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
January, 2006

Dear Colleagues:

Back in 1999, MaineHealth, in collaboration with many partners, launched an initiative that was to become the CarePartners health access program. Over the past six years, CarePartners has become an award-winning, nationally-recognized “donated services network” model, providing eligible adults with a full range of primary and specialty care services in hospitals and physician practices. Enrollees receive not only needed medical care, but care management and pharmacy benefits – a truly comprehensive package of services.

Health care providers know that providing access to care for individuals of all economic means is one of our most important responsibilities. Charity care programs offer one strategy to meet this goal, but they are not the most effective way to provide primary care or care for chronic conditions. As you will learn from reading this report, CarePartners has demonstrated its ability to provide primary, specialty, and hospital care for a significant number of adults in Greater Portland, Kennebec County, and Lincoln County. Here are just a few of the highlights from the Care Partners program:

- Over 7,000 individuals have been served, including 3,800 enrollees in CarePartners, 2,600 individuals referred to MaineCare, and 101 individuals referred to DirigoChoice
- Over $12 million of medical care has been donated by 7 hospitals and a volunteer network of 960 primary care and specialist physicians
- Over $2 million of donated pharmaceuticals was secured from Pharmacy Assistance Programs between 2001 and 2004 (as of December, 2005, the total accessed from PAPs was more than $4.5 million!)
- A reduction in emergency department use, and medical and pharmacy costs of enrollees, over time

What does the future hold? The demand for CarePartners currently exceeds the capacity of the donated services network, and as a result, the three local sites have established enrollment caps. MaineHealth will continue its commitment to supporting CarePartners as a viable local strategy to strengthen the health care safety net. It will also strengthen statewide initiatives such as MaineCare, DirigoChoice, and commercial insurance – toward the goal of providing access to all Maine citizens.

On behalf of MaineHealth, are grateful to the Maine Health Access Foundation for funding this important and insightful analysis of CarePartners, to Anthem Blue Cross and Blue Shield for providing enrollee claims and related data, to Martins Point for the detailed analyses contained in the report, to the Institute for Health Policy at the University of Southern Maine’s Muskie School, for their contributions to the research and the writing of this report, and most importantly, to the generous physician practices and hospitals that have donated their services to the program. We are especially grateful to MaineGeneral Health, which provided the foundation for CarePartners in Augusta and Waterville.

The findings of this report and their implications are sure to be of interest to policymakers, providers, funders, and other stakeholders, as we continue our collective efforts to assure access to health care for all Maine citizens.

Sincerely,

William L. Caron, Jr.
President
Opportunities and Challenges: Improving Access and Health Outcomes through the CarePartners Program

February 2006

Principal Authors

Catherine Ormond
Institute for Health Policy, Muskie School
University of Southern Maine

Sarah B. Gerrish
CarePartners Program
MaineHealth

Supported by Grant No. 2003A-0113 from the MaineHealth Access Foundation
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>7</td>
</tr>
<tr>
<td>Purpose and Organization of Report</td>
<td>9</td>
</tr>
<tr>
<td>I. Program Background and Program Design</td>
<td>10</td>
</tr>
<tr>
<td>II. Methods, Data Sources and Limitations</td>
<td>16</td>
</tr>
<tr>
<td>III. Enrollee Profile</td>
<td>23</td>
</tr>
<tr>
<td>IV. Provider Profile</td>
<td>46</td>
</tr>
<tr>
<td>V. Program Performance</td>
<td>64</td>
</tr>
<tr>
<td>VI. Lessons from CarePartners and Elsewhere</td>
<td>80</td>
</tr>
<tr>
<td>Table of Figures</td>
<td>88</td>
</tr>
<tr>
<td>Appendices</td>
<td>89</td>
</tr>
<tr>
<td>A: CarePartners Advisory Committee</td>
<td>89</td>
</tr>
<tr>
<td>B: Chart of Federal Poverty Rates (FPL)</td>
<td>94</td>
</tr>
<tr>
<td>C: MaineHealth Description</td>
<td>95</td>
</tr>
</tbody>
</table>
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. We thank Maureen Booth and Andy Coburn at the Institute for Health Policy at the Muskie School for reviewing multiple drafts of this report.

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, Executive Director of the Foundation, for her dedication to expanding access to health care in Maine.

The views and opinions 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 of Maine, 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 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 serving 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. The program was originally designed under a one-year planning grant from the Robert Wood Johnson Foundation, and was subsequently awarded a three-year implementation grant, as one of ten national sites of the Foundation’s Communities in Charge program. As of 2005, CarePartners is funded through a combination of public and private sources.

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:

- 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.

- Costs and service utilization rapidly decrease for those who remain in the program more than one year and continue to decline by 18 months. We attribute this to access to care management, pharmacy benefits, and the assignment of a regular PCP.

- Pharmacy benefits require considerable resources which CarePartners has been able to sustain precariously 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.
o 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.

As this report is being finalized, CarePartners is once again adjusting its program and policies in response to public and private market forces as it has done since 2001. Earlier this year, program staff assumed that CarePartners would no longer be needed due to the expansion of Maine’s Medicaid program and the introduction of DirigoChoice. Instead, increasing demand has caused CarePartners to expand to its provider capacity limits, and as a result, the program has reluctantly established enrollment limits and waiting lists.
Purpose and Organization of Report

This report results from a grant awarded by the Maine Health Access Foundation (MEHAF) to CarePartners in 2003. This report reviews program characteristics and performance of the four years since the program began. We focus special attention on components that are unique to this program, specifically, care management and the pharmacy benefit. Reviewing program initiation, development, and evolution leads to conclusions about essential features necessary to develop and sustain an enhanced uncompensated care program. We hope that organizations interested in replicating the program in other regions in Maine or other states will find this report useful.

The paper is organized into six sections:

- Program Background and Design explains eligibility criteria, enrollee responsibility, and service areas.
- Methods, Data Sources and Limitations includes the key questions, details the data sources, and explains the limitations of the report.
- Enrollee Profile - this section provides vignettes of typical CarePartners enrollees, discusses the characteristics of the enrollee population, and describes care management services.
- Provider Profile – this section contains information on the payer mix of hospitals in the CarePartners network, the value of donated services by providers in each site and specialty, and the types of practices in which participating PCPs reside.
- Program Performance – this section includes per member per month analyses, analyses of long term enrollees, and detail of the pharmacy benefit.
- The Lessons section explores conditions necessary to be in place prior to implementing an enhanced donated care program, factors influencing success, and challenges relevant to rural areas.
I. Program Background and Design

A. Program Background

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. Rather than having emergency room and tertiary care services available as a last resort, the stakeholders wanted to explore ways in which primary healthcare and prevention could be available to uninsured Mainers. Many group members were frustrated over the lack of viable national or state strategies to address the problem of health care access and felt strongly about crafting an approach that could offer a concrete, if only partial, solution.

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. The committee’s charge was to explore how free care could be re-configured in the primary service areas to be more rational and more easily navigated. While MaineHealth’s service area includes the ten counties of southern, central, and western Maine, three regions within the larger service area were ultimately included: Kennebec and Lincoln counties and Greater Portland. (Please refer to Appendix A for more information about MaineHealth and Appendix B for a list of the CarePartners Steering Committee members).

With funding from a planning grant from the Robert Wood Johnson Foundation, the committee studied safety net systems in place in other states and contacted national health care experts to examine models of uncompensated care that serve the needs of other communities. The group also contracted for a survey to understand better the level of uninsurance, the service needs, and other characteristics of the uninsured populations in the service areas identified for this initiative.\(^1\) A telephone survey conducted in the Spring of 2000, under the auspices of the Muskie School for Public Service, University of Southern Maine, revealed that 82% of the uninsured and sporadically insured populations in the service areas were between the ages of 19 and 64. Those under age 18, and under 200% FPL, generally had coverage through the SCHIP (States’ Children’s Health Insurance Program) of Medicaid; those over age 65 were covered by Medicare. The percentages of uninsured residents in the target areas of Cumberland, Kennebec, and Lincoln counties were 10%, 14%, and 18%, respectively; another 6%-8% of residents reported they had been sporadically insured.

Based on this information 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.

In addition to hospital providers, other community-based, private practice health care providers, many of whom had regularly provided uncompensated care, were invited to participate in the program. The CarePartners program began enrolling individuals in June 2001. Funding from the initial three-year grant from the Robert Wood Johnson Foundation was supplemented by MaineHealth, the lead hospitals, the Bingham Program, and other funders.

B. Program Design

This section provides a brief overview of the characteristics and benefits of the CarePartners program. Many of these features, such as provider services, enrollee responsibilities and other program service areas, are discussed more thoroughly in the Enrollee Profile and Provider Profile sections of this report.

An important feature of the CarePartners program is its flexibility. This feature is evident both in the overall program design, which has evolved in response to public and private market forces and from internal review and refinements, and in program implementation in each site. We will discuss the program features as originally developed and as they have changed.

**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. Retirement funds, second homes, recreational vehicles, and all bank account balances are counted toward assets. Assets are reviewed at the initial enrollment and at each subsequent re-enrollment.

**Enrollment length:** Enrollees enter CarePartners for six month periods. After that time they may re-apply and, if eligible, they will be enrolled for another six month period. There is no maximum enrollment limit.

**Enrollment caps:** In 2002, finding that the supply of providers in Lincoln County could not sustain a higher enrollment in that region, that site set a limit of 80 enrollees. In the summer of 2005, for the first time since the program’s inception, greater Portland and Kennebec County sites introduced a limit on the number of enrollees in each site. Considering its high ‘churning rate’ (enrollment/disenrollment/re-enrollment), these two sites determined that they could not sustain more than 460 enrollees in Portland and 500 in Kennebec County at any given time.
These caps were introduced in response to the rapid increase in applications to CarePartners resulting from a change in the MaineCare program. In the Spring of 2005 MaineCare announced that it would no longer enroll applicants in its eligibility category of the childless adult population with incomes at or below 100% of FPL (non-categoricals). (While current enrollees in this MaineCare benefit are not being disenrolled, it appears to be a first step in phasing out this eligibility category).

**Income limits/other program eligibility:** Applicants are eligible for CarePartners if their income is less than 175% of the federal poverty level (FPL). (Please refer to Appendix C for past and current FPL levels). 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.

CarePartners was originally designed to provide comprehensive health care services to uninsured or under-insured adults with incomes less than 150% of the federal poverty level (FPL). In October 2002, CarePartners expanded its income eligibility from 150% to 175% of FPL in response to the State of Maine’s expansion of MaineCare eligibility to include childless adults with income of 100% FPL or less. This eligibility group is referred to as the ‘non-categoricals’. Most states do not offer coverage to this population or to parents of children covered in Medicaid. MaineCare has covered both groups and due to budget constraints, it stopped enrolling the childless adult group.

**Private health insurance availability:** Initially, applicants were ineligible for CarePartners if private health coverage was available to them through an employer, union or though another family member. In the Spring of 2003, in response to findings from the Michigan enrollee survey and feedback from intake staff, CarePartners modified its policy regarding applicants who are eligible for private health insurance coverage. 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. This 5% rule also applies to DirigoChoice premiums and deductibles. DirigoChoice is a new insurance product, developed and sponsored by the State of Maine, which became available to individuals in 2004.

**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. However, specialty and ancillary services available in each region are largely a function of both the supply of providers available in that region and a subset of those providers who choose to participate in the program by donating their services. For example, Lincoln County has a lower supply of PCPs and fewer specialists than other regions and, consequently, fewer specialty services are available to enrollees in that area.

Dental services and over-the-counter medicines are not provided through the program.

**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 program through which pharmaceutical companies provide free medications. This is a cumbersome process requiring substantial paperwork for both the enrollee and the CarePartners staff.

Enrollees must obtain a referral for specialty services from their PCP or through the care manager. If enrollees obtain services from any provider who is not enrolled in the CarePartners network, the enrollee is responsible for the charges.

At the time of the initial enrollment and at each re-enrollment, enrollees must complete a health status self-assessment and provide updated financial information including copies of bank statements, employment pay records, income tax returns, etc.

**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 Healthcare 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 program manager, assistant manager, 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, staff is comprised of the following:

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

<table>
<thead>
<tr>
<th>Region</th>
<th>Care Managers</th>
<th>Pharmacy Technicians</th>
<th>Intake Coordinators</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kennebec</td>
<td>2.0 FTE</td>
<td>2.0 FTE</td>
<td>2.0 FTE</td>
<td>6.0 FTE</td>
</tr>
<tr>
<td>500 enrollees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lincoln</td>
<td>0.3 FTE</td>
<td>0.6 FTE pharmacy technician/intake</td>
<td>0.9 FTE</td>
<td></td>
</tr>
<tr>
<td>80 enrollees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portland</td>
<td>1.9 FTE</td>
<td>1.5 FTE</td>
<td>1.9 FTE</td>
<td>5.3 FTE</td>
</tr>
<tr>
<td>460 enrollees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4.2 FTE</td>
<td>4.1 FTE</td>
<td>3.9 FTE</td>
<td>12.2 FTE</td>
</tr>
</tbody>
</table>

Each site’s staffing is slightly different according to enrollees needs and the local environment, not only in terms of the number of enrollees served, but also with respect to space and shared funding. For example, Portland staff are dedicated to and funded entirely from the CarePartners program and are located near other local social service agencies, not in a medical facility. Whereas staff in both the Kennebec and Lincoln sites are housed in either the lead hospitals in those regions or within large practices. Those sites tend to combine services and funding for their staff. In Kennebec County there are six care managers who are partially funded from CarePartners; they represent three full time equivalent (FTE) positions and provide services to patients from other programs in addition to CarePartners enrollees.

Please note that though there are four physical sites, the two in Kennebec County (Augusta and Waterville) are usually combined when reported. Both are supported by MaineGeneral Medical Center and only when analyses show variation are they reported separately in this report.
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. The pharmacy costs of the program have climbed steadily, despite use of free pharmacy programs from pharmaceutical companies, and rose to $481,000 in FY 04. Administrative costs, including salaries and expenses associated with program staff, care managers, intake coordinators, and pharmacy technicians for all four sites, amount to approximately $770,000 per year.

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.

Program Expectations

CarePartners was designed to meet the needs of a small population, in the relevant hospital service areas, that falls between public and private coverage programs. By managing uncompensated care, introducing primary care to this population, and promoting healthy behaviors, the program expects to improve patient outcomes for this population until such time that a more comprehensive or universal program is available to people at these income levels.
II. Methods, Data Sources, and Limitations

The workplan, outlined in the 2003 proposal to the MaineHealth Access Foundation (MeHAF), served as a guide in structuring this program review. The key questions that will be answered by this report include:

- How do CarePartners’ key strategies (linkage with a PCP, access to comprehensive care and pharmaceuticals and care management) affect cost and utilization over time?

- What variations exist in the three sites: Portland (urban), Lincoln County (rural), and Kennebec County (an urban/rural mix)? Variations in enrollee and provider participation, cost, and utilization will be explored.

- How have environmental factors influenced the CarePartners program development over the past four years? Environmental factors include state, federally funded and sponsored programs and costs of services, including pharmaceuticals.

- What are the primary challenges of operating and expanding an enhanced uncompensated care program?

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 enrollment, 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.

Unfortunately, not all practice providers submit proxy claims, feeling that donating their services is sufficient and not wishing to burden their staff with additional paperwork. CarePartners staff estimate that approximately 25% of PCPs do not submit claims for CarePartners enrollees. However, they believe that 100% of hospital claims and claims from specialists are submitted.
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 an 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. We analyzed these data to identify any variations in self-assessment reports by sites and for enrollees who remain in the program for multiple enrollment periods.

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.

The author obtained approval from the institutional review board (IRB) at the University of Southern Maine to conduct interviews with key informants and care managers. A CarePartners staff enrollee interviewed enrollees and provided written transcripts that were used for this report.

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.3

3 Ibid.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Description/Method</th>
<th>Comments/Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Length</td>
<td>CarePartners’ enrollment database</td>
<td>CarePartners staff capture enrollment length of individuals by site and by year. This measure shows the longest continuous enrollment of individuals.</td>
<td></td>
</tr>
<tr>
<td>Most Prevalent Diagnoses of CarePartners Enrollees</td>
<td>Claims data reports from Martin’s Point Informatics</td>
<td>Number of enrollees diagnosed and treated with each condition in each study year. Enrollees treated for multiple conditions appear in each condition. Also included is the total accumulated 4 year total cost of donated services for each condition.</td>
<td></td>
</tr>
<tr>
<td>Self-Reported Health status of Enrollees</td>
<td>CarePartners’ Assessment database</td>
<td>We identified enrollees who had three consecutive assessments during any point in time during the 4 years. We include their self reports for the 1st and 3rd assessments (month one and month 13 of continuous enrollment).</td>
<td>Tobacco use self reports show bias in reporting: enrollees first report that they do not use tobacco, then report that they have stopped using it.</td>
</tr>
<tr>
<td>Tobacco Use of CarePartners Enrollees</td>
<td>CarePartners’ Enrollment database</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reasons for Disenrolling</td>
<td>CarePartners’ Disenrollment database</td>
<td>These data are captured by CarePartners staff at the time of disenrollment from the program.</td>
<td></td>
</tr>
<tr>
<td>Current Insurance Status Post Enrollment</td>
<td>2005 Enrollee Exit Survey</td>
<td>CarePartners staff conducted this telephone survey 3 months after enrollees exit the program.</td>
<td></td>
</tr>
<tr>
<td>Payer Mix of Inpatient Charges 2000-2004</td>
<td>Maine Health Data Organization (MHDO) provided these data from audited financial statements submitted by Maine hospitals</td>
<td>Payer mix for 5 years of inpatient charges are shown for all hospitals in Maine (statewide) and compared to hospitals in the CarePartners network.</td>
<td></td>
</tr>
<tr>
<td>Payer Mix - Inpatient Charges: CarePartners Network Hospitals, 2004</td>
<td>MainHealth</td>
<td>Inpatient charges for CarePartners network hospitals (Inland, Maine General, Maine Medical Center, Mercy, Miles, and St. Andrews hospitals) are compared to statewide totals for 2004.</td>
<td></td>
</tr>
<tr>
<td>Payer Mix - Outpatient Charges: CarePartners Network Hospitals, 2003</td>
<td>Maine Health Data Organization (MHDO) provided these data from audited financial statements submitted by Maine hospitals</td>
<td>Payer mix for 5 years of inpatient charges are shown for all hospitals in Maine (statewide) and compared to hospitals in the CarePartners network.</td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>Data Source</td>
<td>Description/Method</td>
<td>Comments/Limitations</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Value of Medical Services Donated to CarePartners Enrollees CY01-04</strong></td>
<td>Claims data reports from Martin’s Point Informatics</td>
<td>We identified and compared the donated hospital services with the professional and ancillary services for calendar years 2001-2004.</td>
<td></td>
</tr>
<tr>
<td><strong>Value of Donated Hospital Services for All Sites, CY 01-04</strong></td>
<td>Claims data reports from Martin’s Point Informatics</td>
<td>The value of donated hospital services for calendar years 2001-2004 is shown for the seven hospitals in the CarePartners network. The graph shows the value in each year and the cumulative total for 4 years.</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Participation in CarePartners by Site</strong></td>
<td>Census, Maine Board of Licensure, CarePartners provider database</td>
<td>This table shows the distribution of licensed and enrolled providers by geographic region. We used current census reports for the population figures.</td>
<td></td>
</tr>
<tr>
<td><strong>Practice Sizes of PCPs in CarePartners by Region</strong></td>
<td>CarePartners provider enrollment database</td>
<td>We identified the practices in which CarePartners PCPs work. This graph shows the distribution of CarePartners providers by practice size and by region.</td>
<td></td>
</tr>
<tr>
<td><strong>Value of Donated Primary Care Services CY 01-04</strong></td>
<td>Claims data reports from Martin’s Point Informatics</td>
<td>We identified the claims submitted by PCPs and analyzed them by region and by year.</td>
<td></td>
</tr>
<tr>
<td><strong>Value of Selected Donated Services (Series)</strong></td>
<td>Claims data reports from Martin’s Point Informatics</td>
<td>We sorted claims by specialty providers’ claims to show the value of donated specialty services for the program and for each of the sites.</td>
<td></td>
</tr>
<tr>
<td><strong>Enrollees in Need of Services Appropriate referrals</strong></td>
<td>CarePartners 2003 and 2005 provider survey results. PCPs and specialists respond to these surveys.</td>
<td>In 2003 this was conducted as a mailed survey; in 2005 it was web-based. In both years the survey was administered by CarePartners’ staff to all providers in the network. In 2003 there were 111 responses; in 2005 144 providers responded.</td>
<td>Small number of survey responses in each year limit these findings.</td>
</tr>
<tr>
<td><strong>Concerns of Providers Providers’ Overall Satisfaction</strong></td>
<td>CarePartners 2003 and 2005 provider survey results. PCPs and specialists respond to these surveys.</td>
<td>In 2003 this was conducted as a mailed survey; in 2005 it was web-based. In both years the survey was administered by CarePartners’ staff to all providers in the network. In 2003 there were 111 responses; in 2005 144 providers responded.</td>
<td>Small number of survey responses in each year limit these findings.</td>
</tr>
<tr>
<td><strong>Average Per Enrollee per Month Costs (Series)</strong></td>
<td>Claims data reports from Martin’s Point Informatics</td>
<td>PMPM (per member per month) costs for CY 2001 – 2004 are presented in this series. Professional, ancillary, outpatient and inpatient costs for the program total and for each site are presented.</td>
<td>Also shown is a rate for a commercially-insured population (Maine Partners) for comparison purposes.</td>
</tr>
<tr>
<td>Measure</td>
<td>Data Source</td>
<td>Description/Method</td>
<td>Comments/Limitations</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>--------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>ER Visits per 1,000 MM (HEDIS)</td>
<td>Claims data reports from Martin’s Point Informatics</td>
<td>Using HEDIS requirements of 11 months of continuous enrollment was not possible, due to the short length of stay in the program. To capture a sufficient number of observations, we identified rolling averages over a two year period.</td>
<td>National HEDIS benchmarks for Medicaid and commercial populations are also included.</td>
</tr>
<tr>
<td>Hospital Discharges per 1,000 MM (HEDIS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Inpatient LOS (HEDIS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMPM Medical Costs for CarePartners Enrollees Enrolled for at least 18 mos.</td>
<td></td>
<td></td>
<td>Also shown is a rate for a commercially-insured population (Maine Partners) for comparison purposes.</td>
</tr>
<tr>
<td>Pharmacy: Value of Free Medications vs. Real Costs FY02-04 (Series)</td>
<td>CarePartners Pharmacy database</td>
<td>This series of measures shows the total pharmacy cost for enrollees for three years. We compared the value of free medications obtained through the free pharmacy programs with the pharmacy costs CarePartners pays from institutional budget and grant sources.</td>
<td></td>
</tr>
<tr>
<td>Average PMPM Prescription Cost CY 03-04</td>
<td>Claims data reports from Martin’s Point Informatics</td>
<td>We analyzed pmpm prescription costs from claims for each region and for the total program.</td>
<td>Also shown is a rate for a commercially-insured population (Maine Partners) for comparison purposes.</td>
</tr>
<tr>
<td>PMPM Pharmacy Costs for CarePartners Enrollees Enrolled for at least 18 months</td>
<td>CarePartners Pharmacy database</td>
<td>We captured pmpm costs for enrollees who were enrolled for 18 continuous months anytime since the beginning of the program. If enrollees were enrolled longer, we captured only the first 18 months. Costs are plotted over the 18 months.</td>
<td></td>
</tr>
<tr>
<td>2004 Administrative Expenses Compared to Medical and Pharmacy Costs</td>
<td>Bureau of Insurance website, CarePartners budgets, claims data from Martin’s Point Informatics</td>
<td>CarePartners’ program administrative expenses, including care management, are compared to the value of medical and pharmacy services donated to CarePartners. Also included are administrative ratios for Aetna, Cigna, and Maine Partners, taken from the Bureau of Insurance website.</td>
<td>In kind contributions from Anthem and from Martin’s Point Informatics for enrollee cards and for claims processing are not included in the CarePartners’ administrative cost.</td>
</tr>
</tbody>
</table>
Limitations of this Report

The reader should be aware of a number of limitations of data and methods in this report, including:

- Data are available in different formats and encompass different time periods. Some participating hospitals report data on a fiscal year basis; other data are reported by calendar year. All claims data analyses for this report are by calendar year.

- Small numbers of observations limit the report in two ways; the overall number of enrollees at any one time is relatively small (1,000). The number of continuously enrolled participants is very small given the “churning” (enrollment/disenrollment and re-enrollment) that typically occurs among individuals whose income is near MaineCare eligibility levels. The relative short length of stay in the CarePartners program limits our ability to conduct robust analyses. Specifically, HEDIS (Health Plan Employer Data Information Set) analyses require 11 months of continuous enrollment. In order to capture a sufficient number of observations over time, we adapted this method by developing ‘rolling averages’ of CarePartners enrollees.

- Likewise, in developing a cost analysis comparing enrollees who had remained in the program for at least 18 months to an external population, we identified all enrollees who were continuously enrolled for 18 months beginning at any point in time during the study years (2001-2004). Using this method we were able to capture 396 observations; however, these participants were enrolled over a broad timeline which may limit conclusions.

- Clinical data were not available for analysis for this population. Therefore, we cannot draw any conclusions about the quality of care or outcomes when reviewing cost and utilization patterns.

- As discussed in the section above, CarePartners estimates that PCP claims are underreported by 25%. This rate was estimated by comparing enrollee assignments with providers. Most analyses in this report, based on claims data, co-mingle specialty and PCP claims together as “Professional and Ancillary.” Only a few analyses distinguish PCP services from all provider services. In the PCP-specific analyses we note and inflate reported claims amounts to accommodate for this underreporting.

- Data from enrollee self-assessments show evidence of social desirability bias. For example, some enrollees initially report they do not use tobacco products and, after subsequent assessments, report that they would like to learn about smoking cessation programs or they report they have stopped using tobacco. Self-assessment data are also limited during certain time periods in the early stages of the program when data were inadvertently overwritten and rendered unusable.
o Enrollee satisfaction reports should also be viewed with caution. Recipients of donated or low cost services are generally reluctant to appear to be critical of services they depend upon for their healthcare.

o Despite intense efforts to obtain provider feedback by increasing the number of responses to provider surveys, the small number of responses to these surveys limit the dependability of the findings. The 2003 mailed physician survey yielded 111 responses; 144 providers responded to the web-based survey conducted in 2005. This represents approximately 17% of the (854) providers enrolled in the program.
III. CarePartners Enrollee Profile

Interspersed in this section are vignettes taken from interviews with CarePartners enrollees. These profiles are included to convey the personal circumstances, needs, and challenges of typical CarePartners enrollees that can go unnoticed in data tables and graphs.

Sarah

Sarah is a 53 year old single woman living in Kennebec County who works part time at a factory when she is able. She has been enrolled in CarePartners for two non-contiguous six month enrollment periods; she was covered by MaineCare in between the CarePartners coverage. She has never had private health insurance and has been on and off MaineCare over the past seven years, always in a ‘spend-down’ mode. She guesses that she has been a self-pay patient ‘more often than not’ over the past five years, except for her four hospitalizations, which have all made her eligible for MaineCare coverage. At the time of the interview, Sarah was expecting her CarePartners membership to be canceled again because she would have met her MaineCare spend down deductible.

Sarah has kidney disease, high blood pressure, high cholesterol, depression, ‘heart blockages,’ and diabetes. She worries that she will need femoral bypass surgery. A recent hysterectomy for uterine cancer is likely to make her eligible for MaineCare coverage again. It was upon her discharge from the hospital after the hysterectomy that administrators referred her to the CarePartners program.

Access to medications is her primary reason for joining CarePartners; she reports only having taken medications in the past when she could obtain samples from her physicians. Previously, she used her credit cards to the maximum limit to pay for medications, but could no longer sustain that. She was usually not able to obtain antidepressants, high blood pressure medications, and beta blockers. She had always been able to get samples of her kidney medication through her doctor’s office.

Sarah is happy that she has been able to reduce her cigarette consumption from three packs per day to two cigarettes per week and hopes to eliminate the habit altogether. Sarah reports that she needs the services of the CarePartners care manager ‘to motivate’ her. The care manager organizes provider appointments, obtains medications and diabetic supplies, and completes the vast amount of paperwork that Sarah cannot manage herself. When we asked Sarah how she had managed her health affairs previously she said, ‘I’d sit and wait for things to happen.’
Demographics

The following table shows descriptive characteristics of this population.

**Table 3. CarePartners Enrollees’ Demographic Characteristics**

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

For most characteristics there is little variation among the four sites, though there are slightly more males and more widowed/divorced/single enrollees in the Greater Portland area in 2003 and 2004 than in other regions. Self-employment is slightly higher in Lincoln County with 9% of those enrollees reporting self-employment in 2004. Lincoln County enrollees also have a higher rate of no income source; in 2003 and 2004, 20% and 16%, respectively reported having no income.

Ten percent of enrollees report income from Social Security sources in 2004, reflecting increased effort of CarePartners staff to assist enrollees in obtaining other sources of support. The slight increase in the average total household income in 2003 and 2004 is a result of the increase in the eligibility from 150% to 175% FPL which occurred in late 2002.

Demographic and employment data were captured on 300 new enrollees to CarePartners through a survey conducted by University of Michigan researchers and sponsored by the Robert Wood Johnson Foundation. Interviews took place between November 2001 and June 2002. Those findings are consistent with the table above but provide further detail.
### Table 4. CarePartners Enrollee Survey 2001-2002

<table>
<thead>
<tr>
<th>2001-2002 Survey Data Demographic Characteristics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollees who had no health coverage in the past year</td>
<td>53%</td>
</tr>
<tr>
<td>Enrollees who never had any health insurance</td>
<td>15%</td>
</tr>
<tr>
<td>Source of health coverage for the 73% of respondents who had any coverage:</td>
<td></td>
</tr>
<tr>
<td>Employer or union sponsored insurance</td>
<td>57%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>16%</td>
</tr>
<tr>
<td>Enrollees who were born outside the U.S.</td>
<td>3%</td>
</tr>
<tr>
<td>Enrollees who are homeowners</td>
<td>43%</td>
</tr>
<tr>
<td>Enrollees reporting employment</td>
<td>50%</td>
</tr>
<tr>
<td>Average hours worked (among workers)</td>
<td>32</td>
</tr>
<tr>
<td>Workers with 2 or more jobs</td>
<td>13%</td>
</tr>
</tbody>
</table>

Source: University of Michigan Survey

### Where Do Enrollees Come From?

In 2004, approximately half of the enrollees were those who had re-enrolled in the program. More than a quarter of applicant referrals to CarePartners originated from Maine’s Department of Health and Human Services that year. 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.

However, in the beginning of the program, initial enrollment happened very differently at each site. In Kennebec County, enrollees were largely transferred from a similar program, called the MATCH (Mansfield Access to Community Health) program, that was supported by MaineGeneral Hospital. These new enrollees continued to receive services from the same provider. Lincoln County applicants, many of whom had not had any health insurance coverage or a regular source of care, enrolled at that site very quickly, so quickly that it reached capacity within 12 months.

In Portland uptake was somewhat slow. Despite evidence from the pre-program survey of elevated levels of uninsurance and a high need for services in this area, few applicants enrolled in the first year. Though there is high demand for uncompensated care services, there are also more free care providers in Portland than in other regions. CarePartners is a program that offers comprehensive services, but also requires certain responsibilities on the part of enrollees. Responsibilities such as using the services of a PCP and paying the $10 co-pay for an office visit, rather than having an inappropriate (and free) visit to the ER, may be considered negligible. However, prospective enrollees in Portland who had other options were slow to enroll. Portland staff intensified their marketing efforts and full enrollment occurred in 2004.
The table below shows the number of enrollees served by the program in each of the four years. The unduplicated counts of enrollees indicate re-enrollment by participants.

Table 5. CarePartners Enrollees by Site, by Year, and Unduplicated

<table>
<thead>
<tr>
<th>Site</th>
<th>Served by Care Partners</th>
<th>Total Unduplicated Enrollees Ever Served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001</td>
<td>2002</td>
</tr>
<tr>
<td>Kennebec-Augusta</td>
<td>307</td>
<td>371</td>
</tr>
<tr>
<td>Kennebec-Waterville</td>
<td>353</td>
<td>413</td>
</tr>
<tr>
<td>Portland</td>
<td>100</td>
<td>282</td>
</tr>
<tr>
<td>Lincoln County</td>
<td>59</td>
<td>108</td>
</tr>
<tr>
<td>Total</td>
<td>819</td>
<td>1,174</td>
</tr>
</tbody>
</table>
How Long Do Enrollees Stay in the Program?

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

Figure 1. Enrollment Length of CarePartners' Enrollees
CY 01-04, N = 2,186

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. Portland enrollees tend to remain in the CarePartners program for a shorter period; 33% exit the program after 6 months and 36% leave after 11 months. Enrollees in Lincoln and Waterville stay enrolled for slightly longer periods of time.
What are Enrollees’ Unmet Needs?

Uninsured adults are more likely to have delayed 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. This is consistent with a survey of new enrollees conducted in the early stages of the program by University of Michigan researchers who found that 53% of enrollees reported having at least one limiting condition upon enrolling in CarePartners.

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. This analysis shows most frequently treated conditions and includes multiple conditions for patients with multiple unmet needs. For example, in the graph below, it is possible that many of the 273 enrollees treated for mental illness may also be among the 225 enrollees treated for diabetes (endocrine disorders) in 2004.

An Institute of Medicine study found that clinical outcomes for five conditions (diabetes, cardiovascular disease, end stage renal disease, HIV infection, and mental illness) were consistently worse for uninsured adults than for insured adults.\(^5\) Three of the five conditions are on the CarePartners enrollees’ most prevalent condition list, suggesting higher treatment costs for enrollees with these conditions.

Bone and joint condition has consistently been the most reported unmet need and the most treated condition in each of the four program years. In the graph below, a total of 1,099 enrollees have been treated for bone and joint disorders by CarePartners providers since the inception of the program (167, 352, 235, and 345 enrollees in CY 01, CY 02, CY 03, and CY 04, respectively). The total cost for treating those 1,099 enrollees was $1.4M.

Though cardiovascular disease is the lowest of the top ten diagnoses, with a total of 503 enrollees treated for it over the four program years, the total cost is one of the highest, $1.2M. The program profile section of this report provides further discussion of costs.


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.
How Do CarePartners Enrollees Perceive their Health Status?

Enrollees complete self-assessments of their health status at the time of the initial enrollment into the program and also at each re-certification every six months. The following graphs show the self-reports of enrollees who have remained in the program for at least two six-month enrollment periods and who completed a third assessment at the thirteenth month, the beginning of the third period. Please note the small number of observations in each region.

The most dramatic change is seen in Lincoln County where initial reports show that 20% of enrollees were in poor or fair health and, after a year of receiving coordinated services, only 8% remained in poor health.

Enrollees in Kennebec County also reported a reduction in poor health status, though more moderate, from 35% to 31%. However, the 306 continuously enrolled individuals in Kennebec appear to have the lowest health status overall, both in terms of the highest (31%) reporting poor or fair and the lowest (29%) in excellent or very good health.
Portland enrollees, in initially poor health upon entering the program, show no improvement after a year of health care services. In fact, fewer report excellent or very good health after this period. This may reflect difficulty in managing chronic diseases and multiple health concerns that have not been addressed previously by consistent health care services.

For comparison purposes, it is interesting to note the self-reported health status of uninsured adults, age 18-64, from the national behavioral risk factor surveillance survey (BRFSS).\textsuperscript{6} For those who were uninsured for a year or more, 45% reported excellent or very good health, 35% reported to be in good health, and 20% were in poor or fair health. CarePartners enrollees in Lincoln County compare favorably with these reports. However, enrollees in both Kennebec and Portland sites report lower status even after 12 months of enrollment.

What is the Tobacco Use Rate?

Smoking status is also asked at each re-enrollment period. Overall, the self-reported smoking status rate for all enrollees upon entering the program is 37% (N=1,221). This is more than ten points higher than the overall Maine state rate of 23.6% in 2004.7

Below are the results of initial and third assessment reports by actual numbers of persons reporting. Note that reports of never having used tobacco increase by the third enrollment in each region. For example, in Kennebec County, 132 of the 306 enrollees who re-enrolled at the 13th month reported that they had never smoked, whereas only 123 of the same 306 enrollees stated that they had never smoked 13 months earlier, with the remainder reporting former or current tobacco use. These results show evidence of social desirability bias. For example, enrollees may report having recently stopped using tobacco in the second assessment, after having reported never using it in the first assessment. This underscores both the unreliability of self-reports of health behaviors and the difficulty in addressing the subject of smoking cessation.

Staff at all sites refer applicants (whether enrolled or not) to the State’s Tobacco Helpline; enrollees who report using tobacco are also referred to the Helpline, sometimes more than once.

Figure 4. Tobacco Use of CarePartners Enrollees
Change between 1st and 13th month of enrollment

---

Warren

Two years ago Warren, age 47, moved to Portland from New York City where he had been a cab driver for the past 17 years. His wife works part time at a child care facility here. He would like to work as a professional driver in Maine but has been unable to look for work due to health problems. He also failed the Maine driver’s license exam once and hopes to take it again soon.

He has never had health insurance; none of the companies he worked for provided health insurance and he could not afford insurance on his own. He was not eligible for any type of assistance through New York state because his income was too high. Though he was eligible for a sliding fee payment for a hospitalization in New York for which he still owes $25,000 for 50% of that bill.

In Portland he accessed free care programs from different clinics and had a three day hospital stay for ‘heart trouble’ where he qualified for that hospital’s free care program. Subsequently, a free clinic referred him to CarePartners due to the worsening condition of the ulcers on his feet that had not been treated for some time. Various providers and free clinics had provided him with samples for the five medications he needs and also with vouchers to purchase blood sugar test strips and lancets for his insulin. If the clinic did not have samples of his high blood pressure medications or could not provide vouchers for diabetic supplies, he went without. He ‘maxed out’ a credit card to purchase his insulin and he re-used syringes.

Diabetes, high blood pressure, and ‘mental health concerns’ are among Warren’s current health issues. Just after enrolling in CarePartners, his complications with the ulcers on his feet required short term hospitalization followed by six weeks of bed rest upon discharge. Warren now receives free medications through the Patient Assistance Programs (PAP) of various pharmaceutical companies that CarePartners helps him coordinate.

He reports having had significant problems obtaining durable medical equipment and over-the-counter supplies, such as post-surgical bandages. His CarePartners care manager has tried numerous agencies and worked with his home health care providers but still has not been able to resolve this issue to date. He also needs follow-up services from a podiatrist; however, there are no podiatrists participating in the CarePartners program in Portland.

Warren has cancelled medical appointments because he could not walk to the bus stop due to the condition of his feet and he could not afford a taxi. He changed his PCP to one who is more accessible to him. He generally relies on public transportation and his CarePartners care manager has helped him to obtain RTP transportation and other social services.

Improving his nutrition to address his diabetes was difficult before working with the care manager. He and his wife were in the habit of going without food for one week per month, after the monthly budget was depleted, and before his wife’s payroll check was available. The CarePartners care manager subsequently identified soup kitchens and food pantries that could provide food for them during this period.

Looking to the future, Warren would like to work, but knows he is unlikely to obtain employment with health insurance. He is worried that if he gets a job he will no longer qualify for CarePartners and will lose access to health care services and the medications that he says, “keep me alive.”
Do New Applicants Have a Regular Source of Care?

In 2001 and 2002, the first two years of the program, 100% and 97%, respectively, of new enrollees reported having a PCP in the CarePartners network prior to joining the program. This is not surprising as many of the enrollees in Kennebec County had migrated from the MATCH program, the precursor of the CarePartners program, and many PCPs in Portland and Lincoln County had recruited their current patients to CarePartners.

However, after a few years of enrollment churning, in 2003 and 2004, approximately two-thirds of enrollees reported having a PCP in the CarePartners network upon enrolling in the program. This group may largely represent participants who learned of the program from their health care provider. In these two years 10% of enrollees reported having a PCP outside of the CarePartners network.

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. People who have not had the benefit of regular health care may also have more difficulty navigating health care services and understanding program rules and health care terminology. Lack of regular health care can also be a contributing factor to elevated service utilization. Greater Portland has the highest proportion of enrollees without a medical home; in 2003 and 2004, one third of enrollees did not have a usual source of care prior to enrolling in CarePartners.
**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. All enrollees, whether previously receiving services through MaineCare or private insurance, would need orientation to CarePartners program rules and procedures. Initially, one care manager position was identified for each site; now the effort varies according to need with one site requiring two full time equivalent positions and another site requiring a part time position.

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.

To document the care management function, we interviewed an enrollee with relatively complex needs in each site and then interviewed his or her care manager. The reports from both enrollees and care managers from all sites were remarkably similar despite the variation in enrollee need and differences in local service areas. Enrollees require assistance in four general areas:

- program requirements,
- liaison with providers,
- education, disease management, and social service referrals, and
- medication logistics.

New enrollees entering the program who have significant needs, due to a catastrophic illness and/or a personal crisis, and who did not previously have comprehensive health coverage, require intensive care management initially. After both medical and social services are in place and the enrollee receives medications for treatment, that intensity often diminishes. However, the need for care management can be prolonged for a variety of reasons including the following:

- low literacy,
- low health care language literacy,
- confusing system for obtaining medications and supplies when multiple medications are needed,
- stress from their illness or life situation inhibiting understanding of the program requirements, particularly for patients with depression.
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.

Assistance with Program Requirements
New enrollees, who previously had no usual source of care, may have been referred to
CarePartners after being diagnosed with a life-threatening illness or their chronic
condition worsened to the point where they were prompted to seek care. Whatever the
initial reason, enrollees need assistance from care managers to navigate services and the
program including:

- Identifying a PCP if they do not already have one
- Ensuring that referrals are to specialists included in the CarePartners network
- Understanding visit and pharmacy co-payments
- Applying to the pharmacy benefit programs
- Understanding appropriate use of emergency and urgent care services
- Re-certifying for CarePartners re-enrollment after 6 months of enrollment or to
another program if eligible. (Intake coordinators provide this function at some sites).

Assisting enrollees with the CarePartners re-application process involves review of
enrollees’ financial status and assistance with applications to other programs when
appropriate. The care managers often work with enrollees who may be eligible for
MaineCare benefits by assisting with spend down calculations and with completing the
MaineCare application. Some care managers report accompanying CarePartners
enrollees to the Department of Health and Human Services office to assist with the
completion of the application process.

Liaison with Providers
Establishing a new enrollee with a PCP and working with the provider’s office staff to
explain the features and requirements of the CarePartners program are also
responsibilities of the care managers. They assist provider offices in procuring
medications from the pharmacy programs for enrollees. When specialty services are
necessary, care managers coordinate referrals to ensure that the specialty provider is
within the CarePartners network.

If specialty services are needed and no specialist is available in the network, the care
manager will work with the enrollee to explain the circumstances and encourage the enrollee
to obtain the recommended service, though it cannot be covered through the program.

Education, Disease Management, and Social Service Referrals
CarePartners care managers educate enrollees on healthy behaviors, particularly smoking
cessation, and the importance of exercise and good nutrition. In 2004 they began
providing disease management for enrollees with diabetes and depression. In 2006 they
will expand their education and disease management to target enrollees with asthma and
with obesity.
They provide enrollees with resource information about state and local social services and community supports. Resources include basic assistance that might be needed by enrollees such as fuel assistance programs, domestic abuse services, food pantries, soup kitchens, housing assistance programs, or transportation services.

Some care managers are able to refer enrollees to local facilities with which they have arranged for free or reduced rate exercise programs or other services unique to the service area. They also research specific enrollee needs; for example, when an enrollee needed a nebulizer, a care manager researched local suppliers and found a re-conditioned nebulizer, and worked out a payment plan between the vendor and the enrollee. As one enrollee put it, “My care manager works with me on paperwork for things like MaineCare and SSDI. She’s helped me access medications, supplies, assistance with my electrical bills, heat, help with getting my water heater fixed as well as doctor appointments and specialist appointments, but I guess the doctor piece is part of her job.”

Medication Logistics
Enrollees report a high need for a regular, dependable source for medications, often referring to them as ‘life savers.’ Care managers each report that most of their time is spent on medication-related issues with enrollees. The high cost of medications, the unmet needs of this population, and the combination of available resources make obtaining medications a complicated task. Patient Assistance Programs (PAPs) offered by pharmaceutical companies can have dramatic affects on both the financial viability of an enhanced free care program and on enrollees’ ability to acquire costly medications. However, they do not come without a cost.

The following scenario is not unusual. It illustrates the variability in provision and delivery of free medications through the various PAPs of different pharmaceutical companies and it illustrates the importance of the care manager in assisting enrollees with obtaining medications. After gathering the information from the pharmacy technician and the providers offices, a care manager might write out instructions for the enrollee explaining that he/she should obtain:

- medication #1 from provider X who has samples for that particular drug, but only for a 1 month supply
- medication #2 from the local drug store using her CarePartners card and a $15 co-payment for a 2 month maximum supply
- medication #3 from the local drug store using her CarePartners card and a $25 co-payment for a one week maximum supply
- medication #4 from the local drug store using a coupon from the manufacturer’s pharmacy program for a 3 month supply
- medication #5 would be mailed directly to her house via another manufacturer’s pharmacy program; it would be a 60 day supply and it would be renewed in 50 days
medication # 6 would be mailed to provider XX via another manufacturer’s pharmacy program; supply amount unclear - the enrollee should check with that provider,

medication # 7 is available as a generic through ‘Anthem Direct’ for a 3 month supply for which she should pay $5.

When an enrollee has low literacy and/or when he or she is confused due to side effects of certain medications or due to a lack of medications, the care manager might review this information several times until the enrollee is clear about how to obtain all needed medications.

The care manager also works with the enrollee to ensure that he/she understands the change when a name-brand drug, which the enrollee has been using, is replaced by a generic that becomes available or if any source of the medications is changed. Enrollees are often reluctant to obtain medications for which they must pay out of pocket costs; though co-pays range from $5 to $25, this expense may compete with other necessities of life including food or transportation. Care managers emphasize the importance of taking all medications prescribed and encourage enrollees to obtain all medications and take them as directed.

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 that 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.’
How Satisfied are Enrollees?

As with many satisfaction surveys of low cost or public plans, the CarePartners enrollees express virtual unanimous satisfaction with the program, stating repeatedly how much they depend on it and how the program has helped them. Approximately 300 enrollees completed the mailed survey in each of the last three years.

The 12-item survey includes a list of statements about accessing care, understanding program rules and general satisfaction with the program. Enrollees are asked the degree to which they agree or disagree with these statements. Responses range between ‘agree’ and ‘strongly agree’ to every question with very little variation in the three years the survey has been conducted. Respondents nearly unanimously agree that CarePartners staff treat them with courtesy and respect. They also agree, though to a lesser extent, that they understand how to obtain their medications and how the pharmacy benefits. There is no variation in the responses from the four sites or over the three years the survey has been conducted.

The survey also asks for comments and suggestions. Most respondents comment on their appreciation of the services, though a few make suggestions that the program should offer dental services or provide medical equipment. Some comment on their personal circumstances. Below are a few selections:

- I hesitated to enroll because I was afraid to feel humiliated – I’m glad to say the staff was wonderful and did not make me feel uneasy at all.

- This has been a very challenging time in my life and the support I have received through CarePartners has not only allowed me to keep up with important health issues, it has also provided a buffer so that I can finally hold enough together as I work on self-sufficiency again.

- CarePartners allowed me to get treatment when I needed it, not when I could afford it.

- This is an excellent, necessary program for those of us who work but cannot afford healthcare. If there is a question as to its continuing, I would suggest adding a larger co-pay, rather than lose the program.

Disenrollment: Where Do Enrollees Go?
CarePartners staff contact enrollees toward the end of each enrollment period to remind them of the need for re-certification to remain in the program. Enrollees who become eligible for other programs or whose income has increased, disenroll from the program at this time.

The graph below 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%. Very few enrollees exited because they no longer met the residency requirement. The percentage of enrollees leaving because their income exceeded the program limit increased from 6% to 10% in the past two years. The portion representing ‘failed to re-enroll’ should be interpreted with caution. There is often a lapse between enrollments or they may not have re-applied because they knew their income had increased over the limit or they had obtained other coverage.

Figure 5. Reasons for Disenrolling from CarePartners

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, in the summer of 2005, CarePartners staff began surveying enrollees three months after exiting the program. They suspected that this would be sufficient time for the person’s health coverage status to have stabilized. The results from those interviews are presented below.

**Figure 6. Current Insurance Status of Disenrollees**

2005 Exit Survey N=273

<table>
<thead>
<tr>
<th>Reason for Disenrolling</th>
<th>Currently has coverage</th>
<th>Currently does not have coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private ins. eligible</td>
<td>17%</td>
<td>2%</td>
</tr>
<tr>
<td>Income increased</td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td>Public program eligible</td>
<td>44%</td>
<td>2%</td>
</tr>
<tr>
<td>Don't need/ moved/other</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Forgot/plan to re-enroll</td>
<td>5%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Reasons for Disenrolling**

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. Some expressed frustration that they were only a few dollars over the threshold. Of the 6% (n=17) who obtained insurance after exiting because their income increased, two had obtained DirigoChoice insurance.

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.

**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:

### Table 6. CarePartners Enrollee Household Budget

<table>
<thead>
<tr>
<th>Income:</th>
<th>Expenses:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment income $1,196.25</td>
<td>Rent $500.00</td>
</tr>
<tr>
<td>Net after deductions 1,016.81</td>
<td>Utilities $265.00</td>
</tr>
<tr>
<td><strong>Total monthly income $1,016.81</strong></td>
<td>Transportation $59.50</td>
</tr>
<tr>
<td>Assets:</td>
<td>Medication co-pays:</td>
</tr>
<tr>
<td>Checking Account: $112.47</td>
<td>Glucophage $5.00</td>
</tr>
<tr>
<td><strong>Total Assets:</strong> $112.47</td>
<td>Zoloft $15.00</td>
</tr>
<tr>
<td></td>
<td>Enalapril $5.00</td>
</tr>
<tr>
<td></td>
<td>Atenolol $5.00</td>
</tr>
<tr>
<td></td>
<td>Combivent $15.00</td>
</tr>
<tr>
<td></td>
<td>Lovastatin $5.00</td>
</tr>
<tr>
<td></td>
<td>Food 110.00</td>
</tr>
<tr>
<td></td>
<td>Physician co-pays 30.00</td>
</tr>
<tr>
<td><strong>Total expenses:</strong> $1,014.50</td>
<td><strong>Net expenses/income:</strong> $ 2.31</td>
</tr>
</tbody>
</table>

This enrollee accesses food pantries to augment her food budget. Her income makes her eligible for Group B of DirigoChoice; in 2005, that category included a $500 deductible and provided an 80% discount on monthly premiums. A typical premium is $290 per month, requiring the applicant to pay $58 per month. It appears that this subsidy level will continue in 2006, though the rate increase is not known at present.

Enrollees with incomes over 175% of FPL, or $1,395 per month gross income, are not eligible for re-enrollment in CarePartners. Staff work with disenrollees to identify other options. There are at least three issues of concern for typical CarePartners disenrollees when assessing possible enrollment in DirigoChoice:

- Enrollment of individuals (i.e., not in employer plans) filled up very quickly and DirigoChoice froze enrollment for individuals. The efforts of CarePartners’ staff to refer disenrollees to DirigoChoice in 2005 were hampered by this freeze.
- The deductible for DirigoChoice is a barrier. DirigoChoice Group B (101%-150% FPL) is $500. The enrollee in the example above would likely not be able to provide this amount. CarePartners disenrollees, with income at 175%
of FPL, would fall in Group C (151% - 200%); the deductible for that group is $800.

- DirigoChoice requires payment of the full premium - $290 in the case above. The subsidy is provided to DirigoChoice enrollees in the form of a debit card. Though the subsidy is credited to the debit cards the same day the premium is paid, many people at this income level have not had experience using debit cards and they are skeptical of them. Without any other assets, the individual above would essentially use her rent money to temporarily pay the full premium before receiving the subsidy through the debit card. This proves to be a great leap of faith for people with limited incomes.

### Carole

Carole is 39 and recently enrolled in CarePartners in Lincoln County having had employer sponsored health insurance for nine years before she was forced to stop work due to illness.

She has diabetes, high blood pressure, vision problems including cataracts, nerve damage in her hands, and kidney disease. She had had laser surgery on both eyes which caused additional damage and she no longer has peripheral vision. She reports that diabetes is her primary health concern; she is also ‘having difficulty with tendons in both hands’, but she was not able to find a specialist in the CarePartners network and cannot afford to pay for services otherwise.

Carole has never had MaineCare coverage and, as a recent uncompensated care patient, she had accessed critical health care services, but was not able to obtain medications or diabetic supplies to keep her conditions under control. Like Sarah, Carole also notes that medications and medical supplies for her diabetes, including a new insulin pump, are the primary advantages to participating in CarePartners. Unlike Sarah, Carole is able to make her own medical appointments and obtain other social services that she needs. She sees her diabetes specialist every three months and her kidney specialist once a year. Carole relied on the CarePartners care manager to assist her with handling previous medical bills that she could not cover. The care manager also worked out a payment plan for Carole with a non-network optometrist so that she could obtain eyeglasses.

While Carole sees this as a temporary health crisis situation, it is unclear whether she will be able to regain work as a bank teller and once again have access to employer-sponsored health insurance.
IV. 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 practices delivering care to enrollees, provides regional variation of services, and presents 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.

First, to put into context where the CarePartners program fits in the landscape of Maine uncompensated care programs, the graph below shows the proportionate charges for uninsured inpatient care in Maine hospitals. The graph reflects experiences in 2000, the year before the CarePartners program began. The portion of uncompensated inpatient care inched down from 3% in 2000 to 2% in 2004 in all Maine hospitals, most likely due to Medicaid eligibility policy changes.

In 2004, uncompensated care amounted to $38.8M (2%) of the $2.3B of all inpatient hospital charges in the state. Of that $38.8M, $14.1M, or 36%, was recorded for hospitals in the CarePartners network for services provided to uninsured Mainers, including those enrolled in CarePartners. Of that $14.1M in uncompensated care delivered by CarePartners network hospitals, $2.6M was delivered to CarePartners enrollees.

It is important to note that the value of the charges for uninsured patients is greater than that of other payers. Medicare, Medicaid, and private payers pay a discounted rate for charges for all hospital services, whereas charges for uninsured patients, including CarePartners enrollees, are recorded at full cost.
Hospitals providing services to CarePartners enrollees track very closely over the five study years in the total proportion of uncompensated care; with the exception of 2003, 2% of total inpatient charges was generated by the uninsured, whether CarePartners uninsured, or other uninsured Mainers. In 2003, only 1% of all charges was attributed to uninsured patients in CarePartners network hospitals.
Compared to the CarePartners composite payer mix, a much wider 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.
Figure 9. Payer Mix: Outpatient Charges for Hospitals in the CarePartners Network, CY 2003

Payer mix for outpatient charges shows a larger proportion of uninsured, reflecting services provided by emergency and urgent care units. CY 2004 data are not available. However, for CY 2003, (two years after implementation of CarePartners) 4% of the $1.8B in all outpatient charges in Maine hospitals ($71M) was recorded for uninsured Mainers. Almost a quarter of those charges, $17M, was recorded at CarePartners network hospitals for uninsured patients, including CarePartners enrollees. Maine Medical Center shows the lowest portion of federal and state-funded payers, while St. Andrews shows the highest, 28% and 52% respectively.

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 four years of the program, $8.2M was provided by network hospitals and $4.4M was provided by professional and ancillary providers.

**Figure 10. Value of Medical Services Donated to CarePartners Enrollees, $12.6M, CY 01-CY 04**

($8.2M Hospital Services and $4.4M Professional Services)
The graph below shows that MaineGeneral Medical Center (MGMC) provided nearly $5M through its two hospitals in Augusta and Waterville. The impact of the transfer of enrollees from MaineGeneral’s MATCH Program, the precursor of CarePartners, is particularly evident in 2001 and 2002. While other sites in Lincoln County and Greater Portland had a slower ramp-up to enrolling patients in the program, MaineGeneral’s MATCH program enrollees were transferred to CarePartners, creating a ready-made pool of initial enrollees.

In 2004, Maine Medical Center (MMC) provided more than $800,000 in services, 20% of all hospital donated care during the four study years, and a cumulative total of $1.6M. Miles, Mercy, Inland, and St. Andrews hospitals have provided a cumulative portion of 9%, 5%, 3%, and 2% respectively.

In 2003 both MaineGeneral and Miles hospitals showed a decline in donated services from the previous year; this may reflect a decline in enrollment that may be due to the increase in MaineCare eligibility that occurred at the end of 2002. Maine Medical Center, however, increased the value of services it provided from $247,500 in 2002 to $435,559 in 2003, and then almost doubled that amount in 2004. This may be due to the slow start up experienced in the greater Portland site that was followed by intensive marketing efforts. Both of these trends are repeated in the Value of Donated Primary Care Services later in this report.
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.

Sixty-three percent, or 854 of the 1,361 licensed primary and specialty providers, are enrolled in the CarePartners network; 40% of the MDs and DOs in Lincoln County, 55% in Kennebec County and 66% of providers in Greater Portland. Provider participation is in direct proportion to the demand for providers in each region. Portland has both the largest per capita number of physicians and the highest CarePartners participation rate. Lincoln County has the lowest supply of physicians for that population, presumably the highest demand considering the limited number of providers, and the lowest participation rate (40%) in CarePartners. In addition to MDs and DOs, 38 nurse practitioners in the three regions, serve as primary care providers (PCPs) to CarePartners enrollees.

Table 7. Provider Participation in CarePartners by Site

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

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.

A number of factors are considered when assigning enrollees to providers; most important is maintaining any prior relationship an enrollee may have had with a provider. Often, a patient may lose Medicaid or private insurance coverage, enroll in CarePartners, and the same PCP will continue to provide services to the patient under the auspices of CarePartners. The payer, or in this case, the coordinator of services, may change but the continuity of care to the patient is not interrupted. Otherwise, if a new enrollee does not have a regular source of care, the care manager will assign him or her to a PCP who is available in the CarePartners network.
The graph below 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.

Practices with 20 or more physicians in Portland, Augusta, and Waterville, make up 5% of the total number of practices and nearly half (46%) of the practices involved in CarePartners have between two and five physicians.
**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 in the graph below from the original value of donated care of $944K from submitted claims to $1.180M to reflect this underreporting.

**Figure 13. Value of Donated Primary Care Services CY 2001-2004**

*Includes Family Practice and Internal Medicine*

Submitted Claims = $944,000; Estimated total = $1.2M

<table>
<thead>
<tr>
<th>Site</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portland</td>
<td>$61,211</td>
<td>$86,831</td>
<td>$157,956</td>
<td></td>
</tr>
<tr>
<td>Lincoln</td>
<td>$31,545</td>
<td>$92,119</td>
<td>$77,366</td>
<td>$63,996</td>
</tr>
<tr>
<td>Augusta</td>
<td>$33,056</td>
<td>$85,070</td>
<td>$60,571</td>
<td>$144,471</td>
</tr>
<tr>
<td>Waterville</td>
<td>$32,323</td>
<td>$89,601</td>
<td>$68,444</td>
<td>$83,397</td>
</tr>
</tbody>
</table>

In 2004, Portland-based PCPs provided $158,000 in services to the 460 enrollees in the greater Portland area. In Lincoln County, $64,000 in primary care services was provided to the 80 enrollees in that region. Kennebec County, with 17 practices in Waterville and 9 practices in Augusta, provided services to approximately 500 enrollees in 2004.

Note that the value of donated services in Lincoln County was the highest of any other site in 2002. This is an indication of the pent-up demand in that region which had the highest rate of uninsurance at the start of the program. Exceeding provider capacity, this site subsequently imposed an enrollment cap of 80 enrollees in order to sustain the program.

The previously noted trends for hospital services in the Kennebec and Portland sites are repeated here. Kennebec experienced a reduction in 2003 due to the effect of MaineCare eligibility on that population; while Portland’s marketing and outreach efforts came to fruition with steady enrollment in 2003 and 2004.
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. 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. The graph below 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.

Topping the list of services shown is laboratory and pathology with a cumulative value of $339,000 ($59,000, $102,000, $71,000, and $107,000 in years 2001, 2002, 2003, and 2004). The high level of services provided by cardiologists, orthopedics, gastroenterologists, etc. corresponds to the unmet needs of the enrollee population. Donated mental health services appear to be low; most mental health services are provided through outpatient services and are not reflected here. As with all data reported from proxy claims in this report, the accuracy of the data is dependant upon the claims that providers submit and we suspect that some specialists underreport, though the number and amount are unknown.

---

The following 3 pages (Figures 15-17) show the donated specialty services in Kennebec, Lincoln, and Portland in the same format regardless of whether services are donated in all categories. Please note the difference in scales and the lack of services in Lincoln County compared to both Kennebec County and Greater Portland where more providers are available and the difference in donated specialty services.
Figure 15. Value of Selected Donated Services Kennebec County, CY 2001-04 (Excludes Hospital, Radiology, GP and Rx)

<table>
<thead>
<tr>
<th>Service</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab. &amp; Pathology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthal&amp;Optometry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Otolaryngology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oncology/Hematology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery/Dental</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nephrology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Total                    | $221,568 | $185,588 | $141,733 | $103,307 |

CarePartners: Opportunities and Challenges • MaineHealth
Figure 16. Value of Selected Donated Services, Lincoln County:
CY 2001-04 (Excludes Hospital, Radiology, GP, and Rx)

- Anesthesia: $133,254
- Lab. & Pathology: $21,215
- Cardiology: $29,016
- Orthopedics: $8,133
- Neurology: $24,053
- Gastroenterology: $5,671
- General Surgery: $13,231
- Ambulance: $7,334
- Ob/Gyn: $213
- Ophthalmology: $3,560
- Neurosurgery: $0
- Home Health Care: $1,514
- Otolaryngology: $197
- Pulmonary Medicine: $7,474
- Oncology/Hematology: $2,880
- Other Providers: $1,340
- Physical Therapy: $0
- Mental Health: $0
- Plastic Surgery: $180
- Rheumatology: $1,293
- Dermatology: $790
- Podiatry: $0
- Physical Medicine: $0
- Medical Equipment: $1,620
- Allergy: $0
- Oral Surgery/Dental: $0
- Chiropractor: $0
- Nephrology: $0
- Urology: $0
- Emergency Medicine: $0
Figure 17. Value of Selected Donated Services, Portland: CY 2001-04
(Excludes Hospital, Radiology, GP and Rx)

- Anesthesia: $381,611
- Lab. & Pathology: $132,566
- Cardiology: $80,909
- Orthopedics: $126,101
- Neurology: $75,659
- Gastroenterology: $63,580
- General Surgery: $30,779
- Ambulance: $34,981
- Ob/Gyn: $12,049
- Ophthalmology: $20,212
- Neurosurgery: $0
- Home Health Care: $615
- Otolaryngology: $9,513
- Pulmonary Medicine: $14,551
- Oncology/Hematology: $31,670
- Other Providers: $12,264
- Physical Therapy: $21,173
- Mental Health: $11,988
- Plastic Surgery: $9,659
- Rheumatology: $11,204
- Dermatology: $8,408
- Podiatry: $6,143
- Physical Medicine: $0
- Medical Equipment: $335
- Allergy: $2,964
- Oral Surgery/Dental: $4,435
- Chiropractor: $3,057
- Nephrology: $4,676
- Urology: $534
- Emergency Medicine: $336

CarePartners: Opportunities and Challenges • MaineHealth
What Do Providers Say?

Physicians voiced concerns about reimbursement levels in general, and donated care in particular, in both provider interviews and in provider surveys. Whether salaried and part of a large practice or providing service in a single practice, physicians report feeling the pinch of insufficient Medicare and Medicaid reimbursement rates, increasing demands of payers and patients, and ‘burn out’ resulting from the escalating complexity of the healthcare bureaucracy.

Any program that basically relies on the good will of providers and practices to donate time and resources for the greater good runs the risk of relying too heavily on those providers known for their good will. Some providers suggest that if the program were broader-based and everyone ‘did their fair share’, the effort would be more evenly distributed and, thus, more sustainable. However, the conundrum is that largely it is the continuity of the medical home that is the deciding factor in PCP assignment. Though there is a need to spread the effort fairly, patients who lose their private health insurance or MaineCare coverage should not be further penalized by having to change from their long term providers.

Survey Results

In early 2005 CarePartners staff designed a web-based survey hoping to increase feedback from providers. In 2003, 111 providers had responded to a mailed survey. Unfortunately, the increase in 2005 was not significant. The results presented here should be interpreted with caution due to the small number of respondents.

Of the 854 providers in the network (including 300 active PCPs), 144 providers with the following characteristics responded:

- 80 PCPs, 55 specialists, 9 practice managers submitted responses
- More than twenty specialties were represented among the specialists, the largest portion, 20%, was obstetrics/gynecology
- 40% of responses each came from Kennebec County and Portland; the remaining 20% were providers in Lincoln County
- 48% saw CarePartners enrollees in their private, group practice sites; 14% were single private practice providers
- 38% did not know the number of CarePartners enrollees they served; 20% of respondents served more than 10 CarePartners enrollees; 25% had between 4 and 10 enrollees in their practice
- More than half had provided services to CarePartners enrollees for more than two years.
The majority of providers (70%) agree or strongly agree that enrollees are in need of their donated services. The percentage who were not sure rose slightly from 2003 to 2005, however, these providers also stated that they were unaware of the payment or insurance status of their patients.

Specialists also report they agree on the appropriateness of their services for CarePartners enrollees as seen in the graph below. Fifty eight percent agree or strongly agree that referrals to their services are appropriate.

We asked providers their opinions on the appropriateness of both MaineCare eligibility and CarePartners eligibility. The majority (57%) felt that CarePartners was “about right” in terms of eligibility criteria, while a smaller percentage, 40%, felt that MaineCare had appropriate eligibility. Those who did not think MaineCare eligibility was positioned appropriately, largely felt income criteria were too low.
Providers reported their concerns with the provision of care to CarePartners enrollees. Specifically, they reported on the intensity of problems of certain patient behaviors. Behaviors included adhering to care or medication plans, understanding benefits, keeping appointments, and inappropriate use of emergency services. Few reported that they have a ‘big problem’ with any enrollee behaviors. The largest problems had to do with adherence issues; 25% reported that patient adherence to care plans was a big or medium size problem, 20% reported adherence to medication plans was a big or medium size problem.

More providers reported that keeping appointments in the ‘not a problem’ category (37%), than any other behavior.

![Figure 20. Concerns of CarePartners Providers about Enrollees](image)

We asked PCPs their opinions about accessing specialty services for CarePartners enrollees. Approximately one third had trouble finding a specialist or getting an appointment with a specialist. Fewer respondents had difficulty with the timing or efficiency of the process.

When asked about care management services provided by CarePartners, 42% of respondents reported those services were good or excellent. Practice staff would likely be more familiar with the role of care managers, so it is not surprising that a large portion of providers (45%) did not know about these services. However, more providers were aware of the prescription assistance provided by the CarePartners staff. Eighty-four percent were aware of this service and 68% reported this service to be excellent or good.
In terms of overall satisfaction with CarePartners, there appears to be a decrease in the percentage of those satisfied or very satisfied with the program from 2003 respondents. Fifty-eight percent report this level of satisfaction in 2005, while in 2003, 68% reported this level of satisfaction. There was an increase in those who feel neutral during the same period. These may be respondents who previously reported they were not aware of which of their patients were in CarePartners and which were not.

![Figure 21. Providers' Overall Satisfaction with CarePartners Program](image)

Though 58% express satisfaction, fewer providers (47%) would recommend the program to another provider. But providers are more positive when asked if they would recommend the program to other eligible patients; 62% reported that they would. We might conclude that they think the program is good for patients, but not as good for providers. It may also reflect lower satisfaction physicians have reported when providing care to people with chronic conditions. A study conducted by Mathematica Policy Research found that 54% of physicians were very satisfied providing care to general patients while only 36% were very satisfied providing care to patients with chronic conditions.9

---

V. CarePartners Program Performance

This section reviews the overall program performance and compares costs and utilization with state and national benchmarks. A closer look at the pharmacy costs provides further detail on the challenges of that benefit.

**Donated Care and Per Enrollee Per Month Costs**

The graph below shows the value of all services donated to CarePartners enrollees over the past four years, with the exception of the pharmacy benefit. These values are used in calculating the per member per month costs in this section.

![Figure 22. Value of Medical Services Donated to CarePartners Enrollees, $12.6M, CY 01-CY 04: ($8.2M Hospital Services and $4.4M Professional Services)](image)

The following graphs show the per member per month cost for the entire program and also for each of the three counties. 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.\(^\text{10}\)

Please note that in the following graphs, some analyses by site contain few member months and observations which can cause skewing due to small numbers.

**Figure 23. Average Per Member Per Month (PMPM) CarePartners Costs by Service Category and Year, CY2001-2004, All Sites**

- Member months increased from 3,522 in 2001 to 9,782 in 2004.
- Member months rose from 2001 to 2002 and then dipped in 2003, reflecting the expansion of Medicaid (MaineCare) that occurred in late 2002.
- 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.
- Enrollees receive both primary and specialty services in outpatient units of hospitals and from participating providers who donate their services. These services are reflected here as ‘outpatient’ and ‘professional and ancillary’. Taken together, there is little variation over the four years of the program. In 2001 and 2004 they equal $275.
The slower enrollment start-up the Portland site experienced in 2001 and 2002 is reflected in this graph; only 367 member months are included in the first year.

Service trends in 2003 may reflect the eligibility increase from 150% to 175% of income on this subgroup which occurred in late 2002.

2004 shows the highest enrollment (3,783 member months) for this site.

Pmpm costs for both inpatient and outpatient are below the program average for most years.
2001 per member per month costs reflect the fact that enrollees in MaineGeneral’s MATCH program transferred directly to CarePartners in 2001; note the relatively high member months in the first year of the program.

The decrease in member months and in costs in 2003 may reflect the transfer of CarePartners enrollees to the MaineCare non-categorical benefit.
The CarePartners planning survey in 1999 showed that Lincoln County had the highest uninsured rate and the highest reported unmet needs. Higher than average costs in 2001 and 2002 reflect the high level of services this site experienced for new enrollees with pent-up demand.

The Lincoln County site introduced an enrollment cap of 80 enrollees in 2002 in response to the high pmpm at this site.

Costs remained at higher than average levels for the first three years of the program, reducing to average levels in 2004.

Note that the higher outpatient costs and lower than average professional costs reflect the fact that this site has limited access to community-based providers and primarily utilizes services of hospital-based providers.
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. HEDIS quality measures (such as quality of diabetes care or asthma medication use) use clinical data which is not available to us for the CarePartners population. Therefore, we chose utilization measures (length of hospital stay, emergency room use, and hospital discharge rates) which we could analyze using CarePartners claims data.

Using HEDIS measures provides measures that are consistent over time and that can be compared to other populations including national HEDIS benchmarks for both commercial and Medicaid populations. The benchmarks developed by the National HEDIS Benchmarking Project\(^{11}\) (NHBP) represent the national average of all plans reporting on a particular measure. The 2002 Medicaid and commercial HEDIS benchmarks used in the following graphs were developed with data from 163 comprehensive at-risk plans that enroll Medicaid beneficiaries in HMOs and PCCM programs and 306 plans that primarily enroll privately insured enrollees in 33 states.

HEDIS specifies 11 months of continuous program eligibility for enrollees to be included in the analysis. HEDIS also requires the use of data sources from a combination of record reviews and claims. Because CarePartners enrollees have a relatively short length of stay in the program and in order to capture a sufficient number of enrollees for analysis, we adapted the methodology to include the highest number of enrollees continuously enrolled on a twelve-month rolling average basis. Another limitation of this analysis is the data source; claims data are used exclusively.

Each of the three measures shows reduced utilization over time. We would like to attribute this 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 is defined as ER visits that did not result in an admission.

In a survey conducted at the beginning of the CarePartners program development, 80 per 1,000 surveyed enrollees reported that the ER had been their usual source of care.

The graph above shows that the CarePartners ER rate in June 2002 was 51.7 visits per 1,000 member months. After rising slightly in December 2002, it declined to 28.2 visits in December 2003 and rose slightly by June of 2004.

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.

There is little variation in ER rates among the four sites (not shown) with the exception of Lincoln County which has been consistently ten or more visits per 1,000 mm above the average. For example, in June 2004, Lincoln County’s ER rate was 50.2 visits per 1,000 mm. This may be a function of a smaller ‘n’ for this site; only 876 member months were captured.
The national commercial and the Medicaid benchmarks for this measure are very close, 9.3 and 9.5 per 1,000 member months, respectively.

The CarePartners hospital discharge rate is 15 discharges per 1,000 mm in June 2002. However, by June of 2003, the CarePartners discharge rate decreased and, at 6.3 discharges per 1,000 member months, is lower than both HEDIS benchmarks.

Examining site-level rates for this measure (not shown) does not indicate any consistent trends with the exception of the Portland site showing above average discharges for the last two periods, 10.5 and 8.8 discharges per 1,000 mm for December 2003 and June 2004.
The HEDIS commercial and Medicaid benchmark rates for this measure are very close, 3.6 and 3.7 days per 1,000 member months respectively.

At 4.6, the CarePartners average length of stay (ALOS) rate was a full day above both benchmarks in 2002. However, the rate decreased in June 2003 and subsequently increased. In June 2004 the CarePartners ALOS rate is just below both commercial and Medicaid benchmarks.

No consistent trends are indicated by reviewing site-level rates.

This measure may be more sensitive to small numbers variation than other measures. That is, one enrollee’s long hospital stay may be reflected in this rate and cause disproportionate skewing. CarePartners staff will continue to monitor these measures and evaluate their use.
What Happens to Costs When Enrollees Stay in the Program?

Several key informants interviewed for this report asked what we know about utilization of services for long term enrollees of this population and whether health care service use continues at high rates or levels off.

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. This cohort is comprised of 35% from Waterville, 28% from Augusta, 25% from Portland and 12% from Lincoln County. The mean age of the cohort is 50 years.

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). This illustrates that enrollees with high unmet needs enter the program, continue as high utilizers for the first nine months of enrollment, after which time the need for ongoing health care services levels off and decreases. We cannot track associated care manager services to these particular individuals; however, this trend line confirms reports from care managers regarding their services to enrollees. Care managers in each region report high initial needs, followed by a flurry of services, and, unless there is a chronic disease flare-up or another health crisis, a more moderate and consistent use of services.

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.

---

12 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.
A similar 18 month study of pharmacy use appears at the end of the next section.

**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. Success at sustaining this costly benefit has resulted largely from aggressively accessing free medication programs of pharmaceutical companies. Anthem Prescription Management of Anthem Blue Cross and Blue Shield manages the pharmacy benefit, as it has done since the inception of the program. Machigonne Benefit Administrators (a subsidiary of Anthem Blue Cross and Blue Shield) donates the provider claims processing and other important services. 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. Each of the 26 companies CarePartners works with has different application and dissemination rules and processes that can take several months. However, once all the requirements have been satisfied and a patient has been approved, the benefit generally may be renewed for extended periods of time. As discussed in the Enrollee Profile section in this report with respect to care management services, this support on behalf of enrollees does not come without substantial staff time and effort.

The graph below shows the results of that staff effort: the proportion of free medications provided to CarePartners enrollees compared to medications the program provided as a direct program expense. In fiscal year 2004, of the $1,642,627 in pharmaceuticals delivered to enrollees, $1,162,011 or 71%, was provided via free medications programs. The remaining $480,617 was supported through a combination of grant and operating funds. This represents 5,515 prescriptions from pharmaceutical companies and 10,637 prescriptions filled through the CarePartners benefit in FY 2004.

In FY 2002 and 2003 the proportion was similar, with 70% of $1,356,607 in total pharmacy expenditures coming from the free prescription program in 2002 and 74% of $1,211,320 in 2003. To calculate the real value of this benefit, one should reduce the value of the free pharmacy component by the amount of overhead required to generate it, namely, the salaries, fringe benefits and overhead associated with the four pharmacy technicians and at least half of the effort of the five care managers who support this benefit. *See Figure 31 next page.*
Variation in accessing free pharmacy benefits among the CarePartners sites is shown below. The two Kennebec County sites, Augusta and Waterville, have consistently provided approximately 80% of pharmacy benefits to their enrollees from donated sources. In FY04 9,156 prescriptions were filled for the approximately 500 enrollees in Kennebec County.

However, the Portland site, with its relatively short-term population, has not been able to take full advantage of the free prescription programs offered by pharmaceutical companies. The graph below shows that the proportion of free medications is little more than half of the total of $506,192 in FY 04. There are two reasons for this. Portland enrollees generally stay in the program for shorter periods than in Kennebec County; this more rapid ‘churning’ of enrollees limits this site’s ability to reap the benefits of PAPs.
For example, enrollees may have program-funded medications for two months, donated medications for four months, then exit the program. New enrollees enter the program and require program-supported medications again until their PAPs are approved. In addition, inconsistency of pharmacy technician staff performance contributed to low PAP application rates. Staffing issues have been corrected and rates in 2005 show improvement.

The Lincoln County site, with its enrollment cap of 80, has provided 1,656 prescriptions in FY 04 at a total cost of $148,000. Thirty-two percent, or $48,000 has been supported by the program and $100,000 from PAPs.

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.
The values in the graph below are taken from pharmacy claim costs paid by the CarePartners program. Also shown is Maine Partners pmpm pharmacy rate of $34.26, calculated on 26,000 covered lives in Maine.

With the exception of Kennebec County sites, pharmacy costs are above the Maine Partners’ benchmark for calendar years 2003 and 2004. The Portland site’s difficulty with accessing the PAP program for its enrollees has the effect of increasing per member per month costs above those of other sites. In CY 03, the pmpm cost was $85.47 and in CY 04 it declined to $69.83.

**Figure 35. Average per Member per Month (PMPM) Prescription Costs CY 2003 - 2004**

The rates in the graph above show results from all enrollees in each study year regardless of the length of enrollment. Data in the graph below (Figure 36, following page) answer the question: what happens to pharmacy program costs when enrollees stay in the program over time?

The graph below was developed with claims data from enrollees who were continuously enrolled for 18 months (please refer to Figure 30 for more on this methodology). Both the graph above and the graph below represent pharmacy costs to the program; the value of medications acquired through the free pharmacy programs is not included.

All pharmacy per member per month costs are well below the commercial benchmark for the entire duration of the enrollment period.

When enrollees obtain medications upon enrollment, they are charged directly to the program until the free pharmacy applications are approved. It is surprising that in the
first three months of the study period, the pmpm rate is not higher to reflect this temporary subsidy. Not all medications are available through the free pharmacy benefit and the pmpm costs during the 18 month study period increase slightly, reflecting increases in drug prices or increased medication use by this cohort.

Figure 36. PMPM Pharmacy Costs for CarePartners Enrollees Enrolled for at least 18 months (Submitted Claims) N=396
VI. LESSONS FROM CAREPARTNERS AND ELSEWHERE

After reviewing enrollee and provider profiles and trends in previous sections, this section of the report discusses a similar program in another state to illustrate differences in designs and approaches to safety net programs.

We review what has been learned from four years of CarePartners experience and offer suggestions that may be useful to other organizations in Maine or other states contemplating developing an enhanced uncompensated care program with a volunteer network.

How Do Other Hospital-Based Safety Net Programs Operate?

To gauge the effectiveness of CarePartners, several key informants interviewed for this paper asked for comparative data on similar safety net programs that are hospital-based and privately funded. Unfortunately, there are few safety net programs similar to CarePartners. Many programs use the model first developed by Project Access of Buncombe County, North Carolina, of drawing down municipal or county funds to provide short-term (often three month maximum) coverage for lapses in insurance coverage. Other safety net programs cover parents of children enrolled in SCHIP in states where that Medicaid benefit is not in place. Few are hospital-based, comprehensive, and similar to CarePartners.

One somewhat similar program is HealthLink, based in Lakes Region and Franklin hospitals in rural southern New Hampshire, in existence for more than five years when CarePartners was first developed. In the past five years the HealthLink program expanded in some directions and contracted in others; it now operates two programs. The Access Program is designed for persons without insurance and has a six month enrollment period with possible multiple re-enrollments and a churning enrollment of 875 enrollees. The Assist Program is designed for persons who are eligible for Medicare or who have access to private insurance, but cannot afford the premiums; that program has an enrollment of 375 members and is slightly more stable. Both programs are served almost exclusively by physician practices owned by the two hospitals. Care management is routine for Access members and available to the Assist members if needed.

While HealthLink serves persons up to 300% of the FPL, both programs require enrollees to pay graduated co-payments according to the following schedule:

<table>
<thead>
<tr>
<th>Co-Payment for all Outpatient Services</th>
<th>Federal Poverty Level (FPL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>101% - 185%</td>
</tr>
<tr>
<td>25%</td>
<td>186% - 200%</td>
</tr>
<tr>
<td>50%</td>
<td>201% - 250%</td>
</tr>
<tr>
<td>75%</td>
<td>251% - 300%</td>
</tr>
</tbody>
</table>
Pharmacy benefits in both programs were completely eliminated in the past year due to fiscal constraints. Neither program offers assistance with free prescription programs offered by pharmaceutical companies. Another economic streamlining measure was the reduction of enrollment staff and a change from one-on-one enrollment counseling to a mailed enrollment process and group sessions to orient new enrollees with program rules. HealthLink now operates with three care managers and two enrollment coordinators for its 1250 enrollees. Enrollment coordinators also recruit prospective enrollees in the ER after patients indicate inability to pay for services.

Many of HealthLink’s program challenges are similar to those of CarePartners:
- Managing the constant churning of enrollees
- Recruiting specialty physicians
- Maintaining the pharmacy benefit – which was eventually eliminated.

Unlike CarePartners, HealthLink’s primary challenge appears to be monitoring enrollee adherence to program requirements. Specifically, enrollees have difficulty complying with the graduated co-payment schedule.

HealthLink is one example of how many safety net programs have emerged and evolved with slightly different designs, tailored to the needs of the local provider and member communities.

**What Have We Learned in Four Years of CarePartners?**

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.\(^{13}\) 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. However, Patient Assistance Programs, designed differently by each pharmaceutical company, are inherently cumbersome and slow processes, regardless of any software used to complete the initial application.

Appropriate medications are integral to any patient care plan and likely unavailable to a safety net population without access to a subsidized pharmacy program. The benefits of free pharmaceuticals may outweigh staff and administrative effort; however, there is substantive variation in utilization of the free pharmacy programs from site to site. Enrollee length of stay, pharmacy needs, and staff attention to processing free pharmacy applications all affect this benefit. Any organization wishing to replicate a free pharmacy program would be wise to study this volatile process relative to a prospective population.

Case loads of 200 to 250 enrollees per care manager indicate the level of assistance provided to each enrollee. This is not an intensive case management program, rather it provides enrollees, some of whom are in greater need than others, with information, tools, and resources to obtain the care, medications, and services they need. By coaching enrollees on positive health behaviors, providing explanations of services, reminders, and follow-ups, these social workers facilitate access to services. Without this assistance, confusion with provider appointments, care plans, or medication logistics might lead to frustration and the lack of involvement on the part of providers, enrollees, or both.

Care managers report increased effectiveness when located at a practice site or inpatient setting where they have regular access to patients, providers, and electronic medical records. The latter is vital to all aspects of their jobs. Easy access to records showing the enrollees’ providers, prescriptions, and other pertinent information enables the care managers to facilitate appointments and provide support to enrollees and providers more efficiently and effectively.
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 develop the graph below were taken from financial reports available from the Bureau of Insurance.\(^{14}\) 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%.

---

\(^{14}\) Bureau of Insurance website: [www.state.me.us/pfr/ins/inshmo.htm#financial](http://www.state.me.us/pfr/ins/inshmo.htm#financial). Accessed October 18, 2005.
Going Forward

During the past four years, the MaineHealth system, hospitals, providers, payers, and foundations have donated real and in-kind resources to the program. Foundation support, earmarked specifically for start up programs, may no longer be available to CarePartners. However, funding from foundations with mandates to improve access or to enhance existing services may be an option. The principal hospitals associated with the program have provided support from core funds or earmarked special purpose funds for the past four years and there is an expectation that this will continue.

Recruiting new primary care providers to the program to relieve or rotate existing providers will be essential to reducing provider burnout. Expanding the specialty network is especially important given the unlikelihood that enrollees are able to afford out-of-pocket expenses for most specialty services. In discussions for this report some providers referenced a high level of effort they believed they were providing to enrollees, but this effort was not substantiated in the data. Acknowledging the contributions of providers’ time and services through periodic reports, which CarePartners has disseminated at least annually, should continue.

Such reports could also serve the purpose of clarifying issues with reporting donated services via claims data. CarePartners relies heavily on the good will of providers who donate their time and services and staff find it difficult to impose paperwork requirements. However, proxy claims form the basis of much of the program review, analyses, and decision making affecting the program. Staff estimate that approximately 25% of PCPs do not submit claims for their services. In addition to accurate administrative data, access to clinical data would be useful in measuring quality of care of enrollees. Administrative records are useful only for utilization analyses, whereas clinical metrics for diabetes care, for example, could be used to gauge severity of conditions and effectiveness of care. Clinical data may also be more dependable than claims data, considering the increased likelihood of reporting. Regardless of the type of data, if enrollee data are not dependable, staff will be unable to track, monitor, and make reliable improvements. (“If you can’t measure it – you can’t improve it”).

CarePartners’ use of enrollment caps provides program leadership with the ability to control enrollment as they monitor costs. The enrollment caps are fluid and tied to per member per month costs and budget availability. Each site has the ability to expand or contract enrollment as its budget allows, ensuring that each budget can sustain its enrollees.
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 would not be a donated care program. Nevertheless, in some areas where critical providers were not engaged until after substantive planning had already occurred, time and good will were jeopardized until this oversight was rectified.

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:

Table 8. Factors Influencing Uncompensated Care Program Design

<table>
<thead>
<tr>
<th>Influencing Design Factor</th>
<th>Greater Portland</th>
<th>Lincoln County</th>
<th>Kennebec County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply of PCPs</td>
<td>High</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Supply of Specialists</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Other Free Care Programs</td>
<td>High</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Demand of Population</td>
<td>Medium</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Organizational Capacity/Funding</td>
<td>High</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Hospital-based Programs in Place</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
</tr>
</tbody>
</table>

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 program similar to CarePartners.

Program design features are listed in the Program Background and Design section of this report. Many of the features, such as income eligibility thresholds, co-payments, enrollment periods, etc, were designed with sensitivity to local and state free care programs and to public programs.

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 Program 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, it 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.
# Table of Figures

<table>
<thead>
<tr>
<th>Figure No.</th>
<th>Title</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Enrollment Length of CarePartners’ Enrollees</td>
<td>28</td>
</tr>
<tr>
<td>2.</td>
<td>Most Prevalent Diagnoses of CarePartners Enrollees CY 2001-2004</td>
<td>30</td>
</tr>
<tr>
<td>3.</td>
<td>Self-Reported Health Status of CarePartners Enrollees</td>
<td>31</td>
</tr>
<tr>
<td>4.</td>
<td>Tobacco Use of CarePartners Enrollees</td>
<td>33</td>
</tr>
<tr>
<td>5.</td>
<td>Reasons for Disenrolling from CarePartners</td>
<td>41</td>
</tr>
<tr>
<td>6.</td>
<td>Current Insurance Status of Disenrollees</td>
<td>42</td>
</tr>
<tr>
<td>7.</td>
<td>Payer Mix: Inpatient Charges for Hospitals in the CarePartners Network and Statewide CY 2000-2004</td>
<td>47</td>
</tr>
<tr>
<td>8.</td>
<td>Payer Mix: Inpatient Charges for Hospitals in the CarePartners Network, CY 2004</td>
<td>48</td>
</tr>
<tr>
<td>9.</td>
<td>Payer Mix: Outpatient Charges for Hospitals in the CarePartners Network, CY 2003</td>
<td>49</td>
</tr>
<tr>
<td>10.</td>
<td>Value of Medical Services Donated to CarePartners Enrollees, $12.6M, CY 01-CY 04</td>
<td>50</td>
</tr>
<tr>
<td>11.</td>
<td>Value of Donated of Hospital Services for All Sites CY 2001-2004</td>
<td>51</td>
</tr>
<tr>
<td>12.</td>
<td>Practice Sizes of PCPs in CarePartners by Region = 300 providers</td>
<td>53</td>
</tr>
<tr>
<td>13.</td>
<td>Value of Donated Primary Care Services CY 2001-2004</td>
<td>54</td>
</tr>
<tr>
<td>14.</td>
<td>Value of Selected Donated Services for All Sites: CY 2001-04</td>
<td>56</td>
</tr>
<tr>
<td>15.</td>
<td>Value of Selected Donated Services Kennebec County: CY 2001-04</td>
<td>57</td>
</tr>
<tr>
<td>16.</td>
<td>Value of Selected Donated Services, Lincoln County: CY 2001-04</td>
<td>58</td>
</tr>
<tr>
<td>17.</td>
<td>Value of Selected Donated Services, Portland: CY 2001-04</td>
<td>59</td>
</tr>
<tr>
<td>18.</td>
<td>Provider Survey: Enrollees are in Need of My Services</td>
<td>61</td>
</tr>
<tr>
<td>19.</td>
<td>Specialists’ Assessment of Appropriateness of CarePartners Referrals</td>
<td>61</td>
</tr>
<tr>
<td>20.</td>
<td>Concerns of CarePartners providers about Enrollees</td>
<td>62</td>
</tr>
<tr>
<td>21.</td>
<td>Providers’ Overall Satisfaction with CarePartners Programs</td>
<td>63</td>
</tr>
<tr>
<td>22.</td>
<td>Value of Medical Services Donated to CarePartners Enrollees, $12.6M, CY 01-CY 04</td>
<td>64</td>
</tr>
<tr>
<td>23.</td>
<td>Average Per Member Per Month (PMPM) CarePartners Costs by Service Category and Year, CY2001-2004, All Sites</td>
<td>65</td>
</tr>
<tr>
<td>24.</td>
<td>Average Per Member Per Month (PMPM) Costs in Portland by Service Category, CY 2001-2004</td>
<td>66</td>
</tr>
<tr>
<td>25.</td>
<td>Average Per Member Per Month (PMPM) Costs in Kennebec County by Service Category, CY 2001-2004</td>
<td>67</td>
</tr>
<tr>
<td>26.</td>
<td>Average Per Member Per Month (PMPM) Costs in Lincoln County by Service Category, CY 2001-2004</td>
<td>68</td>
</tr>
<tr>
<td>27.</td>
<td>Emergency Room Visits per 1,000 Member Months (MM) All Sites — Twelve-Month Rolling Average</td>
<td>70</td>
</tr>
<tr>
<td>28.</td>
<td>Hospital Discharges per 1,000 Member Months (MM) All Sites — Twelve-Month Rolling Average</td>
<td>71</td>
</tr>
<tr>
<td>29.</td>
<td>Average Inpatient Length of Stay (ALOS) per 1,000 Member Months – All Sites — Twelve-Month Rolling Average</td>
<td>72</td>
</tr>
<tr>
<td>30.</td>
<td>PMPM Medical Costs for CarePartners Enrollees Enrolled for at least 18 months (Submitted Claims) N=396</td>
<td>73</td>
</tr>
<tr>
<td>31.</td>
<td>Pharmacy: Value of Free Medications vs. Real Costs FY02-04, Source: CarePartners Pharmacy Data</td>
<td>75</td>
</tr>
<tr>
<td>32.</td>
<td>Proportion of Pharmacy Costs: Kennebec Sites</td>
<td>75</td>
</tr>
<tr>
<td>33.</td>
<td>Proportion of Pharmacy Costs: Greater Portland Site</td>
<td>76</td>
</tr>
<tr>
<td>34.</td>
<td>Proportion of Pharmacy Costs: Lincoln County Site</td>
<td>76</td>
</tr>
<tr>
<td>35.</td>
<td>Average per Member per Month (PMPM) Prescription Costs CY 2003-2004</td>
<td>77</td>
</tr>
<tr>
<td>36.</td>
<td>PMPM Pharmacy Costs for CarePartners Enrollees Enrolled for at least 18 months (Submitted Claims) N=396</td>
<td>78</td>
</tr>
<tr>
<td>37.</td>
<td>2004 Administrative Expenses Compared to Medical and Pharmacy Costs</td>
<td>83</td>
</tr>
</tbody>
</table>
## Appendix A: MaineHealth Access Advisory Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard Aronson</td>
<td>Century Tire Company</td>
</tr>
<tr>
<td>Meg Baxter</td>
<td>United Way of Greater Portland</td>
</tr>
<tr>
<td>Dick Beal</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>Karen Bell, MD</td>
<td>Anthem Blue Cross and Blue Shield</td>
</tr>
<tr>
<td>Elizabeth Bruenelle</td>
<td>PracticePartners</td>
</tr>
<tr>
<td>Christopher Carpenter</td>
<td>MaineGeneral Medical Center</td>
</tr>
<tr>
<td>Jacquelyn Cawley, DO</td>
<td>Martin’s Point Healthcare</td>
</tr>
<tr>
<td>Jerry Cayer</td>
<td>Health &amp; Human Services, City of Portland</td>
</tr>
<tr>
<td>Tim Churchill</td>
<td>Stephens Memorial Hospital</td>
</tr>
<tr>
<td>Don Comeau</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>Patricia Cook</td>
<td>Stephens Memorial Hospital</td>
</tr>
<tr>
<td>Joseph Ditre</td>
<td>Consumers for Affordable Health Care</td>
</tr>
<tr>
<td>Robert Duranleau</td>
<td>City of Portland Social Services</td>
</tr>
<tr>
<td>John E. Eppits*</td>
<td>Center for Community Dental Health</td>
</tr>
<tr>
<td>Janet Fowle, MD</td>
<td>Miles Memorial Hospital</td>
</tr>
<tr>
<td>Charles R. Gaunce</td>
<td>Central Maine Motors</td>
</tr>
<tr>
<td>Eugene I. Gessow</td>
<td>Maine Department of Human Services</td>
</tr>
<tr>
<td>Mark Grandonico</td>
<td>Maine Medical Center</td>
</tr>
<tr>
<td>Laurence Gross</td>
<td>Southern Maine Area Agency on Aging</td>
</tr>
<tr>
<td>Jim Hagen</td>
<td>Central Maine Medical Group</td>
</tr>
<tr>
<td>Don Harden</td>
<td>Support &amp; Recovery Services</td>
</tr>
<tr>
<td>Peter Hayes</td>
<td>Marsh, Inc.</td>
</tr>
<tr>
<td>Steve Hess, MD</td>
<td>Mercy Primary Care Centers</td>
</tr>
<tr>
<td>David Howes, MD</td>
<td>Martin’s Point Healthcare</td>
</tr>
<tr>
<td>Nathaniel James, MD</td>
<td>Maine Medical Center</td>
</tr>
<tr>
<td>Warren Kessler</td>
<td>MaineHealth</td>
</tr>
<tr>
<td>Beth Kilbreth, PhD</td>
<td>University of Southern Maine</td>
</tr>
<tr>
<td>Dennis King</td>
<td>Spring Harbor Hospital</td>
</tr>
<tr>
<td>Nancy Knapp, MD</td>
<td>Greater Portland Medical Group</td>
</tr>
<tr>
<td>Asher Kramer</td>
<td>Martin’s Point Health Care</td>
</tr>
<tr>
<td>Grant Lee</td>
<td>People’s Regional Opportunity Program</td>
</tr>
<tr>
<td>Douglas Libby</td>
<td>Maine Health Management Coalition</td>
</tr>
<tr>
<td>Jim Lysen</td>
<td>Community Clinical Services, Federally Qualified Health Care (FQHC)</td>
</tr>
<tr>
<td>Julie Marston</td>
<td>Miles Memorial Hospital</td>
</tr>
<tr>
<td>Ted McCarthy</td>
<td>Mercy Hospital</td>
</tr>
</tbody>
</table>

_CarePartners: Opportunities and Challenges • MaineHealth_
Donald McDowell
MaineHealth**

Cindy McLeod, RNC
Lincoln County CarePartners

Steve Michaud
Maine Hospital Association

Lisa Miller
The Bingham Program

Peter Mirkin, MD
Maine Medical Center

Kim Moody
USM College of Nursing & Health

Jan Murton, LSW
Kennebec County CarePartners

Nate Nickerson, NP
Portland Dept. of Health & Human Services

Luc Nya
Maine Department of Mental Health, Mental Retardation and Substance Abuse Services

Peter O’Donnell
Maine Department of Mental Health, Mental Retardation and Substance Abuse Services

Phil Ortolani
Mid Coast Hospital

Paul Parker
Oasis Free Clinic

Michael Patterson
Parkside Neighborhood Association

Margaret Pinkham
St. Andrews Hospital

Carrie Plummer
Community Health Services

Christopher F. Pope, MD
Maine Medical Center

Tim Prince
Mercy Hospital

Jane Pringle
Maine Medical Center

Michael Quint
Legislator

Christopher St. John
Maine Center for Economic Policy

Linda Schumacher
Bureau of Medical Services

Stephen Sears, MD
Maine Central Health

Terrance Sheehan, MD
Southern Maine Medical Center

John Shoos
United Way of Greater Portland

Julianne Alfred Sullivan
Portland Health & Human

Al Swallow
Maine Medical Center

Mark Swan
Preble Street Resource Center

Judith Tarr
Miles Memorial Hospital

David Trunnel
Inland Hospital

Stephanie Walstedt
Planned Parenthood of Northern New England

Matthew Ward
Refugee & Immigration Services

Marilyn Westerfield
Miles Memorial Hospital

Judy Williams
Maine Department of Human Services

Ann Woloson
Consumers for Affordable Health Care

**Staff
Deborah Deatrick
Sarah Gerrish
Phebe King*
Carol Zechman
*Deceased
**Retired

CarePartners: Opportunities and Challenges • MaineHealth 88
Greater Portland Community Advisory Committee 2000 - 2002

Dick Beal  
Department of Human Services

Grant Lee  
People’s Regional Opportunity Program

Elizabeth Bruenelle  
Practice Partners

Ted McCarthy  
Mercy Hospital

Jerry Cayer  
Health & Human Services

Elaine McMahon  
Partnership for Health Aging

Don Comeau  
Department of Human Services

Peter Mirkin, MD  
Maine Medical Center

Kim Crichton  
Maine Health Access Foundation

Kim Moody  
University of Southern Maine  
College of Nursing & Health

Joanne D’Arcangelo  
Legislative Staff

Nate Nickerson, MSN, ANP  
Portland Department of Health  
& Human Services

Bob Duranleau  
City of Portland Social Services

Luc Nya  
Maine Department of Mental Health,  
Mental Retardation and Substance Abuse Services

John E. Eppits*  
Center for Community Dental Health

Peter O’Donnell  
Maine Department of Mental Health, Mental Retardation and Substance Abuse Services

Mark Grandonico  
Maine Medical Center

Michael Patterson  
Parkside Neighborhood Association

Laurence Gross  
Southern Maine Area Agency on Aging

Charlene Rydell  
Representative Tom Allen’s Staff

Capt. James Guest (Moved to another location)  
Capt. Andrew Ferreira (Present Capt.)

John Shoos  
United Way of Greater Portland

Salvation Army

Marjorie Stone  
Maine Medical Center

Steve Hess, MD  
Mercy Primary Care Centers

Al Swallow  
Maine Medical Center

Nathaniel James, MD  
Maine Medical Center

Nadine Turcotte  
Consumers for Affordable Health Care

Dennis King  
Spring Harbor Hospital

Asher Kramer  
Martin’s Point Health Care

*Deceased

CarePartners: Opportunities and Challenges  •  MaineHealth  89
Kennebec County Community Advisory Committee

Bill Addison
Inland Hospital

Mary Frances Bartlett
City of Augusta Health & Welfare

Lois Bouchard
Love Joy Health Center

Chris Carpenter, LCSW
MaineGeneral Medical Center

Jack Comart
Pine Tree Legal

Barbara Crowley, MD
MaineGeneral Health

Beverly Daggett
Legislator

Mary Derosier
United Way of Kennebec County

Mark DiTullio
MaineGeneral Medical Center

Lynn Duguay
HealthFutures

Shelly Fitzgerald, FNP
Maine Darmouth Family Practice

Walter Foster
Togus Veterans Administration Hospital

Claudia Glynn FNP
Gardiner Family Practice

Rob Gordon
United Way of Kennebec County

Terry Hartford, FNP
Sheepscot Valley Health Center

Judi Hawkes
MaineGeneral Health

George Hill
Family Planning Association of Maine

Kate Karragher
Family Violence Project

Suzanne McQuarrie
Kennebec Valley Community Action Program

Don Stephens Minister
Consumer

Linda Mitchell
HealthReach Community Health

Karen Mosher
Kennebec Valley Mental Health

Natalie Morse
MaineGeneral Health

Nancy Olsen
Salvation Army

James Schneid, MD
Maine Darmouth Family Practice

Linda Shapleigh
Catholic Charities

Emillie VanEeghen
HealthReach Network

Consumers for Affordable Health Care
Waterville Family Practice
<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharon Abair</td>
<td>YMCA</td>
</tr>
<tr>
<td>Frederica Luke</td>
<td>St. Andrews Health Care</td>
</tr>
<tr>
<td>Kathy Bean</td>
<td>St. Andrews Health Care</td>
</tr>
<tr>
<td>Beth McPherson</td>
<td>Genesis Community Loan Fund</td>
</tr>
<tr>
<td>Chris Behard</td>
<td>Sweetster</td>
</tr>
<tr>
<td>Stacey Miller</td>
<td>Miles Medical Group</td>
</tr>
<tr>
<td>Victoria A. Bell</td>
<td>St. Andrews Hospital</td>
</tr>
<tr>
<td>John Nickerson</td>
<td>Miles Memorial Health Care</td>
</tr>
<tr>
<td>Barry Costa</td>
<td>YMCA</td>
</tr>
<tr>
<td>Heather O’Bryan</td>
<td>Damariscotta Region Chamber of Commerce</td>
</tr>
<tr>
<td>Janet Fowle, MD</td>
<td>Miles Medical Group</td>
</tr>
<tr>
<td>Nancy Oliphant, MD</td>
<td>Wiscasset Family Medicine</td>
</tr>
<tr>
<td>Jane Gerlach</td>
<td>Mid-Coast Family Planning</td>
</tr>
<tr>
<td>Peter Panagore</td>
<td>St. Andrews Health Care</td>
</tr>
<tr>
<td>Jeffrey Grosser, DDS</td>
<td>Dentistry</td>
</tr>
<tr>
<td>Barbara Roscoe</td>
<td>Coastal Economic Development</td>
</tr>
<tr>
<td>Sue Gruptill</td>
<td>Coastal Economic Development</td>
</tr>
<tr>
<td>Betty Ryder</td>
<td>Boothbay Region Community Adult</td>
</tr>
<tr>
<td>Mike Harrison</td>
<td>YMCA</td>
</tr>
<tr>
<td>Patricia Simmonds</td>
<td>Miles Memorial Hospital</td>
</tr>
<tr>
<td>Cindy Jones</td>
<td>St. Andrews Health Care</td>
</tr>
<tr>
<td>Nadine Turcotte</td>
<td>Consumers for Affordable Health Care</td>
</tr>
<tr>
<td>Tom Keyes</td>
<td>Department of Human Services Rockland District Office</td>
</tr>
<tr>
<td>Anne Woloson</td>
<td>Consumers for Affordable Health Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Persons in Family</th>
<th>100% FPL (MaineCare Non-Categorical Rate)</th>
<th>150% FPL</th>
<th>175% FPL (CarePartners Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$9,570</td>
<td>$14,355</td>
<td>$16,748</td>
</tr>
<tr>
<td>2</td>
<td>12,830</td>
<td>$19,245</td>
<td>$22,453</td>
</tr>
<tr>
<td>3</td>
<td>16,090</td>
<td>$24,135</td>
<td>$28,158</td>
</tr>
<tr>
<td>4</td>
<td>19,350</td>
<td>$29,025</td>
<td>$33,863</td>
</tr>
<tr>
<td>5</td>
<td>22,610</td>
<td>$33,915</td>
<td>$39,568</td>
</tr>
<tr>
<td>6</td>
<td>25,870</td>
<td>$38,805</td>
<td>$45,273</td>
</tr>
<tr>
<td>7</td>
<td>29,130</td>
<td>$43,695</td>
<td>$50,978</td>
</tr>
<tr>
<td>8</td>
<td>32,390</td>
<td>$48,585</td>
<td>$56,683</td>
</tr>
</tbody>
</table>

**SOURCE:** *Federal Register*, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375
Appendix C: MaineHealth Description

MaineHealth’s vision: working together so our communities are the healthiest in America.

MaineHealth is an integrated, not-for-profit, comprehensive healthcare delivery system of leading hospitals, primary care physicians, specialists, and aligned providers organizations serving southern, central and western Maine. Approximately 72% of the state’s total population live in the 10-county MaineHealth service area and over 60% of the state’s acute care is provided by MaineHealth members and affiliates.

Approximately 900,000 residents in the ten counties (Cumberland, York, Lincoln, Kennebec, Somerset, Oxford, Sagadahoc, Knox, Franklin and Androscoggin), an area of 11,944 square miles are served by MaineHealth. Of that 10-county population, 43% live in only two of those counties: Cumberland (with one recognized metropolitan area – Portland) and Androscoggin (with one recognized metropolitan area – Lewiston/Auburn). The remaining counties have no metropolitan areas and are overwhelmingly rural.

MaineHealth member and affiliate organizations include:

- Maine Medical Center (Portland)
- MaineGeneral Medical Center (Augusta/Waterville)
- Mid Coast Hospital (Brunswick)
- Miles Memorial Hospital (Damariscotta)
- New England Rehabilitation Hospital (Portland)
- Southern Maine Medical Center (Biddeford)
- Sisters of Charity Health System (Lewiston)
- Spring Harbor Hospital (South Portland)
- St. Andrews Hospital and Healthcare (Boothbay)
- Stephens Memorial Hospital (Norway)
- HomeHealth/Visiting Nurses (Portland/Windham)
- Nordx
- Synernet

MaineHealth also includes the Maine Physician Hospital Organization, providing linkages to over 600 physicians, including more than 300 primary care physicians.