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October 21, 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. Testimony and Exhibits of Roland P. Mercier

Thank you for your attention to this matter.

Very truly yours,

William H. Stiles

WHS/rdl
Enclosure
cc: Service List ***(by e-mail)***
John Kelly ***(by e-mail and U.S. Mail)***
Kristine Ossenfort

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

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

DOCKET NO. INS-05-700

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

Dated Filed: October 21, 2005

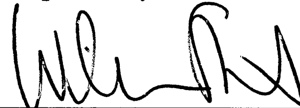
Name of Party: Maine State Chamber of Commerce

Document Title Prefiled Testimony and Exhibits of Roland P. Mercier

Document Type: Testimony

Confidential: No

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	)
	DETERMINED BY DIRIGO	)
	HEALTH FOR THE FIRST	)
	ASSESSMENT YEAR	)

Docket No. INS-05-700

CERTIFICATE OF SERVICE

I, William H. Stiles, attorney for the Maine State Chamber of Commerce, hereby certify that on this day the foregoing document was served on the following parties via first-class mail and electronic mail:

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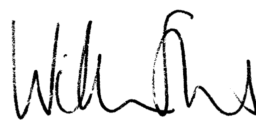

William H. Stiles, Bar No. 8123

NON-CONFIDENTIAL

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

IN RE:	)	EXHIBIT ___
	)	
REVIEW OF AGGREGATE	)	
MEASURABLE COST SAVINGS	)	PREFILED TESTIMONY OF
DETERMINED BY DIRIGO HEALTH	)	ROLAND P. MERCIER
FOR THE FIRST ASSESSMENT	)	
YEAR	)	
	)	
Docket No. INS-05-700	)	October 21, 2005
	)	

NON-CONFIDENTIAL

1 **Q. Please state your name.**

2 A. Roland Mercier.

3 **Q. In what capacity are you currently employed?**

4 A. I am a Principal at the firm of Baker Newman Noyes ("BNN") in Portland, Maine. I
5 received a Bachelors of Science degree in accounting from the University of Maine in 1982.

6 **Q. You will provide testimony today regarding hospital financial information**
7 **contained in Medicare cost reports. What experience do you have in this area?**

8 A. I was employed by Associated Hospital Service of Maine, the Medicare Fiscal
9 Intermediary ("FI") as a Senior Auditor from 1982 to 1987, where I was responsible for
10 training FI staff and auditing Medicare cost reports for all provider types. I then moved on to
11 become the Reimbursement Manager at Eastern Maine Medical Center from 1988 to 1993,
12 where my responsibilities included all facets of third party reimbursement including
13 preparing Medicare and Medicaid cost reports. In addition, I was responsible for properly
14 stating third party reserves for financial statements. Since 1993 I have been employed at
15 BNN, first as a Senior Manager, and since 1998, a Principal. I currently manage, along with
16 two other principals, a Health Care Department of eight consultants.

17 For the past thirteen years, I have provided Medicare, Medicaid and third party payer
18 reimbursement and financial consulting services to hospitals and other types of health care
19 providers. I have assisted hospitals with Medicare and Medicaid cost reporting matters,
20 including the preparation and review of cost reports, assistance during Medicare desk
21 review, focused review and field audits, and analysis of Medicare adjustment reports. I often
22 am called on to quantify reimbursement impacts and advise clients regarding audit findings.
23 In addition, I have prepared Medicare and Medicaid exception requests, assisted with

1 Medicare and Medicaid appeals and position papers, and served as expert witness for clients

2 before the Medicare Provider Reimbursement Review Board and the Medicaid agency.

3 Together with others on my staff, BNN provides cost report preparation/review for

4 over 100 provider types in Maine, New Hampshire, and Vermont.

5 **Q. Does your work require you to be familiar with hospital financial statements?**

6 A. Yes. As a principal, I am responsible for the review of third party reserves which

7 includes properly reporting third party reserves for third party settlements and accounts

8 receivables on audited financial statements.

9 **Q. Have you reviewed the sections of the Final Mercer Report dated September 19,**

10 **2005 addressing Dirigo savings related to hospital consolidated operating margin**

11 **("COM") and cost per case mix adjusted discharge ("CMAD")?**

12 A. Yes, I have.

13 **Q. Let's start with COM. Have you been able to determine how the Mercer Report**

14 **calculated each hospital's COM?**

15 A. Yes. I have reviewed the Excel spreadsheet prepared by Ms. Nancy Kane, a copy of

16 which is attached to my testimony as **Exhibit 8.**

17 **Q. Can you explain the methodology used by Ms. Kane?**

18 A. To determine each hospital's COM, Ms. Kane's starting point was Total Gross

19 Patient Service Revenue. She then deducted free care, bad debt, and contractual allowances

20 to arrive at Net Revenues. After arriving at Net Revenues, other operating revenues were

21 included to arrive at Total Net Revenues. Once Total Net Revenues are computed, total

22 Operating Expenses are deducted to arrive at each hospital's fiscal year net income from

23 operations. This methodology was performed for each fiscal year from 2001 through 2004.

1 Once the provider's fiscal year data was accumulated, Ms. Kane weighted these amounts to

2 reflect the state's fiscal year end of June 30. She than developed a Base Line Operating

3 Margin which is the average of three years (2001, 2002 and 2003) of weighted net operating

4 income as a percentage of adjusted Net Revenues. Finally, she computed the 2004 weighted

5 net operating income as a percentage of adjusted Net Revenues.

6 **Q. Have you been able to determine how Ms. Kane decided whether a hospital has**

7 **produced Dirigo-related savings with respect to COM?**

8 A. Yes. In Appendix E to the Mercer Report, Ms. Kane explained that a savings offset

9 payment would arise if the hospital's baseline margin percentage was above 3% and the 2004

10 year operating margin percentage was less than the baseline average.

11 **Q. In your opinion, was it proper to exclude from a potential saving offset payment**

12 **those hospitals that had a baseline COM below 3%?**

13 A. Absolutely. If hospitals had baseline margins below 3%, the Dirigo voluntary "limit"

14 could not possibly be limiting to them. I believe that Ms. Kane made a statement to that

15 effect in Appendix E to the Mercer Report. Based on the calculations performed by Ms.

16 Kane, it looks like the vast majority of hospitals -- 29 out of 36 -- had a baseline average

17 COM that was below 3%.

18 **Q. Where there any hospitals that had a baseline margin above 3% and a 2004**

19 **adjusted operating margin below its baseline?**

20 A. Yes, there were three: (1) Eastern Maine Medical Center ("EMMC"); (2) Mid Coast

21 Hospital ("MCH"); and (3) Sebasticook Valley Hospital ("SVH").

22

23

1 **Q. How did Ms. Kane calculate the savings offset payment for these three hospitals?**

2 A. The savings offset payment calculated by Ms. Kane was the difference in net income
3 from operations between the baseline margin applied to 2004 Net Revenues, and the actual
4 net income from operations in 2004.

5 **Q. In your opinion, is the methodology used by Ms. Kane a reasonable measure of**
6 **savings related to the voluntary 3% limitation?**

7 A. No. It is not reasonable to assume that there are in fact savings simply because a
8 hospital had a baseline above 3% and that hospital's 2004 COM was less than its baseline
9 average. Let's take EMMC for an example. Using Ms. Kane's own calculations, EMMC's
10 adjusted operating margin was 11.1718% for 2001, 2.4383% for 2002, 1.2648% for 2003,
11 and 2.8229% for 2004. These numbers clearly show that EMMC's COM was trending
12 significantly downward prior to the enactment of the Dirigo Act, and actually increased in
13 the first Dirigo year. Similarly, MCH's COM was trending downward prior to Dirigo, but
14 increased from 2003 to 2004. Again, this conclusion is supported by Ms. Kane's own
15 calculations. Therefore, in my opinion, it is not reasonable to say that these hospitals
16 produced savings in 2004.

17 **Q. Are there other reasons that you believe the methodology is unreasonable?**

18 A. Yes. Even if you assume that this methodology properly identifies savings, which in
19 my opinion is unreasonable, this methodology is also unreasonable because it fails to link
20 these alleged "savings" to the operation of Dirigo. Instead, the methodology simply assumes
21 that a reduction in COM occurred because of Dirigo. This is not a reasonable assumption
22 because there are many randomly occurring influences that can have an impact on a
23 hospital's COM. These include patient volume, payer mix, and governmental payer rates,

1 which affect the revenue side of the calculation. In addition, a COM could decline if
2 expenses rise at a rate that exceeds increases in revenue. As you can see by reviewing Ms.
3 Kane's calculations, a hospital's COM fluctuates from year to year. This was true before
4 Dirigo existed, and these fluctuations will continue to occur in the future with or without
5 Dirigo. Therefore, it is unreasonable for Dirigo to take credit for a reduction of COM
6 without additional proof.

7 **Q. If I understand your last comment, do you question whether the "savings"**
8 **identified by this methodology are attributable to Dirigo?**

9 A. Yes. As previously explained, Dirigo is trying to take credit for the "savings"
10 identified for EMMC and MCH, even though both hospitals' COM were trending downward
11 long before Dirigo was created, and in fact increased from SFY 2003 to SFY 2004. There is
12 a similar problem for SVH. According to Ms. Kane's calculations, SVH's COM was
13 .066326 for SFY 2001, .058641 for SFY 2002, and .053024 for SFY 2003. Although SVH
14 continued this downward trend for SFY 2004 by falling to .036919, it is not reasonable for
15 Dirigo to take credit for these "savings" in the absence of specific proof.

16 **Q. Why is that?**

17 A. Again, there are many influences that affect COM. For example, according to Ms.
18 Kane's calculations for CMAD, SVH's patient volume (discharges) dropped from 3,641 in
19 2003 to 3,127 in 2004. Therefore, declining revenue, rather than cost cutting measures, may
20 have been the major contributing factor to the decline in COM for 2004. In Ms. Kane's
21 analysis, she simply assumes that all positive occurrences are 100% related to Dirigo, an
22 assumption that is unreasonable in such a complex industry.

23

1 **Q. Do you question other aspects of Ms. Kane's methodology?**

2 A. Yes. It is unclear to me why she chose to adjust all hospitals to the State Fiscal Year
3 ("SFY") end of June 30. Most hospitals do not have a June 30 fiscal year end, and thus
4 would not manage their operations to such a period. Ms. Kane's adjustment does not appear
5 to be consistent with Gov. Baldacci's letter to Maine Hospitals dated August 29, 2003, a
6 copy of which I received from the Maine Hospital Association. This letter is attached to my
7 testimony as **Exhibit 9.** It is also inconsistent with how Medicare and Medicaid treat
8 hospital fiscal years when implementing new regulatory changes.

9 **Q. Why is that important?**

10 A. By adjusting the hospital's fiscal year end to June 30, Ms. Kane's analysis may skew
11 the results. For example, according to Ms. Kane's calculations, EMMC's COM for its fiscal
12 years that ended in September 2001, 2002 and 2003 was 5.6%, 1.5% and 1.2%, respectively.
13 So EMMC's baseline average COM using its fiscal year would be 2.76%. Since it is under
14 3%, EMMC would not be eligible for a COM SOP. However, by adjusting EMMC's fiscal
15 year to a state year end of June 30, Ms. Kane overstated the COM percentages, thereby
16 driving EMMC's adjusted baseline above 3%. Because of this, according to Ms. Kane,
17 EMMC produced savings of nearly $7.5 million.

18 **Q. Have you found any other errors in methodology?**

19 A. I have. In reviewing the Excel spreadsheets prepared by Ms. Kane to support her
20 COM SOP findings, the following exceptions and findings were noted:

21 First, the computations to arrive at the baseline COM for EMMC, MCH and SVH are
22 based on dividing net operating income by net revenues. However, net revenues were
23 adjusted by deducting bad debts. Bad debt is not considered a reduction to revenues. Rather,

1 it is reported as an operating expense on the financial statements. Although incorporating
2 bad debts as a reduction to revenue will still produce the correct operating gain or loss, it
3 improperly increases the COM when stated as a percentage of net revenues because the net
4 revenue amount has been understated. Therefore, by incorporating bad debts as a reduction
5 to revenues, Ms. Kane improperly increased each hospital's baseline average COM.
6 Second, I noted that Ms. Kane's computations do not correctly weight the state fiscal
7 year 2001 for the three hospitals identified as producing Dirigo-related "savings." There was
8 no fiscal year 2000 information for EMMC, MCH and SVH included in the "weighted" SFY
9 calculation for 2001. As a result, Ms. Kane did not correctly translate these hospitals from
10 their fiscal year to the SFY, thus misstating the baseline average.
11 Finally, financial statements for SVH's fiscal year 2000 were based on a November
12 30 year end. SVH changed year end to September in fiscal year 2001 when it became part of
13 the Eastern Maine Healthcare System. As a result, the weighting for SVH must be amended
14 to reflect the correct number of months coinciding with SFY 2000.
15 **Q. Have you reviewed each and every calculation contained in Ms. Kane's COM**
16 **spreadsheet?**
17 A. No. The Chamber's attorneys received this information late in the evening on
18 October 14, 2005, so a review of the calculations for each of the 36 hospitals over a four year
19 period was simply not possible in the time provided.
20 **Q. Based upon your review of the Mercer Report and your limited scope review of**
21 **the underlying calculations, what have you concluded regarding the $8.8 million of**
22 **savings identified by Dirigo for COM?**

1 A. I have concluded that it is simply not reasonable to conclude that Dirigo has produced
2 any measurable savings related to COM. First, 29 of the 36 hospitals were already under 3%
3 as measured by Ms. Kane's baseline measurements. Therefore, there can be no savings
4 related to these hospitals. Second, Ms. Kane failed to follow industry accepted practices
5 such as including bad debt as an operating expense (rather than a deduction from revenue),
6 thus artificially inflating the hospitals' baseline COM. Third, even putting aside Ms. Kane's
7 incorrect calculations, it is not reasonable to conclude that EMMC and MCH produced
8 "savings" for 2004 because their operating margins actually increased from 2003 to 2004
9 (although their 2004 COM fell below the baseline average). Finally, it is not reasonable to
10 conclude that Dirigo can claim credit for the fact that SVH's COM dropped from 5.3% in
11 2003 to 3.6% in 2004. As you can see from Ms. Kane's calculations, SVH's COM had been
12 trending downward since 2001, long before Dirigo could have any influence. The fact that
13 such a trend continued under Dirigo does not provide a reasonable link between the alleged
14 "savings" and the operations of Dirigo.
15 **Q. I'd like to discuss the cost per case mix adjusted discharge (CMAD) calculations**
16 **identified in the Mercer Report dated September 19, 2005. Can you please explain how**
17 **this calculation is made?**
18 A. Yes. Based upon review of the Mercer report, the CMAD SOP is computed in
19 various steps. The first step is to compute the cost per CMAD. The cost per CMAD is
20 arrived at by adjusting total expenses to remove non-acute care expenses and dividing the
21 adjusted expenses by total case mix adjusted discharges for inpatient and outpatient services.
22 Inpatient and Outpatient revenues are utilized to develop a conversion of outpatient revenues
23 to outpatient discharges. The result is a cost per CMAD. This calculation is performed for

1 each hospitals fiscal year ending in 2000, 2003 and 2004, and then weighted to coincide with
2 the State's fiscal year ending June 30.

3 The second step in the computation is to calculate the Base Line Compound Growth
4 Rate ("Baseline CGR") adjusted for inflation. This is arrived at by taking the difference in
5 the Cost per Case Mix Adjusted Discharge (CMAD) between fiscal year 2003 and 2000. The
6 2000 cost per CMAD is adjusted the Hospital Market Basket Index ("HMBI") inflation
7 factors from 2001 to 2003 for comparison to 2003 actual cost per CMAD. The difference in
8 the cost per CMAD between 2003 and 2000 is translated into a Baseline CGR over the three
9 year period.

10 The third step is arrived at by taking the difference in the cost per CMAD between
11 fiscal year 2004 ("Dirigo Year") and 2003. The difference in the cost per CMAD is
12 translated to a percentage increase/decrease from 2003 to 2004. This amount is then adjusted
13 to remove inflation by reducing the increase/decrease by the HMBI inflation factor of 3.8%
14 for 2004. Once adjusted for inflation, we arrive at the Dirigo Year percentage increase in
15 cost per CMAD.

16 The fourth step is to determine which providers qualify for the Savings Offset
17 Payment (SOP). Per review of the Mercer report, a hospital will produce "savings" if its
18 Dirigo Year change in cost per CMAD was less than the hospital's Baseline CGR.

19 The fifth step is determining the amount of the "savings." The amount of the
20 "savings" is arrived at by determining the difference between (1) the Baseline CGR times the
21 2003 actual CMAD and (2) the actual Dirigo Year percentage change in cost per CMAD
22 multiplied by 2003 actual CMAD. This difference is than multiplied by the number of total
23 inpatient and outpatient discharges for 2004 to arrive at the SOP.

1 Finally, all of the hospitals with SOP are summed to arrive at the Mercer report
2 amount of $64,187,815. Dirigo does not offset this amount against the increased costs from
3 the hospitals that did not qualify for an SOP because their Dirigo Year costs exceeded the
4 Baseline CGR.
5 **Q. So this is similar to the COM calculation in that it compares a baseline**
6 **measurement with one based upon actual costs in 2004?**
7 A. Yes, and just like COM, costs per CMAD are subject to randomly occurring
8 influences that cause costs per CMAD to rise or fall each year.
9 **Q. What are some of these influences?**
10 A. Patient volume can have a significant effect on cost per CMAD, because hospitals
11 have a high level of fixed and standby costs to provide services on a 24/7/365 basis. These
12 fixed costs include administration, housekeeping, medical records, cafeteria, bricks and
13 mortar, depreciation and interest expense, among others. Therefore, as volume increases,
14 cost per CMAD naturally declines as these same costs are spread over a larger number of
15 discharges. Patient acuity can also have an effect on cost per CMAD, as greater acuity will
16 increase a hospital's case mix index, which in turn creates increased volume.
17 **Q. Have you examined Ms. Kane's calculations that support the summary found at**
18 **Table 2 to Appendix F of the Mercer Report dated September 19, 2005, and the**
19 **corrections to these calculations dated October 13, 2005?**
20 A. Yes, I have. Ms. Kane's calculations are attached to this testimony as **Exhibit 4.**
21 **Q. Did you attempt to verify the Baseline CGR> HMBI and 2004 Growth Rate >**
22 **HMBI calculations set forth on Table 2 of Appendix F?**

1 A. Again, the Chamber's attorneys did not receive Ms. Kane's spreadsheets until late in
2 the evening on Friday, October 14, 2005, so a complete review of such a detailed calculation
3 was not possible. However, I attempted to verify the figures and formulas for the 23
4 hospitals that she identified as producing "savings."

5 **Q. How did you do that?**

6 A. First, based upon the description set forth in Appendix F, I created an Excel
7 spreadsheet designed to replicate her formula. I then tested the spreadsheet by inputting data
8 provided by Ms. Kane for a single provider. Since the same data produced the same result, I
9 was able to verify that the model accurately replicated her formula for hospitals with that
10 fiscal year end. A copy of this spreadsheet is attached to my testimony as **Exhibit 1.** Then,
11 the model was further tested by inputting Ms. Kane's data for all 23 hospitals that produced
12 "savings" in the Mercer Report. The model produced a nearly identical result, with a
13 variance of only six one thousandth of a percent (.0006%). A copy of this spreadsheet is
14 attached to my testimony as **Exhibit 2.**

15 **Q. What did you do next?**

16 A. Using available Medicare cost reporting data, I performed a limited scope audit to
17 determine whether Ms. Kane used the correct input data. In many instances, I determined
18 that she used incorrect information. Each time I discovered a variance between her data and
19 mine, I adjusted the spreadsheet amount to the audited number, highlighted the change, and
20 photocopied my source data. A copy of the revised spreadsheet and the source data is
21 attached to my testimony as **Exhibit 3 and Exhibit 5.** After reviewing, testing and auditing
22 Ms. Kane's data and adjusting her data based on the audit findings, the revised CMAD SOP
23 is adjusted from $64,187,815 to $38,047,344, a reduction of $26,140,471.

1 **Q. Can you explain the types of audit findings that you discovered that had a**
2 **material impact on Ms. Kane's computations?**
3 A. In many instances, the Medicare cost report data did not reconcile to the amounts
4 identified on Ms. Kane's spreadsheet. In other instances, incorrect line numbers were
5 accumulated from the Medicare cost report. On several occasions, incorrect discharges were
6 utilized in Ms. Kane's computation. Discharges did not reconcile to the source documents
7 provided by the Maine Health Data Organization or the Maine Health Information Center.
8 Additionally, Ms. Kane utilized cost reports that covered less than a twelve month period, but
9 utilized a full year of discharge statistic. This last type of error had a profound impact on the
10 CMAD SOP computation.
11 **Q. You testified that your audit findings reduced CMAD "savings" to $38,047,344.**
12 **In your opinion, is it reasonable to believe that these "savings" are related to the**
13 **operation of Dirigo?**
14 A. No. The purpose of the audit was limited to verifying Ms. Kane's formula and data
15 inputs. In my opinion, the methodology identified in Ms. Kane's spreadsheet is not a
16 reasonable measure of savings related to the operation of Dirigo.
17 **Q. Why is that?**
18 A. The methodology itself is not reasonable. It simply compares a baseline growth rate
19 to an actual growth rate, and assumes that an actual growth rate that is lower than the
20 baseline resulted from the operation of Dirigo. Furthermore, it only looks at those hospitals
21 with reductions and ignores those with increases, which seems inconsistent with the concept
22 of "aggregate" savings.
23

1 **Q. Why is that unreasonable?**

2 A. A hospital's cost per CMAD fluctuates each year based upon the hospital's
3 experience in that year. As previously explained, a hospital's experience is influenced by a
4 number of randomly occurring factors such as volume and acuity. Since Ms. Kane's
5 methodology employs an averaging technique, it is unlikely that a hospital's actual 2004
6 experience with follow the baseline experience exactly, so the hospital's actual 2004
7 experience will either be above the baseline rate or below it. In addition, if a hospital's
8 growth in cost per CMAD was already trending downward in the baseline period, the
9 averaging technique will result in a larger difference between (1) the Baseline CGR times the
10 2003 actual CMAD and (2) the actual Dirigo Year percentage change in cost per CMAD
11 multiplied by 2003 actual CMAD. These conclusion are supported by reviewing Ms. Kane's
12 spreadsheet.

13 If you follow the Dirigo methodology, you would only count those hospitals whose
14 actual growth rate fell below the baseline rate, and ignore those who were above it.
15 Therefore, if one or more hospitals meet this test, there will be "savings" related to the
16 operation of Dirigo. Since this methodology would very likely produce "savings" in
17 whatever place or time period it is applied, I agree with Mr. Sheils' testimony that this
18 methodology cannot be relied upon as a reasonable measure of Dirigo-related savings.

19 **Q. You testified earlier that volume can have a substantial impact on cost per**
20 **CMAD. Can you give an example of this?**

21 A. Yes. When reviewing Ms. Kane's calculations, I discovered that she had improperly
22 matched the expense, revenues and discharges statistics for Stephens Memorial Hospital's
23 ("SMH") fiscal year ended 9/30/2000. I found that Ms. Kane used only nine months of

1 expense and revenue for SMH for this period. This is because SMH changed its fiscal year
2 from 12/31 to 9/30 when it affiliated with Maine Health, and therefore SMH's 9/30/2000
3 Medicare cost report covered only a nine month period. However, I noted that Ms. Kane
4 used a full twelve month discharge statistic. As a result, I decreased discharges from 2,231
5 to 1,642. Incorporating this adjustment has a profound impact on SMH's cost per CMAD,
6 and decreased Ms. Kane's SOP from $5,786,000 to $3,334,000 ($2,452,000).

7 Another example of the impact of volume to CMAD SOP is the change in discharges
8 that was incorporated for York Hospital. Based upon audit findings, discharges for York's
9 fiscal year ending June 30, 2003 were increased to 4,384 from 4,326, an increase of only 58.
10 However, this had an impact of reducing York's CMAD SOP from $4,844,000 to
11 $3,741,000, a significant decrease of $1,103,000.

12 As you can see by the examples I just described above, volume changes can have a
13 dramatic impact on the computation to arrive at the CMAD SOP. I don't believe that the
14 Dirigo program should be taking credit for such "savings" if hospital patient volumes are
15 changing from year to year causing impact to CMAD.

16 **Q. Why is volume important?**

17 A. The computation to arrive at the cost per CMAD is heavily influenced by inpatient
18 and outpatient volume. Since total costs are divided by the number of units of CMAD, any
19 changes to volume will impact the cost per CMAD. If a hospital's volume increase between
20 fiscal year 2003 and 2004 and costs remain relatively flat, the cost per CMAD would actually
21 decrease. This decrease would increase the SOP because the difference in the Baseline CGR
22 and the cost increase percentage in the Dirigo Year would increase, thus creating the illusion
23 of "savings." However, this increase would be attributable to volume and not be a savings

1 related to Dirigo. I also question whether there are in fact "savings" -- although cost per

2 CMAD would decrease, there are more units of cost.

3 **Q. Can you provide an example to illustrate this point?**

4 A. Yes. If a hospital has total costs of $1,000,000 and 1,000 case mix adjusted

5 discharged, its cost per CMAD would be $1,000. However, if the next year total costs

6 increased by 3.5% to $1,035,000, but patient volume increased by 5% (50 case mix adjusted

7 discharges), the cost per CMAD would fall to $985.71. Again, although the hospital's cost

8 per CMAD decreased by $14.29 (1.429%), its total costs increased.

9 **Q. Have you compared the 2003 costs and the 2004 costs for the twenty-three**

10 **hospitals that produced an SOP under Ms. Kane's analysis?**

11 A. Yes. Using the information provided in Ms. Kane's spreadsheet, I created an Excel

12 spreadsheet identifying the alleged savings attributed to each hospital, and compared that to

13 each hospital's adjusted total costs as identified by Ms. Kane. I have attached this analysis to

14 my testimony as **Exhibit 6.**

15 Although the total costs for these twenty-three hospitals increased by approximately

16 $70,000,000 from SFY 2003 to SFY 2004, Ms. Kane's analysis determined that these same

17 hospitals produced $64,187,815 of "savings." Examining these findings on a hospital-by-

18 hospital basis shows that Mt. Desert Island Hospital, with total SFY 2003 costs of

19 $16,631,660 produced $5,642,000 of "savings" even though its total SFY 2004 costs actually

20 increased to $19,457,000. This shows the inappropriateness of Ms. Kane's methodology as

21 $5,642,520 represents nearly 29 percent of MDI's total costs. There are similar results for

22 other hospitals.

23

1 **Q. Can you please summarize your findings regarding COM and CMAD?**

2 A. First, based on a limited scope audit, it appears that Ms. Kane made a number of
3 material errors when calculating the SOP for COM and CMAD. In my opinion, it would be
4 unreasonable to rely on Ms. Kane's calculations.

5 Second, and more important, the methodology used to calculate the SOP for COM
6 and CMAD is flawed. It is not designed to measure "savings" that result from the operation
7 of Dirigo. Instead, its compares actual results to a three year baseline average. From a
8 statistical standpoint, it is very unlikely that actual results with exactly reflect the baseline
9 average, so a hospital's cost per CMAD will always be either above or below the baseline. If
10 a hospital's actual cost per CMAD falls below the baseline average, an SOP will result.
11 Again, I agree with Mr. Sheils' testimony that this methodology will almost certainly result
12 in savings in places and at times not affected by the operation of Dirigo. And if a
13 methodology finds Dirigo "savings" in other places, it cannot be a reasonable measure of
14 Dirigo-related savings.

15 **Q. Does this conclude your testimony?**

16 A. Yes.