Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax: (207) 287-3005
TTY: Dial 711 (Maine Relay)

IN THE MATTER OF:

Franklin Memorial Hospital	)	
c/o William Stiles, Esq.	)	
Verrill Dana, LLP	)	**FINAL DECISION**
One Portland Square	)	
Portland, ME 04101-4054	)	

This is the Department of Health and Human Services' Final Decision.

The Recommended Decision of Hearing Officer Longanecker, mailed June 15, 2021, and the responses and exceptions and supplemental reply briefs received from the Department and Franklin Memorial Hospital have been reviewed.

I hereby accept the Hearing Officer's Findings of Fact except that I _do not_ accept: the first sentence of Fact #24; or Fact #39. In addition, I hereby make the following additional Findings of Fact:

49. MaineCare payments to FMH through the cost-settlement process were based upon claims processed and approved by the Department. Testimony of Regan McTier; FMH Exhibit 8 at 0007; FMH Exhibit 10 at 0001.
50. The Department's cost-settlement process relied on Medicare Cost Reports as filed by FMH. DHHS Exhibit 8 at 0010.
51. FMH was not limited by Myers and Stauffer or the Department in the scope of documentation that FMH could provide for the audit to demonstrate that EHR incentive payments were consistent with federal rules and regulations. DHHS Exhibit 7; Testimony of Regan McTier.
52. FMH did not qualify the accuracy of the documentation that it provided for the audit and certified to Myers and Stauffer and the Department during the audit that its documentation was complete and without material error. Testimony of Regan McTier; Testimony of Natasha Erb; DHHS Exhibit 14.2.
53. There is no evidence that suggests that individual claims were removed by the Department based on payment by CHIP.

I hereby accept the Hearing Officer's recommendation that the Department was permitted to conduct a post-payment audit using documentation other than the Medicare cost report. I _do not_ accept the Hearing Officer's recommendation that the Department was not correct when it determined that Franklin Memorial Hospital received an overpayment for the EHR program in the sum of $634,992.72. For the reasons set forth below, I find that the Department was _correct_ when it determined that Franklin Memorial Hospital received an overpayment for the EHR program in the sum of $634,992.72.

The Department's burden in this case was to demonstrate that the amount of the EHR incentive payment for Franklin Memorial Hospital that was calculated during the post-

payment audit was correct (and therefore that Franklin Memorial Hospital had received an overpayment of $634,992.72). The Department satisfied this burden.

There is no dispute that the Department's post-payment audit calculation of the incentive payment was mathematically correct. And Franklin Memorial Hospital certified that the documentation that it provided during the post-payment audit was complete and without material error.

For the reasons set forth by the Hearing Officer in her recommended decision, the number of discharges utilized in average growth rate calculation in the post-payment audit calculation was correct.

For the reasons set forth by the Hearing Officer in her recommended decision, the total number of Acute Medicaid Days and Acute Medicaid Days used in the post-payment audit calculation was correct.

The total number of Acute Hospital Days used in the post-payment audit calculation was correct. This number was correctly calculated based on primary documentation provided by and certified by Franklin Memorial Hospital to be complete and without material error. Any discrepancy with numbers in the original incentive calculation does not, without other evidence, necessarily mean that there was an error in the post-payment calculation as there could be other causes for a discrepancy such as errors in the numbers used in the original calculation.

The Department appropriately utilized a CHIP factor as an across-the-board statistical factor. There is no evidence in the record that the factor was not correct or not correctly applied. There is no possibility of any "double-dip" reduction because the documentation provided by Franklin Memorial Hospital did not distinguish MaineCare-paid and CHIP-paid days.

Generalized assertions of problems with the implementation of the MeCMS system do not provide a basis for determining the post-payment audit calculation of the EHR incentive payment was incorrect. The record does not contain any evidence that the Department did not ultimately pay valid claims of Franklin Memorial Hospital or that the post-payment audit excluded any claims whether they were approved, unapproved, paid or unpaid as a result of the MeCMS system. Moreover, any unreliability created by the MeCMS system would necessarily have been present in the original calculation of the EHR incentive payment.

Finally, any discrepancies between the post-payment audit and Medicare Cost Reports or the MaineCare cost settlement process also do not provide a basis for determining the post-payment audit calculation of the EHR incentive payment was incorrect. The post-payment audit served a different function and did not perform the same analysis.

DATED: 10-26-21 SIGNED: ______________________

JEANNE M. LAMBREW, Ph.D., COMMISSIONER
DEPARTMENT OF HEALTH & HUMAN SERVICES

YOU HAVE THE RIGHT TO JUDICIAL REVIEW UNDER THE MAINE RULES OF CIVIL PROCEDURE, RULE 80C. TO TAKE ADVANTAGE OF THIS RIGHT, A PETITION FOR REVIEW MUST BE FILED WITH THE APPROPRIATE SUPERIOR COURT WITHIN 30 DAYS OF THE RECEIPT OF THIS DECISION.

WITH SOME EXCEPTIONS, THE PARTY FILING AN APPEAL (80B OR 80C) OF A DECISION SHALL BE REQUIRED TO PAY THE COSTS TO THE DIVISION OF ADMINISTRATIVE HEARINGS FOR PROVIDING THE COURT WITH A CERTIFIED HEARING RECORD. THIS INCLUDES COSTS RELATED TO THE PROVISION OF A TRANSCRIPT OF THE HEARING RECORDING.

cc: Thomas Bradley, AAG, Office of the Attorney General

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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TO: Jeanne M. Lambrew, Ph.D., Commissioner
Department of Health and Human Services
109 Capitol Street
11 State House Station
Augusta, ME 04333

DATE MAILED: June 15, 2021

In the Matter of: Franklin Memorial Hospital

ADMINISTRATIVE HEARING RECOMMENDED DECISION

Hearing Officer Tamra Longanecker held an administrative hearing in the above-captioned matter via Microsoft TEAMS on March 8, 2021 and via phone on March 9, 2021[1]. The record was left open for a written summary of Natasha Erb's testimony[2] and closing arguments. The record closed on April 16, 2021. The Hearing Officer's jurisdiction was conferred by special appointment from the Commissioner of the Maine Department of Health and Human Services.

Pursuant to an Order of Reference dated January 2, 2020, the issue presented *de novo* for hearing was whether the Maine Department of Health and Human Services ["Department"] was:

> Was the Department correct when it determined that Franklin Memorial Hospital ("FMH") owes the Department $655,120.30[3] in recoupment due to an overpayment of the Medicaid EHR Incentive Program Aggregate Payment as found in a Final Informal Decision dated August 27, 2019 and Notice of Debt dated October 22, 2018? Ex. HO-3.

[1] There were technical difficulties with TEAMS on the second day. The hearing officer completed the hearing telephonically.
[2] The hearing officer failed to record part of Ms. Erb's testimony on March 9, 2021. When the hearing officer discovered her error, she alerted the parties and allowed Attorney Stiles the opportunity to submit a written summary of her missing testimony. The Department reviewed the summary and did not object to its inclusion in this record.
[3] After hearing, the Department reduced this amount to $634,997.72.

APPEARING ON BEHALF OF THE APPELLANT

- William H. Stiles, Esq.
- Natasha Erb, Senior Director of Finance, Franklin Community Health Network
- Thomas Morgan, Reimbursement Director at Maine Medical Center (observing only)

APPEARING ON BEHALF OF THE DEPARTMENT

- Thomas C. Bradley, AAG
- Patricia Chubbuck, Independent Contractor EHR Incentive Program
- Regan McTier, Myers and Stauffer, LLC
- Phil Burns (observing only)

ITEMS INTRODUCED INTO EVIDENCE

Hearing Officer Exhibits

HO-1: The following items collectively: Scheduling notices
HO-2: The following items collectively: Pre-hearing and status conference orders
HO-3: Order of Reference
HO-4: Fair Hearing Report Form
HO-5: William Logan letter to Mr. Pickering dated 12/27/2019
HO-6: Request for hearing (with attachments) dated 11/9/2018
HO-7: Request for Informal Review (with attachments) dated 11/9/2018
HO-8: Letter from Mr. Pickering dated 2/28/2020
HO-9: Letter from HO dated 03/15/2021

Department Exhibits

D-1: Order of Reference
D-2: Federal Register/Vol 75, No 144
D-3: Department Request for Audit Review of Hospital Payment Calculations
D-4: 2011 Original Hospital Payment Calculation from DHHS
D-5: 2012 Recalculated Hospital Payment from DHHS
D-6: Franklin Hospital Payment Information
D-7: Desk Audit Notification Email & Follow up
D-8: Hospital Documentation Submission Email
D-9: Nursery and Dual Eligible Q & A Email
D-10: Summary of Findings and Response Email
D-11: Audit Review of Original Payment Calculation and Summary of Findings sent to Hospital

D-12: Revised Summary of Findings Updated based on Hospital Response
D-13: Revised Summary of Findings Hospital Approval Email
D-14: Management Representation Letter
D-15: Findings Letter sent to Hospital
D-16: Request for Informal Appeal
D-17: Attachment A to Request for Informal Appeal
D-18: Final Informal Review Decision
D-19: CHIP Factor Email from DHHS
D-20: CHIP Factor Calculation and Effect on Recoupment[4]
D-21: CMS Email – Medicaid Days
D-22: Maine 2011 State Medicaid Health IT Plan (SMHP)
D-23: 2011 SMHP Approval Letter
D-24: 42 U.S.C. §1396b – effective 2011

Appellant Exhibits

A-1: 42 U.S.C. §1396b and 42 U.S.C. §1395ww
A-2: 42 C.F.R. §495.300 *et seq.*
A-3: MaineCare's EHR instructions
A-4: MaineCare's original EHR determination
A-5: Audited 2010 Medicare Cost Report
A-6: MaineCare Final Cost Settlement (PDF and Live Excel Version)
A-7: withdrawn
A-8: MaineCare Benefits Manual, Chapter III, Section 45 (effective in 2010)
A-9: DRG descriptions
A-10: Articles addressing MeCMS Issues
A-11: Request for Informal Review
A-12: Final Informal Review Decision

Other documents in the record

Written Summary of Ms. Erb's testimony
Department's closing argument
Appellant's closing argument

[4] This exhibit was updated after the hearing to correct a calculation error discovered by Ms. Chubbuck, which reduced the recoupment amount to $634,997.72.

RECOMMENDED FINDINGS OF FACT

1. In accordance with agency rules, Franklin Memorial Hospital ["FMH"] was properly notified of the time, date, and location of the immediate proceeding.

2. The Health Information Technology for Economic and Clinical Health Act ["HITECH Act"] enacted as part of the American Reinvestment and Recovery Act of 2009 authorized federal Medicaid funding for Maine to create a Medicaid EHR (electronic health record) incentive program. This program encouraged eligible hospitals to convert from paper health records to electronic health records ["EHR"]. *See,* exhibit D-2.[5]

3. The Medicaid EHR incentive payments are 100% federal dollars.

4. Eligible hospitals voluntarily applied for and participated in the incentive program.

5. In order for Maine to participate in the payment incentive program, it first had to develop its State Medicaid Health Information Technology Plan ["SMHP"] and submit it to the Centers for Medicare and Medicaid Services ["CMS"] for approval. *See,* exhibit D-2.

6. CMS set out general requirements for the payment program, but allowed each state flexibility with which it could design an appropriate program within the guidelines. In terms of data sources the state should use in calculating the payments, CMS wrote:

> *[M]edicare cost reports, Medicaid cost report data, MMIS data, hospital financial statements, and accounting records are all items that we feel confident are accessible to all States and providers. Additionally, we believe that States and their provider communities are better versed at determining the tools that will be most beneficial for their individual programs. As such, we included the standard items listed as auditable data sources, but did not prohibit the use of other appropriate auditable data sources. States must describe their auditable data sources in their SMHP and submit to CMS for review and approval. See,* exhibit D-2, page 0191.

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[5] Federal Register, Vol 75, No. 144.

7. In May 2011, the Department submitted the third draft of its SMHP to CMS.

8. In June 2011, CMS approved the Department's revised SMHP. The approval letter notified the Department that its approval of the SMHP was subject to the provisions found in regulations at 42 CFR Part 495, Subpart D. *See,* exhibit D-23.

9. The 2011 SMHP was an agreement between the Department and CMS. It was not a formally promulgated rule under the Maine Administrative Procedures Act.

10. Among other things, the SMHP set out eligibility requirements for hospital participation and the process by which the Department calculates the Medicaid EHR incentive program aggregate payment[6]. *See,* exhibit D-22.

11. The SMHP stated that the Department would use Medicare cost reports "to verify the Medicaid patient volumes, and to calculate the payment amount." *See,* exhibit D-22 page 0873.

12. In its instructions to eligible hospitals, the Department wrote:

> *Your payment is based on several factors, such as discharges and revenues and in-patient days. MaineCare will calculate the payment amount. MaineCare will need information from the hospital's* ***Medicare cost reports*** *for the most recent hospital fiscal year, and the three previous hospital fiscal years. (A total of four years.) See,* exhibit A-3. (emphasis added by HO).

13. Effective October 4, 2011, and in accordance with the APA, the Department promulgated a Final Rule, "State Medicaid Health Information Technology Program," implementing the MaineCare HIT Program. The rule was published at 10-144 C.M.R. Ch. 101, sub-Ch. I, §2. The same rule chapter and section was amended by a Final Rule published with an effective date of November 23, 2014.

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[6] Hospitals may also receive Medicare EHR incentive payments. The issue of this appeal is solely the Medicaid incentive payment to FMH.

14. The 2011 HIT Program Rules stated that "OMS rules supplement federal law and rules, as amended, in areas where federal law and rules delegate authority to states." *See,* 2011 Manual, Chapter I §2.01.[7]

15. With regard to the amount of the incentive payment, the 2011 HIT Program Rules stated that "After confirming that the hospital meets the above requirements, MaineCare will calculate the total incentive payment for the EH in accord with 42 C.F.R. §§495.310(e),(f) and (g). *See,* 2011 Manual, Chapter I §2.05.B.5.[8]

16. With regard to the calculation of the incentive payment, the 2011 Program Rules did not specify which documents and/or information MaineCare will use to calculate the payment.

17. With regard to audits, the 2011 HIT Program Rules stated that "The Division of Audit or duly authorized Agents appointed by the Department shall have the authority to monitor payments to any EH by an audit or post-payment review under Chapter 1, Section 1, §1.16." *See,* 2011 Manual, Chapter I §2.05-1.D[9].

18. The aggregate EHR incentive payment amount is calculated as the product of the overall EHR amount times the Medicaid Share. *See,* exhibit D-2 (page 271).

19. In general, the overall EHR amount is an estimated dollar amount based on a total number of inpatient acute-care discharges over a theoretical 4-year period. It is only calculated once. The amount consists of an initial amount and a transition factor. After the initial amount is multiplied by the transition factor, all four years are added together to determine the overall EHR amount. *See,* 42 C.F.R. §495.310(g).[10]

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[7] The 2014 Rule was amended to state: "Maine's SMHP, IAPD-U and OMS rules supplement federal law and rules, as amended, in areas where federal law and rules delegate authority to states."

[8] This language remained unchanged in the 2014 Rule.

[9] The 2014 Rule was amended to state: "The Division of Audit or duly authorized Agents of the Department shall conduct pre-payment reviews and must approve all payments before issuance. The Division of Audit or duly authorized Agent shall have the authority to conduct post-payment audits of hospitals that participate only in the Medicaid incentive payment program, to include desk and on-site audits under the Department's SMHP and IAPD-U and Chapter 1, Section 1, §1.16.

[10] Exhibit A-2.

20. The Medicaid Share is equal to the following fraction:

(Numerator) – Sum for a 12 month period of:

- The estimated number of acute-care inpatient-bed-days which are attributable to Medicaid individuals;

  and

- The estimated number of acute-care inpatient-bed-days which are attributable to individuals who are enrolled in a managed care organization, a pre-paid inpatient health plan, or a pre-paid ambulatory health plan under part 438 of this chapter

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(Denominator) – Product of:

- The estimated total number of acute-care inpatient-bed-days with respect to the eligible hospital during such period;

  and

- The estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during such period.

In computing acute-care inpatient-bed-days within the numerator of the fraction, a State may not include estimated acute-care inpatient-bed-days attributable to individuals with respect to whom payment may be made under Medicare Part A, or acute-care inpatient-bed-days attributable to individuals who are enrolled with a Medicare Advantage organization under Medicare Part C. *See*, 42 C.F.R. §495.310(g)(2).[11]

[11] Exhibit A-2.

21. The Department determined that FMH was one of 36 non-psychiatric hospitals eligible for Medicaid EHR incentive payments.

22. For purposes of calculating FMH's incentive payment, the Department used FMH's fiscal year ending June 30, 2010 as its base year.

23. During the relevant time period (FYE June 30, 2010 and the 3 prior fiscal years), FMH was licensed as an acute care non-critical hospital.

24. During the relevant time period, FMH was not reimbursed on a claims basis. The Department paid hospitals through a cost report and settlement process pursuant to the MaineCare Benefits Manual, Chapter III, Section 45. *See,* Erb testimony and exhibit A-8.

25. From January 2005 to September 2010, the Department used MeCMS to process claims. FMH would submit a claim to MeCMS, which would then issue a remittance advice. FMH then would enter the remittance advice into its patient accounts. However, the remittance advices did not reflect the actual payment made to the hospital because FMH was paid based on the cost report, not on individual charges. In addition, the MeCMS system often incorrectly denied and otherwise processed claims incorrectly. In the words of former DHHS Commissioner Harvey, the MeCMS system was "a worst nightmare realized." *See,* Erb testimony and exhibit A-10.

26. Because of all the "glitches" in the MeCMS system, the Department took eight (8) years to issue the final cost settlement for FMH's FYE 2010. The Department usually takes one (1) year to issue the final cost settlement. *See,* Erb testimony and exhibit A-6.

27. Using FYE 2010 for its base year, the Department calculated the hospital's aggregate EHR incentive amount as $1,548,684, which was to be paid over a period of three (3) years. *See,* exhibit D-4.

28. Prior to 2014, the Department's Division of Audit had assigned an audit manager and an auditor for pre- and post-payment audits, and audit reporting functions. *See,* exhibit D-22 (page 0915).

29. States are required to perform post-payment audits of the EHR incentive payments and return any federal incentive payment money that is determined to have been overpaid to hospitals. *See,* exhibit D-2 (pages 0205 and 0279)

30. Sometime in 2012, the Department conducted a post-payment audit of FMH's incentive payment. As a result of this audit, the hospital's revised aggregate EHR incentive amount was increased to $1,552,906. *See,* exhibit D-5.

31. FMH received incentive payments during November 2011, May 2012 and December 2013.

32. Patricia Chubbuck is an independent contractor for the Department who manages the program operation for the Maine EHR program.

33. In 2015, Ms. Chubbuck became concerned about the potential for an adverse review by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG). In 12 of the 14 states examined by the OIG, it found deficiencies in the incentive payment calculations in states that had relied upon the Medicare Cost Reports for the payment calculations without underlying documentation of the data from the hospitals. *See,* Chubbuck testimony.

34. The Department engaged the accounting firm of Myers and Stauffer to perform audits of all 36 Maine hospitals that received Medicaid EHR payments. *See,* exhibit D-3.

35. The Department instructed Myers and Stauffer to conduct the audits "using all available regulations and CMS advisory documents that were in place at the time the Maine Hospitals had their payment calculations developed." *See,* exhibit D-3.

36. The same methodology was used in all 36 audits. *See,* testimony at hearing.

37. Myers and Stauffer determined that 11 Maine hospitals had received underpayments of incentive payments and 25 hospitals had received overpayments.

38. Myers and Stauffer conducted its audits of the Maine hospitals with the same methodology it used for audits of hospitals in other states (i.e. requesting claims information).

39. Myers and Stauffer was unaware that FMH was not paid on a claims basis during the relevant time period.

40. Myers and Stauffer requested claims information from the hospitals because CMS guidance and federal regulations require that the auditors include and/or exclude certain data elements from the Medicaid share calculation. Those elements are not discernable using only Medicare cost reports. *See,* testimony at hearing.

41. On January 31, 2018, Myers and Stauffer notified FMH that it had been selected for a desk audit. Myers and Stauffer requested that FMH provide a significant level of claims data related to fiscal years ending June 30, 2007, 2008, 2009 and 2010. It requested that FMH submit this information by February 14, 2018. *See,* exhibit D-7.

42. On February 26, 2018, FMH submitted the requested information to Myers and Stauffer. FMH subsequently continued to supplement the information through July 2018.

43. On October 22, 2018, the Department issued a Notice of Debt to FMH. The Notice of Debt stated that Myers and Stauffer had determined that FMH received overpayments in the EHR incentive program. The Department demanded that FMH repay $655,120.30.

44. The Notice of Debt stated that the adjustment in the aggregate incentive payment was necessary because:

- The adjusted number of discharges utilized in the average growth rate calculation is less than the number utilized in the original calculation.
- The adjusted number of total acute Medicaid days is less than the number utilized in the original calculation.

- The adjusted number of total acute hospital days is less than the number utilized in the original calculation.
- The adjusted amount of total hospital charges is less than the amount used in the original calculation.
- The adjusted amount of charity care charges is less than the amount used in the original calculation.

45. On November 9, 2018, FMH requested an informal review of the audit's findings. Among its objections to the overpayment amount, FMH argued that it "cannot discern from the Auditor's spreadsheet whether the Auditor used the same data as MaineCare to arrive at its revised calculation, or whether the Auditor used a different data set altogether". FMH referred to the "historically unreliable" MeCMS system and its concern that some information was pulled from that system. FMH also argued that the Auditor used a different and more restrictive interpretation of applicable laws and regulations during the audit than the Department did during the original calculation. *See*, exhibit HO-7 (page 4).

46. In its request for an informal review, FMH also requested numerous times for an opportunity to meet with the Department and discuss the Auditor's findings and FMH's significant concerns with same. This meeting never took place.

47. On August 27, 2019, the Department issued its Final Informal Review Decision. The Decision upheld the Auditor's findings and the determination that FMH was overpaid $655,120.30 in the EHR incentive program.

48. On October 24, 2019, FMH requested an administrative hearing.

RECOMMENDED DECISION

The hearing officer respectfully recommends that the Commissioner find the following:

1. The Department was permitted to conduct a post-payment audit using documentation other than the Medicare cost report.

2. The Department was not correct when it determined that Franklin Memorial Hospital received an overpayment for the EHR program in the sum of $634,992.72.

REASONS FOR RECOMMENDATION

The hearing officer reviews the Department's claim for recoupment against an approved MaineCare services provider *de novo*. DHHS Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (C)(1); Provider Appeals, MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.21-1 (A). The Department bears the burden to persuade the Hearing Officer that, based on a preponderance of the evidence, it was correct in establishing a claim for repayment or recoupment against an approved MaineCare provider. 10-144 C.M.R. Ch. 1, § VII (B)(1), (2).

The Department administers Maine's Medicaid program ["MaineCare"], which is designed to provide "medical or remedial care and services for medically indigent persons," pursuant to federal Medicaid law. 22 M.R.S. § 3173. *See also* 42 U.S.C. §§ 1396a (Medicaid is a cooperative federal-state program through which States accept federal financial assistance in exchange for their agreement to spend that assistance in accordance with Congressionally-imposed conditions.). To support this provision, Congress enacted the American Reinvestment and Recovery Act of 2009, which *inter alia* authorized federal Medicaid funding for the creation of states' payment incentive programs to "encourage the adoption and use of" certified Electronic Health Record ["EHR"] technology by eligible medical providers and hospitals. *See* 42 U.S.C. 139b (a)(3)(F), *as amended by* Pub. L. 111-5 (eff. Feb. 17, 2009). The Act provides that "[i]n order to be provided Federal financial participation ["FFP"] under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State—

(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;

(B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and

(C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange.

42 U.S.C. § 1396b (t)(9)

In order for Maine to participate in the payment incentive program, it first had to develop its State Medicaid Health Information Technology Plan ["SMHP"] and submit it to the Centers for Medicare and Medicaid Services ["CMS"] for approval. *See,* exhibit D-2. The SMHP stated that Maine would use Medicare cost reports in calculating a hospital's Medicaid EHR incentive program aggregate payment. *See,* exhibit D-22. Specifically, the SMHP stated that the Department would use Medicare cost reports "to verify the Medicaid patient volumes, and to calculate the payment amount." *See,* exhibit D-22 page 0873. CMS approved the SMHP in May 2011. The SMHP served as "a comprehensive written commitment by a Medicaid agency" to CMS that it will "administer or supervise the administration of a Medicaid program in accordance with Federal requirements.". *See* 42 C.F.R. § 400.203.

Effective October 4, 2011, and in accordance with the APA, the Department promulgated a Final Rule, "State Medicaid Health Information Technology Program," implementing the MaineCare HIT Program. The rule was published at 10-144 C.M.R. Ch. 101, sub-Ch. I, §2. The same rule chapter and section was amended by a Final Rule published with an effective date of November 23, 2014.

Again, the issue in this case is:

> Was the Department correct when it determined that Franklin Memorial Hospital ("FMH") owes the Department $655,120.30[12] in recoupment due to an overpayment of the Medicaid EHR Incentive Program Aggregate Payment as found in a Final Informal Decision dated August 27, 2019 and Notice of Debt dated October 22, 2018? Ex. HO-3.

Consistent with its approved SMHP, the Department used FMH's cost reports in calculating its Medicaid Share and overall aggregate EHR incentive payment. As a result, the Department initially determined FMH's incentive payment to be $1,548,684. Following a post-payment audit performed by the Division of Audit in 2012, that amount was increased to $1,552,906. The Department paid that amount to FMH over the course of three (3) years (i.e. 2011, 2012 and 2013). In 2018, Myers and Stauffer conducted a second post-payment audit and found that the Department overpaid FMH $655,120.

The Department issued a Notice of Debt for that amount on October 26, 2018. FMH requested an informal review, which was performed and upheld the overpayment. This appeal followed.

I. Authority to conduct a post-payment audit using claims information

Patricia Chubbuck is an independent contractor for the Department who manages the program operation for the Maine EHR program. In 2015, Ms. Chubbuck became concerned about the potential for an adverse review by the Office of the Inspector General of the U.S. Department of Health and Human Services (OIG). In 12 of the 14 states examined by the OIG, it found deficiencies in the incentive payment calculations in states that had relied upon the Medicare Cost Reports for the payment calculations without underlying documentation of the data from the hospitals. *See,* Chubbuck testimony. The Department asked Myers and Stauffer to perform audits of all Maine hospitals that received an incentive payment.

[12] After hearing, the Department reduced this amount to $634,997.72.

The MaineCare Benefits Manual, Chapter 1, Section 2.04-1 states in relevant part: "The Division of Audit or duly authorized Agent shall have the authority to conduct post-payment audits to include desk and on-site audits under the Department's SMHP and IAPD-U and Chapter 1, Section 1, §1.16." Although the Department performed an audit in 2012, this section does not specifically state that the Department is precluded from performing a second post-payment audit.

In addition, the Federal Register states in relevant part: "CMS approval of the State Medicaid HIT plan does not relieve the State of its responsibilities to comply with changes in Federal laws and regulations and to ensure that claims for Federal funding are consistent with all applicable requirements." See, exhibit DHHS-2 (page 206).

In its closing, FMH argues that using claims information rather than the Medicare cost report for this audit is changing the rules "after the game has been played". More specifically, FMH's closing (pages 12 and 13) state in part:

*As demonstrated in Section II.C, CMS granted States the discretion to choose the specific auditable data sources for use in the Incentive Payment calculation. CMS identified several generally available and appropriate sources, such as "Medicare cost reports, Medicaid cost report data, MMIS data, hospital financial statement, and accounting records" but acknowledged "States and their provider communities are better versed at determining the tools that will be most beneficial for their individual programs." 75 Fed. Reg. at 44500 **(DHHS 2, p. 192)**. Accordingly, CMS did not mandate data sources, but instead required a State to decide and "describe their auditable data sources in their SMHP and submit to CMS for review and approval." 75 Fed. Reg. at 44500 **(DHHS 2, p. 191)**.*

*There can be no dispute that CMS has blessed Medicare cost reports as an appropriate auditable data source for the Medicaid share of the Incentive Payment. Indeed, CMS specifically identified that source several times in the preamble to the applicable regulation. Id. Moreover, CMS has mandated the use of Medicare cost reports when calculating the <u>Medicare</u> share of the Incentive Payment. 42 C.F.R. § 495.104(c)(4). **DHHS 2, p. 264.***

*There can also be no dispute that the Department specifically selected Medicare cost reports as the data source for the Incentive Payment calculation. The May 2011 SMHP clearly states "[f]or hospitals, Medicare cost reports will be used to verify the Medicaid patient volumes, and to calculate the payment amounts." **DHHS 22, p. 872-873** (emphasis added). The Department is bound by this election.*

*The Department's own Incentive Payment Instructions further corroborate the Department's intention to use Medicare cost reports. **Hospital 3.** Moreover, the Department's actual use of Medicare cost reports when issuing the Original Determination proves that this*

was no mistake. ***DHHS 4, 5, 6.*** *Indeed, the Department used the required Medicare cost reports when initially calculating the Hospital's Incentive Payment, and used them again when performing the post-payment review.* ***DHHS 4, 5.***

The Department's Revised Determination – which represents a second post-payment audit – admittedly relies on something other than Medicare cost reports. Because the CMS-approved May 2011 SMHP and the Department's own Incentive Payment Instructions specifically required the use of Medicare cost reports, the Hearing Officer must find that the Revised Determination is not correct, and uphold the Original Determination. To do otherwise would allow the Department to ignore the elections it made when seeking approval for the May 2011 SMHP, and then arbitrarily change the rules after the game has been played.

The hearing officer is not persuaded by FMH's arguments. The MaineCare Benefits Manual clearly allows the Department to perform a post-payment audit. The hearing officer does not agree that the Department is changing the rules by requesting documentation to support the information contained in the Medicare cost report.

Again, the Department instructed Myers & Stauffer to audit the payments using the rules in effect at the time those payments were made. The SMHP was not a rule promulgated under the APA. The only promulgated rules at the time the incentive payments were made in 2011, 2012 and 2013 were the 2011 MaineCare HIT Program Rules. These Rules only stated that MaineCare will calculate the payments in accord with the federal regulations. The Rules did not specify which documentation the Department would use in those calculations.

Ms. Chubbuck testified, in effect, that the Department's calculation of the incentive payments was wrong. She learned from reviewing OIG reports that Medicare cost reports alone do not allow MaineCare to include or exclude certain data elements required to calculate proper payments under the federal regulations. And, these payment are 100% federal dollars. MaineCare has a duty to ensure that those federally funded payments are issued correctly. Ms. Chubbuck testified that the Department's request to review claims information is not a request to use "new" information, but rather additional information to comply with federal regulations (i.e. need detail of discharges, need to identify that certain bed-days had been removed, etc.)

Based on the rules[13] that were in effect during the relevant time period, the hearing officer respectfully recommends that the Commissioner find that the Department had the authority to conduct a second post-payment audit and that it had that authority to request claims information in addition to the Medicare cost report. The Department does not dispute that it initially instructed hospitals to provide four (4) years of Medicare cost reports. However, asking for supporting documentation during the audit is not the Department changing the rules, but rather the Department recognizing that it may have made a mistake in the calculation that it must now correct in order to comply with federal regulations that were in effect at the time.

II. Alleged Reasons for the overpayment

The Notice of Debt, dated October 22, 2018, stated that the adjustment in the aggregate incentive payment was necessary because:

- The adjusted number of discharges utilized in the average growth rate calculation is less than the number utilized in the original calculation.
- The adjusted number of total acute Medicaid days is less than the number utilized in the original calculation.
- The adjusted number of total acute hospital days is less than the number utilized in the original calculation.
- The adjusted amount of total hospital charges is less than the amount used in the original calculation.
- The adjusted amount of charity care charges is less than the amount used in the original calculation.

[13] In its closing, the Department referred to the SMHP which states that hospitals may be asked for cost data including discharge information for a 12 month time period related to inpatient bed days by payer type. *See,* exhibit D-22 Appendix D. However, the SMHP was not a promulgated rule during the relevant time period and this section of the SMHP was dated 2014 – after the payments were made. The Department argued that the SMHP is a "living document" that changes when federal requirements change or the state needs to "catch up" with requirements not originally included.

In its request for an informal review, FMH raised the following issues[14]:

A. The adjusted number of discharges utilized in the average growth rate calculation is less than the number utilized in the original calculation.

The Hospital argues that the auditor improperly removed discharges associated with patients receiving inpatient hospital services in an area of the hospital that provides acute care services. Specifically, the hospital argued: "The regulations do not define "acute-care inpatient discharges". *See*, DHHS 0762.

At hearing, Ms. McTier testified that the auditors asked FMH if it had a neonatal intensive care unit. FMH does not. Therefore, the auditors removed days associated with newborns. They treated the newborn days as "non-acute" visits. Ms. McTier also testified that CMS issued guidance which specifically instructed states to exclude nursery days.

Ms. Erb testified that FMH is an acute care hospital. Under 42 C.F.R. §495.310(g)(2), the regulation refers to days which are *attributable* to Medicaid individuals and this regulation does not specifically exclude newborn days. Ms. Erb described in her testimony how some newborns require extra care following delivery and FMH provides that care, even if it does not have a specific NICU wing. FMH also argues that newborn days should be included because the MaineCare Final Audit and Settlement includes newborn discharges.

The Department argues: "the Federal Register in reference to inpatient bed days provides the working definition of inpatient bed days as those in 'the acute care portion of the hospital,' while elsewhere excluding nursery bed days, psychiatric and rehabilitation units" DHHS Exhibit 2 at 0144-45.

Upon review, the hearing officer agrees with the Department. 75 Fed. Reg. 44498 states that: "Thus, we proposed that for purposes of the Medicaid formula, we would count only those days that would count as inpatient-bed-days for Medicare

[14] Appeal proceedings will be limited only to those issues raised during the informal review process. *See*, Manual, Chapter 1, Section 1.23-1.A.

purposes…". 75 Fed.Reg. 44454 states that (re: Medicare inpatient-bed-days): "We exclude the days provided to newborns (except for those in intensive care units of the hospital) because healthy newborn infants are not provided with an acute level of hospital care. (This is not the case with newborns assigned to intensive care units of the hospital, who are included in the counts for those units.) Therefore, the hearing officer agrees with the Department that nursery bed days were correctly excluded.

B. The Department's NODs Failed to Correctly Identify the Total Number of Acute Medicaid Days and Acute Medicaid HMO Days

FMH argues that the Department improperly excluded unpaid Medicaid eligible days, improperly excluded days for which Medicaid was a secondary payor, and/or erred in calculating all Acute Medicaid and Acute Medicaid HMO days.

The Department argues that the auditors requested FMH provide them with information regarding bed days for which Medicaid was a secondary payor to Medicare. FMH told the auditors that no such days were included in the data; therefore, the auditors did not exclude any bed days for which Medicaid was the secondary payor.

The Department also argues that the auditors properly included only paid Medicaid days consistent with the requirement set forth in the Federal Register and informal guidance by CMS. *See,* McTier testimony.

Because the hospital's appeal is largely focused on the issue of the auditors excluding unpaid Medicaid eligible days, the hearing officer has provided the Commissioner with the hospital's specific argument (closing pages 23 and 24) below:

Ms. McTier acknowledged that she excluded "unpaid" Acute Medicaid-eligible days when calculating the Revised Determination. As explained in more detail below, the relevant statutes and regulations do not support the exclusion of unpaid Acute Medicaid Days. The Hospital believes this error helps to explain the significant variance between the Medicare audit findings and Myers and Stauffer's findings.[15]

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[15] Again, Myers and Stauffer declined to provide a reconciliation between the Original Determination (which applied Medicare cost report information) and the Revised Determination (which did not) which identified the exact patient days that were excluded.

According to the plain language of the applicable statute, Acute Medicaid Days includes "the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this subchapter [and who are not entitled to Medicare]." 42 U.S.C. § 1396b(t)(5)(C) (emphasis added). With respect to Acute Medicaid HMO days, the calculation includes "inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan ..." Id.

CMS has adopted a regulation implementing the numerator of the Medicaid Share fraction. 42 C.F.R. § 495.310(g)(2)(i)(A) and (B). It includes: (A) "The estimated number of acute-care inpatient-bed-days which are attributable to Medicaid individuals"; and (B) "The estimated number of acute-care inpatient-bed-days which are attributable to individuals who are enrolled in a managed care organization..." 42 C.F.R. § 495.310(g)(2)(i)(A) and (B)(emphasis added).

The plain language of the statute governing Acute Medicaid Days does not require that the Hospital receive payment for such services. Instead, it applies when the individual is receiving medical assistance. Simply because MaineCare allegedly did not provide payment for a particular hospital visit does not mean the patient was not receiving medical assistance at that time. Indeed, the audit documentation demonstrates that the patient was, in fact, MaineCare eligible, and therefore receiving medical assistance.

While it is true that the statute refers to "inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan..." with respect to Acute Medicaid HMO days, the use of the word "paid" in this context does not refer to Acute Medicaid Days. This reference is limited to Acute Medicaid HMO Days. Because Congress chose to draw a distinction between these two types of days within the same statutory framework, that distinction must be honored. Jewish Hosp., Inc. v. Sec'y of Health and Human Servs., 19 F.3d 270, 275 (6th Cir. 1994) ("Adjacent provisions utilizing different terms, however, must connote different meanings"). Under Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 842 (1984), "if the intent of Congress is clear, that is the end of the matter." Here, the statutory language is clear with respect to Acute Medicaid Days, and that should be the end of the inquiry.

Furthermore, it is important to note that CMS, when addressing this distinction, elected to adopt a regulation that simply refers to "acute-care inpatient-bed-days attributable to Medicaid individuals" or "attributable to individuals enrolled in a [Medicaid] managed care organization." 42 C.F.R. § 495.310(g)(2)(i)(A) and (B)(emphasis added). Thus, the plain language of the applicable regulation does not require "paid" days, and therefore it cannot support the auditor's reduction of Acute Medicaid Days and Acute Medicaid HMO Days. Indeed, the Myers and Stauffer findings confirmed that the patients at issue were Medicaid-eligible patients, and therefore these days were "attributable to Medicaid individuals." 42 C.F.R. § 495.310(g)(2)(i)(A).[16]

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16 Myers and Stauffer cited to **75 Fed. Reg. at 44500 for the proposition that the EHR Incentive Payment calculation includes only paid inpatient-bed days, and does not include unpaid Medicaid eligible days.** ***Id.*** **(**"The criteria for determining Medicaid eligible days and Medicaid managed care days for Medicare DSH and Medicaid managed care days for EHR incentive payments are not the same.

Finally, as previously discussed, Myers and Stauffer failed to verify whether a Medicaid payment was actually made by comparing the information received to the MaineCare Final Audit and Settlement. In light of the significant issues with the MeCMS system, it is possible – if not likely – that the information they relied on was faulty.[17]

Upon review, the hearing officer agrees with the Department that the auditors were correct when they included only Medicaid-paid days in the calculation. 75 Fed.Reg. 44500 states: "The criteria for determining Medicaid eligible days and Medicaid managed care days for Medicare DSH and Medicaid managed care days for EHR incentive payments are not the same. Medicare DSH includes unpaid days, while the EHR incentive payment calculation requires the inclusion of only paid inpatient-bed days." CMS also issued guidance on October 24, 2012, which stated: "Zero pay Medicaid eligible days must continue to be excluded from the Medicaid hospital incentive calculation." *See*, exhibit D-18 (page 0784). The hearing officer agrees with the Department that CMS is entitled to deference in its interpretation. *Trull Nursing Home, Inc. v. Maine Department of Human Services*, 461 A.2d 490,496 (Me.1983). And, if the Commissioner found in favor of FMH on this issue, it would place the Department directly in conflict with CMS' interpretation of the payment calculation.

C. The Auditor Failed to Properly Identify the Total Number of Acute Hospital Days

FMH argues that the auditors excluded a number of discharges they determined were "non acute". *See*, Section A above. However, despite a reduction in discharges, FMH's Total Acute Days remained constant. So, there was either a calculation error made by the auditors or they applied "an inconsistent interpretation that excludes discharges but not the associated inpatient bed days." *See*, exhibit D-16.

Medicare DSH includes unpaid days, while the EHR incentive payment calculation requires the inclusion of only paid inpatient-bed days."). However, this guidance finds no support in the plain language of statutory and regulatory language, and it should therefore not be afforded any deference. Indeed, as demonstrated by the *Jewish Hospital* case, CMS once argued that the Medicare DSH excluded unpaid Medicaid days, a position that CMS has correctly abandoned.

17 Again, as Ms. Erb explained, any payment information contained in the patient account would have been derived from remittance advices received from the MeCMS system. However, this "payment" amount would not have been accurate, as actual payment is determined through the MaineCare Final Audit and Settlement.

The Final Informal Review Decision stated that the auditors received information directly from FMH. FMH was given many opportunities and extensions to review this information. Ultimately, the Department determined that the auditors were correct.

The hearing officer's recommendation in this area is included in Section E.

D. The Auditor Uses Inconsistent Sources to Identify the Hospital's Charges

Charges that are attributable to charity care are excluded from the denominator of the Medicaid Share. At hearing, the Department found an error in the CHIP factor and submitted a revised exhibit 20 after hearing. This revision resulted in a reduction in the recoupment amount.

FMH does not agree with the revised CHIP factor because the claims used do not identify the dates of service. FMH is therefore unable to verify the calculation. And, FMH is concerned that some of those CHIP days may have already been removed by the auditors – resulting in a "double-dip".

The hearing officer's recommendation in this area is included in Section E.

E. Other issues raised by FMH

At hearing, and in its closing argument, FMH argues that the Commissioner should uphold the original determination of its EHR payment amount. Specifically, FMH argues that (a) the Department made the original determination (b) it was done with data sources and instructions to hospitals specified by the Department itself and (c) the Department satisfied the plain language of the applicable laws and regulations in calculating the original determination. FMH argues that if the Commissioner does not uphold the original determination, there is substantial evidence that the revised calculation is not correct.

As outlined above, the hearing officer agreed with the Department that it had the authority to conduct this post-payment review. And, that it had the authority and duty to request supporting documentation to ensure that the incentive payment was made in

accordance with federal regulations. However, the hearing officer is persuaded by FMH's arguments that the Department has failed to prove by a preponderance of the evidence that its revised payment calculation is correct.

At hearing, the Department objected to evidence regarding the MeCMS system because it alleges that the issue was not raised in the informal review process. The hearing officer disagreed and allowed the evidence. Specifically, page 6 of the request for informal review refers to the "significant issues with the MeCMS system" and the hospital's concerns that any information originating from the system may be faulty. Again, Ms. Erb credibly testified that due to the issues with the MeCMS system, the hospital would enter the remittance advices in patient accounts after it received them from MeCMS. Therefore, even though the hospital provided the auditors with the requested claims information, the original source of the information in the hospital's patient accounts was MeCMS.

Second, the request for informal review did raise the issue of the how the audit was performed. FMH specifically argued that the auditors failed to verify "whether or not a Medicaid payment was actually made with respect to the excluded Acute Medicaid Days and Acute Medicaid HMO Days." In addition to failing to verify its findings, FMH argues that the findings cannot be reconciled with the actual audit findings by the Medicare and Medicaid Programs. In its closing (page 20), FMH argues:

> *Ms. Erb explained that an essential part of an audit is a reconciliation that details what an auditor has done, and ties any changes back to the original numbers. She explained that both the Medicare auditors and the Department's MaineCare auditors provide "adjustment reports" which explain any adjustments made during the audit process.*
>
> *Here, the Medicare program, after audit, determined that the Hospital had Total Medicaid Acute Days of 2,436 and Total Acute Days of 9,903.* ***Hospital 5, p. 6.*** *The MaineCare program, after audit, determined that the Hospital had 2,179 Medicaid Acute Days.* ***Hospital 6, p. 6.*** *Ms. Erb explained the difference between the Medicare and the MaineCare numbers. The Medicare cost report includes all days associated with a Medicaid-eligible patient, whether or not Medicaid paid for that discharge (i.e., Medicaid eligible-but-unpaid days).*[18]

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[18] The Medicaid days reported on the Medicare cost report are used to calculate the Medicare DSH adjustment payment. The DSH calculation is the sum of two fractions: (1) the Medicare fraction (Medicare and SSI entitled patient days divided by total Medicare entitled days; and (2) the Medicaid

MaineCare's Final Audit and Settlement naturally includes only those days for which a payment is actually made by MaineCare (because it is used to determine MaineCare's actual payment obligation).

Myers and Stauffer auditors determined that there were only 1,486 Medicaid Acute Days. Myers and Stauffer can explain some of the difference by suggesting that only paid Medicaid days may be included, or that the paid days associated with newborns must be excluded.[19] *However, this explanation fails to account for the entire difference. Indeed, as demonstrated by the Excel version of the Department's MaineCare Final Audit and Settlement for the Hospital's FY 2010, the Department's auditors determined that the Hospital had 787 Medicaid paid discharges consisting of 2,179 paid Medicaid days.* ***Hospital 6 (Excel version), Utilization Tab, Col. S, rows 8 and 53.*** *Of the 2,179 paid Medicaid days, 238 days represented "normal" newborns, and 320 days related to the higher-level-of-care "premie" newborns.* ***Id.*** *Accordingly, the Department's MaineCare Final Audit and Settlement identified 1,941 paid Medicaid days (if normal newborns are excluded), and at least 1,621 paid Medicaid days (if all newborn days are excluded).* ***Hospital 6 (Excel version), Utilization Tab, Col. S, rows 8, 35, 36, and 53.*** *Thus, even assuming that Myers and Stauffer correctly excluded the paid days associated with newborns (which the Hospital disputes), its finding of 1,486 Acute Medicaid Days is clearly wrong, as evidenced by the Department's own MaineCare Final Audit and Settlement.*

The evidence is clear: Myers and Stauffer reached the wrong conclusions because it requested the wrong information (and it requested the wrong information because it did not understand how MaineCare paid hospitals during the applicable time period).

Again, the hearing officer is persuaded by FMH's arguments. There is no dispute that the source of the auditors' findings was claims information provided by the hospital. And, Ms. Erb credibly testified that the claims information FMH provided from its records came from the MeCMS system. Given that the MeCMS system was unreliable, often denying claims incorrectly, and that a former DHHS Commissioner actually called it a "worst nightmare realized", the hearing officer respectfully recommends that the Commissioner find that the Department cannot prove by a

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fraction (Medicaid eligible /non-Medicare days divided by total days). 42 U.S.C. § 1395ww(d)(5)(F). Although CMS originally interpreted this law as including only "paid" Medicaid days in the Medicaid fraction, this interpretation was struck down by four Circuit Courts of Appeal, and CMS ultimately agreed to include all Medicaid "eligible" / non-Medicare days. *See e.g. Jewish Hosp., Inc. v. Sec'y of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

[19] As explained in the Hospital's RFIR and at the hearing, the Hospital disputes Myers and Stauffer's interpretation for the reasons explained in Subsection C.

preponderance of the evidence that its revised EHR incentive payment calculation (based solely on claims information) was correct.

MANUAL CITATIONS

- DHHS Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (eff. Jan. 23, 2006)
- MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101 (eff. Oct. 11, 2011)

RIGHT TO FILE RESPONSES AND EXCEPTIONS

THE PARTIES MAY FILE WRITTEN RESPONSES AND EXCEPTIONS TO THE ABOVE RECOMMENDATIONS. ANY WRITTEN RESPONSES AND EXCEPTIONS MUST BE RECEIVED BY THE DIVISION OF ADMINISTRATIVE HEARINGS WITHIN FIFTEEN (15) CALENDAR DAYS OF THE DATE OF MAILING OF THIS RECOMMENDED DECISION.

A REASONABLE EXTENSION OF TIME TO FILE EXCEPTIONS AND RESPONSES MAY BE GRANTED BY THE CHIEF ADMINISTRATIVE HEARING OFFICER FOR GOOD CAUSE SHOWN OR IF ALL PARTIES ARE IN AGREEMENT. RESPONSES AND EXCEPTIONS SHOULD BE FILED WITH THE DIVISION OF ADMINISTRATIVE HEARINGS, 11 STATE HOUSE STATION, AUGUSTA, ME 04333-0011. COPIES OF WRITTEN RESPONSES AND EXCEPTIONS MUST BE PROVIDED TO ALL PARTIES. THE COMMISSIONER WILL MAKE THE FINAL DECISION IN THIS MATTER.

CONFIDENTIALITY

THE INFORMATION CONTAINED IN THIS DECISION IS CONFIDENTIAL. *See* 42 U.S.C. § 1396a (a)(7); 22 M.R.S. § 42 (2); 22 M.R.S. § 1828 (1)(A); 42 C.F.R. § 431.304; 10-144 C.M.R. Ch. 101 (I), § 1.03-5. ANY UNAUTHORIZED DISCLOSURE OR DISTRIBUTION IS PROHIBITED.

DATED: June 14, 2021

/S/Tamra Longanecker
Administrative Hearing Officer

cc: Thomas C. Bradley, AAG
William H. Stiles, Esq.