Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Acting Commissioner

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

IN THE MATTER OF:

Houlton Regional Hospital)
c/o Steven L. Johnson, Esq.)
KOZAK & GAYER, P.A.) **FINAL DECISION**
157 Capitol Street, Suite 1)
Augusta, ME 04330)

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

The Recommended Decision of Hearing Officer Thackeray, mailed December 4, 2018 and the responses and exceptions filed on behalf of Houlton Regional Hospital have been reviewed.

I hereby adopt the findings of fact and I accept the Recommendation of the Hearing Officer that the Department was permitted to rely upon The Centers for Medicare and Medicaid Services' Medicare unit to determine whether Houlton Regional Hospital qualified for EHR incentive payments under the MaineCare HIT Incentive Payment Program; Houlton Regional Hospital is not entitled under the MaineCare Benefits Manual to an independent review by the Department as to whether Houlton Regional Hospital complied with the specific MaineCare EHR/HIT Incentive Payment Program requirements that were the subject of CMS's audit. The Department correctly established a recoupment claim in the amount of $344,644 against Houlton Regional Hospital based on the audit finding by The Centers for Medicare and Medicaid Services that Houlton Regional Hospital did not meet the Medicare Electronic Health Record Incentive Program's requirements for Program Year 2013.

DATED: 2-7-19 SIGNED: Jeanne M. Lambrew

JEANNE M. LAMBREW, Ph.D., ~~ACTING~~ 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: William Logan, DHHS/OMS

Maine Department of Health and Human Services
Administrative Hearings
11 State House Station
221 State Street
Augusta, Maine 04333-0011

PAUL R. LEPAGE
GOVERNOR

BETHANY L. HAMM
ACTING COMMISSIONER

Bethany L. Hamm, Acting Commissioner
Department of Health and Human Services
11 State House Station • 221 State Street
Augusta, ME 04333

Date Mailed: DEC - 4 2018

In the Matter of:
Houlton Regional Hospital

CMS Audit Case No. 1000020988

ADMINISTRATIVE HEARING RECOMMENDED DECISION

An administrative hearing was convened in the above-captioned matter on August 30, 2018, before Hearing Officer Richard W. Thackeray, Jr., at Augusta, Maine. 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 May 17, 2018, 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 Houlton Regional Hospital ("HRH") owes MaineCare $344,644 in recoupment of MaineCare's 2013 Medicaid incentive program payment made to HRH on 8/14/2013 based on the audit finding by The Centers for Medicare and Medicaid Services ("CMS") that HRH did not meet the Medicare Electronic Health Record ("EHR") Incentive Program's requirements for the 2013 program year? Specifically, was the Department permitted to rely upon the CMS' Medicare audit to determine whether HRH qualified for EHR incentive payment under the Maine Medicaid Incentive Program; and whether HRH is entitled under the MaineCare Benefits Manual to an independent review by the Department as to whether HRH complied with the specific MaineCare EHR Incentive Payment Program requirements that were the subject of CMS' audit?

Ex. HO-2.

APPEARING ON BEHALF OF THE APPELLANT

- Steven L. Johnson, Esq., KOZAK & GAYER, P.A.
- Tom Moakler, CEO, Houlton Regional Hospital
- Cynthia Thompson, CFO, Houlton Regional Hospital

APPEARING ON BEHALF OF THE DEPARTMENT

- William P. Logan, Esq., DHHS, Office of MaineCare Services

ITEMS INTRODUCED INTO EVIDENCE

Hearing Officer Exhibits

HO-1 "Notice of Hearing," dated May 25, 2018

HO-2 "Order of Reference," dated May 17, 2018

HO-3 "Fair Hearing Report Form," dated March 28, 2018, and attachments:

- Hearing Request, dated March 21, 2018
- Request for Informal Review, dated May 27, 2016
- Recoupment Notice, dated March 31, 2016
- Email, Cynthia M. Thompson, dated November 19, 2015
- Email, James Leonard, et al, dated December 29, 2015
- Email, Patti Chubbuck, dated December 29, 2015
- Email exchange, Patti Chubbuck and Cynthia M. Thompson, dated December 30, 2015
- Email, Jonah Howard, dated February 1, 2016
- Email exchange, Jonah Howard and Cynthia M. Thompson, dated February 2, 2016
- Email, Steven L. Johnson, Esq., dated February 9, 2016
- Email, William P. Logan, Esq., dated February 11, 2016
- Email, Steven L. Johnson, Esq., dated February 16, 2016
- HITECH EHR Meaningful Use Audit Determination Letter, dated August 18, 2014
- Appeal Notice (informal), dated August 29, 2014
- Appeal Notice, dated September 16, 2014
- Appeal Decision, CMS, dated September 26, 2014
- Email exchange, Steven L. Johnson, Esq. and William P. Logan, Esq., dated April 26, 2016
- Provider Agreement, dated July 10, 2006
- Email exchange, Cristina Poliseno and Cynthia M. Thompson, dated September 5, 2014
- Email exchange, Danielle K. Hall and Tammy McLean, dated September 5, 2014
- Email exchange, Tammy McLean and Scott Snow, dated August 18, 2014
- Email, Amy Robbins, MPH, dated February 9, 2012
- Email, Amy Robbins, MPH, dated June 12, 2013
- Final Informal Review Decision, dated January 22, 2018

HO-4 "Hearing Request Dispute Correspondence," April 23, 2018 to May 17, 2018

HO-5 "Administrative Prehearing Order," dated August 7, 2018

HO-6 "Joint Stipulation of Agreed-Upon Facts and Joint Exhibit List," dated August 21, 2018

HO-7 "Pre-Hearing Brief," DHHS, dated August 24, 2018

HO-8 "Pre-Hearing Brief," Houlton Regional Hospital, dated August 24, 2018

HO-9 Final Rule: Medicare and Medicaid Programs: Electronic Health Record Incentive Program – Stage 2, Ctrs. For Medicare & Medicaid Servs., 77 Fed. Reg. 53,968 (Sept. 4, 2012)

Joint Exhibits

J-1 "Final Informal Review Decision," dated January 22, 2018

J-2 "Provider Agreement," dated July 11, 2006

J-3 "State Medicaid Health Information Technology Plan," dated May 12, 2011

J-4 "CMS Approval Letter - SMHP," dated April 28, 2011

J-5 "CMS Approval Letter – Revised SMHP," dated June 23, 2011

J-6 "Final Rule – State Medicaid Health Information Technology Program," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. I, § 2 (eff. Oct. 4, 2011)

J-7 Excerpt: Final Rule, "General Administrative Policies and Procedures," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1 (eff. June 24, 2013)

J-8 "HITECH EHR Meaningful Use Audit Determination Letter," dated August 18, 2014

J-9 "Appeal Notice" (informal), dated August 29, 2014

J-10 "Email exchange," Cristina Poliseno and Cynthia M. Thompson, dated August 29, 2014

J-11 "Notice of Appeal," dated September 16, 2014

J-12 "Notice of Final Determination," CMS, dated September 26, 2014

J-13 "Recoupment Notice," dated March 31, 2016

J-14 "Request for Informal Review," dated May 27, 2016

J-15 "Hearing Request," dated March 21, 2018

J-16 "Hearing Right Dispute Acknowledgement," dated April 4, 2018

J-17 "Memorandum in Support of Administrative Hearing Request," dated April 20, 2018

J-18 "Memorandum in Opposition to Administrative Hearing Request," undated

J-19 "Reply Memorandum in Support of Administrative Hearing Request," dated May 2, 2018[1]

RECOMMENDED FINDINGS OF FACT

1. In accordance with agency rules, the Houlton Regional Hospital ["HRH"] was properly notified of the time, date, and location of the immediate proceeding.

2. HRH is an enrolled Medicare provider and participated as an "eligible hospital" in the Medicare Electronic Health Record ["EHR"] Technology Incentive Program ["CMS EHR Program"] administered by the Centers for Medicare and Medicaid Services ["CMS"] for Program Year 2013, i.e. for the attestation period March 15, 2013 through June 15, 2013 ["2013 Attestation Period"]. Ex. HO-6.

3. HRH is an enrolled MaineCare provider and also participated as an "eligible hospital" in the State Medicaid Health Information Technology Program ["MaineCare HIT Program"] administered by the Maine Department of Health and Human Services ["Department"]. Ex. HO-6.

4. In connection with HRH's participation in the CMS EHR Program and MaineCare HIT Program, HRH attested that it had adopted certified EHR technology that met all applicable regulatory requirements for program year 2013. Ex. HO-6.

5. The Department issued a final "State Medicaid Health Information Technology Plan," dated May 12, 2011 ["2011 SMHP"], conditionally approved by CMS on April 28, 2011. Ex. J-3; Ex. J-4; Ex. J-5.

[1] The parties' stipulated list of proposed exhibits included two other items: a Departmental "Reply to HRH's Arguments," dated May 2, 2018, and "Letter Granting Request for Hearing," dated May 17, 2018. No copies of either document were provided by the parties at hearing so they are not included as such in the hearing record. This is supported by the fact that both documents already appear in the record as Hearing Officer's Exhibit 4, and that the Chief Administrative Hearing Officer resolved the issues involved when he granted the hearing request.

6. On an unspecified date in December 2015, the Department issued a revised SMHP. Ex. HO-6.

7. Effective October 4, 2011, the Department issued 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. Ex. J-6; Ex. HO-6.

8. The version of the Maine HIT Program rules, effective on October 4, 2011, controlled all matters at issue in the present appeal relating to HRH's Program Year 2013 and the 2013 Attestation Period. Ex. J-6; Ex. HO-6.

9. The Department's Final Rule, "General Administrative Policies and Procedures," that was in effect at the beginning of HRH Program Year 2013 and 2013 Attestation Period is admitted as Exhibit J-7, and also reflects a subsequent Final Rule that took effect on June 24, 2013. Ex. J-7; Ex. HO-6.

10. HRH received a total of $307,168.84 in incentive payments from CMS for HRH's participation in the CMS EHR Program during Program Year 2013. Ex. HO-6.

11. HRH received a total of $344,644.00 in incentive payments from the Department for HRH's participation in the MaineCare HIT Program during Program Year 2013. The incentive payments transmitted by the Department were comprised of 100 percent federal funds. Ex. HO-6.

12. On August 18, 2014, CMS's auditor, Figliozzi & Company ["Auditor"], provided Notice to HRH of its audit determination pursuant to its review of how HRH "demonstrated meaningful use of certified Electronic Health Record (EHR) technology in accordance with Section 13411 of the Health Information Technology for Economic and Clinical Health Act (HITECH Act)" for Program Year 2013. The Auditor specifically determined that HRH did not meet the meaningful use criteria for Program Year 2013 based on the finding that HRH "[f]ailed to demonstrate access to a CEHRT system." Ex. J-8; Ex. HO-6.

13. On August 29, 2014, HRH requested additional information from CMS's Auditor as to what was lacking or missing from HRH's EHR system, in terms of HRH's effort to demonstrate access to a CEHRT system. Ex. J-9; Ex. HO-6.

14. On August 29, 2014, CMS's Auditor responded to HRH's request for additional information with the following:

> The documentation supplied confirmed access to the following Modular EHR systems during the attestation period:
>
> - Iatric Systems – Clinical Document Exchange- v.1.5.0
> - MEDITECH- MEDITECH MAGIC Emergency Department Management- 5.6.4
> - MEDITECH- MEDITECH MAGIC Data Repository- 5.6.4
> - MEDITECH- MEDITECH MAGIC HCIS Core Set (Modular)- 5.6.4
>
> These modular systems collectively meet only 90% of certification criteria.

> Additional documentation was supplied confirming that interfaces for Menu Measures #8, #9, and #10 were not in place at any point during the attestation period. The EH must have a 100% Certified Electronic Health Record Technology system in place during the attestation period. The EH must have a CEHRT for deferred measures (that they are not attesting to) and for measures they are seeking an exclusion for.

Ex. J-10; Ex. HO-6.

15. On September 16, 2014, HRH submitted to CMS (i) additional documentation in support of HRH's position that it had demonstrated access to a CEHRT system, and (ii) an "Eligible Hospital Appeal Filing Request" appealing the CMS Auditor's HITECH EHR Meaningful Use Audit Determination Letter decision. Ex. J-11; Ex. HO-6.

16. On September 26, 2014, CMS formally denied HRH's September 16, 2014 appeal, and included notice that its decision was "final and not subject to further appeal." Ex. J-12; Ex. HO-6.

17. On March 31, 2016, the Department issued a "Recoupment Notice" to HRH, providing notice of its intent to recoup a sum of $344,644.00 from HRH for payments in the same amount made by the Department for HRH's participation in the MaineCare HIT Program for Program Year 2013." The March 31, 2016 notice expressly identified that its recoupment claim was established based on the CMS Auditor's audit findings issued on August 18, 2014. Ex. J-13; Ex. HO-6.

18. On May 27, 2016, HRH submitted to the Department a Request for Informal Review of the Department's EHR Incentive Payment Recoupment Decision after being encouraged to do so by the Department on April 26, 2016. Ex. J-14; Ex. HO-6.

19. On January 22, 2018, the Department issued a Final Informal Review Decision ["FIRD"] to HRH, finding that the "Department was correct in issuing a recoupment notice for Medicaid incentive payments made to Houlton Regional Hospital for the 2013 program year. Ex. J-1; Ex. HO-6.

20. On March 21, 2018, HRH requested an administrative hearing, appealing the Department's January 22, 2018 FIRD. Ex. J-15; Ex. HO-6.

21. On April 4, 2018, HRH and the Department were invited to brief the question of whether HRH had a right to appeal the FIRD before a Departmental hearing officer, where the Department wholly relied upon findings made by the CMS Auditor in establishing the recoupment claim contained in the FIRD. Ex. J-15; Ex. HO-6.

22. On April 20, 2018, HRH filed a brief in support of its position that it was entitled to a hearing on the FIRD before a Departmental hearing officer. Ex. J-17; Ex. HO-6.

23. On April 23, 2018, the Department filed a brief in support of its position that HRH was not entitled to a hearing on the FIRD before a Departmental hearing officer. Ex. J-18; Ex. HO-6.

24. On May 2, 2018, HRH and the Department both filed reply briefs as to their respective positions. Ex. J-19; Ex. J-20; Ex. HO-6.

25. On May 17, 2018, Chief Hearing Officer James D. Bivins, Esq., issued an Order of Reference, granting HRH's request for an administrative hearing and identifying the following issue for adjudication:

> Was the Department correct when it determined that Houlton Regional Hospital ("HRH") owes MaineCare $344,644 in recoupment of MaineCare's 2013 Medicaid incentive program payment made to HRH on 8/14/2013 based on the audit finding by The Centers for Medicare and Medicaid Services ("CMS") that HRH did not meet the Medicare Electronic Health Record ("EHR") Incentive Program's requirements for the 2013 program year? Specifically, was the Department permitted to rely upon the CMS' Medicare audit to determine whether HRH qualified for EHR incentive payment under the Maine Medicaid Incentive Program; and whether HRH is entitled under the MaineCare Benefits Manual to an independent review by the Department as to whether HRH complied with the specific MaineCare EHR Incentive Payment Program requirements that were the subject of CMS' audit?

Ex. HO-2; Ex. HO-6.

RECOMMENDED DECISION

1. The Department was permitted to rely upon the Centers for Medicare and Medicaid Services' Medicare audit to determine whether Houlton Regional Hospital qualified for EHR incentive payments under [the] MaineCare HIT Incentive Payment Program;

2. Houlton Regional Hospital is not entitled under the MaineCare Benefits Manual to an independent review by the Department as to whether Houlton Regional Hospital complied with the specific MaineCare EHR/HIT Incentive Payment Program requirements that were the subject of CMS's audit.

3. The Department correctly established a recoupment claim in the amount of **$344,644.00** against Houlton Regional Hospital based on the audit finding by The Centers for Medicare and Medicaid Services ["CMS"] that Houlton Regional Hospital did not meet the Medicare Electronic Health Record ("EHR") Incentive Program's requirements for Program Year 2013.

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)

Regulations published by the Centers for Medicare and Medicaid Services ["CMS"] established three graduated stages of requirements, according to which Medicare-eligible hospitals needed to demonstrate their "meaningful use" of certified EHR technology over the course of several years. *See* 42 C.F.R. §§ 495.20, 495.22, 495.24, 495.40. CMS also established a parallel series of Medicaid-specific requirements necessary for state Medicaid agencies to implement in administering their EHR implementation payment incentive programs for eligible professionals and acute care hospitals. 42 C.F.R. §§ 495.300 – 495.370. State Medicaid agencies were required to obtain approval from CMS of state Medicaid health information technology ["HIT"] plans, which outline the agencies' processes of assuring provider compliance with clinical quality reporting and patient volume standards, and standards for "meaningful use" of certified EHR technology. 42 C.F.R. §§ 495.40 (b)(2), 495.306, 495.316. As a part of its Medicaid HIT plan, each state was required to establish "a process in place consistent with the requirements established in § 447.253(e) of this chapter for a provider or entity to appeal the following issues related to the HIT incentives payment program:

(1) Incentive payments.
(2) Incentive payment amounts.
(3) Provider eligibility determinations.
(4) Demonstration of adopting, implementing, and upgrading, and meaningful use eligibility for incentives under this subpart.

42 C.F.R. § 495.370 (a).

Under the federal regulations, each state's appeal process must assure that "the provider (whether an individual or an entity) has an opportunity to challenge the State's determination under this part by submitting documents or data or both to support the provider's claim," that the appeals process is "consistent with the State's Administrative Procedure law(s)," and that subsequent appeal rights are provided. 42 C.F.R. § 495.370 (b), (c). However, the Medicaid-specific state appeal process provisions do "not apply in the case that CMS conducts the audits and handles any subsequent appeals under [42 C.F.R. § 495.312(c)(2)]." 42 C.F.R. § 495.370 (d). Section 495.312 (c) provides:

> (1) Except as specified in paragraph (c)(2) of this section, the State determines the provider's eligibility for the EHR incentive payment under subparts A and D of this part and approves, processes, and makes timely payments using a process approved by CMS.
>
> (2) At the State's option, CMS conducts the audits and handles any subsequent appeals, of whether eligible hospitals are meaningful EHR users on the States' behalf.

42 C.F.R. § 495.312 (c).

To achieve this, CMS authorized each state to include in its State Medicaid HIT Plan "a signed agreement indicating that the State does all of the following:

> (1) Designates CMS to conduct all audits and appeals of eligible hospitals' meaningful use attestations.
>
> (2) Is bound by the audit and appeal findings described in paragraph (g)(1) of this section.
>
> (3) Performs any necessary recoupments if audits (and any subsequent appeals) described in paragraph (g)(1) of this section determine that an eligible hospital was not a meaningful EHR user.
>
> (4) Is liable for any FFP granted to the State to pay eligible hospitals that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users.

42 C.F.R. § 495.332 (g), *as amended by* Final Rule, "Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 2," 77 Fed. Reg. 53,968, 54,162 (Sept. 4, 2012)

In 2011, the Department established the MaineCare HIT Program to effectively allow Maine hospitals access to the federally-funded certified EHR implementation incentives. *See* "State Medicaid Health Information Technology Program," MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 2.01 (eff. Oct. 4, 2011). MaineCare HIT Program regulations identified the existence of Maine's State Medicaid HIT Plan and the requirement to "submit a State Medicaid Health Plan (SMHP) and receive [CMS] approval of the SMHP prior to implementing the incentive payment Program." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 2.01. CMS approved Maine's State Medicaid HIT Plan on May 2, 2011, effectively endorsing Maine's plans for monitoring, verifying, and auditing participating providers' compliance with the requirements, including the "meaningful use" standards. Ex. J-3. The Department's regulations also incorporated by reference the CMS definitions of meaningful use applicable to MaineCare HIT program-eligible professionals and hospitals. *See* 10-144 C.M.R. Ch. 101, sub-Ch. I, § 2.02 ("'Meaningful Use' means the requirements that an Eligible Professional (EP) or

Eligible Hospital (EH) must meet to receive an incentive payment as required by CMS under applicable Stage 1, Stage 2, and Stage 3 rules to be issued and implemented by CMS.").

With respect to MaineCare HIT program participation, the Department's regulations provide that eligible acute care hospitals must "have at least a 10% Medicaid patient volume," meet applicable reporting requirements, document and attest to compliance with applicable "meaningful use" requirements, and be approved for payment by CMS. 10-144 C.M.R. Ch. 101, sub-Ch. I, § 2.05 (A), (B), (D). As to appeal rights, the regulations permit an EH to "appeal the following issues:

1. A determination that the EH is not eligible for the Medicaid HIT Incentive Payment Program;
2. A determination that the EH did not meet attestations of adopting, implementing, or upgrading certified EHRs requirements;
3. An overpayment amount or recoupment as determined by the Department or CMS;
4. The amount of the incentive payment(s); and
5. Audit findings of any of the above.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 2.05-2.

In its State Medicaid HIT Plan, the Department elaborated on the appeals processes and rights reserved to EHs:

> Consistent with the Final Rule, Maine's appeals process for Medicaid incentive payments falls under the State's Administrative Procedures Act. EPs and EHs are given the opportunity to appeal determinations of incentive payment amounts, eligibility determinations, and attestation demonstrations for the Medicaid EHR Incentive Program. There are several escalating steps to the appeals process. First, providers are able to ask for an Informal Review of an HIT decision. MaineCare reviews the decision and issues a written Informal Review response. The provider may appeal that decision and ask for an Administrative Hearing conducted by a DHHS hearings officer. The provider may appeal that written decision through Maine's court system. (This is also the process that non-HIT appeals are conducted and is described in MaineCare rules.)
>
> Dually-eligible hospital appeals of Meaningful Use are under the purview of CMS, not states. Appeals of this nature will follow CMS rules and regulations.

Ex. J-3, p. 95.

In Section D of its State Medicaid HIT Plan, the Department outlined its "audit approach for the HIT and EHR Incentive Payment Program," designed to "promote program integrity, prevent making improper incentive payments, and monitor the program for potential fraud, waste, and abuse." Ex. J-3, p. 119. Authority over "meaningful use" audits was assigned to the Department's Division of Audit, however, specific policy development plans were deferred until after CMS issued its final rule for Stage 2 implementation. Ex. J-3, pp. 119, 126-28.

The facts relevant to this hearing are not in dispute and do not warrant a full recitation here. However, it is prudent to review the CMS Auditor's decision dated August 18, 2014, and its relationship

to recoupment claims established by CMS and the Department. The 2014 audit focused on HRH's participation in the Medicare EHR HITECH incentive program for Program Year 2013, chiefly finding that HRH did not meet the meaningful use criteria for Program Year 2013 where it "[f]ailed to demonstrate access to a CEHRT system." Ex. J-8; Ex. HO-6. The auditor clarified that HRH's failure was that "interfaces for Menu Measures #8, #9, and #10 were not in place at any point during the attestation period," and that this fact resulted in HRH "meet[ing] only 90% of certification criteria," where 100-percent compliance was necessary to demonstrate "meaningful use." Ex. J-10; Ex. HO-6.

On September 16, 2014, HRH appealed the August 18, 2014 audit, arguing that the auditor failed to properly limit its analysis of eligible hospital's compliance with "meaningful use" criteria to those criteria that are "applicable" to them, and that the auditor's lack of flexibility was inconsistent with "CMS's stated public policy goals of increasing efficiencies and controlling costs through the adopting of EHR technology." Ex. J-11. With regard to the first argument, HRH more specifically identified the following grounds for relief:

- HRH was entitled to an exclusion from compliance with "Menu Measure #8 – dealing with immunization data reporting – because Maine's immunization registry was not equipped to electronically receive such data reporting from HRH;
- HRH was entitled to an exclusion from compliance with "Menu Measure #9 – dealing with lab results data reporting – because Maine's public health registry was not equipped to electronically receive such data reporting from HRH;
- HRH was entitled to an exclusion from compliance with "Menu Measure #10 – dealing with syndromic surveillance reporting – because Maine's public health registry was not equipped to electronically receive such data reporting from HRH;

Ex. J-11.

On September 26, 2014, CMS issued notice of its decision in response to HRH's September 16, 2014 appeal letter, stating that "we have denied the documentation you provided to support your appeal. Therefore, CMS denies your appeal. This decision is final and not subject to further appeal." Ex. J-12.[2] In the same notice, CMS re-stated its Medicare recoupment claim in the amount of $307,168.84, for the attestation period of March 15, 2013 to June 15, 2013. Ex. J-12.

On March 31, 2016, the Department issued a recoupment notice to HRH for a single Maine HIT Program incentive payment – in the amount of $344,644.00 – issued to HRH on August 14, 2013. Ex. J-13. The Departmental notice stated that the "MaineCare EHR incentive Program is required to recoup any Medicaid incentive payment made to a hospital that has been deemed ineligible by a CMS audit for the Medicaid EHR incentive program for that program year." Ex. J-13. The Departmental notice observed that "[p]ursuant to 42 C.F.R. § 495.312, the State of Maine elected for CMS to perform 'meaningful use' audits of eligible hospitals," that "[d]ually-eligible hospital appeals of Meaningful Use

[2] As a note, CMS's notice to HRH that its final decision was "not subject to further appeal" was supported by rule – 42 C.F.R. 495.110 – more specifically providing that "[t]here is no administrative or judicial review … [f]or eligible hospitals [to challenge] … [t]he methodology and standards for determining whether an eligible hospital is a meaningful EHR user, including … [t]he means of demonstrating meaningful EHR use." 42 C.F.R. § 495.110 (b)(3).

are under the purview of CMS, not states," and that "HRH has already availed itself of those appeal rights back in 2014 and CMS has denied HRH's appeal." Ex. J-13.

HRH timely requested informal review from the Department on May 27, 2016, cross-referencing substantial informal correspondence between HRH and the Department leading to the March 31, 2016 recoupment notice. Ex. J-14. In that request, HRH first challenged the Department's determination that HRH was not entitled to appeal the Department's March 31, 2016 decision, where that decision was entirely based on a CMS-sponsored audit that triggered federal appeal rights HRH had already exhausted. Ex. J-14, pp. 3-8. HRH then raised six issues for informal review – the first of which was whether the Department was authorized to wholly rely upon the CMS Medicare audit as grounds for establishing a recoupment claim for the MaineCare EHR/HIT program incentive payments. Ex. J-14, pp. 8-12. The second issue was whether HRH was "entitled under the MaineCare Benefits Manual to an independent review by the Department as to whether HRH complied with the specific MaineCare EHR Incentive Payment Program requirements that were the subject of CMS' audit." Ex. J-14, pp. 8, 12-14. Issues three through six were substantially indistinguishable from the issues presented on appeal to CMS on September 16, 2014. Ex. J-14, pp. 8, 14-18; Ex. J-11.

On January 22, 2018, the Department issued a Final Informal Review Decision ["FIRD"], upholding the Department's recoupment claim and specifically concluding:

1. The Department was authorized to rely upon the findings reached by CMS Auditor in its Medicare EHR Incentive Payment Program audit as grounds for establishing a recoupment claim against HRH for MaineCare EHR/HIT Program incentive payments made.
2. HRH was not entitled under the MaineCare Benefits Manual to an independent review of the question of whether HRH's receipt of MaineCare EHR/HIT Program incentive payments was done in compliance with meaningful use criteria.
3. HRH was specifically not entitled to an independent Departmental review of the specific questions of whether HRH demonstrated access to a CEHRT system and whether HRH was entitled an exclusion from the compliance requirement for Menu items #8, #9, and #10.

Ex. J-1.

The regulatory tension at issue in this dispute results from the federal requirements that must be met before a state is able to delegate its Medicaid EHR/HIT Program incentive appeals authority back to CMS. Where audit and appeals authority over EHR incentive payments "meaningful use" is reserved by a state agency, CMS requires that the state appeals processes over such audits must comport to the state APA's due process protections, but not where "CMS conducts the audits and handles any subsequent appeals under [42 C.F.R. § 495.312(c)(2)]." 42 C.F.R. § 495.370 (b), (c), (d) (*emphasis added*). However, the State delegation of "all audits and appeals of eligible hospitals' meaningful use attestations" to CMS and acceptance to be bound by CMS's "audit and appeal findings" must be reflected in "a signed agreement." 42 C.F.R. § 495.332 (g) (*emphasis added*).

It cannot be said that the MaineCare HIT Program rules have incorporated by reference all terms and provisions published in the Maine's State Medicaid HIT Plan, where the HIT Plan has not been formally promulgated by the Department. Without adoption after an opportunity for notice and public comment, it cannot be said that the terms of the HIT plan has the force of law enforceable by or against the Department by any party other than CMS. *See* 42 C.F.R. § 400.203 (State Medicaid plan defined 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."). However, the wording of the CMS regulatory mandate suggests that there is no reasonable reading that might allow a state to delegate audit authority to CMS while reserving to itself the authority to administer appeals over CMS audits. All of the relevant CMS regulations include the conjunctive phrase, "and," reflecting that the delegation of audit and appeals authority cannot be bifurcated. *See* 42 C.F.R. § 495.332 (g); 495.370 (d). Further, CMS regulations provide that "[a]t the State's option, CMS conducts the audits and handles any subsequent appeals, of whether eligible hospitals are meaningful EHR users on the States' behalf." 42 C.F.R. § 495.312 (c) (*emphasis added*). This provision identifies not that the state has "options," but a single "option" to allow CMS's audit and appeals scheme to govern dual eligible hospitals' meaningful use attestation reviews as they relate to MaineCare. More simply put, CMS regulations permit states to reserve "audit and appeals" authority and to delegate "audit and appeals" authority to CMS, but the same regulations do not permit states to delegate one of those two functions to CMS while retaining the other.

The MaineCare regulations in effect for Program Year 2013 did not specify whether the Department would retain audit and appeals authority or delegate CMS to perform those functions on its behalf. *See* 10-144 C.M.R. Ch. 101, sub-Ch. I, §§ 2.05, 2.05-1, 2.05-2 (eff. Oct. 4, 2011). Section 2.05-1 specifically provided that "[t]he 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." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 2.05-1 (eff. Oct. 4, 2011) (*emphasis added*). Section 2.05-2 specifically provided that "An EH may appeal ... [a] determination that the EH did not meet attestations of adopting, implementing, or upgrading certified EHRs requirement," "[a]n overpayment amount or recoupment as determined by the Department or CMS," and "[a]udit findings of any of the above." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 2.05-2 (A)(2), (3) (eff. Oct. 4, 2011) (*emphasis added*).

The Hearing Officer's "decision must be based on the agency regulations and the evidence which is a matter of hearing record." Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (B)(3). "Where the agency's regulations are ambiguous or silent on the point critical to a determination, reference to other sources of law for guidance in interpreting the agency's regulations is appropriate." *Id.* As with statutory interpretation, the reviewer must first look to the plain language of regulatory provision, which "should be construed to avoid absurd, illogical, or inconsistent results," and in light of the whole regulatory scheme "for which the section at issue forms a part so that a harmonious result ... may be achieved." *See Dep't of Human Servs. ex rel. Hampson v. Hager*, 2000 ME 140, ¶21, 756 A.2d 489, 493.

As noted, the October 2011 version of the MaineCare HIT Program rules expressly avoided any indication as to whether the Department was retaining or delegating meaningful use audit and appeals authority. By using the disjunctive, "or," in both Section 2.05-1 and 2.05-2, the Department created an ambiguity that, by its explanations, it intended to be clarified after CMS's adoption of a relevant final rule and through its own State Medicaid HIT Plan with CMS. Ex. J-20. Because the plain language is ambiguous, it is appropriate to consider it in terms of other sources of law relevant to the larger regulatory scheme.

First, CMS regulations require that a State's delegation of meaningful use audits and appeals to CMS and acceptance to be bound by CMS's findings must be reflected in "a signed agreement." 42 C.F.R. § 495.332 (g). To determine whether Maine effectuated that delegation in writing, we look to the terms of the State Medicaid HIT Plan. Ex. J-3. As noted, the Department specified in writing that the Department generally authorized its Division of Audit to audit EHR meaningful use, yet deferred its specific policy development plans until after CMS issued its final rule for Stage 2 implementation. Ex. J-3, pp. 119, 126-28. However, the same document identified both that "Maine's appeals process for Medicaid incentive payments falls under the state's Administrative Procedures Act" and that "Dually-eligible hospital appeals of Meaningful Use are under the purview of CMS, not states. Appeals of this nature will follow CMS rules and regulations." Ex. J-3, p. 95. By so doing, the Department formalized by "signed agreement" that CMS's audit and appeal process for dual-eligible hospitals would be binding upon it with respect to MaineCare EHR/HIT Program incentive payments made. And, because CMS rules and regulations construe authority over audits and appeals to be a single, un-bifurcated function, it necessarily follows that because the Department designated CMS as its duly-authorized agent to conduct binding meaningful use appeals over dual-eligible hospitals in Maine, it also designated CMS as having authority to conduct the audits that would be subject to such appeals.

It also merits noting that to conclude the opposite – that Maine might defer to CMS's findings with respect to audits of Medicare-eligible hospitals' "meaningful use" of certified EHR technology, but retain the authority to administer appeals over those findings – would create a system under which different tribunals could reach different conclusions from the same set of findings. It is illogical and absurd to conclude that CMS would create a system in which states could essentially adopt the determinations of CMS's fact-finding agents but separately adjudicate the same set of operative facts. The law forbids "relitigation of factual issues already decided if the identical issue was determined by a prior final judgment, and the party estopped had a fair opportunity and incentive to litigate the issue in a prior proceeding," even in administrative proceedings. *Portland Water Dist. v. Town of Standish*, 2008 ME 23, ¶9, 940 A.2d 1097, 1100. Issue preclusion, or collateral estoppel, will prevent such re-litigation but "only if the identical issue necessarily was determined by a prior final judgment." *Macomber v. MacQuinn-Tweedie*, 2003 ME 121, ¶25, 834 A.2d 131, 140. "A party asserting collateral estoppel has the burden of demonstrating that the specific issue was actually decided in the earlier proceeding." *Id.*

Here, there is no disagreement between the parties as to the operative facts at issue were HRH permitted to challenge the Department's MaineCare EHR/HIT Program recoupment claim before an independent adjudicator. HRH raised the same operative factual issues in its September 16, 2014 appeal

of the CMS Auditor's HITECH EHR Meaningful Use Audit" that it raised in its May 27, 2016 Request for Informal Review of the Department's EHR Incentive Payment Recoupment Decision. Ex. J-11; Ex. J-14. The Medicare and MaineCare recoupment figures are notably different, but this fact owes merely to the difference between the respective payments made under the two programs. Because HRH does not dispute the amounts of the payments or recoupment claims, the difference in dollar values has no bearing on this appeal. To be sure, the only matters raised in the May 27, 2016 request not raised on September 16, 2014, concerned HRH's assertions of procedural rights for the Department to re-visit the factual issues that were duplicative of those raised on September 16, 2014. CMS issued its final determination, rejecting HRH's Medicaid EHR Incentive Program appeal on September 26, 2014. Ex. J-12. The hearing officer does not have cause to question whether the CMS final determination exhibits all of the badges of a "final judgment" where the CMS regulatory scheme deprives eligible hospitals of any further appeals. However, to the extent that 42 C.F.R. § 495.110 remains good law, the September 26, 2014 CMS determination is sufficiently final for the purposes of having binding effect over the Department's review. As such, HRH should be collaterally estopped from re-litigating the CMS Auditor's findings concerning its non-compliance with certain "meaningful use" criteria before a Departmental hearings officer or any other authorized adjudicator.

Based on the foregoing, the Hearing Officer respectfully recommends that the Commissioner conclude that:

1. The Department was permitted to rely upon the Centers for Medicare and Medicaid Services' Medicare audit to determine whether Houlton Regional Hospital qualified for EHR incentive payments under [the] MaineCare HIT Incentive Payment Program;

2. Houlton Regional Hospital is not entitled under the MaineCare Benefits Manual to an independent review by the Department as to whether Houlton Regional Hospital complied with the specific MaineCare EHR/HIT Incentive Payment Program requirements that were the subject of CMS's audit.

3. The Department correctly established a recoupment claim in the amount of **$344,644.00** against Houlton Regional Hospital based on the audit finding by The Centers for Medicare and Medicaid Services ["CMS"] that Houlton Regional Hospital did not meet the Medicare Electronic Health Record ("EHR") Incentive Program's requirements for Program Year 2013.

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: 12/3/2018

Richard W. Thackeray, Jr.
Administrative Hearing Officer

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