Dirigo Health Agency

Annual Report State Fiscal Year 2008

Presented to:

The Honorable John E. Baldacci, the Governor of Maine
and
The Joint Standing Committees on:
Appropriations and Financial Affairs
Insurance and Financial Services
Health and Human Services

Dirigo Health Board of Trustees

Robert McAfee, M.D., Chair
Former President, Maine Medical Association and American Medical Association

Jonathan Beal
Attorney

Joseph Bruno
CEO, Community Pharmacies, LP

Edward David, MD

Deputy Chief Medical Examiner

State of Maine

Sara Gagne Holmes

Executive Director, Maine Equal Justice Partners

Mary E. McAleney

Former Director of the US Small Business Administration-Maine District

Marianne Ringel

Program Specialist-Konbit Sante,Cap Haitien Health Partnership

Mary Anne Turowski
Director of Politics & Legislation MSEA/SEIU

Ex Officio

Trish Riley
Director, Governor's Office of Health Policy and Finance

Ellen Schneiter
Department of Administrative and Financial Services

Anne Head
Commissioner Department of Professional and Financial Regulation

David Lemoine
State Treasurer

PL 2007 Chapter 447 changed the composition of the Dirigo Board from 5 voting and 3 ex officio members to 9 voting and 4 ex officio members. Members Bruno, Gagne Holmes, and Ringel joined the Board September 15, 2008.

For more information or additional copies of this report, contact the Dirigo Health Agency, 211 Water St., Augusta ME 04333 at 207-287-9900 or visit the Dirigo Health Agency website at www.dirigohealth.maine.gov .

Table of Contents

Agency Mission

On January, 9, 2003, Governor Baldacci's first official act as Governor was the creation of the Governor's Office of Health Policy and Finance (GOHPF). Governor Baldacci directed this Office to develop and implement his plan to achieve access to quality and affordable health care for all Maine people. On June 18, 2003, Governor Baldacci signed into law Dirigo Health Reform. Dirigo Health Reform was enacted by two-thirds bi-partisan majorities in both the Maine House of Representatives and the Maine State Senate.

Part of the Dirigo Health Reform Legislation was the creation of the Dirigo Health Agency. The Reform created the Agency "to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals on a voluntary basis… and is also responsible for monitoring and improving the quality of health care in this State." (24-A M.R.S.A. §6902)

When enacted in 2003, Governor Baldacci's Dirigo Health Reform Initiative was the first major health reform to be enacted in any state in over a decade. In the years since passage of Dirigo Health Reform, other states have followed suit.

The following report describes the activities and achievements of the Dirigo Health Agency during the State Fiscal Year 2008.

Executive Summary

State Fiscal Year 2008 was one of important accomplishment and of challenge for the Dirigo Health Agency. During the year the Agency continued to pursue its mission of expanding access to and improving the quality of health care in the State of Maine. The Agency:

- Expanded the total number of Maine citizens who had obtained access to care through its programs to 28,745
- Continued to work against national trends by reducing the rate of uninsured in the State, consistent with its operations every year since 2003.
- Saw continued reduction in hospital costs due to the hospitals' compliance with the voluntary targets set in the Dirigo Reform Act, consistent with its operations every year since 2003.
- Completed collection and analysis of key hospital performance indicators for heath care associated infection (HAI) prevention. This collection and analysis allows citizens and health care professionals to compare hospital performance in the prevention of HAI and provides a baseline for future comparisons.
- Facilitated the creation of the Maine Infection Control Collaborative, a quality improvement consortium aimed at the spread of best practices in hospitals for infection prevention and control. Nearly all of Maine's acute care hospitals are now members of the Collaborative.
- Led a successful application to Medicare to designate Maine as a demonstration site for the use of electronic medical record in small and medium size primary care medical practices. Up to 45% of Maine's primary care practices will participate in this program, meaning new federal dollars approaching $29 million for successful performance.

While reaching these goals, the Agency continued to face challenges with on-going financing. To meet these challenges, the Agency:

- Increased the amount of the office visit and prescription drug copayments in the DirigoChoice program
- Capped enrollment in the DirigoChoice program effective September, 2007 (there are over 2,000 citizens currently on a waiting list to enroll)
- Transitioned the DirigoChoice program from Anthem Blue Cross Blue Shield to Harvard Pilgrim Health Care because of a better financial arrangement.

Furthermore, the Agency has continued to exert tight control over its financial operations. In SFY 2008 the Agency:

- Reduced the operating expense ratio to 3.4% from 5.9% in SFY 2007 for the DirigoChoice product
- Completed SFY 2007 financial audit with no findings
- Managed total Agency expenses to 95% of Agency forecast

Agency Funding

The primary source of funding for the Agency is the Savings Offset Payment (SOP). The SOP is an assessment the State levies on health insurance companies (and self-insured companies) in Maine based on a determination of Aggregate Measurable Cost Savings (AMCS) due to the operations of Dirigo Health (24-A M.R.S.A. §6913).

To date the SOP process has proven contentious and logistically challenging for the Agency. Consider that:

- The Chamber of Commerce, the Maine Automobile Dealer's Insurance Trust, and the Maine Association of Health Plans have intervened each year the AMCS process has occurred to dispute the AMCS amount. In 2005 these parties pursued their objections to the Maine Supreme Court. The Supreme Court upheld the State's determination. At the time of this report these parties along with Anthem Blue Cross and Blue Shield of Maine are appealing the most recent AMCS decision to Kennebec Superior Court.

- The AMCS process costs the Agency a million dollars a year in consulting services.

- Because the AMCS is variable from year to year, the SOP assessment is variable from year to year, making forecasting and planning difficult for both the Agency and the payers.

- Because the SOP is levied as each insured account renews and then applied for a full twelve months, it actually takes two years for the Agency to collect a full SOP. This phenomena, collecting one year's worth of revenue over two years, creates a cash flow problem, where the timing of the payout of expenses does not match the timing of the receipt of revenue.

The Legislature recognized these challenges in passing Public Law 2007 Chapter 629. This new law repealed the Savings Offset Payment and replaced it with new funding, including a tax on beer, wine and soda, eliminating the challenges of the SOP. This effort was repealed through a People's Veto on November 4, 2008 and so the current funding mechanism remains in place. In order for the Agency to meet its monthly obligations it borrows from the State's cash pool. As the Agency receives SOP revenue it returns the borrowed funds to the cash pool. The Agency looks forward to working with the Governor and the 124th Legislature to find a solution to the challenges of the SOP.

Year in Review

The Dirigo Board of Trustees met for a total of twelve times in State fiscal year 2008. The substance of the discussions ranged from contractual considerations and negotiations, legal matters, financial review and oversight, program design, quality related updates, legislative bills and their impact on the Agency, recommendations of the Blue Ribbon Commission on Dirigo Health, the amount of Aggregate Measurable Cost Savings, the calculation of savings offset payments, and planning for the future of the Dirigo Health Agency. All of the meeting minutes as well as handouts are available at www.dirigohealth.maine.gov. Key activities and decisions made by the Board since the last annual report are as follows:

- Per the recommendation of the Governor's Blue Ribbon Commission on Dirigo Health, the Board directed Staff to create and facilitate a Bad Debt and Charity Care Workgroup.
- Adopted Rules of Practice and Proceedings for Adjudicatory Hearings.
- Approved $78.1 million in Aggregate Measurable Cost Savings (AMCS) for year three.
- Determined the year three Savings Offset Payment in the amount of 1.74%
- Increased the amount of the office visit and prescription drug copayments in the DirigoChoice program as a way to manage program expenses to revenue.
- Approved a one year extension with Anthem Blue Cross and Blue Shield of Maine beginning January 1, 2007.
- Capped enrollment in the DirigoChoice program effective September, 2007 as a way to manage expenses to revenue.
- Negotiated a one year contract with up to a one year renewal provision with non profit Harvard Pilgrim Health Care (HPHC) effective January 1, 2008 when renewal terms with Anthem proved to costly.
- Approved a six month renewal contract with Harvard Pilgrim Health Care beginning January 1, 2009 with an option to extend for an additional six months.

As a result of the guidance and support of the Dirigo Board of Trustees, staff of the Dirigo Health Agency has been able to continue to advance the comprehensive strategies put in motion by the Dirigo Health Reform Act of 2003 with the goal of improving Maine's health care system by improving quality, reducing costs and expanding access.

Key accomplishments with the DirigoChoice program over the fiscal year include:

- Reduced the operating expense ratio to 3.4% from 5.9% in SFY 2007 for the DirigoChoice product
- Managed DirigoChoice enrollment to 100.16% of Agency forecast, representing over 15,000 members
- Maintained 97.75% of DirigoChoice renewing enrollment
- Managed a successful operational conversion to Harvard Pilgrim Health Care effective January 1, 2008.

Key accomplishments in promoting quality in health care include:

- Completed analysis and website posting of hospital quality metrics (Chapter 270 data)
- Began cost driver study based on paid claims database

- Received expanded grant under Robert Wood Johnson Foundation Aligning Forces for Quality initiative, now $1.5 million over 3 years for extension of AF4Q activities into hospital quality improvement (with emphasis on disparities in care and consumer engagement).

- Selected as demonstration site for CMS electronic health record initiative which has the potential to bring to the state up to $ 29 million for reimbursement for providers selected for project.

- Increased number of primary care practices and physicians assessed in the Voluntary Practice Assessment Initiative (109 of desired 150 physicians)

- Developed comprehensive statewide primary care provider database

- Facilitated development of the Maine Critical Access Hospital Safety Collaborative

- Facilitated the development of the Maine Patient-Centered Medical Home Pilot, including exploration of reimbursement models, practice selection, and evaluation components

- Continued to support In a Heartbeat activities including community awareness, development of Emergency Medical System (EMS) capabilities, and hospital performance analysis

- Supplied quality analysis of five CON project applications for CON Unit of DHHS

- Developed collaborative partnership (with Quality Counts, Maine Health Management Coalition, and HealthInfoNet) to apply for Chartered Value Exchange status from U.S. Department of Health and Human Services, awarded February 2008

- Recommended that 2008-2010 State Health Plan emphasize healthcare-associated infection, health information technology, patient-centered medical home, and health care services variation analysis

- Led formation of the Maine Infection Control Consortium

- Led multi-organization reassessment of performance of the Northeast Healthcare Quality Foundation as Medicare Quality Improvement Organization for Maine (and as a result supported NEHQF proposal to accomplish Medicare QIO 9th Scope of Work)

- Supported and helped organize

    - MMA/MHA joint quality conference on subject of unwarranted variation
    - Quality Counts 2008 annual conference on population-based care management
    - 2008 Governor's Summit of the Maine Cardiovascular Health Council, on patient-centered medical home
    - 2008 Hanley Forum on patient-centered medical home and public policy
    - Team STEPPS conference on patient safety (with Maine DHHS and Maine Medical Center)
    - 2008 Maine Center for Public Health Focus conference, on patient-centered medical home

Other key Agency accomplishments:

- Completed SFY 2007 financial audit with no findings

- Managed total Agency expenses to 95% of Agency forecast

- Developed the methodology and provided the supporting documentation and calculations for the determination of Aggregate Measurable Cost Savings for year 3

- Improved the usability of the Dirigo Health Agency website with staff resources.

Lastly, there were several Legislative attempts within the last 24 months to change the Agency's current funding mechanism to address the cash flow challenges created by the amended construct of the Savings Offset Payment (SOP) in 24-A M.R.S.A. §6913 and the expensive and contentious nature of the process to measure aggregate measurable cost savings It takes the Agency 27 months to collect one full year of assessment. This extended period is a result of the SOP application to each plan year and collection 60 days at the close of each quarter.

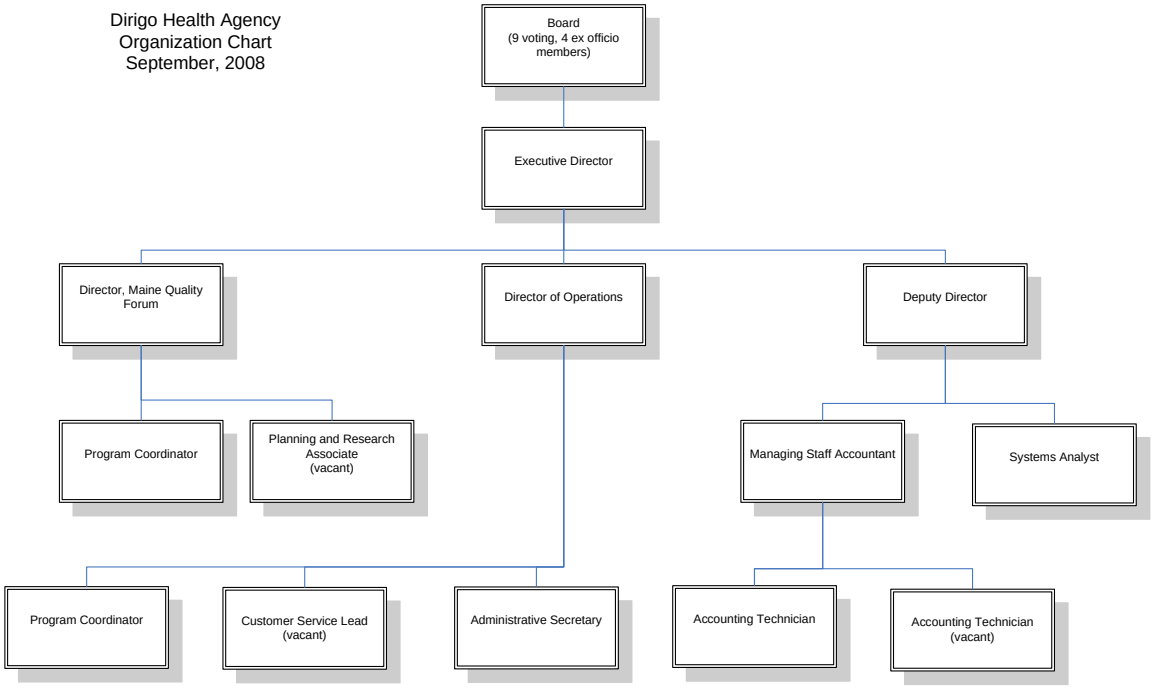
In April of 2008 the Legislature passed LD 2247 which became PL 2007 Chapter 629. Among other actions, Ch. 629 repealed the Savings Offset Payment and replaced it with new funding, including a tax on beer, wine and soda.

The revenue generated in Ch. 629 was payable to the Agency on a monthly basis and as such eliminated the cash flow problems associated with the construct of the Savings Offset Payment. A People's Veto of the new funding was successful and as such the Agency is faced with a cash flow challenge where the timing of the SOP revenue payments to the Agency does not match the monthly payout of expenses. The Agency will continue to work with the Governor, Legislature and stakeholders to find a solution to this issue so that the work to improve quality, reduce costs and expand access for the people of Maine can continue.

Agency Staff

24-A M.R.S.A. §6909 creates the Executive Director position.

The Agency has 12 additional permanent positions in its current budget. Three of these positions are currently vacant.



.

Agency Financials

Full Agency financial statements (income statements and balance sheets) are available at www.dirigohealth.maine.gov .

Expenses

In March 2007, the State approved the Agency's change package for reduced expense allocation in SFY 2008 as follows:

Cost Category	Amount (in millions)
Cost of DirigoChoice Subsidy – Agency Expense	$47.1
Cost of DirigoChoice coverage – Employer and Member Share	$43.5
MaineCare Parent Expansion	$4.7
Operating Costs	$2.8
MQF Program costs	$1.0
Total	$100.1

Based on the failure of LD 1890 in October of 2007 the Agency reforecast its expenses as follows:

Cost Category	Amount (in millions)
Cost of DirigoChoice Subsidy – Agency Expense	$42.1
Cost of DirigoChoice coverage – Employer and Member Share	$38.6
MaineCare Parent Expansion	$4.7
Operating Costs	$2.8
MQF Program Costs	$1.0
Total	$90.2

Actual SFY 2008 expenses:

Cost Category	Amount (in millions)
Cost of DirigoChoice coverage Subsidy[1] – Agency Expense	$41.5
Cost of DirigoChoice coverage – Employer and Member Share	$36.8
MaineCare Parent Expansion	$4.1
DirigoChoice Operating Costs (staff and contracts)	$2.8
MQF Program Costs (staff and contracts)	$.7
Total	$85.9
% to Reforecast	95%

Operating Cost Breakdown:

Cost Category	% of Total
DirigoChoice salaries and benefits	21%
MQF salaries and benefits	8%
MQF projects	12%
Staffing	14%
Aggregate Measurable Cost Savings (AMCS) process	33%
Other	12%

[1] The Agency's cost of DirigoChoice coverage includes direct EBT discounts paid to Small Group employees. The Agency reports this item as an offset to revenue on its financial statements. For that reason, the Agency cost of coverage appears here as $3.0 million greater than it does on the Agency's income statements. Correspondingly, the Agency's reported revenue will appear $3.0 million greater in the revenue section below.

DirigoChoice Coverage Cost Breakdown:

Cost Category	Amount	PMPM[2]	% of Total
Employer and Member Contributions	$ 36,777,738	221.28	53%
Subsidy paid by Agency	$ 41,490,780	249.63	47%
Total DirigoChoice Coverage Cost	**$ 78,268,518**	**470.91**	
Total Operating Cost DirigoChoice	$ 2,754,158	16.57	
Operating Cost as % of Agency DirigoChoice Expenses	3.4%		
Total Member Months[3]	166,207		

[2] Refers to the cost or revenue from each plan member for a month. Indicates revenue, expenses or utilization of services.
[3] The total of all months that each member is covered by a plan. A plan with 1,000 members in January and 1,200 members in February has year-to-date 2,200 member months as of March 1. Member months, and ratios calculated by member months provide the most relevant statistics for evaluating a plan's financial performance.

Revenues and Available Cash Carry Forward from SFY 2007

In March 2007, the Agency's anticipated revenue and cash carry forward requirement was $56.7 million (not including funds from Employers and Members).

Based on the failure of LD 1890 the Agency reforecast its anticipated revenues and cash carry forward requirement in October 2007:

Revenue Category	Amount (in millions)
Employer and Member contributions	$38.6
Membership Fees	$1.0
Savings Offset Payments	$39.4[4]
Cash carry forward	$11.2
Total	$90.2

Actual Agency revenue and cash carry forward:

Revenue Category	Amount (in millions)
Employer and Member contributions[5]	$34.8
Membership Fees	$1.1
Savings Offset Payments	$21.4
Misc	$.8
Savings Offset Payments (projected assessed in SFY 2008 collected in SFY 2009)	$18.7
Cash carry forward	$9.1
Total	$85.9
% to Reforecast	95%

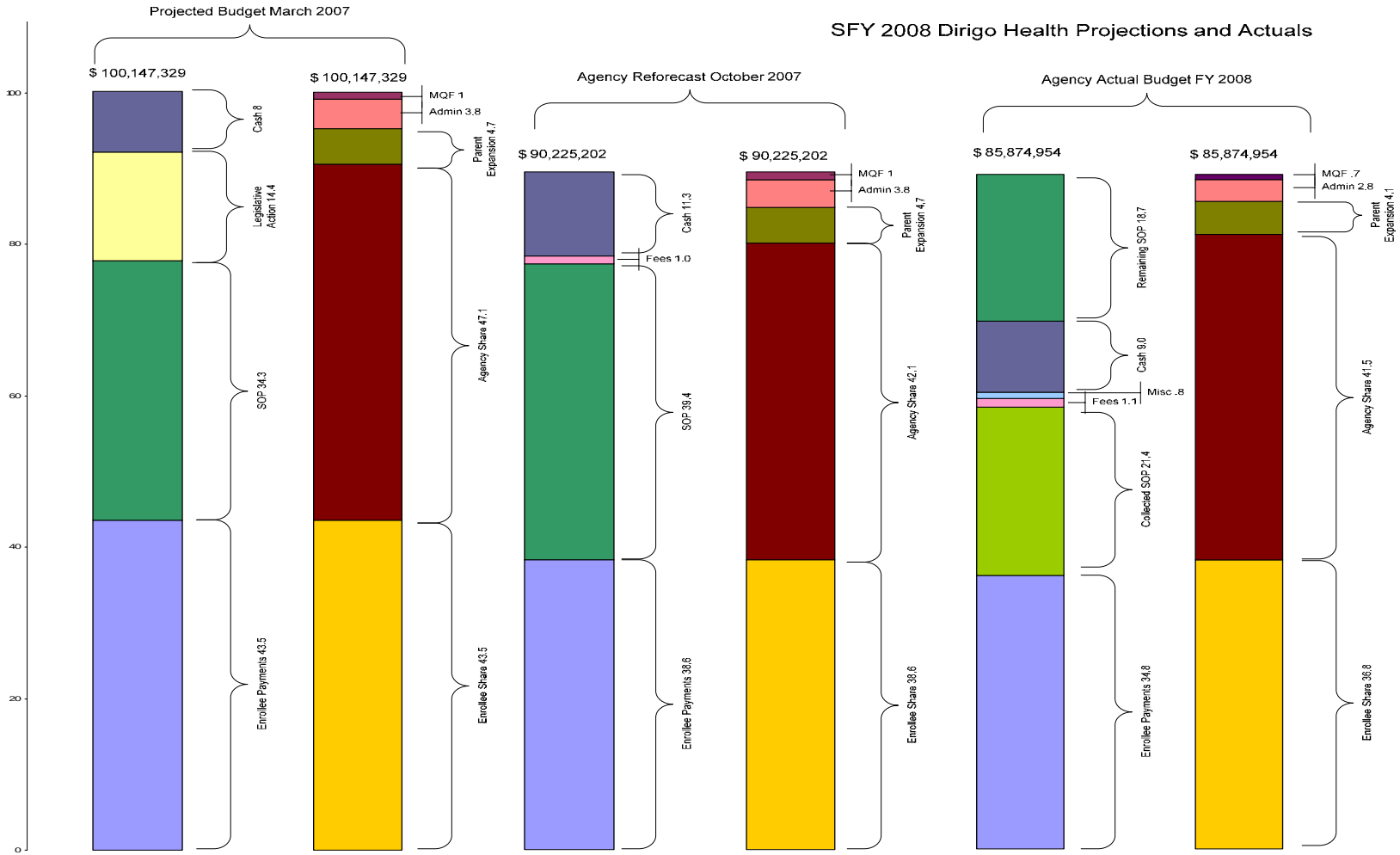
[4] Anticipated SOP revenue includes SOP 3 collected after the end of SFY 2008.

[5] Employer and Member contributions do not match Employer and Member share of expenses for two reasons:

a. Timing of returned membership fees from carrier. Carrier initially collects all membership fees and then returns them to the Agency. If the membership fee return occurs after the end of the FY (in this case, Q1 and Q2 were returned to the Agency in August) this discrepancy will occur.

b. As described under expenses, the Agency's cost of DirigoChoice coverage includes direct EBT discounts paid to Small Group employees. The Agency reports this item as an offset to revenue on its financial statements but shows it as expenses for the purposes of this report.

1)


SFY 2008 Dirigo Health Projections and Actuals
Projected Budget March 2007
$ 100,147,329
$ 100,147,329
Cash 8
Legislative Action 14.4
SOP 34.3
Enrollee Payments 43.5
MQF 1
Admin 3.8
Parent Expansion 4.7
Agency Share 47.1
Enrollee Share 43.5
Agency Reforecast October 2007
$ 90,225,202
$ 90,225,202
Cash 11.3
Fees 1.0
SOP 39.4
Enrollee Payments 38.6
MQF 1
Admin 3.8
Parent Expansion 4.7
Agency Share 42.1
Enrollee Share 38.6
Agency Actual Budget FY 2008
$ 85,874,954
$ 85,874,954
Remaining SOP 18.7
Cash 9.0
Misc .8
Fees 1.1
Collected SOP 21.4
Enrollee Payments 34.8
MQF .7
Admin 2.8
Parent Expansion 4.1
Agency Share 41.5
Enrollee Share 36.8
100
80
60
40
20
0

Quality

The Dirigo Health Agency focuses not only on expansion of access but also on improving quality and lowering costs of care. The Maine Quality Forum is the arm of the Agency that works on advancing the Agency's quality agenda.

24-A M.R.S.A. §6951 (2) describes the duties of the Maine Quality Forum as:

- Research Dissemination
- Quality and Performance Measures
- Data Coordination
- Public Reporting
- Consumer Education
- Technology Assessment
- Health Information Technology
- State Health Plan
- Health Care Associated Infection Surveillance and Prevention

Quality Measurement and Reporting

The information the Forum uses to evaluate care quality in Maine is derived from three main sources. Data from all three sources is submitted to and coordinated by the Maine Health Data Organization. These include the hospital discharge dataset, in which discharge diagnoses and services provided to each hospitalized patient in the state is submitted (a subset of hospital data is designated as care quality and safety indicators by the federal Agency for Health Care Research and Quality); the paid claims database, which includes information on health care claims filed by all payers who are active in the state including commercial health insurance carriers, MaineCare, and Medicare; and clinical quality data, which includes indicators required by Medicare (called "core measures") on heart attack care, pneumonia care, and surgical infection prevention, as well as several measures specified by the Maine Quality Forum Advisory Council of nursing-dependent indicators, infection-prevention indicators, and measures of effective transitions of patients across the continuum of care settings. All clinical indicators used by the Maine Quality Forum have been endorsed by the National Quality Forum, an independent nonprofit agency which evaluates individual quality measures.

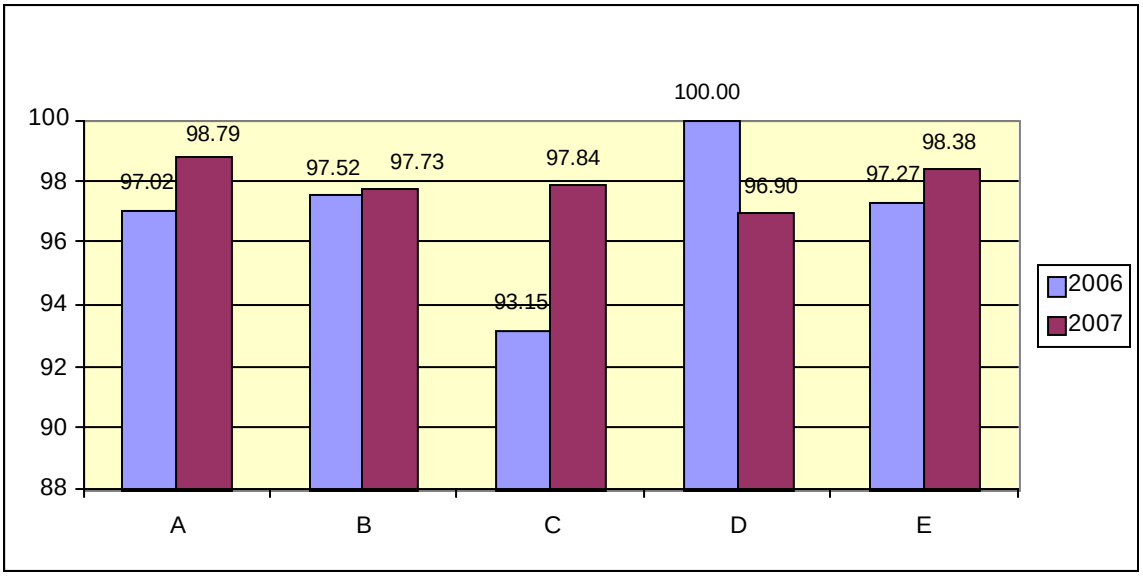
Although the **discharge dataset** contains a large number of elements, the areas of concentration have been on the use of cardiac catheterization, rates of cardiac, spine, gynecological, vascular, and orthopedic procedures, rates of hospital admission for certain conditions, and hospital complication and mortality rates. In addition to being reported publicly on the Agency's website, hospital discharge information has been used in these specific activities:

- Used to illustrate regional variations in care at public health district "listening tour" 2007-2008
- Used to inform Certificate of Need (CON) evaluation
- Used to inform policy articulated in State Health Plan

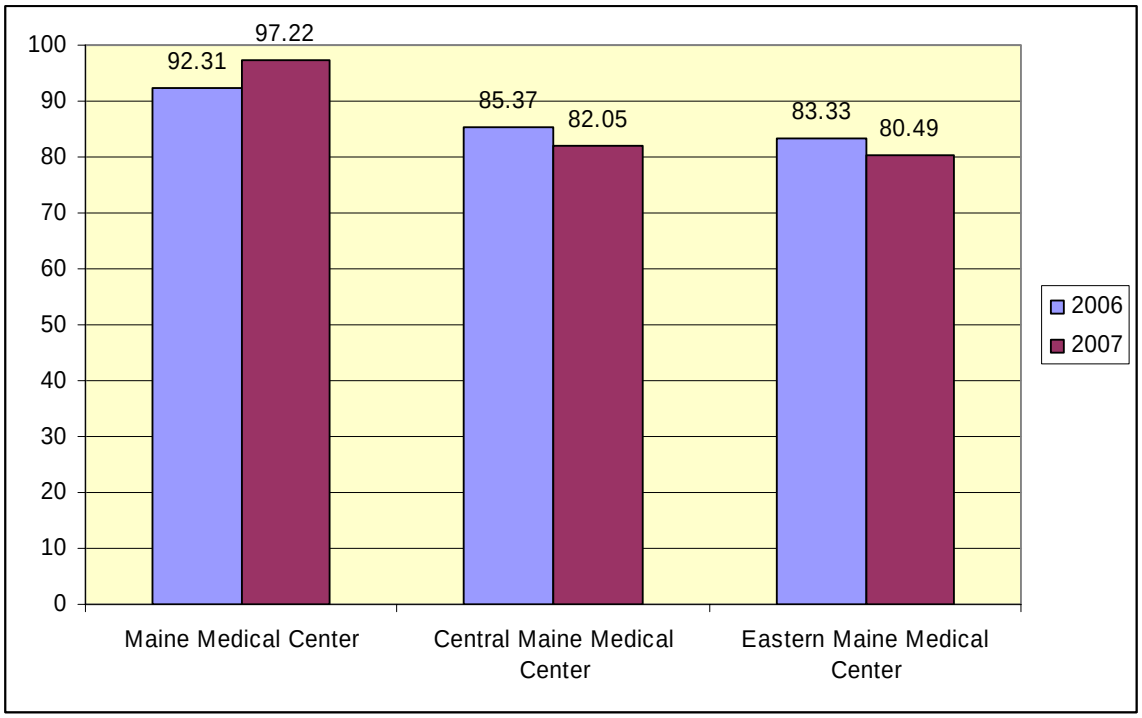
- Basis for relationship with the Agency for Healthcare Research and Quality (AHRQ) and ability to analyze Maine-specific data using AHRQ quality tools, methodology, and technical assistance. Examples:
    - PQI (patient-quality indicator) analysis is fed back to hospitals (not publicly reported) for internal quality analysis.
    - PQI analysis of avoidable hospitalizations has been done on public health district level as part of health status evaluation.

The **clinical quality data** submitted by Maine's hospitals to the MHDO now includes 53 specific measures. Data from most of these measures has been updated and can be seen on the Agency's website at http://www.mainequalityforum.gov/mqsp01f.html. Several examples of the information developed from the data are displayed below:

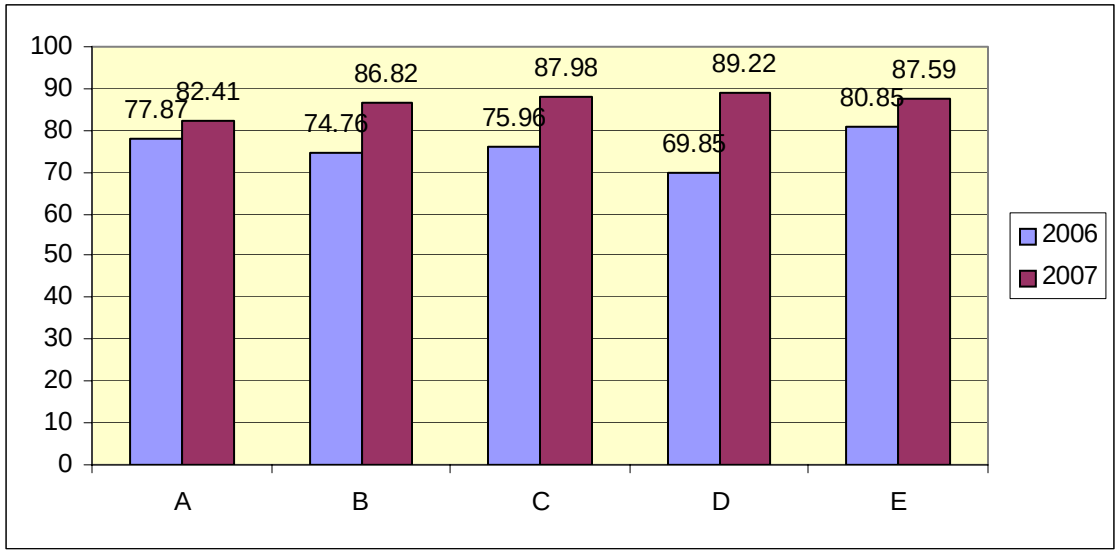
Percent of acute myocardial infarction (heart attack) patients without aspirin contraindications who received aspirin within 24 hours before or after hospital arrival



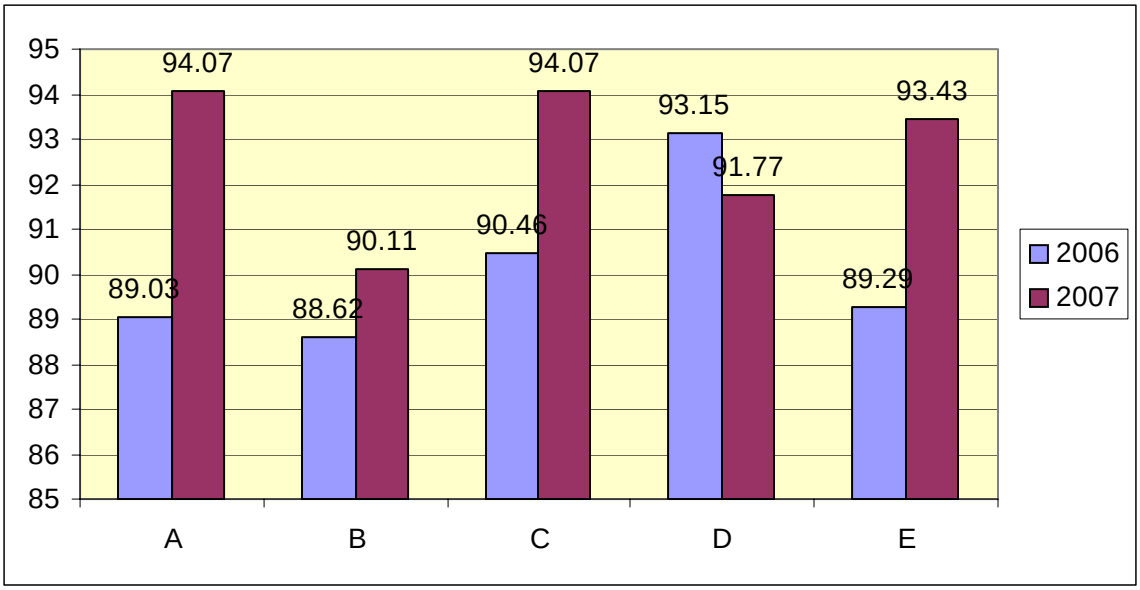
Percent of acute myocardial infarction (heart attack) patients who received percutaneous coronary intervention (PCI) within 120 minutes or less of arrival at hospital (for discharges prior to July 1, 2006) or 90 minutes or less of arrival at hospital (for discharges as of July 1, 2006)



Percent of pneumonia patients age 50 and older, hospitalized any time between October and February, who were screened for flu vaccine status and vaccinated prior to discharge, if indicated (by hospital peer group)



Percent of seven types of surgical patients that received prophylactic antibiotic within one hour prior to surgical incision (by hospital peer group)



In most cases, a trend toward improvement and high performance is seen in the measures.

In those areas where the data suggests there is an opportunity for improvement in a measure the MQF has implemented an intervention to address the issue and then a re measurement period to determine if the intervention changed behavior. The nurse-sensitive indicator NSPC-1(patients with stage II or greater pressure ulcer acquired in hospital) is a good illustration of how the Agency uses the data to inform and then through an intervention improve quality.

Pressure ulcers are painful and costly complications of bed rest. As most pressure ulcers can be prevented through identification of patients at risk and application of appropriate preventive measures, their frequency is a potentially useful indicator of care quality for inpatient facilities.

According to one national estimate 7% of hospitalized patients acquire a pressure ulcer during their stay. Pressure ulcers increase costs of hospitalization through added length of stay and additional costs of medical treatment. Estimates of added costs vary widely from $1,300 to $22,000.

The table below shows two years of hospital pressure ulcer prevalence by peer group, compared to a national benchmark (National Database of Nursing Quality Indicators). Underlying this table is a wide variation in incidence reported by individual hospitals. Because of this, the Maine Quality Forum engaged an audit of 12 Maine hospitals in which reported incidence was very high or very low. This resulted in improvement of reporting methodologies.

Hospital Peer Group	Benchmark (NDNQI 4th Q 2007)	Maine Hospitals Peer Group Rate 2007	Maine Hospitals Peer Group Rate 2006
A	2.3772	2.096	2.979
B	2.1187	2.194	3.796
C	2.1187	1.478	5.179
D	2.1187	3.443	3.529
E	2.1187	1.299	3.448

In addition, MQF developed a quality improvement activity for hospital teams to improve detection, prevention, and reporting of pressure ulcers. A pressure ulcer summit was convened in the fall of 2008. Over 225 people from 25 hospitals and long term care facilities attended. Participating teams reviewed findings of the above audit, received information on accurate diagnosis and management of pressures ulcers, and developed action plans aimed at the prevention of pressure ulcers.

The third body of information available for analysis is **the all-payer claims database**. In 2006, the Agency engaged Health Dialog Analytic Solutions, a Portland-based health services research organization, to evaluate the ability of the database to analyze care quality in Maine. A pilot analysis completed in early 2007 demonstrated this capability. Since then, the focus of analysis has shifted to the identification of cost drivers in Maine's health care system. The study will identify the common conditions and procedures that drive 80% of Maine's total health care spending. These drivers will be assessed on the basis of unwarranted variation (supply-sensitive, preference-sensitive, or effective care). This analysis will be shared with the Advisory Council of the Maine Quality Forum, the Advisory Council on Health Systems Development (ACHSD) and other stakeholder groups (including provider groups, purchasers, and payers). Based on these discussions, MQF will make recommendations on how each area of variation should best be addressed.

MQF and other Maine health care quality organizations are working together on a Robert Wood Johnson Foundation funded initiative entitled "Aligning Forces for Quality (AF4Q). AF4Q is focused on performance measurement, public reporting, and consumer engagement. The consumer engagement activities are designed to increase consumer awareness of quality healthcare, where to access information about quality, and how to use that information to make informed healthcare choices. Additionally, MQF is advising the AF4Q efforts on selecting hospital improvement activities using nurse leadership as the central change mechanism in quality improvement. These activities currently center on pressure ulcer care.

As part of the AF4Q project, the Maine Quality Forum, in collaboration with MaineCare, is directing a study of MaineCare members asking whether care patterns for chronic disease and service use in minority populations differ from care for members in general. The Muskie School of Public Service is performing the analyses.

Disparity data analysis will provide information on:

- Emergency Department utilization for conditions more appropriately treated in the primary care office.
- Avoidable complications of chronic diseases
- Utilization of care patterns.
- Hospital stay patterns
- Re-hospitalizations

To ensure accuracy, MQF and the Maine CDC's Office of Minority Health are developing a plan to train hospital registration personnel in collection of minority health data (ethnicity, race, and primary language). As a result,

- Collection of race, ethnicity, and primary language data will be uniform and accurate.
- The state will be better able to identify care patterns of its minority populations and plan accordingly.
- The state will be better positioned for federal funds that require minority specific data.

In 2006, MQF began providing no-cost quality audits for unaffiliated and/or isolated primary care practices. The purpose of this **Voluntary Practice Assessment Initiative (VPAI)** program is to provide opportunities to stimulate quality improvement in medical practices that are not connected to other healthcare provider systems. VPAI stimulates medical care practices to seek out resources to improve their systems of care. Since September 2006, the VPAI program has assessed 37 practices and 109 physicians on quality of care. This represents 73% of the project's goal of 150 physician assessments.

The Maine Critical Access Hospital Safety Collaborative grew out of the realization that Maine's 15 critical access hospitals comprise a substantial portion of Maine's acute care beds (approximately 365) and form an important component of the safety net in rural health care in Maine. Many of the safety and quality issues that concern large hospitals and many of the metrics used to evaluate them are less valuable in the assessment of care in small rural hospitals, mainly because of a different patient mix and small numbers. Each hospital in the group has committed to and started a specific safety project. Most concentrate on medication safety. Updates are available on the collaborative's website, http://www.mainecahpatientsafety.net.

As a result of its emphasis in the State Health Plan and its prioritization by the 123rd Legislature's Commission to Study Primary Care Medical Practice, the Maine Quality Forum has been a leader in convening a taskforce to develop a **Patient Centered Medical Home Pilot** for Maine. Research and experience in the United States and other developed nations has shown that a health care system organized around strong primary care results in better health care outcomes at lower costs, largely through appropriate use of effective preventive and chronic disease care strategies and less overuse of specialty and imaging services.

The three-year pilot with ten to twenty practices is anticipated to start in January 2009. Progress to date includes

- Development of the criteria for patient-centered medical homes
- Development of evaluation design for measuring impact on cost and quality
- Evaluation of principles and mechanisms of reimbursement for comprehensive primary care services

Consumer Education

In addition to the provider quality information available on the MQF website, the Forum has led a vigorous effort to educate the public concerning the signs and symptoms of acute myocardial infarction (heart attack) through its **In a Heartbeat** program.

A campaign to directly engage the public has been supervised by the Forum working with the Cardiovascular Health Program of Maine CDC. This was motivated by the discovery through a public health survey that only 11% of Mainers could correctly identify the signs and symptoms of AMI. Working with public health educators, a curriculum was developed intended to be delivered to community groups. This program was piloted in mid 2007, with over 300 people receiving training. Follow-up testing of participants demonstrated substantial increases in heart attack awareness. In 2008, train-the-trainer sessions were held in several communities throughout the state, including Presque Isle, Bangor, Augusta, Lewiston, and Scarborough. 138 trainees attended. These trainers have provided ongoing community training sessions, as evidenced by the fact that over 17,300 handouts and kitchen magnets have been distributed to participants in

subsequent sessions. A follow-up public health survey in 2009 and data from emergency medical systems will be used to measure the effect of this public education process.

Technology Assessment

Five Certificate of Need applications were reviewed. In the review process, discharge data and clinical data were used to profile the general quality of care provided at the applicant institution and to describe the applicants' performance in areas of care related directly to the technology applied for in the application.

Health Information Technology

In 2008, following a legislative resolve, the Maine Quality Forum co-convened, with **HealthInfoNet**, a stakeholder process for identifying a return on investment in interoperable health information technology and new sources of funding for the health information exchange. This group met throughout the spring and summer 0f 2008 and prepared a report for submission to the legislature in January 2009.

As the lead organization in a collaborative of several key stakeholders the Maine Quality filed a successful application with the Center for Medicare and Medicaid Services (CMS) for Maine to be a participating community in the **Medicare Electronic Health Records (EHR) Demonstration Project**. Maine joins eleven other communities in the country in this project. In 2009, 200 small and medium-sized adult primary care practices will be recruited to participate in the demonstration project. All primary care practices are required to have approved electronic health records by the end of the first year of the five year project. CMS will provide 100 practices with incentive payments based on the functionality of the technology in the practice, its use for tracking and reporting on practice quality, and for documented quality improvement in several measures of chronic disease and preventive care. In preparation for the start of this program, MQF has

- Convened the state's health systems, medical and hospital associations, and independent practice groups to publicize the opportunity and discuss strategies for practice recruitment
- Inventoried the state's primary care physicians to help in practice identification and recruitment
- Issued an RFP for a person to: supervise recruitment, build a system for collaborative support for practices in and out of the project, supervise a vetting process for recommended electronic systems, and advise on practice readiness assessment and the provision of technical assistance for practices
- Explored collaboration with HealthInfoNet on system interoperability and quality indicator clearinghouse functions
- Explored with the Maine Health Access Foundation mechanisms for supporting primary care practices' acquisition of this technology with low-interest loan guarantees.

State Health Plan

The Maine Quality Forum Advisory Council recommended to the Governor's Office of Health Policy and Finance, the body responsible for the State Health Plan, the following areas of emphasis for the Quality Forum in April 2008:

- Healthcare-associated infections
- Variation analysis
- Patient-centered primary care medical home
- Advancement of health information technology

Health Care Associated Infection Surveillance and Prevention

As noted, the Forum coordinates the submission of several **infection-related metrics** to the Maine Health Data Organization. These include the CMS core measures of pneumonia care and perioperative antibiotic administration. In addition, process measures, including the provider's compliance with evidence-based strategies to prevent central line associated bloodstream infections and ventilator-associated pneumonia, and the institutional incidence of central line-associated bloodstream infections have been reported since 2007. These hospital-specific metrics are currently displayed in updated graphic form on the MQF website.

The Maine Quality Forum took a leadership role in the creation of the **Maine Infection Control Consortium**. All acute hospitals in the state of Maine are members of the consortium. Membership is divided between hospitals in northern and eastern Maine and southern and western Maine. A coordinating committee meets frequently. Current Consortium accomplishments and projects include:

- Commitment to share data among member institutions
- Development of a common hand hygiene assessment tool, with intent to share hand hygiene performance data for process improvement
- Participation in the federal CDC "National Healthcare Safety Network" system of data reporting and feedback
- Survey of infection control program characteristics and capabilities in Maine's hospitals

Other consortium initiatives under discussion include:

- Development of a collaborative antibiotic stewardship program
- Public awareness campaign to disseminate information on drug-resistant organisms, especially methicillin-resistant staph aureus (MRSA)

Discharge and completion of the responsibilities and initiatives of the Dirigo Health Agency's Maine Quality Forum is not possible without the collaboration of other groups within and outside state government. The Forum is pleased to work with many effective organizations and acknowledge particularly the contributions of the following groups:

- Maine Health Data Organization
- Maine Medical Association
- Maine Hospital Association
- Maine Health Management Coalition
- Quality Counts
- HealthInfoNet
- Maine Health Access Foundation
- Northeast Healthcare Quality Foundation (QIO for Maine)
- Voluntary Hospitals of America
- Maine Health Information Center
- Maine Data Processing Center
- Hanley Center for Health Leadership
- Muskie School of Public Service, University of Southern Maine
- Maine Center for Disease Control
- MaineCare
- Maine Emergency Medical System

Access

Dirigo has three strategies to assure all Mainers have access to affordable, quality health care.

- Address health care system costs and quality reforms to assure those who have private coverage can continue to afford it.

- Provide a modest expansion in MaineCare, the state's Medicaid program, to leverage Federal investment in the program.

- Offer sliding scale subsidies to individuals and families with household incomes up to 300% of the federal poverty level.

DirigoChoice

Contractual Arrangement

Effective January 1, 2007, the Agency entered into a one year contract extension with Anthem Blue Cross Blue Shield of Maine to continue to offer DirigoChoice.

The Agency and Anthem negotiated throughout the summer of 2007 in good faith to reach an agreement for services in 2008. However, the Agency and Anthem were not able to agree to financial terms. When it became clear to the Agency that the parties were not going to be able to reach terms, the Agency negotiated a one year contract with Harvard Pilgrim Health Care (HPHC), a nonprofit health plan, effective for January 1, 2008. The Agency determined that HPHC represented a better financial arrangement for DirigoChoice, as HPHC was willing to enter into a fully insured contract with no risk sharing provision.

HPHC is nationally recognized as being among the best health plans available, ranked as the "Highest Member Satisfaction with Commercial Health Plans in the Northeast," according to the J.D. Power and Associates 2007 National Health Insurance Plan Satisfaction Study. Harvard Pilgrim also scored highest in the nation among plans in the study. Harvard Pilgrim Health Care was also ranked as the No. 1 health care plan in America in 2006, according to a joint ranking by *U.S. News & World Report* and the National Committee for Quality Assurance.

DirigoChoice Staff Responsibilities

Finance

- Manage payments to Carrier (Anthem and Harvard Pilgrim Health Care)
- Manage payments to EBT/EFT accounts
- Reconcile billed and paid accounts
- Manage Savings Offset Payments and collection process
- Produce monthly income statements and balance sheets
- Produce year end financial statements
- Work with State Controller and Office of Audit
- Coordinate DHHS and DHA accounting

Eligibility

- Determine annual discount eligibility and level
- Provide customer service for over 15,000 members
- Coordinate enrollment and benefit issue resolution with Carrier
- Manage annual renewal process

Systems

- Manage and produce reports and ad hoc data requests
- Manage data files sent to and received from Carrier (Anthem and Harvard Pilgrim Health Care)
- Develop and maintain website and online tool development
- Provide end user support
- Develop and maintain call tracking, financial, and enrollment systems

Management

- Coordinate product offerings with Carrier
- Manage the Memorandum of Understanding Agreement with DHHS
- Provide community relations and outreach
- Liaison with the Carrier's appointed producers
- Administer Agency policy

Plan Eligibility[6]

DirigoChoice is available to:

- Small Business (2-50 employees) Employees
- Self employed of one
- Individuals who:
    - Are unemployed
    - Work for a Small Business that does not offer insurance
    - Own a Small Business but cannot get enough employees to join a Small Group plan
    - Work less than 20 hours a week for any single employer
    - Are early retirees whose employer does not contribute to health benefits

Subsidy Eligibility

Subsidy eligibility is based on household income and household size as summarized below:

Household income is based on:

- Applicant gross wages, tips and salaries (before any deductions)
- Spouse or domestic partner gross wages, or tips and salaries (before any deductions)
- Net self-employment income (gross receipts minus allowable business expenses)
- Investment income (dividends from stocks, bonds, annuities, trusts, mutual fund shares)
- IRA and 401K distributions
- Pensions and annuities
- Net rental income (gross rents minus allowable expenses), royalties, trusts, etc
- Unemployment compensation
- Social Security
- Gross child support and/or alimony received

The following deductions are allowed:

- Childcare expenses - $200 per child per month if under 2, $175 per child per month if 2 or older. Caregiver must be a person outside the household.
- Child support paid out (only allowed for children that will not be covered by the applicant's policy).

[6] Plan eligibility presented in this report is a summary. For more details on plan eligibility criteria please see www.dirigohealth.maine.gov .

Household size includes the plan applicant and all of his or her dependents (i.e., spouse, domestic partner, unmarried child under 19, student under 23, or child of any age who is disabled and dependent upon the applicant).

Contribution Requirements

Small Group Employers (2-50 employees) and Self-Employed of One are required to contribute a minimum of 60% of the employee only (One Adult) coverage cost for employees who work more than 30 hours per week. Employers may pro-rate their contribution for employees who work 30 hours or less per week.

Subsidy Structure

The Subsidy program for DirigoChoice enrollees has two parts:

1. subsidy on the monthly coverage cost and
2. reduced deductibles and out of pocket expenses.

- Households with income under 300% of FPL[7] receive subsidies on the cost of coverage.
- The subsidies are structured on a sliding scale, with 4 separate subsidy levels:

Subsidy Group	B 100-149%	C 150-199%	D 200-249%	E 250-299%
Subsidy level on eligible coverage cost	80%	60%	40%	20%
Household Size				
1	$14,700.00	$19,600.00	$24,500.00	$29,400.00
2	$19,800.00	$26,400.00	$33,000.00	$39,600.00
3	$24,900.00	$33,200.00	$41,500.00	$49,800.00
4	$30,000.00	$40,000.00	$50,000.00	$60,000.00
5	$35,100.00	$46,800.00	$58,500.00	$70,200.00
6	$40,200.00	$53,600.00	$67,000.00	$80,400.00

- Deductibles and Out of Pocket levels based on Subsidy Group:

	B	C	D	E	F (Non Subsidized)
$1250					
Deductible (Single)	$250	$500	$750	$1000	$1250
Out of Pocket[8] (Single)	$800	$1600	$2400	$3200	$4000
Deductible (Family)	$500	$1000	$1500	$2000	$2500
Out of Pocket (Family)	$1,600	$3200	$4800	$6400	$8000
$1750					
Deductible (Single)	$500	$800	$1125	$1450	$1750
Out of Pocket (Single)	$1600	$2600	$3600	$4600	$5600
Deductible (Family)	$1,000	$1600	$2250	$2900	$3500
Out of Pocket (Family)	$3200	$5200	$7200	$9200	$11200
$2500					
Deductible (Single)	$500	$1000	$1500	$2000	$2500
Out of Pocket (Single)	$700	$1400	$2100	$2800	$3500
Deductible (Family)	$1,000	$2000	$3000	$4000	$5000
Out of Pocket (Family)	$1400	$2800	$4200	$5600	$7000

[7] 2007 Federal guidelines

[8] Out of pocket includes the deductible

Examples of the Application of the Subsidy

Small Business Employee

- An employer selects the DirigoChoice $1750 Plan for her employees. The monthly cost is based on $1750 individual / $3500 family deductible.
- One employee has a wife and 2 children.
- The employee's family's household earned and unearned income, based on filed tax returns, is $36,000, putting them in Group C.
- In this example, monthly cost for family coverage is $1,032.
- The employer pays 60% or $206.24 of the employee only monthly cost (monthly cost in this example is $343.74)
- The employer withholds the remainder of the monthly cost ($825.76) from the employee's paycheck.
- The employee receives a monthly cash subsidy through a debit card in the amount of $495.46
- This leaves the employee with a $330.30 monthly obligation vs. $825.76
- Additionally, this family's deductible is $1,600 vs. $3,500.

Individual

- An individual selects the DirigoChoice $1750 Plan. The monthly cost is based on $1750 individual / $3500 family deductible.
- The individual has a wife and 2 children.
- The employee's family's household earned and unearned income, based on filed tax returns, is $27,000, putting them in Group B.
- In this example, monthly cost for family coverage is $1,213.00
- The employee receives a monthly cash subsidy through a debit card in the amount of $970.56.
- This leaves the employee with a $242.44 monthly obligation vs. $1213.00.
- Additionally, this family's deductible is $1,000 vs. $3,500.

DirigoChoice Product: SFY 2008

- PPO[9] plan with three options (1) $1250 deductible, (2) $1750 deductible, or (3) $2500 deductible (Individuals and Sole Props are only eligible for options 2 and 3). Final deductible amounts are based on subsidy group level.
- Preventive services as defined by Carrier is covered at 100% (in network); mental health parity for all; no pre-existing exclusions; no lifetime maximum.
- Effective January 1, 2007, the copayment structure for RX increased to $10 generic/$30 formulary/$50 non-formulary; and the office visit copayment increased to $25.
- Care Management programs for asthma, diabetes, coronary artery disease (CAD), congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD).

Pricing: SFY 2008

For January 2007 Anthem filed[10] and the Bureau of Insurance approved the following unadjusted rates for DirigoChoice:[11]

Small Group - Per month

1250	One Adult	Two Adults	Two Adults and Child(ren)	One Adult and Child(ren)
	$357.02	$749.74	$1071.06	$642.64
1750				
	$330.08	$693.17	$990.24	$594.14
2500				
	$324.58	$693.17	$990.24	$594.14

These rates represented, on average, a 5.5% increase from the Agency's 2006 contract. The rates incorporate the benefit changes outlined above.

Non-Group (Individuals and Self Employed of One) - Per month

1750	One Adult	Two Adults	Two Adults and Child(ren)	One Adult and Child(ren)
	$392.16	$784.32	$1176.48	$705.89
2500				
	$385.62	$771.25	$1156.87	$694.12

These rates, on average, represented a 13.4% increase from the Agency's 2007 contract. The rates incorporate the benefit changes outlined above.

[9] Preferred Provider Organization.
[10] Due to the timing of the Anthem rate filings, 2007 rates did not take effect for the non-group market until March 2007.
[11] The Carrier may adjust rates up or down under current rating regulations for group size, geography, and age.

For January 2008 HPHC filed and the Bureau of Insurance approved the following unadjusted rates for DirigoChoice:

Small Group - Per month

1250	One Adult	Two Adults	Two Adults and Child(ren)	One Adult and Child(ren)
	$364.16	$764.74	$1092.48	$655.49
1750				
	$336.68	$707.03	$1010.04	$606.03
2500				
	$331.07	$695.25	$993.21	$595.93

These rates represented, on average, a 2% increase from the Agency's 2007 contract.

Non-Group (Individuals and Self Employed of One) - Per month

1750	One Adult	Two Adults	Two Adults and Child(ren)	One Adult and Child(ren)
	$458.83	$917.65	$1376.48	$825.89
2500				
	$451.18	$902.36	$1353.54	$812.12

These rates, on average, represented a 17% increase from the Agency's 2007 contract.

The rates and rate increases detailed above are competitive with small group and non-group plans in the Maine market with similar benefit designs.

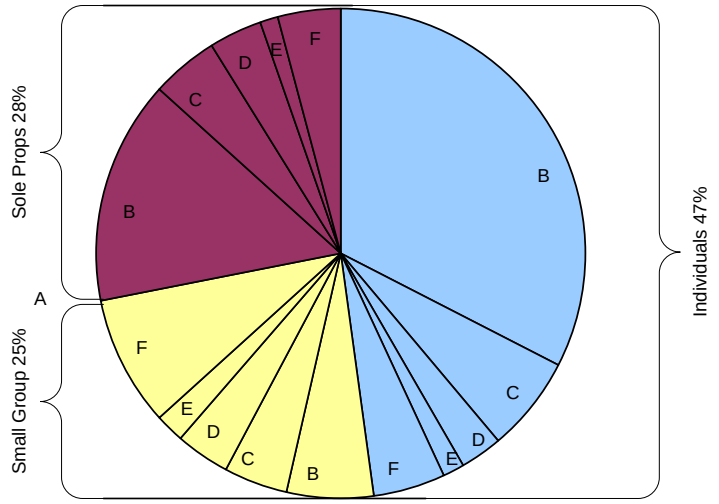
The Agency has taken steps to minimize the rate of increase through benefit design changes which has increased cost sharing to DirigoChoice members.

Enrollment/Membership as of June 2008

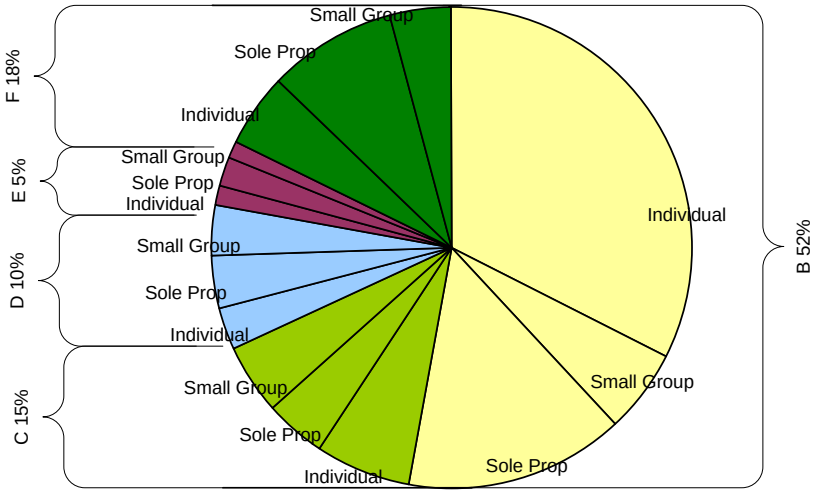
Dirigo Health Monthly Numbers June 2008
Dirigo Health Agency 07/02/2008

Total Members Served, DC + Parents	28,745
New DC Members (un/subsidized)	81 (29/52)
HCTC Members	78
Total Enrolled DC Members	12,050
New DC Small Groups	4
Total Enrolled DC Small Groups	637
Total Enrolled Parents	5,597
New Parents	0
CY 2008 Member / Employee Share of coverage cost	$ 17,446,174.08 (48%)
CY 2008 Dirigo Share of coverage cost (subsidy)	$ 19,202,837.59 (52%)
CY 2008 total coverage cost	$ 36,649,011.67 (100%)
CY Member Months	77,742 (100.16% to projected)
CY Subsidy PMPM	$247.01 (95.14% to projected)
FY 2008 Member / Employee Share of coverage cost	$34,834519.60 (46%)
FY 2008 Dirigo Share of coverage cost (subsidy)	$40,133,369.82 (54%)
FY 2008 total coverage cost	$74,967,889.42 (100%)
FY Member Months	178,223
FY Subsidy PMPM	$225.19

Members by Employer Type



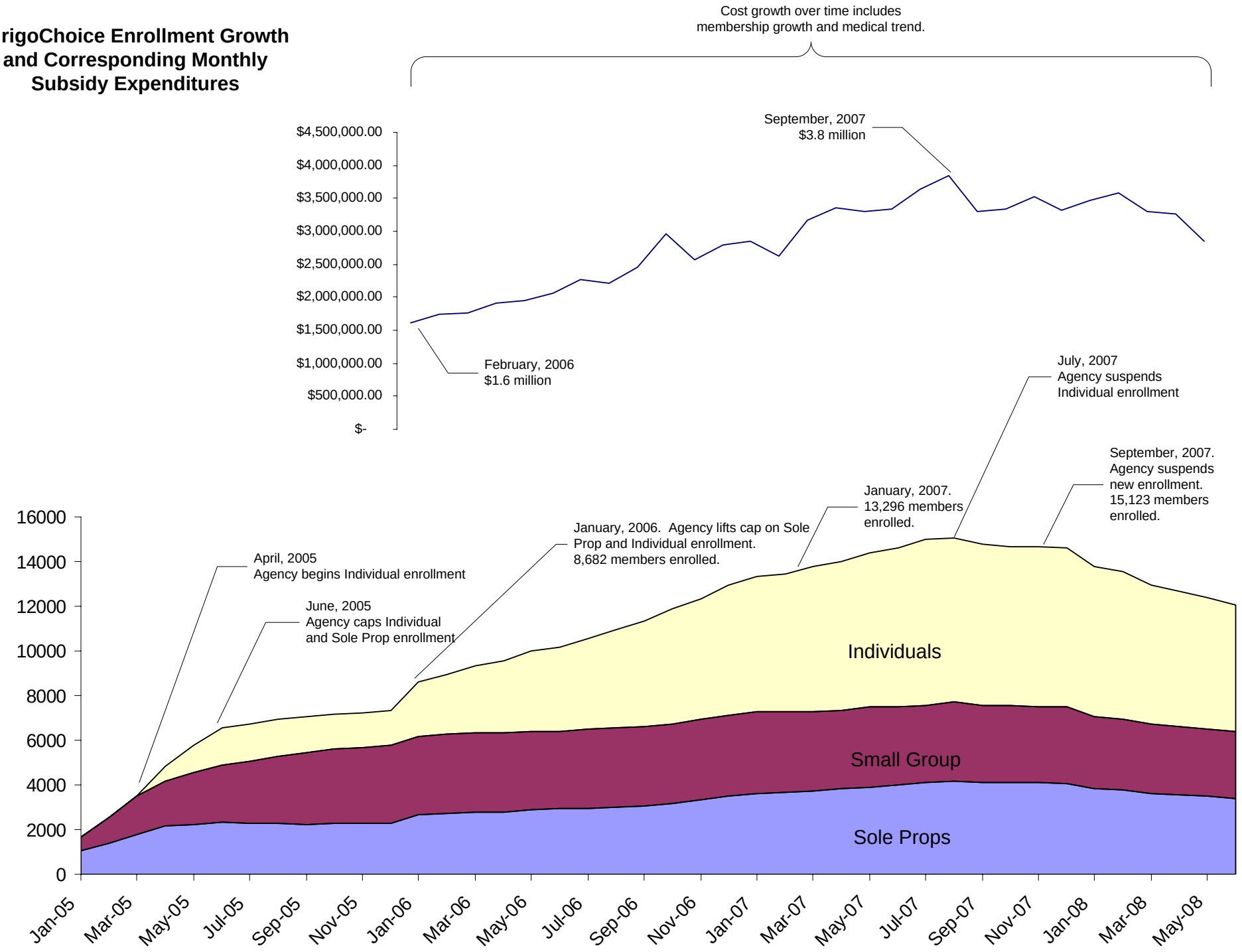
Members by Discount Level



Notes:

1. Total Members Served refers to the total number of members ever enrolled (beginning 01/01/2005) for any period of time in the DirigoChoice or MaineCare Parent Expansion programs
2, Total New Members refers to the number of new members enrolled in the reporting month.
3. Total Enrolled Members refers to the number of members currently enrolled in the reporting month.
4. Annual subsidy PMPM is the average “per member per month” annual cost for the Agency in 2008.

DirigoChoice Enrollment Growth and Corresponding Monthly Subsidy Expenditures



DirigoChoice Program Experience SFY 2008

Duration

The plan enrolls members monthly for a 12 month contract period.

- In SFY 2008, DirigoChoice experienced an 85% monthly persistency rate, meaning 85% of members eligible to renew at the end of their 12 month contract period chose to do so for another 12 month period.
- The average monthly off-cycle termination rate (members leaving due to non-payment and new employment are the top two reasons for off-cycle termination) is 3%.

Demographics

- Approximately 36% of DirigoChoice members were previously uninsured.[12]
- Approximately 31% of DirigoChoice members were previously under-insured.[13]
- 67% of the DirigoChoice population is under 200% of FPL.
- Approximately 46% of Small Employers enrolled were previously uninsured.
- The average household income[14] for DirigoChoice (subsidy eligible) members is $15,025.20.

Average Household Income by Subsidy Level

Level	Avg. Income	Avg. Declared Household	Avg. Enrollment	Income per Declared	Income per Enrolled
B	$8,121.56	1.90	1.57	$4,274.51	$5,172.97
C	$24,238.04	2.19	1.79	$11,067.60	$13,540.80
D	$30,480.71	2.12	1.75	$14,377.69	$17,417.55
E	$36,193.24	2.02	1.66	$17,917.45	$21,803.16
Avg.	$15,144.38	1.99	1.60	$7,610.24	$9,465.24

- The average household size for DirigoChoice (subsidy eligible) members is 1.99, with an average enrollment of 1.60.
- The average age of women enrolled in DirigoChoice is 42.3
- The average age of men enrolled in DirigoChoice is 38.8

Claims Utilization

- Approximately 1% of DirigoChoice members drive approximately 27% of the plan cost
- Claims cost distribution by service category[15]:
  - Inpatient 25%
  - Rx 18%
  - Professional 25%
  - Outpatient 33%
  -
- 60% - 67% of pharmacy claims were for Generic (Tier 1) drugs

[12] Based on Muskie DirigoChoice member survey and DirigoChoice application material.
[13] Defined as deductibles exceeding 5% of income and income was less than 200% FPL. The DHA Board adopted this definition of underinsured in 2005.
[14] Household income as defined in subsidy eligibility above.
[15] Figures do not sum to 100% due to rounding

DirigoChoice Aggregate Experience and Costs

Reports from Anthem and Harvard Pilgrim Health Care reflect the DirigoChoice Loss Ratio[16] for claims incurred January 2005 paid through June 2008[17] is 84.95%. The breakdown by segment is as follows:

- Small Group 68.63%,
- Self employed of one 71.52% and
- Individuals 102.63%.

Since January 2005 out of pocket costs (copayments and coinsurance) for members have been 19.1% of the total payments to providers.

In aggregate since January 2005 the total DirigoChoice premium (i.e., the amount paid by the Agency, Members, and Employers to the carriers) was $179 million[18], broken down as:

- Agency share: $100 million
- Employer / Member share: $79 million

Of the $179 million in premium, the carrier retained $27 million for administrative costs, taxes, reserves, and profit (based on the loss ratio reports from the carrier).

- Administrative costs, etc.: $27 million
- Payments to providers: $152 million

In addition to the payments the carrier made to providers for DirigoChoice member claims, the members have been responsible for copayments and coinsurance as described above.

- Carrier payments to providers: $152 million
- Member copayments and coinsurance: $36 million

In summary:

Total member/employer payments:	$115 million
Total Agency payments (subsidy)	$100 million
Total:	$215 million
Total payments to providers:	$188 million.
Total carrier administration/profit:	$27 million
Total	$215 million

[16] The ratio of the annual claims paid by an insurance company to the premiums received.
[17] This time period represents 36 months with Anthem and 6 months with HPHC.
[18] Figures in this section have been rounded to the nearest million.

MaineCare Parent Eligibility Expansion

New enrollment in SFY 2008 for the MaineCare parent expansion was 178, resulting in an ending membership of 5,610 and a total of 67,201 member months[19] for the year.

The total cost to the Agency (State share of coverage cost) in SFY 2008 for the MaineCare parent expansion was $4,128,205, representing a $61.43 PMPM.

[19] The total of all months that each member is covered by a plan. A plan with 1,000 members in January and 1,200 members in February has year-to-date 2,200 member months as of March 1. Member months, and ratios calculated by member months provide the most relevant statistics for evaluating a plan's financial performance.

Determination of Aggregate Measurable Cost Savings 2007/2008

Pursuant to 24-A M.R.S.A. § 6913 (1) (A), the Board of Trustees of the Dirigo Health Agency is required to determine annually no later than August 1st the aggregate measurable cost savings (AMCS), including any reduction or avoidance of bad debt and charity care costs to health care providers in the State as a result of the operation of the Dirigo Health Agency. The Board's determination of AMCS is made after a hearing conducted in accordance with the Maine Administrative Procedure Act (APA).

The Board's determination of AMCS is reviewed by the Superintendent of Insurance as described in 24-A M.R.S.A. § 6913 (1) (C).

The Dirigo Board of Trustees issued a Notice of Pending Proceeding and Hearing on June 14, 2007. The Notice set a date for the hearing, made the Dirigo Health Agency a party to the proceedings and set the terms and conditions for intervention. The Maine Association of Health Plans, the Maine State Chamber, the Maine Automobile Dealers Association Insurance Trust and Consumers for Affordable Health Care filed applications to intervene. The Board granted intervener status to all applicants.

The evidentiary portion of the adjudicatory hearing on AMCS for the third assessment year was held by the Board on July 23 and July 24. On July 26, 2007, the Board deliberated and rendered its decision.

The Dirigo Health Agency presented to the Board the following three initiatives to be included in AMCS for the third assessment year:

- Hospital Savings (Cost Per Case Mix-Adjusted Discharge (CMAD)
- Uninsured/Under insured (Bad Debt & Charity Care (BD&CC)
- Health Care Provider Fee (Hospital and Physician fee initiatives)

For CMAD, the Dirigo Health Agency's consultant, schrammraleigh Health Strategy, determined savings in the amount of $70.6 million; for BD&CC $14.0 million and for the health care provider fee initiative $7.8 million. Schrammraleigh determined there was $4.0 million in overlap and as such deducted this amount from the final total of $88.4 million in AMCS.

In developing the year three methodology and calculations schrammraleigh attempted to address the key concerns raised in the Superintendent's year two decision. The schrammraleigh report also set forth reasonableness checks to test the accuracy and sensitivity of the calculations.

Based upon the expert testimony and evidence provided, the Dirigo Board determined on July 26, 2007, that it was reasonable to include the three initiatives the Agency presented in the year three AMCS. The total amount approved was $78.1 million.

The Dirigo Board filed its report and the record with the Superintendent of Insurance on August 6, 2007.

The Superintendent conducted a hearing pursuant to 24-A M.R.S.A. § 6913(1) (C); the Maine Administrative Procedure Act, 5 M.R.S.A. chapter 375, subchapter 4; 24-A M.R.S.A. §§ 229 to 236; Bureau of Insurance Rule Chapter 350; and orders of the Superintendent in this matter.

The purpose of the Superintendent's hearing is for the Superintendent to review the filing of the Dirigo Board and "issue an order approving, in whole or in part, or disapproving the filing." 24-A M.R.S.A. § 6913(1) (C).

Based on the evidence provided to the Superintendent of Insurance, the Superintendent determined on September 17, 2007 that the Dirigo Board's determination of aggregate measurable cost savings for year three was approved in part in the amount of $32.8 million.

Following the Superintendent's decision and pursuant to 24-A M.R.S.A § 6913(2) the Board is required to determine annually a savings offset amount to be paid by health insurance carriers, employee benefit excess insurance carriers and 3rd-party administrators.

On September 19, 2007, the Board voted unanimously to accept the Agency's recommendation to assess $32.8 million which translated to a 1.74% assessment on paid claims beginning with plan years starting July 1, 2008.

Agency staff and the Board continued to discuss the cash flow challenges created as a result of the construct of the application (plan year) and collection of the savings offset payment (60 days at the close of each quarter).

There were several legislative attempts to repeal the savings offset payment and replace it with a more sustainable, less controversial funding mechanism. In April of 2008, the Legislature passed LD 2247, which was signed into PL 2007, Chapter 629. Among other actions, Chapter 629 repealed the savings offset payment and replaced the funding of the Dirigo Health Agency with a new tax on beer, wine and soda and a flat surcharge on paid claims. The new funding mechanisms in Chapter 629 eliminated the cash flow problems of the savings offset payment as well as the significant expense of determining AMCS each year.

Immediately following the passage of PL 2007, Chapter 629, a People's Veto was organized and the outcome was a repeal of the new funding. As a result, the cash flow challenge of the savings offset payment continues. The Agency will look to the 124th Legislature in the January 2009 session for their leadership and guidance specific to how the Agency continues to advance its goal of expanding access and improving the quality of health care in the State.