NO. 97557-4

**SUPREME COURT OF THE STATE OF WASHINGTON**

PEACEHEALTH ST. JOSEPH MEDICAL CENTER AND
PEACEHEALTH ST. JOHN MEDICAL CENTER,

Petitioners,

v.

STATE OF WASHINGTON, DEPARTMENT OF REVENUE,

Respondent.

# DEPARTMENT OF REVENUE'S ANSWER TO BRIEFS OF AMICI CURIAE SEATTLE CHILDREN'S HOSPITAL, SEATTLE CANCER CARE ALLIANCE, HARBORVIEW MEDICAL CENTER, AND THE WASHINGTON STATE HOSPITAL ASSOCIATION

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## I. INTRODUCTION

This Court should deny PeaceHealth's petition for review because this case does not present a close call regarding the plain meaning or constitutionality of the B&O tax deduction statute at issue. To the extent the amici curiae Hospitals raise debatable issues of tax policy, the Legislature is the appropriate forum to address the issues.

In providing a B&O tax deduction for medical services covered under Washington's Medicaid program, the Legislature appropriately furthers its policy objective of extending the purchasing power of the limited dollars available for appropriation from the State's general fund. Neither the Medicaid Act nor the Commerce Clause required it to provide a tax subsidy for any other state's Medicaid program.

## II. ARGUMENT

### A. RCW 82.04.4311 Does Not Apply to Hospital Revenues From Out-of-State Medicaid/CHIP Programs

None of the amicus briefing submitted in support of PeaceHealth's petition for review provides additional argument or authority casting doubt on the correctness of the Court of Appeals' interpretation of the statute at issue. The Hospitals overstate the scope of the general statement of legislative intent, which in any event cannot trump the operative provisions of RCW 82.04.4311. Further, the federal regulations discussed

by the Washington State Hospital Association (WSHA) reinforce the conclusion that each state is financially responsible for the Medicaid services provided to its residents. No state has to finance any other state's Medicaid program via a tax subsidy or otherwise.

### 1. The legislative findings in RCW 82.04.4311 do not supersede its operative provisions and are misconstrued by the Hospitals

The Hospitals rely heavily on the legislative findings in the 2002 session law to argue that the Court of Appeals misinterpreted RCW 82.04.4311 by concluding the statute does not apply to out-of-state Medicaid receipts. The Legislature found that providing publicly financed health care benefits for elderly, disabled and low-income persons is a "vital government function" and that it would be inconsistent with that function to tax a public or nonprofit hospital for amounts received "under a health service program subsidized by federal or state government." Laws of 2002, ch. 314, § 2. The Hospitals contend that "state government" means "government writ large" and reflects legislative intent to exempt out-of-state Medicaid receipts from the B&O tax.

The legislative findings in section one of House Bill 2732 do not broaden the scope of the B&O tax deduction, which is authorized in sections two and three of the session law. Codified legislative findings are relevant in discerning the plain meaning of a statute, but they cannot

trump the operative statutory provisions or create ambiguity where none exists. *State v. Reis*, 183 Wn.2d 197, 212, 351 P.3d 127 (2015). This is true even when the statement of intent "speaks directly to the enacted statute." *Kilian v. Atkinson*, 147 Wn.2d 16, 23-24, 50 P.3d 638 (2002). Although the Legislature referred generally to "state government" in the intent section, it specifically described the health services programs established under Washington law when defining the scope of the deduction. If the Legislature had intended to provide a deduction for any state's Medicaid program it could have done so by referencing the federal Medicaid Act, just as it did in authorizing a deduction for Medicare.

Moreover, even if this Court were to consider the legislative findings, the Hospitals overstate their meaning, which must be read in the context of the legislation's purpose and history. The Legislature first introduced the statutory language at issue here as an amendment to former RCW 82.04.4297 for the purpose of addressing a gap in the reimbursement process created through the rising use of managed care organizations. Former RCW 82.04.4297 only allowed public and nonprofit health care providers to deduct payments "from" Washington State or the federal government and their various instrumentalities or subdivisions, not through contracted managed care organizations. The Legislature closed this gap by adding the statutory language at issue first as an *amendment* to

RCW 82.04.4297, then as a standalone, substantively similar statute codified as RCW 82.04.4311. AR 87 (H.B. Rep. 2732, 57th Leg. (2002)); AR 73 (H.B. Rep. 1624, 57th Leg. (2001)).

When the statutory language was first added to RCW 82.04.4297, however, the Legislature explained that the purpose of the B&O deduction *and* the amendment was "to provide government with greater purchasing power when government provides financial support for the provision of health or social welfare services to benefited class of persons." *See* AR 73 (H.B. Rep. 1624, 57th Leg. (2001)); *see also id.* (confirming "[t]he legislature further finds that the objective of these changes is again to extend the purchasing power of scarce government health care resources . . ."). These findings confirm the Court of Appeals' conclusion that the B&O deduction was intended to stretch *Washington's* dollars as a participant in the market for medical services. Nothing in the Legislature's findings for RCW 82.04.4311, reflecting substantively similar language as the prior amendment to RCW 82.04.4297 (and which also focused on public and nonprofit hospitals), suggests the Legislature suddenly intended to subsidize the care of other states' residents, or to stretch the dollars of other states for the provision of medical services.

To the contrary, the legislative findings are entirely consistent with limiting the B&O tax deduction to Washington's Medicaid program when

the reference to "state government" is properly understood as referring to the Washington state government. The Legislature was not purporting to speak on behalf of any other legislative body. Each state government sets its own tax policy relating to Medicaid financing.[1] Congress affirmatively gave the states permission to fund Medicaid through "health care related taxes" imposed on hospitals and 18 other categories of health care providers. *See* 42 U.S.C. § 1396b(w)(3)(A); AR 113 (discussing the "significant variation" in state funding sources, including reliance on "provider taxes" to finance the state share of Medicaid); AR 157.

Other state governments may decide that taxing Medicaid receipts is entirely consistent with their vital governmental functions. The State of Oregon, for example, funds the bulk of its Medicaid program through a 4.3 percent hospital tax, which it then uses to secure federal matching funds for covered services. AR 153-54 ("Smooth Passage Expected for Four-Year, $1.4 Billion Hospital Tax"). When Washington residents receive Medicaid services at Oregon hospitals, Washington must shoulder the economic burden of the health care related taxes imposed by the Oregon state government. Likewise, when out-of-state residents receive

[1] *See* Medicaid and CHIP Program Access Commission (MACAC), 2012. *Health Care Related Taxes in Medicaid, available at* https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-HealthCareRelatedTaxesInMedicaid_2012-08.pdf.

Medicaid services in Washington, the financially responsible state must shoulder the economic burden of Washington's tax policies.

The Court of Appeals correctly held that RCW 82.04.4311 clearly and unambiguously allows a deduction only for compensation received for providing medical services covered under Washington's Medicaid, CHIP, and other state-funded programs, not those of any other state.

### 2. The federal regulations on residency and out-of-state services underscore that each state is financially liable for out of state Medicaid services

WSHA contends review is warranted because the Court of Appeals failed to interpret RCW 82.04.4311 in the context of pertinent federal regulations. But the cited regulations only underscore that each state is financially responsible for the Medicaid services its residents receive.

WSHA points to a federal regulation, 42 C.F.R. § 435.403(m), which addresses thorny issues of residency status that can arise when an eligible individual has ties to multiple states. The regulation creates rules for specific situations and otherwise allows the states to resolve residency status through interstate agreements. WSHA fails to explain, however, how the potential uncertainty over residency has any bearing on this case.

This case does not raise any issues of ambiguous residency. PeaceHealth claims it is entitled to a B&O tax refund on its gross receipts from services that were clearly covered under another state's Medicaid

program, primarily Oregon. If and when uncertainty over residency causes a B&O tax dispute, this Court can address such issues then.

The existence of interstate agreements on residency does not transform medical services provided to those insured under another State's Medicaid program into services "covered under" Washington's Medicaid program within the meaning of RCW 82.04.4311. The federal regulation discussed by WSHA makes clear the purpose of an interstate agreement is to ensure Medicaid-eligible individuals receive necessary services pending the determination of state residency. Once residency is established, either one state or the other will be financially liable. If Washington assumes financial liability by virtue of a federal regulation or an interstate agreement, those services will be "covered under" Washington's Medicaid program and the B&O deduction will apply. But payments for medical services covered under another state's Medicaid program are outside the clear scope of RCW 82.04.4311.

WSHA also fails to show how the Court of Appeals' interpretation is inconsistent with the federal regulation addressing out-of-state Medicaid services. 42 C.F.R. § 431.52 requires each state "to pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries" in limited circumstances (e.g. medical emergencies). If anything, the regulation shows that the Hospitals should

look to the financially-liable state for reasonable compensation: Washington has no duty to make up for any shortfalls resulting from another state's inadequate Medicaid reimbursement policies.

WSHA points to language in 42 C.F.R. § 431.52 requiring each state to provide "procedures" for "facilitating" access to care for out- of-state Medicaid patients. The State's duty to provide such procedures does not mean medical services provided to nonresidents are "covered under" Washington's Medicaid program for purposes of the deductibility of hospital revenues. The Legislature was not required to provide a tax subsidy of any other state's medical expenditures.

Washington hospitals are free to challenge the adequacy of the reimbursement rates paid by other states. *See Mary Hitchcock Memorial Hospital v. Cohen,* No. 15-cv-453-LM, 2016 WL 1735818 (D.N.H. 2016) (allowing Vermont hospital to challenge adequacy of rates paid by New Hampshire as contrary to 42 C.F.R. § 431.52). Apart from certain emergency services hospitals nationwide are required to make available under federal law without regard to a patient's ability to pay, Washington hospitals can demand higher reimbursement rates as a condition of providing services covered under another state's Medicaid program. *See Asante v. Calif. Dep't of Health Care Servs.*, 886 F.3d 795, 801 (9th Cir.

2018) ("the Hospitals are not required to participate in the Medi-Cal insurance program; no hospital is").

The B&O taxes imposed on public and nonprofit hospitals are part of the costs of doing business in Washington that hospitals can pass on through their billed charges. Taxes are included in the "allowable costs" of Medicaid services for which a state may reimburse a hospital.[2] 42 U.S.C. § 1396b(w)(3); *Breckinridge Health, Inc. v. Price*, 869 F.3d 422, 425 (6th Cir. 2017). Thus, extending the deduction to out-of-state Medicaid receipts actually would lower the amount another state could reimburse a Washington hospital with the support of federal matching funds.

### 3. The tax policy considerations raised by the Hospitals do not support the petition for review

The Hospitals assert this case raises an issue of substantial public importance because "[t]axing out of state Medicaid receipts reduces the resources available to provide unreimbursed care." Seattle Children's Hosp. at 5. It is just as true that exempting such receipts would reduce the resources available to provide other public services, such as roads, police, and fire protection, our state government provides for everyone's benefit,

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[2] CMS Provider Reimbursement Manual 15-1, Section 2122.1 ("The general rule is that taxes assessed against the provider, in accordance with the levying enactments of the several States…for which the provider is liable for payment, are allowable costs"), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R448PR1.pdf

including those who come into Washington to access medical services. The Legislature has the discretion to tax or not to tax amounts Washington hospitals receive from out-of-state Medicaid patients. These are issues to raise to the Legislature, not to this Court.

Here, the Legislature has spoken. By imposing the B&O tax on public and nonprofit hospitals, the Legislature deemed it appropriate to allocate part of the cost of state government to these entities. *See* RCW 82.04.260(10) (B&O tax classification for public and nonprofit hospitals).

The relationship between state tax policy and Medicaid financing is complex. Congress permitted the states to cover the state share of Medicaid with revenues raised from "health care related taxes." 42 U.S.C. § 1396b(w)(3)(A); 42 C.F.R. § 433.56. Nearly every state does so, including Washington.[3] A state can use the proceeds to pay for Medicaid and then receive federal funds for those payments, so every tax dollar collected results in at least two dollars of Medicaid funding.[4]

For example, in 2010, Washington hospitals asked the Legislature to impose a hospital excise tax to leverage the availability of federal

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[3] *See* https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-HealthCareRelatedTaxesInMedicaid_2012-08.pdf.

[4] The percentage of federal matching funds varies from 50% to 90% based on the category of Medicaid eligibility and state-specific personal income data. *See* http://files.kff.org/attachment/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates-issue-brief.

matching funds during an economic downturn that reduced the general fund revenues available for appropriation to the Medicaid program. *See Washington State. Hosp. Ass'n v. State*, 175 Wn. App. 642, 309 P.3d 534 (2013). The legislative intent of the excise tax, known as the Hospital Safety Net Assessment Program (SNAP), is to generate additional state and federal Medicaid funding and increase Medicaid payment rates to hospitals. Laws of 2010, 1st Sp. Sess., ch. 30, § 1; *see* RCW 74.60.005. The Legislature has worked in collaboration with WSHA in subsequent legislative sessions to refine and expand the program.[5]

WSHA's successful collaboration with the Legislature in crafting the SNAP program shows how the relationship between Medicaid financing and the State's tax policy is complicated and dynamic. It also demonstrates WSHA's ability to shape the State's tax policy through the legislative process. Here, WSHA and the Hospitals are trying to make an end-run around the legislative process by persuading the courts to broadly interpret a B&O tax deduction the Legislature enacted at their behest in 2002. The legislative history shows RCW 82.04.4311 was specifically intended to ensure the preexisting deduction for "amounts received

[5] During the most recent legislative session, the Legislature extended the hospital excise tax in order "[t]o generate approximately one billion dollars per state fiscal biennium" to fund Medicaid hospital services in Washington. *See* Laws of 2019, ch. 318, § 1.

from....the State of Washington" remained deductible after the State opted to deliver public health assistance services through private managed care organizations. WSHA and the Hospitals are overreaching in asking the courts to judicially expand the scope of the B&O tax deduction.

The Superior Court and the Court of Appeals properly interpreted RCW 82.04.4311 in concluding it does not apply to amounts received for providing services covered under another state's Medicaid program. The courts below correctly adhered to the principles that tax deduction statues are to be strictly construed to avoid unanticipated revenues losses and to respect the Legislature's prerogative to set the State's tax policy. This Court should deny review because this case does not present a close call as to the legislative intent or constitutionality of RCW 82.04.4311.

### B. Harborview's Interest in a Tax Refund for Past Periods Does Not Warrant the Exercise of Judicial Review

Harborview asserts this case raises an issue of substantial public importance because if the Court of Appeals' decision is reversed, it can recover the B&O taxes it paid on out-of-state Medicaid receipts for past tax periods. Harborview's interest in a potential tax refund does not warrant this Court's acceptance of review.

Notably, Harborview does not assert any interest in avoiding B&O taxes for future tax periods. That is because the Legislature exempted it

from the B&O tax altogether during the most recent legislative session. *See* Laws of 2019, ch. 451, § 2. If the Legislature had wanted to provide Harborview a remedy with respect to past tax periods, it would have done so. The Legislature specifically affirms the importance of Harborview's economic viability each legislative session when it appropriates funds to Medicaid and other state-funded health services programs. *See, e.g.,* Laws of 2019, ch. 415, § 211(9) ("The legislature affirms that it is in the state's interest for Harborview medical center to remain an economically viable component of the state's health care system").

Harborview has no uncompensated care costs from providing medical services covered under Washington's Medicaid program. It is fully compensated for those services through Washington's federally authorized certified public expenditure (CPE) program. *See* WAC 182-550-4950 (explaining that the CPE "provides payments to participating government-operated hospitals based on the 'full cost' of covered medically necessary services"). The Medicaid Act allows the State to treat Harborview's total allowable costs as the State's share of Medicaid and to claim federal matching funds for that amount. *See* 42 C.F.R. § 433.51. Under the CPE program, public hospitals in Washington are fully reimbursed for their "allowable hospital cost" for inpatient hospital

services. Laws of 2018, ch. 299, § 213(1)(q).[6]

### C. The Hospitals' References to "Uncompensated Care Costs" Do Not Warrant Review

The Hospitals assert this case raises an issue of substantial public importance because they incur significant "uncompensated care costs" in providing care to out-of-state Medicaid patients. The Hospitals' references to uncompensated care costs are irrelevant for several reasons.

First, this case does not involve the taxation of uncompensated care costs: the B&O tax applies only to payments the Hospitals actually received, not amounts they billed but did not receive (e.g. bad debts or charity care). Second, the B&O tax is measured by a taxpayer's gross receipts without regard to profit or loss. It is a cost of doing business in Washington that all taxpayers are free to pass on to customers in pricing their products or services, including Medicaid services. Finally, the existence of a gap between the costs of providing services and Medicaid reimbursement rates is an ordinary result of the Medicaid Act; it does not justify an overly broad interpretation of the B&O tax deduction.

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[6] *See Inpatient Hospital Certified Public Expenditure Program*, available at https://www.hca.wa.gov/assets/essb-6032-inpatient-hospital-certified-expenditure-10-1-18.pdf (HCA legislative report) ("Under the program, hospitals are paid for the cost to provide hospital inpatient services to Medicaid recipients and for uncompensated care.")

Hospitals nationwide are required to report their uncompensated care costs annually on a Medicare cost report submitted to state and federal regulators. The reported amount of uncompensated care defines the hospital-specific limit on the amount a state can pay the hospital *in addition to* its base Medicaid reimbursement rate. *See* WAC 182-550-4900. The states can draw on a number of different sources of funding in setting Medicaid reimbursement rates and payment methodologies.[7] Each year, Congress gives the states a lump sum to be distributed to hospitals serving a disproportionate share of Medicaid beneficiaries. The supplemental payments, however, cannot exceed any single hospital's actual cost of "uncompensated care," as determined by each hospital's annual Medicare cost report and other hospital-specific financial data. 42 U.S.C. § 1396r-4(g)(1); *see also id.* § 1396r-4(j)(2)(C) (requiring states to verify annually that its DSH payments were limited to each hospital's "uncompensated care costs"); WAC 182-550-4900.

The calculation of "uncompensated care costs" is politically charged, complicated, and counterintuitive. As a result of federal court litigation brought by Seattle Children's Hospital and other hospitals, their reported "uncompensated care costs" include payments received from

[7] *See* MACPAC 2019. *Medicaid Base and Supplemental Payments to Hospitals*. Washington D.C.; MACPAC, available at https://www.macpac.gov/wp-content/uploads/2018/06/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf.

Medicare and private insurers.[8] Federal courts invalidated a federal rule requiring hospitals to exclude third party payments from their "uncompensated care costs" on the ground that Congress did not specifically address third party payments in authorizing federal funding to the states to make up for any Medicaid shortfall. *See Children's Hosp. Assoc. of Texas et al v. Azar*, 300 F. Supp. 3d 190 (D.C. Cir. 2018), *reversed*, 933 F.3d 674 (D.C. Cir. 2019).[9]

The invalidation of the CMS rule has had a dramatic impact on the reporting of "uncompensated care costs" by hospitals. For example, when third party payments are excluded, Seattle Children's Hospital had $165,211,523 of uncompensated care costs for the year 2015; when third party payments are included, the hospital actually received $43,261,566 in compensation over its actual costs of providing services to Medicaid and uninsured individuals, including out-of-state residents.[10]

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[8] The issue is discussed in recent reports published by the Medicaid and CHIP Payment and Access Commission (MACPAC). *See* MACPAC 2019. *Treatment of Third Party Payments in the Definition of Medicaid Shortfall.* Washington D.C.; MACPAC, available at https://www.macpac.gov/publication/treatment-of-third-party-payments-in-the-definition-of-medicaid-shortfall/.

[9] On November 9, 2019, the Eighth Circuit Court of Appeals reinstated the CMS rule in *Missouri Hospital Assoc. v. Azar*, 941 F.3d 896 (8th Cir. 2019). But the issue remains under consideration in other federal court circuits. *See* https://eymanlaw.com/wp-content/uploads/sites/79/2019/09/DSH-Litigation-Summary_September-2019-018726-3xCD31A.pdf. (summarizing status of federal court litigation relating to treatment of third party payments in measuring hospital uncompensated care costs).

[10] *See* https://www.medicaid.gov/medicaid/finance/dsh/index.html (follow hyperlink under "Annual DSH Reports," labeled "SPRY 2015 DSH Reports").

This Court should give no weight to the Hospitals' references to "uncompensated care costs" because they are irrelevant and misleading.

### D. This Case Does Not Present a Significant Issue of Constitutional Law

Amici offer no argument or authority bolstering PeaceHealth's assertion that denying a B&O tax deduction for out-of-state Medicaid receipts violates the dormant Commerce Clause. Seattle Children's Hospital and Seattle Cancer Care Alliance merely reiterate PeaceHealth's contention that the differential tax treatment "is precisely the type of discrimination that the Supreme Court held unconstitutional" in *Camps Newfound/Owatonna, Inc. v. Town of Harrison, Me.,* 520 U.S. 564, 117 S. Ct. 1590, 137 L. Ed. 2d 852 (1997). The Hospitals are incorrect, as detailed in the Department's Answer to PeaceHealth's petition for review. The Department does not restate those arguments here.

Amici do not substantively grapple with the State's clear role as a participant in the market for medical services. The fact that the federal government provides funding to allow the State to purchase benefits for its citizens does not remove the State's activity from the category of market participation. *See Asante v. California Dep't of Health Care Servs.*, 886 F.3d 795, 802 (2018) (holding that California's Medicaid reimbursement rate-setting policies for out-of-state hospitals are immune from dormant

Commerce Clause scrutiny under the market participation doctrine); *Big Country Foods, Inc. v. Board of Educ. of Anchorage School Distr.*, 952 F.2d 1173, 1180 (9th Cir. 1992) ("Federal funds provide the wherewithal to make the milk purchases, but it is Alaska that is the direct participant in the market. Accordingly, the market participant exception applies").

The Medicaid Act is a quintessential example of cooperative federalism. It leaves the states free to exercise their sovereign powers of taxation and regulation within broad federal guidelines, resulting in significant variation in state tax policies relating to Medicaid. The Legislature's exercise of its taxing power was perfectly appropriate under both the Medicaid Act and the Commerce Clause. The Legislature was not required to provide a tax subsidy for any other state's Medicaid program.

The Hospitals argue the B&O tax deduction does not in fact support Washington's participation in the market for health care services because hospitals are compelled to provide Medicaid services and "may not discriminate against Medicaid patients based on their state of residency." Childrens Hospital/Cancer Care Alliance at 9. The Hospitals' argument actually proves the point that RCW 82.04.4311 does not burden a nonresident's ability to access emergency medical services or affect the amount paid by them—the primary concern animating the dormant Commerce Clause. Nonresidents receive needed medical services because

federal law requires hospitals nationwide to provide emergency services without regard to ability to pay. *See* 42 U.S.C. § 1395dd.

However, it is not true that hospitals are required to participate in any state's Medicaid program. No hospital is. Seattle Cancer Care Alliance and Seattle Children's Hospital accept Medicaid insurance from just three states other than Washington, according to their websites.[11] Presumably, these hospitals decided to participate in the Medicaid programs of Alaska, Idaho, and Montana because they were able to contractually negotiate acceptable payment terms with the Medicaid administrators of those states. The Hospitals were free to pass on their B&O tax liabilities to those states in negotiating payment terms.

Each state is financially responsible for Medicaid services its residents receive while traveling out of state. *See* 42 C.F.R. § 431.52. The B&O tax is part of a Washington hospital's reimbursable costs of providing Medicaid services for which the financially responsible state may obtain federal matching funds.

Every state has a duty to ensure its Medicaid reimbursement rates and payment methodologies are reasonably adequate to ensure sufficient coverage for their enrollees. *See generally* 42 U.S.C. § 1396a(a)(30)(A).

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[11] *See* https://www.seattlecca.org/new-patients/insurance-coverage-and-bills (Seattle Cancer Care Alliance website); https://www.seattlechildrens.org/clinics/paying-for-care/insurance/insurance-plans/ (Seattle Children's Hospital website).

The B&O tax deduction supports the State's ability to provide Medicaid services by helping close any gap between Washington's Medicaid reimbursement rates and the costs of providing covered services.

The differential tax treatment of in-state and out-of-state Medicaid receipts is not only constitutionally permissible, it is an ordinary result of Medicaid's federal statutory design. Congress affirmatively gave the states permission to either tax or not tax medical services covered under the state's Medicaid program. It also made each state financially liable for the Medicaid services its residents receive while traveling outside the state. Limiting the B&O tax deduction affects how costs are allocated, not who gets access to care.

## III. CONCLUSION

The Court should deny review.

RESPECTFULLY SUBMITTED this 26th day of November, 2019.

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## PROOF OF SERVICE

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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 26th day of November, 2019, at Tumwater, WA.

Jamie Falter, Legal Assistant

## ATTORNEY GENERAL'S OFFICE - REVENUE & FINANCE DIVISION

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## Transmittal Information

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