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<sup>1</sup> All WAC references are to those in place at time period under consideration and contained in Appendix C.

**I.**  
**INTRODUCTION**

Petitioner, MultiCare Health System (“the Hospital”) operates a 72-bed pediatric hospital in Tacoma, Washington. The Hospital has a contract with the Department of Social and Health Services (the “Department”) to provide services to Medicaid recipients. (AR 571.<sup>2</sup>) The Department audited Medicaid payments to the Hospital and determined that the Hospital had been overpaid and the interest was due on the overpayment. *Id.* The Hospital appealed the audit findings in an administrative hearing before the Department. (AR 1.)

At the administrative hearing the ALJ was not charged with “verify[ing] that the [auditor] Ms. Panelo did a good job on her audit or that she made correct decisions, but to independently make the same decisions or different decisions on each file [i.e. patient claim].”

Transcript of Proceedings, Vol. II, pg. 126:20-22.

The ALJ issued an Order (the “Order”) reducing the audit assessment and eliminating interest. *Id.* Both parties appealed the ALJ’s decision to the Department’s Board of Appeals and a Review Decision and Final Order was issued on August 9, 2010 (“the Review Decision”).

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<sup>2</sup> The record from the administrative hearing is included in the Thurston County Clerk’s Papers certified to this Court. *See* Page 69 of Clerk’s Papers. We refer in this Brief to the Certified Copy of the Original Agency Record for Judicial Review as the AR followed by the page number assigned to that document in that record. We refer to the Clerk’s Papers as CP followed by the page number.

*Id.* The Review Decision affirmed the overpayment finding set out in the Order and reinstated the interest assessment. (AR 33.) The Thurston County Superior Court upheld the overpayment assessment but overturned the interest assessment. (CP 169-171.) The Hospital challenged the overpayment assessment.

## **II.** **ASSIGNMENTS OF ERROR**

1. The Review Judge erred in finding that the Hospital was overpaid \$214,397.97 (the “Overpayment”) for services rendered to Medicaid patients enrolled in the Medically Needy Program. (AR 33.)
2. The Review Judge erred in adopting Finding of Fact No. 3 that the Hospital “received an overpayment of federal Medicaid funds for amounts which the patients themselves owed” the Hospital. (AR 2.)
3. The Review Judge erred in adopting Finding of Fact No. 6 that states in part that “the beneficiary need never pay the medical expense used to meet spenddown.” (AR 3.)
4. The Review Judge erred in adopting Finding of Fact No. 6 that “Spenddown means the amount of medical expenses a Medically Needy medical assistance beneficiary must incur before she becomes eligible for medical assistance benefits for the remainder of the three or six month base period.” (AR 2, 3.)

5. The Review Judge erred in adopting Finding of Fact No. 6 that “because beneficiaries are typically impoverished and in poor health, they are also typically unable to pay for those medical expenses and [are] judgment proof.” (AR 3.)

6. The Review Judge erred in adopting Finding of Fact No. 8 that “when a patient met her spenddown with hospital bills only, coverage began on the first day of the base period.” (AR 4.)

7. The Review Judge erred in adopting Finding of Fact No. 9 that states in part that “the testimony of Mary Thomas, Billing Manager of MultiCare does not reflect (a) how patient care is or should be billed differently from other hospital care, (b) how to identify which bills were for outpatient care, or even (c) which bills represented outpatient care. Therefore, no evidentiary basis exists to consider these.” (AR 4.)

8. The Review Judge erred in adopting Finding of Fact No. 11 that states “when a beneficiary incurs a medical bill that meets and exceeds her spenddown the bill is called a ‘split bill’, because it is partly the beneficiary’s responsibility as spenddown and partly the Department’s responsibility. Because the beneficiary has become qualified, providers must bill the entire split bill at the Medicaid contracted rate, like a bill meeting and exceeding a private insurance deductible.” (AR 5.)

9. The Review Judge erred in adopting Finding of Fact No. 16 that states the “most recent Amended Claims Spreadsheet is adopted as findings except where expressly noted.” (AR 7.)

10. The Review Judge erred in adopting Finding of Fact No. 19 concerning Jeremy A’s spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding. (AR 7.)

11. The Review Judge erred in adopting Finding of Fact No. 20 concerning Haley A’s spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding. (AR 8.)

12. The Review Judge erred in adopting Finding of Fact No. 21 concerning Susan A’s spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding. (AR 8.)

13. The Review Judge erred in adopting Finding of Fact No. 22 concerning Mason A’s spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding. (AR 8.)

14. The Review Judge erred in adopting Finding of Fact No. 23 concerning Mason A’s spenddown. The full text of the Finding is set out

in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 8-9.)

15. The Review Judge erred in adopting Finding of Fact No. 24 concerning Nicholas B's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 9.)

16. The Review Judge erred in adopting Finding of Fact No. 26 concerning Jeremie B's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 9-10.)

17. The Review Judge erred in adopting Finding of Fact No. 27 concerning Miya B's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 10.)

18. The Review Judge erred in adopting Finding of Fact No. 28 concerning Tyler B's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 10.)

19. The Review Judge erred in adopting Finding of Fact No. 29 concerning Daniel B's spenddown. The full text of the Finding is set out

in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 10-11.)

20. The Review Judge erred in adopting Finding of Fact No. 30 concerning Ethan D's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 11.)

21. The Review Judge erred in adopting Finding of Fact No. 31 concerning Julian D's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 11.)

22. The Review Judge erred in adopting Finding of Fact No. 32 concerning Karl D's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 11-AR 12.)

23. The Review Judge erred in adopting Finding of Fact No. 33 concerning Nathaniel E's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 12.)

24. The Review Judge erred in adopting Finding of Fact No. 34 concerning Samantha H's spenddown. The full text of the Finding is set

out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 12.)

25. The Review Judge erred in adopting Finding of Fact No. 36 concerning Grace J's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 13.)

26. The Review Judge erred in adopting Finding of Fact No. 37 concerning Elizabeth H's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 13.)

27. The Review Judge erred in adopting Finding of Fact No. 38 concerning Brittany L's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 13-14.)

28. The Review Judge erred in adopting Finding of Fact No. 40 concerning Khi U's spenddown. The full text of the Finding is set out in Appendix B. Appellant assigns error to the entirety of the finding.

(AR 14.)

**III.**  
**ISSUES PERTAINING TO THE ASSIGNMENTS OF ERROR**

1. Is it appropriate to subtract spenddown from the Hospital's Medicaid payments for services covered by the MN program?  
(Assignments of Error 1, 2, 7, 8, 9, 10-28.)
2. Did the review Judge properly determine the start date of each patient's Medically Needy coverage? (Assignments of Error 3, 4, 5, 6 and 8.)
3. Did the Review Judge correctly determine the amount of each patient's spenddown? (Assignments of Error 1, 2, 3, 4, 5, 8, 9, 10-28.)
4. Did the Review Judge correctly determine the medical bills which each patient used to meet his/her spenddown obligation? (Assignments of Error 1, 2, 3, 4, 8, 9, 10-28.)

**IV.**  
**STATEMENT OF THE CASE**

**A. Statement of the Facts.**

The Review Judge determined that the Hospital was overpaid with respect to medical care provided to patients enrolled in the Medicaid-Medically Needy ("MN") program because an amount, referred to as spenddown, should have been deducted from payments made by the Department to the Hospital. (AR 2.) The amount at issue is \$214,397.76. (AR 33.) The Hospital claims that neither federal nor state law supports

subtracting spenddown from Medicaid payments because spenddown is simply a calculation used by the Department to determine when a patient is enrolled in the MN program. WAC 388-519-0100(8).

**V.**  
**ARGUMENT**

**A. There Is No Authority to Deduct Spenddown from Payments Made to a Provider under the MN Program.**

Spenddown cannot be deducted from MN payments for the following reasons:

1. Neither the federal nor state Medicaid regulations governing the MN program authorize the Department to deduct spenddown from monies payable to the Hospital. Spenddown is simply a process by which health care bills incurred by a patient prior to the time he/she is eligible for medical coverage under the MN program are used to determine the date on which the patient qualifies for MN coverage.

(WAC 388-519-0100(8).)

2. Although the Review Judge concluded that spenddown is “like a privately insured person’s deductible” (AR 3), spenddown is not properly analogized to either a patient co-pay or insurance deductible. The fundamental difference is that spenddown relates to medical expenses incurred **before** a patient is covered by a health plan whereas copays and

deductibles relate to medical expenses incurred while a patient is covered by a medical plan.

3. Deducting spenddown from MN payments would lead to the following absurd result — bills for patient care provided prior to the start date of MN enrollment were offset against payments due the Hospital for covered MN services rendered after the enrollment start date.

For example, assume that a person with a \$500 spenddown is hospitalized, incurs a hospital bill of \$500 for the first two days of a hospital stay, is enrolled in the MN program effective on day 3, and then incurs an additional \$250 in covered hospital bills for day 3. In analyzing MN's payment obligation for this type of patient, the Review Judge concluded that all of the Hospital's charges should be added together (days 1 through 3; even though only day 3 is covered by the MN program); the payment for these 3 days should be calculated using the discounted Medicaid payment rate as if all days had been covered (in this example \$250), and then the \$500 spenddown should be deducted from the payment that would otherwise be made by the Department to the Hospital. Applying this methodology, the Review Judge reasoned that the Hospital should have been paid 0 for the services rendered on the third day of the Hospital-stay. (*See* for example Finding of Fact 21, AR 8.) In fact, this is the exact result in no less than 14 of the findings entered by the

Review Judge. (See Claims 1, 3, 4, 6, 13, 14, 15, 16, 17, 23, 25, 26, 27, and 47. (AR 7-14))

**B. Spenddown is an Enrollment Qualification Calculation; Not a Deduction from Payments.**

Spenddown is a feature of federal Medicaid law and is a feature of the state Medicaid program. Sections 1092(a)(17) and 1903(f)(2) of the Social Security Act provide that “for individuals applying as medically needy, certain incurred medical expenses must be deducted from income if income exceeds the eligibility standard established by the State.”

Consistent with federal law, our Washington Medicaid regulations applicable to the MN program state that “a person who meets. . . [certain other requirements] is eligible for MN medical coverage if their MN countable income is at or below the medically needy income level (MNIL) in WAC 388-478-0070.” WAC 388-519-0100(5). If the person would otherwise qualify for MN coverage, but he/she has excess income, the individual “may become eligible for MN medical coverage when they have or expect to have medical expenses” which reduce income below the MNIL. WAC 388-519-0100(6). “Those medical expenses or obligations may be used to offset any portion of their income which is over the MNIL.” WAC 388-519-0100(6).

Further, the regulations explain that “[w]hen a person has or will have ‘excess income’ they are not eligible for MN coverage until they have medical expenses which are equal in amount to that excess income. This is the process of meeting ‘spenddown.’” WAC 388-519-0100(8). WAC 388-519-0110 provides further details about “spenddown of excess income for the medically needy program” by stating that

the amount of a person’s ‘spenddown’ is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL [medically needy income limit]. The excess income from each of the months in the base period is added together to determine the ‘spenddown’ for the base period.

WAC 388-519-0110(7) then describes the purpose of the spenddown calculation. The regulation provides as follows:

[o]nce a person’s spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount **to determine the date of eligibility.**

(Emphasis added.)

Thus, meeting spenddown is a process of subtracting liabilities for certain medical expenses that will not be covered by the MN program. The amount of these liabilities is subtracted from income to determine the date on which a patient qualifies for MN coverage. The type of expense used to meet spenddown and the timing of when the patient presents that bill to the Department in the application process affects the start date for

coverage (WAC 388-519-0110(8) and (9)) and the length of coverage (WAC 388-416-0020). A patient's spenddown requirement must be satisfied before the patient can be enrolled in the MN program. "If a person's spenddown amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets the spenddown amount." WAC 388-519-0110(9). The Department's regulations are clear; spenddown is a mechanism for determining the date on which a patient is enrolled in the MN program.

**C. It is Improper to Deduct Spenddown from the Department's Payment to the Hospital — The Concept of Spenddown is Relevant to Expenses and Countable Income, Not to Payments.**

Assuming, for argument's sake, that spenddown should be deducted in some way to determine what is owed to the Hospital, the amounts allowed as deductions in this case are problematic because the Review Judge did not have credible information to:

1. properly determine the amount of each patient's spenddown; or
2. properly determined which of the Hospital's bills could be used by the patient to meet spenddown.

The only bills which the regulations allow a patient to use to meet spenddown are unpaid bills existing at the time the base period began and bills paid by the patient during the base period. *See* WAC 388-519-

0110(10). However, the Department's calculation of the overpayment assessment included bills that were neither paid by the patient nor existing at the time the base period began. ("[Q:] If I understood your testimony today though, I think you indicated that a liability that . . . arises during a base period could be used to meet spenddown. [A:] Yes." Fisher Testimony, Vol. I, 166:16-20.) The Review Judge adopted the Department's calculations which calculations did not comply with WAC 388-519-0110(10).

Further, the Department acknowledged that it did not apply bills towards spenddown in the order required by the regulations. (*See* Fisher Testimony Vol. I, 175:6-176:3.) By adopting the Department's calculations the Review Judge continued this error as well.

The Department's own auditor recognized that "taking spenddown" is not as simple as subtracting the spenddown amount from the Department's payment to the Hospital. The auditor, in making her findings, recognized that frequently, the spenddown assigned to a Hospital visit was greater than the amount paid by the Department. In this case, Claims 1, 3, 4, 6, 13, 14, 15, 16, 17, 23, 25, 26, 27, and 47 (AR 7-14), the Department has made overpayment findings equal to the amount paid even if the amount paid was less than the spenddown by limiting the

spenddown amount to the MN payment. Recovery of these amounts results in a net payment to the Hospital of \$0.

Further, it was impossible for the Review Judge to determine how a patient met his/her spenddown because the Department could not provide that information. The Department did not create a record of how patients met their spenddown nor did the Department attempt to retain copies of the bills which Department staff reviewed at the time they enrolled patients in the MN program. (*See*, Fisher Testimony, Vol. I, pg. 163:1-5.) Included in the evidence is a detailed analysis which described the problems with the Department's conflicting and/or missing data about each patient's spenddown obligation. *See* CP 124-130.

This unreliability of the data used in the audit was briefed extensively at CP 305 to 319. In the interests of avoiding redundancy, those arguments will not be repeated here as they are fully set out in the record and we incorporate them herein by this reference.

By adopting the Department's calculation, the Review Judge simply adopted calculations which were not supported by evidence, and he thus incorporated these unsupported calculations into his ruling.

To recover the alleged overpayments, the Department must satisfy the Court that a preponderance of the evidence supports a finding that (1) there is a certain amount of total spenddown liability for the applicable

base period; (2) spenddown is properly assigned to the Hospital; and (3) the spenddown should be deducted from the Department's payment to the Hospital. ("The standard of proof is a preponderance of the evidence." WAC 388-02-0485.)

As the testimony at the hearing and the evidence demonstrate, the Department has not sustained its burden of proof. The Department's overpayment case is fraught with flaws, the most problematic of which is the unreliability of the data on which the Department's assessment relies. (See discussion pertaining to each claimed overpayment in Appendix A.)

**D. The Department May Not Deduct Spenddown for Indian Health Services Clients.**

Even if spenddown is normally properly deducted from a payment made to the Hospital, such a deduction may not be made with respect to IHS clients. (Patients Jeremy A., Susan A., Julian D., Samantha H., Dennis L., Cassandra M., Marcus M. and Seth S, each had IHS coverage. See Appendix A.)

IHS occupies a special position in the framework of assistance programs. While Medicaid is normally secondary to other payors, this is not true vis à vis IHS. IHS is always the payor of last resort. 42 C.F.R. § 136.61(a) (stating that IHS "is the payor of last resort, notwithstanding any State or local law or regulation to the contrary") ("payor of last resort

rule”). This regulation also provides that IHS will not pay if there is another source of health care funds available. 42 C.F.R. § 136.61(b), (c). The federal government funds health care for Indians by providing some funding to IHS facilities and by reimbursing states 100% of the cost of care for Indians enrolled in the Medicaid program (*see* 42 U.S.C. § 1396j). Because IHS funding is limited, in 1976, Congress enacted the Indian Health Care Improvement Act to “permit IHS facilities to obtain Medicaid reimbursement for services provided to Medicaid-eligible Indians.” *Arizona Health Care Containment v. McClellan*, 508 F.3d 1243, 1246 (9th Cir. 2007).

IHS facilities refer patients to hospitals when the tribal facility cannot provide the service which the patient requires. The referring IHS facility can bill Medicaid for these referred services in certain situations or the receiving hospital can bill for Medicaid directly. As stated above, nine of the audited claims were for IHS patients where the hospital billed Medicaid directly.

Federal regulations provide that IHS “is the payor of last resort . . . notwithstanding any state or local law or regulation to the contrary.” 42 C.F.R. § 136.61(a). Although WAC 388-519-0100 clearly states that spenddown is used only to determine the date of patient enrollment in Medicaid, the Department’s treatment of spenddown as a deduction from

Medicaid payment and an obligation of the patient violates 42 C.F.R. § 136.61(c) for the following reason. This approach shifts part of the cost of a Medicaid-covered service to the patient in a situation where the patient would be entitled to treat IHS as an alternative resource available to pay the spenddown amount. Equally problematic is that IHS's liability for the spenddown could actually exceed the total Medicaid rate for the service, and this Department's approach is inconsistent with another federal regulation which provides that Medicare-participating hospitals "must accept no more than the rates of payment [under the Medicare prospective payment system] . . . as payment in full for all items and services authorized by IHS, Tribal, and Urban Indian organization entities." 42 C.F.R. § 136.30(a).

In the case of IHS clients, the Department's policy of deducting spenddown from payments made to providers has the impermissible effect of shifting the cost of this care back to IHS. But 42 C.F.R. § 136.61(b) and (c), which are supreme over any Washington state law or regulations to the contrary, *see* 42 C.F.R. § 136.61(a), forbid this. With respect to the IHS clients at issue in this audit, funds other than IHS funds are available — *i.e.*, state Medicaid funds — and those funds must be used to pay for these services.

In *McClellan*, the Ninth Circuit rejected just such an attempt by a state Medicaid program to shift costs to IHS. 508 F.3d 1243, 1246 (9th Cir. 2007). The Ninth Circuit addressed the question of whether a state Medicaid program could be reimbursed at the 100% level for services rendered by non-IHS providers to IHS clients, or whether those services could be reimbursed only at the normal rate at which the federal government reimburses for Medicaid expenditures (“FMAP”). The longstanding practice had been to reimburse state Medicaid programs 100% for services provided by IHS for Medicaid-eligible Indians when IHS billed Medicaid directly for those services, and to reimburse at normal FMAP levels for services rendered by non-IHS providers to IHS clients. The state of Arizona sought to expand the scope of 100% reimbursements to those services provided by non-IHS providers to IHS clients pursuant to referrals from IHS. The Court rejected this attempt, upholding the Health Care Financing Administration’s interpretation of the applicable statute as consistent with and giving effect to the language of the statute.

While the issue in the case at bar is not one of applicable reimbursement rates, the basic legal principle applicable to IHS clients still holds — absent specific federal authority to do so, state Medicaid programs may not shift costs to IHS.

**E. DRG Payments Are Not Impacted By Spenddown.**

Hospitals treat inpatients and outpatients. An inpatient admission is “an acute hospital stay for longer than 24 hours.” (AR 1766.)<sup>3</sup> An outpatient is defined as “a client who is receiving medical services in other than an inpatient hospital setting.” (AR 1767.)

The Hospital is generally paid a discounted flat fee for a Medicaid inpatient stay. (AR 3198.) The Hospital is paid a discounted per service fee for outpatient services. (AR 3199, 3201.)<sup>4</sup>

The Hospital is paid a flat rate for an inpatient stay even if less than the full stay is covered by the MN program. Thus, if a patient met his/her spenddown while hospitalized, the DRG payment to the Hospital is not affected.

In calculating the overpayment in the audit, the Department did not examine the charges based on date of service; it “look[ed] at the total expense for their entire stay. . . . We don’t break it down by which date – on which day of the stay that client met the spenddown, just that they met the spenddown.” Fisher Testimony, Vol. 1, pg. 179:22-180:4. The

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<sup>3</sup> The Remittance and Status Report (the “R/A”) issued by the Department indicates the day each patient was admitted and the day discharged, thus easily indicating patients who are inpatients versus those who are outpatients. (See for example AR 1860, pertaining to Haley A. (pt. account No. 4459667664). Line one of the R/A, indicates that Haley was admitted to the Hospital on 1/29/05 and discharged on 1/31/05, thus indicating she was an inpatient.)

<sup>4</sup> Patient Jeremy A. is an example of an outpatient. (See AR 1842 and 1845. Jeremy – Patient 455080200 per AR 1842 – and was seen at the Hospital on 10/5/03 and discharged on that same day, and thus, was an outpatient.)

Department gathered information about all care delivered throughout the inpatient hospital stay, even if only the final days of the hospital inpatient stay were covered by the MN program. (*See Fisher Testimony, Vol. I, pg. 128:13 – 129:11.*)

This only becomes a problem when, as here, someone comes to the mistaken conclusion that a patient's spenddown obligation should reduce the Medicaid payment under the MN program and not the allowed charges. In this case, the Review Judge treated the entire hospital stay as covered by the MN program and then adjusted the payment to the Hospital by deducting an amount equal to spenddown as a proxy for the charges for the non-covered days. This inherently mis-matched discounted payment rates with the Hospital's full charges and is in direct conflict with both federal regulations which directly address this possible occurrence.

The federal regulations provide that when a stay includes covered and non-covered dates of care, you "[m]ust reduce the amount of provider charges [not Medicaid payments] that would otherwise be reimbursable under Medicaid." 42 C.F.R. § 435.831. (*See CP 96-123.*)

A reduction in provider charges has no effect on a DRG payment because the DRG payment is a fixed fee and is not based on charges. Had the Review Judge applied the federal rules, no overpayment would have been found because the DRG payment would not have decreased.

If the Department paid for outpatient services which were eligible to be used to satisfy a spenddown obligation, those changes should have been disallowed and the payment to the hospital recalculated. The Review Judge did not identify any outpatient charges in the audit which were appropriately used to meet spenddown, and thus he did not recalculate any outpatient charges, nor could he, because as detailed below, the Department did not provide the evidence required for this adjustment to have been made.

**F. In the Alternative, this Court Should Reject Specific Overpayment Findings.**

In the event the Court is hesitant to reject the Review Judge's overpayment findings wholesale for the systemic reasons discussed above, the Hospital requests that the Court reject specific overpayment findings as shown in the strikethroughs on the summary table found at CP 124-130. each of which is explained on a patient specific basis in the Hospital's Brief before the administrative law judge found at pages 319 to 395, the text of which is appended to this Brief as Appendix A<sup>5</sup>.

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<sup>5</sup> Appendix A is a true and correct copy of the text in CP 319 to 395 with the following change. We have changed the cross references appearing at pages 316-395 which were by exhibit number assigned at the administrative level, to reflect instead on Appendix A, the page number of that document in the CP's or the AR.

**VI.**  
**CONCLUSION**

For the reasons stated above, the Hospital requests that the Court reject *in toto* the Department's overpayment findings, or, in the alternative, reject the overpayment line items with strikethroughs in the detailed spread sheet found at CP 124-130.

DATED this 17th day of November, 2011.

Respectfully submitted,

GARVEY SCHUBERT BARER

By   
Carlo M. DewBerry, Bar #  
15746  
Attorneys for Appellant  
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STATE OF WASHINGTON  
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DEPUTY

### CERTIFICATE OF SERVICE

I, Kristin Heuser, certify under penalty of perjury under the laws of the State of Washington that, on November 17, 2011, I provided a copy of **Appellant's Opening Brief and Appendices** to a legal messenger to be served on the persons listed below in the manner shown:

Stephen S. Manning, AAG  
Office of the Attorney General  
Social and Health Services Division  
7141 Cleanwater Drive S.W.  
Olympia, WA 98504

- United States Mail, First Class
- By Legal Messenger
- By Facsimile

Dated at Seattle, Washington, November 17, 2011.

Kristin Heuser  
Kristin Heuser

SEA\_DOCS:1038253.6

## APPENDIX A

## APPENDIX A

### **(1)<sup>1</sup> Jeremy A.**

Claim 1, for Jeremy A., is documented in AR 597-611 under the tab for Jeremy A. Ms. Panelo concluded that the Hospital had been overpaid \$608.68. (AR 595<sup>2</sup>, line 1.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$1,917.00, but since the Hospital had only been paid \$608.68 for the service against which spenddown had been assessed, the Department seeks to recoup \$608.68, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$4,423.85. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Rachelle B., had expenses recorded in the ACES system. (AR 602-603.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

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<sup>1</sup> This number is the patient numbering system used in audit and the Review Opinion. It is retained here to facilitate cross reference to the briefs and other documents in the Administrative record.

<sup>2</sup> Throughout this document, the original citations to Exhibit numbers assigned during the administrative hearing have been replaced with pinpoint citations to the pages in the Clerks Papers or Administrative Record, where the Exhibit can be found.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period October 2003, was \$1,917.14. (AR 602.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES. Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo’s analysis cannot be verified.

According to the ACES CME detail, Rachelle B. incurred an expense of \$4,423.85 on October 12, 2003. But the HWT data available to Ms. Panelo reflects no line item for a Rachelle B. on October 12, 2003. (AR 595, line 1, pertaining to Jeremy A. for October 5.) Instead, the HWT data showed that the Hospital had billed the Department for charges for Jeremy A. for a beginning service date of October 5, 2003. Hospital records and other documentation submitted by the Department for this overpayment claim also show that the expenses related to care delivered to Jeremy A., not Rachelle B. Despite these discrepancies in the information before her, Ms. Panelo concluded that the spenddown assigned by the CSO caseworker to Rachelle B. would properly be deducted from a payment to the Hospital for care delivered to Jeremy A. This conclusion is supported by no more than a guess on Ms. Panelo’s part and should be rejected by this Court.

Another problem with Ms. Panelo's process for this claim is that she did not take into account the fact that the expenses for Jeremy A. are outpatient expenses (*see* AR 607 (remittance advice)), and are therefore not paid under DRG. Had Ms. Panelo considered each line item reflected on the remittance advice to be a separate charge, and applied each charge to the assigned spenddown until the spenddown was met, the amount recoverable from the Hospital would be \$196.97.

Charge	Payable by Department	Spenddown remaining	Amount recoverable by Department	Comment
\$3.85	\$1.32	\$1,913.29	\$1.32	Not covered; amount paid by Department recoverable
\$829.00	\$83.72	\$1,084.29	\$83.72	Not covered; amount paid by Department recoverable
\$1,294.00	\$111.93	\$0	\$111.93	First charge covered by Department. \$1,084.29 left of spenddown to recover, but exceeds payment from Department. Recover full amount paid by Department.

The Hospital does not concede that any aspect of the Department's treatment of spenddown is appropriate. However, in the event the Court agrees with the Department that spenddown is assignable to providers, the Court should calculate spenddown as follows: until spenddown is met, the amounts relevant to the spenddown calculation are the amounts charged, not the amounts paid by the Department. Because the Department will not pay bills prior to the time spenddown is met, the amount paid by the Department is irrelevant to this calculation. The earliest time the amount

paid by the Department is relevant to the spenddown calculation is the charge with which the patient meets his or her spenddown.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$608.68 on this claim. While the Hospital, for reasons stated more fully in the general discussion above, believes that spenddown should never be assessed against a provider, the Hospital asks that if the Court agrees with the Department that spenddown is assignable to providers, the Court permit a maximum recovery on this claim of \$196.97. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

Even if this Court is satisfied that Ms. Panelo's conclusion is supported by the preponderance of the evidence, the evidence also shows that Jeremy A. has Indian Health coverage. (*See, e.g.*, AR 599; 604.) For the reasons discussed more fully above, the Department may not properly assign spenddown to a patient with Indian Health coverage.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. If there is such evidence, it is simply not in the record in this proceeding.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$608.68 on this claim because the claim is not supported by a preponderance of the evidence, or in the alternative, is an Indian Health claim and therefore not appropriate for use towards

spenddown. In the alternative, the Hospital requests that because this is an outpatient claim, the Court permit a maximum recovery of \$196.97. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(2) Haley A.**

Claim 2, for Haley A., is documented in AR 612-631 under the tab for Haley A. Ms. Panelo concluded that the Hospital had been overpaid \$2,005.44. (AR 595, line 2.) Recovery of this amount will result in a net payment to the Hospital of \$660.98 on services originally billed at \$11,647.75. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Haley A., had expenses recorded in the ACES system. (AR 618-619.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

The ACES CME detail page reflects that Haley A. incurred an expense on January 31, 2005 (AR 617), but HWT data for Haley A. reflects dates of service from January 29, 2005 to January 31, 2005 (AR 595 at line 2). Hospital records and the remittance advice also reflect dates of service from January 29, 2005 to January 31, 2005. (AR 620,

625.) This discrepancy between the ACES data and other data sources highlights the fundamental unreliability of the ACES data. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. There is simply no other source of information that permits this Court to judge the reliability of the total spenddown amount or spenddown calculations and assignments. Because of this, the Hospital urges the Court to be especially skeptical of ACES spenddown data for an individual when other ACES data for that individual is demonstrably unreliable. Here, the ACES data for Haley A. is demonstrably unreliable with respect to the dates involved. For this reason, the Court should conclude that Ms. Panelo's overpayment finding is not supported by a reliable preponderance of evidence and reject the Department's attempt to recover \$2,005.44 on this claim.

Further, it appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met her spenddown with an expense incurred on January 31, 2005. (AR 617.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letter dated April 4, 2005, informing the patient she had qualified for medically needy benefits, states that her coverage period began on November 1, 2004, almost three months before she had met her spenddown obligation. (AR 612.) This

letter is generated by CSO caseworkers through the ACES system. (C. Fisher Testimony; AR 615.)

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. If there is such evidence, it is simply not in the record in this proceeding.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$2,005.44 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(3) Susan A.**

Claim 3, for Susan A., is documented in AR 632-652 under the tab for Susan A. Ms. Panelo concluded that the Hospital had been overpaid \$3,003.99. (AR 595, line 3.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$12,940.45, but since the Hospital had only been paid \$3,003.99 for the service against which spenddown had been assessed, the Department seeks to recoup \$3,003.99, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$12,940.45. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are five members in this assistance unit, and that of these five, only one member, Susan A., had expenses recorded in the ACES system. (AR 643-

644.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

The ACES CME detail page lists two items used to meet spenddown: a \$12,940.45 Mary Bridge expense incurred on August 10, 2001, and a \$2,304.00 "Work A Round" expense, also incurred on August 10, 2001. While the expense attributed to Mary Bridge was used in its entirety to meet spenddown, the "Work A Round" expense was split, with only \$1,817 used to meet spenddown. At the hearing, Cathy Fisher testified that "Work A Round" expenses are input into ACES to make the system generate benefits when, based on the information entered into the system at the time, the system deems the client ineligible for benefits. (C. Fisher Testimony.) According to Ms. Fisher, "workarounds" are used, among other things, to comply with administrative hearing decisions or to keep benefits going pending a hearing or a decision. (C. Fisher Testimony.) Here, it appears that for some reason, the Department had decided that an overall spenddown calculation adjustment of \$2,304.00 was appropriate, resulting in an effective total spenddown amount of \$12,453.60 for the period, compared to the \$14,757.60 originally entered into ACES by the CSO worker. But apparently because of the order in which the expense information had been entered into ACES, the total spenddown calculation was only adjusted by \$1,817. Had the spenddown adjustment been properly made, only \$12,453.60 of spenddown would

have been assigned to the Hospital, instead of the \$12,940.45 reflected in ACES.

The Hospital recognizes that these differences are at the margin, but their significance is not that they affect the degree of the Department's recovery (*i.e.*, how much the Department should recover), but whether the Department should recover any amount at all. The lack of clarity about the Work A Round expense and its use raises doubts about whether the information relied upon by Ms. Panelo to make her finding is sufficiently reliable to adequately support the finding. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. There is simply no other source of information that permits this Court to judge the reliability of the total spenddown amount or spenddown calculations and assignments. Because of this, the Hospital urges the Court to be especially skeptical of ACES spenddown data for an individual when other ACES data for that individual is demonstrably unreliable. Here, the Work A Round entry reflects that the total spenddown amount in the ACES system was manually adjusted. The record contains no explanation of why that adjustment should not affect the spenddown amount assigned to the Hospital. Because of this lack of information regarding a fundamentally important piece of data underpinning Ms. Panelo's calculations, it would

be unreasonable to conclude that the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.

Even if this Court is satisfied that Ms. Panelo's conclusion is supported by the preponderance of the evidence, the evidence also shows that Susan A. has Indian Health coverage. (*See, e.g.*, AR 645-648.) For the reasons discussed more fully above, the Department may not properly assign spenddown to a patient with Indian Health coverage.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. The Hospital's Last Word account notes do not reflect that the Department ever informed it of a spenddown, or that it saw or received a copy of a letter with spenddown details. If there is such evidence, it is simply not in the record in this proceeding.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$354.11 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(4) Mason A.**

**(5) Mason A.**

Claims 4 and 5, for Mason A., are documented in AR 653-701 under the tab for Mason A. Ms. Panelo concluded that the Hospital had

been overpaid \$2,856.46 on Claim 4 and \$6,955.20 on Claim 5. (AR 595, lines 4, 5.) On Claim 4, Ms. Panelo concluded that the spenddown attributable to the Hospital was \$7,057.15, but since the Hospital had only been paid \$2,856.46 for the service against which spenddown had been assessed, the Department seeks to recoup \$2,856.46, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$11,457.50. On Claim 5, Ms. Panelo concluded that the spenddown attributable to the Hospital was \$6,955.20. Recovery of this amount will result in a net payment to the Hospital of \$14,284.88 on services originally billed at \$56,334.55. Claims 4 and 5 are not supported by the preponderance of the evidence.

The Department omitted to supply any evidence of the proper amount of total spenddown liability for either of the periods at issue here. Unlike for many of the other patients involved in this audit, the Department did not produce spenddown letters detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amounts listed in ACES. Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo’s analysis cannot be verified.

It would be unreasonable for this Court to now overlook this deficiency in the foundational data for Ms. Panelo’s calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at

issue, and then to assess an overpayment against the Hospital for these claims.

*Further Problems Specific to Claim 4*

The data Ms. Panelo relied upon in computing the alleged overpayment are fundamentally unreliable. The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Tanya A., had expenses recorded in the ACES system. (AR 665-666.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

While ACES lists Tanya A. as the patient who incurred expenses (AR 663, Tanya A. listed as the client), the HWT data relied upon by Ms. Panelo lists no expenses for Tanya A. (AR 595.) Instead, HWT lists two line items for Mason A., a member of the same assistance unit as Tanya A. (AR 595, lines 4, 5.)

Further, it appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on October 13, 2003. (AR 664.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letters dated March 4 and 9, 2004, informing the patient he had qualified for medically needy benefits, states that his coverage period began on September 1, 2003,

almost six weeks before he had met his spenddown obligation. (AR 653, 655.)

These letters are generated by CSO caseworkers through the ACES system. (C. Fisher Testimony.) Parts of the letters are static text, generated by a system letter template, while other parts are manually entered by the CSO caseworkers. (C. Fisher Testimony.) Both types of parts appear equally susceptible to error. The March 9, 2004 letter states that an expense of \$8,084.40 dated October 13, 2003, from Multicare Health Systems, was used to meet spenddown. (AR 655.) But there is no information in either ACES or HWT corresponding to this expense amount. A handwritten note reflects that Ms. Panelo added two numbers from the ACES CME detail page together to see if the total was \$8,084.40. While her attempt to make sense of the number is appealing, it does not suffice to explain what the CSO caseworker meant when she entered the data this way. Another equally apparently sensible explanation could be that the caseworker had input \$8,084.40 because that was the total spenddown amount for the period at issue. The point is that all of these recreations are no more than speculation. This Court has no way of determining what the \$8,084.40 number in the letter means or why it was put there.

The ACES narrative notes for March 5, 2004, entered by the author of the March 9, 2004 letter, state that the patient should be eligible on October 13, 2004. While it is likely that this is simply a typographical error by the CSO caseworker inputting the note, again, this Court can only

speculate how this date came to be typed in by the caseworker. Like the inaccuracy contained in the March 9, 2004 letter, this error highlights the susceptibility of the ACES system to human error. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. There is simply no other source of information that permits this Court to judge the reliability of the total spenddown amount or spenddown calculations and assignments. Because of this, the Hospital urges the Court to be especially skeptical of ACES spenddown data for an individual when other ACES data for that individual is demonstrably unreliable. Here, the ACES data for this patient has been shown to be in error with respect to the name of the patient, the ACES narrative, and the coverage dates in the award letters. For this reason, the Court should conclude that Ms. Panelo's overpayment finding is not supported by a reliable preponderance of evidence and reject the Department's attempt to recover \$2,856.46 on this claim.

**(6) Nicholas B.**

Claim 6, for Nicholas B., is documented in AR 702-725 under the tab for Nicholas B. Ms. Panelo concluded that the Hospital had been overpaid \$1,029.57. (AR 595, line 6.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$3,065.80, but since the Hospital had only been paid \$1,029.57 for the service against which

spenddown had been assessed, the Department seeks to recoup \$1,029.57, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$5,740.45. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Shelly A., had expenses recorded in the ACES system. (AR 709-710.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate. In this case, the record contains evidence that another member of this assistance unit had incurred an expense during the same spenddown period — a printout retrieved by Ms. Panelo from the Department's DMS (*see* handwritten notation on AR 711) reflects that Daniel B. incurred expenses at Tacoma General Hospital for dates of service from July 24, 2004 through July 26, 2004. Yet this expense, also capable of meeting spenddown and also evidently available to the CSO caseworker, was not entered into ACES and was therefore not taken into consideration when spenddown assignments were being made. This deficiency in a fundamental piece of data shows both that the caseworker made an error and that the Department's treatment of spenddown is flawed, unworkable and basically arbitrary.

Furthermore, while ACES lists Shelly A. as the patient who incurred expenses (AR 708, Shelly A. listed as the client), the HWT data relied upon by Ms. Panelo lists no expenses for Shelly A. (AR 595-596.) Instead, HWT lists one line item for Nicholas A., a member of the same assistance unit as Shelly A. (AR 595, line 6.)

These flaws are particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Because of this, the Hospital urges the Court to be especially skeptical of ACES spenddown data for an individual when other ACES data for that individual is demonstrably unreliable. Here, the ACES data is demonstrably incomplete (does not include an expense for another member of the same assistance unit) and inaccurate (attributes the single expense listed to the wrong person). It would be unreasonable to conclude that despite these inconsistencies regarding a foundational piece of data in Ms. Panelo's calculation, the preponderance of the evidence supports a conclusion that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital.<sup>3</sup>

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<sup>3</sup> In contrast to the unresolvable problems discussed in this paragraph, the Department was able to resolve one inconsistency in the data. The ACES CME detail reflects an expense of \$5,935.45. (AR 708.) But the HWT data reflects an expense of \$5,740.45. (AR 595 at line 6.) Ms. Panelo

A further problem with Ms. Panelo's process for this claim is that she did not take into account the fact that the expenses for Nicholas B. are outpatient expenses (*see* AR 719-720 (remittance advice)), and are therefore not paid under DRG. Had Ms. Panelo considered each line item reflected on the remittance advice to be a separate charge, and applied each charge to the assigned spenddown until the spenddown was met, the amount recoverable from the Hospital would be \$377.17.

Charge	Paid by Department	Spenddown remaining	Amount recoverable by Department	Comment
\$56.45	\$19.48	\$3,009.35	\$19.48	Not covered; amount paid by Department recoverable
\$138.00	\$47.61	\$2,871.35	\$47.61	Not covered; amount paid by Department recoverable
\$12.00	\$4.14	\$2,859.35	\$4.14	Not covered; amount paid by Department recoverable
\$28.00	\$9.66	\$2,831.35	\$9.66	Not covered; amount paid by Department recoverable
\$24	\$7.22	\$2,807.35	\$7.22	Not covered; amount paid by Department recoverable

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concluded that the disparity was explained by subtracting the professional fee portion from the \$5,935.45 total amount owed to the Hospital — this subtraction yields the \$5,740.45 figure reflected in HWT. Documentation in the record supports Ms. Panelo's conclusion that the disparity between the ACES and HWT amounts was due to the HWT amount not including the professional fee portion of the hospital expenses. The availability of other corroborative data in this instance is in stark contrast to many other instances in which there is no information that can help the Court assess Ms. Panelo's speculative conclusions or other problems.

Charge	Paid by Department	Spenddown remaining	Amount recoverable by Department	Comment
\$23.00	\$7.67	\$2,784.35	\$7.67	Not covered; amount paid by Department recoverable
\$26.00	\$9.50	\$2,758.35	\$9.50	Not covered; amount paid by Department recoverable
\$15.00	\$2.85	\$2,743.35	\$2.85	Not covered; amount paid by Department recoverable
\$18.00	\$2.90	\$2,725.35	\$2.90	Not covered; amount paid by Department recoverable
\$17.00	\$2.90	\$2,708.35	\$2.90	Not covered; amount paid by Department recoverable
\$26.00	\$8.66	\$2,682.35	\$8.66	Not covered; amount paid by Department recoverable
\$1,389.00	\$113.12	\$1,293.35	\$113.12	Not covered; amount paid by Department recoverable
\$1,765.00	\$141.46	\$0	\$141.46	First charge covered by Department. \$1,293.35 left of spenddown to recover, but exceeds payment from Department. Recover full amount paid by Department.

The Hospital does not concede that any aspect of the Department's treatment of spenddown is appropriate. However, in the event the Court agrees with the Department that spenddown is assignable to providers, the Court should calculate spenddown as follows: until spenddown is met, the

amounts relevant to the spenddown calculation are the amounts charged, not the amounts paid by the Department. Because the Department will not pay bills prior to the time spenddown is met, the amount paid by the Department is irrelevant to this calculation. The earliest time the amount paid by the Department is relevant to the spenddown calculation is the charge with which the patient meets his or her spenddown.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$1,029.57 on this claim. While the Hospital, for reasons stated more fully in the general discussion above, believes that spenddown should never be assessed against a provider, the Hospital asks that if the Court agrees with the Department that spenddown is assignable to providers, the Court permit a maximum recovery on this claim of \$377.17. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

Finally, it appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on July 24, 2004. (AR 708.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But an approval letter dated December 8, 2004, informing the patient he had qualified for medically needy benefits, states that his coverage period began on June 1, 2004, almost two months before he had met his spenddown obligation. (AR 702.) This letter does not specify how spenddown for the period was to be met. Yet another

approval letter, also dated December 8, 2004, does not cite any beginning date at all, although it does report that spenddown for the period at issue was met with a \$5,935.45 bill from Mary Bridge Hospital (AR 705.) Both letters were generated by CSO caseworkers through the ACES system. (C. Fisher Testimony.) The record does not specify which letter was seen by the Hospital.

**(8) Jeremie B.**

Claim 8, for Jeremie B., is documented in AR 749-769 under the tab for Jeremie B. Ms. Panelo concluded that the Hospital had been overpaid \$3,414.84. (AR 595, line 8.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$3,414.84. Recovery of this amount will result in a net payment to the Hospital of \$3,722.15 on services originally billed at \$21,916.15. This overpayment claim is not supported by the preponderance of the evidence.

The Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. Unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES. Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo's analysis cannot be verified. It would be unreasonable for this Court to now overlook this deficiency in the foundational data for Ms. Panelo's

calculation and to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue.

Other data Ms. Panelo relied upon in computing the alleged overpayment are fundamentally unreliable. The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Jeremie B., had expenses recorded in the ACES system. (AR 754-755.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

The problem with Ms. Panelo's process for this claim is that she did not take into account the fact that the expenses for Jeremie B. are outpatient expenses (*see* AR 761, 763 (remittance advice)), and are therefore not paid under DRG. Had Ms. Panelo considered each line item reflected on the remittance advice to be a separate charge, and applied each charge to the assigned spenddown until the spenddown was met, the amount recoverable from the Hospital would be \$2,418.46.

Charge	Paid by Department	Spenddown remaining	Amount recoverable by Department	Comment
\$592.10	\$197.17	\$2,549.74	\$197.17	Not covered; amount paid by Department recoverable
\$33.10	\$11.02	\$2,516.64	\$11.02	Not covered; amount paid by Department

Charge	Paid by Department	Spenddown remaining	Amount recoverable by Department	Comment
\$237.00	\$78.92	\$2,279.64	\$78.92	recoverable Not covered; amount paid by Department recoverable
\$104.00	\$34.63	\$2,175.64	\$34.63	Not covered; amount paid by Department recoverable
\$7,498.00	\$2,496.83	\$0	\$2,175.64	First charge covered by Department. Deduct \$2,175.64 from amount paid by Department because amount paid is amount payable and represents negotiated rate applicable to covered persons.

The Hospital does not concede that any aspect of the Department's treatment of spenddown is appropriate. However, in the event the Court agrees with the Department that spenddown is assignable to providers, the Court should calculate spenddown as follows: until spenddown is met, the amounts relevant to the spenddown calculation are the amounts charged, not the amounts paid by the Department. Because the Department will not pay bills prior to the time spenddown is met, the amount paid by the Department is irrelevant to this calculation. The earliest time the amount paid by the Department is relevant to the spenddown calculation is the charge with which the patient meets his or her spenddown.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$3,414.84 on this claim. While the Hospital, for reasons stated more fully in the general discussion above,

believes that spenddown should never be assessed against a provider, the Hospital asks that if the Court agrees with the Department that spenddown is assignable to providers, the Court permit a maximum recovery on this claim of \$2,418.46. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(9) Miya B.**

Claim 9, for Miya B., is documented in AR 770-789 under the tab for Miya B. Ms. Panelo concluded that the Hospital had been overpaid \$639.98. (AR 595, line 9.) Recovery of this amount will result in a net payment to the Hospital of \$4,409.78 on services originally billed at \$29,147.75. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are two members in this assistance unit, and that of these two, only one member, Miya B., had expenses recorded in the ACES system. (AR 775.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. Unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated

the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES. Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo's analysis cannot be verified. It would be unreasonable for this Court to now overlook this deficiency in the foundational data for Ms. Panelo's calculation, and to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue.

For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

It appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met her spenddown with an expense incurred on November 18, 2005. (AR 774.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letter dated January 5, 2006, informing the patient she had qualified for medically needy benefits, states that her coverage period began on November 1, 2005, more than 2 weeks before she had met her spenddown obligation. (AR 770.)

**(10) Tyler B.**

Claim 10, for Tyler B., is documented in AR 790-803 under the tab for Tyler B. Ms. Panelo concluded that the Hospital had been overpaid \$3,592.74. (AR 595, line 10.) Recovery of this amount will result in a net payment to the Hospital of \$6,299.45 on services originally billed at \$22,640.50.

The ACES summary sheet for this patient reflects that there are two members in this assistance unit, and that of these two, only one member, Tyler B., had expenses recorded in the ACES system. (AR 793.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

It appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on September 4, 2004. (AR 792.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letter dated October 15, 2004, informing the patient he had qualified for medically needy benefits, states that his coverage period began on July 1, 2004, more than two months before he had met his spenddown obligation. (AR 790.)

For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of

whether the Department's recovery of any spenddown monies is appropriate.

**(11) Daniel B.**

Claim 11, for Daniel B., is documented in AR 804-828 under the tab for Daniel B. Ms. Panelo concluded that the Hospital had been overpaid \$954.30. (AR 595, line 11.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$2,593.14, but since the Hospital had only been paid \$954.30 for the service against which spenddown had been assessed, the Department seeks to recoup \$954.30, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$3,010.50.

The ACES summary sheet for this patient reflects that there are two members in this assistance unit, and that of these two, only one member, Daniel B., had expenses recorded in the ACES system. (AR 810.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

It appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on October 8, 2004. (AR 809.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letter dated December 18, 2004, informing the patient he had qualified for medically needy benefits, states that his coverage period began on June 1, 2004, more than four months before he had met his spenddown obligation. (AR 804.)

**(12) Ethan C.**

Claim 12, for Ethan C., is documented in AR 829-852 under the tab for Ethan C. Ms. Panelo concluded that the Hospital had been overpaid \$8,948.10. (AR 595, line 12.) Recovery of this amount will result in a net payment to the Hospital of \$8,796.10 on services originally billed at \$66,924.40. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are two members in this assistance unit, and that of these two, only one member, Ethan C., had expenses recorded in the ACES system. (AR 833.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. Unlike for

many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES. Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo's analysis cannot be verified. It would be unreasonable for this Court to now overlook this deficiency in the foundational data for Ms. Panelo's calculation, and to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue.

For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

It appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on August 20, 2004. (AR 834.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letter dated February 11, 2005, informing the patient he had qualified for medically needy benefits, states that his coverage period began on August 1, 2004, almost three weeks before he had met his spenddown obligation. (AR 829.)

**(13) Caelan C.**

Claim 13, for Caelan C., is documented in AR 853-872 under the tab for Caelan C. Ms. Panelo concluded that the Hospital had been overpaid \$2,666.42. (AR 595, line 13.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$8,291.04, but since HWT reflected that the Hospital had only been paid \$2,666.42 for the service against which spenddown had been assessed, the Department seeks to recoup \$2,666.42. If the Hospital was in fact paid this amount, recovery of the amount sought will result in a net payment to the Hospital of \$0 on services originally billed at \$32,668.00. This overpayment claim is not supported by the preponderance of the evidence.

The data Ms. Panelo relied upon in computing the alleged overpayment are fundamentally unreliable. The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Gena C., had expenses recorded in the ACES system. (AR 861-862.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Furthermore, while the ACES system reflects expenses for Gena C., the patient for whom HWT reflects an expense at the Hospital during the audit period is Caelan C. (AR 595, line 13.)

The ACES CME detail reflects an expense of \$22,668.00. (AR 860.) But the HWT data reflects an expense of \$32,668. (AR 595 at line 13.) Hospital documents also reflect an expense amount of \$32,668. Ms. Panelo appears to have concluded that the disparity between the amount reflected in ACES and the amount in HWT and the Hospital records was explained by a document she retrieved from the DMS after her audit was completed. (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 863.) However, the quality of the document is so poor that it is impossible to tell exactly what numbers are on the document. An illegible document cannot properly be used as evidence to support Ms. Panelo's speculation.

These inaccuracies in the ACES data have a cumulative effect of calling into question the reliability of the ACES data for this patient. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. There is simply no other source of information that permits this Court to judge the reliability of the total spenddown amount or spenddown calculations and assignments. Because of this, the Hospital urges the Court to be especially skeptical of ACES spenddown data for an individual when other ACES data for that individual is demonstrably unreliable. Here, data that should have been able to be confirmed by other sources (patient name,

expense amount) in fact conflicts with the other sources made available to this Court. Worse, unlike in other instances, the discrepancies cannot be explained even by speculative subtraction of a professional fee or addition of expenses from different hospitals. On the basis of the evidence in the record, the Court should not find that Ms. Panelo's assignment of spenddown to the Hospital is supported by a preponderance of the evidence.

Even if the Court elects to find that the assignment of spenddown to the Hospital is proper, the Department has failed to show by a preponderance of the evidence that the Hospital was paid for the care provided to Caelan C. If the Hospital was not paid, there can have been no overpayment. Unlike for most of the other patients for whom the Department made audit findings, the Department neither produced nor provided to the Court a copy of the remittance advice. This document is proof of the Department's payment. (*See discussion, supra.*) There is no other proof that the Hospital was paid for this incident of care. Accordingly, the Department has failed to sustain its burden of showing that there was a payment for which an overpayment can be collected.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$2,666.42 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(14) Julian D.**

Claim 14, for Julian D., is documented in AR 770-789 under the tab for Julian D. Ms. Panelo concluded that the Hospital had been overpaid \$3,969.72. (AR 595, line 14.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$7,794.00, but since the Hospital had only been paid \$3,969.72 for the service against which spenddown had been assessed, the Department seeks to recoup \$3,969.72, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$12,941.20. This overpayment claim is not supported by the preponderance of the evidence.

The evidence also shows that Julian D. has Indian Health coverage. (*See, e.g.*, AR 883.) For the reasons discussed more fully above, the Department may not properly assign spenddown to a patient with Indian Health coverage.

The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Cricket C., had expenses recorded in the ACES system. (AR 880-881.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Furthermore, while the ACES data reflects an expense for Cricket C., the patient for whom the HWT data reflects an expense is Julian D. (AR 595, line 14.)

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$3,969.72 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(15) Karl D.**

Claim 15, for Karl D., is documented in AR 892-913 under the tab for Karl D. Ms. Panelo concluded that the Hospital had been overpaid \$6,003.21. (AR 595, line 1.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$10,638.00, but since HWT reflected that the Hospital had only been paid \$6,003.21 for the service against which spenddown had been assessed, the Department seeks to recoup \$6,003.21. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$17,715.45. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Karl D., had expenses recorded in the ACES system. (AR 898-899.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Even if the Court elects to find that the assignment of spenddown to the Hospital is proper, the Department has failed to show by a

preponderance of the evidence that the Hospital was paid for the care provided to Karl D. If the Hospital was not paid, there can have been no overpayment. Unlike for most of the other patients for whom the Department made audit findings, the Department neither produced nor provided to the Court a copy of the remittance advice. This document is proof of the Department's payment. (*See discussion, supra.*) There is no other proof that the Hospital was paid for this incident of care. Accordingly, the Department has failed to sustain its burden of showing that there was a payment for which an overpayment can be collected.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$6,003.21 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(17) Jillian E.**

Claim 17, for Jillian E., is documented in AR 946-961 under the tab for Jillian E. Ms. Panelo concluded that the Hospital had been overpaid \$3,969.72. (AR 595, line 17.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$6,504.66, but since the Hospital had only been paid \$3,969.72 for the service against which spenddown had been assessed, the Department seeks to recoup \$3,969.72, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$7,446.65. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Stephanie E., had expenses recorded in the ACES system. (AR 947-948.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

The ACES narrative in this case suggests that the spenddown calculation was subject to change. (AR 949-950.) The entry for April 2, 2004, states, "Processed F06 for both current and retro medical. Income of father caused trickle to F99 for current and retro, client had submitted hospital bill for Jan 04 that met January's retro spenddown amount, approval sent for Jan med benefits as of 1/29/04, date of admissions. Letter sent for s/d for 11/03 and 12/03 retro ad for 2/04 onward for current s/d months." (AR 949-950.) The next entry, for April 7, 2004, states, "Stephanie called very confused about getting the medical coupon and the letter on spenddown. Explained it all to her. She is pregnant now. The addition of an unborn can reduce the spenddown." (AR 950.) The letters referred to in the narrative were not produced and are not part of the record. Without them, there is no way to tell what the original spenddown calculation was, how it was calculated, or whether the calculation was correct in the first instance or properly adjusted to reflect the pregnancy.

Furthermore, while the ACES data reflect expenses for Stephanie E. (AR 946), the HWT data reflect expenses relating to Jillian E. (AR

595, line 17.) The ACES data also reflects that the expense was coded as an MC-type expense when it should have been coded as an HO-type expense. While that coding error did not affect how spenddown was assigned in this particular case, this kind of inaccuracy, together with the other inaccuracies and data gaps discussed above, calls into question the reliability of the ACES data.

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings. The discrepancies particularly cast into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, there is no data in the record about how spenddown was calculated and whether that calculation was adjusted appropriately.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 17. The necessary data simply is not sufficiently reliable. For these

reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$3,962.72 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. The Hospital's Last Word account notes do not reflect that the Department ever informed it of a spenddown, or that it saw or received a copy of a letter with spenddown details. If there is such evidence, it is simply not in the record in this proceeding.

**(18) Trenton F.**

Claim 18, for Trenton F., is documented in AR 962-977 under the tab for Trenton F. Ms. Panelo concluded that the Hospital had been overpaid \$3,511.80. (AR 595, line 18.) Recovery of this amount will result in a net payment to the Hospital of \$4,076.79 on services originally billed at \$25,053.20. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Trenton F., had expenses recorded in the ACES system. (AR 967-968.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without

full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. Unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES. Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo's analysis cannot be verified. It would be unreasonable for this Court to now overlook this deficiency in the foundational data for Ms. Panelo's calculation, and to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue.

For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

It appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on November 28, 2003. (AR 966.) According to applicable WAC, 388-519-0110(7), coverage begins only

once spenddown has been met. But the approval letter dated January 9, 2004, informing the patient he had qualified for medically needy benefits, states that his coverage period began on August 1, 2003, almost four months before he had met his spenddown obligation. (AR 962.)

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known that the spenddown assigned to this patient had been assigned to the Hospital. While the Hospital's Last Word account notes reflect that the Hospital was aware of a spenddown (AR 971, 975), it does not appear that the Hospital was informed that the spenddown would be assigned to the Hospital bills for dates of service from November 28, 2003 through December 4, 2003. Furthermore, the single letter in the record contains no spenddown details. If there is evidence that the Hospital knew that this patient's spenddown obligation would be assigned to its bill for the November 28, 2003 through December 4, 2003 service, that evidence simply not in the record in this proceeding.

**(19) Carson F.**

Claim 19, for Carson F., is documented in AR 978-993 under the tab for Carson F. Ms. Panelo concluded that the Hospital had been overpaid \$3,951.93. (AR 595, line 19.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$5,820.82, but since the Hospital had only been paid \$3,951.93 for the service against which spenddown had been assessed, the Department seeks to recoup \$3,951.93, the amount paid. Recovery of this amount will result in a net payment to

the Hospital of \$0 on services originally billed at \$23,886.20. This overpayment claim is not supported by the preponderance of the evidence.

The Department has not provided any evidence to support the accuracy of the spenddown calculation contained in ACES. Unlike for most of the other patients involved in this audit, the Department did not provide any copies of spenddown letters which could have served to support the accuracy of the Department's calculation of total spenddown obligations. Without this information, there is no way for this Court to assess the accuracy of the total spenddown obligation reflected in ACES.

Furthermore, the ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Carson F., had expenses recorded in the ACES system. (AR 979, 980.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

The ACES CME detail page reflects an expense of \$22,809.20, dated January 23, 2006, and attributed to Mary Bridge Child Hosp. (AR 978.) But the HWT data for this patient for this date of service reflects an expense amount of \$23,886.20. (AR 595, line 19.) Ms. Panelo appears to have concluded that the disparity between the amount reflected in ACES and the amount in HWT and the Hospital records was explained by a document she retrieved from the DMS after her audit was completed (A. Panelo Testimony re not having access to BarCode at the time she made

her original audit findings.) (AR 982.) But this document and other Hospital records do not square either. While this document and the other Hospital records (AR 983, 986) are associated with the same account number, there is no explanation for the difference in expense amounts that appear on each set of documents (the Hospital Last Word documents track with HWT).

The ACES data also reflects that the expense was coded as an MC-type expense when it should have been coded as an HO-type expense. While that isolated coding error did not affect how spenddown was assigned in this particular case, this kind of inaccuracy, together with the other inaccuracies and data gaps discussed above, calls into question the reliability of the ACES data.

The aggregate effect of these errors and inaccuracies is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings. The discrepancies particularly cast into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, there is no data in the record about how spenddown was calculated and whether that calculation was adjusted appropriately.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 19. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$3,951.93 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(21) Elizabeth H.**

Claim 21, for Elizabeth H., is documented in AR 1022-1049 under the tab for Elizabeth H. Ms. Panelo concluded that the Hospital had been overpaid \$3,306.11. (AR 595, line 21.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$4,691.10, but since the Hospital had only been paid \$3,306.11 for the service against which spenddown had been assessed, the Department seeks to recoup \$3,306.11, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$11,806.30. This overpayment claim suffers from the same kind of deficiencies as Christopher B's, which was withdrawn by the Department. (*See discussion, supra.*)

The ACES summary sheet for this patient reflects that there are two members in this assistance unit, and that of these two, only one member, Elizabeth H., had expenses recorded in the ACES system. (AR 1030.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Information from the ACES system demonstrates that the amount of spenddown assigned to the Hospital is, indeed, wrong. The ACES narrative entry for February 15, 2005 states, in relevant part:

A/R called yesterday re status of appl.  
Compltd processing F06 using lmen curr  
4/04 qtr earnings—F06>F99 with 5088  
spndwn liability for base 1/05-6/05; used  
prior med bills to reduce spndwn to 1495 &  
called Multicare Health Svcs this morning to  
ck on svc date for a 12000+ past due med  
bill stmt date 1/9/05 – Multicare indicated  
svc date of bill was 9/15/04; ck'd with lead  
to see if can use this bill to meet old spndwn  
base 5/04-10/04 but cannot bec bill recvd  
more than 30 days past end of spndwn  
period.

(AR 1046.) The base period at issue in this overpayment claim is the period from May 1, 2004 through October 31, 2004. (AR 1029.)

According to the ACES spenddown summary for this base period, the total spenddown liability for this base period is \$4,691.10. (AR 1030.) The ACES CME detail page reflects that this entire amount was assigned to an expense of \$12,090.30, dated September 14, 2004, attributed to “Multicare

Acct # 458339231.” (AR 1029.) But the HWT report contains no information for a September 14, 2004 date of service. (AR 595 at line 21.) Nor does it contain information for this patient reflecting a \$12,090.30 expense. (AR 595 at line 21.) Instead, the HWT report reflects an incident of care from September 15, 2004 through September 18, 2004, which was billed at \$11,806.30. (AR 595 at line 21.) Despite this discrepancy, Ms. Panelo appears to have decided that assignment of this \$4,691.10 spenddown amount to the September 15, 2004 incident of care was appropriate.

But according to the ACES narrative entry excerpted above, the bill for this incident of care *could not be used* to meet spenddown for the period from May 1, 2004 through October 31, 2004. (AR 1046 (stating “ck’d with lead to see if can use this bill to meet old spndwn base 5/04-10/04 but cannot”).) Despite this notation, the ACES system does not appear to have been updated to reflect this, and worse, Ms. Panelo did not take this comment into account when conducting her audit.

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings. The discrepancies particularly cast into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and

amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, the ACES narrative itself indicates that the bill Ms. Panelo sought to assign spenddown to cannot be used for that purpose.

It would be unreasonable for this Court to now overlook this comment, to conclude that a preponderance of the evidence supports a finding that spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 21. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$3,306.11 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(22) Samantha H.**

**(23) Samantha H.**

Claims 22 and 23, for Samantha H., are documented in AR 1050-1108 under the tab for Samantha H. For Claim 22, Ms. Panelo concluded that the Hospital had been overpaid \$2,043.56. (AR 595, line 22.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$5,971.20, but since the Hospital had only been paid \$2,043.56 for the service against which spenddown had been assessed, the Department seeks to recoup \$2,043.56, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$20,737.55. For Claim 23, Ms. Panelo concluded that the Hospital had

been overpaid \$804.21. (AR 595, line 23.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$3,391.75, but since the Hospital had only been paid \$804.21 for the service against which spenddown had been assessed, the Department seeks to recoup \$804.21, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$3,391.75. These overpayment claims are not supported by the preponderance of the evidence.

The evidence shows that Samantha H. has Indian Health coverage. (*See, e.g.*, AR 1058, AR 1083,1084.) For the reasons discussed more fully above, the Department may not properly assign spenddown to a patient with Indian Health coverage. For this reason alone, the Court should reject the Department's attempts to recover spenddown amounts associated with this patient.

#### *Claim 22*

The ACES summary sheet for this patient reflects that there are two members in this assistance unit, and that of these two, only one member, Samantha H., had expenses recorded in the ACES system. (AR 1055, 1056.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects

that the total spenddown liability for the base period January 1, 2005 through June 30, 2005, was \$5,971,20. (AR 1055.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

There are further problems with the ACES data. The ACES CME detail page reflects an expense of \$6,941.05, dated March 14, 2005, attributed to Mary Bridge Children's Hsp. (AR 1054.) But the HWT report reflects an expense amount of \$20,737.55 for a March 14, 2005 date of service. (AR 595 at line 22.) Ms. Panelo was able to match the amount listed in ACES with a document she retrieved from the Department's DMS. (AR 1057.) But there is no explanation on the record of what this document is, or how it connects the expense in ACES to which spenddown has been assigned with the expense reflected in HWT. Indeed, when she testified about the discrepancy, Ms. Panelo speculated that the caseworker "probably" got an interim statement of charges (A. Panelo Testimony) but had no definitive assertions to make.

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings. The discrepancies particularly cast into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of

information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, there is no data in the record about how spenddown was calculated, and errors in other aspects of ACES data suggest that the ACES data about this patient is cannot be relied upon in the absence of corroborative sources.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 22. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$2,043.56 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

*Claims 23 and 24*

The data and Ms. Panelo's process for Claim 23 are completely unreliable. The ACES CME detail assigns spenddown to two expenses apparently from Mary Bridge, one for \$3,391.75 dated September 20, 2005, and another one for \$3,026.25, dated September 23, 2005. (AR 1079.) Ms. Panelo originally concluded that spenddown was properly

assignable to two expenses that appeared in her HWT report, one for \$3,391.75, dated September 20, 2005, and another one for \$1,472.00, dated September 20, 2005. (AR 595, lines 23, 24.) She arbitrarily concluded that the September 23, 2005 expense in ACES corresponded to the second September 20, 2005 expense in HWT despite the fact that the dates and the amounts did not match. She stated, “When I did the audit, I didn’t have Barcode, so I went to the closest date I could find.” (A. Panelo Testimony.)

It was not until after she had been made aware that the Hospital was appealing her audit findings that she conducted further research and found documents contradicting her original finding. (A. Panelo Testimony.) Those documents show that the September 23, 2005 expense in ACES actually corresponds to an expense from Tacoma General Hospital. (AR 1072.) In light of these documents, Ms. Panelo deleted her finding for Claim 24.

The ACES data and Ms. Panelo’s conclusions for Claim 23 are tainted by the deficiencies of her findings with respect to Claim 24. Even if the Court elects to find that the assignment of spenddown to the Hospital for Claim 23 is proper, the Department has failed to show by a preponderance of the evidence that the Hospital was paid for the care provided to Samantha H. If the Hospital was not paid, there can have been no overpayment. Unlike for most of the other patients for whom the Department made audit findings, the Department neither produced nor provided to the Court a copy of the remittance advice for the

September 20, 2005 expense of \$3,391.75. This document is proof of the Department's payment. (*See discussion, supra.*) There is no other proof that the Hospital was paid for this incident of care. Accordingly, the Department has failed to sustain its burden of showing that there was a payment for which an overpayment can be collected.

It would be unreasonable for this Court to now overlook these deficiencies in the data and the process for Claim 23, and to then to assess an overpayment against the Hospital for Claim 23. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$804.31 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(25) Grace J.**

Claim 25, for Grace J., is documented in AR 994-1021 under the tabs for Anthony J. and Grace J. Ms. Panelo concluded that the Hospital had been overpaid \$2,955.70. (AR 595, line 25.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$5,878.00, but since the Hospital had only been paid \$2,955.70 for the service against which spenddown had been assessed, the Department seeks to recoup \$2,955.70, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$10,037.35. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are seven members in this assistance unit, and that of these seven, three members, Paula J., Grace J. and Anthony J., had expenses recorded in the ACES system. (AR 1114, 1115.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate. Ms. Panelo acknowledged in the hearing that she does not look for information about other assistance unit members' expenses. (A. Panelo Testimony.) She also confirmed that she does not inquire into whether spenddown is appropriately taken against one unit member's expenses and not another's. (A. Panelo Testimony ("I'd assumed that the three bills used to meet spenddown are enough and I don't have to get to Anthony's bill."))

Ms. Panelo acknowledged that she did not have the documents she needed to ascertain whether spenddown had been deducted from the payment to the Hospital for Anthony J.'s bill. (A. Panelo Testimony (testifying that the way one verifies whether spenddown has been deducted from a bill is to look at the remittance advice, not HWT.) Without confirmation that spenddown has not already been taken from Anthony J.'s bill, it is improper to conclude that any particular amount of spenddown should be taken from Grace J.'s bill.

It would be unreasonable for this Court to now overlook these deficiencies in Ms. Panelo's analysis, to conclude that a preponderance of

the evidence supports a finding that any particular amount of spenddown has not yet been paid, and then to assess an overpayment against the Hospital for Claim 25. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$2,955.70 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(26) Kieren J.**

Claim 26, for Kieren J., is documented in AR 1131-1144 under the tab for Kieren J. Ms. Pabelo concluded that the Hospital had been overpaid \$109.38. (AR 595, line 26.) Recovery of this amount will result in a net payment to the Hospital of \$44.84 on services originally billed at \$447.00. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are five members in this assistance unit, and that of these five, only one member, Kieren J., had expenses recorded in the ACES system. (AR 1132-1133.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period May 2004 through

July 2004, was \$109.38. (AR 1132.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

This deficiency particularly casts into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, there is no data in the record about how spenddown was calculated and whether that calculation was adjusted appropriately.

It would be unreasonable for this Court to now overlook this deficiency in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 26. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$109.38 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal

issue of whether the Department's recovery of any spenddown monies is appropriate.

**(27) Brittany K.**

Claim 27, for Brittany K., is documented in AR 1145-1164 under the tab for Brittany K. Ms. Panelo concluded that the Hospital had been overpaid \$19,094.63. (AR 595, line 27.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$26,063.10, but since the Hospital had only been paid \$19,094.63 for the service against which spenddown had been assessed, the Department seeks to recoup \$19,094.63, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$30,357.10. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Brittany K., had expenses recorded in the ACES system. (AR 1155-1156.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

The ACES data and Ms. Panelo's analysis for this claim are hopelessly confused. There appear to be two spenddown base periods at issue, one from December 2000 through February 2001, and the period immediately following, from March 2001 through August 2001. (See CP

2276-2295.) The ACES data from *both* periods reflect that spenddown was assigned to expenses attributed to Mary Bridge. The ACES data from the 12/00–02/01 base period lists an expense of \$31,186.10, dated February 17, 2001, attributed to Mary Bridge. (CP 2276-2278.) The ACES data from the next period lists an expense of \$26,063.10, dated March 1, 2001, attributed to Mary Bridge. (CP 2284.)

But HWT data does not line up with either of these apparent expenses. Instead, HWT reflects an expense of \$30,357.10 for dates of service from February 17, 2001 through March 3, 2001. (AR 595 at line 27.) HWT also listed other incidents of care for this patient, but the next incident of care does not begin until March 4, 2001. Ms. Panelo confirmed that she ignored these subsequent incidents of care. (A. Panelo Testimony.) That left a single incident of care, per HWT, to which two spenddowns, per ACES, were assigned.

At the hearing, Ms. Panelo had no explanation for how she reconciled this mess of information into a conclusion that \$26,063 of spenddown from the second base period at issue should be collected against an expense which had already apparently been used for spenddown from the first base period. In Ms. Panelo's defense, this conclusion was no less rational than a conclusion to collect the spenddown from the first period would have been.

Aside from the lack of evidentiary material to justify Ms. Panelo's conclusion, the Department may not assign two spenddowns from two separate base periods to what appears to be a single incident of care. The

applicable regulation permits an expense to be used only once to meet spenddown. WAC 388-519-0110(10). Despite this, ACES reflects a regulatorily impermissible assignment of spenddown.

This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, ACES reflects an assignment of spenddown that goes against what is prescribed in the applicable WAC. Further, the data in ACES with respect to amounts and dates is not corroborated by other data sources.

It would be unreasonable for this Court to now overlook these deficiencies in Ms. Panelo's analysis and in the foundational data for Ms. Panelo's calculation, and then to assess an overpayment against the Hospital for Claim 27. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$19,094.63 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(29) Travis K.**

Claim 29, for Travis K., is documented in AR 1185-1204 under the tab for Travis K. Ms. Panelo concluded that the Hospital had been

overpaid \$2,255.25. (AR 595, line 29.) Recovery of this amount will result in a net payment to the Hospital of \$1,515.57 on services originally billed at \$7,363.00. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Taryn K., had expenses recorded in the ACES system. (AR 1191.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Furthermore, while the ACES data reflect expenses for Taryn K. (AR 1190), the HWT data reflect expenses relating to Travis K. (AR 595, line 29.)

The ACES CME detail page lists an expense for Taryn K. of \$7,383.00, dated June 25, 2004, attributed to Multicare. (AR 1190.) But HWT has no corresponding line item. Instead, HWT lists an expense for Travis K. of \$7,363.00, dated June 16, 2004. (AR 595, line 29.) Ms. Panelo appears to have concluded that the disparity between the amount reflected in ACES and the amount in HWT and the Hospital records was explained by a document she retrieved from the DMS after her audit was completed. (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 1193.) This means that at the time of her audit, Ms. Panelo was sufficiently convinced, even without

the corroborating documentation, that the ACES data corresponded with the HWT data, to conclude that the Hospital had been overpaid by thousands of dollars. She was convinced of this despite the fact that at the time of her audit, the information available to her did not match either in amount or in date. It goes without saying that had she *not* been satisfied, and had she not made an audit finding, no further research would have been done.

The ACES data also reflects that the expense was coded as DE-type expense when it should have been coded as an HO-type expense. While that coding error did not affect how spenddown was assigned in this particular case, this kind of inaccuracy, together with the other inaccuracies and data gaps discussed above, calls into question the reliability of the ACES data.

Furthermore, it appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on June 25, 2004. (AR 1190.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letter dated April 5, 2005, informing the patient he had qualified for medically needy benefits, states that his coverage period began on June 1, 2004, more than 3 weeks before he had met his spenddown obligation according to the information in the ACES system. (AR 1185.)

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo

relied to make her audit findings. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Because of this, the Hospital urges the Court to be especially skeptical of ACES spenddown data for an individual when other ACES data for that individual is demonstrably unreliable. Here, the ACES data has been shown to be inaccurate in several respects.

It would be unreasonable for this Court to now overlook these deficiencies in the ACES data and to assume that foundational data for Ms. Panelo's calculation is accurate, and then to assess an overpayment against the Hospital for Claim 29. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$2,255.25 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. The Hospital's Last Word account notes do not reflect that the Department ever informed it that any spenddown would be assigned to it,

or that it saw or received a copy of a letter with spenddown details. If there is such evidence, it is simply not in the record in this proceeding.

**(30) Dennis L.**

Claim 30, for Dennis L., is documented in AR 1205-1227 under the tab for Dennis L. Ms. Panelo concluded that the Hospital had been overpaid \$2,701.63. (AR 595, line 30.) Recovery of this amount will result in a net payment to the Hospital of \$1,214.93 on services originally billed at \$22,897.85. This overpayment claim is not supported by the preponderance of the evidence.

Dennis L. has Indian Health coverage. (*See, e.g.*, AR 1216.) For the reasons discussed more fully above, the Department may not properly assign spenddown to a patient with Indian Health coverage. Therefore, for this reason alone, the Court should reject the Department's attempt to recover on Claim 30.

Aside from the Indian Health issue, the Department's overpayment claim is not supported by a preponderance of the evidence. The ACES summary sheet for this patient reflects that there are two members in this assistance unit, and that of these two, only one member, Shirley L., had expenses recorded in the ACES system. (AR 1212.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Furthermore, while the ACES data reflect expenses for Shirley L. (AR 1211, 1212), the HWT data reflect expenses relating to Dennis L. (AR 595, line 30.)

The ACES CME detail page lists an expense for Shirley L. of \$23,002.86, dated April 18, 2005, attributed to Mary Bridge Hospital. (AR 1211.) But HWT does not have an expense of that amount or for that date. Instead, HWT lists an expense for Dennis L. of \$22,897.85 for an incident of care beginning on April 17, 2005. (AR 595, line 30.) Ms. Panelo appears to have concluded that the disparity between the amount reflected in ACES and the amount in HWT and the Hospital records was explained by documents she retrieved from the DMS after her audit was completed. (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 1214, 1215.) But it is not clear from the face of these documents how they relate to the HWT line item or to the other Hospital records available for this patient (*see* AR 1216-1219).

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings.

In sum, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$2,701.63 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(31) Dontis L.**

Claim 31, for Dontis L., is documented in AR 1228-1261 under the tab for Dontis L. Ms. Panelo concluded that the Hospital had been overpaid \$1,773.49. (AR 595, line 31.) Recovery of this amount will result in a net payment to the Hospital of \$892.93 on services originally billed at \$31,675.50. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Annabelle L., had expenses recorded in the ACES system. (AR 1247.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period October 2004 through December 2004, was \$1,773.49. (AR 1247.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

Furthermore, while the ACES data reflect expenses for Annabelle L. (AR 1247-1248), the HWT data reflect expenses relating to Dontis L.

(AR 595, line 31.) The ACES data lists three expenses for Annabelle L., all attributed to Mary Bridge Hospital as follows:

10/04/2004	\$3,073.00
10/04/2004	\$37.40
10/04/2004	\$36.00

(AR 1234.) All of these expenses were coded as MC-type expenses, even though it appears they should have been coded HO-type expenses. HWT does not contain any line items which correspond to these expenses listed in ACES. (AR 595, line 31.) Ms. Panelo appears to have concluded that the disparity between the first amount reflected in ACES and the amount in HWT and the Hospital records was explained by a document she retrieved from the DMS after her audit was completed. (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 1236.) But this document only explains the first expense. It does not explain the other expenses. It is not even clear that it does that — there is no identifying information about this document at all, including hospital name, patient name, or date. (AR 1236.) There is no explanation about how the DMS document is related to the Hospital records, which track the HWT data.

The aggregate effect of these deficiencies is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings. The discrepancies particularly cast into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. This is particularly troubling, as

discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, there is no data in the record about how spenddown was calculated and there is inconclusive data about amounts and providers.

In light of the fundamental flaws in the data, it was arbitrary for Ms. Panelo to have relied on the ACES data in the way she did.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 31. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$1,773.49 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(32) Laura L.**

Claim 32, for Laura L., is documented in AR 1262-1281 under the tab for Laura L. Ms. Panelo concluded that the Hospital had been overpaid \$3,561.50. (AR 595, line 32.) Ms. Panelo concluded that the

spenddown attributable to the Hospital was \$4,075.23, but since the Hospital had only been paid \$3,561.50 for the service against which spenddown had been assessed, the Department seeks to recoup \$3,561.50, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$11,511.10. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are seven members in this assistance unit, and that of these seven, only one member, Laura L., had expenses recorded in the ACES system. (AR 1267-1268.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period December 2004 through February 2005, was \$4,075.23. (AR 1267.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

The ACES CME detail page lists an expense of \$11,667.10, dated December 17, 2004, attributed to Mary Bridge. (AR 1266.) But HWT data for a date of service December 17, 2004, lists an expense of \$15.00.

(Ex. A-13 at CP 131-136, line 144.) HWT contains another line item for date of service December 8, 2004, for an expense of \$141.00. (Ex. A-13 at CP 131-136, line 140.) HWT contains a third line item for date of service December 13, 2004, for an expense of \$11,511.10. (Ex. A-13 at CP 131-136, line 142.) Ms. Panelo appears to have concluded that the disparity between the amount reflected in ACES and the amount in HWT and the Hospital records was explained by a document she retrieved from the DMS after her audit was completed (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 1269.) But instead of properly prioritizing the expenses by date, she arbitrarily chose to assign all of the spenddown to the HWT line item for date of service December 13, 2004, for an expense of \$11,511.10.

A further problem with Ms. Panelo's process for this claim is that she did not take into account the fact that the expenses for Laura L. are outpatient expenses (*see* AR 1274 (remittance advice)), and are therefore not paid under DRG. Had Ms. Panelo considered each line item reflected on the remittance advice to be a separate charge, and applied each charge to the assigned spenddown until the spenddown was met, the maximum amount recoverable from the Hospital would be \$2,081.16.

Charge	Paid by Department	Spenddown remaining	Amount recoverable by Department	Comment
\$141.00	\$11.66	\$3,934.23	\$11.66	Not covered; amount paid by Department recoverable
\$196.96	\$65.58	\$3,737.27	\$65.58	Not covered; amount paid by Department recoverable
\$24.40	\$8.13	\$3,712.87	\$8.13	Not covered; amount paid by Department recoverable
\$652.00	\$217.12	\$3,060.87	\$217.12	Not covered; amount paid by Department recoverable
\$408	\$135.86	\$2,652.87	\$135.86	Not covered; amount paid by Department recoverable
\$10.00	\$3.33	\$2,642.87	\$3.33	Not covered; amount paid by Department recoverable
\$32.00	\$8.36	\$2,610.87	\$8.36	Not covered; amount paid by Department recoverable
\$35.00	\$2.46	\$2,575.87	\$2.46	Not covered; amount paid by Department recoverable
\$26.00	\$8.66	\$2,549.87	\$8.66	Not covered; amount paid by Department recoverable
\$169.00	\$11.56	\$2,380.87	\$11.56	Not covered; amount paid by Department recoverable
\$835.00	\$62.57	\$1,545.87	\$62.57	Not covered; amount paid by Department recoverable

Charge	Paid by Department	Spenddown remaining	Amount recoverable by Department	Comment
\$6,120.00	\$2,037.98	\$0	\$1,545.87	First charge covered by Department. Deduct \$1545.87 from amount paid by Department because amount paid is amount payable and represents negotiated rate applicable to covered persons.

The Hospital does not concede that any aspect of the Department's treatment of spenddown is appropriate. However, in the event the Court agrees with the Department that spenddown is assignable to providers, the Court should calculate spenddown as follows: until spenddown is met, the amounts relevant to the spenddown calculation are the amounts charged, not the amounts paid by the Department. Because the Department will not pay bills prior to the time spenddown is met, the amount paid by the Department is irrelevant to this calculation. The earliest time the amount paid by the Department is relevant to the spenddown calculation is the charge with which the patient meets his or her spenddown.

It appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met her spenddown with an expense incurred on December 17, 2004. (AR 1266.) According to applicable WAC, 388-519-0110(7), coverage begins only

once spenddown has been met. But the approval letters dated April 1, 2005, informing the patient she had qualified for medically needy benefits, states that her coverage period began on December 1, 2004, more than two weeks before she had met her spenddown obligation. (CP 1205 and 1207.)

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings and Ms. Panelo's analysis itself. The discrepancies particularly cast into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, there is no data in the record about how spenddown was calculated. Furthermore, the ACES data conflicts with other data sources. Finally, Ms. Panelo's process for resolving those conflicts is purely arbitrary.

It would be unreasonable for this Court to now overlook these deficiencies in the data and in Ms. Panelo's process, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 32. The

necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$3,561.50 on this claim, or in the alternative, to permit a maximum recovery of \$2,081.16. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(33) Cassandra M.**

Claim 33, for Cassandra M., is documented in AR 1282-1298 under the tab for Cassandra M. Ms. Panelo concluded that the Hospital had been overpaid \$2,882.26. (AR 595, line 33.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$6,700.40, but since the Hospital had only been paid \$2,882.26 for the service against which spenddown had been assessed, the Department seeks to recoup \$2,882.26, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$13,351.05. This overpayment claim is not supported by the preponderance of the evidence.

The evidence shows that Cassandra M. has Indian Health coverage. (*See, e.g.*, AR 1288.) For the reasons discussed more fully above, the Department may not properly assign spenddown to a patient with Indian Health coverage. For this reason alone, the Court should reject the Department's attempts to recover spenddown amounts associated with this patient.

Putting aside the Indian Health issue, there are numerous problems with the data and process underlying this overpayment claim.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Cassandra M., had expenses recorded in the ACES system. (AR 1285-1286.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period October 2005 through December 2005, was \$6,700.40. (AR 1285.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

The ACES CME detail page lists an expense of \$12,372.05, dated December 20, 2005, attributed to Mary Bridge. (AR 1284.) But HWT data for this patient does not contain a line item with this date or this amount. (*See* Ex. A-13 at CP 131-136.) In the absence of an exact match, Ms. Panelo assigned the spenddown assigned in ACES to the December 20, 2005 expense to a line item in HWT dated December 21, 2005, for \$13,351.05. (AR 595, line 33.) Ms. Panelo appears to have concluded that the disparity between the amount reflected in ACES and the amount in HWT and the Hospital records was explained by two documents she

retrieved from the DMS after her audit was completed. (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 1287, 1297.) But there is no explanation about how the DMS document is related to the Hospital records, which track the HWT data. In the absence of such an explanation, there is no evidence to support Ms. Panelo's arbitrary decision to associate the spenddown ACES assigned to an expense of \$12,372.05 dated December 20, 2005, to an HWT line item dated December 21, 2005, for \$13, 351.05.

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings and Ms. Panelo's analysis itself. The discrepancies particularly cast into doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, there is no data in the record about how spenddown was calculated and the data there is inconclusive.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. The Hospital's Last Word account notes do not reflect that the Department ever informed it of a spenddown, or that it saw or received a

copy of a letter with spenddown details. If there is such evidence, it is simply not in the record in this proceeding.

It would be unreasonable for this Court to now overlook the deficiencies in Ms. Panelo's analysis and in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 33. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$2,882.26 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(34) Cody M.**

Claim 34, for Cody M., is documented in AR 1299-1317 under the tab for Cody M. Ms. Panelo concluded that the Hospital had been overpaid \$3,306.11 (AR 595, line 34.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$6,249.12, but since the Hospital had only been paid \$3,306.11 for the service against which spenddown had been assessed, the Department seeks to recoup \$3,306.11, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$15,088.05. This overpayment claim is not supported by the preponderance of the evidence. The data for this patient suffer from the same deficiencies as the data for

Christopher B., for whom the Department withdrew their overpayment claim.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Cody M., had expenses recorded in the ACES system. (AR 1305-1306.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

The ACES CME detail page for the base period April 2005 through June 2005 lists an expense of \$15,100.05, dated June 7, 2005, attributed to Mary Bridge Hospital. (AR 1304.) But HWT data for this patient contains no line item for this date for this amount. (*See* Ex. A-13 at CP 131-136, line 198.) Instead, the HWT data contains a line item for an incident of care from June 4, 2005, through June 7, 2005. (*See* Ex. A-13 at CP 131-136, line 198.) Ms. Panelo appears to have concluded that the disparity between the amount reflected in ACES and the amount in HWT and the Hospital records was explained by a document she retrieved from the DMS after her audit was completed (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 1307.) But this document, while agreeing with the ACES data, does not line up with the HWT data either (different expense amounts). Nor does it line up with the Hospital's Last Word documents in the record (different expense amounts). Unlike for many other patients

involved in this audit, no explanation was offered about the discrepancies for this patient.

In addition, the record contains award letters relating to two different spenddown base periods. The first period was from April 2005 through June 2005; the second period was from July 2005 through December 2005. (AR 1299-1303.) According to these two spenddown letters, it appears that the CSO caseworker used the same incident of care to meet spenddown in each period. The August 1, 2005 letter, about the April 2005 through June 2005 spenddown period states that a Mary Bridge bill for \$15,100 was used to meet spenddown. (AR 1299-1300.) The July 13, 2005, letter, about the subsequent spenddown base period, states that a bill from Multicare Health System incurred on June 4, 2005 for \$15,100.05 was used to meet spenddown. (AR 1302.)

The Department may not assign two spenddowns from two separate base periods to what appears to be a single incident of care. The applicable regulation permits an expense to be used only once to meet spenddown. WAC 388-519-0110(10). Despite this, ACES reflects a regulatorily impermissible assignment of spenddown.

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings. The discrepancies particularly cast into doubt a foundational piece of data — whether spenddown is correctly assigned to a provider. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms.

Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, the cumulative nature of the errors contained in the ACES data render the data unreliable.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown can be assigned to the Hospital, and then to assess an overpayment against the Hospital for Claim 34. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$3,306.11 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(35) Marcus M.**

Claim 35, for Marcus M., is documented in AR 1318-1337 under the tab for Marcus M. Ms. Panelo concluded that the spenddown attributable to the Hospital was \$2,620.00, but that the Hospital had reported \$4,445.00 in spenddown. (AR 595, line 35; AR 1331 (remittance advice).) Ms. Panelo concluded that the Hospital had been underpaid \$1,825.00. (AR 595, line 35.)

The evidence shows that Marcus M. has Indian Health coverage. (*See, e.g.*, AR 1326.) For the reasons discussed more fully above, the

Department may not properly assign spenddown to a patient with Indian Health coverage. For this reason alone, the Court should reject the notion that this patient is liable for any amount of spenddown, and find that the Hospital is due a refund of the full \$4,445.00 deducted from the Department's payment to the Hospital.

Putting aside the Indian Health issue, the data for Marcus M. is rife with deficiencies and is insufficient to support any claim for spenddown.

The ACES summary sheet for this patient reflects that there are six members in this assistance unit, and that of these six, Carma M. and Marcus M., had expenses recorded in the ACES system. (AR 1324-1325.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period February 2002 was \$4,445.00. (AR 1322.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES. It further appears that a manual adjustment was made to the total spenddown liability calculation. (*See* AR 1322 (reflecting a "Calculation Correction")). There is insufficient information

to determine what the correction is, why it was made, or what its effect should properly be on the expense to which spenddown was assigned in ACES. For example, why is the \$1,825 deducted from Mary Bridge's original reported spenddown amount of \$4,445.00 and not the \$2,620.00 spenddown ACES lists as assigned to Mary Bridge?

Furthermore, the ACES expense data does not square with other data sources. The ACES CME page lists an expense of \$37,323.00, dated February 8, 2002, attributed to Mary Bridge. (AR 1323.) But HWT data for this patient lists an expense amount of \$37,017.00 for this date of service. (AR 595, line 35.) Unlike for other patients involved in this audit, there appears to have been no effort to reconcile the data in any way or to find any support for Ms. Panelo's arbitrary conclusion to associate the ACES data with a line item from HWT that does not match.

Moreover, it appears that the reliability of the HWT data is in doubt. Ms. Panelo testified at the hearing that she would have expected to see the \$4,445.00 Mary Bridge reported as spenddown reflected in the HWT report produced by the Department. (A. Panelo Testimony.) She was surprised to see that the report did not reflect that amount. (A. Panelo Testimony.) She had no explanation for the data gap, but in the face of the data gap, asserted that she just "knew" the information that should have been contained in the report. (A. Panelo Testimony.) But "knowing" is not evidence sufficient to support an overpayment claim.

The aggregate effect of these deficiencies in the data is to cast doubt onto the reliability and integrity of the information on which Ms.

Panelo relied to make her audit findings, both from ACES and from HWT. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are normally susceptible to confirmation from other sources, but spenddown calculations and assignments are not. In this case, given the apparent flaws in the HWT data, there is not even any reliable source of data against which to compare the ACES data.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown should be assigned to the Hospital, and then to assess an overpayment against the Hospital for Claim 35. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's assignment of \$2,620.00 of spenddown to the Hospital and order the Department to refund the full \$4,445.00 to the Hospital. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(36) Daniel M.**

Claim 36, for Daniel M., is documented in AR 1338-1354 under the tab for Daniel M. Ms. Panelo concluded that the Hospital had been

overpaid \$4,768.96. (AR 595, line 36.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$7,998.00, but since the Hospital had only been paid \$4,768.96 for the service against which spenddown had been assessed, the Department seeks to recoup \$4,768.96, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$10,061.10. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Daniel M., had expenses recorded in the ACES system. (AR 1340-1341.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period October 2003 through March 2004, was \$7,998.00. (AR 1340.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

In addition, the ACES data and HWT data for this patient do not match. The ACES CME detail page lists an expense of \$9,480.10, dated

October 21, 2003, attributed to Mary Bridge Hospital. (AR 1339.) But the HWT data for this patient lists an expense of \$10,061.10 for that date of service from October 21, 2003. (AR 595, line 36.) Ms. Panelo appears to have concluded that the disparity between the amount reflected in ACES and the amount in HWT and the Hospital records was explained by a document she retrieved from the DMS after her audit was completed. (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 1342.) But while this document reflects the same expense amount as the ACES expense amount, there is no explanation about how the DMS document is related to the Hospital records, which track the HWT data. Furthermore, it is not clear that the DMS document is even attributable to Mary Bridge. The DMS document contains no provider name. (AR 1342.)

It further appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on October 21, 2003. (AR 1339.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letter dated December 19, 2003, informing the patient he had qualified for medically needy benefits, states that his coverage period began on October 1, 2003, three weeks before he had met his spenddown obligation. (AR 1338.)

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings. The discrepancies particularly cast into

doubt a foundational piece of data — the total amount of spenddown liability for this patient for this period. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, there is no data in the record about how spenddown was calculated.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 36. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$4,768.96 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. The Hospital's Last Word account notes do not reflect that the Department ever informed it of a spenddown, or that it saw or received a

copy of a letter with spenddown details. If there is such evidence, it is simply not in the record in this proceeding.

**(37) Ana M.**

Claim 37, for Ana M., is documented in AR 1355-1387 under the tab for Ana M. Ms. Panelo concluded that the Hospital had been overpaid \$3,197.07. (AR 596, line 37.) Recovery of this amount will result in a net payment to the Hospital of \$719.49 on services originally billed at \$22,608.10.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Ana M., had expenses recorded in the ACES system. (AR 1364-1365.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

The ACES CME detail page lists two expenses attributed to Mary Bridge Hospital:

9/19/2004	\$5,056.30
9/20/2004	\$11,835.00

(AR 1362.) But the HWT data for this patient lists only one line item, an expense of \$22,608.10 for an incident of service for service dates September 19, 2004 through September 23, 2004. (Ex. A-13 at CP 131-136, line 126.) For reasons that are not evident, Ms. Panelo concluded it was appropriate to associate the spenddown assigned in ACES to an

expense of \$5,056.30 to an HWT expense of \$22,608.10. Ms. Panelo appears to have concluded that the disparity between the amounts reflected in ACES and the amount in HWT and the Hospital records were explained by documents she retrieved from the DMS after her audit was completed. (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 1366-1372.) But these documents do not square with the ACES data either. On one page, Ms. Panelo underlined an expense amount of \$5,058.30. (AR 1366.) But not only is this amount different from the amount in ACES, there is no explanation about how this DMS document is related to the Hospital records, which track the HWT data.

Further, there is no support at all for the second expense, dated September 20, 2004 listed in ACES.

It further appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met her spenddown with an expense incurred on September 19, 2004. (AR 1362.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letters in the record state that her coverage period began on September 1, 2004, almost three weeks before she had met her spenddown obligation. (AR 1355, 1357.)

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of

information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, the discrepancies between ACES and HWT with respect to expense amounts are not resolved by the evidence in this record.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of reliable evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 37. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$3,197.07 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(39) Aiden P.**

Claim 39, for Aiden P., is documented in AR 1407-1430 under the tab for Aiden P. Ms. Panelo concluded that the Hospital had been overpaid \$9,198.00. (AR 596, line 39.)

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Aiden P., had expenses recorded in the ACES system. (AR

1412-1413.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

It appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on July 28, 2003. (AR 1411.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letter dated October 14, 2003, informing the patient he had qualified for medically needy benefits, states that his coverage period began on July 1, 2003, almost one month before he had met his spenddown obligation. (AR 1407.)

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. The Hospital's Last Word account notes do not reflect that the Department ever informed it of a spenddown, or that it saw or received a copy of a letter with spenddown details. If there is such evidence, it is simply not in the record in this proceeding.

**(40) Jorge P.**

Claim 40, for Jorge P., is documented in AR 1431-1466 under the tab for Jorge P. Ms. Panelo concluded that the Hospital had been overpaid \$6,647.34. (AR 596, line 40.) Recovery of this amount will result in a net payment to the Hospital of \$2,516.12 on services originally billed at

\$33,022.79. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Noelia L., had expenses recorded in the ACES system. (AR 1435-1436.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period October 2004 through March 2005, was \$6,857.34. (AR 1435.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

Furthermore, while the ACES data reflect expenses for Noelia L. (AR 1433-1434), the HWT data reflect expenses relating to Jorge P. (Ex. A-13 at CP 131-136, lines 133, 148, 149, 156, 158.)

The ACES CME detail page reflects that \$6,647.34 worth of expenses were assigned to spenddown. (AR 1433-1434.) But according to the ACES spenddown summary page, the spenddown for the period is

\$210 more than that. (AR 1435.) Despite this, the Department evidently deemed this patient eligible for coverage. (AR 1431 (award letter).)

The ACES CME detail page lists 5 expenses, each for \$1,536.00 for the following dates: October 11, 12, 13, 14, and 15. (AR 1433-1434.) But the HWT data for Jorge P. does not contain corresponding line items. Instead, there is a line item for an incident of service from October 11, 2005 through October 16, 2005, for an expense of \$33,022.79. (AR 596, line 40.) Not only do the line items not match up, the total of the 5 expenses listed in ACES does not match to the single HWT line item. Ms. Panelo appears to have concluded that these discrepancies are adequately explained by a document she retrieved from the Department's DMS after her audit was completed. (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 1439-1446.) But there is no explanation about how the DMS document is related to the Hospital records, which track the HWT data. The gap between ACES and HWT data remains unresolved.

It further appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on October 15, 2005. (AR 1434.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letter in the record states that his coverage period began on October 1, 2005, two weeks before he had met his spenddown obligation. (AR 1431.)

The aggregate effect of these errors is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings. The internal discrepancies in the ACES data particularly cast into doubt foundational data — the total amount of spenddown liability for this patient for this period and the proper assignment of that spenddown. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, there is no data in the record about how spenddown was calculated and the expenses data in ACES does not reconcile with other sources.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 40. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$6,647.34 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(41) Brianna R.**

Claim 41, for Brianna R., is documented in AR 1467-1517 under the tab for Brianna R. Ms. Panelo concluded that the Hospital had been overpaid \$8,318.00. (AR 596, line 41.) Recovery of this amount will result in a net payment to the Hospital of \$61,853.78 on services originally billed at \$209,356.91. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Brianna R., had expenses recorded in the ACES system. (AR 1473-1474.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

The ACES CME detail page lists an expense of \$210,991.00, dated April 15, 2005, attributed to Mary Bridge Hospital. (AR 1472.) But the HWT data for this patient does not contain a line item for a date of service of April 15, 2005. (*See* Ex. A-13 at CP 131-136.) HWT does contain a line item for an expense close to the amount listed in ACES — the dates of service are March 2, 2005 through March 14, 2005 for an expense of \$209,356.91. (AR 596, line 41.)

Ms. Panelo appears to have concluded that the disparity between the amount reflected in ACES and the amount in HWT and the Hospital records was explained by documents she retrieved from the Department's

DMS after her audit was completed. (A. Panelo Testimony re not having access to BarCode at the time she made her original audit findings.) (AR 1475-1477.) But while these documents correspond to some of the ACES data, there is no explanation about how the DMS documents are related to the Hospital records, which track the HWT data. For example, what appears to be a bill for \$210, 991.91 (close to, but not the same as the ACES CME expense), does not contain dates of service. (AR 1475.) This bill amount does not correspond to the Hospital's Last Word account notes either. The next document contains dates of service that match with HWT, but there is no apparent relationship between the amount on that document and the amounts in either the Hospital's Last Word account notes or HWT. (AR 1476.)The gaps between ACES and HWT data remain unresolved.

It further appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met her spenddown with an expense incurred on April 15, 2005. (AR 1472.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letter dated July 15, 2005, states that her coverage period began on March 1, 2005, six weeks before she had met her spenddown obligation. (AR 1467.)

The aggregate effect of these inconsistencies is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown should be assigned to the Hospital, and then to assess an overpayment against the Hospital for Claim 41. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$8,318.00 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(42) Mikael R.**

Claim 42, for Mikael R., is documented in AR 1518-1534 under the tab for Mikael R. Ms. Panelo concluded that the Hospital had been overpaid \$1,598.04. (AR 596, line 42.) Recovery of this amount will result in a net payment to the Hospital of \$10,210.47 on services originally billed at \$39,841.00. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are two members in this assistance unit, and that of these two, only one member, Diema R., had expenses recorded in the ACES system. (AR 1523.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period June 2005 was \$1,598.04. (AR 1523.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

Furthermore, while the ACES data reflect expenses for Diema R. (AR 1522), the HWT data reflect expenses relating to Mikael R. (AR 596, line 42.)

It appears that the Department may have miscalculated this patient's eligibility period. According to ACES, this patient met his spenddown with an expense incurred on June 18, 2005. (AR 1522.) According to applicable WAC, 388-519-0110(7), coverage begins only once spenddown has been met. But the approval letters in the record state that his coverage period began on June 1, 2005, more than two weeks before he had met his spenddown obligation. (AR 1518.)

The aggregate effect of these errors and deficiencies is to cast doubt onto the reliability and integrity of the ACES information on which Ms. Panelo relied to make her audit findings. Of special concern is the lack of supporting data for a foundational piece of data — the total amount of spenddown liability for this patient for this period. This is particularly troubling, as discussed more fully above, because ACES is the *sole* source

of information used by Ms. Panelo to determine whether and how much spenddown is to be assigned to a particular provider. Dates of service and amounts of charges are susceptible to confirmation from other sources, but spenddown calculations and assignments are not. Here, there is no data in the record about how spenddown was calculated.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 42. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$1,598.04 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(43) Todd S.**

Claim 43, for Todd S., is documented in AR 1535-1554 under the tab for Todd S. Ms. Panelo concluded that the Hospital had been overpaid \$15,809.18. (AR 596, line 43.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$16,678.32, but since the Hospital had only been paid \$15,809.18 for the service against which spenddown had been assessed, the Department seeks to recoup \$15,809.18, the amount paid. Recovery of this amount will result in a net payment to the Hospital

of \$0 on services originally billed at \$117,168.80. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Christina S., had expenses recorded in the ACES system. (AR 1538.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period August 2004 through January 2005, was \$16,678.32. (AR 1538.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

Furthermore, while the ACES data reflect expenses for Christina S. (AR 1537), the HWT data reflect expenses relating to Todd S. (AR 596, line 43.)

Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo's analysis cannot be verified.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 43. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$15,809.18 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(44) Seth S.**

Claim 44, for Seth S., is documented in AR 1555-1581 under the tab for Seth S. Ms. Panelo concluded that the Hospital had been overpaid \$3,071.98. (AR 596, line 44.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$5,610.00, but since the Hospital had only been paid \$3,071.98 for the service against which spenddown had been assessed, the Department seeks to recoup \$3,071.98, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$9,225.05. This overpayment claim is not supported by the preponderance of the evidence.

The evidence shows that Seth S. has Indian Health coverage. (*See, e.g.,* AR 1571.) For the reasons discussed more fully above, the Department may not properly assign spenddown to a patient with Indian

Health coverage. For this reason alone, the Court should reject the Department's attempts to recover spenddown amounts associated with this patient.

Aside from the Indian Health issue, the ACES data for this patient contains some deficiencies. The ACES summary sheet for this patient reflects that there are two members in this assistance unit, and that of these two, only one member, Seth S., had expenses recorded in the ACES system. (AR 1563.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

The ACES CME detail page for this patient four expenses, all dated March 10, 2005, and all attributed to Mary Bridge. (AR 1561.) When asked about it, Ms. Fisher, a veteran CSO worker, stated, "I've never seen a hospital bill broken up like that before." (C. Fisher Testimony.)

**(45) Mateusz S.**

Claim 45, for Mateusz S., is documented in AR 1582-1602 under the tab for Mateusz S. Ms. Panelo concluded that the Hospital had been overpaid \$18,064.68. (AR 596, line 45.) Recovery of this amount will result in a net payment to the Hospital of \$72,534.92 on services originally billed at \$245,901.15. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are three members in this assistance unit, and that of these three, only one member, Mateusz S., had expenses recorded in the ACES system. (AR 1586-1587.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period November 2002 through April 2003, was \$18,064.68. (AR 1586.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo's analysis cannot be verified.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 43. The necessary data simply is not sufficiently reliable. For these

reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$15,809.18 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(46) Michael T.**

Claim 46, for Michael T., is documented in AR 1603-1622 under the tab for Michael T. Ms. Panelo concluded that the Hospital had been overpaid \$2,666.42. (AR 596, line 46.) Ms. Panelo concluded that the spenddown attributable to the Hospital was \$8,834.13, but since the Hospital had only been paid \$2,666.42 for the service against which spenddown had been assessed, the Department seeks to recoup \$2,666.42, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$14,732.40. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are five members in this assistance unit, and that of these five, only one member, Angela T., had expenses recorded in the ACES system. (AR 1608-1609.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects

that the total spenddown liability for the base period April 2005 through June 2005, was \$8,834.13. (AR 1608.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo's analysis cannot be verified.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo's calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 46. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$2,666.42 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

**(50) Jovan W.**

Claim 50, for Jovan W., is documented in AR 1696-1716 under the tab for Jovan W. Ms. Panelo concluded that the Hospital had been overpaid \$2,666.42. (AR 596, line 50.) Ms. Panelo concluded that the

spenddown attributable to the Hospital was \$9,501.00, but since the Hospital had only been paid \$2,666.42 for the service against which spenddown had been assessed, the Department seeks to recoup \$2,666.42, the amount paid. Recovery of this amount will result in a net payment to the Hospital of \$0 on services originally billed at \$22,231.00. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are six members in this assistance unit, and that of these six, only one member, Shannon W., had expenses recorded in the ACES system. (AR 1628.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period May 2005 through October 2005, was \$7,118.00. (AR 1628.) But an award letter dated July 21, 2005, states that spenddown for this base period will be \$9,501.00. (AR 1625.) However, this award letter does not detail how that figure was calculated. Unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Worse, the ACES data for this assistance unit is internally inconsistent. As noted above, the ACES spenddown summary page reflects a total spenddown

liability for the period of \$7,118.00. (AR 1628.) But the ACES CME detail page appears to be applying a total spenddown amount of \$9,501.00. (AR 1627, assigning \$9,501.00 of spenddown to the expense listed therein.) Based on this information, and without the information about how the CSO caseworker calculated total spenddown liability for this base period, the Court has no way to assess the accuracy of the amount listed in ACES.

Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo’s analysis cannot be verified.

It would be unreasonable for this Court to now overlook these deficiencies in the foundational data for Ms. Panelo’s calculation, to conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 50. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department’s attempt to recover \$2,666.42 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department’s recovery of any spenddown monies is appropriate.

**(51) Peter Y.**

Claim 51, for Peter Y., is documented in AR 1717-1733 under the tab for Peter Y. Ms. Panelo concluded that the Hospital had been overpaid

\$18,528.00. (AR 596, line 51.) Recovery of this amount will result in a net payment to the Hospital of \$1,495.04 on services originally billed at \$55,211.54. This overpayment claim is not supported by the preponderance of the evidence.

The ACES summary sheet for this patient reflects that there are four members in this assistance unit, and that of these four, only one member, Lyubov Y., had expenses recorded in the ACES system. (AR 1722-1723.) As explained more fully above, expenses incurred by other members of an assistance unit may be used to meet spenddown. Without full and accurate information about other assistance unit members' expenses, spenddown assignments are likely to be inaccurate.

Further, the Department omitted to supply any evidence of the proper amount of total spenddown liability for the period. ACES reflects that the total spenddown liability for the base period November 2001 through April 2002, was \$18,528.00. (AR 1722.) But unlike for many of the other patients involved in this audit, the Department did not produce a spenddown letter detailing how the Department had calculated the appropriate amount of spenddown. Without this information, the Court has no way to assess the accuracy of the amount listed in ACES.

Without evidence to support a foundational piece of data — the total amount of spenddown liability for this patient for this period — Ms. Panelo's analysis cannot be verified.

It would be unreasonable for this Court to now overlook this deficiency in the foundational data for Ms. Panelo's calculation, to

conclude that a preponderance of the evidence supports a finding that any particular amount of spenddown is appropriate for the coverage period at issue, and then to assess an overpayment against the Hospital for Claim 51. The necessary data simply is not sufficiently reliable. For these reasons, the Hospital respectfully requests that this Court reject the Department's attempt to recover \$18,528.00 on this claim. In so doing, the Hospital does not waive its right to appeal the underlying legal issue of whether the Department's recovery of any spenddown monies is appropriate.

Finally, there is no evidence on the record that indicates that the Hospital knew or should have known of the spenddown assigned to this patient. The Hospital's Last Word account notes do not reflect that the Department ever informed it of a spenddown, or that it saw or received a copy of a letter with spenddown details. If there is such evidence, it is simply not in the record in this proceeding.

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## APPENDIX B

**APENDIX B**  
**Disputed Finding of Facts**

19. Claim 1. Patient Jeremy A. received care for a kick to the head at MBCH on October 5, 2003. Records for Claim 1, Exhibit 6, p. 8. He had a remaining spenddown of \$1,917.14. Exhibit 6, p. 5. MBCH's usual and customary charge for the services delivered was \$4,423.85. Exhibit 6, p. 8. On March 29, 2004, the Department paid \$608.68 at the full Medicaid contract rate for Jeremy A.'s care. Exhibit 6, p. 9. Jeremy A. was also covered by IHS. Because the usual and customary charge exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets Jeremy A.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$608.68 paid an overpayment.

20. Claim 2. Patient Haley A. received emergency care at MBCH on January 31, 2005. Records for Claim 2, Exhibit 7, p. 9. She had a remaining spenddown of \$2,005.44. Exhibit 7, p. 6. MBCH's usual and customary charge for the services delivered was \$11,647.75. Exhibit 7, p. 8. On March 29, 2004, the Department paid \$2,666.42 at the full Medicaid contract rate for Haley A.'s care. Exhibit 7, p. 14. Because the usual and customary charge exceeds the spenddown and the Medicaid contract rate, the MBCH hospital bill meets Haley A.'s spenddown, and

the Department, following its methodology, should have paid MBCH only the difference between Haley A.'s spenddown and the Medicaid contract rate. That makes the first \$2,005.44 paid an overpayment.

21. Claim 3. Patient Susan A. received care at MBCH on August 14, 2001. Records for Claim 3, Exhibit 8, p. 8. She had a remaining spenddown of \$12,940.45. Exhibit 8, p. 6. MBCH's usual and customary charge for the services delivered was \$12,966.45. Exhibit 8, p. 14. On December 24, 2001, the Department paid \$3,003.99 at the full Medicaid contract rate for Susan A.'s care. Exhibit 7, p. 14. Susan A. was also covered by IHS. Because the usual and customary charge exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets Susan A.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$3,003.99 paid an overpayment.

22. Claim 4. Patient Mason A. received care at MBCH on October 16, 2003. Records for Claim 4, Exhibit 9, p. 15. He had an original spenddown of \$8,084.40. Exhibit 9, p. 3. MBCH's usual and customary charge for the services delivered was \$11,457.50. Exhibit 9, p. 15. On March 29, 2004, the Department paid \$2,856.46 at the full Medicaid contract rate for Mason A.'s care. Exhibit 9, p. 21. Mason incurred \$735 in medical bills to AMR for ambulance services on October

13, 2003. Exhibit 9, p. 11. He incurred a further \$1,027.25 in hospital bills to Auburn Regional Medical Center on October 13, 2003. *Id.* The Department counted the Auburn bill against Mason's spenddown, but not the AMR bill. Because the usual and customary charge for MBCH's services exceeds the spenddown, but the Medicaid contract rate is less than the spenddown by more than the combined bills of AMR and Auburn Regional, the MBCH hospital bill meets the remainder of Mason A.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$2,856.46 paid an overpayment.

23. Claim 5. Patient Mason A. received emergency care at MBCH on May 12, 2004. Records for Claim 5, Exhibit 10, p. 9. He had a spenddown of \$6,955.20. Exhibit 10, p. 5. MBCH's usual and customary charge for the services delivered was \$56,568.55. Exhibit 10, p. 10. On June 7, 2004, the Department paid MBCH \$21,240.08 at the full Medicaid contract rate for Mason A.'s care. Exhibit 10, p. 10. Because the usual and customary charge exceeds the spenddown and the Medicaid contract rate, the MBCH hospital bill meets Mason A.'s spenddown, and the Department, following its methodology, should have paid MBCH only the difference between Mason A.'s spenddown and the Medicaid contract rate. That makes the first \$6,955.20 paid an overpayment.

24. Claim 6. Patient Nicholas B. received care at MBCH on July 24, 2004. Records for Claim 6, Exhibit 11, p. 9. His family had a remaining spenddown of \$3,065.80. Exhibit 11, p. 7. MBCH's usual and customary charge for the services delivered to Nicholas B. was \$5,935.45. Exhibit 11, p. 10. MBCH affiliate Tacoma General Hospital provided hospital care to Nicholas B.'s family member Daniel B. on July 24, 2004. Exhibit 11, p. 10. Tacoma General's usual and customary charge for services delivered to family member Daniel B. on the same date was \$21,905.60. *Id.* On January 24, 2005, the Department paid \$1,029.57 at the full Medicaid contract rate for Nicholas B.'s care. Exhibit 11, p. 12. With the MBCH and Tacoma General hospital bills on the same day for members of the same Medical Assistance assistance unit, no clear rule establishes priority; however, the records presented do not show that Daniel B. timely submitted his bill. Exhibit A-1, pp. 87-103, 958-960. Because the usual and customary charge for MBCH's services exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets the remainder of Nicholas B.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$1,029.57 paid an overpayment.

25. Claim 7. The Department no longer finds claim 7 overpaid.

26. Claim 8. Patient Jeremie B. received care at MBCH on March 2, 2005. Records for Claim 8, Exhibit 13, p. 1. He had a remaining spenddown of \$3,414.84. Exhibit 13, p. 5. MBCH's usual and customary charge for the services delivered was \$21,916.15. Exhibit 13, pp. 3, 5, 8, 15. On March 29, 2004, the Department paid \$7,136.99 at the full Medicaid contract rate for Jeremie B.'s care. Exhibit 13, p. 15. Because the usual and customary charge exceeds the spenddown and the Medicaid contract rate, the MBCH hospital bill meets Jeremie B.'s spenddown, and the Department, following its methodology, should have paid MBCH only the difference between Jeremie B.'s spenddown and the Medicaid contract rate. That makes the first \$3,414.84 paid an overpayment.

27. Claim 9. Patient Miya B. received care at MBCH on November 24, 2005. Records for Claim 9, Exhibit 14, p. 1. She had a remaining spenddown of \$639.98. Exhibit 14, p. 1. MBCH's usual and customary charge for the services delivered was \$29,147.75. Exhibit 14, p. 9. On January 23, 2006, the Department paid \$5,049.76 at the full Medicaid contract rate for Miya B.'s care. Exhibit 14, p. 9. Because the usual and customary charge exceeds the spenddown and the Medicaid contract rate, the MBCH hospital bill meets Miya B.'s spenddown, and the Department, following its methodology, should have paid MBCH only the

difference between Miya B.'s spenddown and the Medicaid contract rate.

That makes the first \$639.98 paid an overpayment.

28. Claim 10. Patient Tyler B. received care at MBCH on September 9, 2004. Records for Claim 10, Exhibit 15, p. 1. He had a remaining spenddown of \$3,592.74. Exhibit 15, p. 3. MBCH's usual and customary charge for the services delivered was \$22,674.50. Exhibit 15, p. 11. On November 1, 2004, the Department paid \$9,892.19 at the full Medicaid contract rate for Tyler B.'s care. Exhibit 15, p. 1. Because the usual and customary charge exceeds the spenddown and the Medicaid contract rate, the MBCH hospital bill meets Tyler B.'s spenddown, and the Department, following its methodology, should have paid MBCH only the difference between Tyler B.'s spenddown and the Medicaid contract rate. That makes the first \$3,592.74 paid an overpayment.

29. Claim 11. Patient Daniel B. received care at MBCH on October 8, 2004, after an automobile wreck. Records for Claim 11, Exhibit 16, pp. 1, 16-17. He had a remaining spenddown of \$2,593.14. Exhibit 16, p. 3. MBCH's usual and customary charge for the services delivered was \$3,257.50. Exhibit 16, pp. 6, 9, 20, 24. On March 14, 2005, the Department paid \$7,136.99 at the full Medicaid contract rate for Daniel B.'s care. Exhibit 16, p. 1. Because the usual and customary charge exceeds the spenddown and the Medicaid contract rate, the MBCH

hospital bill meets Daniel B.'s spenddown, and the Department, following its methodology, should have paid MBCH only the difference between Daniel B.'s spenddown and the Medicaid contract rate. That makes the first \$2,593.14 paid an overpayment.

30. Claim 12. Patient Ethan D. received care at MBCH on September 2, 2004. Records for Claim 12, Exhibit 17, p. 1. He had a remaining spenddown of \$8,948.10. Exhibit 17, p. 4, 18. MBCH's usual and customary charge for the services delivered was \$36,072.60. Exhibit 17, pp. 4, 7, 8, 19. On March 14, 2005, the Department paid \$17,744.20 at the full Medicaid contract rate for Ethan D.'s care. Exhibit 17, p. 19. Because the usual and customary charge exceeds the spenddown and the Medicaid contract rate, the MBCH hospital bill meets Ethan D.'s spenddown, and the Department, following its methodology, should have paid MBCH only the difference between Ethan D.'s spenddown and the Medicaid contract rate. That makes the first \$8,948.10 paid an overpayment.

31. Claim 14. Patient Julian D. received care at MBCH on December 16, 2003. Records for Claim 14, Exhibit 19, p. 7. He had a remaining spenddown of \$7,794.00. Exhibit 20, p. 2. MBCH's usual and customary charge for the services delivered was \$12,924.95. Exhibit 19, p. 7, 10-11. On February 9, 2004, the Department paid \$3,969.72 at the

full Medicaid contract rate for Julian D.'s care. Exhibit 19, p. 11. Julian was also covered by IHS. A1, p. 235. Because the usual and customary charge for MBCH's services exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets the remainder of Julian D.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$3,969.72 paid an overpayment.

32. Claim 15. Patient Karl D. received care at MBCH on August 19, 2005. Records for Claim 15, Exhibit 20, p. 9. He had a remaining spenddown of \$10,638. Exhibit 20, p. 3. MBCH's usual and customary charge for the services delivered was \$18,172.45. Exhibit 20, pp. 6-7, 9-10. On November 7, 2005, the Department paid \$6,003.21 at the full Medicaid contract rate for Karl D.'s care. Exhibit 20, p. 11. Because the usual and customary charge for MBCH's services exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets the remainder of Karl D.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$6,003.21 paid an overpayment.

33. Claim 16. Patient Nathaniel E. received care at MBCH on August 25, 2004. Records for Claim 16, Exhibit 21, p. 10. He had a remaining spenddown of \$6,185.19. Exhibit 21, p. 1. MBCH's usual and

customary charge for the services delivered was \$27,480.50. Exhibit 21, pp. 8, 10. On February 7, 2005, the Department paid \$3,466.03 at the full Medicaid contract rate for Nathaniel E.'s care. Exhibit 21, p. 11. Because the usual and customary charge for MBCH's services exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets the remainder of Nathaniel E.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$3,466.03 paid an overpayment.

34. Claim 23. Patient Samantha H. received care at MBCH on September 20, 2005. Records for Claim 23, Exhibit 28, p. 9. She had a remaining spenddown of \$5,971.20. Exhibit 23, p. 1. MBCH's usual and customary charge for the services delivered was \$3,391.75. Exhibit 23, pp. 6, 17. On January 9, 2006, the Department paid \$508.34 at the full Medicaid contract rate for Samantha H.'s care. Exhibit 23, p. 11. Because the usual and customary charge for MBCH's services exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets the remainder of Samantha H.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$508.34 paid an overpayment.

35. Claim 24. The Department no longer finds Claim 24 overpaid.

36. Claim 25. Patient Grace J. received care at MBCH on March 24, 2005. Records for Claim 25, Exhibit 30, p. 1; Exhibit A1, p. 1093. Grace J. has a brother in her household, Anthony J., who incurred \$6,114.80 in hospital bills from MBCH on March 25, 2005. Exhibit A1, pp. 1091, 1093. The Department did not use Anthony J.'s hospital bills to reduce Grace J.'s spenddown; however, it allowed Anthony J.'s hospital bills at the full Medicaid rate, but failed to make a payment for reasons not established in the record. A1, p. 1092. At the time of service, Grace had a remaining spenddown of \$5,878.00. Exhibit 30, p. 3; Exhibit A-1, 422. MBCH's usual and customary charge for the services delivered was \$10,037.35. Exhibit 30, p. 8. On May 23, 2005, the Department paid \$2,955.70 at the full Medicaid contract rate for Grace J.'s care. Exhibit 17, p. 10. Because the usual and customary charge for MBCH's services exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets the remainder of Grace J.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$2,955.70 paid an overpayment.

37. Claim 26. Patient Elizabeth H. received care at MBCH on September 18, 2004. Records for Claim 26, Exhibit 31, p. 3. She had a remaining spenddown of \$4,691.10. Exhibit 26, pp. 3, 5. MBCH's usual

and customary charge for the services delivered was \$12,090.30. Exhibit 26, pp. 8-12. On April 25, 2005, the Department paid \$3,306.11 at the full Medicaid contract rate for Elizabeth H.'s care. Exhibit 26, p. 12. Because the usual and customary charge for MBCH's services exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets the remainder of Elizabeth H.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$3,306.11 paid an overpayment.

38. Claim 27. Patient Brittany L. received care at MBCH on March 1, 2001. Records for Claim 27, Exhibit 32, p. 1. She had a remaining spenddown of \$26,647.86. Exhibit 32, p. 1. Brittany L. had a \$311 Medicare premium. Testimony of Amparo Panelo. MBCH's usual and customary charge for the services delivered was \$30,357.10. Exhibit 32, p. 19. On March 4, 2002, the Department paid \$19,094.63 at the full Medicaid contract rate for Brittany L.'s care. Exhibit 32, p. 19. Because the usual and customary charge for MBCH's services exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets the remainder of Brittany K.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$19,094.63 paid an overpayment.

39. Claim 35. The Department conceded that it underpaid MBCH by \$1,825 for Claim 35, because it deducted too much for Marcus A.'s spenddown.

40. Claim 47. Patient Khi U. received care at MBCH on April 1, 2005. Records for Claim 47, Exhibit 52, p. 1. He or she had a remaining spenddown of \$9,695.56 after deduction of a prior \$2,603.54 hospital bill from Valley Medical Center. Exhibit 52, p. 4. MBCH's usual and customary charge for the services delivered was \$27,820.50. Exhibit 52, pp. 6, 10, 11. On September 5, 2005, the Department paid \$2,666.42 at the full Medicaid contract rate for Khi U.'s care. Exhibit 52, p. 11. Because the usual and customary charge for MBCH's services exceeds the spenddown, but the Medicaid contract rate is less than the spenddown, the MBCH hospital bill meets the remainder of Khi U.'s spenddown, and the Department, following its methodology, should not have paid any part of the bill. That makes the entire \$2,666.42 paid an overpayment.

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## APPENDIX C

## SPENDDOWN

WAC

519-0110

Spendedown of excess income for the medically needy program.

**WAC 388-519-0110 Spendedown of excess income for the medically needy program.** (1) The person applying for MN medical coverage chooses a three month or a six month base period for spenddown calculation. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section apply.

(2) A person's base period begins on the first day of the month of application, subject to the exceptions in subsection (4) of this section.

(3) A separate base period may be made for a retroactive period. The retroactive base period is made up of the three calendar months immediately prior to the month of application.

(4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:

(a) A three month base period would overlap a previous eligibility period; or

(b) A client is not or will not be resource eligible for the required base period; or

(c) The client is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

(d) The client is or will be eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The client was not otherwise eligible for MN coverage for each of the months of the retroactive base period.

(5) The amount of a person's "spendedown" is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL. The excess income from each of the months in the base period is added together to determine the "spendedown" for the base period.

(6) If income varies and a person's MN countable income falls below the MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 388-519-0100(5).

(7) Once a person's spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount to determine the date of eligibility. The following medical expenses are used to meet spenddown:

(a) First, Medicare and other health insurance deductibles, coinsurance charges, enrollment fees, or copayments;

(b) Second, medical expenses which would not be covered by the MN program;

(c) Third, hospital expenses paid by the person during the base period;

(d) Fourth, hospital expenses, regardless of age, owed by the applying person;

(e) Fifth, other medical expenses, potentially payable by the MN program, which have been paid by the applying person during the base period; and

(f) Sixth, other medical expenses, potentially payable by the MN program which are owed by the applying person.

(8) If a person meets the spenddown obligation at the time of application, they are eligible for MN medical coverage for the remainder of the base period. The beginning date of eligibility would be determined as described in WAC 388-416-0020.

(9) If a person's spenddown amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets the spenddown amount.

(10) To be counted toward spenddown, medical expenses must:

(a) Not have been used to meet a previous spenddown; and

(b) Not be the confirmed responsibility of a third party. The entire expense will be counted unless the third party confirms its coverage within:

(i) Forty-five days of the date of the service; or

(ii) Thirty days after the base period ends; and

(c) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period and be for services for:

(A) The applying person; or

(B) A family member legally or blood-related and living in the same household as the applying person.

(ii) Be for medical services either paid or unpaid and incurred during the base period; or

(iii) Be for medical services paid and incurred during a previous base period if that client payment was made necessary due to delays in the certification for that base period.

(11) An exception to the provisions in subsection (10) of this section exists. Medical expenses the person owes are applied to spenddown even if they were paid by or are subject to payment by a publicly administered program during the base period. To qualify, the program cannot be federally funded or make the payments of a person's medical expenses from federally matched funds. The expenses do not qualify if they were paid by the program before the first day of the base period.

(12) The following medical expenses which the person owes are applied to spenddown. Each dollar of an expense or obligation may count once against a spenddown cycle that leads to eligibility for MN coverage:

(a) Charges for services which would have been covered by the department's medical programs as described in chapter 388-529 WAC, less any confirmed third party payments which apply to the charges; and

(b) Charges for some items or services not typically covered by the department's medical programs, less any third party payments which apply to the charges. The allowable items or services must have been provided or prescribed by a licensed health care provider; and

(c) Medical insurance and Medicare copayments or coinsurance (premiums are income deductions under WAC 388-519-0100(4)); and

(d) Medical insurance deductibles including those Medicare deductibles for a first hospitalization in sixty days.

(13) Medical expenses may be used more than once if:

(a) The person did not meet their total spenddown amount and did not become eligible in that previous base period; and

(b) The medical expense was applied to that unsuccessful spenddown and remains an unpaid bill.

(14) To be considered toward spenddown, written proof of medical expenses must be presented to the department. The deadline for presenting medical expense information is thirty days after the base period ends unless good cause for delay can be documented.

(15) Once a person meets their spenddown and they are issued a medical identification card for MN coverage, newly identified expenses cannot be considered toward that spenddown. Once the application is approved and coverage begins the beginning date of the certification period cannot be changed due to a clients failure to identify or list medical expenses.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090.05-08-093, § 388-519-0110, filed 4/1/07, effective 5/2/05; 98-16-044, § 388-519-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1830, 388-518-1840, 388-519-1905, 388-519-1910, 388-519-1930 and 388-522-2230.]

## Chapter 388-523 WAC MEDICAL EXTENSIONS

### WAC

388-523-0130 Medical extension—Redetermination.

**WAC 388-523-0130 Medical extension—Redetermination.** (1) When the department determines the family or an individual family member is ineligible during the medical extension period, the department must determine if they are eligible for another medical program.

(2) Children are eligible for twelve month continuous eligibility beginning with the first month of the medical extension period.

(3) When a family reports a reduction of income, the family may be eligible for a family medical program instead of medical extension benefits.

(4) Postpartum and family planning extensions are described in WAC 388-462-0015.

[Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-523-0130, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209. 02-10-018, § 388-523-0130, filed 4/22/02, effective 5/23/02.]

## Chapter 388-530 WAC PHARMACY SERVICES

### WAC

388-530-1280 Preferred drug list(s).

**WAC 388-530-1280 Preferred drug list(s).** This section contains the medical assistance administration's (MAA) rules for preferred drug list(s) (PDL). Under RCW 69.41.190 and 70.14.050, MAA and other state agencies cooperate in developing and maintaining preferred drug list(s).

(1) The Washington preferred drug list (PDL):

(a) Washington state contracts with evidence-based practice center(s) for systematic reviews of drug(s).

(b) The pharmacy and therapeutics (P&T) committee reviews and evaluates the safety, efficacy, and outcomes of prescribed drugs, using evidence-based information provided by the evidence-based practice center(s).

[2006 WAC Supp—page 1638]

(c) The P&T committee makes recommendations to state agencies as to which drug(s) to include on the Washington PDL, under chapter 182-50 WAC.

(d) The appointing authority makes the final selection of drugs included on the Washington PDL.

(e) Nonpreferred drugs within a therapeutic class on the Washington PDL are subject to the therapeutic interchange program (TIP) according to WAC 388-530-1290.

(2) The medical assistance administration's (MAA's) PDL. Drugs on MAA's PDL:

(a) Are not part of the Washington PDL;

(b) Are not subject to TIP; and

(c) Continue to require prior authorization when they are designated as nonpreferred.

(3) Combination drugs that are not on the Washington PDL, that are not reviewed by the evidence-based practice center(s), and that are not subject to TIP under WAC 388-530-1290, are considered for coverage according to MAA's prior authorization program.

[Statutory Authority: RCW 69.41.190, 70.14.050, and 74.08.090. 05-11-078, § 388-530-1280, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1280, filed 12/30/04, effective 1/30/05.]

## Chapter 388-531 WAC

### PHYSICIAN-RELATED SERVICES

#### WAC

388-531-0150	Noncovered physician-related services—General and administrative.
388-531-0200	Physician-related services requiring prior authorization.
388-531-0250	Who can provide and bill for physician-related services.
388-531-0650	Hospital physician-related services not requiring authorization when provided in MAA-approved centers of excellence or hospitals authorized to provide the specific services.
388-531-1600	Bariatric surgery.
388-531-2000	Increased payments for physician-related services for qualified trauma cases.

**WAC 388-531-0150 Noncovered physician-related services—General and administrative.** (1) Except as provided in WAC 388-531-0100 and subsection (2) of this section, MAA does not cover the following:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation;

(d) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness;

(e) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 388-501-0165;

(f) Hair transplantation;

(g) Marital counseling or sex therapy;

(h) More costly services when MAA determines that less costly, equally effective services are available;

(i) Vision-related services listed as noncovered in chapter 388-544 WAC;

COLA does not effect the eligibility of either applicants or clients of Medicare savings programs until April 1st of each year.

(6) The department pays the following benefits for Medicare savings program clients:

(a) Under the QMB program: Medicare Part A if any, Part B premiums, coinsurance, deductibles as described in subsection (7) of this section, and medical expenses the client's Medicare managed care plan charges;

(b) Under the SLMB or QI-1 programs: Only Medicare Part B premiums (see the exception under subsection (11) of this section);

(c) Under the QDWI program: Only Medicare Part A premiums;

(d) Under the QI-2 program: Only a part of the client's Medicare Part B premiums. The Centers for Medicare and Medicaid (CMS) determine the amount which is paid. The department pays the client on an annual basis (see the exception under subsection (11) of this section); and

(e) Under the state-funded buy-in program: Medicare Part B premiums, coinsurance, deductibles as described in subsection (7) of this section, and medical expenses a client's Medicare managed care plan charges.

(7) The department has certain maximum payments for services provided to Medicare savings programs clients:

(a) Medicare co-insurance charges are paid only if the Medicaid payment rate is higher than the amount paid by Medicare, and within that limit, only the cost-sharing liability;

(b) Dual eligible clients are those who are eligible for QMB and SLMB programs and another Medicaid program. For dual eligibles, the department's maximum payment is:

(i) for covered services, the Medicaid or the Medicare payment rate whichever is lower; and

(ii) for services only covered by Medicare, the Medicare deductibles and co-insurance is the maximum Medicaid payment.

(8) The department does authorize QMB, SLMB or state-funded buy-in programs for the client receiving categorically needy (CN) or medically needy (MN) programs. The state-funded buy-in program is only for a client receiving CN or MN medical coverage who is not eligible for the QMB or SLMB programs.

(9) The department does not authorize QI-1, QI-2, or QDWI programs for a client receiving CN or MN medical program benefits.

(10) The department does not authorize the QI-2 program for a client who is eligible for one of the other Medicare savings programs.

(11) When the department's annual allotment of federal funds for the QI-1 and QI-2 programs is exhausted, the department does not authorize benefits under the respective program for the remainder of that calendar year.

(12) For certification periods for the Medicare savings programs, refer to WAC 388-416-0035.

[Statutory Authority: RCW 74.08.090, 74.09.530, 02-11-074, § 388-517-0300, filed 5/13/02, effective 6/13/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-517-0300, filed 3/1/98, effective 9/1/98. Formerly WAC 388-517-1710, 388-517-1730, 388-517-1750 and 388-517-1770.]

[Title 388 WAC—p. 968]

**WAC 388-517-0400 Medicare coinsurance payment—Extended care patient.** The department will pay for a long-term care client's Medicare coinsurance if the:

(1) Client is eligible for extended care Medicare benefits;

(2) Client is eligible for Medicaid, qualified Medicare beneficiary (QMB) program, or the special low-income Medicare beneficiary (SLMB) program; and

(3) Medicare coinsurance costs less than the Medicaid nursing facility rate.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055, 01-06-033, § 388-517-0400, filed 3/2/01, effective 4/2/01.]

## Chapter 388-519 WAC

### SPENDDOWN

#### WAC

388-519-0100

Eligibility for the medically needy program.

388-519-0110

Spenddown of excess income for the medically needy program.

#### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-519-0120

Spenddown—Medically indigent program. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-519-0120, filed 7/31/98, effective 9/1/98. Formerly WAC 388-519-1905.] Repealed by 04-20-045, filed 9/30/04, effective 10/31/04. Statutory Authority: RCW 74.08.090 and 34.05.353(2).

388-519-1905

Base period. [Statutory Authority: RCW 74.08.090 and Budget Note 17, 96-16-092, § 388-519-1905, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090, 95-22-039 (Order 3913, #100246), § 388-519-1905, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-519-1905, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-416-0025 and 388-519-0120.

388-519-1910

Allowable income deductions and exemptions. [Statutory Authority: RCW 74.08.090, 96-14-057 (Order 3986), § 388-519-1910, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1910, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-020 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0020, 388-450-0110, 388-450-0150, 388-450-0210 and 388-519-0110.

388-519-1930

Computing spenddown; allowable spenddown expenses. [Statutory Authority: RCW 74.08.090, 96-14-057 (Order 3986), § 388-519-1930, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1930, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-020 and 388-99-030.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-519-0100 and 388-476-0070.

388-519-1950

Institutional spenddown. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-519-1950, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

**WAC 388-519-0100 Eligibility for the medically needy program.** (1) A person who meets the following conditions is considered for medically needy (MN) coverage under the special rules in chapter 388-513 WAC.

(a) A person who meets the institutional status requirements of WAC 388-513-1320; or

(2005 Ed.)

(b) A person who receives waiver services under chapter 388-515 WAC.

(2) MN coverage is considered under this chapter when:

(a) Is not excluded under subsection (1) of this section;

and

(b) Is not eligible for categorically needy (CN) medical coverage because they have CN countable income which is above the CN income standard.

(3) MN coverage is available for children, for persons who are pregnant or for persons who are SSI-related. MN coverage is available to an aged, blind, or disabled ineligible spouse of an SSI recipient even though that spouse's countable income is below the CN income standard. Adults with no children must be SSI related in order to be qualified for MN coverage.

(4) A person not eligible for CN medical and who is applying for MN coverage has the right to income deductions in addition to those used to arrive at CN countable income. The following deductions are used to calculate their countable income for MN. Those deductions to income are applied to each month of the base period and determine MN countable income:

(a) All health insurance premiums expected to be paid by the client during the base period are deducted from their income; and

(b) For persons who are SSI-related and who are married, see the income provisions for the nonapplying spouse in WAC 388-450-0210; and

(c) For persons who are not SSI-related and who are married, an income deduction is allowed for a nonapplying spouse:

(i) If the nonapplying spouse is living in the same home as the applying person; and

(ii) The nonapplying spouse is receiving community and home based services under chapter 388-515 WAC; then

(iii) The income deduction is equal to the one person MNIL less the nonapplying spouse's actual income.

(5) A person who meets the above conditions is eligible for MN medical coverage if their MN countable income is at or below the medically needy income level (MNIL) in WAC 388-478-0070. They are certified as eligible for up to twelve months of MN medical coverage. Certain SSI or SSI-related clients have a special MNIL. That MNIL exception is described in WAC 388-513-1305.

(6) A person whose MN countable income exceeds the MNIL may become eligible for MN medical coverage when they have or expect to have medical expenses. Those medical expenses or obligations may be used to offset any portion of their income which is over the MNIL.

(7) That portion of a person's MN countable income which is over the department's MNIL standard is called "excess income."

(8) When a person has or will have "excess income" they are not eligible for MN coverage until they have medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown."

(9) A person who is considered for MN coverage under chapter 388-515 WAC may not spenddown excess resources to become eligible for the MN program. Under this chapter a person is ineligible for MN coverage if their resources exceed the program standard in WAC 388-478-0070. A person who is considered for MN coverage under chapter 388-513 WAC is allowed to spenddown excess resources.

(10) No extensions of coverage or automatic redetermination process applies to MN coverage. A client must submit an application for each eligibility period under the MN program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0320, 388-518-1840, 388-519-1930 and 388-522-2230.]

**WAC 388-519-0110 Spenddown of excess income for the medically needy program.** (1) The person applying for MN medical coverage chooses a three month or a six month base period for spenddown calculation. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section apply.

(2) A person's base period begins on the first day of the month of application, subject to the exceptions in subsection (4) of this section.

(3) A separate base period may be made for a retroactive period. The retroactive base period is made up of the three calendar months immediately prior to the month of application.

(4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:

(a) A three month base period would overlap a previous eligibility period; or

(b) A client is not or will not be resource eligible for the required base period; or

(c) The client is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

(d) The client is or will be eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The client was not otherwise eligible for MN coverage for each of the months of the retroactive base period.

(5) The amount of a person's "spenddown" is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL. The excess income from each of the months in the base period is added together to determine the "spenddown" for the base period.

(6) If income varies and a person's MN countable income falls below the MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 388-519-0100(5).

(7) Once a person's spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount to determine the date of eligibility. The following medical expenses are used to meet spenddown:

(a) First, Medicare and other health insurance deductibles, coinsurance charges, enrollment fees, or copayments;

(b) Second, medical expenses which would not be covered by the MN program;

(c) Third, hospital expenses paid by the person during the base period;

(d) Fourth, hospital expenses, regardless of age, owed by the applying person;

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(e) Fifth, other medical expenses, potentially payable by the MN program, which have been paid by the applying person during the base period; and

(f) Sixth, other medical expenses, potentially payable by MN program which are owed by the applying person.

(8) If a person meets the spenddown obligation at the time of application, they are eligible for MN medical coverage for the remainder of the base period. The beginning date of eligibility would be determined as described in WAC 388-416-0020.

(9) If a person's spenddown amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets the spenddown amount.

(10) To be counted toward spenddown, medical expenses must:

(a) Not have been used to meet a previous spenddown; and

(b) Not be the confirmed responsibility of a third party. The entire expense will be counted unless the third party confirms its coverage within:

(i) Forty-five days of the date of the service; or

(ii) Thirty days after the base period ends; and

(c) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period and be for services for:

(A) The applying person; or

(B) A family member legally or blood-related and living in the same household as the applying person.

(ii) Be for services received and paid for during the base period; or

(iii) Be for services received and paid for during a previous base period if that client payment was made necessary due to delays in the certification for that base period.

(11) An exception to the provisions in subsection (10) of this section exists. Medical expenses the person owes are applied to spenddown even if they were paid by or are subject to payment by a publicly administered program during the base period. To qualify, the program cannot be federally funded or make the payments of a person's medical expenses from federally matched funds. The expenses do not qualify if they were paid by the program before the first day of the base period.

(12) The following medical expenses which the person owes are applied to spenddown. Each dollar of an expense or obligation may count once against a spenddown cycle that leads to eligibility for MN coverage:

(a) Charges for services which would have been covered by the department's medical programs as described in chapter 388-529 WAC, less any confirmed third party payments which apply to the charges; and

(b) Charges for some items or services not typically covered by the department's medical programs, less any third party payments which apply to the charges. The allowable items or services must have been provided or prescribed by a licensed health care provider; and

(c) Medical insurance and Medicare copayments or coinsurance (premiums are income deductions under WAC 388-0100(4)); and

(d) Medical insurance deductibles including those Medicare deductibles for a first hospitalization in sixty days.

(13) Medical expenses may be used more than once if:

(a) The person did not meet their total spenddown amount and did not become eligible in that previous base period; and

(b) The medical expense was applied to that unsuccessful spenddown and remains an unpaid bill.

(14) To be considered toward spenddown, written proof of medical expenses must be presented to the department. The deadline for presenting medical expense information is thirty days after the base period ends unless good cause for delay can be documented.

(15) Once a person meets their spenddown and they are issued a medical identification card for MN coverage, newly identified expenses cannot be considered toward that spenddown. Once the application is approved and coverage begins the beginning date of the certification period cannot be changed due to a client's failure to identify or list medical expenses.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-519-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1830, 388-518-1840, 388-519-1905, 388-519-1910, 388-519-1930 and 388-522-2230.]

## Chapter 388-523 WAC MEDICAL EXTENSIONS

### WAC

388-523-0100

388-523-0110

388-523-0120

388-523-0130

Medical extensions—Eligibility.

Medical extensions—Reporting requirements.

Medical extensions—Premiums.

Medical extension—Redetermination.

### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-523-2305

Medical extensions. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997, 98-15-066, § 388-523-2305, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-523-2305, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-029.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.

388-523-2320

Medicaid quarterly reporting. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-523-2320, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.

### WAC 388-523-0100 Medical extensions—Eligibility.

(1) A family who received temporary assistance for needy families (TANF), or family medical program in any three of the last six months in the state of Washington is eligible for extended medical benefits when they become ineligible for their current medical program because the family receives:

(a) Child or spousal support, which exceeds the payment standard described in WAC 388-478-0065, and they are not eligible for any other categorically needy (CN) medical program; or

(b) Increased earned income, resulting in income exceeding the CN income standard described in WAC 388-478-0065.