

The Costs and Adequacy of Safety Net Access for the Uninsured South Coastal Maine (CarePartners)

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August 2010

This report examines the CarePartners program based in south coastal Maine, as part of a series of case studies whose purpose is to explore whether well-structured safety net systems are able to provide low-income uninsured people adequate access to care at reasonable cost. Safety net providers include a variety of public and private hospitals, clinics and physicians who serve disadvantaged patients, with or without health insurance (Snow Jones and Sajid 2009). While the newly enacted Patient Protection and Affordable Care Act of 2010 will cover an additional 30 million people and offer other protections to many more, at least 20 million people will likely remain uninsured, leaving many to rely on safety net care for most of their health needs (Holahan and Garrett 2010). As a result, the cost and adequacy of safety net care remain vitally important issues for health care public policy (Hall 2009).

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I. Background

In Maine hospitals are required by law to provide free care to all uninsured patients below the federal poverty level (FPL), and many hospitals extend their charity care policies up to 150% or even 200% FPL (John Snow 2006, Zuckerman et al. 2007, Franklin Memorial Hosp. 2009). This obligation applies to all services offered by the hospital, including physician and other outpatient care. Some hospitals employ a substantial number of primary care physicians and therefore are subject to this requirement for a broad range of outpatient services. Others are interested in organizing better access for primary care as part of their mission, and in order to reduce the unnecessary and more expensive use of the emergency room for outpatient care.

Therefore, hospitals in several different communities in Maine have organized safety net programs for low-income uninsured that include both inpatient and outpatient services (John Snow 2006). The most notable such effort is the CarePartners program operated by the MaineHealth hospital system based in Portland.¹ CarePartners is a network of volunteer physicians and hospitals that provides care to low-income uninsured residents of Cumberland, Kennebec and Lincoln Counties, whose principal cities are Portland, Augusta and Wiscasset, in the south coastal region of Maine.

¹ The primary sources for this description are Ormond and Gerrish 2006, MaineHealth 2009, and MaineHealth 2003. Other notable programs have included Franklin Health Access and a program offered by Blue Hill Memorial Hospital (John Snow 2006), but they are not as active now as several years ago.

CarePartners' service area (which is not entirely contiguous) has roughly 250,000 people spread over roughly 2,000 square miles, much of which is rural. Incomes are well below national and regional averages, especially outside of the two principal cities. In 2008, about 11% of non-elderly adults were uninsured in Cumberland and Kennebec Counties, which is better than the national average of 17%. In part, this is because Maine has more generous Medicaid eligibility than most states, covering parents up to 200% of the federal poverty level (FPL) and childless adults up to 100% FPL.

CarePartners has been profiled as a model program of its type nationally (Taylor et al. 2006, Kullgren et al. 2005). It was developed in 2001 to provide a more coordinated approach to uncompensated care for the uninsured, with the idea that it would be needed only temporarily until state reforms extended coverage to most or all eligible people, but state reforms never reached their goals. Therefore, CarePartners continues to extend eligibility to uninsured adults ages 19-64, regardless of citizenship, who reside in the service area and whose income is below 175% FPL, if they do not have health insurance available through their work that costs less than 5% of gross income (counting both premium contribution and deductible).² Members are given enrollment cards, which must be renewed every six months.

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In 2008 enrollment was capped at 1,080 people at any one time, with 80 in Lincoln County and 500 each in Kennebec County and the greater Portland region. (Lincoln County has since lifted its cap to 400.) The demands on enrollment have risen and subsided as funding for Maine's expansion of Medicaid has ebbed and flowed (Anderson et al. 2009). CarePartners thus serves both as a permanent source of access for those who have never qualified for Medicaid or employer coverage, and as a bridge for shorter-term access for those who temporarily are ineligible for comprehensive insurance (Ormond and

Gerrish 2006).

CarePartners covers nearly a full range of health care services, including prescription drugs, mental health, home health, laboratory and diagnostic testing, and ambulance transport.³ In addition to primary and specialist care, CarePartners covers ambulatory surgery and procedures, and all hospital-based services such as laboratory, radiology and other testing. However, routine dental services are not covered, and coverage is very limited for specialized treatment of substance abuse. Also, nursing homes do not participate, although several of the general hospitals offer some long-term care services.

CarePartners assigns every member a primary care physician and a care manager who assists with coordinating access and with education and referrals for social services. Providers that are not hospital-affiliated may charge a copayment of \$10 per visit, but most outpatient services are rendered by hospital-affiliated physicians, and many of the others waive the copayment.

² In 2002, only about 10% of new CarePartners enrollees reported having any access to employer-sponsored insurance. Another 5% subsequently disenrolled within six months because employer insurance became available (Kullgren et al. 2005).

³ Prescriptions for inexpensive and moderate-cost drugs are filled for copayments of \$10-\$25. Patients requiring expensive brand-name drugs are enrolled with the assistance programs maintained by the major pharmaceutical companies.

Copayments for prescription drugs are more substantial, ranging in 2008 from \$5 for generics (increased to \$10 in 2009) to \$25 for non-formulary brands, which patients pay directly to the participating pharmacies.

Over 850 physicians participate, almost two-thirds of area doctors, but at any time only about 300 primary care physicians are seeing patients. Specialists agree to receive up to 20 referrals a year and primary care physicians can have up to 10 patients a year, but most have only one or two patients enrolled with them at any time. All seven area hospitals participate (Maine Medical Center, MaineGeneral Medical Center, Spring Harbor Hospital, Mercy Hospital (two locations), Inland Hospital, Miles Memorial Hospital, and St. Andrews Hospital). These hospitals fund the operating costs in rough proportion to their size.

II. Adequacy of Access

There is no established gold standard for adequate access (Ricketts and Goldsmith 2005; Davidson et al. 2004), but the general approach employed here is to compare CarePartners members with similar insured populations in their ability to get necessary care of reasonable quality.

One indication of adequate access is the extent to which members use the emergency room, since ER visits tend to be higher when primary care access is poor. Based on data sources described more below, CarePartners members used the emergency room substantially less in 2004 than non-disabled adults on Medicaid did in the same counties in 2007-2008, and at the same rate as reported by adults nationally (Table 1). Also, this visit rate is similar to that (0.30) reported in 2006 by Maine residents (adults and children) with private insurance (Kilbreth et al. 2009). Hospitalization rates are another indication of the ability to access necessary care. CarePartners' hospitalization rate is similar to that for local Medicaid adults and to the national rate for adults generally (Table 1).

Table 1: Annual Utilization per Non-Elderly Adult

	CarePartners 2004	Local Medicaid 2007-08	National 2006-07
ER Visits	0.37	0.82	0.39
Hospitalization	0.8	0.10	0.10

Sources: CarePartners report; analysis of Medicaid data; National Health Interview Survey (2007 data for ER visits, 2006 for hospitalization).

Note: National and local rates are not directly comparable due to differences in data sources, survey methods, and population characteristics.

In surveys done in 2001-2003 (Taylor et al 2006, Kullgren et al. 2005), 99% of CarePartners enrollees reported being somewhat or very satisfied with the care they received. Their receipt of preventive care “increased dramatically” after enrollment, with 99% receiving some preventive care in the year following enrollment. Those receiving a physical exam in a year increased from 51% prior to enrollment to 80% following enrollment and those reporting unmet medical needs

dropped from 58% to 26% following enrollment. Overall, “almost all enrollees reported that they felt more secure knowing that they had health care coverage or access after enrolling in the program.”

III. Cost Comparison

To evaluate the CarePartners’ costs, they are compared with the per-person costs for a similar population under Medicaid (Table 2). It is not conventional to measure uncompensated care on a “per member per month” (pmpm) basis since, by definition, the uninsured are not enrolled in an insurance plan. However, an adequate safety net can be thought of as providing a form of coverage for a defined population when the safety net system is structured like CarePartners, in a manner that enrolls eligible patients and provides them a primary care medical home (Hall 2009).

Table 2: Characteristics of Uninsured and Medicaid Adults in Three Maine Counties, Fiscal Year 2008

	CarePartners Uninsured	Medicaid
Members	1,383	9,356
Average enrollment	10.0 months	10.2 months
High-cost members	Top 10% incurred approx. 60% of costs. Top 20% = approx. 75% of costs	Top 9% incurred 50% of costs. Top 21% = 72% of costs

Notes: Adults are under age 65. Medicaid enrollees are non-disabled adults in Cumberland, Kennebec and Lincoln Counties enrolled at least six months in fiscal year July 2007 – June 2008. Age was calculated at start of year and county location at end of year. High-cost members were calculated based on the proportion of those with any expense (that is, disregarding those with no expense).

CarePartners provided administrative reports from its third-party administrator showing members and claims amounts by county, gender and ten-year age groups, for July 2007 - June 2008. These were used as follows to calculate the value of services provided (Table 3). Hospital services were reported based on charges, which were discounted by the average cost-to-charge ratios for inpatient and outpatient services in each county, as reflected in 2008 Medicaid data for adults living in these same counties. Physician and other professional services were valued based on local rates paid by CHAMPUS in 2003 (the latest available). Prescription drugs were valued at actual costs to the program. Other services were valued at their full charged amounts. This resulted in a total of \$267 pmpm for the value of services provided. Added to this is administrative overhead of 16%,⁴ resulting in a total pmpm of \$308.

⁴ This includes staffing for care management and for enrolling patients with drug companies’ prescription access programs for expensive medications provided free to uninsured low-income people.

Table 3: Average Monthly Costs for CarePartners and Local Medicaid Adults, Fiscal Year 2008

	CarePartners Uninsured	Medicaid Adjusted	Ratio: Medicaid/Uninsured
Inpatient	\$75	\$86	1.15
Outpatient	\$90	\$108	1.21
Professional services & misc	\$81	\$61	0.75
Rx	\$21	\$85	3.96
Total medical	\$267	\$340	1.28
Admin. costs	\$42	n/a	
Total	\$308	\$340	1.10

Notes: Adults are under age 65. Medicaid costs are adjusted by age and gender to reflect the demographic mix among CarePartners adults. CarePartners costs are measured as explained in text.

To compare these costs, researchers at the University of Southern Maine’s Muskie School of Public Service analyzed Medicaid data from the same time period (July 2007 - June 2008) for 9,356 non-disabled and non-elderly adults living in Cumberland, Kennebec and Lincoln Counties (Table 2).⁵ The analysis was limited to such adults enrolled for at least six months. Medicaid costs were measured based on claims data from the state.⁶ Because CarePartners has very limited coverage of specialized substance abuse services, the costs for all substance abuse services (amounting to \$20 pmpm) were subtracted from the Medicaid total.

To adjust for demographic differences between the Medicaid and CarePartners populations, average Medicaid costs were calculated separately for 10-year age groups divided by gender, and then weighted according to the age/gender distribution of the CarePartners population. This resulted in a calculation of \$340 pmpm, as the estimated costs for Medicaid to have covered a population consisting of the same age/gender mix as CarePartners that year (Table 3). The estimate is 10% higher than the value of services actually provided by CarePartners. CarePartners was less expensive overall despite showing physician costs that were one-third greater than Medicaid. Also, CarePartners appears to have a somewhat greater concentration of high-cost members (Table 2).

This cost analysis is limited by two imperfections in the data sources and analysis. First, the valuation of care is imprecise, especially for physician and other services. Second, the method used to adjust for health status is based only on demographics and not on actual health conditions in the two comparison populations. Therefore, the difference in cost between Medicaid and CarePartners might be greater or lesser than estimated here.

⁵ These were members who qualified for Medicaid through the parent expansion and childless adult waiver programs. About 85% of members had dependent children.

⁶ Physician services are valued based on actual claims paid, whereas hospital services are valued based on an estimate of claims amounts that will be payable once billed claims are finally reconciled.

IV. Implications

During the next few years, until health insurance reforms take full effect nationally, states and communities will continue to struggle with substantial numbers of uninsured people. Even after implementing federal reforms, many millions will remain uncovered by expansions in Medicaid and private insurance. These uninsured will include people for whom insurance remains unaffordable, people who are temporarily uninsured while transitioning between public and private coverage, and low-income people who do not qualify for Medicaid or public subsidies due to citizenship status.

CarePartners in southern Maine is an instructive example of one model to improve access to health care for people who remain uninsured both leading up to and following national reforms. By linking volunteer physicians with charitable hospital services, CarePartners has succeeded in providing a thousand low-income uninsured residents, regardless of citizenship, good access to a full range of medical services based in primary care medical homes. The value of services provided appears to be less than the cost of covering this population by Medicaid. Despite this success, CarePartners has several limitations. The area's needs outstrip its capacity such that it has to cap enrollment. Moreover, it is doubtful that all communities could provide even this extent of charity care. Nevertheless, this case study demonstrates that local providers in smaller communities could form effective referral networks for low-income uninsured, if adequate funding were available. Learning the structures and services required to meet this population's needs might help inform efforts to develop more sustainable funding sources for the uninsured in smaller communities elsewhere.

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Acknowledgements

Work on this report was supported by grants from the Robert Wood Johnson Foundation and the Maine Health Access Foundation. The following people provided very helpful data, information, or analysis: Andy Coburn, Sarah B. Gerrish, Tina Gressani, Janice Lawlor, Gerardo Maradiaga, Catherine McGuire, and Carol Zechman. The presentation and conclusions are solely those of the author.

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