

Chapter 20:

Government Payors of Medical Services

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Chapter Outline

20.1	Chapter Summary	2
20.2	Medicare.....	2
	20.2.1 Overview	2
	20.2.2 Part A.....	3
	20.2.3 Part B.....	6
	20.2.4 Part C (Medicare Advantage).....	9
	20.2.5 Part D (Prescription Drug Plans).....	10
	20.2.6 Medicare Audits	12
	20.2.7 Medicare Appeals.....	13
20.3	Other Federal Health Care Programs	14
	20.3.1 TRICARE.....	14
	20.3.2 Veteran’s Administration Healthcare System (“VA”).....	16
	20.3.3 Federal Employee Health Benefits Program (“FEHBP”).....	17
	20.3.4 Indian Health Service (“IHS”).....	18
20.4	Medicaid	19
	20.4.1 Overview	19
	20.4.2 Medicaid Eligibility.....	20
	20.4.3 Medicaid Coverage.....	21
	20.4.4 Medicaid Financing.....	22
	20.4.5 Medicaid Payment Methodology.....	22
	20.4.6 Washington Medicaid Waivers	23
	20.4.7 Medicaid Audits	24
	20.4.8 Medicaid Appeals.....	26
20.5	Children’s Health Insurance Program (“CHIP”).....	26
20.6	Other State Medical Programs.....	27
	20.6.1 Public Employee Benefits Board.....	27
	20.6.2 Washington State Department of Labor and Industries (“L&I”).....	27
	20.6.3 Washington State Health Insurance Pool	28

Volume 3: Financing and Engaging in the Business of Healthcare

20.1 Chapter Summary

Federal, state, and local governments pay for a large percentage of total health care costs in the United States, either by directly reimbursing providers for care rendered to patients, or through subsidies paid to private insurers for the purchase of insurance by individuals. The two largest government programs, Medicare and Medicaid, together currently insure about 27 percent of the American population.¹ In 2012, these programs accounted for 36 percent of national health care expenditures.² By 2023, the Centers for Medicare & Medicaid Services (“CMS”) estimates that federal, state, and local governments will pay for 48 percent of national health care expenditures, with the increase largely driven by Medicaid coverage expansion and cost-sharing, and premium subsidies for private insurance mandated by the Affordable Care Act (“ACA”).³ Due to the sheer size of government health care programs, and the fact that the private health insurance industry often looks to them to set standards for the entire industry, at least a basic understanding of government programs that pay for health care is critical to an understanding of health care payment and delivery in Washington State.

This chapter provides basic information about the coverage and payment structures of the largest and most prominent government health insurance programs in Washington State, including Medicare, the Indian Health Service (“IHS”), TRICARE, the Veteran’s Administration (“VA”), the Federal Employee Health Benefits Program (“FEHBP”), Apple Health (Washington’s Medicaid program), and the State Children’s Health Insurance Program (“CHIP”). All of these programs are complex. This chapter provides a basic overview of these programs. Lawyers working in this area will need to delve more deeply into the specific statutes, rules, regulations, and administrative pronouncements that govern specific programs of interest.

20.2 Medicare

20.2.1 Overview

Medicare was established in 1965 through amendments to the Social Security Act (Pub. L. 89-97).⁴ Medicare is an entirely federally funded health insurance program, funded mainly through general tax revenues, payroll taxes paid by both employers and employees, and premiums for certain services paid by those who use Medicare services, known as beneficiaries. The program is administered by CMS, which is a division of the United States Department of Health and Human Services (“HHS”). Most Medicare beneficiaries are United States citizens aged 65 and older, although there are some other groups who are Medicare-eligible.⁵

Medicare is divided into four distinct parts, Parts A through D. Part A generally covers the costs of inpatient care in the hospital, care in a skilled nursing facility following a stay in an inpatient hospital, hospice care, and qualified home health services.⁶ Part B generally covers outpatient care, including physicians’ services, some home health care, physical and occupational therapy, durable medical equipment, laboratory services, and ambulance services.⁷ Part C, also known as “Medicare Advantage,” consists of Medicare managed care plans, which provide comprehensive services including those traditionally covered separately by Parts A and B.⁸ Part D is a prescription drug benefit, which became effective in 2006.⁹ In addition, some insurers offer combined Medicare Advantage and Medicare Part D plans, which are attractive to beneficiaries seeking comprehensive coverage from a single insurer.

CMS contracts with private entities throughout the country to administer claims payments under the

¹ CMS Office of the Actuary, National Health Expenditure Projections 2013-2023, Forecast Summary and Selected Tables (June 2013), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>.

² *Id.*

³ *Id.*

⁴ See 42 U.S.C. §§1395 *et seq.* (Medicare is also referred to as “Title XVIII” of the Social Security Act).

⁵ See, e.g. 42 U.S.C. §§426, 1395c (eligibility upon reaching age 65); 42 U.S.C. §426(b) (disabled); 42 U.S.C. §426-1 (persons with end stage renal disease); 42 U.S.C. §426(h) (persons with amyotrophic lateral sclerosis).

⁶ See 42 U.S.C. §1395d (2009) (describing Part A coverage).

⁷ See 42 U.S.C. §§1395k, 1395x (2009); 42 C.F.R. §410.3 (2002) (describing Part B coverage).

⁸ See 42 U.S.C. §1395w-22 (2009) (describing Part C).

⁹ See 42 U.S.C. §1395w-101 *et seq.* (2009) (describing Part D).

program, commonly known as Medicare Administrative Contractors (“MACs”).¹⁰ CMS also contracts with private entities to administer payments for specialized services, such as durable medical equipment, prosthetics, orthotics and supplies (“DMEPOS”), home health, and hospice. In Washington State, the MAC and DMEPOS is currently Noridian Health Care Solutions.¹¹

The ACA did not make major structural changes to the Medicare program. It did, however, make some changes to payment methodology and payment amounts, designed to contain cost and slow spending growth in the program. Changes made to the Medicare program by the ACA will be discussed below in the context of their effects on a specific part of the Medicare program.

20.2.2 Part A

Medicare Part A covers primarily inpatient hospitalization, but also covers limited post-hospital extended-care services, limited extended-care services that are not post-hospital care services, some home health services, certain hospice care, and inpatient psychiatric hospital care.¹² It is funded by the Medicare Hospital Insurance Trust, which is primarily funded by federal payroll taxes, with additional funds coming from general federal tax revenues, enrollee premiums, and interest on trust investments.¹³

A person who has worked in Medicare-eligible employment for 10 years, or has a spouse who has worked in Medicare-eligible employment for 10 years, is automatically eligible for Part A benefits when he or she reaches age 65.¹⁴ U.S. citizens and lawful permanent residents of at least five years over age 65, not otherwise eligible for Medicare, may voluntarily enroll in Part A by paying a monthly premium. The monthly premium is \$407 for 2015.¹⁵ Medicare Part A is also available before age 65 to people suffering from end-stage renal disease (“ESRD”), people suffering from amyotrophic lateral sclerosis (“ALS”), and people who have been receiving Social Security disability benefits for at least two years.¹⁶ These groups are not required to pay a monthly premium for Part A coverage.

Part A covers up to 90 days of inpatient hospital care during any “spell of illness,” which is defined as a period of time beginning the day a beneficiary is hospitalized or admitted to a nursing home and ending 60 days after the beneficiary’s release from the hospital or skilled nursing facility.¹⁷ Beneficiaries must pay a yearly deductible, set at \$1,260 for 2015.¹⁸ Starting on the 61st day of inpatient care, through the 90th day, a beneficiary must also pay coinsurance of \$315 per day in 2015.¹⁹ Beneficiaries also have 60 “lifetime reserve days” which can be used at any time over the course of the beneficiary’s lifetime.²⁰ Lifetime reserve days are subject to coinsurance of \$630 per day in 2015.²¹ The beneficiary must affirmatively elect to use the lifetime reserve days.²² Washington, like most other states, assists certain low-income and/or disabled individuals by subsidizing their premiums, deductibles, and coinsurance payments for Medicare

¹⁰ See <http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors.html>. Contractors that administer the Part A program were previously referred to as “fiscal intermediaries.” Contractors that administer the Part B program were previously referred to as “carriers.” These terms are sometimes still used.

¹¹ See <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/#wa>.

¹² See 42 U.S.C. §1395d (2009).

¹³ 42 U.S.C. §1395i (2009); 26 U.S.C. §§1401(b), 1411, 3191(b), 3111(b) (2010).

¹⁴ 42 U.S.C. §§426 (2010), 1395 (2009).

¹⁵ See Medicare 2014 & 2015 Costs at a Glance, <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>.

¹⁶ 42 U.S.C. §§426(b), 426-1, 426(h) (2010).

¹⁷ 42 U.S.C. §§1395d(a); 1395x(a) (2009).

¹⁸ See Medicare 2014 & 2015 Costs at a Glance, available at <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>; 42 U.S.C. §1395x(a)(1)-(2) (2009).

¹⁹ *Id.*

²⁰ 42 U.S.C. §1395(d)(a) (2009).

²¹ See Medicare 2014 & 2015 Costs at a Glance, *supra* note 15.

²² 42 C.F.R. §409.65(a)(3) (2009).

Volume 3: Financing and Engaging in the Business of Healthcare

Part A.²³ Inpatient services covered under Part A include:

- Bed and board;
- Nursing services and other related services;
- Use of hospital facilities;
- Medical social services;
- Drugs, biologicals, supplies, appliances, and equipment;
- Certain diagnostic or therapeutic services;
- Medical or surgical services provided by interns or residents-in-training; and
- Transportation services (including transport by ambulance).²⁴

Part A beneficiaries are also covered for up to 100 days of post-inpatient hospital extended care services in a skilled nursing facility (“SNF”) if the beneficiary transfers to a SNF within 30 days of a qualified inpatient hospital stay that lasts at least three days.²⁵ There is no coinsurance for the first 20 days of care in a SNF, but for days 21 through 100, a coinsurance amount of \$157.50 per day attaches in 2015.²⁶ Part A also covers some home health care with no coinsurance, including part-time or intermittent nursing or home health care, physical, occupational, and speech therapy, medical social services, drugs, biologicals, and medical supplies.²⁷ Durable medical equipment is covered, but the beneficiary will pay 20% of the Medicare-approved amount as coinsurance.²⁸

Hospice care is also covered under Part A, if a beneficiary is terminally ill and a doctor certifies that the beneficiary is expected to live six months or less.²⁹ The beneficiary may need to make small copayments for prescription drugs, and 5% coinsurance for inpatient respite care.³⁰ The Medicare hospice benefit does not cover room and board in a hospice facility or in one’s own home while the beneficiary is receiving hospice care.³¹

Health care entities providing services that are reimbursed under Medicare Part A are called “providers.” References to “provider of services” in the Medicare program mean a hospital, SNF, comprehensive outpatient rehabilitation facility (“CORF”), hospice, home health agency, ESRD facility, Federally Qualified Health Center (“FQHC”), Rural Health Clinic (“RHC”) or organ procurement organization.³² Providers who wish to participate in the Medicare program must enter into provider agreements by which they agree to accept the payment amount Medicare authorizes, plus permitted deductibles and coinsurance, as payment in full, as well as comply with other specified conditions of participation.³³

Providers of inpatient hospital services are paid under Medicare Part A according to the Medical Severity Diagnosis Related Group (“MS-DRG”) inpatient prospective payment system (“IPPS”).³⁴ Under IPPS, providers are paid prospectively fixed rates for treatment for a particular diagnosis, based on the average resources used by an efficient hospital to treat patients with that particular diagnosis.³⁵ IPPS payments can be adjusted based on the presence of comorbidities and/or major complications that present along with the

²³ See <http://www.dshs.wa.gov/esa/community-services-offices/medicare-savings-program>.

²⁴ See 42 U.S.C. §§1395x(b) (2010); 42 C.F.R. §§409.10 – 409.18 (2010).

²⁵ 42 U.S.C. §§1395d(a)(2), (f), 1395x(i) (2009).

²⁶ See Medicare 2014 & 2015 Costs at a Glance, *supra* note 15.

²⁷ 42 U.S.C. §1395d(a)(3) (2010).

²⁸ 42 U.S.C. §1395x(m) (2010); 42 C.F.R. §§409.40-409.50 (2010).

²⁹ 42 U.S.C. §§1395d(a)(4), d(d) (2009).

³⁰ 42 U.S.C. §1395e(a)(4) (2010).

³¹ See Medicare Hospice Benefits, <http://www.medicare.gov/Pubs/pdf/02154.pdf>.

³² 42 U.S.C. §1395x(u) (2010).

³³ 42 U.S.C. §§1395cc (2010); 42 C.F.R. Parts 482-489.

³⁴ See Social Security Amendments of 1983, Pub. L. No. 98-21 (1983); 73 Fed. Reg. 48434 (Aug. 19, 2008).

Medicare also uses a prospective payment system to reimburse long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and distinct part units.

³⁵ See Barry R. Furrow et al., *Health Law* 424-425 (3d ed. 2015).

Chapter 20: Government Payors of Medical Services

(prepared from reference materials available as of December 31, 2014)

primary discharge diagnosis and up to eight secondary diagnoses.³⁶ Each hospital discharge is assigned to one of 751 MS-DRGs.³⁷ Each MS-DRG is assigned a relative weight, based on the historic average costs of the cases in that MS-DRG compared to historic average costs for all other cases.³⁸

Under IPPS, a hospital's initial payment for inpatient services rendered to Medicare beneficiaries consists of a "standardized amount," which takes into account a hospital's labor-related costs, non-labor-related costs, and capital costs.³⁹ The base year for the standardized amount is 1981, which has been updated yearly by an inflationary factor set by Congress.⁴⁰ Hospitals in large urban areas (over 1 million in population) receive one standardized amount, and a different standardized amount is used for hospitals in other locations.⁴¹ In addition, the labor-related cost share of the standardized amount is adjusted by a "wage index" applicable to the geographic area in which the hospital is located.⁴²

The standardized amount components are then multiplied by the MS-DRG relative weight and added together to yield the initial IPPS payment amount.⁴³ A hospital may also be eligible to receive a number of add-ons to its initial IPPS payment, including enhancements for treating a high percentage of low-income patients (disproportionate share or "DSH" adjustments), for training medical residents (indirect medical education or "IME"), or for treating a patient whose care substantially exceeded expected costs ("outliers").⁴⁴ Certain rural hospitals also receive enhancements to their IPPS payments, in order to maintain access to services for Medicare beneficiaries who live in far-flung areas.⁴⁵ The initial IPPS payment may be reduced if a patient is discharged to another care setting, and the length of stay at the discharging facility is below average for the MS-DRG assigned.⁴⁶

Medicare Part A also pays for the direct costs of medical education programs in teaching hospitals (graduate medical education or "GME" payments).⁴⁷ It also reimburses inpatient hospitals for a percentage of the unpaid coinsurance and deductibles they incur when Medicare beneficiaries fail to pay their own cost-sharing ("Medicare bad debt").⁴⁸ Reasonable organ acquisition costs and some costs for new medical services or technologies that are inadequately paid under the applicable MS-DRG may also be reimbursed. The total IPPS plus these pass-through payments constitute the entire amount paid by Medicare Part A to a hospital for a payment period.⁴⁹

In order to control escalating Medicare costs under IPPS, CMS has instituted a number of "pay-for-performance" programs which link program payments to achievements of certain quality measures. Under the Inpatient Quality Report ("IQR") program, hospitals are required to report on specified quality measures.⁵⁰ Hospitals failing to report are penalized via a reduction to the annual IPPS inflationary update factor.⁵¹ Furthermore, Medicare does not pay hospitals for costs of treating conditions that occur due to certain preventable errors, known as "never events" (such as surgery on wrong body part).⁵² Payments to

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.* at 425.

⁴⁰ See Acute Care Hospital Inpatient Prospective Payment System, <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctst.pdf>.

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ See Hospital Inpatient Quality Reporting Program, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html>.

⁵¹ *Id.*

⁵² See CMS State Medicaid Directors' Letter, <http://downloads.cms.gov/cmsgov/archived->

Volume 3: Financing and Engaging in the Business of Healthcare

hospitals for hospital-acquired conditions (“HACs”) may be reduced, and under the ACA, hospitals that are in the top 25% of national rates for HACs will have their base MS-DRG payments for all discharges reduced by 1%.⁵³ Examples of HACs include retention of foreign objects in the body after surgery, blood incompatibility, and falls and fractures while in the hospital.⁵⁴

Under the ACA, Part A payments to hospitals are reduced by specified percentages for what CMS considers to be preventable hospital readmissions for heart attacks, heart failure, and pneumonia, and as of 2015 for hip and knee replacements and chronic obstructive pulmonary disease (“COPD”).⁵⁵ The ACA also mandates a reduction in DSH payments to hospitals of \$22.1 billion between federal fiscal years 2014-19, under the rationale that hospitals will see fewer uninsured patients because of the ACA’s expansion of Medicaid and the expected greater availability of private health insurance to previously uninsured people under the ACA.⁵⁶ CMS has also instituted a value-based purchasing (“VBP”) initiative, which is funded through reduction in IPPS initial payments to all hospitals.⁵⁷ The withheld funds are redistributed to eligible hospitals engaged in value-based purchasing.⁵⁸

A limited number of hospitals remain IPPS-exempt or are reimbursed under a different methodology. These include cancer care hospitals, children’s hospitals, and renal transplantation centers.⁵⁹ Skilled nursing facilities, home health, and hospice services are also reimbursed under separate prospective payment systems.⁶⁰

20.2.3 Part B

Medicare Part B covers “medical and other health services,” as long as they are “medically necessary.”⁶¹ Excluded from coverage are those services which CMS does not consider to be “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”⁶² CMS clarifies and interprets this very general statutory coverage prohibition by promulgating National Coverage Determinations (“NCDs”) and Medicare Coverage Manuals. In addition, MACs or other CMS contractors make Local Coverage Determinations (“LCDs”) for services and supplies that are not the subject of an NCD or manual provision, and MACs make specific coverage decisions in individual cases.

Part B coverage is available to anyone who is eligible for Part A coverage, but unlike Part A coverage, enrollment in Part B is not automatic.⁶³ Beneficiaries must affirmatively enroll in Part B, and are required to pay a monthly premium.⁶⁴ In 2015, for most Medicare beneficiaries, the monthly premium is \$104.90, but for higher-income beneficiaries, the premium is higher.⁶⁵ Part B also carries a small yearly deductible (\$147 for 2015), and for most physicians’ services, outpatient therapies, and durable medical equipment, a 20 percent coinsurance requirement.⁶⁶ Certain preventive and screening services are covered with no coinsurance under Part B.⁶⁷ Washington State, like most other states, assist certain low-income and/or disabled individuals by subsidizing their premiums, deductibles, and coinsurance payments for Medicare

[downloads/SMDL/downloads/SMD073108.pdf](#).

⁵³ See Patient Protection and Affordable Care Act (“ACA”), Pub. L. 111-148, § 3008, 24 Stat. 119 (2010).

⁵⁴ *Id.* §3025.

⁵⁵ *Id.*

⁵⁶ *Id.* §3133.

⁵⁷ See Acute Care Hospital Inpatient Prospective Payment System, *supra* note 40.

⁵⁸ *Id.*

⁵⁹ 42 C.F.R. §§412.23(d), (f), 412.22(c), 412.100 (2011).

⁶⁰ See, e.g. 42 C.F.R. Part 412, subparts O, P, and N (2011).

⁶¹ 42 C.F.R. §410.12(a)(3) (2011).

⁶² 42 U.S.C. §1395y(a)(1)(A) (2010).

⁶³ 42 U.S.C. §1395o (2010).

⁶⁴ 42 U.S.C. §1395q(b) (2010).

⁶⁵ See Medicare 2014 & 2015 Costs at a Glance, *supra* note 15.

⁶⁶ *Id.*

⁶⁷ 42 U.S.C. §1395l(a)(1)(B), (b)(1) (2010).

Part B.⁶⁸

Services covered under Part B include, among other things:

- Physicians' services and services performed by physicians' assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives;
- Outpatient hospital services;
- Clinical social worker services;
- Diagnostic services furnished to outpatients by or under arrangements made by a hospital;
- Prescription drugs used in immunosuppressive therapy;
- X-ray therapy and other radiation therapy services;
- Medical supplies, appliances, and devices;
- Durable medical equipment;
- Ambulance services;
- Qualified rural health clinic services;
- Institutional and home dialysis services, supplies and equipment;
- Outpatient physical and occupational therapy, and speech pathology services.⁶⁹

A health care professional or entity that provides services payable under Medicare Part B is known as a "supplier;"⁷⁰ nevertheless, hospitals which accept both Part A and Part B are universally called "providers."

Most outpatient hospital services are paid under the Outpatient Prospective Payment System ("OPPS").⁷¹ OPPS assigns services into Ambulatory Payment Classifications ("APCs") based on resource utilization and costs for each service.⁷² Unlike IPPS DRGs, hospitals may be paid on multiple APCs for different services furnished during a single outpatient encounter.⁷³ APC payment amounts are calculated by multiplying the APC relative weight times a conversion factor that is set annually by CMS. This figure is then adjusted to account for geographic differences in labor and non-labor costs.⁷⁴ In order to control costs and ensure efficiency, supplies (including drugs) related to a particular outpatient service are "bundled" and are included in the APC payment, rather than being paid separately.⁷⁵ Likewise, if multiple procedures are performed in a single encounter, discounts apply to the separate APC payments for the procedures.⁷⁶ Services provided by a hospital to an outpatient, which are paid under a separate fee schedule, are excluded from OPPS, as are certain services that CMS considers to be "inpatient only." Like IPPS, certain payments are added on to OPPS hospital payments.⁷⁷ Additional payment may be made for outliers, new technologies, and certain new chemotherapy and immunosuppressive drugs.⁷⁸

Suppliers desiring to bill the Medicare program must choose either to participate in the Medicare program by signing a participation agreement, or to be "non-participating." If a supplier participates in Medicare, the supplier agrees to accept the Medicare allowable amount (generally 80 percent program payment plus the 20 percent patient coinsurance) as payment in full for the service provided.⁷⁹ Participation in the Medicare program is mandatory for certain services and suppliers, such as non-physician professionals and

⁶⁸ See <http://www.dshs.wa.gov/esa/community-services-offices/medicare-savings-program>.

⁶⁹ 42 U.S.C. §1395x(s) (2010).

⁷⁰ 42 C.F.R. §400.202 (2010).

⁷¹ See Quick Facts About Payment for Outpatient Services for People with Medicare Part B, <http://www.medicare.gov/Pubs/pdf/02118.pdf>.

⁷² See Hospital Outpatient Prospective Payment System, (Jan. 2014), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsh.pdf>.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ See 42 U.S.C. §§1395u(i)(1)-(2) and 1395u(b)(3)(B)(ii) (2009).

clinical diagnostic laboratories. Non-participating suppliers are limited to receiving 95 percent of the Medicare fee schedule amount, and cannot charge the beneficiary more than 115 percent of the fee schedule amount (“the limiting charge”).⁸⁰

Under most circumstances, physicians and practitioners are required to submit claims to the program on behalf of Medicare beneficiaries for all services for which Medicare may make payment under Part B. However, physicians and some non-physician practitioners may opt out of the Medicare program entirely by entering into private contracts with their Medicare patients and following program requirements for opting out.⁸¹ A practitioner choosing to opt out of Medicare must do so on a global basis. The practitioner cannot pick and choose which Medicare patients will be billed privately and for which patients Medicare will be billed. A practitioner who opts out of Medicare may not bill Medicare for anything for a period of two years.⁸² Patients of an opt-out practitioner must agree to be responsible for all physician charges, without any Medicare billing limits.⁸³ Some practitioners, such as chiropractors and physical and occupational therapists in private practice, are not permitted to opt out of Medicare.⁸⁴

Part B pays for professional services based on fee schedules, which vary depending on practice setting and type of practitioner rendering the service.⁸⁵ Although Part B payment is required to be the lesser of either the actual charge for the service or the fee schedule amount, CMS does not dictate what practitioners may charge. Because practitioner charges are almost invariably higher than the fee schedule, virtually all Part B services are paid based on the relevant fee schedule.

For physicians, CMS uses a methodology called the Resource-Based Relative Value Unit System (“RBRVS”) to determine the Part B fee schedule.⁸⁶ To set payment under RBRVS, CMS first considers the amount of work required to provide a particular service based upon relative value units (“RVUs”).⁸⁷ RVUs measure the cost of a particular physicians’ service relative to other physicians’ services.⁸⁸ There are three components to RVUs, which represent the cost to the physician of providing the service: work, practice expense, and liability insurance.⁸⁹ The work RVU refers to the physician’s time and effort exerted in providing the service. The practice expense RVU accounts for the various costs physicians incur in providing services, including general overhead and wages paid to staff. The liability insurance RVU reflects the physician’s medical malpractice insurance cost.⁹⁰ The three RVUs for a service are assigned to a Healthcare Common Procedure Coding System (“HCPCS”) code that identifies a Part B service. HCPCS codes include both Current Procedural Terminology (“CPT”) codes established by the American Medical Association (“AMA”), and CMS-established codes.⁹¹ The three RVUs assigned to each HCPCS are then adjusted for geographic variations in the cost of providing care (geographic practice cost indices or “GCPIs”). Finally, the sum of the geographically adjusted RVUs is multiplied by a conversion factor, which is updated annually, to determine the final payment for the service.⁹² Further adjustments may be made based on the licensure of the billing practitioner, location in a Health Professional Shortage Area

⁸⁰ 42 U.S.C. §1395w-4(g)(1)(A)(I) (2010).

⁸¹ See 42 U.S.C. §1395a(b) (2010); CMS, Medicare Benefit Policy Manual, (CMS-Pub. 100-02), Ch. 15, §40, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>.

Practitioners who can opt out include doctors of medicine, osteopathy, dental surgery or dental medicine, podiatric medicine, and optometry, as well as physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and registered dietitians.

⁸² CMS, Medicare Benefit Policy Manual (CMS-Pub. 100-02), *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ See Barry R. Furrow, Health Law 426-428, *supra* note 35, for a description of Part B payment to physicians.

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

(“HPSA”), or for certain primary care and surgical procedures (only through 2015).⁹³

Although the RBRVS payment system was instituted to slow the growth in Medicare Part B spending for physicians’ services, Part B spending has continued to increase. The “sustainable growth rate” (“SGR”) was instituted by Congress in order to keep growth in Part B spending on physicians’ services in line with growth in the national economy.⁹⁴ Because growth in physicians’ spending has consistently been higher than growth in the national economy since 2002, application of the SGR would result in significant cuts to Part B payments for physicians’ services every year. Application of the SGR would result in a 21.2 percent payment cut starting in April 2015.⁹⁵ Since 2002, Congress has acted to reverse the cuts that would be mandated by application of the SGR, and replacing the SGR with something more viable has been discussed in Congress every year since, but no political solution has been found to date.⁹⁶

Other Part B suppliers that are paid off of Part B fee schedules include clinical laboratories, independent diagnostic testing facilities (“IDTFs”), ambulatory surgery centers (“ASCs”) and durable medical equipment suppliers (“DMEPOS”).⁹⁷

20.2.4 Part C (Medicare Advantage)

Medicare Advantage (“MA”) plans are managed care plans for Medicare beneficiaries. There are several different types of MA plans, mirroring the types of managed care products that are available in the private insurance market. They include health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”), and point-of-service plans (“PSPs”).⁹⁸ These plans can be local or regional in nature, but regional plans must be PPOs and must serve a region that comprises at least an entire state.⁹⁹ The majority of Medicare beneficiaries nation-wide who enroll in MA plans enroll in HMOs, and most of the beneficiaries who enroll in MA plans live in urban areas.¹⁰⁰ In Washington, about 29 percent of Medicare beneficiaries were enrolled in MA plans in 2014.¹⁰¹ Medicare Advantage also offers “private fee-for-service” plans (“PFFS”), which generally offer a wider choice of providers to beneficiaries than other MA plans, but only a small percentage of Medicare beneficiaries enroll in such plans.¹⁰² They typically have higher costs for beneficiaries than other MA plans. There are also Special Needs Plans (“SNPs”) that serve persons who are eligible for both Medicare and Medicaid, and the severely disabled.¹⁰³

Generally, any Medicare beneficiary who is entitled to receive Part A benefits and who has enrolled in Part B is eligible to enroll in an MA plan. Nevertheless, persons with end-stage renal disease (except for persons who acquire the disease while covered in an MA plan) are not eligible.¹⁰⁴ There must also be an MA plan that serves the beneficiary’s geographic area. As of 2014, approximately 30% of Medicare beneficiaries are enrolled in an MA plan.¹⁰⁵

⁹³ *Id.*

⁹⁴ *Id.* at 428.

⁹⁵ See Fact Sheets: Policy and payment changes to the Medicare Physician Fee Schedule for 2015, (October 31, 2014), <http://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2014-Fact-sheets-items/2014-10-31-7.html>.

⁹⁶ Medicare Payment Advisory Comm’n. (MedPAC), Report to Congress: Assessing Alternatives to the Sustainable Growth Rate System 7 (June 2011).

⁹⁷ See CMS Fee Schedules – General Information, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html>.

⁹⁸ See Medicare Advantage Plans, <http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html>.

⁹⁹ See Kaiser Family Foundation, Medicare Advantage Fact Sheet (May 1, 2014), <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ See Medicare Advantage Plans, What if I Have End-Stage Renal Disease, <http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/esrd-and-medicare-advantage-plans.html>.

¹⁰⁵ See Kaiser Family Foundation, Medicare Advantage Fact Sheet, *supra* note 99.

MA plans contract with CMS and must provide Medicare beneficiaries with services traditionally covered under Medicare Parts A and B.¹⁰⁶ Many MA plans supplement coverage with additional benefits that are not covered under Parts A and B, making them attractive alternatives to traditional Medicare for many beneficiaries. Many MA plans also include a pharmacy benefit in addition to the traditional Part A and B benefits, obviating the need for Medicare beneficiaries to purchase a separate Part D prescription drug plan (discussed in Section 20.2.5, below).¹⁰⁷

MA plans are paid based on their competitive bids for contracts with CMS. CMS sets a county benchmark based on a statutory formula, which has produced benchmarks that are generally higher than the cost for traditional Medicare to provide care to an average beneficiary under Parts A and B.¹⁰⁸ If the plan bids higher than the benchmark, the plan receives the benchmark amount from CMS, and a beneficiary who enrolls in the plan pays the difference as a monthly premium.¹⁰⁹ If the bid is lower than the benchmark, CMS retains a portion of the contractual savings, and the MA plan gets to keep a portion of the savings.¹¹⁰ However, the savings kept by the plan must be returned to the plan enrollees in the form of lowered cost-sharing or premiums, or by providing enhanced benefits to enrollees.¹¹¹ CMS reviews each bid for actuarial soundness and to confirm it reflects the costs of providing the proposed benefit package, and uses risk adjustment to compare bids based on populations with different health statuses or characteristics.¹¹² MA plans may vary beneficiary cost-sharing as long as the overall benefit package is equivalent in value to the benefit package in traditional Medicare Parts A and B.¹¹³

Because the plan benchmarks have been high in the past, it has cost CMS more to deliver care through MA plans than for it to deliver care through traditional Medicare Parts A and B.¹¹⁴ The expense of maintaining MA plans has cut the expected life of the Medicare Part A trust fund by two years, and resulted in an increase in Part B premiums paid by Medicare beneficiaries of \$2 per month.¹¹⁵ In order to address this inequity, the ACA requires phasing in a reduction to the plan benchmarks between 2012-2016 to be closer to the cost of caring for enrollees in traditional Medicare Parts A and B.¹¹⁶ By 2017, benchmarks will range from 95 percent of traditional Medicare costs in counties where Medicare costs are high, to 115 percent of costs in counties where Medicare costs are low.¹¹⁷ It also instituted a quality rankings system for MA plans, under which high quality MA plans will receive bonuses, contractual savings for plans that bid under the benchmark will be lowered overall, and savings will be allocated to MA plans according to quality ratings.¹¹⁸ Overall payments to MA plans are capped, and MA plans that do not spend sufficient amounts of their revenue on patient care must remit partial payments to CMS.¹¹⁹

20.2.5 Part D (Prescription Drug Plans)

Part D is an optional prescription drug benefit, available to all persons who are eligible for Medicare Part A benefits. Certain low-income beneficiaries and those who are eligible for both Medicare and Medicaid are automatically enrolled in Part D if they do not voluntarily enroll.¹²⁰ Funding for Part D comes from

¹⁰⁶ 42 U.S.C. §1395w-22(a)(1)(A-B) (2010); 42 C.F.R. §422.101(a-b) (2012).

¹⁰⁷ See Kaiser Family Foundation, Medicare Advantage Fact Sheet, *supra* note 99.

¹⁰⁸ See Barry R. Furrow, Health Law 433, *supra* note 35.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ See Kaiser Family Foundation, Medicare Advantage Fact Sheet, *supra* note 99.

¹¹² *Id.*

¹¹³ 42 U.S.C. §1395w-24 (2010).

¹¹⁴ See Barry R. Furrow, Health Law 435, *supra* note 35.

¹¹⁵ See Brian Biles *et al.*, *Realizing Health Reform's Potential*, The Commonwealth Fund (October 2012), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Oct/1637_Biles_impact_hlt_reform_Medicare_Advantage_rb.pdf.

¹¹⁶ See Kaiser Family Foundation, Medicare Advantage Fact Sheet, *supra* note 99.

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ See Brian Biles *et al.*, *Realizing Health Reform's Potential*, The Commonwealth Fund (October 2012), *supra* note 115.

¹²⁰ CMS, Medicare Prescription Drug Benefit Manual (CMS-Pub. 100-18) §40 (August 7, 2012).

general tax revenues, beneficiary premiums, and state payments to enroll Medicaid beneficiaries in Part D plans.¹²¹ Part D benefits are available through stand-alone Prescription Drug Plans (“PDPs”) and through MA plans that also offer Part D benefits (“MA-PDP”).¹²² In 2015, there will be just over 1,000 stand-alone PDPs nationwide. In Washington and Oregon, there will be 30 stand-alone PDPs.¹²³

Stand-alone PDPs bid for contracts with CMS, which uses the bids to establish a nationwide average bid and a nationwide average premium.¹²⁴ In 2015, the nationwide average bid is \$70.15, and the nationwide average premium is \$33.13.¹²⁵ Each bid is then adjusted to account for the actual health status of plan enrollees.¹²⁶ Each plan’s adjusted bid is compared to the nationwide average bid. If the plan’s bid is lower than the nationwide average, the beneficiaries will pay a lower premium than the nationwide average premium. If it is higher, the beneficiaries will pay premiums that are higher than the nationwide average.¹²⁷ Low-income beneficiaries generally do not pay a premium, or pay a substantially reduced premium.¹²⁸ CMS also subsidizes low-income beneficiary cost-sharing. Higher-income beneficiaries pay higher premiums.¹²⁹

Payments to PDPs may also be adjusted based on a plan’s performance within a “risk corridor.”¹³⁰ Under the risk corridor, if a PDP’s cost of providing prescription drugs to plan enrollees is substantially higher than anticipated, CMS absorbs a substantial portion of the excess costs. If a PDP’s cost of providing prescription drugs to plan enrollees is substantially lower than anticipated, the PDP pays a substantial portion of the savings to CMS.¹³¹ This ensures that PDPs are neither overly generous with prescription drug benefits, thus incurring unnecessary costs, nor overly conservative with prescription drug benefits, thus compromising quality.

Unlike Medicare Part A and Part B, where CMS sets maximum prices through fee schedules and prospective payment systems, under Part D the prices that PDPs pay for prescription drugs are entirely the product of negotiation between the PDPs and the drug manufacturers. PDPs must charge enrollees amounts that accurately reflect the actual prices that they negotiate for drugs, including discounts, rebates or other remuneration.¹³² Although PDPs can vary their formularies, every PDP must include at least one drug from each therapeutic category and class of covered drugs.¹³³

CMS sets a yearly standard benefit amount that represents the actuarial value of the plans that PDPs must offer to beneficiaries.¹³⁴ PDPs may offer benefits that differ from the standard benefit, as long they are “actuarially equivalent,” and in 2015, no PDP is offering the standard benefit.¹³⁵ In 2015, the standard benefit requires the enrollee to pay a \$320 deductible.¹³⁶ After the enrollee has incurred prescription drug

¹²¹ See Barry R. Furrow, Health Law 410-415, *supra* note 35.

¹²² *Id.* at 411.

¹²³ See Kaiser Family Foundation, The Medicare Prescription Drug Benefit Fact Sheet, (Sept. 19, 2014) <http://kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/>.

¹²⁴ *Id.*

¹²⁵ CMS, Annual Release of Part D National Average Bid Amount and other Part C & D Bid Information, (July 14, 2014) <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2015.pdf>.

¹²⁶ See Barry R. Furrow, Health Law 412, *supra* note 35.

¹²⁷ *Id.*

¹²⁸ *Id.* at 414; 42 U.S.C. §1395w-114 (2010).

¹²⁹ 42 U.S.C. §1395w-113(a)(7) (2010); CMS, Medicare Costs at a Glance, <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>.

¹³⁰ 42 U.S.C. §1395w-115(e) (2010); Barry R. Furrow, Health Law 412, *supra* note 35.

¹³¹ Barry R. Furrow, Health Law 412, *supra* note 35.

¹³² 42 U.S.C. §1395w-102(d) (2010).

¹³³ 42 U.S.C. §1395w-104(b)(3)(B), (C) (2010).

¹³⁴ 42 U.S.C. §1395w-102(b) (2010).

¹³⁵ 42 U.S.C. §§1395w-102(a), (c); Kaiser Family Foundation, The Medicare Prescription Drug Benefit Fact Sheet, *supra* note 123.

¹³⁶ CMS, Costs for Medicare Drug Coverage, <http://www.medicare.gov/part-d/costs/part-d-costs.html>.

costs sufficient to meet the deductible, the PDP will pay 75 percent of additional drug costs, and the enrollee will pay 25 percent of additional drug costs, up to a total of \$2,960 in drug costs.¹³⁷ If an enrollee's drug costs exceed this amount, the enrollee falls into what is known as the "coverage gap" or "doughnut hole." In the "doughnut hole," the PDP will pay 35 percent of drug costs for generic drugs and the enrollee will pay 65 percent of the costs.¹³⁸ For name-brand drugs, manufacturers must discount the price by 50 percent; the PDP then pays 5 percent of the discounted cost, with the enrollee paying the remainder (45 percent of total undiscounted cost).¹³⁹ This arrangement continues until an enrollee has incurred \$7,062 in total drug costs, or \$4,700 out-of-pocket.¹⁴⁰ If an enrollee's costs escalate beyond the \$7,062 in total drug costs, the enrollee pays only 5 percent, the PDP pays 15 percent, and Medicare pays 80 percent of additional costs.¹⁴¹ The ACA mandates that enrollee costs for prescription drugs in the "doughnut hole" be gradually lowered, so that by 2020 enrollees will pay only 25 percent of the cost of prescription drugs in the "doughnut hole."¹⁴²

20.2.6 Medicare Audits

There are numerous entities that conduct audits and provide oversight of health care providers that accept Medicare payments. MACs often perform pre- or post-payment audits of individual providers, as well as region-wide audits on specific services. MACs frequently publicize common errors noted in audits, or provide educational information regarding comparability data (e.g., which suppliers have claims that are outliers compared to their peers).

The primary federal auditor is the DHHS Office of the Inspector General ("OIG"). The OIG can focus its attention on a single payment issue at a single health care provider, or can do more comprehensive multi-provider audits, using data-mining techniques to identify multiple areas of possible overpayments. If the OIG detects an overpayment, it may work with the local MAC to recoup the overpayment, but the OIG also has the authority to exclude entities that engage in fraud or abuse from participation in federal health care programs.¹⁴³ It can also impose civil money penalties ("CMPs") on health care providers for engaging in certain misconduct related to federal programs.¹⁴⁴

In addition, CMS contracts with private entities to audit and educate providers, suppliers, and MACs, and to seek recovery of improper payments. Among these entities are Recovery Audit Contractors ("RACs" or "RAs") and Zone Program Integrity Contractors ("ZPICs", which may soon be replaced by Unified Program Integrity Contractors or "UPICs"). The current RAC for Washington State is Health Data Insights, and the current ZPIC for Washington State is AdvanceMed Corporation.¹⁴⁵

RACs must receive CMS approval for all audit issues, and inform the public of the audit issues they are investigating by posting them to a publicly available website.¹⁴⁶ RACs are supposed to identify both over- and under-payments made by Medicare, but have historically identified far more overpayments than underpayments. Many RAC findings are appealed by providers, which has resulted in a large backlog of appeals at CMS and significantly slowed RAC activity.¹⁴⁷

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² Barry R. Furrow, Health Law 413, *supra* note 35.

¹⁴³ 42 U.S.C. §1320a-7 (2010).

¹⁴⁴ 42 U.S.C. §1320a-7a (2010).

¹⁴⁵ See CMS Review Contractor Directory – Interactive Map, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/#wa>.

¹⁴⁶ See CMS Announces New Recovery Audit Contractors to Help Identify Improper Medicare Payments, <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2008-Fact-Sheets-Items/2008-10-06.html>.

¹⁴⁷ See, e.g. Office of Medicare Appeals (OMHA) Adjudication Timeline, http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html; Bob Herman, *CMS Offers Deal in Lieu of RAC Appeal*, Modern Healthcare, Sept. 6, 2014, available at

ZPICS are expected to perform program integrity functions for Medicare, including data analysis and data-mining, investigating fraud and abuse, and medical review and audit.¹⁴⁸ They also perform Medicare-Medicaid audits (“Medi-Medi”), reviewing claims to see if duplicate payment was made under both programs, or whether payment was inappropriately made by one program when it should have been made by another.¹⁴⁹

Among the most common bases for audits findings requiring repayments, or pre-payment denials, are missing or insufficient medical documentation, failure to meet eligibility criteria for payment, incorrect coding, and lack of evidence of medical necessity for the service.

State surveyors and CMS’ federal surveyors, as well as Quality Improvement Organizations (“QIOs”) that contract with CMS, conduct audits that are focused on the relationship between quality of care and reimbursement.¹⁵⁰ Often such audits will focus on perceived “shorting” of patient care to maximize reimbursement, or to manipulate payment methodologies. Surveyors focus increasingly on sub-acute care providers, such as SNFs. Penalties for adverse findings can include imposition of CMPs or denial of payment for services.¹⁵¹

20.2.7 Medicare Appeals

Virtually all complaints about the administration of the Medicare program, including disputes over payment, survey or certification decisions, or challenges to rules and policies, require exhaustion of an administrative appeals process prior to seeking judicial review.¹⁵² Federal courts do not have subject matter jurisdiction to hear claims about the Medicare program in most instances, until the administrative appeals process has been exhausted.¹⁵³

There are three separate avenues of Medicare appeals. The first avenue is for Part A providers who want to appeal the final determination of Medicare reimbursement based on their cost reports. Cost reports are a series of forms that collect descriptive, financial, and statistical data to determine if Medicare over or underpaid the provider.¹⁵⁴ Providers can appeal their cost report reimbursement to the Provider Reimbursement Review Board (“PRRB”) if the amount in controversy is at least \$10,000 for a single provider, or at least \$50,000 for a group appeal.¹⁵⁵ The PRRB’s decision can be overturned by the CMS Administrator on review, and that decision can be appealed to a federal district court if the jurisdictional amount is met.¹⁵⁶

If a Medicare provider has been found to have deficiencies by a survey agency, and wishes to appeal findings and penalties imposed, it may appeal to the Departmental Appeals Board (“DAB”), an administrative agency within DHHS.¹⁵⁷

Denials of individual fee-for-service claims can be appealed by program beneficiaries, Medicare providers and suppliers, or a Medicaid State Agency (for claims for services rendered to beneficiaries eligible for

<http://www.modernhealthcare.com/article/20140906/MAGAZINE/309069959>.

¹⁴⁸ See Zone Program Integrity Contractor (ZPIC), <https://med.noridianmedicare.com/web/jeb/cert-reviews/zpic>.

¹⁴⁹ See Dep’t. of Health and Human Services Office of Inspector General, OEI-09-08-00370, The Medicare-Medicaid (Medi-Medi) Data Match Program (April 2012), available at <http://oig.hhs.gov/oei/reports/oei-09-08-00370.pdf>.

¹⁵⁰ See CMS, Quality Improvement Organization Manual §13000, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c13.pdf>.

¹⁵¹ *Id.* at §9100 *et seq.*

¹⁵² 42 U.S.C. §§405(h) (2011), 1395ii (2010) .

¹⁵³ *Mathews v. Eldridge*, 424 U.S. 319, 328 (1976).

¹⁵⁴ See CMS, Cost Reports, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/?redirect=/CostReports/>.

¹⁵⁵ 42 U.S.C. §1395oo(b) (2010); 42 C.F.R. §§405.1837, 405.1839 (2011).

¹⁵⁶ 42 U.S.C. §1395oo(f)(2010); 42 C.F.R. §405.1877 (2011).

¹⁵⁷ 42 C.F.R. pt. 1001 (2011).

both Medicare and Medicaid). There are four levels of administrative appeal before there is any right to judicial review, with a threshold amount of \$150 (for 2015) in controversy at the third step of administrative appeal.¹⁵⁸ Ultimately, review by a federal district court is available if the amount in controversy meets the required jurisdictional amount (\$1,460 in 2015).¹⁵⁹ Although statutory timelines exist to ensure timely review at each level, they have largely been ignored. The average time to complete an appeal is currently over two years, and the American Hospital Association (“AHA”) has filed a lawsuit regarding CMS’ failure to comply with the statutory timelines.¹⁶⁰ There is currently a backlog of more than 300,000 appealed claims at CMS, in part due to increased appeals of RAC findings by hospitals and other providers.¹⁶¹ To reduce this backlog, CMS has recently offered to settle provider appeals of denials based on findings that the hospital inappropriately designated patients as inpatients rather than observation outpatients by paying providers 68 percent of the amount in dispute.¹⁶²

A separate appeals process exists for appealing adverse benefits decisions of Medicare Advantage plans.¹⁶³

20.3 Other Federal Health Care Programs

In addition to Medicare, there are numerous other federal purchasers of health care. The United States Military, the Federal Employees Health Benefits Program (“FEHBP”), and the Indian Health Service (“IHS”) all purchase significant amounts of health care in Washington State. This section provides a brief overview of these government payors; the reader should consult additional resources for more detailed descriptions of these programs.

20.3.1 TRICARE

The Department of Defense’s (“DOD”) TRICARE program provides coverage for active duty service members, National Guard and Reserve members, retirees, their families, survivors, and certain former spouses all over the world.¹⁶⁴ In FY 2013, TRICARE covered approximately 9.6 million people, 360,265 in Washington State.¹⁶⁵ TRICARE is a successor to the program known as the Civilian Health and Medical Program of the Uniformed Services (“CHAMPUS”), which was discontinued when military health care costs began to outpace those of the private sector.¹⁶⁶

TRICARE beneficiaries receive care directly from the government in military treatment facilities. The DOD supplements this care by contracting with networks of private-sector providers.¹⁶⁷ Private-sector care is provided through a family of health plans, based on three primary options:

- TRICARE Standard is a non-network benefit open to all eligible beneficiaries except for active duty service members. It is the direct successor to the CHAMPUS program. Beneficiaries in TRICARE

¹⁵⁸ See CMS, Original Medicare (Fee-for-Service) Appeals, <http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html>.

¹⁵⁹ *Id.*

¹⁶⁰ See Legal Resources: AHA Litigation, available at <http://www.aha.org/advocacy-issues/legal/litigation.shtml>. The lawsuit was dismissed by the Federal District Court for the District of Columbia on Dec. 18, 2014, but the AHA has stated that it plans to appeal the dismissal.

¹⁶¹ See Office of Medicare Hearings and Appeals, http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html.

¹⁶² See Office of Medicare Hearings and Appeals (OMHA) Adjudication Timeline, *supra* note 147.

¹⁶³ 42 U.S.C. §1394w-22(g) (2010); see Barry R. Furrow, Health Law 450-51, *supra* note 35, for a description of the Medicare Advantage benefit determination appeal process.

¹⁶⁴ See Department of Defense, Evaluation of the TRICARE Program Fiscal Year 2014 Report to Congress, available at

<http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20%28FY%202014%29%201.pdf>.

¹⁶⁵ *Id.*

¹⁶⁶ See, e.g. GAO, Defense Health Care: Issues and Challenges Confronting Military Medicine, GAO/HEHS-95-104 (1995).

¹⁶⁷ See Department of Defense, Evaluation of the Tricare Program Fiscal Year 2014 Report to Congress, *supra* note 164.

Chapter 20: Government Payors of Medical Services
(prepared from reference materials available as of December 31, 2014)

Standard pay an annual deductible and cost-shares for care received. In FY 2013, approximately 17 percent of active duty families and 29 percent of retiree families were in this plan.¹⁶⁸

- TRICARE Extra is the network benefit for beneficiaries eligible for TRICARE Standard. When a non-enrolled beneficiary obtains services from TRICARE network providers, the cost-shares are reduced by five percent. The annual deductible is the same as for TRICARE Standard.¹⁶⁹
- TRICARE Prime is the health maintenance organization-like benefit offered in many areas. Enrollees have primary care managers (“PCM”), health-care professionals who are responsible for helping the patient manage care, promoting preventive health services, and arranging for specialty provider services. Enrollees may seek care from providers other than the PCM without a referral, but will pay significantly higher deductibles and cost-shares than those under TRICARE Standard if they do so.¹⁷⁰ In FY 2013, approximately 79 percent of active duty families and 54 percent of retiree families were in this plan.¹⁷¹

There are a number of additional TRICARE plans that some beneficiaries qualify for based on their location, status, or other factors. These plans provide additional benefits or blend Prime and Standard/Extra benefits, with some limitations.¹⁷²

TRICARE is administered by three regional contractors in the United States and an overseas contractor. These contractors manage purchased care operations and coordinate medical services available through contracted providers with military treatment facilities. United Healthcare is the contractor for the West Region, which includes Washington State.¹⁷³

TRICARE’s payment methodologies for institutional and professional services are based on those of the Medicare program.¹⁷⁴ TRICARE has adopted the MS-DRG system of classifying inpatient hospital cases to conform to changes made to the Medicare Inpatient Prospective Payment System.¹⁷⁵ TRICARE also uses an Outpatient Prospective Payment System modeled on Medicare’s OPSS.¹⁷⁶

Beneficiaries and providers have appeal rights under TRICARE for denied payments, denied preauthorizations, or termination of payment for services previously authorized.¹⁷⁷ Providers who are denied approval as a TRICARE-authorized provider, or who are expelled from TRICARE, may also appeal these decisions.¹⁷⁸ There are different appeals processes for medical necessity determinations and factual determinations such as coverage determinations.¹⁷⁹ Provider status issues and determinations regarding dual Medicare-TRICARE eligibility go through separate appeals processes.¹⁸⁰ Certain issues cannot be appealed, such as the amount of the allowable charge for a particular medical service, requests for additional information about a claim or appeal, and TRICARE eligibility decisions.¹⁸¹

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ See Tricare contact information, available at <http://www.tricare.mil/contactus/callus.aspx>; Washington State Joint Commission on Veterans’ and Military Affairs, Briefing on Tricare in Washington State (Oct. 3, 2012), [http://leg.wa.gov/JointCommittees/JCVMA/Documents/2012-10-03/WA%20Vets%20Cmte%20Presentation%2010_3_12%20FINAL%20Handout%20\(2\).pdf](http://leg.wa.gov/JointCommittees/JCVMA/Documents/2012-10-03/WA%20Vets%20Cmte%20Presentation%2010_3_12%20FINAL%20Handout%20(2).pdf).

¹⁷⁴ 10 U.S.C. §§1079(h), 1079(j)(2) (2010).

¹⁷⁵ See Defense Health Agency, DRG Home, <http://www.tricare.mil/drgates/>.

¹⁷⁶ See Defense Health Agency, Outpatient Prospective Payment System, <http://www.tricare.mil/opps/>.

¹⁷⁷ See Tricare Appeals Fact Sheet, (March 2013) www.tricare.mil/~media/Files/TRICARE/.../Appeals_FS.pdf.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

The Defense Health Agency (“DHA”) Program Integrity Office is responsible for all program integrity activities related to TRICARE, including anti-fraud activities, post-payment claims payment review, prepayment initiatives to prevent erroneous health care payments, and post-payment duplicate claims review.¹⁸² These activities resulted in savings and recoveries of over \$125 million in 2012.¹⁸³

20.3.2 Veteran’s Administration Healthcare System (“VA”)

The VA operates a separate health care system from TRICARE, through the Veteran’s Health Administration (“VHA”). The VHA provides medical and related care to over 8.76 million eligible veterans, at over 1,700 sites.¹⁸⁴ Those who were on active duty in the Army, Navy, Air Force, Marines, or Coast Guard, and who were separated from the military in any way other than through dishonorable discharge, are eligible.¹⁸⁵ Current and former members of the Reserves or National Guard who were called to active duty by a federal order and completed the full period for which they were called or ordered to active duty may be eligible for VA health benefits as well.¹⁸⁶ Surviving spouses and dependents of veterans may be eligible to receive care through the VA health care system under the Civilian Health and Medical Program of the Department of Veterans Affairs, or “CHAMPVA.”¹⁸⁷ There are also limited health care programs for children of women Vietnam Veterans, children of veterans of the Korean and Vietnam wars with spina bifida, and caregivers of certain veterans.¹⁸⁸

Veterans seeking care from the VA are categorized into eight different priority groups, based on disability status, income level, combat status, or “environmental exposure” (e.g. exposure to Agent Orange).¹⁸⁹ Ability to enroll for health care is prioritized by groups, and depends on the amount of funding provided to the VA by Congress every year.¹⁹⁰ Cost-sharing for services varies by priority category, with higher priority veterans paying little or no cost-sharing, and lower priority veterans paying more significant cost-sharing.¹⁹¹

Traditionally, the VA provided most of its covered health care services through VA-owned and operated hospitals, nursing facilities, ambulatory care clinics, and other health care service providers. VA facilities and clinics are organized into 23 regional networks known as Veterans Integrated Service Networks (“VISNs”).¹⁹² Washington is in VISN 20, which operates hospitals in Seattle, Tacoma, Spokane, Walla Walla, and Vancouver, and numerous outpatient and community-based clinics and Veterans’ Centers.¹⁹³

In the wake of recent scandals in the VA regarding wait times for veterans seeking care at VA facilities, allegedly resulting in over 40 patient deaths, Congress passed the Veterans Access, Choice and Accountability Act of 2014 (“Act”), which was signed into law by the president on August 7, 2014.¹⁹⁴ The Act allows enrolled veterans to choose to receive their care through private providers if they have to wait for an appointment at a VA facilities for more than 30 days, or if they live more than 40 miles from a VA

¹⁸² See Department of Defense, Evaluation of the Tricare Program Fiscal Year 2014 Report to Congress, *supra* note 164.

¹⁸³ *Id.*

¹⁸⁴ U.S. Dep’t of Veterans Affairs, Veterans Health Administration, <http://www.va.gov/health/>.

¹⁸⁵ U.S. Dep’t. of Veterans Affairs, Veterans Health Administration, Health Benefits, <http://www.va.gov/health/>.

¹⁸⁶ U.S. Dep’t. of Veterans Affairs, Veterans Health Administration, Health Benefits, Veterans Eligibility, <http://www.va.gov/HEALTHBENEFITS/apply/veterans.asp>.

¹⁸⁷ 38 U.S.C. §1781 (2011); 38 C.F.R. §§17.270-17.278 (2009).

¹⁸⁸ U.S. Dep’t. of Veterans Affairs, Veterans Health Administration, Health Benefits, Family Members of Veterans, http://www.va.gov/HEALTHBENEFITS/apply/family_members.asp.

¹⁸⁹ U.S. Dep’t. of Veterans Affairs, Veterans Health Administration, Priority Groups Table, http://www.va.gov/HEALTHBENEFITS/resources/priority_groups.asp.

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² U.S. Dep’t. of Veterans Affairs, Veterans Health Administration, Locations, <http://www.va.gov/directory/guide/division.asp?dnum=1>.

¹⁹³ U.S. Dep’t of Veterans Affairs, Veterans Health Administration, VISN 20, <http://www.va.gov/directory/guide/region.asp?map=1&ID=20>.

¹⁹⁴ Veterans Access, Choice and Accountability Act of 2014, Pub. L. No. 113-146, 128 Stat. 1754.

facility.¹⁹⁵ The program will end with a \$10 billion Veterans Choice Fund is exhausted, or in three years, whichever comes first.¹⁹⁶ The Act also includes \$5 billion for the VA to hire and train additional medical personnel, with a focus on hiring for mental health, primary care, gastroenterology and women’s health needs.¹⁹⁷ Also provided are 1,500 medical residency slots over five years with focus in these areas, and doubling of student loan forgiveness for providers choosing to practice with the VA.¹⁹⁸

The VA allocates funds to its VISNs on a capitated basis, by assigning a fixed amount per enrollee based on the anticipated complexity of care the veteran will require. Each VISN is then responsible for allocating its resources among the VA facilities in its geographic area, using various methods.¹⁹⁹ When VA beneficiaries obtain authorized care from a non-VA private or public facility or professional, the VA pays such entities using methodologies based on those of the Medicare program.²⁰⁰

VA beneficiaries can appeal benefit determinations, first to the local VA office, and ultimately to the Board of Veterans’ Appeals (“BVA”).²⁰¹ Decisions of the BVA may be appealed to the U.S. Court of Appeals for Veterans’ Claims.²⁰² Both beneficiaries and non-VA providers of care can appeal reimbursement determinations of the VA.²⁰³

20.3.3 Federal Employee Health Benefits Program (“FEHBP”)

The FEHBP is the health insurance program provided by the federal government for most current federal employees, annuitants, and their eligible family members. Eligible family members include spouses, children under age 26, and qualified disabled children aged 26 years or older.²⁰⁴ Under the ACA, active Members of Congress and certain congressional staff can no longer receive health benefits through FEHBP while they are employed in those roles, but may be eligible to enroll in FEHBP when they retire.²⁰⁵ Eligible Indian tribes, tribal organizations, and urban Indian organizations may also purchase FEHBP for their tribal employees.²⁰⁶ The federal government is the largest employer in the United States, and FEHBP is the largest employer-sponsored health insurance program in the country.²⁰⁷ It covers approximately 8.2 million individuals.²⁰⁸

The FEHBP is administered by the Office of Personnel Management (“OPM”). The OPM contracts with private health plans, known as “carriers,” to provide health care benefits to beneficiaries. Each carrier negotiates a contract specifying rates and benefits with OPM on an annual basis.²⁰⁹ For the 2014 plan year, there were 256 different plan choices, but as a practical matter, an individual’s choice of plan is often limited by geography to 10 or 15 plans.²¹⁰ Although there are many plans, FEHBP enrollment is

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ U.S. Gov’t Accountability Office (formerly the U.S. General Accounting Office), GAO/HEHS 96-48, Veterans’ Health Care Facilities’ Resource Allocations Could be More Equitable (1996).

²⁰⁰ *See, e.g.*, 38 C.F.R. §, 17.56 (2011).

²⁰¹ U.S. Dep’t of Veterans Affairs, “How Do I Appeal?” Pamphlet, *available at* http://www.bva.va.gov/How_Do_I_APPEAL.asp.

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ Annie L. Mach and Ada S. Cornell, Cong. Research Serv., RS21974, Federal Employees Health Benefits Program (FEHBP): Available Health Insurance Options 1-2 (2013), *available at* <http://fas.org/sgp/crs/misc/RS21974.pdf>.

²⁰⁵ *Id.* at 1.

²⁰⁶ *Id.* at 2.

²⁰⁷ *Id.* at 1.

²⁰⁸ *Id.*

²⁰⁹ 5 U.S.C. §8902 (2011). The primary regulations implementing this program are at 5 C.F.R part 890, but additional requirements are set forth in the Federal Acquisition Regulations at 48 C>F.R. chapters 1 and 16.

²¹⁰ Annie L. Mach and Ada S. Cornell, Cong. Research Serv., RS21974, *supra* note 204, at 3.

Volume 3: Financing and Engaging in the Business of Healthcare

concentrated among a few parent organizations.²¹¹ The vast majority of enrollees are in Blue Cross Blue Shield Association Plans, and 94 percent of all policyholders are enrolled in the top 10 parent organizations.²¹²

There are three types of participating plans currently offered in FEHBP:

- The government-wide service benefit plan, which is a fee-for-service benefit plan that pays providers directly for services. Within this plan, there are standard and basic options. The standard option is a preferred-provider organization, and the basic option is an HMO-like plan, where enrollees may use only contracted providers except for emergency care;
- Employee organization plans, which are also fee-for-service plans. These plans include options for high-deductible plans coupled with Health Savings Accounts (“HSA”) or Health Reimbursement Accounts (“HRA”);
- Comprehensive medical plans, which are local HMOs. The plans also include options for high-deductible plans.²¹³

The government’s share of the premiums for FEHBP is set at 72 percent of the weighted average premium of all plans in the program, not to exceed 75 percent of any given plan’s premium.²¹⁴ The government’s contributions are capped at a yearly maximum.²¹⁵ OPM may contract with carriers on either an experience-rated basis or a community-rated basis.²¹⁶

There is no core or standard benefit package for FEHBP. Nevertheless, all FEHBP plans must cover basic hospital, surgical, physician, and emergency care.²¹⁷ OPM also requires plans to cover prescription drugs, mental health care at parity with general medical care coverage, and child immunizations.²¹⁸ There is also a catastrophic limit on an enrollee’s out-of-pocket expenditures.²¹⁹

20.3.4 Indian Health Service (“IHS”)

The IHS is the primary vehicle through which the federal government provides health care services to American Indians and Alaska Natives. The IHS provides health care and disease prevention services to approximately 2.2 million American Indians and Alaska Natives throughout the United States.²²⁰ As of 2012, approximately 69,000 American Indians and Alaska Natives lived in Washington State, or approximately one percent of the state population.²²¹ The IHS has a network of hospitals, clinics, and health stations through which it provides services to eligible persons. In general, these services are available only to members of and descendants of members of federally recognized tribes that live on or near federal reservations.²²² The IHS also contracts with non-Indian providers to provide health care services, mostly to persons who do not otherwise meet IHS eligibility criteria and/or are not living on or

²¹¹ *Id.* at 6.

²¹² *Id.*

²¹³ *Id.* at 7-8.

²¹⁴ *Id.* at 4; see also Office of Personnel Management, *OPM Announces 2015 Federal Employees Health Benefits Program Premium Rates*, available at <http://www.opm.gov/news/releases/2014/10/opm-announces-2015-federal-employees-health-benefits-program-premium-rates/>.

²¹⁵ *Id.*

²¹⁶ Annie L. Mach and Ada S. Cornell, Cong. Research Serv., RS21974, *supra* note 204, at 4.

²¹⁷ *Id.* at 5.

²¹⁸ *Id.* at 5-6.

²¹⁹ *Id.* at 6.

²²⁰ Samantha Artiga, *et al.*, Kaiser Family Foundation (hereafter, “KFF”), *The Kaiser Commission on Medicaid and the Uninsured, Health Coverage and Care for American Indians and Alaska Natives* (Oct. 7, 2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/10/8502-health-coverage-and-care-for-american-indians-and-alaska-natives.pdf>.

²²¹ KFF, *State Health Facts*, <http://kff.org/other/state-indicator/total-native-americans/>.

²²² Samantha Artiga, *et al.*, *supra* note 220.

near reservations.²²³ Hospitals supplying inpatient care to IHS-eligible persons are generally paid “Medicare-like” rates for their services.²²⁴ Contracted non-hospital services have generally been paid based on negotiated contracts, which have often produced payments substantially in excess of Medicare payments for the same services.²²⁵ Pending proposed regulations would require non-hospital services to be paid via Medicare payment methodology.²²⁶ All payments made to non-IHS providers are subject to the availability of funds; if there are no funds remaining for the fiscal year, no payment can be made by IHS.²²⁷ In FY 2013, total IHS funding was \$5.46 billion.²²⁸ IHS funding is insufficient to meet the health care needs of the eligible population; therefore, access to services varies significantly by geographic location.²²⁹

Most IHS services are primary care services, although some ancillary and specialty services are included. Eligible persons receiving services through IHS providers are not charged or billed for the cost of their services.²³⁰ Nevertheless, the IHS is required to identify and recover third party resources to pay for care provided to IHS eligible beneficiaries. Medicaid is the largest third-party payer for IHS, accounting for 70 percent of total third party revenues and 13 percent of total IHS funding for FY 2013.²³¹ There are special Medicaid eligibility rules for American Indians and Alaska Natives, and the federal government covers 100 percent of the cost of covered Medicaid services provided to American Indian and Alaska Native beneficiaries through IHS facilities, while a state’s regular federal matching rate applies to the cost of services provided to American Indian and Alaska Native beneficiaries through an urban Indian health program or non-Indian health provider.²³²

20.4 Medicaid

20.4.1 Overview

Medicaid is the largest health insurance program in the United States, covering more than 68 million Americans.²³³ Total Medicaid expenditures in FY 2013 totaled over \$438 billion, and 16 percent of total national spending on personal healthcare was funded by Medicaid in FY 2011.²³⁴ Medicaid is jointly financed by the federal government and the states. It is means-tested, meaning that eligibility for Medicaid depends on income (usually tied to the federal poverty level (“FPL”)), and traditionally also depended on a person’s disability or dependency status. Medicaid is also known as “Title XIX” (of the Social Security Act) and is codified at 42 U.S.C. §1396 *et seq.* Medicaid has been in existence since 1965, and was enacted as an adjunct to the Medicare program. The Medicaid program is administered on a day-to-day basis by the states, but the states must comply with applicable federal requirements, unless CMS has approved a state’s request for a waiver of specific federal requirements. State administration of the Medicaid program is overseen by CMS, and each state must designate a single state agency to administer its program.²³⁵ States have broad flexibility in defining eligibility and coverage under the Medicaid program, as long as they remain within federal parameters or within an approved federal waiver. Therefore, every Medicaid program is unique to its administering state. Washington’s Medicaid program is called “Apple Health,” and the state agency that administers the program is the Washington Health Care

²²³ *Id.*

²²⁴ See Indian Health Service, Contract Health Services, http://www.ihs.gov/chs/index.cfm?module=chs_medicare_like_rates.

²²⁵ See *Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated With Non-Hospital-Based Care*, 79 Fed. Reg. 72160 (proposed Dec. 5, 2014) (to be codified at 42 C.F.R. pt. 136).

²²⁶ *Id.*

²²⁷ Samantha Artiga, *et al.*, *supra* note 220.

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ *Id.*

²³² *Id.*

²³³ See KFF, Medicaid Moving Forward, <http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/> (Jan. 6, 2015).

²³⁴ *Id.*

²³⁵ 42 U.S.C. §1396 a(a)(5) (2010).

Authority (“WHCA”).²³⁶ Washington State Medicaid was formerly administered by the agency known as the Department of Social and Health Services (“DSHS”).

All states that receive federal Medicaid funds under Title XIX must submit a state plan for medical assistance to CMS for approval.²³⁷ The lengthy list of requirements that a state Medicaid plan must meet is set forth in 42 U.S.C. §1396a. Any modification to the state plan must occur through the formal submission of a State Plan Amendment (“SPA”) to CMS for review and approval.²³⁸ Furthermore, any time that a state wishes to make any significant changes to its methods and standards for setting payment rates for Medicaid services, it must provide public notice of the proposed changes before they take effect, with limited exceptions.²³⁹

20.4.2 Medicaid Eligibility

All individuals eligible for Medicaid must be residents of the state providing the coverage, and U.S. citizens or qualified aliens.²⁴⁰ Federal law requires participating states to cover certain mandatory populations of low-income individuals, but gives states the option to cover other populations under their Medicaid programs.²⁴¹ Among the mandatory populations that must be covered by Medicaid are the low-income elderly (“dual-eligibles”), the blind, disabled persons receiving federal cash welfare benefits (“SSI”), low-income pregnant women and infants, and dependent children and their caretakers who are receiving cash assistance under Temporary Assistance for Needy Families (“TANF”).²⁴² These populations are called the “categorically needy.”²⁴³ Washington Medicaid covers all of these populations.²⁴⁴ In addition, the state pays for all or part of the Medicare cost-sharing responsibilities of certain low-income Medicare beneficiaries under its Medicaid program.²⁴⁵ These beneficiaries are called “Qualified Medicare Beneficiaries” or “QMBs.”²⁴⁶ QMBs do not receive actual Medicaid benefits, but receive Medicare benefits paid for in part by the state Medicaid program.

Optional populations that a state may choose to cover under Medicaid include the “medically needy,” or persons who fit into one of the categorically needy classifications, who also have high medical expenses that cause them to fall within mandatory eligibility levels after they spend-down their assets on their medical care, despite having incomes in excess of these levels.²⁴⁷ They also include certain 19 and 20 year-olds (“Ribicoff children”) who do not qualify for cash assistance, but are of sufficiently low income that they are determined to need medical assistance.²⁴⁸ Washington covers medically needy persons, and covered Ribicoff children under a Section 1115 waiver (discussed in Section 20.4.6, below) prior to expanding Medicaid under the ACA. In FY 2011, Washington Medicaid covered more than 1,300,000 residents under the mandatory and optional populations.²⁴⁹

The Affordable Care Act (“ACA”) mandated that all states with Medicaid programs expand Medicaid

²³⁶ See Washington State Health Care Authority, <http://www.hca.wa.gov/Pages/index.aspx>.

²³⁷ 42 U.S.C. §1396a (2010).

²³⁸ See Medicaid.gov, Medicaid State Plan Amendments, <http://medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html>.

²³⁹ See 42 C.F.R. §447.205 (2011).

²⁴⁰ See Medicaid.gov, Eligibility, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html>.

²⁴¹ *Id.*

²⁴² See Medicaid.gov, Waivers, List of Medicaid Eligibility Groups, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf>.

²⁴³ *Id.*

²⁴⁴ See Washington State Health Care Authority, Medicaid (Title XIX) State Plan, Client Coverage and Eligibility (Attachment 2), <http://www.hca.wa.gov/medicaid/medicaidsp/Pages/index.aspx>.

²⁴⁵ See Medicaid.gov, Waivers, List of Medicaid Eligibility Groups, *supra* note 242.

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ KFF, The Kaiser Commission on Medicaid and the Uninsured, Chapter 1, Medicaid Eligibility at 13, *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/05/mrbeligibility.pdf>.

²⁴⁹ KFF, Total Medicaid Enrollment, <http://kff.org/medicaid/state-indicator/total-medicaid-enrollment-2/>.

eligibility to all U.S. citizens and legal immigrants with income under 138 percent of the FPL, regardless of age, disability, or health status, or they would lose federal funds to run their existing Medicaid programs.²⁵⁰ Nevertheless, the United States Supreme Court held that requiring the states to expand Medicaid to this population by threatening to withhold all federal funding from the states' existing Medicaid programs was unconstitutional, and made the decision to expand Medicaid to this population optional for the states.²⁵¹ As of December 17, 2014, 27 states plus the District of Columbia have decided to expand their Medicaid programs to this ACA population.²⁵² Washington has expanded its Medicaid program to this ACA population, and it is estimated that around 300,000 Washington residents may gain access to Medicaid via this expansion.²⁵³

20.4.3 Medicaid Coverage

Traditional Medicaid coverage is very comprehensive. Federal law requires that the program cover most of the types of services covered under Medicare, such as hospital and physician services, with certain key differences driven by the nature of the populations covered under the different programs. Because Medicaid's patient population has a large component of children and pregnant women, Medicaid covers a number of services that are not generally covered by Medicare, or for which Medicare has very limited coverage. For example, with respect to children, under federal law Medicaid has expansive coverage for early and periodic screening, diagnosis, and treatment ("EPSDT") services, which can include vision, dental, hearing, and other preventive care.²⁵⁴ Medicaid prescription drug coverage has traditionally been much more comprehensive than Medicare's prescription drug benefit. And Medicaid's long-term care benefits are much more extensive than Medicare's long-term care benefits. Therefore, many individuals who are institutionalized for a long period of time eventually end up on Medicaid.

Under federal law, Medicaid services must be sufficient in amount, duration and scope to reasonably achieve their purpose, must be uniform in amount, duration, and scope throughout the state, and must allow beneficiaries free choice of providers.²⁵⁵ However, many states, including Washington, have received waivers to run Medicaid programs that do not comply with all of these requirements. And within these broad parameters, states have broad discretion to structure benefits, so coverage among states varies.

For some categories of beneficiaries, the state can provide a narrower or different set of benefits, modeled on an "Alternative Benefit Plan (ABP)", or "benchmark" plan.²⁵⁶ In Washington, the ACA expansion population receives Medicaid under an ABP, rather than the traditional Medicaid package of coverage.²⁵⁷ Although the coverage under an ABP can vary from the coverage required by federal law for traditional Medicaid, ABPs must cover essential health benefits under the ACA. These essential health benefits are:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;

²⁵⁰ See Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, §20011, 24 Stat. 119 (2010)

²⁵¹ *NFIB v. Sebelius*, 567 U.S. ___, 132 S.Ct. 2566 (2012).

²⁵² See KFF, Status of State Action on the Medicaid Expansion Decision, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

²⁵³ See KFF, How is the ACA Impacting Medicaid Enrollment? <http://kff.org/medicaid/issue-brief/how-is-the-aca-impacting-medicaid-enrollment/>.

²⁵⁴ See Medicare.gov, Medicaid Benefits, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html>.

²⁵⁵ 42 U.S.C. §1396a(a)(10) (2010).

²⁵⁶ 42 U.S.C. §1396a(a)(1)(A) (2010).

²⁵⁷ See Washington State Health Care Authority, Medicaid (Title XIX) State Plan, Attachment 3.1-L, *supra* note 244.

Volume 3: Financing and Engaging in the Business of Healthcare

- Preventive and wellness, and chronic disease management;
- Pediatric services, including oral and vision care.

Also, all ABPs must cover family planning services and supplies.²⁵⁸

20.4.4 Medicaid Financing

Federal Medicaid law requires states to share in the costs of Medicaid program expenditures based on a statutory formula.²⁵⁹ The federal government pays each state an amount equal to the federal medical assistance percentage (“FMAP”) of the total amount expended as medical assistance under the state’s Medicaid plan. This is referred to as federal financial participation (“FFP”) or federal match.²⁶⁰ The amount of federal match that each state receives is based on each state’s per capita income relative to the national average.²⁶¹ The lower the state’s per capita income, the higher the FMAP for the state. However, under federal law, no state can receive less than 50 percent FMAP.²⁶² Because Washington’s per capita income is relatively high compared to the national average, its FMAP for fiscal year 2016 is 50 percent.²⁶³ This will apply to all persons who were traditionally eligible for Medicaid prior to the passing of the ACA. Under the ACA, FMAP for the expansion Medicaid population (otherwise eligible persons with income under 138 percent of FPL, regardless of disability or health status) is 100 percent through 2016, decreasing to 90 percent in 2020 and subsequent years.²⁶⁴ FMAP is funded by general tax revenues.

States must share the costs of providing medical assistance under Medicaid, and the costs of Medicaid administration. States use a variety of methods to fund their portions of Medicaid costs, including appropriation of state general funds, intergovernmental transfers (“IGTs”) from government-owned providers or using Certified Public Expenditures (“CPEs”) from such providers, and specific provider taxes and provider donations.²⁶⁵ Because IGTs, specific provider taxes, and provider donations have been used by some states to maximize the amount of FMAP provided to the state while minimizing the amount of actual state money being used to fund Medicaid, CMS has placed some restrictions on the use of these financing mechanisms, including an aggregate upper payment limit (“UPL”) on payments to certain providers, and restrictions on provider-specific taxes.²⁶⁶

20.4.5 Medicaid Payment Methodology

Washington Medicaid operates both fee-for-service and managed care programs. In 2014, 79 percent of Washington Medicaid recipients were enrolled in a managed care program.²⁶⁷ The Medicaid managed care program in Washington is called Apple Health (formerly “Healthy Options”).²⁶⁸ The HCA contracts with licensed health carriers, whom are paid on a capitated basis, to provide care to enrollees in the Apple Health program. In 2014, there were 5 contracted Apple Health carriers.²⁶⁹ Enrollment in Apple Health is mandatory for most low-income adults under age 65, children, and pregnant women.²⁷⁰

²⁵⁸ 42 U.S.C. §1396u-7(b)(5)–(7) (2010).

²⁵⁹ 42 U.S.C. §1301(a)(8), 1396d(b) (2010).

²⁶⁰ 42 U.S.C. §1396b(a) (2010).

²⁶¹ 42 U.S.C. §1301(a)(8), 1396d(b) (2010).

²⁶² 42 U.S.C. §1301(a)(8) (2010).

²⁶³ See KFF, Federal Medical Assistance Percentage for Medicaid and Multiplier, <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>.

²⁶⁴ See Patient Protection and Affordable Care Act (“ACA”), *supra* note 250.

²⁶⁵ See Statement of Kathryn G. Allen, Government Accountability Office, Medicaid – Intergovernmental Transfers Have Facilitated State Financing Schemes, GAO-04-574T, available at <http://www.gao.gov/products/GAO-04-574T> (March 18, 2004).

²⁶⁶ See Medicaid.gov, Accountability Guidance, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/accountability-guidance.html>.

²⁶⁷ KFF, Total Medicaid MCO Enrollment, <http://kff.org/other/state-indicator/total-medicaid-mco-enrollment/>.

²⁶⁸ See Washington State Health Care Authority home page, <http://www.hca.wa.gov/Pages/index.aspx>.

²⁶⁹ KFF, Medicaid MCOs and Their Parent Firms, <http://kff.org/other/state-indicator/medicaid-mcos-and-their-parent-firms/>.

²⁷⁰ See Washington State Health Care Authority, Apple Health (Managed Care), <http://www.hca.wa.gov/medicaid/healthyoptions/pages/healthyoptions.aspx>; see also Northwest Health Law

The Apple Health carriers then contract with providers to deliver health care to enrolled beneficiaries. Such downstream contracts may pay providers based on a variety of models, including capitation, fee-for-service, or other arrangements. All Medicaid providers must sign a Core Provider Agreement with the HCA, even if they are also contracted with an Apple Health carrier.²⁷¹ The Core Provider Agreement generally imposes unilateral obligations on the enrolling provider.²⁷²

Washington's fee-for-service program uses a variety of payment methodologies, depending on the category of service or provider. The Medicaid program mimics many of Medicare's prospective payment systems, but may alter the conversion factors or adjustments included in them. In addition, Washington Medicaid uses per diem payments for a number of services, such as psychiatric inpatient, inpatient rehabilitation, and inpatient detoxification services.²⁷³ The payment methodology is described in detail in the Washington state Medicaid plan.²⁷⁴

Under federal law, Medicaid beneficiaries can be subject to limited cost-sharing. Cost-sharing cannot be more than five percent of a family's monthly or quarterly income.²⁷⁵ No Medicaid cost-sharing is permitted for most children under 18, most low-income pregnant women, and for individuals receiving hospice care.²⁷⁶ Also, no cost-sharing is permitted for certain services, such as emergency services, family planning, or preventive services for children.²⁷⁷ Washington does impose some cost-sharing obligations on Medicaid recipients, such as for unnecessary use of the emergency room.²⁷⁸

20.4.6 Washington Medicaid Waivers

Although states must generally comply with all federal requirements applicable to Title XIX state plans, the federal government may grant waivers to those requirements under two sections of the Social Security Act: 1115 and 1915.²⁷⁹ Section 1115 waivers are broader in scope than Section 1915 waivers, because they allow states greater flexibility to expand both coverage and eligibility, in order to encourage innovative Medicaid programs likely to assist in promoting the objectives of Title XIX. In the past, Section 1115 waivers were used by the states to set up "demonstration projects" that continued for years with little oversight.²⁸⁰ The ACA amends Section 1115 to require that most applications or renewals for waivers under this section provide for more public input and HHS oversight of waiver Section 1115 waiver requests.²⁸¹ Section 1915 waivers are designed to promote cost effectiveness and efficiency, and to encourage the provision of home or community-based services.²⁸² Washington has obtained waivers under both of these authorizations.

Washington currently has only one active Section 1115 waiver, for family planning services. It is known as "Take Charge," and is designed to expand Medicaid-covered family planning services to uninsured people

Advocates, Apple Health Managed Care and Your Rights, http://www.washingtonlawhelp.org/files/C9D2EA3F-0350-D9AF-ACAE-BF37E9BC9FFA/attachments/CECBCA85-4B12-4B85-8BB3-F024CDCF04B9/5111en_apple-health-managed-care-your-rights.pdf.

²⁷¹ See Washington State Health Care Authority, Apple Health (Medicaid), New Providers, <http://www.hca.wa.gov/medicaid/provider/Pages/newprovider.aspx>.

²⁷² See Washington State Health Care Authority, Core Provider Agreement, available at http://www.hca.wa.gov/medicaid/forms/documents/09_015.pdf.

²⁷³ See Washington State Health Care Authority, Medicaid (Title XIX) State Plan, Attachment 4, available at <http://www.hca.wa.gov/medicaid/medicaidsp/Pages/index.aspx>.

²⁷⁴ *Id.*

²⁷⁵ 42 U.S.C. §1396o-1 (2010).

²⁷⁶ *Id.*

²⁷⁷ *Id.*

²⁷⁸ See Washington State Health Care Authority, Medicaid (Title XIX) State Plan, Attachment 4, *supra* note 273.

²⁷⁹ 42 U.S.C. §§1315, 1396n (2010).

²⁸⁰ Barry R. Furrow, Health Care Law 485, *supra* note 35.

²⁸¹ 42 U.S.C. §1315(d) (2010).

²⁸² See Medicaid.gov, 1915(c) Home and Community-Based Waivers, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/home-and-community-based-1915-c-waivers.html>.

of childbearing age who are below 250 percent of FPL, and are not otherwise eligible for Medicaid or the State Children's Health Program ("SCHIP"). This program was first authorized in 2001, and is currently authorized through 2015.²⁸³

Washington currently has 10 active Section 1915 waivers.²⁸⁴ Most of them are related to provision of community-based services for the elderly or people with developmental disabilities. There is also a waiver to allow the state to provide integrated mental health services to the Medicaid population.²⁸⁵

20.4.7 Medicaid Audits

Because Medicaid is a joint federal-state program, audits can be performed by both federal and state agencies. On the federal level, the HHS Office of Inspector General ("OIG"), CMS's Medicaid Integrity Contractors ("MICs"), and Payment Error Rate Measurement Program Contractors ("PERM") may audit Medicaid expenditures. The OIG audits individual Medicaid providers on specific issues, and also performs more comprehensive audits using data-mining to target specific providers for audit. When it targets a specific provider, it may identify multiple areas of expected overpayment for the provider. The OIG has the authority to exclude entities who have engaged in fraud and abuse from participation in federal health care programs, and can impose Civil Money Penalties ("CMPs") for certain misconduct related to federal programs.²⁸⁶ The statute of limitations for fraud claims under the civil False Claims act is six years, with a 10-year statute of repose.²⁸⁷

MICs were created by the Deficit Reduction Act of 2005 ("DRA").²⁸⁸ Their primary purpose is to identify and prevent trends and patterns of aberrant Medicaid billing practices.²⁸⁹ CMS contracts with MICs to perform reviews via data-mining to identify areas of potential Medicaid fraud and abuse, to audit providers, and to carry out educational activities.²⁹⁰ The MIC program has not been successful for CMS; in 2012 the Government Accountability Office ("GAO") reported that although \$102 million had been spent on the MIC program since 2008, only \$20 million in overpayments had been identified during the same time period.²⁹¹ MICs currently use a five-year look-back period from the date of notice of audit.²⁹² In Washington State, the MIC is HMS Federal.²⁹³ The MIC in Washington has reportedly been engaged in audits of dental services recently.²⁹⁴

PERM contractors are hired by CMS, and are supposed to measure and report to Congress improper payment rates annually for Medicaid, and the agency actions being taken to reduce those errors.²⁹⁵ The error rate is measured for each state and then rolled into a national error rate. States must return federal

²⁸³ See Medicaid.gov, Waivers, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html.

²⁸⁴ *Id.*

²⁸⁵ *Id.*

²⁸⁶ See Office of Inspector General, United States Department of Health and Human Services, Civil Money Penalties and Affirmative Exclusions, <https://oig.hhs.gov/fraud/enforcement/cmp/background.asp>.

²⁸⁷ 31 U.S.C. §3731(b) (2011).

²⁸⁸ See CMS.gov, Medicaid Integrity Program – General Information, <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html?redirect=/medicaidintegrityprogram/>.

²⁸⁹ CMS, Dep't of Health and Human Services, Comprehensive Medicaid Integrity Plan 2014-2018

²⁹⁰ CMS, Medicaid Integrity Program Fact Sheet (November 2012), <http://www.cms.gov/medicare-medicicaid-coordination/fraud-prevention/provider-audits/downloads/mip-audit-fact-sheet.pdf>.

²⁹¹ U.S. Gov't Accountability Office, GAO-13-50, Medicaid Integrity Program: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency (2012).

²⁹² *Id.*

²⁹³ Washington State Health Care Authority, Office of Program Integrity, MIC Audits, http://www.hca.wa.gov/medicaid/pi/Pages/opi_mic.aspx.

²⁹⁴ Washington State Dental Association, Medicaid Audits—Will Your Practice be Next? (July 21, 2014), <http://www.wsda.org/headlines/2014/7/21/medicaid-audits-will-your-practice-be-next.html>.

²⁹⁵ See CMS.gov, Research, Statistics, Data & Systems, Payment Error Rate Measurement, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/index.html?redirect=/perm>.

Chapter 20: Government Payors of Medical Services
(prepared from reference materials available as of December 31, 2014)

match associated with any errors identified in their sampled claims, and will be required to develop corrective action plans. States are audited on a three-year rotating schedule, with 17 states measured annually.²⁹⁶ Washington is part of cycle three, which was most recently audited for FY 2014.²⁹⁷ The PERM contractors for all 50 states are The Lewin Group (statistical contractor) and A+ Government Solutions (review contractor).²⁹⁸

On the state level, audits are performed by the Medicaid Recovery Audit Contractors (“RACs”), the state Medicaid agencies, and the state Medicaid Fraud Control Unit (“MFCU”). The ACA extended the pre-existing Medicare RAC program to Medicaid.²⁹⁹ The Medicaid RAC program is similar to the Medicare RAC program, but is run by the states, rather than CMS. Medicaid RACs use a three-year look-back period.³⁰⁰ Washington selected CGI Federal to be the Medicaid RAC, but this contract ended in June 2014.³⁰¹ As of this writing, no announcement has been made regarding the current Medicaid RAC contract.³⁰²

State Medicaid agencies also run their own program integrity audits. The HCA uses both algorithms and complex medical record reviews to audit Medicaid program expenditures in Washington. HCA audits can result in recovery of overpayments based on post-payment review and audit, pre-service denial of authorization requests for services, termination of Core Provider Agreements based on billing and quality of care issues, seeking payment from third parties found liable for payments previously made by Medicaid, and inviting providers to self-review claims identified as potentially improper.³⁰³ The HCA has authority to look back six years, but usually confines audits to a two or three-year period.³⁰⁴

The Medicaid Fraud Control Unit (“MFCU”) is a branch of the Washington State Attorney General’s Office, and employs a full-time team of investigators, auditors, and attorneys. It investigates and prosecutes Medicaid fraud, as well as patient abuse and neglect in health care facilities. The state’s MFCU spending is matched 75% by the federal government.³⁰⁵ The MFCU has historically focused most of its attention on investigation of beneficiary/welfare fraud and egregious provider fraud and abuse cases, rather than routine audits.³⁰⁶ The MFCU can pursue criminal or civil fraud charges against a provider, and can impose monetary penalties.³⁰⁷ Usually, if simple overpayments are at issue, the MFCU will refer the case to HCA for collection.³⁰⁸

²⁹⁶ See CMS.gov, Payment Error Rate Measurement Overview, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/PERMOverview.pdf>.

²⁹⁷ See CMS.gov, Research, Statistics, Data & Systems, Payment Error Rate Measurement, Cycle Three, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Cycle_3.html.

²⁹⁸ See CMS.gov, Research, Statistics, Data & Systems, Review Contractor Directory Interactive Map, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/#wa>.

²⁹⁹ See Patient Protection and Affordable Care Act (“ACA”), Pub. L. No. 111-148 §6411, 124 Stat. 119 (2010).

³⁰⁰ See CMS.gov, Frequently Asked Questions Section 6411(a) of the Affordable Care Act, December 2011, https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/Downloads/Medicaid_RAC_FAQ.pdf.

³⁰¹ Washington State Health Care Authority, Office of Program Integrity, http://www.hca.wa.gov/medicaid/pi/Pages/federal_audits_reviews.aspx.

³⁰² *Id.*

³⁰³ Washington State Health Care Authority, Office of Program Integrity, Frequently Asked Questions, <http://www.hca.wa.gov/medicaid/pi/Pages/faq.aspx>.

³⁰⁴ *Id.*

³⁰⁵ See Washington State Office of the Attorney General, Medicaid Fraud Control Unit, 2013 Annual Report to the Office of Inspector General,

http://www.atg.wa.gov/uploadedFiles/Another/Supporting_Law_Enforcement/Medicaid_Fraud/2013-MFCU-Annual-Report.pdf.

³⁰⁶ *Id.*

³⁰⁷ *Id.*

³⁰⁸ *Id.*

20.4.8 Medicaid Appeals

Providers wanting to challenge payments, reimbursement rates, audit findings, or licensing actions are generally expected to follow an administrative appeals process prior to seeking judicial review.³⁰⁹ The state's appeals process is not subject to any real federal oversight or involvement.³¹⁰ There are greater federal protections for beneficiaries seeking to challenge denials of services or payments for services.³¹¹ There are different rules and regulations that apply to different types of appeals and different types of services; counsel should take care to review the specific rules and regulations applicable to the specific type of appeal at issue.

20.5 Children's Health Insurance Program ("CHIP")

In addition to Medicaid, Washington's Apple Health for Kids program includes another joint federal-state health care program targeting low and moderate-income children, known as the Children's Health Insurance Program ("CHIP," formerly known as the State Children's Health Program or "SCHIP"). The CHIP program was created as part of the 1997 Balanced Budget Act, Title XXI of the Social Security Act.³¹² Unlike Medicaid, the program is not an entitlement program, but a grant-in-aid program whereby the federal government provides block grants to the states, which have considerable flexibility in designing the program within broad federal guidelines.³¹³ States must match the federal funds they receive in accordance with a formula that provides more generous federal financial participation than is afforded under Medicaid. Under the ACA, beginning in 2015, states receive a 23 percent increase in the CHIP match rate, up to a cap of 100 percent. Washington currently receives a match of 65 percent, and will receive enhanced federal financial participation of 88 percent starting in October 2015, through September 2019.³¹⁴ Nevertheless, funding for CHIP is currently extended only through 2015.³¹⁵ If there are insufficient funds to enroll all eligible children in CHIP, CHIP-eligible children should be covered through the ACA's health exchanges with tax credits and premium subsidies available.³¹⁶

States participating in CHIP may use CHIP funds to expand their existing Medicaid programs to cover additional children, or to establish a separate program to cover children who are not eligible for Medicaid nor covered by private health insurance, or they may combine the two approaches.³¹⁷ Washington has established a separate program for CHIP, although Washington uses the same application for CHIP as it uses for its Medicaid program.³¹⁸

Children residing in families below 210 percent of the federal poverty level ("FPL") are eligible for free coverage under CHIP.³¹⁹ Families above 210 percent of the FPL but not above 260 percent of the FPL must pay \$20 per month per child in premiums.³²⁰ Families above 260 percent of the FPL and below 312 percent of the FPL pay a \$30 per month per child premium, but no family pays more than two premiums, regardless of the number of children enrolled.³²¹ Children under age 19, who are Washington residents, not covered by any other health insurance (including Medicaid or affordable employer-based insurance), and U.S. nationals, citizens, or legally present aliens, are eligible.³²² Washington has eliminated any waiting

³⁰⁹ See, e.g., WAC 188-502 and WAC 188-502A.

³¹⁰ 42 C.F.R. §447.253(e) (2010).

³¹¹ See 42 U.S.C. §1396a(a)(3) (2011); 42 C.F.R. §§431.200-431.250 (2010).

³¹² 42 U.S.C. §§1397aa-1397jj (2011).

³¹³ Barry R. Furrow, Health Law 497, *supra* note 35.

³¹⁴ *Id.* at 498.

³¹⁵ Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, §10203, 24 Stat. 119 (2010).

³¹⁶ *Id.* at §2101(b).

³¹⁷ Barry R. Furrow, Health Law 497, *supra* note 35.

³¹⁸ National Academy for State Health Policy, Washington 2014 CHIP Fact Sheet, <http://www.nashp.org/washington-2014-chip-fact-sheet>.

³¹⁹ *Id.*

³²⁰ *Id.*

³²¹ *Id.*

³²² See Washington Apple Health For Kids, http://www.hca.wa.gov/applehealth/pages/more_information.aspx.

period for CHIP coverage.³²³ In 2012, over 88 percent of eligible children in Washington were enrolled in CHIP.³²⁴

Benefits under CHIP are substantially identical to the children’s benefits in the state’s Medicaid program, and the services are delivered through the Medicaid managed care delivery system, Healthy Options.³²⁵ There are “carve-outs” for certain services that are separately contracted and paid for on a fee-for-service or other contract basis, such as dental care, chemical dependency, and institutional long-term care.

20.6 Other State Medical Programs

There are a few other medical assistance programs offered by the Department of Social and Health Services (“DSHS”). They generally target small, specific populations with emergency medical needs, who are not eligible for other medical assistance programs such as Medicaid or CHIP. Among these are the Alien Emergency Medical (“AEM”) program, for aliens who are ineligible for other state or federal benefits due to their immigration status,³²⁶ medical care services for lawful immigrants who are disabled or over age 65 but not eligible for Medicaid,³²⁷ and the Psychiatric Indigent Inpatient (“PII”) program, which covers inpatient hospital services for low-income clients who voluntarily commit themselves to inpatient treatment for an emergent psychiatric condition.³²⁸ Each program has its own rules and regulations that must be followed.

20.6.1 Public Employee Benefits Board

The WHCA oversees the Public Employee Benefits Board (“PEBB”), which purchases and coordinates health insurance benefits for eligible public employees and retirees.³²⁹ The PEBB contracts with several different health plans to provide medical services to its members, including Group Health Cooperative, Kaiser Permanente, and the Uniform Medical Plan (“UMP”).³³⁰ The UMP is self-insured by Washington State, and is a preferred provider network administered by Regence BlueShield and Washington State Rx Services.³³¹ Insurance options available to PEBB members include HMOs and a high-deductible consumer-directed health plan.³³² As of November 2014, over 350,000 people were covered by the PEBB, and over 225,000 of those covered by the PEBB were enrolled in the UMP.³³³

20.6.2 Washington State Department of Labor and Industries (“L&I”)

Programs administered by L&I include the state workers’ compensation program and the Crime Victims Compensation Program (“CVCP”). Both of these programs provide some medical coverage. The state workers’ compensation program provides coverage for persons suffering job-related injury or illness. Washington’s workers’ compensation program is a no-fault system funded by premiums paid by employers and workers, and investment earnings.³³⁴

CVCP provides medical coverage for certain victims of serious crimes and their families. CVCP is the payor of last resort, and will only pay if the victim has no insurance, the victim’s insurance does not cover

³²³ National Academy for State Health Policy, Washington 2014 CHIP Fact Sheet, *supra* note 318.

³²⁴ *Id.*

³²⁵ See Northwest Health Law Advocates, Coverage for Children, <http://nohla.org/infoAnalysis/coverOps-child.php>.

³²⁶ See Washington Health Care Authority, Alien Emergency Medical (AEM), <http://www.hca.wa.gov/medicaid/aem/Pages/index.aspx>.

³²⁷ *Id.*

³²⁸ See Washington State Department of Social and Health Services, Emergency Assistance – Psychiatric Indigent Inpatient (PII), http://www.dshs.wa.gov/manuals/eaz/sections/MedicalAssistance/EA_MI.shtml.

³²⁹ See Washington State Health Care Authority, PEBB – About PEBB, http://www.hca.wa.gov/pebb/Pages/about_pebb.aspx; RCW 41.05.

³³⁰ See Washington State Health Care Authority, PEB- PEBB Medical Plans, <http://www.hca.wa.gov/pebb/Pages/medical.aspx>.

³³¹ *Id.*

³³² *Id.*

³³³ See Washington State Health Care Authority, PEBB Enrollment Report for November 2014 Coverage, http://www.hca.wa.gov/pebb/Documents/carrier_112014.pdf.

³³⁴ See RCW Title 51.

the medical treatment needed, or the victim has exceeded the insurer's coverage limit.³³⁵ Reimbursement rates are quite low, similar to Medicaid rates for most hospital services, and a percentage of the L&I rate for most physicians' services.³³⁶ Total funding available for fiscal year 2015 is approximately \$11.5 million.³³⁷

20.6.3 Washington State Health Insurance Pool

The Washington State Health Insurance Pool ("WSHIP") is a legislatively created non-profit health plan.³³⁸ Prior to the ACA, it operated as a statewide high-risk health insurance pool for those who could not find private insurance or Medicare supplemental coverage because of high-cost pre-existing health conditions.³³⁹ Because the ACA prohibits private insurers from discriminating based on pre-existing health conditions, the WSHIP no longer serves this function, except for a very limited group of people who were in the pool prior to January of 2014 and/or do not have private insurance available to them.³⁴⁰ Non-Medicare insurance through the WSHIP is scheduled to be discontinued on December 31, 2017.³⁴¹

WSHIP continues to provide supplemental insurance to Medicare beneficiaries who cannot find adequate private supplemental Medicare insurance for various reasons such as pre-existing conditions or unavailability of policies where the beneficiary lives, and do not have a reasonable choice of Medicare Advantage plans.³⁴² The program is funded through premiums and assessments on health carriers doing business in Washington.³⁴³ WSHIP uses Benefit Management Inc. ("BMI") to administer its insurance plans, and Express Scripts to administer its pharmacy benefits.³⁴⁴ WSHIP uses First Choice Health's Preferred Provider Organization as its provider network.³⁴⁵ As of October 2014, 712 people were enrolled in the non-Medicare WSHIP plans, and 1,070 were enrolled in the Medicare plans.³⁴⁶

³³⁵ See Washington State Department of Labor & Industries, Crime Victims Compensation Program, Helping Providers Understand the Crime Victims Compensation Fund, available at <http://www.lni.wa.gov/IPUB/800-102-000.pdf>.

³³⁶ See Washington State Department of Labor & Industries, Help for Crime Victims, Provider Resources, <http://lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/default.asp#Pmt>.

³³⁷ See Washington State Department of Labor & Industries, About Crime Victims Compensation, <http://lni.wa.gov/ClaimsIns/CrimeVictims/About/Default.asp>.

³³⁸ See Washington State Health Insurance Pool, <https://www.wship.org/>.

³³⁹ See Washington State Health Insurance Pool, About WSHIP, History and Purpose, <https://www.wship.org/wship.asp>.

³⁴⁰ *Id.*

³⁴¹ *Id.*

³⁴² See Washington State Health Insurance Pool, Eligibility, https://www.wship.org/medicare_eligibility.asp.

³⁴³ See Washington State Health Insurance Pool, About WSHIP, Structure and Administration, <https://www.wship.org/structure.asp>.

³⁴⁴ *Id.*

³⁴⁵ *Id.*

³⁴⁶ See Washington State Health Insurance Pool, About WSHIP, Yearly and Monthly Operating Reports, https://www.wship.org/yearly_reports.asp.