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
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IN THE MATTER OF:

Maine Medical Center	)	
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 February 11, 2022, and the responses and exceptions received from the Department and Maine Medical Center have been reviewed.

I hereby accept the Hearing Officer's Findings of Fact except that Findings 26 and 53 are revised to read as follows:

> 26. For the purposes of calculating Maine Medical Center's incentive payment, the Department used Maine Medical Center's fiscal year ending September 30, 2010 as its base year.
>
> 53. In conducting its audit of Maine Medical Center, Myers and Stauffer requested claims information from Maine Medical Center.

In addition, I hereby make the following additional Findings of Fact:

> 73. The Department relied upon documentation provided by Maine Medical Center to ascertain the approved MaineCare-paid claims, discharges and total acute inpatient days.
>
> 74. There is no evidence in the record demonstrating that any of the claims information supplied by Maine Medical Center and relied upon by the Department's auditors is inaccurate, incomplete, or otherwise unreliable.

I hereby accept the Hearing Officer's recommendations that: 1) The Department was permitted to conduct a post-payment audit using documentation other than the Medicare cost report; and 2) The Department was correct in its interpretation of applicable federal regulations in its post-payment review for the EHR program. I *do not* accept the Hearing Officer's recommendation that the Department was not correct when it determined that Maine Medical Center received an overpayment for the EHR program in the sum of $1,608,344. For the reasons set forth below, I find that the Department was *correct* when it determined that Maine Medical Center received an overpayment for the EHR program in the sum of $1,608,344.

The Department's burden in this case was to demonstrate that the amount of the EHR incentive payment for Maine Medical Center that was calculated during the post-payment audit was correct (and therefore that Maine Medical Center had received an overpayment of $1,608,344). The Department satisfied this burden.

The only evidence in the record that the Department's post-payment audit calculation of the incentive payment was incorrect involved a minor issue involving the CHIP factor. The Department corrected the overpayment amount to account for this issue.

There is no evidence that the documentation that Maine Medical Center provided during the post-payment audit was inaccurate, incomplete or otherwise unreliable. Notwithstanding Maine Medical Center's subsequent dissatisfaction with the audit results, the Department was entitled to rely upon this documentation.

Any discrepancies between the post-payment audit and the MaineCare Final Settlement and Audit do not provide a basis for determining the post-payment audit calculation of the EHR incentive payment was incorrect or that the documentation provided by Maine Medical Center was inaccurate, incomplete or otherwise unreliable. The post-payment audit served a different function and did not perform the same analysis as the MaineCare Final Settlement and Audit.

DATED: 5-31-22 SIGNED: Jeanne M. Lambrew

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: Brendan D. Kreckel, AAG, Office of the Attorney General
Margaret Machaiek, 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: February 11, 2022

In the Matter of: Maine Medical Center

ADMINISTRATIVE HEARING RECOMMENDED DECISION

Hearing Officer Tamra Longanecker held an administrative hearing in the above-captioned matter via Microsoft TEAMS on November 29, 2021 and November 30, 2021. The record was left open for closing arguments, which were received and made part of the record. The record closed on December 17, 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 following issue was presented *de novo* for hearing:

> Was the Department correct when it determined that Maine Medical Center owes the Department $1,617,494.98[1] in recoupment due to an overpayment of the Medicaid EHR Incentive Program Aggregate Payment as found in a Final Informal Decision dated September 4, 2019 and Notice of Debt dated September 10, 2018? Ex. HO-3.

APPEARING ON BEHALF OF THE APPELLANT

- William H. Stiles, Esq.
- Thomas Morgan, Vice President of Reimbursement for MaineHealth
- Brian Moran, DHHS Division of Audit, Senior Auditor

[1] The Department reduced this amount to $1,608,344.00 based on a recalculation using a revised CHIP factor.

APPEARING ON BEHALF OF THE DEPARTMENT

- Thomas C. Bradley, AAG
- Patricia Chubbuck, Independent Contractor EHR Incentive Program
- Regan McTier, Myers and Stauffer, LLC

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 10/24/2019
HO-7: Request for Informal Review (with attachments) dated 11/08/2018
HO-8: Letter from Mr. Pickering dated 2/28/2020 (assigning one HO to all 5 appeals)
HO-9: Motion to Consolidate dated 09/21/2021
HO-10: Opposition to Motion to Consolidate dated 09/28/2021
HO-11: Decision on Motion to Consolidate dated 09/28/2021
HO-12: Entry of Appearance dated 11/16/2021
HO-13: Franklin Memorial Hospital Recommended Decision
HO-14: Franklin Memorial Hospital Final Decision
HO-15: Franklin Memorial Hospital administrative hearing recording and summary of Natasha Erb's testimony
HO-16: Penobscot Bay Medical Center administrative hearing recording
HO-17: Waldo County General Hospital administrative hearing recording

Department Exhibits (pages 000001-001729)

D-1: Order of Reference
D-2: Federal Register/Vol 75, No 144
D-3: Department Request for Audit
D-4: Department Payment Calculation
D-5: EH Payment Information
D-6: Acute Services Email
D-7: Original Summary of Findings
D-8: Revised Summary of Findings Email
D-9: Summary of Findings follow-up email
D-10: Final Findings letter

D-11: Notice of Debt
D-12: Signed Management Representation Letter
D-13: Request for Informal Appeal
D-14: Final Information Review Decision
D-15: CHIP Factor email from DHHS
D-16: DHHS CHIP Factor Detail Report
D-17: CMS Email – Medicaid days
D-18: Revised CHIP Factor calculation
D-19: Revised Recalculation of Incentive Payment (New CHIP factor)
D-20: Summary of OIG Findings/OIG Reports
D-21: MaineCare Benefits Manual Ch. I, Sec. I (effective 7/5/2017)
D-22: Maine Care Benefits Manual Ch. I, Sec. I (effective 1/11/2010)
D-23: MaineCare Benefits Manual Ch. I, Sec. I (effective 2/13/2011)
D-24: MaineCare Benefits Manual Ch. I, Sect I (effective 6/30/2013)
D-25: 2011 Maine State Medical Health IT Plan (SMHP)
D-26: 2011 SMHP Approval Letter
D-27: 2014 SMHP Supplemental Submission
D-28: 2014 SMHP Approval
D-29: MaineCare Benefits Manual Ch. III, Sec. 45 (effective 9/28/2009)
D-30: DHHS Communications re: MeCMS System
D-31: 42 U.S.C. §1396b – effective 2011

Appellant Exhibits (pages 1 – 360)

A-1: Applicable EHR Statutes
A-2: Applicable Federal Medicaid EHR regulations
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 Version)
A-7: MaineCare Regulations Effective in 2010
A-8: DRG Descriptions
A-9: Articles Addressing MeCMS Issues
A-10: Request for Informal Review
A-11: Final Informal Review Decision
A-12: Excel spreadsheet – Revised Summary of Findings (sortable version of D-8)

Other documents in the record

Department's closing argument
Appellant's closing argument

RECOMMENDED FINDINGS OF FACT

1. In accordance with agency rules, Maine Medical Center ["MMC"] 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.[2]

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

4. Eligible hospitals ("EH") voluntarily applied for and participated in the incentive program.

5. EHs are required to maintain evidence of qualification to receive incentive payments for ten (10) years after the date they register for the program. *See*, exhibit D-2 and testimony at hearing.

6. 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.

7. 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:

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

[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. See, exhibit D-2, page 0191.

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

9. 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-26.

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

11. 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[3]. *See,* exhibit D-25.

12. 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-25.

13. 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).

14. Effective October 4, 2011, and in accordance with the APA, the Department promulgated a Final Rule, "State Medicaid Health Information Technology Program,"

[3] Hospitals may also receive Medicare EHR incentive payments. The issue of this appeal is solely the Medicaid incentive payment to Maine Medical Center.

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.

15. The MaineCare HIT Program Rules state that "The incentive payment program process and requirements for EHs are those described in 42 C.F.R. §§ 495.310(e) through (j), 495.314 and 495.312(b)." *See*, HIT Program Rules, Chapter I §2.03.

16. With regard to audits, the Division of Audit or its duly authorized agents have the authority to conduct post-payment reviews. *See*, HIT Program Rules, Chapter I §2.05-1.D.

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

18. 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).

19. 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

(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).

20. Only Medicaid paid inpatient-bed days are included in the calculation of the Medicaid Share fraction. *See,* exhibit D-2 page 190.

21. Bed days paid by the Children's Health Insurance Program ("CHIP") are not paid by Medicaid and must be subtracted out of the numerator of the Medicaid Share fraction. *See,* exhibit D-2 page 179 and Chubbuck testimony.

22. Nursery newborn bed days are not considered acute care bed days in the numerator or the denominator of the Medicaid share formula and are not considered acute care for the discharges utilized to calculate the overall EHR amount, with the exception of an intensive neonatal care unit. *See,* exhibit D-2 page 144 and McTier testimony.

23. Maine Medical Center does have an intensive neonatal care unit. *See,* testimony at hearing.

24. Charity care is subtracted out from the total bed days, which has the effect of increasing the proportion of Medicaid-paid bed days. *See*, exhibit D-2 page 270 and McTier testimony.

25. The Department determined that Maine Medical Center was one of 36 non-psychiatric hospitals eligible for Medicaid EHR incentive payments.

26. For purposes of calculating Maine Medical Center's incentive payment, the Department used Maine Medical Center's fiscal year ending June 30, 2010 as its base year.

27. During the relevant time period Maine Medical Center was licensed as an acute care non-critical access hospital.

28. During the relevant time period, 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-7.

29. Generally, as an acute care non-critical access hospital, MaineCare reimbursed Maine Medical Center with a rate per discharge for inpatient services, and a percentage of cost basis for outpatient services. *See*, exhibit A-7.

30. Maine Medical Center's reimbursement was based on several findings by a MaineCare auditor. Those findings included:

- The number of paid MaineCare inpatient acute care discharges;
- The number of MaineCare inpatient acute care days associated with those paid discharges; and
- The number of total inpatient acute care days (regardless of payor) *See*, Moran testimony.

31. Maine Medical Center, as a teaching hospital, also received an additional payment known as the Graduate Medical Education ("GME") payment based on the number of paid MaineCare inpatient days to total inpatient days.

32. From January 2005 to September 2010, the Department used MeCMS to process claims. Maine Medical Center would submit a claim to MeCMS, which would then issue a remittance advice. Maine Medical Center 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 Maine Medical Center 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-9.

33. Difficulties of the MeCMS system were resolved through the Department's manual research and review of claims. The Department gave MaineCare providers spreadsheets of the results of the research and review of "paper claims" submitted by the provider. The provider then had the opportunity to resolve any remaining issues with the Department regarding the paper claims. *See*, Goodale testimony.

34. For two (2) years after the MeCMS system was decommissioned, the Department continued to allow providers to submit paper claims. The Department did not issue remittance advices following the adjudication of paper claims. However, the hospital would be aware of the result of the paper claims and could upload that information into its own internal system. *See*, Goodale testimony.

35. Maine Medical Center did not upload the results of paper claims, which were adjudicated outside of the MeCMS system, into its own system because it was paid through the cost settlement process and not on individual claims. *See*, Morgan testimony.

36. The Department at all times relevant to the incentive payments at issue used a claims-based system. While actual MaineCare payments to Maine hospitals are through a cost settlement process by the Department's division of Audit, the MaineCare claims are adjudicated and designated as "paid claims" by the MaineCare program prior to the Division of Audit's cost settlement process. In the cost settlement process, the Division of Audit does not adjudicate or determine MaineCare-paid claims or hospital

discharges. *See,* Moran testimony and MaineCare Benefits Manual, Chapter III, §45.03-5.

37. In the cost settlement process, if there is a difference between the hospital's documentation regarding claims and the Department's documentation, a MaineCare auditor would rely on the Department's documentation. *See,* Moran testimony.

38. Because of all the "glitches" in the MeCMS system, the Department took seven (7) years to issue the final cost settlement for Maine Medical Center's FYE 2010. The Department usually takes one (1) year to issue the final cost settlement. *See,* Erb testimony and exhibit A-6.

39. Using FYE 2010 for its base year, the Department calculated the hospital's aggregate EHR incentive amount as $3,685,872.00, which was to be paid over a period of three (3) years. *See,* exhibit D-5.

40. On December 7, 2011, Maine Medical Center received its first incentive payment in the amount of $1,842,93600.

41. On November 27, 2013, Maine Medical Center received its second incentive payment in the amount of $1,474,349.00.

42. On February 18, 2015, Maine Medical Center received its third incentive payment in the amount of $368,587.00.

43. 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.

44. 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.

45. The Department contracted with the accounting firm of Myers and Stauffer to perform a function previously assumed by the Division of Audit. Specifically, Myers

and Stauffer was contracted to conduct post-payment reviews on behalf of the Department.

46. Because Myers and Stauffer was a contractor performing a function previously conducted by the Department's own Division of Audit, Maine Medical Center made the assumption that the accounting firm would also have all of the information in the Department's possession when conducting a post-payment review.

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

48. 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 and exhibit D-20.

49. 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.

50. 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.

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

52. Myers and Stauffer determined that 11 Maine hospitals had received underpayments of incentive payments and 25 hospitals had received overpayments. One of the MaineHealth hospitals which received an underpayment did not appeal the audit findings.

53. 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).

54. Myers and Stauffer was not aware of how the State of Maine paid hospitals during the relevant time period.

55. 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.

56. Myers and Stauffer notified Maine Medical Center that it had been selected for a desk audit. Myers and Stauffer requested that Maine Medical Center provide a significant level of claims data related to fiscal years ending June 30, 2007, 2008, 2009 and 2010. *See*, exhibit D-6.

56. Myers and Stauffer notified Maine Medical Center that it had completed its audit and summarized its findings. It invited Maine Medical Center to comment, question, and/or supplement its documentation related to those findings prior to finalizing its review. *See*, exhibit D-7.

57. Myers and Stauffer auditors had discussions with MMC regarding its initial audit findings. Based on these discussions, Myers and Stauffer issued revised findings.

58. Myers and Stauffer's revised audit findings included a sortable spreadsheet which allowed Maine Medical Center to review each of the audit's findings. The spreadsheet contained over 30,000 entries.

59. Maine Medical Center did not raise any questions or concerns with Myers and Stauffer with regard to its revised audit findings. Maine Medical Center did not submit any supplemental documentation.

60. On July 27, 2018, Chris Coon, Chief Financial Officer for Maine Medical Center, certified that the documentation it submitted was "complete and without material error." Mr. Coon also certified that Maine Medical Center had a responsibility to present any subsequent information to the Department that would impact the audit findings. *See,* exhibit D-12.

61. On September 10, 2018, the Department issued a Notice of Debt to Maine Medical Center. The Notice of Debt stated that Myers and Stauffer had determined that Maine Medical Center received overpayments in the EHR incentive program. The Department demanded that Maine Medical Center repay $1,617,494.98.

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

- 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 greater than the number utilized in the original calculation.
- The adjusted number 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.
- Bad debt expense was not removed from the reported Charity Care Charges.

63. On November 9, 2018, Maine Medical Center requested an informal review of the audit's findings. Among its objections to the overpayment amount, Maine Medical Center 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". Maine Medical Center referred to the "historically unreliable" MeCMS system and its concern that some information was pulled from that system. Maine Medical Center 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 D-13.

64. On September 4, 2019, the Department issued its Final Informal Review Decision. The Decision upheld the Auditor's findings and the determination that Maine Medical Center was overpaid $1,617,494.98 in the EHR incentive program.

65. On October 24, 2019, Maine Medical Center requested an administrative hearing.

66. Prior to the administrative hearing, the Department revised the numerical factor applied to account for payments by the Children's Health Insurance Program (CHIP), reducing the recoupment sought from Maine Medical Center to $1,608,344.00. CHIP paid days are not included in the formula for calculating the incentive payment. Myers and Stauffer did not have documentation to distinguish between CHIP paid days from MaineCare paid days. Myers and Stauffer relied on the Department to calculate this factor.

67. Before Myers and Stauffer submits its audit findings to the Department, those findings undergo two (2) levels of review. Ms. McTier, a manager at Myers and Stauffer, described the process as thorough and the findings as very accurate.

68. Maine Medical Center requested a "live" version of the auditor's spreadsheet in order to review the calculations. Myers and Stauffer refused to share a "live" version because it contained formulas developed by Myers and Stauffer.

69. The Department did not review the formulas created by Myers and Stauffer. The Department's manager of the program, Ms. Chubbuck, accepted the findings without any further review.

70. In connection with a different audit, a formula created by Myers and Stauffer incorrectly excluded a DRG code, which slipped through its thorough review process. *See*, Waldo County General Hospital recording.

71. In creating its formulas, Myers and Stauffer reviews the information submitted by a hospital, determines what fields are available to use in its formulas, and then determines the best way to identify services. *See*, McTier testimony 11/29/2021 (2 of 2 at approximately 10:20).

72. In the audit for Maine Medical Center, Myers and Stauffer determined that service codes would be the most efficient way to remove non-acute services such as regular nursery days, emergency room visits (reimbursed as outpatient services) and psych unit days. *See*, McTier testimony.

73. In order to be consistent, Myers and Stauffer interpreted claims that had an emergency room service code as a non-acute service and created a formula which removed all claims with an emergency room service code, even if that claim also had a DRG code and a Medicaid payment. *See*, McTier testimony.

74. Myers and Stauffer admits that it is possible for its auditors to interpret the hospital's data incorrectly. *See*, McTier testimony 11/29/2021 (1 of 2 at approximately 3:05).

75. Maine Medical Center is Maine's only Level 1 Trauma Center. Many patients are admitted as inpatients as a result of an emergency. *See*, Moran testimony.

76. Myers and Stauffer excluded acute care days for at least twelve (12) patients who were admitted through the emergency room, had inpatient DRG codes, and had MaineCare as the only payor. *See*, exhibit A-12 (sortable version of exhibit D-8) and Appellant's closing page 34 with sorting instructions.

77. Based on its formulas, Myers and Stauffer found that a 45 day inpatient stay, for which MaineCare paid $170,594.99, to reattach a patient's limb was a non-acute visit. This patient had an emergency room service code because he was admitted through the emergency room, but had a DRG code for limb reattachment. Myers and Stauffer excluded these Medicaid acute care days because the patient had an emergency room service code. Myers and Stauffer did not review the DRG code to determine why an emergency room visit resulted in a 45 day hospital stay. *See*, McTier testimony and exhibit D-8 row 185.

78. Based on its formulas, Myers and Stauffer found that a combined 86 day inpatient stay, paid by Medicaid, for a set of twins with DRG code "extreme immaturity or respiratory distress syndrome, neonate" was a normal nursery visit and therefore excluded from the total number of Medicaid acute care days. *See*, exhibit D-8 rows 3695 and 3696.

79. While the purposes of a MaineCare Audit and Settlement and an EHR incentive payment audit may have been different, both auditors had to first identify paid MaineCare inpatient acute care days. The Myers and Stauffer auditor was then

required to remove certain days consistent with federal regulations and CMS guidance. *See,* testimony at hearing.

80. If Ms. Chubbuck had had a copy of the MaineCare Final Audit and Settlement, she would have forwarded a copy to Myers and Stauffer. *See,* Waldo County General Hospital recording (10/13/2021 3:51).

81. If Myers and Stauffer had had a copy of the MaineCare Final Audit and Settlement, it would have "explored" any issues between its findings and MaineCare's findings. However, Myers and Stauffer still would have requested documentation to support any claims. *See,* McTier testimony.

82. In its audit, Myers and Stauffer intended to exclude normal nursery days and psychiatric inpatient days (which are included in a MaineCare Final Audit and Settlement).

83. Maine Medical Center's FY 2010 MaineCare Final Audit and Settlement documented 160,318 total inpatient acute days (excluding observation bed days) and 29,387 paid MaineCare inpatient acute days (including nursery and psych days). If nursery and psych days are excluded, the MaineCare auditor found 148,451 total acute days and 23,278 paid MaineCare days. *See,* exhibit A-6.

84. Myers and Stauffer found documentation to support 148,059 total acute days (a 0.34% variance from the MaineCare auditor) and 16,783 paid MaineCare days (a variance of over 25% from the MaineCare auditor).

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 correct in its interpretation of applicable federal regulations in its post-payment review for the EHR program.

3. The Department was not correct when it determined that Maine Medical Center received an overpayment for the EHR program in the sum of $1,608,344.

   If the Commissioner does not find in favor of Maine Medical Center because the Department has failed to meet its burden that the calculation of the overpayment was correct, the hearing officer respectfully recommends that the Commissioner, in the alternative, remand this matter back to the Department to recalculate the amount of the alleged overpayment.

   Specifically, Myers and Stauffer found claims documentation to support 148,959 total acute days, which represents only a 0.34% variance from the MaineCare auditor (if nursery and psych days are excluded)[4]. This means that the issue in this case is not a lack of documentation to support claims but a difference in how those claims were interpreted by the auditor (i.e. included/excluded as MaineCare paid days), which would account for an over 25% variance in MaineCare paid days between the auditors. The above Findings support that a large number of days were incorrectly excluded as a result of Myers and Stauffer's formulas and/or misinterpretation of MMC's documentation.

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

[4] Please see Appellant's closing starting on page 26 for a through explanation of the numbers and variances.

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-27. 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-27. 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 Maine Medical Center owes the Department $1,617,494.98[5] in recoupment due to an overpayment of the Medicaid EHR Incentive Program Aggregate Payment as found in a Final Informal Decision dated September 4, 2019 and Notice of Debt dated September 10, 2018? Ex. HO-3.

Consistent with its approved SMHP, the Department used Maine Medical Center's cost reports in calculating its Medicaid Share and overall aggregate EHR incentive payment. As a result, the Department initially determined Maine Medical Center's incentive payment to be $3,685,872.00. The Department made three payments to Maine Medical Center in 2011, 2013 and 2015. Myers and Stauffer conducted a post-payment audit and found that the Department had allegedly overpaid Maine Medical Center $1,617,494.98.

The Department issued a Notice of Debt for that amount on September 10, 2018. Maine Medical Center requested an informal review, which was performed and upheld the overpayment. This appeal followed. Prior to hearing, the Department used a revised CHIP factor in the calculation which reduced the overpayment to $1,608,344.00.

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

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,*

[5] The Department reduced this amount to $1,608,344.00 based on a recalculation using a revised CHIP factor.

Chubbuck testimony. The Department asked Myers and Stauffer to perform audits of all Maine hospitals that received an incentive payment.

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." The MaineCare Benefits Manual, Chapter I, §1.16 also gives the Department the authority to conduct post-payment reviews of MaineCare providers.

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 205).

In its closing, MAINE MEDICAL CENTER argues that the Department's use of claims information rather than the Medicare cost report for this audit arbitrarily changed the rules six years after the initial determination. More specifically, MAINE MEDICAL CENTER's closing (pages 13 and 14) states 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 (bottom of middle column to top of third column) ***(DHHS 2, p. 190)****. 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." Id.*

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 Medicare share of the Incentive Payment. 42 C.F.R. § 495.104(c)(4). ***DHHS 2, p. 263.***

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 25, p. 1314-15** (emphasis added). The Department is bound by this election.*

*The 2014 SMHP Supplement confirms this election. **DHHS 27, p. 1608.** It reads: "For EH incentive payments: MaineCare will verify hospital incentive payment calculations based on the hospital's Medicare cost reports and audited financial statements." **Id.***

*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.** Indeed, the Department used the required Medicare cost reports when initially calculating the Hospital's Incentive Payment. **DHHS 4.***

The Department's Revised Determination 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 <u>not</u> 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 over six years later.

The hearing officer is not persuaded by Maine Medical Center'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.

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 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.

II. The Department was correct in its interpretation of applicable federal regulations in its post-payment review for the EHR program.

The Notice of Debt, dated September 10, 2018, stated that the adjustment in the aggregate incentive payment was necessary because:

- 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 greater than the number utilized in the original calculation.
- The adjusted number 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.
- Bad debt expense was not removed from the reported Charity Care Charges.

In making the above adjustments, Myers and Stauffer relied on the applicable federal regulations and CMS guidance. For example, Myers and Stauffer did not include regular nursery newborn bed days in the numerator. And, the auditor included only Medicaid paid inpatient-bed days in the calculation of the Medicaid Share fraction. Myers and Stauffer also excluded claims for which MaineCare was the secondary payor

to Medicare and charity care (which is specifically excluded in the denominator of the Medicaid Share).

The Federal Register 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. See, exhibit D-2 page 190.*

On October 24, 2012, CMS also clearly communicated that: "Zero pay Medicaid eligible days must continue to be excluded from the Medicaid hospital incentive calculation." *See*, exhibit D-16.

Specifically with regard to nursery days, the Federal Register states:

> *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. See, exhibit D-2 page 144.*

Maine Medical Center argues that 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 regular newborn days. However, the hearing officer is not persuaded by the hospital's argument. The guidance from CMS is clear that only paid Medicaid days are included in the calculation and only newborn days in intensive care units are included.

With regard to CHIP paid days, Ms. Chubbuck testified that the auditor was unable to identify those claims from the hospital's documentation. CHIP paid days are different from Medicaid paid days and therefore, must be excluded from the calculation. The Department performed a data run of inpatient claims to create a ratio of CHIP paid claims compared to Medicaid paid claims within the relevant time period. The auditor then applied this ratio to the paid Medicaid days to remove that percentage of CHIP paid days. Ms. Chubbuck testified that since the CHIP factor is a ratio it is not claim specific in every respect.

Based on the testimony and evidence presented at hearing, the hearing officer respectfully recommends that the Commissioner find the that Department was correct

in its interpretations of the applicable regulations and CMS guidance when performing the post-payment audit.

III. The Department was not correct when it determined that Maine Medical Center received an overpayment for the EHR program in the sum of $1,608,344.00

The hearing officer agrees with the Department that it had the authority to conduct this post-payment audit using information other than cost reports, and that its interpretations of federal regulations and CMS guidance in performing that audit were also correct. However, for the reasons described below, the hearing officer respectfully does not agree that the Department has met its burden to prove that the actual calculation of the alleged overpayment was correct.

Brian Moran testified at hearing. He is a senior auditor within the Department's Division of Audit. Prior to working at the Department, Mr. Moran was a Medicare auditor for over thirteen (13) years.

In completing the FY 2010 Final Audit and Settlement, Mr. Moran testified that an auditor would review many sources of information such as the Medicare cost report, MaineCare paid claims history and Maine Medical Center's audited financial statements. An auditor would make adjustments to account for paper claims adjudicated outside of the MeCMS system and for claims paid by third parties. If there was a discrepancy between the Department's records and Maine Medical Center's records, the auditor would rely on the Department's records.

The Department's auditor made findings regarding the number of paid MaineCare inpatient acute care discharges and the number of MaineCare inpatient days associated with the paid acute care discharges. The auditor did not include days awaiting placement and/or observation days in either of those numbers. In this case, the hospital was also paid a Graduate Medical Education ("GME") payment based on the number of paid MaineCare inpatient days to total inpatient days.

Mr. Morgan testified at hearing. He is the Vice President of Reimbursement for MaineHealth. Mr. Morgan testified that one of the disputes Maine Medical Center has with the Myers and Stauffer findings is that Myers and Stauffer auditors failed to reconcile their numbers with those contained in the cost reports. And, even if Maine Medical Center agreed with the auditors' interpretations of federal regulations (which it does not) and excluded newborn days, for example, the auditors' findings do not match those made by the Department's auditors in the Final Audit and Settlement.

Mr. Morgan has testified that the paper claims adjudicated outside of the MeCMS system were not contained in the hospital's internal system. The hospital did not input that information because it never received remittance advices from those paper claims and the hospital's payment was not based on those claims, but rather through the cost report. Mr. Morgan also testified that because Myers and Stauffer was the Department's agent, the hospital assumed that it had access to and was reviewing all of the Department's documentation relevant to this audit (i.e. claims information, cost reports, etc.).

In this case, Mr. Morgan testified that MMC faced two specific challenges during the audit. First, MMC changed data systems between 2010 and this audit, which made collecting the claims information difficult. Second, since so much time had passed since the original determination had been made, MMC no longer had any staff employed who were part of the initial process to qualify for the incentive payment.

Mr. Morgan credibly testified that he thought Myers and Stauffer would obtain and verify MMC's documentation with MaineCare. MMC is experienced with the rigorous audit process through MaineCare and Medicare. MMC did not understand that the Myers and Stauffer audit would function entirely different from those audits, in that it was never clear that only the hospital's documentation would be considered. In that way, this audit was different than any other audit MMC has ever experienced.

Mr. Morgan does not remember discussing the issue of emergency room service codes with Myers and Stauffer. Mr. Morgan testified that any patient admitted through the emergency room would have an emergency room service code in his/her claim. When MMC received exhibit D-8, Mr. Morgan agrees that the document was a sortable document. But, again, MMC assumed that the auditor was verifying information with MaineCare. MMC also did not have the formulas used by the auditor to understand how the claims information was interpreted.

Mr. Morgan testified that the documentation submitted by MMC was as complete as it could be based on the remittance advices sent to it from the MeCMS system. Again, MMC would receive a remittance advice from MeCMS and then input that information into a patient account. In this way, MMC argues that the Department's system, MeCMS, was actually the primary source of information. Mr. Morgan testified that there was no business reason to update a patient's account based on the paper claims which were adjudicated outside of MeCMS because the payment on those claims did not represent the actual payment made by MaineCare to the hospital.

In response to the testimony about paid inpatient days being incorrectly excluded based on service codes, the Department first argues that MMC failed to preserve this issue in its request for informal review. The Department argues that MMC failed to argue "with sufficient specificity" in order for it to respond to this issue. *See,* Department's closing page 15.

The Department then argues that if the issue surrounding service codes related to nursery and emergency room visits is considered, then it responds as follows:

MMC had not provided the necessary documentation to support inclusion of the patient visits as acute bed days. MMC instead contends they should be considered acute bed days based on inferences from their lengths of stay and MMC's assignment of a DRG code.

In respect to the patient with an Emergency Room service code, the audit treated all the Emergency Room service codes consistently, MMC reviewed the draft audit findings and did not contest them in the audit process and did not provide any additional documentation or information to support a contrary finding. Testimony of Regan McTier (MMC). Again, MMC certified its documentation as accurate, on which the audit relied. DHHS Exhibit 12 at 000469.

In respect to these particular nursery bed days, MMC submitted additional documentation to identify high-level nursery bed-days after receiving draft audit findings and did not question or provide additional documentation regarding these particular nursery bed days. Testimony of Regan McTier (MMC). Ms. McTier said that these particular bed days were classified correctly by the audit according to the documentation provided by MMC. Testimony of Regan McTier (MMC).

The auditor does not have the prerogative to draw inferences in substitution for the hospital's affirmative documentation. Testimony of Regan McTier (MMC). Again, it was MMC's obligation to support the incentive payment amount with documentation. A power to draw an inference in an audit also could be a two-edge sword, possibly drawn against a hospital. It is fair to assume that a hospital would object if an inference were drawn by the auditor that reduced the hospital's incentive payment. See, closing pages 15 and 16.

Upon review, the hearing officer respectfully disagrees with the Department's argument that MMC failed to raise the above issues in its Request for Informal Review. Its request clearly questioned the data set used by the auditor, questioned the failure of the auditor to reconcile the data with MaineCare, questioned whether the information was faulty and also raised the issue of the MeCMS system and the challenges of using any information based on that system.

MMC also specifically challenged the audit as follows: (A) The Department's NOD failed to correctly identify the total number of Acute Medicaid Days, including (1) eligible but unpaid; (2) non-Medicare secondary days; and (3) other days (failure to reconcile/CHIP factor; (B) The Department failed to properly identify Total Acute Days; and (C) inconsistent use of data sources for charges. *See*, exhibit A-10. Yes, the request failed to cite a specific DRG code and a specific line item out of the 31,000 claims on the spreadsheet. But, just a review of the headings contained within the Request for Informal Review supports that MMC raised those issues and should be allowed to present evidence and testimony which specifically supports the above challenges to the audit findings.

Like the other hospitals, MMC requested a meeting with the Department to try and understand the audit findings. And, like the other cases, the Department denied this request. Although there is no dispute that the Department was not required to meet with MMC as part of the informal review process, the decision to not meet resulted in "years and four testimonial hearings for the Hospital to gain an understanding of what Myers and Stauffer did and why". *See*, closing page 35.

And, even with an understanding now of how Myers and Stauffer conducted this audit, MMC argues that it still is at a disadvantage because it does not have access to the "secret formulas". As noted in the above Findings, Myers and Stauffer created its own formulas to calculate the incentive payment. Myers and Stauffer has refused to share these formulas because it claims those formulas represent its work-product. The Department has never even reviewed those formulas. Maine Medical Center argues that it has been denied due process at this hearing because those formulas have not been produced. The testimony at hearing was that Myers and Stauffer used different formulas in this case from those used in other audits.

MMC's closing argument contains specific examples of how the formulas produced "logic-defying results". *See*, closing page 35. In addition to the issues raised regarding the treatment of nursery days and emergency visits, which resulted in some days being incorrectly excluded from the total number of Medicaid acute care days, MMC also raised the issue of a specific insurance code "S09" and how patients with that code were treated in the formulas. *See*, testimony at hearing and MMC's closing page 32. MMC argued that the MaineCare auditor correctly included those paid acute care days, but the formulas did not.

In any event, the above Findings related to Myers and Stauffer's use of service codes for nursery days and emergency visits support that a large number of days were incorrectly excluded as a result of Myers and Stauffer's formulas and/or misinterpretation of

MMC's documentation. Therefore, the hearing officer respectfully recommends that the Commissioner resolve this matter in favor of Maine Medical Center.

If the Commissioner does not find in favor of Maine Medical Center, the hearing officer respectfully recommends that the Commissioner, in the alternative, remand this matter back to the Department to recalculate the amount of the alleged overpayment.

Specifically, Myers and Stauffer found claims documentation to support 148,959 total acute days, which represents only a 0.34% variance from the MaineCare auditor (if nursery and psych days are excluded)[6]. This means that the issue in this case is not a lack of documentation to support claims but a difference in how those claims were interpreted by the auditor (i.e. included/excluded as MaineCare paid days), which would account for an over 25% variance in MaineCare paid days between the auditors.

By the end of this hearing, the hearing officer believes that MMC had a better understanding of how Myers and Stauffer handled this audit. And, Myers and Stauffer had a better understanding of MMC's service codes and other relevant pieces of information related to claims. If the parties can effectively communicate regarding the use of the hospital's documentation in identifying MaineCare paid days, then the Commissioner may perhaps only be left to decide whether the Department was correct in its interpretation of applicable federal regulations in calculating the incentive payment. Again, among its challenges to the audit, MMC also challenges whether unpaid days should be included if they are attributable to MaineCare members, whether all nursery days and psych days should be included and whether estimates of the number of days are enough to satisfy the requirements of the federal regulations.

Of all the MaineHealth hospital appeals, this one appears to have the most miscommunication between the parties. Perhaps this is because MMC does have a NICU, a psych unit and is the only Trauma 1 hospital in the Maine. Indeed, Myers and Stauffer had to create new and different formulas to analyze the data from MMC because it was more extensive than the other hospitals.

In its closing, the Department argues that the auditor cannot draw inferences from a length of stay, for example, to find that those days were paid acute care days. However, the Department never specifically argues that an individual who had a 45 day inpatient stay, for which MaineCare paid $170,594.99 to reattach a limb, would never be considered a non-acute visit. Instead, the Department argues that MMC should have followed up with Myers and Stauffer about this finding, among others, explained that

[6] Again, please see Appellant's closing starting on page 26 for a through explanation of the numbers and variances.

the emergency room service code was not appropriate to use and/or submitted supplemental documentation to support the inclusion of those paid days. Because MMC failed to respond within five days of receiving the findings which contained over 31,000 lines and/or request an extension, MMC is at fault for any days which were incorrectly excluded. This position is contrary to the Department's own witness' testimony. Ms. Chubbuck is the program manager. She consistently testified at each of these hearings that the reason she recalculated the overpayment using a revised CHIP factor is because the Department wanted to be fair and wanted to "get it right". Again, this factor was revised years after the NOD had been issued and in one case, even after the hearing had already been held. If the Department is truly interested in accurately calculating this alleged overpayment then it should not selectively revise one part of the calculation (i.e. the CHIP factor) and not allow the hospital, now that it has a better understanding of how the audit was handled, to more fully explain its data to the auditors for Myers and Stauffer to accurately compute the number of MaineCare paid days. In the case of Waldo County, the auditor agreed that a mistake was made with a DRG code. The Department agreed to fix the error and issue a second revised computation – after the hearing. Again, in this case, the MaineCare auditor and Myers and Stauffer reached very similar conclusions regarding the number of total days. It was the number of paid MaineCare days, specifically, where the two audits widely differed. The above Findings support that the reason for this wide variance was, at least in part, Myers and Stauffer's interpretation of the hospital data.

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: February 10, 2022

/S/Tamra Longanecker
Administrative Hearing Officer

cc: Margaret Machaiek, AAG
Brendan D. Kreckel, AAG
William H. Stiles, Esq.