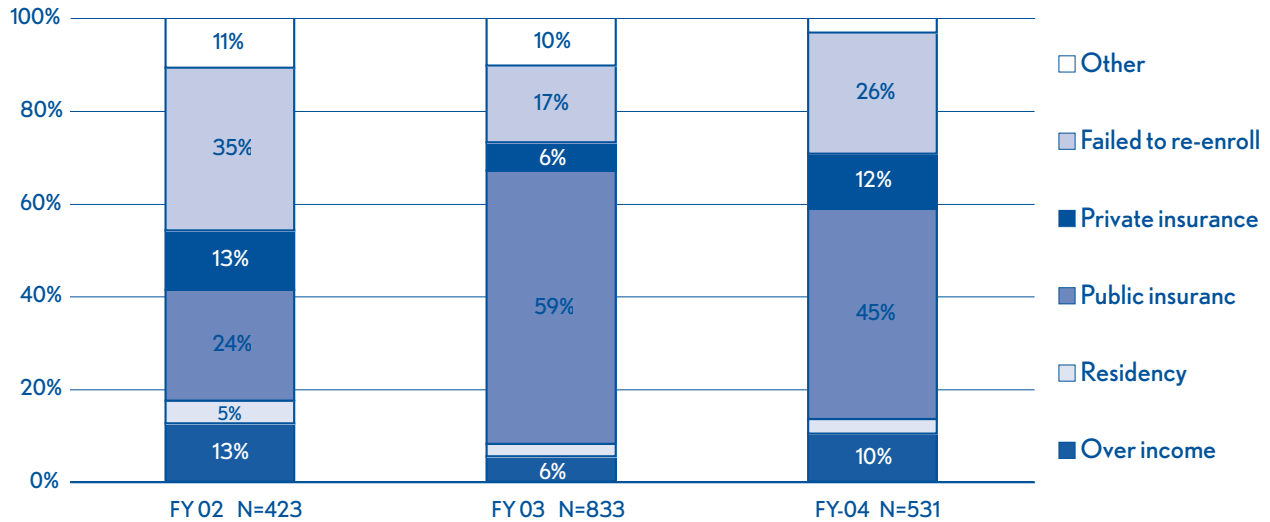
DEBORAH, AGE 47, has had employer sponsored insurance in the past, but when she changed jobs to work as a waitress in a different restaurant, she lost her coverage. Subsequently, she was unable to work due to the pain in her knees and back. She was initially enrolled in CarePartners for one year, her income decreased and she became eligible for the MaineCare non-categorical benefit (for adults with less than 100% of FPL income). When her income increased, she once again became eligible for CarePartners and has been enrolled for the past eight months.

Before joining CarePartners, Deborah went to the emergency room when her arthritis flared up. She has also been treated for high blood pressure, high cholesterol, depression, and back problems, though she only took medications when they were offered as samples, not being able to afford to have prescriptions filled. Her primary motivation for joining CarePartners was to obtain treatment for her knees, the pain had intensified to impede her day to day functioning and her ability to work.

Her new CarePartners PCP recommended that Deborah see an orthopedic specialist who, in turn, recommended a complete knee replacement. She is currently receiving post-operative physical therapy and hopes to return to work soon. She receives medications for all her conditions through the CarePartners pharmacy benefit and now counts medications as the primary benefit of the program.

>> *She says that she can, 'stay healthier because my diseases are under control and I'm not treated like a charity case.'*

Figure 9. Reasons for Disenrolling from CarePartners



Disenrollment: Where Do Enrollees Go?

Figure 9 above shows that, of the enrollees who exited the program in the past two years, 59% and 45% exited because they became eligible for MaineCare, Veteran Administration benefits, or Medicare, the latter most likely if they turned 65. The percentage of enrollees exiting to private insurance doubled from FY 03 to FY 04, from 6% to 12%.

MaineCare Referrals

In addition to referrals to MaineCare when CarePartners enrollees meet that eligibility, CarePartners staff routinely assess new applicants for MaineCare eligibility when they apply to the CarePartners program. More than 2,500 individuals have been referred to MaineCare from the CarePartners program.

Do Disenrollees Get Coverage After Leaving CarePartners?

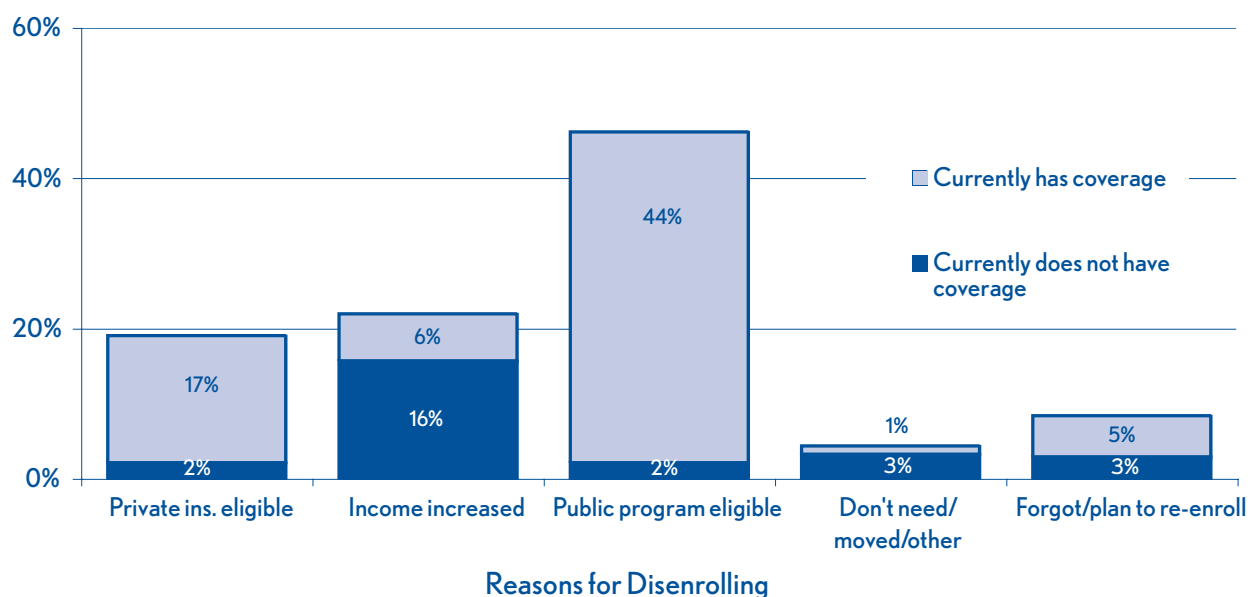
In order to learn more about enrollees' health coverage status after they left the program, CarePartners staff began surveying enrollees three months after exiting the program in the summer of 2005.

Of the 46% of all surveyed disenrollees who left CarePartners because they became eligible for Medicaid, Medicare, or VA benefits, only 2% did not have coverage three months after exiting CarePartners. Those who were eligible for public programs, and still did not have insurance, were MaineCare-eligible; they stated that they did not want to be in a state-sponsored program.

Sixteen percent of the 22% who exited because their income or assets increased, had not obtained health insurance three months after leaving CarePartners. When asked what they would do if they needed health care, they stated that they would try to negotiate a payment plan with their provider, use the ER or free clinics, or they would not seek care.

CarePartners enrollees who are eligible for private health insurance with premiums of 5% or less of their household income are no longer eligible for the program. Nineteen percent of the surveyed population fell in this category. All but 2% (N=6) did, in fact, obtain private health insurance after disenrolling from CarePartners, seen in Figure 10 below.

Figure 10. Current Insurance Status of Disenrollees
2005 Exit Survey N=273



Why Don't Disenrollees Enroll in DirigoChoice?

When new applicants apply to CarePartners or when enrollees re-apply at six month intervals, CarePartners staff review their income and expenses and other financial information. If they are ineligible for CarePartners, staff advise them of their other options, including assisting them with applying for DirigoChoice coverage.

DirigoChoice is providing insurance to many Mainers in need of health insurance coverage and has been particularly successful in filling the need for persons who are underinsured and employees of small firms. However, the premium and deductible

costs of DirigoChoice, while less than that of private health insurance, appear to be out of reach of the CarePartners population. To illustrate this, we show a monthly budget of a real CarePartners enrollee who lives alone and whose income is 150% FPL.

This enrollee accesses food pantries to augment her food budget. Her income makes her eligible for Group B of DirigoChoice; currently, that category includes a \$500 deductible and provides an 80% discount on monthly premiums. A typical premium is \$313 per month, requiring the applicant to pay \$63 per month which is beyond her current financial means.

Table 3. CarePartners Enrollee Household Budget

INCOME:		EXPENSES:	
Employment income	\$1,196.25	Rent	\$500.00
Net after deductions	1,016.81	Utilities	\$265.00
Total monthly income:	\$1,016.81	Transportation	\$59.50
		Medication co-pays:	
		Glucophage	\$5.00
		Zoloft	\$15.00
		Enalapril	\$5.00
		Atenolol	\$5.00
		Combivent	\$15.00
		Lovastatin	\$5.00
		Food	110.00
		Physician co-pays	30.00
		Total expenses:	\$1,014.50
		Net expenses/income:	\$ 2.31
ASSETS:			
Checking Account:	\$112.47		
Total assets:	\$112.47		

V. CarePartners Provider Profile

A wide array of services are donated to CarePartners enrollees including hospital services, ancillary services and services donated by primary care and specialty physicians and nurse practitioners. This section shows characteristics of participating hospitals and other health professionals delivering care to enrollees, provides an overview of regional variation of services, and summarizes provider feedback from surveys and interviews.

Does Payer Mix Affect Participation in CarePartners?

Hospital administrators in other regions who are considering developing a managed uncompensated care program may worry that only large hospitals with sufficient portions of private insurance payers could underwrite an enhanced donated care program. The next series of graphs shows that hospitals participating in CarePartners are small, medium and large and have a broad range of payer mix.

A wide variation is seen among the individual hospitals in the CarePartners hospital network.

Forty-five bed St. Andrews Hospital has both the largest proportion of uninsured (3%) and of Medicare reimbursements (82%), while 600 bed Maine Medical Center has the largest proportion of privately insured patients at 39%. MaineGeneral, including two hospitals with 287 long term care beds and 304 acute care beds, has a slightly larger Medicare portion (58%) than the state average of 53%. For complete comparison purposes, note that Inland Hospital and Mercy Hospital have 46 and 230 acute care beds, respectively, and Miles Hospital has 32 acute beds and 70 long term care beds, seen in Figure 11 below.

Figure 11. Payer Mix: Inpatient Charges for Hospitals in the CarePartners Network, CY 2004

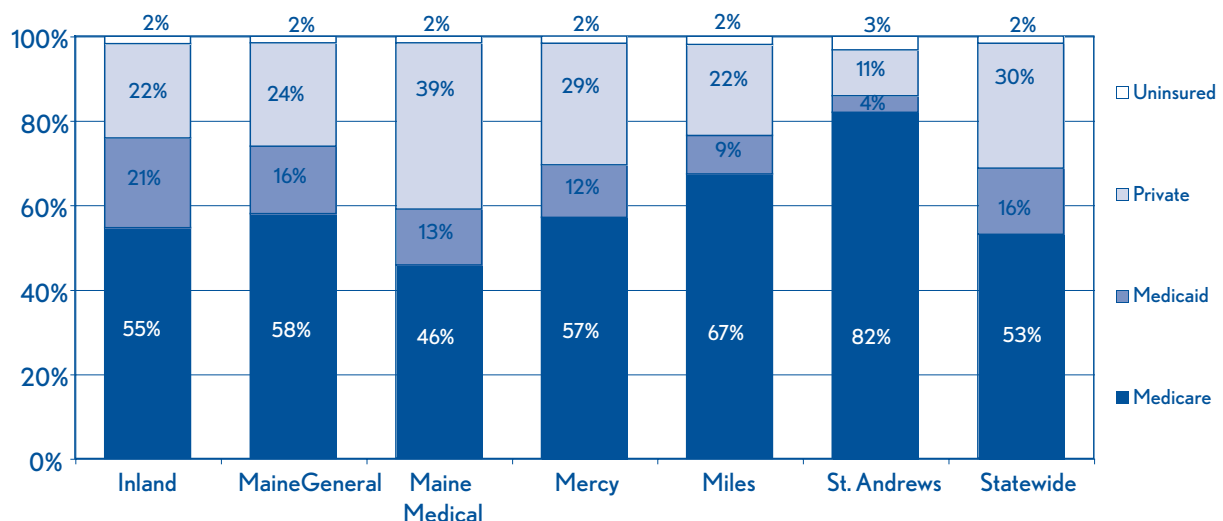
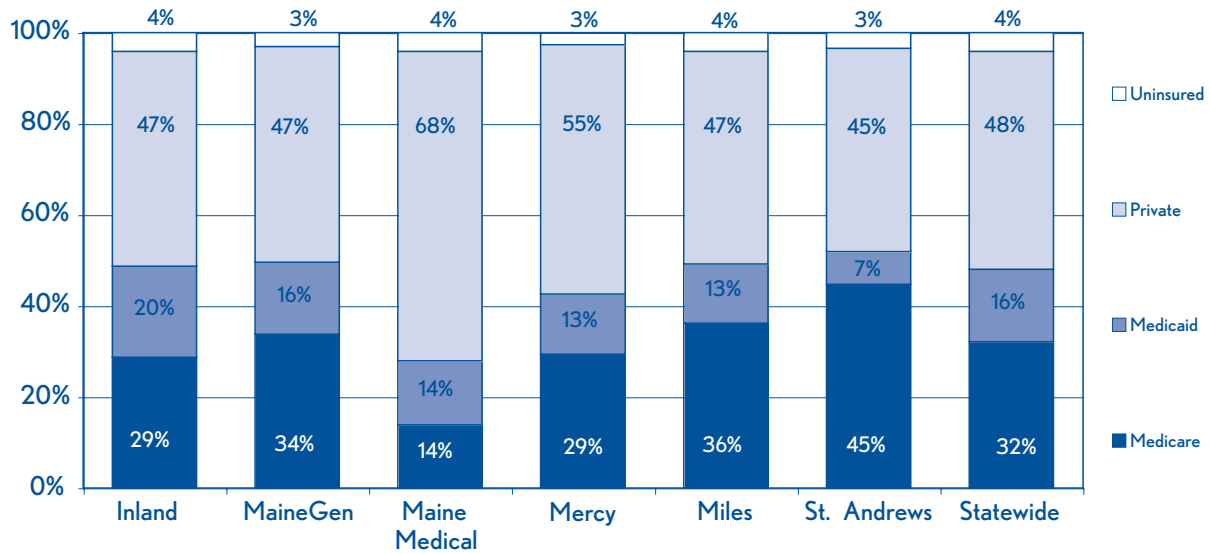


Figure 12. Payer Mix: Outpatient Charges for Hospitals in the CarePartners



Payer mix for outpatient charges shows a larger proportion of uninsured, reflecting services provided by emergency and urgent care units.

Clearly, the level of care delivered through the CarePartners program is a small fraction of the State’s uncompensated care activity for both inpatient and outpatient services. It is also a small fraction of the uncompensated care delivered by hospitals within the CarePartners network. Nevertheless, we can conclude that the hospitals participating in CarePartners have widely divergent characteristics including bed sizes and funding streams. Their individual and combined contribution to delivering services to uninsured patients is consistent with that of other hospitals in the state.

What is the Value of Hospital Services Donated to CarePartners Enrollees?

Of the \$12M in donated services to CarePartners enrollees over the first four years of the program, \$8.2M was provided by network hospitals and \$4.4M was provided by professional and ancillary providers, seen above in Figure 12.

Table 4. Provider Participation in CarePartners by Site

Region	Total Population	Licensed MDs and DOs	Enrolled in CarePartners Network	% of Participating Providers	Licensed Providers in Population
Lincoln County	35,200	57	23	40%	0.0016
Kennebec County	120,600	287	158	55%	0.0024
Greater Portland	70,000	1,017	673	66%	0.0145
TOTAL	225,800	1,361	854	63%	0.0060

How Many Providers Participate in CarePartners?

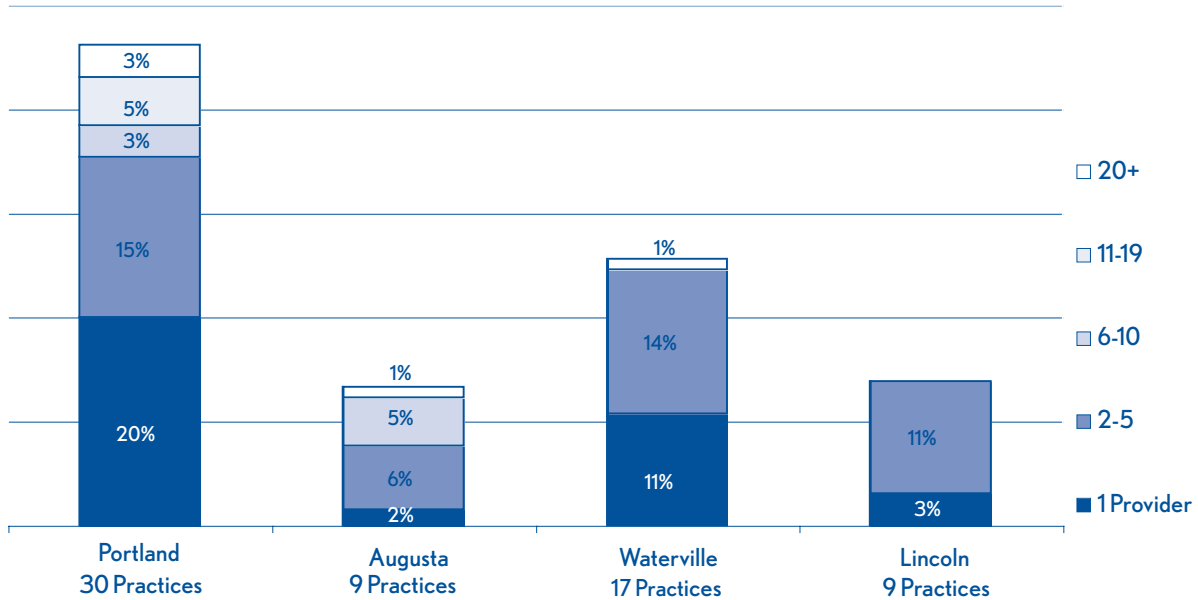
More than half of the licensed MDs and DOs in the program regions are enrolled in the CarePartners network. Primary care providers enroll by agreeing to participate and provide services to up to 10 CarePartners enrollees at no cost beyond the \$10 payment required of enrollees. Specialty providers enroll by agreeing to accept 20 referrals per year for CarePartners enrollees, also for \$10 per visit.

At any given time approximately 300 PCPs are actively engaged in the network; many provide services to one or two enrollees while the largest panel for one PCP currently includes 14 CarePartners enrollees.

Figure 13, on page 23, shows the practice sizes of participating PCPs.

We examined the size of the practices in which CarePartners PCPs reside, to understand any correlation between practice size and likelihood of PCPs to participate in CarePartners. As expected, large practices (20+ providers) associated with MaineGeneral and Maine Medical Center participate in CarePartners, but a larger than expected number of solo practice providers participate in Portland. Twenty percent of all PCP practices that participate in CarePartners are single practice providers in the greater Portland region, see Figure 13.

Figure 13. Practice Sizes of PCPs in CarePartners by Region, N=300 providers



What is the Value of Donated Primary Care?

Primary care providers have donated approximately \$1M in services over the four years of the program. Comparing enrollees receiving services to proxy claims that are submitted by PCPs, CarePartners staff estimate that a quarter of PCPs providing care do not submit claims, not wanting to burden their office staff with paperwork, knowing that reimbursements would not be forthcoming. Therefore, we have adjusted the figures from the original value of donated care of \$944K from submitted claims to \$1.180M to reflect this underreporting.

What are the Types and Regional Variations of Donated Specialty Services?

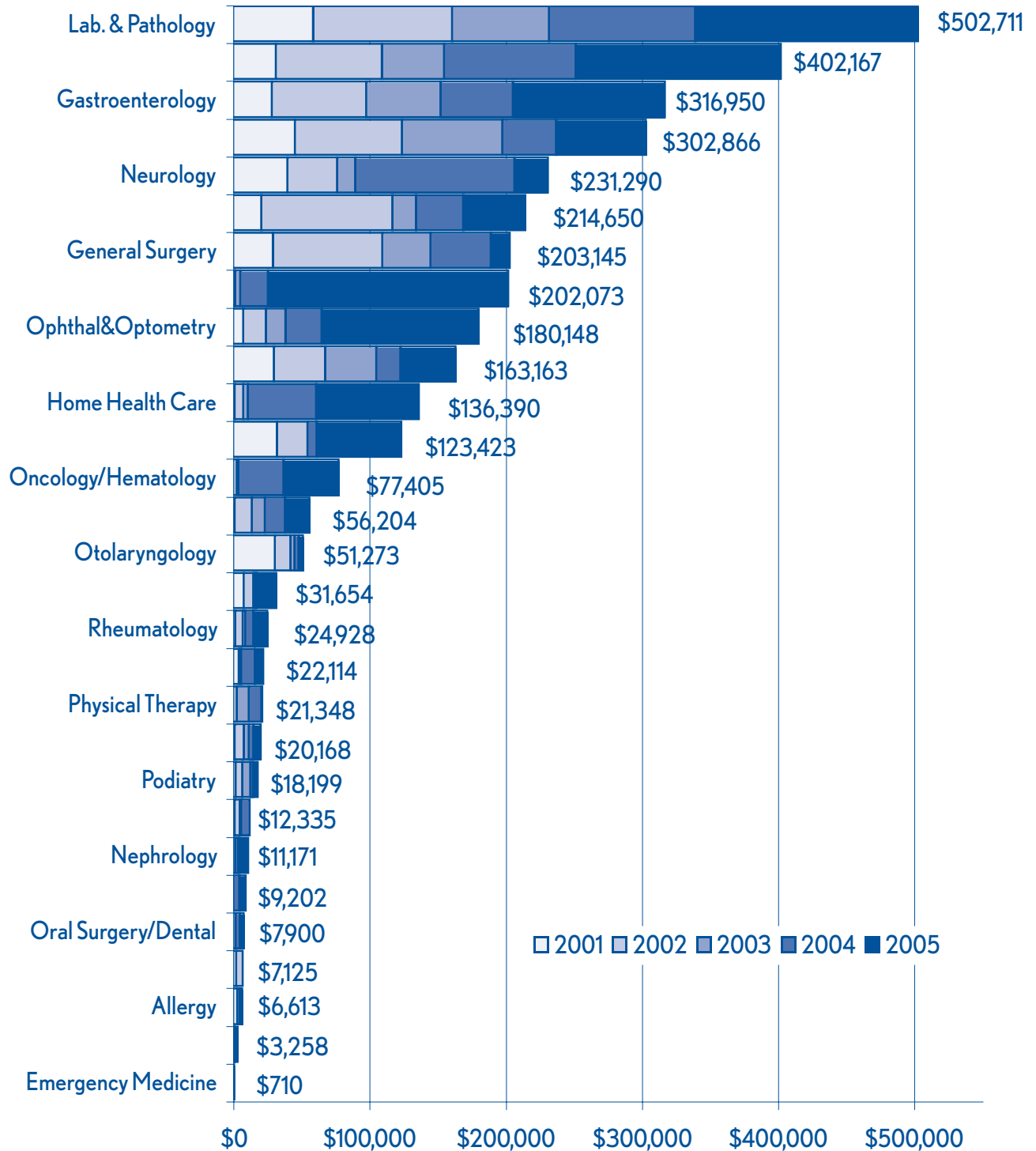
Support from specialists is critical for any donated care or reduced-reimbursement program, considering the continuing shortage of specialists, particularly in rural states.⁵ Many specialty practices in Maine operate at full capacity, often entirely with patients for whom services are fully reimbursed. Asking practices to essentially forgo a paying customer to serve a non-paying one, relies very heavily on their good will and not all specialists are willing to share in this effort.

Nevertheless, many specialty practices in each region have donated services to CarePartners enrollees, many for the full four years the program has been in existence. Figure 14 shows the value of donated services by most types of specialty providers. Radiology and anesthesia services are not shown on the following graph due to the high value of those services, \$531,000 and \$736,000, respectively.

⁵ Institute of Medicine. *A Shared Destiny: Community Effects of Uninsurance*. National Academies Press, 2003.

Figure 14. Value of Selected Donated Services for All Sites

CY 2001-04 (Excludes Hospital, Radiology, Anesthesia, GP. and Rx)



VI. Lessons Learned

When CarePartners was first envisioned, its architects thought that it would be a temporary safety net program until such time that a state or national universal health care program was established or until MaineCare expanded eligibility to CarePartners' levels. The challenge was to develop an organized system of care, one with primary, specialty, ancillary, pharmacy, and care management services, while using a relatively disparate network of donor/providers to provide care to a slightly different group of enrollees every six months. The comprehensive services offered to its enrollees are intended to be a safety net program first, one that is temporary until the enrollee is eligible for another program, whether public or private. It is the combination of these two factors, comprehensive and short term, that generates both challenges and successes.

Program success is evident from enrollee satisfaction survey findings, from the continued involvement of providers who donate their services, and from the results of the 18 month study. The 18 month study demonstrates a dramatic decrease in costs and utilization after 12 months of comprehensive services to a continuously enrolled cohort. We know that adults with chronic conditions in late middle age and with low health status have a high need for health care services.¹⁰ That CarePartners has demonstrated effectiveness with this challenging population may be instructive to state policy makers interested in developing enhanced care models for similar populations.

A comprehensive free care program for a population that is churning, has low literacy and high needs, requires substantial support. Certain program design features require considerable support. For example, a six month eligibility program requires staff to send reminder notices, contact enrollees, review re-enrollment forms, input self-assessment reports and provide information about alternative programs

every six months for each enrollee. CarePartners automated these processes to the extent they are possible; nonetheless, a fair amount of staff time is involved in these activities.

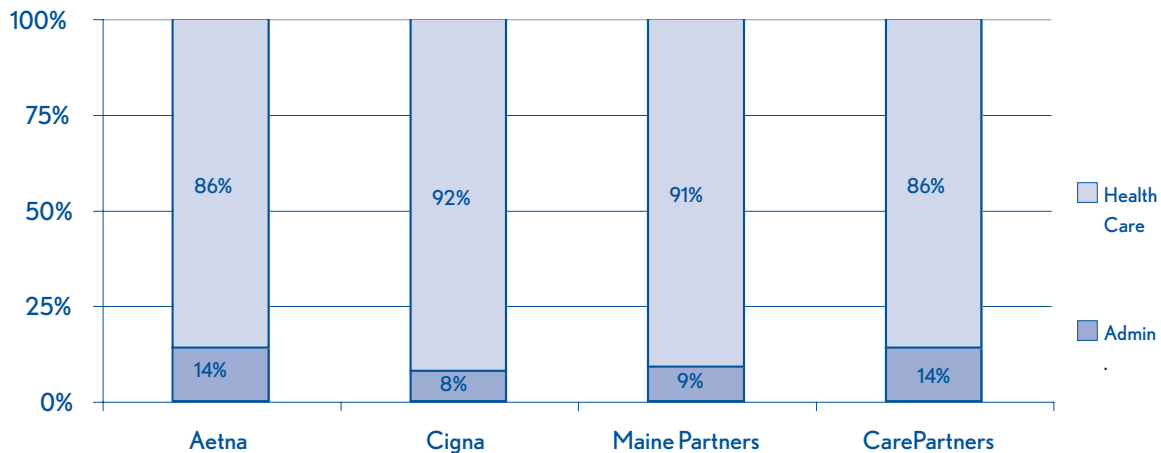
The advantage of re-certification at six month rather than annual intervals ensures that persons who are truly in need are enrolled/retained in the program. The advantage of a 12 month period would be a reduction in staff time and administrative expense.

Likewise, the pharmacy benefit is labor intensive. Propelled by the skyrocketing cost of medications, CarePartners staff explored and mined every avenue of free pharmaceutical programs on behalf of its enrollees. They are now automating the application process through a new software program with the expectation is that it will speed these procedures, reduce errors, and improve efficiency.

Despite intense staff effort for intake, assessments, care management for all enrollees, pharmacy assistance, and other administrative functions, CarePartners administrative costs appear reasonable. We compared the costs of administration to the costs of medical and pharmacy of CarePartners to those of large, commercial providers. Figures used to

¹⁰ Institute of Medicine. *Care without Coverage, Too Little, Too Late*. 2002. National Academies Press.

Figure 15. 2004 Administrative Expenses Compared to Medical and Pharmacy Costs



develop Figure 15 were taken from financial reports available from the Maine Bureau of Insurance.¹¹ Included in the health care expenses are all medical and pharmacy expenses of the HMOs. For CarePartners, these are the *value* of all donated medical and pharmacy services and the real cost for the subsidized pharmacy benefit. Care management services are included in the CarePartners administrative numbers along with other overhead costs, however, the value of donated claims processing and enrollee card services are not. A program with a population of 1,000 enrollees is not likely to achieve economies of scale attained by large commercial organizations. Yet, even with the intensity of the services provided to its enrollees, CarePartners is able to achieve an administration expense ratio of 14%.

¹¹ Bureau of Insurance website: www.state.me.us/pfr/ins/inshmo.htm#financial. Accessed October 18, 2005.

So You Want to Start an Enhanced Safety Net Program?

The experience of the CarePartners program can be instructive to organizations looking to develop an enhanced uncompensated care program in their region or network. While not an exhaustive list, some of the factors below, culled from the CarePartners experience, may be generalizable to the development of other programs in Maine or elsewhere. These are organized into considerations to be taken into account prior to implementation and those required for continued growth and sustainability of the program.

Prior to Implementation

1. Organizational and provider capacity and will.

Developing even a small program requires considerable effort, time, and resources. From the beginning, the leadership of the MaineHealth system and the principal CarePartners hospitals were committed to the program and authorized institutional resources including staff time, start up resources, and funding.

CarePartners engaged key providers in the original planning and design of the program who in turn engaged other providers in the initial stages of the project. It may seem obvious to say that without providers donating their services, there could not be a donated care program.

2. Wide array of stakeholders.

The CarePartners program was designed with input from a broad group of stakeholders from every domain (providers, consumer advocacy, state agencies, foundations) in addition to the leadership of each of the principal hospitals. Input from people with different perspectives strengthened the design of the program. Diverse participants also provided an opportunity to support the program by providing in-kind contributions or by networking and engaging others, including potential funders.

3. Know your niche.

Rather than importing a program that was designed in another environment, the CarePartners architects commissioned a study to understand the unmet needs and uninsurance levels of the populations in the three regions in which they planned to

implement the program. Because each region had different provider and potential enrollee characteristics, the program needed to fit the needs of both providers and enrollees and also be adaptable to different environments.

The chart below shows some of the environmental factors in each of the sites that influenced program development:

Supply factors include the availability of primary care providers, specialists, and also of other free care programs in the region that might influence enrollee demand for the product. Portland has the highest concentration of ‘competitors’: other safety net providers and free clinics. Demand of the population relates to the level of uninsurance and unmet needs; the highest was in Lincoln County, according to the pre-program survey. Both Kennebec and Portland have large hospitals, each with a history of providing free care; whereas, the small hospitals in rural Lincoln County have fewer resources with which to satisfy their population’s needs. Kennebec County had benefited from having staff trained in supporting the MATCH program at MaineGeneral, a similar program that formed the basis for CarePartners.

Table 5. Factors Influencing Uncompensated Care Program Design

Influencing Design Factor	Greater Portland	Lincoln County	Kennebec County
Supply of PCPs	High	Low	High
Supply of Specialists	Low	Low	Low
Other Free Care Programs	High	Low	Low
Demand of Population	Medium	High	Medium
Organizational Capacity/Funding	High	Low	High
Hospital-based Programs in Place	Low	Low	High

4. Program performance measures and data capability.

Identifying measures to gauge program success and provide early warning signs that will enable project directors to make timely, mid-course corrections requires agreement in advance. It also requires agreement on data collection methods and reporting. Compatible data systems are particularly important for programs that span multiple institutions with different information systems.

5. Linkages to diverse, external funding streams.

External grants and internal startup funding were critical to the development of this program. Without the early award of a substantive planning grant, and subsequent complementary grants, program developers would not have had access to technical assistance and resources for program development.

After Implementation

In addition to good program management, communication, outreach, an engaged advisory and provider group, there are a number of other factors needed to sustain an enhanced free care program.

1. Flexibility

As with any safety net, eligibility guidelines may need to be tightened, raised or lowered to accommodate fluctuating demand and need. There are many examples of how CarePartners has adapted the program, here are two:

CarePartners first set its net at 150%, found it had more capacity, and then raised it to 175%. After two years of relatively stable enrollment, the program experienced sudden growth due to external pressures and found the need to contain growth.

Rather than reducing the income eligibility criteria, the program contained growth by instituting enrollment caps.

Similarly, CarePartners increased its program flexibility with regard to employer-sponsored insurance. Initially, applicants with access to any employer-sponsored health insurance were ineligible for the program. After survey results showed that enrollees who were disenrolled when they became eligible for private insurance were not accessing it because premiums were too expensive, the program modified this criterion. The rule was changed so that only if premiums were in excess of 5% of their household income, would participants be disenrolled.

2. Innovation

The explosion of costs associated with the pharmacy benefit first led to investigating the use of patient assistance program applications on behalf of enrollees. CarePartners has now fully expanded this activity, automated the application process, and has begun providing this service, free of charge, to providers and patients who are not enrolled in CarePartners.

Another example is CarePartners use of web-based programs for surveys and data collection. This year the program experimented with using a web-based survey to obtain provider feedback. Data managers are also exploring ways in which to use web-based programs to link with remote sites for data collection.

3. Diverse funding

A secure funding base, coupled with program-enhancing large and small grants, has enabled CarePartners to grow and adapt the program to its changing needs. Without such continuous and varying external support, a safety net program of this type would be severely limited in scope.



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