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:

Penobscot Bay 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 December 21, 2021, and the responses and exceptions received from the Department and Penobscot Bay Medical Center have been reviewed.

I hereby accept the Hearing Officer's Findings of Fact except that Findings 25 and 26 are revised to read as follows:

> 25. For the purposes of calculating Pen Bay's incentive payment, the Department used Pen Bay's fiscal year ending March 31, 2010 as its base year.
>
> 26. During the relevant time period (FYE March 31, 2010 and the three prior fiscal years), Pen Bay was licensed as an acute care non-critical hospital.

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

> 58. The Department relied upon documentation provided by Pen Bay to ascertain the approved MaineCare-paid claims, discharges and total acute inpatient days.
>
> 59. There is no evidence in the record demonstrating that any of the claims information supplied by Pen Bay and relied upon by the Department's auditors is inaccurate, incomplete, or otherwise unreliable.
>
> 60. There is no evidence in the record demonstrating that the Department's auditors made any calculation error during the audit of Pen Bay.

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 Penobscot Bay Medical Center received an overpayment for the EHR program in the sum of $92,705.73. For the reasons set forth below, I find that the

Department was *correct* when it determined that Penobscot Bay Medical Center received an overpayment for the EHR program in the sum of $92,705.73.

The Department's burden in this case was to demonstrate that the amount of the EHR incentive payment for Penobscot Bay Medical Center that was calculated during the post-payment audit was correct (and therefore that Penobscot Bay Medical Center had received an overpayment of $92,705.73). The Department satisfied this burden.

There is no evidence that there was a calculation error in the Department's post-payment audit calculation of the incentive payment.

There is no evidence that the documentation that Penobscot Bay Medical Center provided during the post-payment audit was inaccurate, incomplete or otherwise unreliable. 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 Penobscot Bay 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: 3-7-22 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: Thomas Bradley, AAG, Office of the Attorney General
Brendan D. Kreckel, 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: December 21, 2021

In the Matter of: Penobscot Bay Medical Center

ADMINISTRATIVE HEARING RECOMMENDED DECISION

Hearing Officer Tamra Longanecker held an administrative hearing in the above-captioned matter via Microsoft TEAMS on September 7, 2021 and September 8, 2021. The record was left open for closing arguments, which were received and made part of the record. The record was then re-opened in order to include the Commissioner's Final Decision in the Franklin Memorial Hospital ("FMH") appeal. The record closed on November 5, 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 Penobscot Bay Medical Center ("Pen Bay") owes the Department $114,949.95[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.

[1] The Department subsequently reduced this amount to $92,705.73.

APPEARING ON BEHALF OF THE APPELLANT

- William H. Stiles, Esq.
- Thomas Morgan, Vice President of Reimbursement for MaineHealth

APPEARING ON BEHALF OF THE DEPARTMENT

- Thomas C. Bradley, AAG
- Patricia Chubbuck, Independent Contractor EHR Incentive Program
- Regan McTier, Myers and Stauffer, LLC
- Heidi Goodale, DHHS Manager of Provider Relations
- Brian Moran, Division of Audit, Senior Auditor

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 11/9/2018
HO-8: Letter from Mr. Pickering dated 2/28/2020
HO-9: Reopening letter dated 10/25/2021
HO-10: Pen Bay's objection dated 10/29/2021
HO-11: DHHS letter dated 11/1/2021
HO-12: HO letter dated 11/5/2021
HO-13: FMH recommended decision mailed 06/15/2021
HO-14: FMH Final Decision dated 10/22/2021

Department Exhibits (pages 000001-001732)

D-1: Order of Reference
D-2: Federal Register/Vol 75, No 144
D-3: Department Request for Audit Review of Hospital Payment Calculations
D-4: Department Payment Calculation
D-5: EH Payment Information
D-6: Audit Notification Email
D-7: Acute Nursery Email
D-8: Summary of Findings Email

D-9: Summary of Findings sent to Hospital
D-10: Final Findings Email and Reissuance Email
D-11: Final Findings letter (reissued)
D-12: Reissued findings Letter Notice
D-13: Request for Informal Appeal
D-14: Attachment A to Request for Informal Appeal
D-15: Final Informal Review Decision
D-16: CHIP Factor Email from DHHS
D-17: CMS Email – Medicaid Days
D-18: Follow up Email per Department Request
D-19: Message Read Notification 11_2018
D-20: Revised CHIP Factor Calculation
D-20A: Details of CHIP Factor
D-21: Revised Calculation of Incentive Payment (New CHIP Factor)
D-22: MaineCare Benefits Manual Ch. I, Sec. I (effective 7/5/2017)
D-23: Maine Care Benefits Manual Ch. I, Sec. I (effective 1/11/2010)
D-24: MaineCare Benefits Manual Ch. I, Sec. I (effective 2/13/2011)
D-25: MaineCare Benefits Manual Ch. I, Sect I (effective 6/30/2013)
D-26: Summary of OIG findings/OIG Reports
D-27: 2011 Maine State Medical Health IT Plan (SMHP)
D-28: 2011 SMHP Approval Letter
D-29: 2014 SMHP Supplemental Submission
D-30: 2014 SMHP
D-31: MaineCare Benefits Manual Ch. III, Sec. 45 (effective 9/28/2009)
D-32: DHHS Communications re: MeCMS System
D-33: 42 U.S.C. §1396b – effective 2011

Appellant Exhibits (pages 1 – 310)

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

Other documents in the record

Audio recording of FMH hearing
Written Summary of Ms. Erb's testimony from the FMH hearing
Department's closing argument
Appellant's closing argument

RECOMMENDED FINDINGS OF FACT

1. In accordance with agency rules, Penobscot Bay Medical Center ["Pen Bay"] 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. In order for Maine to participate in the payment incentive program, it first had to develop its State Medicaid Health Information Technology Plan ["SMHP"] and submit it to the Centers for Medicare and Medicaid Services ["CMS"] for approval. *See*, exhibit D-2.

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

[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.

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

8. In June 2011, CMS approved the Department's revised SMHP. The approval letter notified the Department that its approval of the SMHP was subject to the provisions found in regulations at 42 CFR Part 495, Subpart D. *See,* exhibit D-28.

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

10. Among other things, the SMHP set out eligibility requirements for hospital participation and the process by which the Department calculates the Medicaid EHR incentive program aggregate payment[3]. *See,* exhibit D-27.

11. The SMHP stated that the Department would use Medicare cost reports "to verify the Medicaid patient volumes, and to calculate the payment amount." *See,* exhibit D-27 pages 1332 and 1333.

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

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

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

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

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.

14. 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.

15. 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.

16. The aggregate EHR incentive payment amount is calculated as the product of the overall EHR amount times the Medicaid Share. *See*, exhibit D-2 (page 270).

17. 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).

18. 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).

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

20. 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.

21. 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.

22. Pen Bay does not have an intensive neonatal care unit. *See*, testimony at hearing.

23. 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.

24. The Department determined that Pen Bay was one of 36 non-psychiatric hospitals eligible for Medicaid EHR incentive payments.

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

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

27. 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.

28. From January 2005 to September 2010, the Department used MeCMS to process claims. Pen Bay would submit a claim to MeCMS, which would then issue a remittance advice. Pen Bay 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 Pen Bay 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.

29. 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.

30. 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.

31. Pen Bay 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.

32. 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.

33. 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.

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

35. Using FYE 2010 for its base year, the Department calculated the hospital's aggregate EHR incentive amount as $1,324,826.00, which was to be paid over a period of three (3) years. *See,* exhibit D-5.

36. Prior to 2014, the Department's Division of Audit had assigned an audit manager and an auditor for pre- and post-payment audits, and audit reporting functions. *See,* exhibit D-27.

37. 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.

38. Pen Bay received incentive payments during 2011, 2013 and 2014. *See,* D-5.

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

40. 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-26.

41. 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.

42. 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.

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

44. 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.

45. 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).

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

47. 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.

48. On January 31, 2018, Myers and Stauffer notified Pen Bay that it had been selected for a desk audit. Myers and Stauffer requested that Pen Bay provide a significant level of claims data related to fiscal years ending June 30, 2007, 2008, 2009 and 2010. *See,* exhibit D-6.

49. Pen Bay was unable to submit information for the earliest year. Myers and Stauffer therefore substituted a subsequent year (2011) in order to calculate a growth rate factor.

50. On April 26, 2018, Myers and Stauffer notified Pen Bay that it had completed its audit and summarized its findings. It invited Pen Bay to comment, question, and/or supplement its documentation related to those findings prior to finalizing its review.

51. Pen Bay did not raise any questions or concerns with Myers and Stauffer with regard to its audit findings. Pen Bay did not submit any supplemental documentation.

52. On September 10, 2018, the Department issued a Notice of Debt to Pen Bay. The Notice of Debt stated that Myers and Stauffer had determined that Pen Bay received overpayments in the EHR incentive program. The Department demanded that Pen Bay repay $114,949.95.

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

- The adjusted number of discharges utilized in the average growth rate calculation differs from the number utilized in the original calculation.
- The hospital submitted a subsequent year of discharges rather than the prior year 3 discharges.

- 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 amount of charity care charges is less than the amount used in the original calculation.

54. On November 9, 2018, Pen Bay requested an informal review of the audit's findings. Among its objections to the overpayment amount, Pen Bay 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". Pen Bay referred to the "historically unreliable" MeCMS system and its concern that some information was pulled from that system. Pen Bay 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 (page 4).

55. On September 4, 2019, the Department issued its Final Informal Review Decision. The Decision upheld the Auditor's findings and the determination that Pen Bay was overpaid $114,949.95 in the EHR incentive program.

56. On October 24, 2019, Pen Bay requested an administrative hearing.

57. Prior to the administrative hearing, the Department revised the numerical factor applied to account for payments by the Children's Health Insurance Program (CHIP) factor, reducing the recoupment sought from Pen Bay to $92,705.73. 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.

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 Penobscot Bay Medical Center received an overpayment for the EHR program in the sum of $92,705.73.

REASONS FOR RECOMMENDATION

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

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

order to be provided Federal financial participation ["FFP"] under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State—

> (A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;
>
> (B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and
>
> (C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange.

42 U.S.C. § 1396b (t)(9)

In order for Maine to participate in the payment incentive program, it first had to develop its State Medicaid Health Information Technology Plan ["SMHP"] and submit it to the Centers for Medicare and Medicaid Services ["CMS"] for approval. *See*, exhibit D-2. The SMHP stated that Maine would use Medicare cost reports in calculating a hospital's Medicaid EHR incentive program aggregate payment. *See*, exhibit D-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 Pen Bay owes the Department $92,705.73 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 PEN BAY's cost reports in calculating its Medicaid Share and overall aggregate EHR incentive payment. As a result, the Department initially determined Pen Bay's incentive payment to be $1,324,826.00. The Department paid that amount to Pen Bay over the course of three (3) years (i.e. 2011, 2013 and 2014). In 2018, Myers and Stauffer conducted a post-payment audit and found that the Department overpaid Pen Bay $114,949.95.

The Department issued a Notice of Debt for that amount on September 10, 2018. Pen Bay 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 $92,705.73.

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,* 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, PEN BAY 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, PEN BAY's closing (pages 12 and 13) 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 27, p. 1332-33** (emphasis added). The Department is bound by this election.*

The 2014 SMHP Supplement confirms this election. ***DHHS 29, p. 1626.*** *I 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 not correct, and uphold the Original Determination. To do otherwise would allow the Department to ignore the elections it made when seeking approval for the May 2011 SMHP, and then arbitrarily change the rules over six years later.

The hearing officer is not persuaded by PEN BAY'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 discharges utilized in the average growth rate calculation differs from the number utilized in the original calculation.
- The hospital submitted a subsequent year of discharges rather than the prior year 3 discharges.
- 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 amount of charity care charges is less than the amount used in the original calculation.

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 nursery newborn bed days in the numerator because Pen Bay does not have an intensive neonatal care unit. 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-17.

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.*

In its closing, Pen Bay 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 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. There is no dispute that Pen Bay does not have a neonatal intensive care unit.

With regard to CHIP paid days, Ms. Chubbuck testified that 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 Penobscot Bay Medical Center received an overpayment for the EHR program in the sum of $92,705.73.

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 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. Mr. Moran is the auditor of record for Pen Bay's FY 2010 Final Audit and Settlement. *See*, exhibit A-6.

In completing the FY 2010 Final Audit and Settlement, Mr. Moran reviewed many sources of information such as the Medicare cost report, MaineCare paid claims history and Pen Bay's audited financial statements. He made 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 Pen Bay's records, Mr. Moran would rely on the Department's records.

Mr. Moran 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. Mr. Moran testified that he did not include days awaiting placement and/or observation days in either of those numbers.

Specifically, Mr. Moran found documentation to support 1,108 paid MaineCare inpatient acute care discharges and 4,483 paid MaineCare inpatient days associated with those discharges. Subtracting out nursery days (473) leaves a remainder of 4010 paid MaineCare inpatient days. *See*, exhibit A-6. This number is greater than the original number found by Myers and Stauffer by 499. *See*, exhibit D-9 and Pen Bay's closing pages 25 and 26. Mr. Moran was confident that only paid days were included in his findings. Ms. McTier generally testified at hearing that the greater number of paid Medicaid days results in a higher payment to the hospital. So, if the actual number of paid Medicaid days during the relevant time period was greater than the number of days found by Myers and Stauffer, then that increase in days would result in a significant decrease in the overpayment.

Mr. Morgan testified at hearing. He is the Vice President of Reimbursement for MaineHealth. Mr. Morgan testified that one of the disputes Pen Bay 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 Pen Bay 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 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 its closing, the Department argues that Mr. Moran had no way of knowing if Pen Bay properly documented internally the adjudications of MaineCare claims. Although Pen Bay may not have had a "business reason" to do so, it had a responsibility to still maintain documentation to support the amount of the incentive payment. A cost report or a cost settlement is not a substitute for hospital documentation. And, Mr. Moran's review served a different function from that of Myers and Stauffer. The Department argues that Mr. Moran did not have to perform the same analysis and did not use the same parameters for his audit on behalf of the Department as Myers and Stauffer did. The way the hospital prepared summary data could also account for the differences in findings. In short, the Department argues that "No basis exists to conclude that the Myers and Stauffer review relying on the hospital's own original documentation should yield to the summary data used for the Medicare cost report of MaineCare cost settlement". *See*, closing.

In its closing, Pen Bay notes that the purpose of this hearing "is not to assign blame but discover the truth". *See*, page 25. The purpose of the Myers and Stauffer audit may have been different from the cost settlement process, but both of those audits made findings regarding Medicaid-paid acute inpatient days. And even after adjustments were made based on the Department's interpretations of federal regulations, the findings between Myers and Stauffer and the Department cannot be reconciled.

Based on the totality of the testimony and evidence at hearing, the hearing officer respectfully recommends that the Department has not met its burden to prove that the actual calculation of the overpayment was correct.

MANUAL CITATIONS

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

RIGHT TO FILE RESPONSES AND EXCEPTIONS

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

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

CONFIDENTIALITY

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

DATED: December 17, 2021

/S/Tamra Longanecker
Administrative Hearing Officer

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