NO. 96110-7

SUPREME COURT OF THE STATE OF WASHINGTON

CHEHALIS CHILDREN'S CLINIC, P.S.,

Appellant,

v.

WASHINGTON STATE HEALTH CARE AUTHORITY,

Respondent.

RESPONDENT'S ANSWER TO PETITION FOR REVIEW

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Rules

Regulations

I. INTRODUCTION

The Health Care Authority ("HCA") overpaid Chehalis Children's Clinic, P.S. ("CCC") by approximately $212,000 in connection with services provided by CCC to Medicaid clients in calendar year 2009. The Legislature forgave nearly $138,000 of the overpayment, meaning CCC still owed approximately $74,000. CCC did not dispute that it was overpaid. Instead, CCC invoked the principle of equitable estoppel in an attempt to avoid repaying the money. CCC failed to establish by clear, cogent, and convincing evidence (the standard required by law) that equitable estoppel prevents HCA from complying with federal and state law by recouping money that CCC conceded should not have paid in the first instance. The final administrative order rejected the argument, as did the Superior Court and the Court of Appeals in an unpublished decision.

Review by this Court is not warranted. The Court of Appeals applied a straightforward analysis of equitable estoppel as outlined in HCA's regulation, which in turn was the progeny of this Court's decision in *Kramarevcky v. Dep't of Soc. & Health Servs.*, 122 Wn.2d 738, 863 P.2d 535 (1993). Contrary to the assertion of CCC, there is no conflict between *Kramarevcky* and the Court of Appeals' decision. The Court should deny the Petition for Review ("Petition").

II. ISSUE PRESENTED

Did CCC fail to establish by clear, cogent, and convincing evidence that equitable estoppel prevented HCA from recovering the overpayment to the extent not forgiven by the Legislature, when (a) CCC conceded it was overpaid; (b) CCC did not reasonably rely on an expectation of not being subject to an audit; and (c) applying estoppel would impair the exercise of HCA's governmental functions to ensure compliance with federal and state law regarding proper levels of Medicaid payments?

III. COUNTERSTATEMENT OF THE CASE

The Medicaid program provides healthcare benefits to low-income individuals. *See* RCW 74.09.500. HCA administers the program in Washington. *See* Court of Appeals Opinion ("Slip Op.") at 2.[1] HCA enters into contracts with healthcare providers who, in turn, furnish medically necessary services to Medicaid clients. CP at 11 (Review Decision and Final Order, Finding of Fact 1). As required by federal and state Medicaid law, HCA periodically reviews the payments it has made to healthcare providers to ensure they were neither underpaid nor overpaid. *See* Slip Op. at 4-6; CP

[1] CCC incorrectly states that HCA is a unit within the Department of Social and Health Services ("DSHS"). *See* Petition at 8. In fact, HCA is a separate Cabinet-level agency, on par with DSHS and others. *See* RCW 41.05.006(2) (HCA's overall responsibilities); RCW 43.20A.010 (DSHS's overall responsibilities). HCA assumed responsibility from DSHS for the Medicaid program in 2011. *See* RCW 41.05.021(1)(m); RCW 74.09.500; Slip Op. at 1 n.1.

at 13-14 (Review Decision and Final Order, Finding of Fact 12). If a discrepancy is discovered, HCA either makes an additional payment or recoups the excess payment. CP at 13-14 (Review Decision and Final Order, Finding of Fact 12).

HCA has two types of contractual arrangements in order to provide healthcare benefits to Medicaid clients. First, under the "fee-for-service" component of the program, HCA contracts with individual providers who then directly bill HCA for their services. *See* RCW 74.09.120(5). Second, HCA contracts with managed care organizations ("MCOs"), who in turn enter into contracts with individual providers. *See* RCW 74.09.522. Under the MCO arrangement, HCA makes a monthly per-client payment to the MCO, and providers bill the MCO for services furnished to Medicaid clients enrolled in the MCO. *St. John Med. Ctr. v. State ex rel. Dep't of Soc. & Health Servs.*, 110 Wn. App. 51, 56, 38 P.3d 383 (2002).

During the time for which HCA seeks recovery, CCC had a contract with HCA for the fee-for-service component of Medicaid. *See* Slip Op. at 6; CP at 11 (Review Decision and Final Order, Finding of Fact 1). CCC also had contracts with MCOs. *See* Slip Op. at 6. As such, depending on the client being served, CCC received payments from either HCA or an MCO.

Federal law specifies how HCA must pay rural health clinics, such as CCC, for their Medicaid services. *See* Slip Op. at 3; CP at 25-26 (Review

Decision and Final Order, Conclusions of Law 12-13). If the parties choose to use the standard methodology, known as the Prospective Payment System, HCA pays the clinic its reasonable costs. *See* Slip Op. at 3. If the parties choose to use a different methodology, known as the Alternative Payment Methodology, HCA pays an amount that at least equals what the clinic would have received under the Prospective Payment System. *Id.* Under either system, HCA's payments are known as the "encounter rate." *See* Slip Op. at 2, 6. For the time periods relevant to this case, CCC chose to be paid under an Alternative Payment Methodology. *See* Slip Op. at 6.

When a clinic sees a Medicaid client who is enrolled in managed care, it is paid by the MCO. *See* Slip Op. at 3. Plus, the clinic can receive an extra payment from HCA, known as an "enhancement payment," if the MCO's payment is lower than what the Prospective Payment System amount would have been. *Id.* In this case, for services provided to Medicaid clients enrolled in MCOs in 2009, CCC received payments from MCOs as well as enhancement payments from HCA. *See* Slip Op. at 6-7. To make sure CCC was neither underpaid nor overpaid, HCA performed a reconciliation of the payments that it and the MCOs had made. *Id.* The purpose was to ensure CCC's overall payments matched what it would have received under the Prospective Payment System. *See* Slip Op. at 4-6.

HCA concluded that it had overpaid CCC by approximately $212,000 in enhancement payments. *See* Slip Op. at 7. Through a provision in the 2014 operating budget, the Legislature forgave CCC and other clinics of approximately two-thirds of the 2009 overpayments, thus reducing CCC's obligation to about $74,000. *Id.*

CCC disputed the overpayment and requested an adjudicative proceeding at the Office of Administrative Hearings. *See* Slip Op. at 7. The initial findings by an administrative law judge determined that HCA overpaid CCC but that equitable estoppel foreclosed HCA from recovering the money. *See* Slip Op. at 8, 9. HCA appealed to the agency Board of Appeals, which reversed the estoppel finding and allowed HCA to pursue the recovery. *See* Slip Op. at 10-11. On judicial review, the Thurston County Superior Court and then the Court of Appeals, Division II, affirmed the Board of Appeals. *See* Slip Op. at 11.

The Court of Appeals held that CCC had failed to establish two of the five required elements of equitable estoppel. *See* Slip Op. at 12, 19, 21, 24. In particular, CCC did not establish either (1) "reasonable reliance" on HCA's actions prior to its recoupment efforts or (2) that HCA's required government functions, such as complying with federal Medicaid law, would not be impaired if HCA were precluded from recouping the overpayment. *See* Slip Op. at 21, 24.

IV. REASONS WHY THE COURT SHOULD DENY REVIEW

Under RAP 13.4(b), there are four limited circumstances in which the Court may accept review of a Court of Appeals decision. CCC argues that one criterion applies—RAP 13.4(b)(1)—and that the Court of Appeals decision conflicts with this Court's decision in *Kramarevcky*. *See* Petition at 7. CCC is mistaken.

A. The Court of Appeals Ruling Does Not Conflict with *Kramarevcky*

The issue in *Kramarevcky* was whether recipients of public assistance could assert the defense of equitable estoppel when DSHS attempted to recoup alleged overpayments from them and, if so, whether the plaintiffs had satisfied each element. *Kramarevcky*, 122 Wn.2d at 740, 743. The trial court ruled in that case that the plaintiffs could assert estoppel (which DSHS did not appeal). *Id.* at 740. This Court ultimately held that the plaintiffs had satisfied one element of estoppel and that DSHS had not preserved arguments concerning two of the elements. *Id.* at 744, 750. In the instant case, since the Court of Appeals unambiguously recognized that CCC could claim equitable estoppel, there is no conflict at all on the key ruling from *Kramarevcky*. At most, the Petition presents this Court with a fact-bound question of whether the law established in that case was correctly applied.

CCC does not show any meaningful conflict between *Kramarevcky* and the Court of Appeals decision. CCC makes the bare assertions that the Court of Appeals decision "is at odds with the decision in *Kramarevcky*" and "is in conflict with *Kramarevcky*." *See* Petition at 8. But CCC never explains how or why the decision conflicts with *Kramarevcky*. In fact, there is no conflict and no basis for review under RAP 13.4(b)(1).

For example, the Court of Appeals ruled "that the Board's findings support its conclusion that the Clinic failed to prove that it reasonably relied on the Agency's overpayment." *See* Slip Op. at 21. This fact-bound determination of no reasonable reliance is limited to this case and thus cannot conflict with *Kramarevcky*. Indeed, the Court of Appeals decision takes pains to confirm that the relevant findings are fully supported by the record, *see* Slip Op. at 21-23, which illustrates how CCC cannot claim any conflict with substantive law and merely seeks to reargue the factual basis for its lack of any reasonable reliance.

Similarly, the Court of Appeals concluded that estoppel could not apply because it would impair the exercise of government functions. *See* Slip Op. at 23. CCC's argument on this element depended on a dubious theory that no government function was at risk when HCA sought to reconcile payments and recover overpayments. That view of HCA's functions has no basis in state or federal law. *See* Slip Op. at 24. In any

event, it is implausible to claim that this ruling conflicts with *Kramarevcky*, which neither involved those same governmental functions nor suggested that such functions these should be impaired by equitable estoppel.

B. The Court of Appeals Ruling Makes No Change to the Substantive Law Concerning Equitable Estoppel

CCC agrees that DSHS, which administered Medicaid until 2011, adopted a regulation in the wake of *Kramarevcky* outlining how public assistance clients could assert equitable estoppel against the agency. *See* Petition at 8. CCC then acknowledges that HCA later "adopted the same definition of equitable estoppel" as DSHS. *Id.* The elements of estoppel outlined in *Kramarevcky* and HCA's regulation are the same. *See* WAC 182-526-0495; *Kramarevcky*, 122 Wn.2d at 743-44. Again, the presence of this regulation, which is admittedly based on *Kramarevcky*, disproves the existence of any substantive conflict in the legal principles that govern equitable estoppel. The principles have not changed, and the Court of Appeals applied them appropriately.

C. The Clinic's Appeal Seeks to Retry its Case and Avoid the Findings

CCC claims it satisfied all five of the estoppel elements, including reasonable reliance and impairment of government functions. *See* Petition at 10-15. But this is not a basis for a third level of appellate review on the fact-bound issue decided by the Superior Court and the Court of Appeals.

In any event, the Court of Appeals was correct on the merits. As the party asserting estoppel, CCC had the heavy burden of proving each element by clear, cogent, and convincing evidence. *Kramarevcky*, 122 Wn.2d. at 744. "Courts should be most reluctant to find the government equitably estopped when public revenues are involved." *Id.* CCC did not meet its burden. *See* Slip Op. at 21, 25.

CCC did not cite to any contract or other binding obligation under which the State promised to pay the clinic more than what it was entitled to receive under the Prospective Payment System. Similarly, CCC did not deny receiving direct communications from HCA, stating explicitly that the amount of the encounter payments and enhancement payments must exactly match what CCC would have received under the Prospective Payment System. *See* Slip Op. at 22-23; CP at 28 (Review Decision and Final Order, Conclusion of Law 20).

As noted above, the two elements of estoppel where the Court of Appeals rejected CCC's claim were reasonable reliance and impairment of government functions. *See* Slip Op. at 21-25.[2] With respect to reliance, CCC "had full notice of federal Medicaid statutes and instructions from the

[2] Given its holding on these two elements, the Court of Appeals deemed it unnecessary to examine the "manifest injustice" element, which CCC also had raised. *See* Slip Op. at 25. The remaining two elements of estoppel were not at issue, having been decided by the agency's final order.

federal government about the reconciliation and enhancement payment process." *See* Slip Op. at 21-22. Plus, under its contract with the State, CCC was subject to all applicable statutes, regulations, billing instructions, and similar guidelines. *See* Slip Op. at 22. CCC also knew about a federal audit that required the State to change its methodology to ensure that the combination of the encounter and enhancement payments exactly matched what CCC would have received under the Prospective Payment System. *Id.* Further, CCC knew about an amendment to the State's Medicaid Plan, approved by the federal government, specifying the methodology that had been updated after the federal audit. *Id.* Finally, CCC received a letter from the State in 2008 summarizing the federal audit, the amendment to the State Plan, the reconciliation process, and the possibility of recouping overpayments. *See* Slip Op. at 22-23. Accordingly, CCC did not meet its burden on the reliance element. *See* Slip Op. at 23.

> Based on these facts, it was not reasonable for [CCC] to believe that it would never be requested to repay overpaid enhancement payments or that the enhancement payments were simply "additional" income.

Id.

CCC also did not meet its burden on the impairment of government functions prong. *See* Slip Op. at 24. As the Court noted, the federal Centers for Medicare and Medicaid Services ("CMS"):

> authorized the [State's] enhancement payment and reconciliation process in 2009 after the [State] amended its process. CMS approved the amended [Medicaid State Plan] which required the [State] to pay estimated enhancement payments to [rural health clinics such as CCC] throughout the year followed by a reconciliation of those payments to determine if enhancement payments brought the [clinics] total to an amount exactly equal to what the [clinic] were entitled to receive. Thus, it is clear that any restriction on the [State's] ability to collect enhancement overpayments would impair the [State] from obeying its federal Medicaid mandate[.]

See Slip Op. at 24. The Court of Appeals' reasoning is sound and does not implicate any of the criteria of review in RAP 13.4(b).

V. CONCLUSION

In arguing against publication of the Court of Appeals decision, CCC stated that "this case is not of general public interest or importance[.]" *See* Appellant's Answer to Resp't's Mot. to Publish Op. at 3. CCC also stated that "this case does nothing to clarify [the] already established principle" of equitable estoppel; instead, the case "merely proclaims that [CCC] failed to persuade the Court as to two" of the estoppel elements. *Id.* These statements confirm that the Petition does not present any conflict and does not satisfy the requirements of RAP 13.4(b)(1). The State respectfully requests that the Court deny the Petition.

RESPECTFULLY SUBMITTED this 30th day of August 2018.

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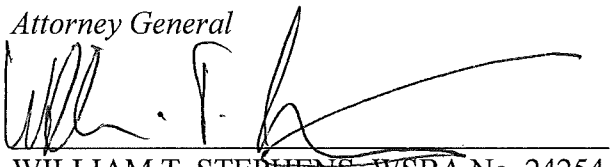

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I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 30th day of August 2018, at Tumwater, Washington.

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SOCIAL AND HEALTH SERVICES DIVISION, ATTORNEY GENERALS OFFICE

August 30, 2018 - 11:06 AM

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