

NO. 44613-8-II

**COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON**

AUBURN REGIONAL MEDICAL CENTER,

Appellant,

v.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Respondent.

BRIEF OF RESPONDENT

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TABLE OF CONTENTS

I. INTRODUCTION.....1

II. RESTATEMENT OF THE ISSUES.....2

 1. Can the Department deduct a client’s spenddown obligation from its negotiated payment rate to the Hospital under federal and state regulations as they existed during the audit time period?2

 2. Given that Medicaid providers are required to follow billing instructions, and given that billing instructions required providers to notate spenddown on bills submitted to the Department, was the Department correct in assessing an overpayment on claims in which the Hospital failed to notate spenddown?2

 3. Does res judicata apply given that the first administrative hearing was dismissed by the Administrative Law Judge (ALJ) based on lack of subject matter jurisdiction without a determination on the merits?3

 4. Does collateral estoppel apply given that the Hospital’s argument is based on documents not in the administrative record and this case does not concern the same subject matter, the same cause of action, or the same persons or parties of the prior litigation?.....3

III. RESTATEMENT OF THE CASE.....3

IV. ARGUMENT5

 A. The Department’s Authority To Audit5

 B. Standard Of Review7

 C. Eligibility For Medically Needy Coverage.....8

1.	Hypothetical Examples Of Meeting Spenddown	10
D.	Expenses Used To Meet Spenddown Liability Are Not Reimbursable Under Medicaid	11
1.	When Spenddown Obligations Result In A “Split Bill,” Medicaid Can Only Be Used To Reimburse Expenses In Excess Of The Patient’s Obligations	13
E.	Neither Res Judicata Nor Collateral Estoppel Apply	17
1.	The First Administrative Hearing Did Not Result In A Determination On The Merits.....	17
2.	The Capital Medical Center Litigation Is Not Relevant To This Proceeding And Therefore, Does Not Constitute Grounds For Collateral Estoppel.....	19
F.	The Hospital’s Failure To Notate Spenddown On Claims It Submits To The Department Is An Overpayment.....	21
G.	The Hospital Cannot Challenge The Client Expenses Used To Meet Spenddown.....	22
H.	The Data Used By The Department Was Reliable	23
I.	The Hospital’s Argument Concerning Government Auditing Standards Is Not Supported By The Administrative Record	25
J.	The Hospital’s Arguments In Appendices A And B Should Be Stricken	26
V.	CONCLUSION	27

APPENDIX

TABLE OF AUTHORITIES

Cases

<i>Atkins v. Rivera</i> , 477 U.S. 154, 106 S. Ct. 2456 (1986).....	9
<i>Brown v. Dep't of Health Dental Disciplinary Bd.</i> , 94 Wn. App. 7, 972 P.2d 101 (1999).....	7
<i>Burnham v. Dep't of Soc. & Health Servs.</i> , 115 Wn. App. 435, 63 P.3d 816 (2003).....	8
<i>City of Redmond v. Cent. Puget Sound Growth Mgmt. Hearing's Bd.</i> , 136 Wn.2d 38, 959 P.2d 1091 (1998).....	7
<i>Cohen v. Quern</i> , 608 F. Supp. 1324 (N.D. Ill. 1984).....	12
<i>Coye v. U.S. Dept. of Health and Human Serv.</i> , 973 F.2d, 786 (9th Cir. 1992)	9
<i>Faylor's Pharmacy v. Dep't of Soc. & Health Servs.</i> , 125 Wn.2d 488, 886 P.2d 147 (1994).....	5
<i>Heinmiller v. Dep't of Health</i> , 127 Wn.2d 595, 903 P.2d 433 (1995)	7
<i>Hillis v. Dep't of Ecology</i> , 131 Wn.2d 373, 932 P.2d 139 (1997).....	7
<i>Lemond v. Dep't of Licensing</i> , 143 Wn. App. 797, 180 P.3d 829 (2008).....	18
<i>Lynn v. Dep't of Labor & Indus.</i> , 130 Wn. App. 829, 125 P.3d 202 (2005).....	18
<i>Multicare v. Dep't of Soc. & Health Servs.</i> , 173 Wn. App. 289, 294 P.3d 768 (2013).....	passim

<i>Overhulse Neighborhood Ass'n v. Thurston Cnty.</i> , 94 Wn. App. 593, 972 P.2d 470 (1999).....	19
<i>Pinehurst Park Royal Convalescent Ctr., Inc. v. Thompson</i> , 97 Wn.2d 637, 647 P.2d 1016 (1982).....	5
<i>Port of Seattle v. Pollution Control Hearings Bd.</i> , 151 Wn.2d 568, 90 P.3d 659 (2004).....	8
<i>R.D. Merrill Co. v. Pollution Control Hearings Bd.</i> , 137 Wn.2d 118, 969 P.2d 458 (1999).....	8
<i>Roller v. Dep't of Labor & Indus.</i> , 128 Wn. App. 922, 117 P.3d 385 (2005).....	8
<i>State v. Kalakosky</i> , 121 Wn.2d 525, 852 P.2d 1064 (1993).....	27
<i>Thompson v. Dep't of Licensing</i> , 138 Wn.2d 783, 982 P.2d 601 (1999).....	20
<i>U.S. ex rel. Humphrey v. Franklin-Williamson Human Servs., Inc.</i> , 189 F. Supp. 2d 862 (S.D. Ill. 2002).....	12
<i>U.S. West Comm'ns, Inc. v. Wash. Utils. & Transp. Comm'n</i> , 134 Wn.2d 74, 949 P.2d 1337 (1997).....	27

Statutes

42 U.S.C. § 1396a(a)(10)(A)(ii)	8
42 U.S.C. § 1396a(a)(10)(C)(i).....	9
42 U.S.C. § 1396a(a)(37)(B).....	5
42 U.S.C. § 1396d(a)	9
RCW 34.05	8
RCW 34.05.554	19, 25

RCW 34.05.570(1)(a)	7
RCW 43.20B.010(5)	6, 21, 22
RCW 43.20B.675(4)	24
RCW 43.20B.695	6
RCW 74.09	5
RCW 74.09.220	6
RCW 74.09.500	5
RCW 74.09.700	10
RCW 74.09.700(1)	9
RCW 74.09.700(3)	9

Rules

Former WAC 388-416-0020 (1998)	12, 14
Former WAC 388-478-0070 (2002)	9
Former WAC 388-500-005 (1998)	6
Former WAC 388-502-0010 (2003)	6
Former WAC 388-502-0020(1)(i) (1998)	6
Former WAC 388-502-0100(1)(e) (2000)	21
Former WAC 388-519-0100(6) (1998)	10
Former WAC 388-519-0100(5) (1998)	9
Former WAC 388-519-0100(6) (1998)	10
Former WAC 388-519-0100(7) (1998)	10

Former WAC 388-519-0100(8) (1998)	10
Former WAC 388-519-0110(1) (1998)	9
Former WAC 388-519-0110(7) (1998)	12
Former WAC 388-519-0110(8) (1998)	12
RAP 10.3(a)(6).....	26
WAC 388-472-0005(1)(k)	22
WAC 388-472-0005(2)(b)(c).....	22

Regulations

42 C.F.R. § 433.304	22
42 C.F.R. § 435, subpart C.....	8
42 C.F.R. § 435, subpart D	9
42 C.F.R. § 435.831(d)	12
42 C.F.R. § 435.831(i)(5).....	12, 14, 16

Other Authorities

59 Fed. Reg. 1659 (Jan. 12, 1994)	15
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I. INTRODUCTION

The issue in this case is whether Auburn Regional Medical Center (Hospital) should be allowed to keep \$75,971.84 in excess Medicaid money that has been determined to be the financial obligations of the patients it serves. From the time services were initially rendered to the Hospital's patients, the Hospital was entitled to collect the \$75,971.84 it is owed from them. Instead of, or in addition to, collecting the money from its patients, the Hospital is now asking this Court to require the Department of Social and Health Services (Department or DSHS) to use Medicaid funds to pay the spenddown obligations of the Hospital's patients, which the Department is legally prohibited from doing.

Spenddown is the amount of medical expenses a patient must incur to become eligible for medical assistance. It is a client obligation that cannot be paid for with Medicaid funds. As such, the Department's billing instructions direct hospitals to include unmet spenddown obligations as amounts "due from patient" on claims submitted to the Department. Medicaid providers are instructed that not adding the spenddown amount on submitted claims may result in an overpayment to the Hospital. Through the audit at issue here, the Department found that in almost every single instance, the Hospital failed to list spenddown in

the “due from patient” field on its claim forms, and was erroneously paid by the Department for spenddown obligations.

The Hospital appealed the Department’s overpayment determination and a hearing at the Office of Administrative Hearings took place. The Department prevailed at the administrative hearing and the Hospital’s subsequent appeal to the DSHS Board of Appeals was denied. Because the Board of Appeals Review Decision and Final Order is based on substantial evidence and contains no errors of law, this Court should affirm the overpayment determination.

II. RESTATEMENT OF THE ISSUES

1. Can the Department deduct a client’s spenddown obligation from its negotiated payment rate to the Hospital under federal and state regulations as they existed during the audit time period?
2. Given that Medicaid providers are required to follow billing instructions, and given that billing instructions required providers to notate spenddown on bills submitted to the Department, was the Department correct in assessing an overpayment on claims in which the Hospital failed to notate spenddown?

3. Does res judicata apply given that the first administrative hearing was dismissed by the Administrative Law Judge (ALJ) based on lack of subject matter jurisdiction without a determination on the merits?
4. Does collateral estoppel apply given that the Hospital's argument is based on documents not in the administrative record and this case does not concern the same subject matter, the same cause of action, or the same persons or parties of the prior litigation?

III. RESTATEMENT OF THE CASE

The Department initially sought to recover the overpayment identified in this case in an earlier case that was dismissed on procedural grounds. In that earlier case, the ALJ presided over oral argument on a summary judgment motion filed by the Hospital. Administrative Record (AR) at 2122. The ALJ dismissed the case for lack of subject matter jurisdiction, due to the Department's inability to prove that it served the Hospital with the final audit. AR at 2129.

The Department then re-served the final audit report and the Hospital requested another administrative hearing. AR at 5; AR at 2097. The Department audited the Hospital for amounts the Department paid to it for medical services provided to Medically Needy patients from the

period of January 1, 1999, to May 31, 2005. AR at 6. The audit report assessed an overpayment of \$85,649.84, relating to the issue of spenddown. AR at 2111. The Hospital appealed the audit to the Office of Administrative Hearings and a bi-furcated hearing was held. AR at 1. The first portion of the bi-furcated hearing took place in June 2008 concerning the legal issue of spenddown. *Id.* On January 28, 2009, the Administrative Law Judge issued an Initial Order on DSHS' Billing Practice of Deducting Spenddown, which held that the Department is allowed to deduct the spenddown amount from its payment to the Hospital in order to prevent the Department from spending Medicaid dollars on spenddown expenses. AR at 2. The second portion of the hearing, concerning the claims that were audited, was heard on September 14–17, 2009. *Id.* The Department submitted an Amended Final Audit Report at the close of the hearing, stating the amount of the overpayment was \$80,982.87. AR at 2061.

On December 29, 2010, a Corrected Initial Order was mailed by the Office of Administrative Hearings stating that the Department overpaid the Hospital \$75,971.84 during the audited time period. AR at 189. The Hospital filed a petition for review with the Board of Appeals and on June 28, 2012, the Board of Appeals affirmed the Corrected Initial Order. AR at 63. The Hospital appealed to superior

court, which upheld the Board of Appeals determination. The Hospital's appeal to this Court followed.

IV. ARGUMENT

A. The Department's Authority To Audit

The Department administers the Medicaid program in the state of Washington. Ch. 74.09 RCW; *Faylor's Pharmacy v. Dep't of Soc. & Health Servs.*, 125 Wn.2d 488, 490, 886 P.2d 147 (1994). The Medicaid Purchasing Administration is the division within the Department that actually runs Medicaid and similar programs. See RCW 74.09.500; *Pinehurst Park Royal Convalescent Ctr., Inc. v. Thompson*, 97 Wn.2d 637, 640-41 n.3, 647 P.2d 1016 (1982). In order for the state to receive federal matching funds, it must provide a post payment review process to ensure the proper payment of Medicaid claims. See 42 U.S.C. § 1396a(a)(37)(B). Pursuant to this federal authority and to the authority granted under RCW 74.09, the Department conducts audits and investigations to ensure that its Medicaid payments to providers are proper.

Any legal entity that obtains Medicaid payments from the Department to which that entity is not otherwise entitled is liable for the excess payments received plus interest as calculated by

RCW 43.20B.695.¹ RCW 74.09.220. To be eligible for Medicaid payments from the Department, a provider must be enrolled with the Department. Former WAC 388-502-0010 (2003) (Appendix 1-4); *see also* former WAC 388-500-005 (1998) (Appendix 5-10) (a “provider” is an institution, agency, or person who has a signed agreement with the Department and is eligible to receive payment). Enrolled providers must provide services “according to federal and state laws and rules, and billing instructions issued by the department.” Former WAC 388-502-0020(1)(i) (1998) (Appendix 11). The Core Provider Agreement each enrolled provider signs also requires the provider to bill in accordance with the rules and billing instructions in effect at the time the service is rendered. AR at 1172. In this case, the Hospital is an enrolled Medicaid provider. AR at 3. The Department assigned an overpayment to the Hospital because it failed to notate spenddown on claims it billed to the Department as required by Department-issued billing instructions. AR at 1116, 1156. The Hospital’s failure to follow the billing instructions violated Department regulations, which in turn created the overpayment at issue in this case. Former WAC 388-502-0020(1)(i) (2001) (Appendix 11); RCW 43.20B.010(5).

¹ Citations to the Revised Code of Washington and Washington Administrative Code reflect the statute or WAC in effect during the audited time period. Some citations have changed due to the single state agency for Medicaid changing from the Department to the Health Care Authority.

B. Standard Of Review

Under the Administrative Procedure Act, the Hospital must demonstrate the invalidity of the Final Order. RCW 34.05.570(1)(a); *Hillis v. Dep't of Ecology*, 131 Wn.2d 373, 381, 932 P.2d 139 (1997). When reviewing an administrative agency decision, the court reviews issues of law de novo. *Brown v. Dep't of Health Dental Disciplinary Bd.*, 94 Wn. App. 7, 12, 972 P.2d 101 (1999) (citing *Kellum v. Dep't of Ret. Sys.*, 61 Wn. App. 288, 291, 810 P.2d 523 (1991)). The court can substitute its judgment for that of the administrative body. *Id.* However, the court accords substantial weight to the agency's interpretation of the law it administers, especially when the issue falls within the agency's expertise. *Id.* (citing *Haley v. Med. Disciplinary Bd.*, 117 Wn.2d 720, 728, 818 P.2d 1062 (1991)).

The reviewing court sustains an agency finding of fact if it is supported by substantial evidence "when viewed in light of the whole record before the court." *Heinmiller v. Dep't of Health*, 127 Wn.2d 595, 607, 903 P.2d 433 (1995), cert. denied, 518 U.S. 1006 (1996). Substantial evidence is "a sufficient quantity of evidence to persuade a fair-minded person of the truth or correctness of the order." *City of Redmond v. Cent. Puget Sound Growth Mgmt. Hearing's Bd.*, 136 Wn.2d 38, 46, 959 P.2d 1091 (1998) (citation omitted). This Court applies the standards

of RCW 34.05 directly to the record before the agency, sitting in the same position as the superior court. *Burnham v. Dep't of Soc. & Health Servs.*, 115 Wn. App. 435, 438, 63 P.3d 816 (2003).

Unchallenged facts contained in an agency's final decision are treated as verities on appeal by a reviewing court. *Roller v. Dep't of Labor & Indus.*, 128 Wn. App. 922, 927, 117 P.3d 385 (2005). To the extent that a proper challenge to an agency's findings of fact is raised on appeal, a reviewing court must give substantial deference to such findings of fact: agency findings of fact may be overturned only if they are "clearly erroneous," *Port of Seattle v. Pollution Control Hearings Bd.*, 151 Wn.2d 568, 588, 90 P.3d 659 (2004), and the court is "definitely and firmly convinced that a mistake has been made." *Id.* (quoting *Buechel v. Dep't of Ecology*, 125 Wn.2d 196, 202, 884 P.2d 910 (1994)); see also *R.D. Merrill Co. v. Pollution Control Hearings Bd.*, 137 Wn.2d 118, 135, 969 P.2d 458 (1999) ("Agency findings on factual matters are entitled to great deference.").

C. Eligibility For Medically Needy Coverage

Each state has the option of extending Medicaid benefits to "optionally categorically needy" categories of individuals set forth in 42 U.S.C. § 1396a(a)(10)(A)(ii); 42 C.F.R. § 435, subpart C; *Coye v. U.S. Dept. of Health and Human Serv.*, 973 F.2d, 786, 789 (9th Cir.

1992). In addition, the state may choose to extend coverage to the “medically needy”, but is not required to do so. 42 U.S.C. § 1396a(a)(10)(C)(i); 42 U.S.C. § 1396d(a); 42 C.F.R. § 435, subpart D; *Atkins v. Rivera*, 477 U.S. 154, 157, 106 S. Ct. 2456 (1986); *Coye*, 973 F.2d at 789.

Washington has chosen to provide coverage to the Medically Needy under the “limited casualty program,” which provides coverage for medical services to persons “who are medically needy as defined in the social security Title XIX state plan.” RCW 74.09.700(1). The statute directs the Department to establish eligibility requirements, including “minimum levels of incurred medical expenses” for the Medically Needy to incur before becoming eligible, and requires the Medically Needy to apply “[a]ll nonexempt income and resources” to “the cost of their medical care services.” RCW 74.09.700(1), (3).

The Department’s eligibility rules impose an income limit for the Medically Needy program, called the “medically needy income level”. Former WAC 388-478-0070 (2002) (Appendix 13). A person’s countable income is compared to the medically needy income level, using a “base period” of three or six consecutive months. Former WAC 388-519-0100(5), 0110(1) (1998) (Appendix 14, Appendix 16). If the patient’s countable income is higher than the medically needy income

level, the amount by which his or her income exceeds the medically needy income level is called “excess income”. Former WAC 388-519-0100(7) (1998) (Appendix 14). The patient may reduce excess income by incurring medical expenses. Former WAC 388-519-0100(6) (1998) (Appendix 14). Once the patient’s income is reduced by the amount of excess income, the person qualifies for Medically Needy coverage. Former WAC 388-519-0100(8) (1998) (Appendix 15). This process is called “meeting spenddown”. *Id* at 15.

1. Hypothetical Examples Of Meeting Spenddown

In *Multicare*, the Court utilized examples to illustrate how the Department would apply spenddown in different situations. *Multicare v. Dep’t of Soc. & Health Servs.*, 173 Wn. App. 289, 295-96, 294 P.3d 768 (2013). In the first example, a patient has a spenddown liability of \$500, total hospital charges of \$450, and a negotiated hospital rate of \$200. Here, the total charges would apply to the spenddown liability, but since \$50 remains to satisfy that spenddown, the patient would not qualify for the Medically Needy program and would owe the Hospital the \$450. *Multicare*, 173 Wn. App. at 295-96; *see* RCW 74.09.700; former WAC 388-519-0100(6-8) (1998) (Appendix 14-15).

In the second example, a patient has a spenddown liability of \$500, total hospital charges of \$4,000, and a negotiated rate of \$2,000. Here, the

total charges would meet the spenddown, resulting in the patient qualifying for the Medically Needy program. The patient would owe \$500, and because the patient now qualifies (and did since the beginning of the month) for the Medically Needy program, the negotiated rate of \$2,000 would apply. *Multicare*, 173 Wn. App. at 296. In the final example used by this Court, a patient has a spenddown liability of \$500, total hospital charges of \$2,000, and a negotiated contract rate of \$450. Here, the total charges would meet the spenddown, resulting in the patient qualifying for the Medically Needy program. However, the Department would not owe the Hospital anything since the negotiated rate is less than the spenddown. *Id.*

D. Expenses Used To Meet Spenddown Liability Are Not Reimbursable Under Medicaid

This Court has already answered in the affirmative the legal question of whether spenddown can be deducted from a hospital's negotiated payment rate. *Multicare*, 173 Wn. App. 289. This Court held that federal regulations allowed the Department to deduct spenddown and that the audit did not have to examine how each spenddown amount was calculated for each individual or how each bill applied the spenddown. *Id.* at 291.

Despite this decision and a federal regulation to the contrary, the Hospital argues that the Department is not allowed to deduct expenses used to meet spenddown from payments made by the Department to it. However, Federal regulation clearly states: **“Expenses used to meet spenddown liability are not reimbursable under Medicaid.”** 42 C.F.R. § 435.831(i)(5) (emphasis added). By requiring the patient to “incur” medical expenses to meet spenddown (42 C.F.R. § 435.831(d)), the regulations impose liability for spenddown on the patient. *See U.S. ex rel. Humphrey v. Franklin-Williamson Human Servs., Inc.*, 189 F. Supp. 2d 862, 871 (S.D. Ill. 2002) (“[c]learly, the word ‘incur’ connotes taking on a liability”); *see also Cohen v. Quern*, 608 F. Supp. 1324, 1327 (N.D. Ill. 1984) (“‘incurred’ generally is defined as ‘becom[ing] liable or subject to’”).

Once a person’s spenddown amount is known, their qualifying medical expenses are subtracted from their spenddown amount to determine the date of eligibility. Former WAC 388-519-0110(7) (1998) (Appendix 16). If a spenddown obligation is met, the beginning date of eligibility would be determined by Former WAC 388-416-0020 (1998) (Appendix 19); former WAC 388-519-0110(8) (1998) (Appendix 16).

1. When Spenddown Obligations Result In A “Split Bill,” Medicaid Can Only Be Used To Reimburse Expenses In Excess Of The Patient’s Obligations

Amongst the arguments that the Hospital makes is an argument concerning the split-bill scenario, in which the contract rate negotiated with the Department exceeds the patient’s spenddown obligation (so that the patient is responsible for part of the bill and Medicaid is responsible for the remainder). Br. of Appellant at 13-14. In the second example given by this Court (supra at 10-11), a patient has a spenddown liability of \$500, total hospital charges of \$4,000 and a negotiated contract rate of \$2,000. In this instance, the total bill, based on the negotiated rate, would be \$2,000, and the provider would be allowed to collect \$500 from the patient, The Department would pay the hospital \$1500 (\$2,000 negotiated rate minus the \$500 spenddown). In this way, the expense is split between the patient and the Department, with each responsible for a portion of the bill. Federal regulation contemplates adjudication of the split-bill in such a fashion to ensure that Medicaid does not pay for spenddown obligations of the Medically Needy:

Expenses used to meet spenddown liability are not reimbursable under Medicaid. [Therefore,] to the extent necessary to prevent the transfer of an individual’s spenddown liability to the Medicaid program, States must reduce the amount of provider charges that would otherwise be reimbursable under Medicaid.

42 C.F.R. § 435.831(i)(5).

The Hospital further argues that regulations do not allow for spenddown to be deducted from the negotiated rate, which governs payments to hospitals; rather, the Hospital argues that spenddown has to be deducted from the hospital's total billed charges. Br. of Appellant at 14. First, that argument was answered in *Multicare*. This Court held that the Hospital must subtract the spenddown liability from the negotiated rate to assure that the patient's debt is not being transferred to the Department. *Multicare*, 173 Wn. App. at 298. Second, the Hospital's argument overlooks the fact that, in many instances, spenddown is met with the split-bill—i.e., a bill exceeding the client's spenddown obligation. Because federal and state law require the Medically Needy to incur medical bills in the exact amount of spenddown—not more—the Department must enroll the client using the split-bill because he or she will have met the requirement for eligibility. The client becomes eligible on the first day of the base period in which spenddown is met. Former WAC 388-416-0020 (1998) (Appendix 19). Therefore, the negotiated payment rate applies once the client is eligible for the Medicaid program and the total charges billed by the Hospital become irrelevant.

By considering the “split-bill” as partially reimbursable, the Department can then apply its regulatory and contractual provisions in

order to legally prohibit the Hospital from billing the client for any amount in excess of spenddown. The Department's contractual and regulatory restrictions governing its maximum payment to the Hospital also apply. Because the Hospital can bill the client for the amount withheld as spenddown, it also receives the full amount due under its contract with the Department, i.e. the "allowed charges", by the combination of the Department's payment plus the spenddown payment from the patient. That is why the claim is paid by deducting the amount of the patient's unmet spenddown obligation from the maximum allowed amount, paying any balance due to the Hospital.

The Hospital's argument also overlooks the fact that the Department's claims payment practice is consistent with federal and state rules and the Department's contractual and regulatory billing restrictions. In commenting on the rules for spenddown, the Department of Health and Human Services remarked that:

[R]egardless of when eligibility begins in a budget period, expenses used to meet spenddown liability are not reimbursable under Medicaid. . . . States may need to reduce the otherwise reimbursable amount of provider charges by spenddown expenses to prevent the transfer of spenddown liabilities to the Medicaid program.

59 Fed. Reg. 1659, 1662 (Jan. 12, 1994).

The effect of the Hospital's argument that spenddown cannot be deducted from hospital charges would be to require the Department to pay the Hospital for spenddown obligations in instances where federal and state rules require a deduction to ensure Medicaid does not pay spenddown obligations. This thwarts federal and state laws, regulations and the Hospital's contract obligations. By entering into the Department's Core Provider Agreement (AR at 1172) and providing services to the Department's Medically Needy clients, the Hospital agreed to abide by the Department's limitations on billing clients and accept its maximum payment rates.

Finally, the Hospital's argument that spenddown must be deducted from the hospital's total billed charges simply ignores the federal regulation at issue. This regulation instructs States to "reduce the amount of provider charges that would otherwise be reimbursable under Medicaid." 42 C.F.R. § 435.831(i)(5). Taking one word from this regulation, the Hospital argues that a provider's "charges" must mean a provider's usual and customary charges. Br. of Appellant at 14-15. However, this regulation concerns "charges that would otherwise be reimbursable under Medicaid." A hospital's usual and customary charges, or total billed charges, are not reimbursable under Medicaid.

E. Neither Res Judicata Nor Collateral Estoppel Apply

The Hospital claims that res judicata and collateral estoppel apply because the overpayment assessment was allegedly dismissed in a prior administrative hearing and because the treatment of spenddown from hospital payments has allegedly been resolved in the Hospital's favor previously in prior litigation concerning *Capital Medical Center et al v. DSHS*. Br. of Appellant at 4. However, neither res judicata nor collateral estoppel apply for the reasons set forth below.

1. The First Administrative Hearing Did Not Result In A Determination On The Merits

The Hospital contends that this case is barred by res judicata or collateral estoppel, because the same audit at issue in this matter was previously the subject of an administrative hearing before Administrative Law Judge Gail G. Maurer. In that case, ALJ Maurer presided over oral argument on a summary judgment motion filed by the Hospital on March 27, 2007. AR at 2122. However, ALJ Maurer did not reach the merits of the issues raised in the Hospital's summary judgment motion. *Id.* at 2129. Instead, ALJ Mauer dismissed the case for lack of subject matter jurisdiction, due to the Department's inability to prove that it served the Hospital with the final audit. *Id.* ALJ Mauer held that because there was no subject matter jurisdiction, he "may do nothing other than

dismiss the proceedings.” *Id.* The Hospital appealed the ALJ’s initial order, AR at 2119-121, but the Board of Appeals upheld the initial order dismissing the case for lack of subject matter jurisdiction in its Review Decision and Final Order dated July 3, 2007.

The Department then re-served the final audit report and the Hospital requested another administrative hearing. The Hospital asserts that this second administrative hearing is barred by res judicata or collateral estoppel, because the same audit was subject to the prior administrative proceeding.

Res judicata, or claim preclusion, applies where a prior final judgment is identical to the challenged action in (1) subject matter, (2) cause of action, (3) persons and parties, and (4) the quality of persons for or against whom the claim is made. *Lynn v. Dep’t of Labor & Indus.*, 130 Wn. App. 829, 836, 125 P.3d 202 (2005). Similarly, re-litigation of an issue is barred by the doctrine of collateral estoppel when the party asserting the doctrine can establish “that issues are identical and that they were determined on the merits in the first proceeding”. *Lemond v. Dep’t of Licensing*, 143 Wn. App. 797, 805, 180 P.3d 829 (2008). Both doctrines necessarily require a final determination on the merits. The Department’s audit was never subject to a final determination on the merits by ALJ Maurer. ALJ Maurer simply dismissed the matter for lack

of subject matter jurisdiction, leaving the Department free to re-serve the audit. The long-settled general rule is that a dismissal for want of jurisdiction is not grounds for res judicata because there has been no final decision on the merits. *Overhulse Neighborhood Ass'n v. Thurston Cnty.*, 94 Wn. App. 593, 972 P.2d 470 (1999). Thus, neither res judicata nor collateral estoppel apply.

2. The Capital Medical Center Litigation Is Not Relevant To This Proceeding And Therefore, Does Not Constitute Grounds For Collateral Estoppel

Capital Medical Center et al v. DSHS was a lawsuit brought by 26 hospitals that provided emergency medical treatment to low income individuals who were not Medicaid eligible under a now-discontinued program commonly referred to as the Medically Indigent program. The Letter Opinion in that case cited by the Hospital (Appellant's proposed Exhibit A-10 (AR at 2172)) was specifically not admitted as an exhibit during the administrative hearing. AR at 377 (Order on Exhibits, Setting Date for Documents and Closing Argument and Close of Record Date). The Hospital failed to raise the issue of whether proposed exhibit A-10 should be admitted before the Board of Appeals. Issues not raised before the agency may not be raised on appeal. RCW 34.05.554. Therefore, this proposed exhibit should not be considered part of the administrative record.

In the alternative, should this Court decide to consider the Letter Opinion, a plain reading of this opinion shows that the Capital Medical Center case is unrelated to this case. This case concerns an audit of one hospital concerning the medically needy program. AR at 5-6, Finding of Fact (FF) No. 1(t), 1(x), 2-3. The issue in this case is whether the Department properly assessed overpayments after concluding that spenddown expenses had not been deducted from Medicaid payments made to the Hospital. In contrast, the Capital Medical Center case does not concern spenddown in the medically needy arena, but concerns Medicaid payments to 26 disproportionate share hospitals treating medically indigent patients. The issue decided in the Capital Medical Center case concerned EMER payments made to hospitals that provided care to medically indigent patients.

For collateral estoppel to apply, the party asserting the doctrine must prove four elements: (1) the issue decided in the prior adjudication is identical; (2) the prior adjudication ended in a final judgment on the merits; (3) the party against whom collateral estoppel is asserted was a party to the prior adjudication; and (4) application of the doctrine does not work on injustice. *Thompson v. Dep't of Licensing*, 138 Wn.2d 783, 790, 982 P.2d 601 (1999). Here, at a minimum, one factor of the doctrine is

not met because the issues in the two cases are not identical. Thus, collateral estoppel does not apply.

F. The Hospital's Failure To Notate Spenddown On Claims It Submits To The Department Is An Overpayment

The Hospital argues that it was not overpaid because it was not paid in excess of the Medicaid allowable rate. Br. of Appellant at 10. However, an overpayment is defined as any payment or benefit to a provider in excess of what that provider is entitled to by law, rule, or contract. RCW 43.20B.010(5). Department regulations require that a provider follow applicable billing instructions issued by the Department. Former WAC 388-502-0100(1)(e) (2000) (Appendix 20). Pursuant to Department billing instructions, the provider is to indicate in claims submitted to the Department the amount that is due from the patient, including spenddown. AR at 1116 (Outpatient Hospital Billing Instructions); AR at 1156 (Inpatient Hospital Billing Instructions). These billing instructions are clear that the spenddown amount must be listed in the claim form sent to the Department and that failing to do so may result in an overpayment that will be recouped during a subsequent audit. *Id.* If a provider fails to adhere to billing instructions, it is in violation of regulations. Former WAC 388-502-0100(1)(e) (2000) (Appendix 20). Billing in excess of that which is allowed by rule is an

overpayment. RCW 43.20B.010(5). Further, since spenddown expenses are not reimbursable under Medicaid, any spenddown expenses billed by the Hospital would be in excess of the amount allowable by Medicaid. Therefore, as a matter of law, the spenddown expenses billed by the Hospital are overpayments. 42 C.F.R. § 433.304.

G. The Hospital Cannot Challenge The Client Expenses Used To Meet Spenddown

Should this Court decide that the issue of whether overpayments occurred is not resolved as a matter of law, the Department will respond to the factual arguments of the Hospital. First, the Hospital argues that reliable data was not used because the auditor did not further analyze what the client submitted to the Department or whether there were additional bills that the client could have used to meet spenddown. Br. of Appellant at 16, 23. However, producing the expenses necessary to become eligible for Medicaid is a client responsibility. WAC 388-472-0005(2)(b)(c). If a client disagrees with an eligibility decision made by the Department, he or she can request a fair hearing. WAC 388-472-0005(1)(k). There is no obligation on the Department to inquire about other bills that might be used to meet spenddown once eligibility has been determined. Although the Hospital may disagree with

the bills that were used to meet spenddown, eligibility determinations are between the Department and the client.

The Hospital further argues that the audit did not assess whether spenddown was properly assigned or whether the bills used to meet spenddown were properly prioritized. Br. of Appellant at 15-16. However, that is why an administrative hearing took place: to determine if the audit done by the Department was correct. The Hospital has failed to bring up any instances in the Board of Appeals' Review Decision and Final Order of how an overpayment was incorrect due to spenddown being improperly assigned or due to medical bills being improperly prioritized. It is not enough for the Hospital to generally claim that the record does not support the Department's reimbursement claim. *Multicare*, 173 Wn. App. at 299. Rather, the Hospital would have needed to challenge specific findings of fact and establish why such findings are unsupported by substantial evidence. However, the Hospital did not challenge the findings and they are therefore verities in this appeal.²

H. The Data Used By The Department Was Reliable

The Hospital argues that data within the ACES system and the award letter used by the Department were "fundamentally unreliable".

² Although the Hospital has not challenged findings of fact in its brief, it attempts to challenge specific findings in appendices to its brief. As discussed *infra*, these "appendix arguments" should be stricken.

Br. of Appellant at 17. However, this argument fails to account for the other evidence the Department used in this audit. For example, in addition to ACES and the award letters, the Department used the following: (1) the MMIS payment processing database (AR at 8, FF 9); (2) the HWT claims database, which listed every paid claim to the Hospital for the audited time period (*Id.*, FF 10); (3) the Hospital's account receivable billing statements, which provides information on billing and conversations with patients and family members concerning billing, including obtaining Medicaid coverage (AR at 8-9, FF 12); and (4) Barcode, which is an imaging system for medical expenses, used consistently by the Department since 2004 (AR at 9, FF 13). If there were discrepancies in the data used by the Department, the auditor sought additional information from the Hospital to try to resolve the discrepancy. AR at 11, FF 17. After reviewing all of this information, a draft audit report was issued to the Hospital, which stated it did not have any questions about the audit when asked. AR at 12, FF 20.

The numerous sources of data considered by the Department support a finding of reliability of the overall audit process. *Id.*, FF 22. Even so, the ALJ and Review Judge must determine the amount, if any, of the overpayment. RCW 43.20B.675(4). Thus, the Review Decision and Final Order goes through the evidence for each and every claim in this

audit. AR at 13-48. The Hospital only relies on generalized arguments concerning the data used by the Department. The Hospital has not brought forth any evidence in its Opening Brief as to why any of these specific overpayment findings were incorrect, nor does the Hospital challenge specific findings of fact. The Hospital cannot generally claim that the record does not support the Department's reimbursement claim without specific citations to the record or challenges to the findings. *Multicare*, 173 Wn. App. at 299.

I. The Hospital's Argument Concerning Government Auditing Standards Is Not Supported By The Administrative Record

The Hospital argues that the Department failed to adhere to the Government Auditing Standards in this audit. Br. of Appellant at 22. In support of its argument, the Hospital cites to the Government Auditing Standards (AR at 332-40) produced during its written closing argument after the conclusion of the administrative hearing. The Department objected to this very exhibit and the ALJ did not admit it. AR at 150. The Hospital did not appeal the decision to not admit this exhibit to the Board of Appeals. Again, issues not raised before the agency may not be raised on appeal. RCW 34.05.554. Therefore, this proposed exhibit should not be considered part of the administrative record. Regardless, the Hospital did not assert or challenge during the hearing that the Department failed to

comply with Government Auditing Standards. AR at 7, FF 4. Even if this Court should consider the exhibit referenced by the Hospital, it was never established that this particular chapter of the Government Auditing Standards even applied to the Department. The Hospital simply failed to bring forth any evidence during the administrative hearing that the Department failed to comply with Government Auditing Standards. Thus, the Hospital has failed to meet its burden below and cannot challenge the Board of Appeals decision on this basis. *Multicare*, 173 Wn. App. at 299.

J. The Hospital's Arguments In Appendices A And B Should Be Stricken

In appendices to its brief, the Hospital requests this Court reject specific findings of the Review Judge. Br. of Appellant at 26. The appendices consist of 49 pages of arguments made by the Hospital at the administrative level. *Id.* This Court should strike these arguments that are improperly contained in appendices. Rather, it is the Hospital's brief that must "contain . . . [t]he argument in support of the issues presented for review, together with citations to legal authority." RAP 10.3(a)(6). It is inappropriate to incorporate by reference arguments made to tribunals below. *Multicare*, 173 Wn. App. at 299 (*citing Kwiatkowski v. Drews*, 142 Wn. App. 463, 499-500, 176 P.3d 510 (2008) (Washington courts

“have consistently rejected attempts by litigants to incorporate by reference arguments contained in trial court briefs, holding such arguments are waived.”); *see U.S. West Comm'ns, Inc. v. Wash. Utils. & Transp. Comm'n*, 134 Wn.2d 74, 111-12, 949 P.2d 1337 (1997); *State v. Kalakosky*, 121 Wn.2d 525, 540 n.18, 852 P.2d 1064 (1993).

V. CONCLUSION

The Hospital has failed to demonstrate why the Board of Appeals' Review Decision is invalid. Therefore, the Department respectfully requests that that the Board of Appeals decision be affirmed.

RESPECTFULLY SUBMITTED this 19th day of June, 2013.

ROBERT W. FERGUSON
Attorney General

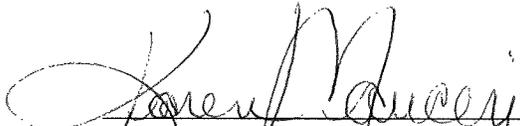

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CERTIFICATE OF SERVICE

I certify that I mailed a copy of the foregoing Brief of Respondent to Carla M. Dewberry, Garvey Schubert Barer, 1191 Second Ave., 18th Floor, Seattle, WA 98101-2939, via ABC Legal Messenger, on June 19, 2013.


KAREN MAUCERI, Legal Assistant

APPENDIX TO BRIEF – TABLE OF CONTENTS

<u>APPENDIX #</u>	<u>EFFECTIVE DATE</u>	<u>DESCRIPTION</u>	<u>BEGINS IN TEXT ON PAGE</u>
1-4	(eff. 7/31/03)	Former WAC 388-502-0010	6
5-10	(eff. 7/30/98)	Former WAC 388-500-005	6
11-12	(eff. 4/20/01)	Former WAC 388-502-0020(1)(i)	6
13	(eff. 5/31/02)	Former WAC 388-478-0070	9
14-15	(eff. 9/1/98)	Former WAC 388-519-0100(5)	9
16-18	(eff. 9/1/98)	Former WAC 388-519-0110(1)	9
19	(eff. 9/1/98)	Former WAC 388-416-0020	13
20	(eff. 8/17/00)	Former WAC 388-502-0100(1)(e)	21

WAC 388-502-0010

Payment—Eligible providers defined.

The department reimburses enrolled providers for covered medical services, equipment and supplies they provide to eligible clients.

(1) To be eligible for enrollment, a provider must:

- (a) Be licensed, certified, accredited, or registered according to Washington state laws and rules; and
- (b) Meet the conditions in this chapter and chapters regulating the specific type of provider, program, and/or service.

2) To enroll, an eligible provider must sign a core provider agreement or a contract with the department and receive a unique provider number. (Note: Section 13 of the core provider agreement, DSHS 09-048 (REV. 06/2002), is hereby rescinded. The department and each provider signing a core provider agreement will hold each other harmless from a legal action based on the negligent actions or omissions of either party under the terms of the agreement.)

(3) Eligible providers listed in this subsection may request enrollment. Out-of-state providers listed in this subsection are subject to conditions in WAC 388-502-0120.

(a) Professionals:

(i) Advanced registered nurse practitioners;

(ii) Anesthesiologists;

(iii) Audiologists;

(iv) Chiropractors;

(v) Dentists;

(vi) Dental hygienists;

(vii) Denturists;

(viii) Dietitians or nutritionists;

(ix) Maternity case managers;

(x) Midwives;

(xi) Occupational therapists;

(xii) Ophthalmologists;

(xiii) Opticians;

(xiv) Optometrists;

(xv) Orthodontists;

(xvi) Osteopathic physicians;

- (xvii) Podiatric physicians;
- (xviii) Pharmacists;
- (xix) Physicians;
- (xx) Physical therapists;
- (xxi) Psychiatrists;
- (xxii) Psychologists;
- (xxiii) Registered nurse delegators;
- (xxiv) Registered nurse first assistants;
- (xxv) Respiratory therapists;
- (xxvi) Speech/language pathologists;
- (xvii) Radiologists; and
- (xviii) Radiology technicians (technical only);
- (b) Agencies, centers and facilities:
 - (i) Adult day health centers;
 - (ii) Ambulance services (ground and air);
 - (iii) Ambulatory surgery centers (Medicare-certified);
 - (iv) Birthing centers (licensed by the department of health);
 - (v) Blood banks;
 - (vi) Chemical dependency treatment facilities certified by the department of social and health services (DSHS) division of alcohol and substance abuse (DASA), and contract through either:
 - (A) A county under chapter 388-810 WAC; or
 - (B) DASA to provide chemical dependency treatment services;
 - (vii) Centers for the detoxification of acute alcohol or other drug intoxication conditions (certified by DASA);
 - (viii) Community AIDS services alternative agencies;
 - (ix) Community mental health centers;
 - (x) Early and periodic screening, diagnosis, and treatment (EPSDT) clinics;
 - (xi) Family planning clinics;
 - (xii) Federally qualified health care centers (designated by the Federal Health Care Financing Administration);
 - (xiii) Genetic counseling agencies;

- (xiv) Health departments;
 - (xv) HIV/AIDS case management;
 - (xvi) Home health agencies;
 - (xvii) Hospice agencies;
 - (xviii) Hospitals;
 - (xix) Indian Health Service;
 - (xx) Tribal or urban Indian clinics;
 - (xxi) Inpatient psychiatric facilities;
 - (xxii) Intermediate care facilities for the mentally retarded (ICF-MR);
 - (xxiii) Kidney centers;
 - (xxiv) Laboratories (CLIA certified);
 - (xxv) Maternity support services agencies;
 - (xxvi) Neuromuscular and neurodevelopmental centers;
 - (xxvii) Nursing facilities (approved by DSHS Aging and Adult Services);
 - (xxviii) Pharmacies;
 - (xxix) Private duty nursing agencies;
 - (xxx) Rural health clinics (Medicare-certified);
 - (xxxi) Tribal mental health services (contracted through the DSHS mental health division); and
 - (xxxii) Washington state school districts and educational service districts.
- (c) Suppliers of:
- (i) Durable and nondurable medical equipment and supplies;
 - (ii) Infusion therapy equipment and supplies;
 - (iii) Prosthetics/orthotics;
 - (iv) Hearing aids; and
 - (v) Oxygen equipment and supplies;
- (d) Contractors of:
- (i) Transportation brokers;
 - (ii) Interpreter services agencies; and

(iii) Eyeglass and contact lens providers.

(4) Nothing in this chapter precludes the department from entering into other forms of written agreements to provide services to eligible clients.

(5) The department does not enroll licensed or unlicensed practitioners who are not specifically addressed in subsection (3) of this section, including, but not limited to:

(a) Acupuncturists;

(b) Counselors;

(c) Sanipractors;

(d) Naturopaths;

(e) Homeopaths;

(f) Herbalists;

(g) Massage therapists;

(h) Social workers; or

(i) Christian Science practitioners or theological healers.

[Statutory Authority: RCW 74.08.090, 74.09.080, 74.09.120, 03-14-106, § 388-502-0010, filed 6/30/03, effective 7/31/03. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530, 01-07-076, § 388-502-0010, filed 3/20/01, effective 4/20/01; 00-15-050, § 388-502-0010, filed 7/17/00, effective 8/17/00.]

WAC 388-500

MEDICAL DEFINITIONS

WAC 388-500-0005 Medical definitions.

Unless defined in this chapter or in other chapters of the *Washington Administrative Code*, use definitions found in the *Webster's New World Dictionary*. This section contains definitions of words and phrases the department uses in rules for medical programs. Definitions of words used for both medical and financial programs are defined under WAC 388-22-030.

"Assignment of rights" means the client gives the state the right to payment and support for medical care from a third party.

"Base period" means the time period used in the limited casualty program which corresponds with the months considered for eligibility.

"Beneficiary" means an eligible person who receives: *A federal cash Title XVI benefit; and/or *State supplement under Title XVI; or *Benefits under Title XVIII of the Social Security Act.

"Benefit period" means the time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a "spell of illness" for Medicare payments.

"Cabulance" means a vehicle for hire designed and used to transport a physically restricted person.

"Carrier" means: *An organization contracting with the federal government to process claims under Part B of Medicare; or *A health insurance plan contracting with the department.

"Categorical assistance unit (CAU)" means one or more family members whose eligibility for medical care is determined separately or together based on categorical relatedness.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-503-0310, chapter 388-517 WAC and WAC 388-523-2305.

"Children's health program" means a state-funded medical program for children under age eighteen: *Whose family income does not exceed one hundred percent of the federal poverty level; and *Who are not otherwise eligible under Title XIX of the Social Security Act.

"Coinsurance-Medicare" means the portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is twenty percent of reasonable charges.

"Community services office (CSO)" means an office of the department which administers social and health services at the community level.

"Couple" means, for the purposes of an SSI-related client, an SSI-related client living with a person of the opposite sex and both presenting themselves to the community as husband and wife. The department shall consider the income and resources of such couple as if the couple were married except when determining institutional eligibility.

"Deductible-Medicare" means an initial specified amount that is the responsibility of the client.

"Part A of Medicare-inpatient hospital deductible" means an initial amount of the medical care cost in each benefit period which Medicare does not pay.

"Part B of Medicare-physician deductible" means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay.

"Delayed certification" means department approval of a person's eligibility for medicaid made after the established application processing time limits.

"Department" means the state department of social and health services.

"Early and periodic screening, diagnosis and treatment (EPSDT)" also known as the "healthy kids" program means a program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid or the children's health program.

"Electronic fund transfers (EFT)" means automatic bank deposits to a client's or provider's account.

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: *Placing the patient's health in serious jeopardy; *Serious impairment to bodily functions; or *Serious dysfunction of any bodily organ or part.

"Emergency medical expense requirement" means a specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program.

"Essential spouse" see **"spouse."**

"Extended care patient" means a recently hospitalized Medicare patient needing relatively short-term skilled nursing and rehabilitative care in a skilled nursing facility.

"Garnishment" means withholding an amount from earned or unearned income to satisfy a debt or legal obligation.

"Grandfathered client" means: *A noninstitutionalized person who meets all current requirements for Medicaid eligibility except the criteria for blindness or disability; and* Was eligible for Medicaid in December 1973 as blind or disabled whether or not the person was receiving cash assistance in December 1973; and *Continues to meet the criteria for blindness or disability and other conditions of eligibility used under the Medicaid plan in December 1973; and *An institutionalized person who was eligible for Medicaid in December 1973 or any part of that month, as an inpatient of a medical institution or resident of an intermediate care facility that was participating in the Medicaid program and for each consecutive month after December 1973 who: *Continues to meet the requirements for Medicaid eligibility that were in effect under the state's plan in December 1973 for institutionalized persons; and *Remains institutionalized.

"Health maintenance organization (HMO)" means an entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis.

"Healthy kids," see **"EPSDT."**

"Home health agency" means an agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

"Hospital" means an institution licensed as a hospital by the department of health.

"Income for an SSI-related client," means the receipt by an individual of any property or service which the client can apply either directly, by sale, or conversion to meet the client's basic needs for food, clothing, and shelter.

***"Earned income"** means gross wages for services rendered and/or net earnings from self-employment.

***"Unearned income"** means all other income.

"Institution" means an establishment which furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. This includes medical facilities, nursing facilities, and institutions for the mentally retarded.

***"Institution-public"** means an institution, including a correctional institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

***"Institution for mental diseases"** means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services.

***"Institution for the mentally retarded or a person with related conditions"** means an institution that: *Is primarily for the diagnosis, treatment or rehabilitation of the mentally retarded or a person with related conditions; and *Provides, in a protected residential setting, on-going care, twenty-four hour supervision, evaluation, and planning to help each person function at the greatest ability.

***"Institution for tuberculosis"** means an institution for the diagnosis, treatment, and care of a person with tuberculosis.

***"Medical institution"** means an institution: *Organized to provide medical care, including nursing and convalescent care; *With the necessary professional personnel, equipment and facilities to manage the health needs of the patient on a continuing basis in accordance with acceptable standards; *Authorized under state law to provide medical care; and *Staffed by professional personnel. Services include adequate physician and nursing care.

"Intermediary" means an organization having an agreement with the federal government to process Medicare claims under Part A.

"Legal dependent" means a person for whom another person is required by law to provide support.

"Limited casualty program (LCP)" means a medical care program for medically needy, as defined under WAC 388-503-0320 and for medically indigent, as defined under WAC 388-503-0370.

"Medicaid" means the federal aid Title XIX program under which medical care is provided to persons eligible for: *Categorically needy program as defined in WAC 388- 503-0310 and 388-511-1105; or *Medically needy program as defined in WAC 388-503- 0320.

"Medical assistance." See **"Medicaid."**

"Medical assistance administration (MAA)" means the unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs.

"Medical assistance unit (MAU)" means one or more family members whose eligibility for medical care is determined separately or together based on financial responsibility.

"Medical care services" means the limited scope of care financed by state funds and provided to general assistance (GAU) and ADATSA clients.

"Medical consultant" means a physician employed by the department.

"Medical facility" see **"Institution."**

"Medically indigent (MI)" means a state-funded medical program for a person who has an emergency medical condition requiring hospital-based services.

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Medically needy (MN)" is the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

"Medicare" means the federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

"Part A" covers the Medicare inpatient hospital, posthospital skilled nursing facility care, home health services, and hospice care.

"Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

"Medicare assignment" means the method by which the provider receives payment for services under Part B of Medicare.

"Month of application" means the calendar month a person files the application for medical care. When the application is for the medically needy program, at the person's request and if the application is filed in the last ten days of that month, the month of application may be the following month.

"Nursing facility" means any institution or facility the department [of health] licenses as a nursing facility, or a nursing facility unit of a licensed hospital, that the: *Department certifies; and *Facility and the department agree the facility may provide skilled nursing facility care.

"Outpatient" means a nonhospitalized patient receiving care in a hospital outpatient or hospital emergency department, or away from a hospital such as in a physician's office, the patient's own home, or a nursing facility.

"Patient transportation" means client transportation to and from covered medical services under the federal Medicaid and state medical care programs.

"Physician" means a doctor of medicine, osteopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed.

"Professional activity study (PAS)" means a compilation of inpatient hospital data, conducted by the commission of professional and hospital activities, to determine the average length of hospital stay for patients.

"Professional review organization for Washington (PRO-W)" means the state level organization responsible for determining whether health care activities: *Are medically necessary; *Meet professionally acceptable standards of health care; and *Are appropriately provided in an outpatient or institutional setting for beneficiaries of Medicare and clients of Medicaid and maternal and child health.

"Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law to: *Artificially replace a missing portion of the body; *Prevent or correct physical deformity or malfunction; or *Support a weak or deformed portion of the body.

"Provider" or **"provider of service"** means an institution, agency, or person: *Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and *Is eligible to receive payment from the department.

"Resources for an SSI-related client," means cash or other liquid assets or any real or personal property that an individual or spouse, if any, owns and could convert to cash to be used for support or maintenance. *If an individual can reduce a liquid asset to cash, it is a resource. *If an individual cannot reduce an asset to cash, it is not considered an available resource. *Liquid means properties that are in cash or are financial instruments which are convertible to cash such as, but not limited to, cash, savings, checking accounts, stocks, mutual fund shares, mortgage, or a promissory note. *Nonliquid means all other property both real and personal evaluated at the price the item can reasonably be expected to sell for on the open market.

"Retroactive period" means the three calendar months before the month of application.

"Spell of illness" see **"benefit period."**

"Spendedown" means the process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department.

"Spouse" means:

***"Community spouse"** means a person living in the community and married to an institutionalized person or to a person receiving services from a home and community-based waived program as described under chapter 388-515 WAC.

***"Eligible spouse"** means an aged, blind or disabled husband or wife of an SSI-eligible person, with whom such a person lives.

***"Essential spouse"** means, a husband or wife whose needs were taken into account in determining old age assistance (OAA), aid to the blind (AB), or disability assistance (DA) client for December 1973, who continues to live in the home and to be the spouse of such client.

***"Ineligible spouse"** means the husband or wife of an SSI-eligible person, who lives with the SSI-eligible person and who has not applied or is not eligible to receive SSI.

***"Institutionalized spouse"** means a married person in an institution or receiving services from a home or community-based waived program.

***"Nonapplying spouse"** means an SSI-eligible person's husband or wife, who has not applied for assistance.

"SSI-related" means an aged, blind or disabled person not receiving an SSI cash grant.

"Supplemental security income (SSI) program, Title XVI" means the federal grant program for aged, blind, and disabled established by section 301 of the Social Security amendments of 1972, and subsequent amendments, and administered by the Social Security Administration (SSA).

"Supplementary payment (SSP)" means the state money payment to persons receiving benefits under Title XVI, or who would, but for the person's income, be eligible for such benefits, as assistance based on need in supplementation of SSI benefits. This payment includes:

***"Mandatory state supplement"** means the state money payment to a person who, for December 1973, was a client receiving cash assistance under the department's former programs of old age assistance, aid to the blind and disability assistance; and

"Optional state supplement" means the elective state money payment to a person eligible for SSI benefits or who, except for the level of the person's income, would be eligible for SSI benefits.

"Third party" means any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

"Title XIX" is the portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

"Transfer" means any act or omission to act when title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person; including delivery of personal property, bills of sale, deeds, mortgages, pledges, or any other instrument conveying or relinquishing an interest in property. Transfer of title to a resource occurs by: *An intentional act or transfer; or *Failure to act to preserve title to the resource.

"Value-fair market for an SSI-related person" means the current value of a resource at the price for which the resource can reasonably be expected to sell on the open market.

"Value of compensation received" means, for SSI related medical eligibility, the gross amount paid or agreed to be paid by the purchaser of a resource.

"Value-uncompensated" means, for SSI-related medical eligibility, the fair market value of a resource, minus the amount of compensation received in exchange for the resource.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-500-0005, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-500-0005, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-500-0005, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-80-005, 388-82-006, 388-92-005 and 388-93-005.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-502-0020

General requirements for providers.

(1) Enrolled providers must:

(a) Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

(i) Patient's name and date of birth;

(ii) Dates of services;

(iii) Name and title of person performing the service, if other than the billing practitioner;

(iv) Chief complaint or reason for each visit;

(v) Pertinent medical history;

(vi) Pertinent findings on examination;

(vii) Medications, equipment, and/or supplies prescribed or provided;

(viii) Description of treatment (when applicable);

(ix) Recommendations for additional treatments, procedures, or consultations;

(x) X-rays, tests, and results;

(xi) Dental photographs and teeth models;

(xii) Plan of treatment and/or care, and outcome; and

(xiii) Specific claims and payments received for services.

(b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains;

(c) Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation;

(d) Bill the department according to department rules and billing instructions;

(e) Accept the payment from the department as payment in full;

(f) Follow the requirements in WAC 388-502-0160 and 388-538-095 about billing clients;

(g) Fully disclose ownership and control information requested by the department;

(h) Provide all services without discriminating on the grounds of race, creed, color, age, sex, religion, national origin, marital status, or the presence of any sensory, mental or physical handicap; and

(i) Provide all services according to federal and state laws and rules, and billing instructions issued by the department.

(2) A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern the department's programs.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530. 01-07-076, § 388-502-0020, filed 3/20/01, effective 4/20/01; 00-15-050, § 388-502-0020, filed 7/17/00, effective 8/17/00.]

WAC 388-478-0070

Monthly income and countable resource standards for medically needy (MN) and medically indigent (MI) programs.

(1) Beginning January 1, 2002, the medically needy income level (MNIL) and MI monthly income standards are as follows:

(a) One person	\$571.00
(b) Two persons	\$592
(c) Three persons	\$667
(d) Four persons	\$742
(e) Five persons	\$858
(f) Six persons	\$975
(g) Seven persons	\$1,125
(h) Eight persons	\$1,242
(i) Nine persons	\$1,358
(j) Ten persons and more	\$1,483

(2) The MNIL standard for a person who meets institutional status requirements is in WAC 388-513-1305(3).

(3) Countable resource standards for the MN and MI programs are:

(a) One person	\$2,000
(b) Two persons	\$3,000
(c) For each additional family member add	\$50

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 1396r-5. 02-10-116, § 388-478-0070, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924 (42 U.S.C. 1396R-5). 01-12-073, § 388-478-0070, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, and 74.09.575. 00-10-095, § 388-478-0070, filed 5/2/00, effective 5/2/00; 99-11-054, § 388-478-0070, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710. 388-507-0720. 388-511-1115. 388-518-1820. 388-518-1830. 388-518-1840 and 388-518-1850.]

WAC 388-519-0100

Eligibility for the medically needy program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 388-519-0110

Spenddown of excess income for the medically needy program.

- (1) The person applying for MN medical coverage chooses a three month or a six month base period for spenddown calculation. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section apply.
- (2) A person's base period begins on the first day of the month of application, subject to the exceptions in subsection (4) of this section.
- (3) A separate base period may be made for a retroactive period. The retroactive base period is made up of the three calendar months immediately prior to the month of application.
- (4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:
 - (a) A three month base period would overlap a previous eligibility period; or
 - (b) A client is not or will not be resource eligible for the required base period; or
 - (c) The client is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or
 - (d) The client is or will be eligible for categorically needy (CN) coverage for part of the required base period; or
 - (e) The client was not otherwise eligible for MN coverage for each of the months of the retroactive base period.
- (5) The amount of a person's "spenddown" is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL. The excess income from each of the months in the base period is added together to determine the "spenddown" for the base period.
- (6) If income varies and a person's MN countable income falls below the MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 388-519-0100(5).
- (7) Once a person's spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount to determine the date of eligibility. The following medical expenses are used to meet spenddown:
 - (a) First, Medicare and other health insurance deductibles, coinsurance charges, enrollment fees, or copayments;
 - (b) Second, medical expenses which would not be covered by the MN program;
 - (c) Third, hospital expenses paid by the person during the base period;
 - (d) Fourth, hospital expenses, regardless of age, owed by the applying person;
 - (e) Fifth, other medical expenses, potentially payable by the MN program, which have been paid by the applying person during the base period; and
 - (f) Sixth, other medical expenses, potentially payable by the MN program which are owed by the applying person.
- (8) If a person meets the spenddown obligation at the time of application, they are eligible for MN medical coverage for the remainder of the base period. The beginning date of eligibility would be determined as described in WAC 388-416-0020.

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

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

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

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

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

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

(c) Meet one of the following conditions:

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

(A) The applying person; or

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

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

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

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

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

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

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

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

(d) Medical insurance deductibles including those Medicare deductibles for a first hospitalization in sixty days. (13) Medical expenses may be used more than once if:

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

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

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

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

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

WAC 388-416-0020

Certification periods for noninstitutionalized medically needy (MN) program.

(1) The certification period for the noninstitutionalized medically needy (MN) program begins:

(a) On the first day of the month in which hospital expenses equal the spenddown amount; or

(b) On the day that spenddown is met, when hospital expenses are less than the spenddown amount or no hospital expenses are involved.

(2) The certification period continues through the last day of the final month of the base period as described in chapter 388-519 WAC.

(3) The certification period can begin up to three months immediately prior to the month of application as described in chapter 388-519 WAC.

(4) The certification period for MN clients with income below the medically needy income level (MNIL) is twelve months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2105 and 388-521-2130.]

WAC 388-502-0100

General conditions of payment.

- (1) The department reimburses for medical services furnished to an eligible client when all of the following apply:
- (a) The service is within the scope of care of the client's medical assistance program;
 - (b) The service is medically or dentally necessary;
 - (c) The service is properly authorized;
 - (d) The provider bills within the timeframe set in WAC 388-502-0150;
 - (e) The provider bills according to department rules and billing instructions; and
 - (f) The provider follows third-party payment procedures.
- (2) The department is the payer of last resort, unless the other payer is:
- (a) An Indian health service;
 - (b) A crime victims program through the department of labor and industries; or
 - (c) A school district for health services provided under the Individuals with Disabilities Education Act.
- (3) The provider must accept Medicare assignment for claims involving clients eligible for both Medicare and medical assistance before MAA makes any payment.
- (4) The provider is responsible for verifying whether a client has medical assistance coverage for the dates of service.
- (5) The department may reimburse a provider for service provided to a person if it is later determined that the person was ineligible for the service at the time it was provided if:
- (a) The department considered the person eligible at the time of service;
 - (b) The service was not otherwise paid for; and
 - (c) The provider submits a request for payment to the department.
- (6) The department does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the department.
- (7) Information about medical care for jail inmates is found in RCW 70.48.130.
- (8) The department pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the department, whichever is lower.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0100, filed 7/17/00, effective 8/17/00.]

WASHINGTON STATE ATTORNEY GENERAL

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