

Draft Payor Caucus Report to Dirigo Health Board of Directors Re: the Measurement of Savings under the Dirigo Health Initiatives (08-24-05 Draft)

Introduction

The payor representatives of the Dirigo Health Working Group believe that the measurement of savings under Dirigo must be guided by three primary criteria:

- The savings must be *directly attributable to the operations of Dirigo Health*;
- The savings must be *measurable*; and
- The savings must *accrue directly to payors (employers and consumers)*.

These criteria are directly supported by the Dirigo law itself, which requires the Dirigo Health Board of Directors to determine “*the aggregate measurable cost savings*, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State *as a result of the operation of Dirigo Health* and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.” 24-A MRSA § 6913(1)(A) (*emphasis added*). Furthermore, the criteria that the savings must accrue directly to payors is found in 24-A MRSA § 6913(7), which requires health insurance carriers and health care providers to demonstrate that best efforts have been made to ensure that carriers have recovered savings offset payments “through negotiated reimbursement rates that reflect health care providers’ reductions or stabilization in the cost of bad debt and charity care as a result of the operation of Dirigo Health and any increased enrollment due to an expansion of MaineCare eligibility occurring after June 30, 2004.”

The payor representatives firmly believe that in order to look at the aggregate savings, it is necessary to look at the entire system, not just those elements that result in savings while ignoring those that result in increased costs. While recognizing that the measures proposed cannot always be directly attributable to Dirigo Health initiatives, the payor representatives have attempted to propose reasonable and credible proxy measures or modifications to the proposals made. The payor representatives believe that it is critical that all measures result in understandable, reasonable and credible results to ensure broad-based understanding and support for the measurement process.

At the meeting on August 2, Mercer Government Human Resource Consulting, the actuarial firm hired by the Dirigo Health agency to assist in the development of the proposed methodology, indicated that it was difficult or impossible to develop a methodology that could attribute savings to the Dirigo Health reform initiatives, particularly within the time frame allowed. The payor representatives agree with Mercer that it is difficult to attribute savings to Dirigo initiatives. In the spirit of compromise, however, the payor representatives were willing to consider an approach that would apportion some of the measured savings to the Dirigo Health initiatives, recognizing that it would be necessary to reach agreement on how much could fairly be attributed to the Dirigo Health program. Some portion of those savings attributable to Dirigo Health would then be recovered through the savings offset payment. This is particularly true if the savings cannot be directly attributed to the Dirigo Health initiatives, as is required by the law.

Neither of the methodologies for measuring aggregate savings put forward at this time meet the requirements or intent of the law, which contemplates a measurement of savings that is rigorous enough to ascertain the savings attributable to Dirigo and to allow those who must pay the Savings Offset Payment to be assured that their disbursements represent only a portion of the savings accrued as a result of Dirigo Health operations, not all of those savings and not another tax that will affect their ability to invest and compete in whatever market they operate in.

Notwithstanding that there is no rigorous actuarial or financial methodology that can be identified at this time that can identify the aggregate measurable cost savings resulting from Dirigo Health reform initiatives, some methodologies will be less flawed and arbitrary than others.

Methodologies that are fatally flawed and very arbitrary are those that (1) ignore the prices that private payors pay in the marketplace; (2) fail to recognize that health care providers and health insurance carriers operate in an environment where other external factors play a much larger role in determining cost and price increases, operating margins, and underwriting gains; and (3) attribute 100% of reduced cost or price increases or reduced margins/underwriting gain increases to Dirigo.

Methodologies that are less flawed and less arbitrary are those that (1) use the price data that private payors pay in the marketplace, and (2) recognize that there are external factors, outside the scope of Dirigo Health, that play a significant role in determining changes in price and margin/underwriting gain. Any attempt to measure the annual change to these indicators must also recognize that Dirigo Health reform initiatives are only partly responsible for the outcomes, and apportion those changes to the Dirigo Health initiatives on a reasonable statistical basis or by using another methodology that accounts for these additional factors.

The payor representatives recognize and appreciate the fact that the Dirigo representatives have made some changes to the proposed methodology, in an effort to address some of the concerns expressed. Nonetheless, the payor representatives believe that their proposed methodology is less flawed and less arbitrary than the methodologies developed by the Dirigo Health Agency and, therefore, represents a more viable and equitable proposal.

Payor Caucus Alternative Proposal

As an alternative to the voluntary hospital targets (COM and CMAD) and the uninsured/underinsured (bad debt and charity care) measures, the payor representatives suggested an approach that would measure changes in a hospital's approved charges over time.

Exhibit A outlines the manner in which a typical hospital would calculate its Gross Patient Service Revenue (GPSR), which in turn will determine any changes in its charges that are required (either increases or decreases) to meet its annual budget. The calculation of GPSR includes a variety of factors, including changes in the hospital's expenses, the hospital's operating margin, the payments received by both public and private payors, and uncompensated care.

Exhibit A (Calculation of Gross Patient Service Revenue):

$$\text{GPSR} = \frac{\text{E} - \text{OOR} - \text{MP} - \text{MCP} + \text{OM}}{1 - \text{M}\% - \text{MC}\% - \text{PP}\%(\text{PPD}) - \text{CC}\%}$$

Where:

GPSR = Total Charges
 OOR = Other Operating Revenue
 MP = Medicare Payment
 MCP = MaineCare Payment
 OM = Operating Margin
 M% = Medicare % of charges
 MC% = MaineCare (Medicaid) % of charges
 PP% = Private Payors % of charges
 PPD = Private Payors Discount
 CC% = Charity Care % of charges

Example (in millions):

$$\text{GPSR} = \frac{\$50 - \$1 - \$15 - \$10 + \$1}{1 - .40 - .25 - .30(0.05) - 0.5} = \frac{25}{.285} \text{ GPSR} = \$87.7$$

	Charges	Payments	% of Payments
<i>Medicare</i>	35.0	15.0	30%
<i>MaineCare (Medicaid)</i>	22.0	10.0	20%
<i>Private Payors</i>	26.3	25.0	50%
<i>Charity Care</i>	4.4	—	0%
TOTAL	\$87.7	\$50.0	100%

The proposed method for measuring savings using charges, which was outlined by the payor representatives at the August 9 meeting of the working group, would be calculated as follows:

Exhibit B: Example of Methodology for Measuring Hospital Savings (in millions)

	(1)	(2)	(3)	(4)	(5)	(6)
Hospital	Average Annual Price Increase (2001-2003)	Dirigo Yr 1 Price Increase (2004)	Total Charges Private Purchasers (2003)	1x3	2x3	4-5
1	8%	6%	\$200	\$216	\$212	\$4
2	6%	6%	\$40	\$42.4	\$42.4	\$0
3	6%	8%	\$20	\$21.2	\$21.6	(\$0.4)
4	7%	5%	\$50	\$53.5	\$52.5	\$1.0
Repeat for hospitals 5-39						
Total	7%*	6%*	\$1,000	\$1,070	\$1,060	\$10
<i>Weighted averages</i>						

The payor representatives believe that this approach has a number of advantages over the hospital measures and the uninsured/underinsured measures proposed by the Dirigo Health Agency:

1. It is a simple and efficient measure that includes many of the components that the Dirigo Health Agency proposal tries to measure separately.
2. This measure, which establishes a clear "line of sight" between the Dirigo Health initiatives and their impacts on the prices paid by health care consumers and payors, essentially replaces the COM, CPAD, and the uninsured/underinsured (Bad Debt and Charity Care) measures, since all of these components are incorporated into, and affect the outcome of, this one measurement.
3. Although most consumers of health care do not pay charges, it is charges that determine what the consumer does pay, since the vast majority of Maine hospital reimbursement is a percentage reduction from charges.

Representatives of the Dirigo Health program expressed concern that the increases in charges would be difficult to confirm or verify, as they are not reported separately on hospital financial statements. In an attempt to address that concern, the payor representatives believe that it may be possible to develop a proxy using a "charges per adjusted discharge" methodology, which would utilize publicly available data, on an interim basis until the data necessary to perform the charge calculations can be captured for a period sufficient to enable the historical and ongoing calculations.

Additionally, the payor representatives expect that at least 50% of the aggregated total savings (summed from all the measures) be shared with the payors with 50% attributable to Dirigo Health for the determination of the savings offset payment assessment.

Voluntary Hospital Targets

▪ *Consolidated Operating Margin (COM)*

The payor representatives understand that the methodology proposed by the Dirigo Health Agency ("DHA") seeks to:

- Calculate the historical three year average hospital consolidated operating margin ("COM") as the baseline margin for each hospital;
- Calculate the consolidated operating margin for 2004 as the baseline margin; compare to actual 2004 consolidated margin (on a per hospital basis);
- Calculate all decreases in consolidated hospital operating margins (by identifying only those hospitals that experienced a reduction in actual COM); and
- Sum the total of individual hospital savings to get total savings for 2004.

The concerns with this methodology include:

- That it does not take an aggregated system wide approach—it only looks at the positive results;
- It fails to count hospitals that experienced an increase in their COMs;
- It does not reflect or take into account the voluntary nature of the limits, nor does it prove that those savings are actually the result of the Dirigo Health initiative;

- It is possible for a hospital's COM to decrease and for its charges and the prices paid for services to its patients to actually increase.

The payor representatives have proposed a method that would measure the change in Total Gross Patient Service Revenue, as outlined above, and replace this proposed measure, as well as others as described more fully herein. The charge measurement described earlier is strongly preferred by the payor caucus. However, if the DHA's proposed COM measure is adopted by the Dirigo Health Board of Directors, several improvements are required from the payors' perspective.

Those required changes include:

1. Measuring all hospitals that have historically had a COM at or above 3% and whether or not they have reduced their COM;
2. Measuring hospitals that have reduced prices to payors to try to meet the 3% target during the course of the fiscal year;
3. The measure of aggregate savings must include all hospitals that meet the criteria specified in either #1 or #2, not just those hospitals that saw reductions in their COM in 2004.

▪ ***Case Mix Adjusted Discharge (CMAD)***

The payor representatives understand that the methodology proposed by the DHA seeks to:

- Calculate the historical three year baseline trend (arithmetic average) in case mix adjusted discharge ("CMAD) for each hospital (inclusive of outpatient costs);
- Calculate the expected CMAD for each hospital's 2004 fiscal year by using a baseline average rate of growth and then compare it to actual 2004 CMAD (on a per hospital basis);
- Multiply the differences between the expected CMAD and actual CMAD in each hospital times the number of patients served by that hospital in 2004; and
- Sum the total of individual hospital decreases in CMAD to get total savings for 2004.

The concerns with this methodology include that:

- It does not take an aggregate system wide approach—it only looks at positive results;
- When calculated for any period of time, "savings" would likely be identified because of external variables – with or without the presence of the Dirigo Health initiatives;
- It does not reflect or take the voluntary limits established with the Dirigo Health Act into account;
- It does not show that those savings are actually the result of the Dirigo Health initiative;
- The proposed methodology does not reflect changes in volume;
- The proposed methodology does not reflect changes in reimbursement by public payors such as MaineCare and Medicare;
- The proposed methodology does not reflect changes in the underlying rate of inflation;
- The proposed methodology does not recognize that it is possible for a hospital's CMAD to decrease while the charges and prices paid by its patients increase.

The payor representatives have proposed an alternative method, as described above, that would measure the change in Total Gross Patient Service Revenue and replace the CMAD measure as

well as others, as described more fully herein. The charge measurement is strongly preferred by the payor caucus, which believes that this measure is far more accurate. However, if the DHA's proposed methodology is adopted by the Dirigo Health Board of Directors, several improvements must be made to the CPAD measure as proposed. Those changes include:

1. Historical data should be adjusted for inflation;
2. The measure must reflect Cost Per Adjusted Discharge, which incorporates outpatient services into its methodology—CMAD only reflects inpatient;
3. The historical growth rate should be computed as a compounded (or "geometric") average rate of growth rather than just the arithmetic mean of the annual growth rates;
4. Each hospital's CPAD should be compared to its historical CPAD compounded growth rate;
5. The calculation must factor in the rate of inflation (the differential in the rate of change in CPAD as compared to the rate of change in hospital inflation); and
6. The measure must be an aggregate measure that includes both those hospitals for which the CPAD increased, as well as those that decreased

Voluntary Insurance Target

The payor representatives understand that the Dirigo Health Agency has proposed to:

- Measure the after tax underwriting gain as a percentage of premium for every carrier with members in Maine for the three fiscal years prior to 2004 and establish an arithmetic average for each carrier;
- Multiply the average by each carrier's 2004 premium to approximate expected underwriting gain in 2004 for each carrier;
- Measure any reductions in actual underwriting gain compared to expected underwriting gain as savings.

Again, this methodology does not:

- Reflect or take the voluntary limits into account; and
- Does not show that those savings are actually the result of the Dirigo Health initiative.

The payor representatives believe that this measurement must:

1. Be measured for one year period only since the voluntary measure was established for only one year;
2. Include only those carriers that voluntarily agreed to participate as reflected in responses to a Bureau of Insurance bulletin;
3. Include only those carriers whose average underwriting gain was at or above 3% in previous years and in their 2004 fiscal year; and
4. Count both increases and decreases for carriers described in #2 and #3.

Insuring the Uninsured (Bad Debt and Charity Care)

The payor representatives understand that the Dirigo Health Agency proposes to:

- Identify the portion of bad debt and charity care related to the uninsured and the underinsured

- Convert that total savings to a per member per month (PMPM) figure based on avoided bad debt and charity care costs for hospitals and other providers
- Determine the “incurred” member months for previously uninsured and underinsured enrollees in MaineCare or DirigoChoice;
- Multiply the enrolled member months in 2004 for previously uninsured and underinsured enrollees in MaineCare and DirigoChoice by the PMPM figure for avoided bad debt and charity care to establish the total savings.

The payor representatives agree that there are savings that result from coverage of the previously uninsured and that there may be very limited savings from changes to coverage of the previously underinsured. While the methodology suggested by the payor caucus incorporates these savings into its formula, the payor representatives have significant concerns about the proposed methodology for measuring the savings that result from a reduction in bad debt and charity care and believe that certain modifications are required to ensure the integrity of this measure. Those concerns and/or modifications include:

1. The basis for the determination of the PMPM figure of \$87 per member per month was never fully explained. There is concern about the assumption about the portion of bad debt and charity care that is attributable to non-hospital providers, since that assumption was based upon information provided by two mental health hospitals, rather than physicians and other non-hospital providers;
2. The measure must take into account not only people who were covered under the MaineCare expansions that took place after July 1, 2004 but also those people who are no longer covered due to changes in eligibility after July 1, 2004;
3. Although there may be some savings associated with coverage of the previously underinsured, a number of issues exist with respect to this measurement. There has been no agreement on the definition of underinsured that was proposed by the Dirigo Health Agency and the payor representatives have expressed concerns about the appropriateness of the proposed definition, which reflects a national standard, in a state such as Maine. In addition, any recognition of savings must be offset by the fact that some of the enrollees in the DirigoChoice product have moved to *higher* deductibles and/or out-of-pocket expenses, thus *increasing* their risk of contributing to increases in bad debt and charity care;
4. The other measures outlined (previously MaineCare, previously insured, MaineCare Group A and “woodwork,” and non-Dirigo previously uninsured) are inappropriate to include;
5. Bad debt and charity care must be measured on a cost basis, rather than on a charge basis to reflect actual costs that accrued to providers as a result of bad debt and charity care; and
6. Savings estimates should be adjusted to reflect the portion of these savings that are actually passed back to consumers in the form of lower prices.

The payor representatives have proposed an alternate method that would measure the change in Total Gross Patient Service Revenue and replace this proposed measure along with others as described more fully herein. This measurement is strongly preferred by the payor caucus.

Certificate of Need

Additional information that would more fully explain the proposed measurements with respect to savings resulting from Certificate of Need (CON) has been requested but has not yet been received, making it difficult to comment on the proposed measurement.

Some of the concerns of the payor representatives with respect to the proposed measurement include the following:

1. Whether or not this measure is duplicative and provides “double-counting” of savings through an overlap with other measures.
2. It is unlikely that there would be measurable savings in 2004 or 2005 as any savings would be based on third year operating costs avoided and the projects delayed would not have been operational in 2004 or 2005, even if they had not been delayed by the moratorium.
3. While it is possible that the one-year moratorium will result in some savings, those savings are not includable at the present time, but may be included at an appropriate time in the future; and
4. Any savings resulting from the CON initiatives should be apportioned to reflect the savings attributable to private-pay patients only.

It should be noted that these are only preliminary comments; as previously noted, additional information on this proposed measure is needed in order for the payor representatives to make informed comment.

Budget Initiatives

The payor representatives understand that the Dirigo Health Agency has proposed that the measurement of the savings resulting from the Dirigo Health initiatives should include the following:

- Approximately \$18 million in increased MaineCare reimbursement to physicians;
- Approximately \$139 million in increased prospective interim payments to hospitals, including settlement of prior PIP payment periods; and
- Approximately \$90 million paid to 12 hospitals in settlement of litigation.

The payor representatives believe that none of these payments are directly attributable to the Dirigo Health reform initiatives and that they are unlikely to result in any cost reductions to private-pay health care consumers and payors. The specific concerns include the following:

1. Any increases in physician reimbursement are unlikely to result in savings to payors and certainly not on a dollar for dollar basis; again, the increase in reimbursement is not, in any case, a “Dirigo” initiative;
2. Hospital settlement payments do not increase the amount of hospital reimbursement, only the timing of the payments—this will not result in any savings to payors and, again, it is not a Dirigo initiative. The fact that the issue was referenced in the Commission to Study Maine’s Hospitals’ Report to the legislature does not make it a Dirigo Health reform initiative.