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October 24, 2005

By E-mail and U.S. Mail

Alessandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon, Docket No. INS-05-700
Bureau of Insurance
Maine Department of Professional & Financial Regulation
124 Northern Avenue
Gardiner, Maine 04345

**Re: In Re: Review of Aggregate Measurable Cost Savings Determined by Dirigo
Health for the First Assessment Year
Docket No. INS-05-700**

Dear Superintendent Iuppa:

Enclosed for filing in the above-referenced matter please find the original and one (1) copy of the following documents:

1. Filing Cover Sheet; and
2. Maine State Chamber of Commerce's Pre-Hearing Brief.

Thank you for your attention to this matter.

Very truly yours,



William H. Stiles

WHS/rdl
Enclosure
cc: Service List (***Hand Delivered & Email***)

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE)
MEASURABLE COST SAVINGS)
DETERMINED BY DIRIGO) FILING COVER SHEET
HEALTH FOR THE FIRST)
ASSESSMENT YEAR)

DOCKET NO. INS-05-700

To: Alessandro Iuppa, Superintendent of Insurance
Attn: Vanessa J. Leon

Dated Filed: October 24, 2005

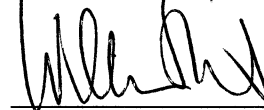
Name of Party: Maine State Chamber of Commerce

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Respectfully submitted,



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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE:)	
)	
REVIEW OF AGGREGATE)	
MEASURABLE COST SAVINGS)	MAINE STATE CHAMBER
DETERMINED BY DIRIGO HEALTH)	OF COMMERCE'S PRE-
FOR THE FIRST ASSESSMENT YEAR)	HEARING BRIEF
)	
)	
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)	
Docket No. INS-05-700)	

Pursuant to the Second Procedural Order dated October 11, 2005, the Maine State Chamber of Commerce ("Chamber"), by and through its attorneys, hereby submits its Pre-Hearing Brief.

I. INTRODUCTION.

On September 14, 2005, the Dirigo Health Board of Directors ("Board") voted three to one to adopt aggregate measurable cost savings related to the operation of Dirigo Health in the amount of approximately \$137,000,000. On September 19, 2005, the Board filed with the Superintendent of Insurance its determination of aggregate measurable cost savings for the first year of the savings offset payment ("Dirigo Filing").

II. APPLICABLE LAW.

The statutory provisions governing this proceeding are found at 24-A M.R.S.A. § 6913 (as amended by P.L. 2005 c. 400, Section B-2(B)). It reads, in pertinent part, as follows:

[T]he Board shall file with the Superintendent of Insurance its determination as to the aggregate measurable cost savings in this State, including any reduction or avoidance of bad debt and charity care costs to health care providers 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 ...

Id. This provision plainly requires that savings be “aggregate,” “measurable,” and “as a result of” (1) “the operation of Dirigo Health” and (2) “an expansion in MaineCare eligibility occurring after June 30, 2004.” The Board carries the burden of proof regarding this threshold requirement.

III. THE BOARD UTILIZED UNREASONABLE METHODOLOGIES TO DETERMINE THE AMOUNT OF AGGREGATE MEASURABLE COST SAVINGS.

The Board’s determination that there are nearly \$137,000,000 of aggregate measurable cost savings is not reasonable. As discussed in more detail below, the Board adopted flawed methodologies for measuring cost savings resulting from the operation of Dirigo Health, used incorrect information when applying those flawed methodologies, and took credit for influences and trends that were not related to Dirigo Health.

A. Hospital Initiatives.

The Board determined that there was approximately \$83.8 million of aggregate measurable cost savings related to the so-called Hospital Initiatives. According to the Board, those savings arose from the voluntary limitations specified in Section F-1(B) of the Dirigo Act,¹ which reads as follows:

B. Each hospital ... is asked to voluntarily restrain cost increases, measured as expenses per case mix adjusted discharge, to no more than 3.5% for the hospital fiscal year beginning July 1, 2003 and ending June 30, 2004. Each hospital is asked to voluntarily hold hospital consolidated operating margins to no more than 3% for the hospital’s fiscal year beginning July 1, 2003 and ending June 30, 2004.

Id. Although this unallocated language does create voluntary limits that apply to hospitals, it does not follow that a hospital’s attempt to comply with these limits would produce “savings” to be measured under 24-A M.R.S.A. § 6913(1) (as amended). Indeed, the plain language of

¹ P.L. 2003, c. 469.

Section 6913 refers to savings “as a result of the operations of Dirigo Health” -- not as a result of the implementation of the Dirigo Act. Dirigo Health was established “to arrange for the provision of comprehensive, affordable health care coverage” 24-A M.R.S.A. § 6902. The powers and duties delegated by law to Dirigo Health reflect this purpose, and do not include monitoring or enforcing the voluntary limits on hospitals or other persons or entities. 24-A M.R.S.A. § 6908 (specifying the powers and duties of Dirigo Health). Therefore, the Chamber objects to the inclusion in “aggregate measurable cost savings” any amount related to the Hospital Initiatives.²

1. CONSOLIDATED OPERATING MARGIN.

To determine hospitals’ compliance with the voluntary 3% limit on consolidated operating margin (“COM”), the Board compared each hospital’s adjusted 2004 COM³ to a baseline average COM. **Board Filing, p. 4.** If a hospital’s baseline average COM was above 3% and the actual adjusted 2004 COM was less than the baseline (whether or not under 3%), then the Board attributed the “savings” to Dirigo. **Id.** The amount of the savings was calculated as the difference in operating income between the baseline margin applied to 2004 operating revenue, and the actual operating income in 2004. **Board Filing, Attachment 11, Appendix E.** Using this formula, the Board found \$8.8 million of “savings” attributable to three hospitals only: Eastern Maine Medical Center (“EMMC”) (\$7.44 million); Mid Coast Hospital (“Mid Coast”) (\$971,210); and Sebecook Valley Hospital (“SVH”) (\$383,344).⁴ **Id.**

² On this same basis, the Chamber objects to consideration of the Carrier Initiatives, CON/CIF Initiatives, and the Budget Initiatives.

³ As described on Appendix E to the Final Mercer Report (Attachment 11 to the Dirigo Filing), operating margin is defined as operating income (operating revenue minus operating expense) divided by operating revenue. In order to “standardize” the definition of operating income across Maine hospitals, the Board excluded investment income, gifts, and equity investments from operating income. In addition, the Board translated the calculations to a June 30 fiscal year end.

⁴ Only three hospitals produced alleged saving because 29 of the 36 hospitals reviewed had a baseline COM below the 3% threshold, and thus could not produce savings attributable to the 3% margin limitation.

The Board's COM savings methodology is flawed because it merely looks at raw results, and fails to exclude from these results known occurrences, factors and trends that are unrelated to the operation of Dirigo Health. For example, it is reasonable to conclude that no "savings" can be attributed to a hospital whose baseline COM was below 3% because that hospital is already in compliance with the voluntary target. However, it is not reasonable to assume that if a hospital's baseline exceeded 3%, any reduction for 2004 is necessarily attributable to the operation of Dirigo Health. Indeed, the hospital's COM may have been trending downward prior to the Dirigo Act's enactment, or it may have dropped suddenly due to a reduction in volume, payor mix, increased expenses or a combination of these (and other) factors. Furthermore, it is also quite possible that the baseline COM may have been artificially high due to the events of a single year or occurrence.

These factors compel rejection of the alleged savings attributable to the three hospitals. For example, EMMC's baseline margin was skewed by a single year (FY 2001) in which EMMC's COM was 5.6%. Thereafter, EMMC's margin trended downward to 1.4% (FY 2002) and 1.2% (FY 2003) due to a significant decrease in patient volume. However, when EMMC's volume rebounded during FY 2003 and FY 2004, its COM actually increased in the first Dirigo year, rising from 1.2% in FY 2003 to 2.8229% in FY 2004.⁵ Similarly, both SVH and Mid Coast experienced a downward trend in the baseline years, with Mid Coast experiencing an increase in 2004.⁶

The experience of these hospitals highlights several fundamental flaws in the Board's methodology. First, the Board's methodology assumes that "savings" occurred based solely

⁵ In fact, only by adjusting EMMC's fiscal year to coincide with the State's fiscal year does the Mercer Report qualify EMMC for a COM SOP. If EMMC's fiscal year remains unadjusted, its baseline average COM falls below 3%.

⁶ Furthermore, measuring "savings" by comparing the 2004 COM against the baseline average overstates savings if a hospital's COM was already trending downward.

upon a comparison of a three-year baseline average to the first Dirigo year actual experience. As explained above, both EMMC's and Mid Coast's COM actually increased in the first Dirigo year as compared to the prior year, and thus could not have resulted in savings related to the operation of Dirigo Health. Therefore, the methodology adopted by the Board to determine "savings" is not reasonable because it disregards relevant trends, fails to exclude outlier years, and ignores more accurate comparisons.

Second, the Board simply assumes that the "savings" identified by its methodology are attributable to the operation of Dirigo Health.⁷ However, since the Board's methodology makes absolutely no attempt to exclude commonly experienced external factors (volume, payer mix, etc.) that have a substantial impact on COM, this assumption is not reasonable. For example, increased patient volume plays a significant role in profitability, as it allows a hospital to spread its substantial fixed costs over a larger patient population. This drives down the cost per unit of service and, because more patients are paying for services, there is a concomitant increase in revenue. Similarly, a change to a hospital's payer mix (the ratio of commercial payer, Medicaid, Medicare and self-pay patients) can affect a hospital's "profitability" if the ratio of higher paying commercial patients declines in favor of lower paying governmental patients. By disregarding the import of these random fluctuations, the Board's methodology allows Dirigo Health to take credit for "savings" that are not attributable to the operation of Dirigo Health. Unless and until the Board can show that the identified "savings" are attributable to the operation of Dirigo Health -- and not to other external commonly occurring factors -- any alleged "savings" identified by the Board's methodology can not be considered reasonable.

⁷ Interestingly, as explained above, the Board does not assume that increased costs identified by its methodology are related to Dirigo, and accordingly it refuses to offset these costs.

Finally, even putting aside the issue of attribution, the flawed methodology was incorrectly implemented. First, the methodology improperly inflated the base year COM for all hospitals by reducing net operating expense by the amount of bad debt.⁸ Second, the methodology improperly weighted all non 6/30 hospitals' 2001 COM by failing to determine COM for 2000.⁹ Third, it utilized an improper Excel spreadsheet formula when adjusting EMMC's 2001 COM to coincide with the State's fiscal year.¹⁰

2. COST PER CASE MIX ADJUSTED DISCHARGE.

In an attempt to measure hospitals' adherence to the voluntary 3.5% limitation related to cost increases, the Board compared two projected figures for 2004 cost per case mix adjusted discharge ("CMAD"). The first was calculated "by applying the base line average rate of growth¹¹ to the 2003 CMAD." **Board Filing, p. 5.** The second was determined "by applying the difference between the target rate and the inflation rate to the 2003 CMAD." **Id.** If the first projection exceeded the second, as it did for twenty-three (23) hospitals, the Board assumed that there were savings related to Dirigo Health. It then calculated the "savings" for these hospitals "by taking the difference between the two amounts and multiplying by the number of 2004 case-mix adjusted and outpatient adjusted discharges." **Id.** However, the Board failed to aggregate the savings by also including the cost "increases" experienced by the other thirteen (13) hospitals (as measured by the Board's methodology).

⁸ Bad debt is properly reflected as an expense, not a reduction to revenue. See Dirigo Response to Chamber Request for Information #11.

⁹ See Pre-Filed Testimony of Roland Mercier.

¹⁰ Although EMMC's COM for 2001 was 5.6% on Ms. Kane's spreadsheet, the same spreadsheet identified EMMC's 2001 adjusted COM at 11.1718%. Ms. Kane's spreadsheet contained a formula error. Total operating expense in column BA30 derives from BA14 (other operating expense) rather than BA15 (total operating expense). By correcting this reference in Ms. Kane's spreadsheet, EMMC's adjusted COM for 2001 automatically dropped to 5.6%, its State fiscal year adjusted baseline average similarly dropped to just over 3%, and the SOP amount identified dropped from approximately \$7.5 million to \$992,450 -- a \$6,366,215 error.

¹¹ The base line average rate of growth is the rate of growth that exceeds the hospital market basket index ("HMBI").

The Board's CMAD "savings" methodology suffers from the same infirmity as its COM methodology -- it makes unreasonable assumptions based upon a comparison of raw results without excluding from those results known occurrences and factors unrelated to Dirigo Health. Again, it is not reasonable to assume that if a hospital's historical growth rate slowed in the first Dirigo year, those reductions are automatically attributable to the operation of Dirigo Health. This is because the Board's methodology cannot distinguish whether the decreased growth rate is related to cost cutting measures implemented to meet the voluntary limit or simply a product of other influences, such as increased patient volume. Indeed, a hospital that disregarded the voluntary limit by increasing its costs 5% across the board could still produce significant "savings" under the Board's methodology if its actual patient volume increased unexpectedly. Hospitals must carry significant fixed operating and stand-by costs to meet patient demands 24 hours a day, 7 days a week, 365 days a year (bricks and mortar, administrative, overhead, core staff, etc.), and these costs are incurred regardless of how many patients actually utilize the hospital's services. In addition, because a core direct care staff is required, and accepted patient-to-staff ratios are not 1:1, a hospital can absorb certain levels of increased volume before adding incremental staffing costs. Therefore, increases in patient volume help the hospital to achieve economies of scale by spreading the same substantial fixed costs over a larger number of patients. As a result, increased patient volume will generally reduce a hospital's cost per CMAD (even though gross expenses may remain constant).¹²

Because the Board's methodology failed to consider the impact of these randomly occurring factors, the "savings" produced are not a reliable indicator of Dirigo Health's impact on the 23 hospitals. For example, the Board's methodology attributes \$5,642,520 of "savings" to Mount Desert Island Hospital ("MDI"), a small critical access hospital -- even though its total

¹² Similarly, decreased patient volume will usually increase a hospital's cost per CMAD.

operating expenses increased from \$16,631,660 in 2003 to \$19,457,307 in 2004. Furthermore, the alleged savings represent 29% of its operating budget for 2004. A reasonable methodology would not produce such absurd results. Similarly, Stephens Memorial Hospital (“SMH”), a small hospital in Norway, Maine, produced “savings” of \$5,787,878 (or nearly 24% of its operating budget) despite the fact that its total expenses increased by \$1,046,349 from 2003 to 2004.¹³ Such a result is facially unreasonable, as is the methodology that produced it.

Again, the experiences of these hospitals highlights several fundamental flaws in the Board’s methodology. First, the Board counted only the hospitals that produced alleged “savings,” and did not reduce this amount by the increased cost per CMAD experienced by nearly on third of Maine’s hospitals. Therefore, the Board’s methodology does not show “aggregate” cost savings and does not measure the impact of Dirigo Health on all of Maine’s hospitals.

Second, the Board merely assumes that “savings” arise from a reduction in the growth of a hospital’s cost per CMAD. However, the Board’s methodology does not differentiate between (1) a hospital whose rate of growth in its cost per CMAD declined because of expense cutting measures; and (2) a hospital whose rate of growth in its cost per CMAD declined because of commonly experienced external factors (such as volume, state and national trends, employer initiatives, managed care initiatives). For example, if a hospital’s volume increases, its cost per CMAD will very likely decrease because its fixed costs will be spread over a larger patient population. Although this would drive down the cost per unit of service (CMAD), it would not necessarily indicate “savings” because there were more units of service (albeit at a lower cost per unit).

¹³ A summary comparison of the CMAD SOP amount, total expenses, and volume increases for all 23 hospitals is attached to Mr. Mercier’s pre-filed testimony as **Exhibit 6**.

Third, the Board’s methodology does not measure cost savings that are the result of the operation of Dirigo Health. At best, it measures the fluctuation in the hospitals’ cost per CMAD, and assumes that any reduction in the rate of growth is related to the operations of Dirigo Health. Since much of this fluctuation relates to random, naturally occurring factors (such as volume, state and national trends, employer initiatives, managed care initiatives), this methodology will always produce savings so long as at least one hospital’s cost per CMAD declined from the baseline projection to the measured year. This is a near certainty in an industry saddled with a high percentage of fixed costs and cyclical volume patterns. By disregarding the impact of these numerous and well known external influences, the Board’s methodology hijacks savings that would have materialized in Dirigo’s absence. This is why the Lewin Group could use the same methodology to identify “savings” in Maine prior to the law’s enactment. In fact, it even found “savings” from Dirigo in New Hampshire. Clearly, a methodology that finds “savings” in times and places not implicated by Dirigo cannot be a reasonable measure of aggregate measurable cost savings related to the operation of Dirigo Health.

Finally, even putting aside the issue of attribution, the Mercer Report incorrectly implemented its flawed methodology. As explained in the pre-filed testimony of Mr. Mercier, a limited review of the spreadsheet supporting the CMAD calculations found material errors that resulted in a substantial overstatement of the “savings” identified in the Mercer Report.¹⁴

B. Carrier Initiatives.

The Chamber contends that voluntary underwriting gain (“VUG”) initiative is improperly before the Superintendent. Although there is unallocated statutory language that creates a

¹⁴ This is in addition to the approximately \$11 million of errors identified by a Mercer “peer review” of Ms. Kane’s calculations. Since Ms. Kane’s calculations (which were adopted by the Board) contained an error rate of nearly 15%, the Chamber submits that it is unreasonable to rely upon them.

voluntary limit that apply to carriers, for the reasons explained in Section III.A, the savings, if any, attributed to the Carrier Initiatives cannot be attributed to the operations of Dirigo Health.

Furthermore, the Board's methodology was inappropriately modified for Anthem BCBS so that data for much of 2000 was excluded. In 2000, underwriting gains were low throughout the country. By eliminating a portion of 2000, the Board's methodology grossly overstates Anthem's historical level of UG, which in turn has the effect of inflating the VUG savings estimate.

C. Uninsured / Under-Insured Initiatives.

Pursuant to the Dirigo legislation, the Board is directed to measure savings related to any reduction or avoidance of bad debt and charity care costs ("BD / CC") to health care providers as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004. 24-A M.R.S.A. § 6913(1). The Board adopted Mercer's determination that \$5.7 million in "savings" is attributable to Dirigo Health's uninsured/under-insured initiatives. This includes \$1.6 million related to the uninsured, \$1.1 million to the under-insured, and \$3 million for a so-called "woodwork effect" ("WW").

Regarding all of these categories (uninsured, under-insured, WW), Mercer identifies and values BD / CC on a charge basis, rather than the required cost basis required by the plain language of § 6913(1).

In addition, Mercer's methodology is highly theoretical, with multiple assumptions that can not be verified. Despite the ready availability of data from reliable (governmental) sources to measure what actually happened to BD / CC costs, Mercer does not compare its results to the reported uncompensated care data for providers to measure or confirm their presumption that

uncompensated care costs were reduced. Employing a highly theoretical method without any analysis of available data on what actually happened is unreasonable.

For example, with respect to the under-insured, Mercer's method assumes that the full amount of uncompensated care for DirigoChoice enrollees would become fully covered. DirigoChoice survey data indicates that about 12 percent of the previously insured people enrolling in the program had no deductible under their prior plan, and about 11 percent had a deductible of less than \$500. Deductibles under DirigoChoice can be up to \$1,750 per person depending upon the policy selected and the individual's income level. The Lewin Group estimates that the average out-of-pocket expense for these previously insured DirigoChoice enrollees would decline from about \$775 under their prior plans to about \$450 under DirigoChoice. Based on the above information, it is reasonable to expect that some BD care will continue for these out-of-pocket amounts, yet Mercer's approach assumes there will be none. This assumption, which maximizes "savings," is unreasonable.

Regarding the WW effect, Mercer assumes that one-half of the increase in MaineCare enrollment in SFY 2005 is attributed to the WW effect. However, MaineCare enrollment has been increasing at an average annual rate of 3.5 percent since 2001. The total increase in MaineCare enrollment in 2005 was only about 2.5 percent, which is well under the average in recent years. Nonetheless, Mercer provides no explanation for the assumption that one-half of the increase in MaineCare enrollment is due to the WW effect, as opposed to normal MaineCare enrollment rates. Even more troubling, the failure to provide a basis for its assumptions can not be based on the lack of studies. As Mr. Sheils will testify, a recent study of expansions in children's coverage in California supports the conclusion that about 1,170 people enrolled as a

result of the WW effect, compared with Mercer's assumption of 3,881.¹⁵ However, to the extent these people were eligible to enroll in MaineCare prior to June 30, 2004, the legislation requires that they be excluded from the calculation of savings.

D. Certificate of Need ("CON") / Capital Investment Fund ("CIF") Initiatives.

The Board determined that there was a total of \$9.8 million dollars in "savings" as a result of changes to the State's CON law and the establishment of the CIF -- \$4.1 million related to hospital projects, and another \$5.7 million related to non-hospital projects. For at least the following reasons, the Board's determination is unreasonable:

First, Dirigo Health's powers and duties do not include regulating CON matters; instead, such matters are within the purview of the Maine Department of Health and Human Services (the "Department"). 22 M.R.S.A. § 326; 10-144 CMR ch. 503. Thus, any "savings" related to CON cannot possibly be attributed to the operation of Dirigo Health. This conclusion is consistent with the legislative history of Dirigo,¹⁶ as well as pronouncement's from the Governor's Office of Health Policy and Finance.

Second, even assuming the CON changes are an appropriate Dirigo initiative, the Board's adopted methodology for measuring CON savings is flawed because it assumes that the operating costs for each approval drop to zero after the first three years, even though these facilities would continue to be in operation. **See Appendix M to Mercer's Final Report.** This has the effect of artificially reducing the amount of costs associated with approved projects in 2004 and thereafter, and lends the appearance of a dramatic reduction in spending relative to the historical trends.

¹⁵ The Chamber also finds it questionable that the WW effect had more of an effect on BD and CC than the uninsured and underinsured combined (\$3 million as compared to \$2.7 million).

¹⁶ For example, the summary to Committee Amendment "A" to L.D. 1611, which ultimately was adopted by the Legislature and enacted as P.L. 2003, c. 469 stated: "savings offset payments may not exceed the aggregate cost savings attributable to reductions in bad debt and charity care costs as a result of the operation of Dirigo Health"

Third, the Board unreasonably assumes that operating costs begin to accrue in the same State fiscal year in which the CON application was approved. This assumption ignores reality, as many CON projects require substantial construction before the operating costs will begin to accrue. Mr. Schramm admitted in his testimony before the Board that, “if you look at the type of projects that go through the certificate of need approval process, they are very large, complex initiatives. [Such as] Cardiac cath labs, complete renovations, new buildings, structures associated with a hospital.”¹⁷ Although acknowledging the fact that many CON projects are complex construction projects, the methodology proposed by Mercer and adopted by the Board nonetheless assumes operating costs begin to accrue in the same month as a project is approved. This is an unreasonable assumption which would necessarily yield an unreasonable result. By failing to allow for acquisition and/or construction, the Board’s methodology artificially and inappropriately moves any savings forward by at least one year, perhaps two or more, depending upon the type of project. **See Pre-filed testimony of John Sheils, at page 32.** Indeed, simply by moving the CMMC cardiac surgery CON forward one year, all the “savings” identified by Mercer disappears. **See Exhibit 9 to Pre-filed testimony of John Sheils.**

E. Budget Initiatives.

The Board adopted “savings” of \$14 million related to the Department’s decision to settle multiple MaineCare administrative appeals and lawsuits by 12 hospitals in exchange for a payment of approximately \$96.4 million dollars.¹⁸ In addition, the Board adopted “savings” of \$12.3 million of savings related to the Department’s decision to increase MaineCare physician

¹⁷ Transcript of Dirigo Health Board of Directors, September 6, 2005 Board Meeting, p. 49.

¹⁸ Under the terms of the Settlement Agreements, half of the payment would be paid by December 31, 2005 (SFY 2006) and the remained by July 31, 2006 (SFY 2007). To help close a budget shortfall, the Department elected to pay the full amount by September 30, 2005 (SFY 2006), the last day on which it could receive a higher federal Medicaid matching rate (i.e., the federal government paid a higher share of the \$96.4 million).

fee schedule payments by \$12.3 in SFY 2006 and 2007, and hospital periodic interim payments (“PIP”) for SFY 2006 and 2007. This methodology is not reasonable.

First, the Board justifies its use of Medicaid funds because the Dirigo Act created the Commission to Study Maine Hospitals (“Commission”), and the Commission’s Report (“Report”) happened to mention various problems with hospital and physician Medicaid funding in a section explaining “cost shifting.” See Report, pp. 60-63. While creative, this attenuated connection does not satisfy the plain language of Section 6913. Again, the law requires savings “as a result of the operations of Dirigo Health” -- not as a result of the Dirigo Act, the Commission, MaineCare or the Department. Furthermore, it is clear that neither Dirigo Health nor the Commission has the authority to administer the MaineCare program. Indeed, pursuant to the MaineCare State Plan (a document required by the federal government), the Department is the single state agency authorized to administer the MaineCare program. Therefore, this matter is not properly before the Superintendent.

Second, even assuming that Dirigo Health can bootstrap MaineCare payments into Dirigo Health “savings,” the Board has offered no explanation for its conclusion that the time value of payments to be made in the future have already resulted in present “measurable cost savings.”

Third, with respect to the physician fee initiative, the basis for including a MaineCare fee schedule increase appears to be the opportunity to reduce cost shifting. However, there is no evidence in the Dirigo filing to support that such a reduction of cost shifting has actually occurred -- or even could occur.

Finally, the Board’s methodology unreasonably assumes that the MaineCare physician fee schedule increase will reduce cost shifting because the physicians will automatically pass through the entire long overdue MaineCare fee increase to commercial payors. However, as

explained by Anthem's witnesses, Medicare, Medicaid and most commercial payers make payments to physicians based upon a fixed fee schedule, and therefore a reduction to a physician's charges would not have the effect assumed by the Board.

Conclusion

The Board's determination of the aggregate measurable cost savings is unreasonable and must be rejected because: (1) it includes matters not related to Dirigo Health; (2) it adopted flawed methodologies that do not distinguish between naturally occurring fluctuation in COM/CMAD/VUG; (3) it implemented the flawed methodologies incorrectly; and (4) it relies upon unsupported and unsupportable assumptions.

Dated: October 24, 2005

Respectfully submitted,



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CERTIFICATE OF SERVICE

I, William H. Stiles, attorney for the Maine State Chamber of Commerce, hereby certify that on this 24th day of October 2005 I caused the foregoing document to be served upon all counsel of record via Hand-Delivery and E-mail as follows:

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Respectfully submitted,



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