

NO. 49569-4-II

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

CHEHALIS CHILDREN'S CLINIC P.S.,

Petitioner,

v.

WASHINGTON STATE HEALTH CARE AUTHORITY,

Respondent.

BRIEF OF RESPONDENT

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I. INTRODUCTION

The Health Care Authority (“HCA”) overpaid Chehalis Children’s Clinic, P.S. (“Chehalis”) by approximately \$212,000 in connection with services provided by Chehalis to Medicaid clients in calendar year 2009. Even after the Legislature forgave nearly \$138,000 of the overpayment, Chehalis still owed approximately \$74,000. Chehalis does not dispute the fact that it was overpaid. Instead, relying on the principle of equitable estoppel, Chehalis contends that it should not be required to repay the money. Yet, Chehalis has failed to establish by clear, cogent, and convincing evidence that equitable estoppel should prevent HCA from complying with federal Medicaid law and state law by recouping money that Chehalis concedes should not have paid in the first instance. The final administrative order rejected the argument, as did the Superior Court. This Court should affirm the administrative order and allow HCA to recover the overpayment.¹

¹ In its Introduction, without any citation to evidence, Chehalis asserts that this case will determine other appeals that it and other health clinics may be pursuing against HCA. *See* Brief of Appellant (“Br. Appellant”) at 1. HCA objects to the attempted introduction of facts that are wholly unsupported by the evidentiary record on appeal. *See, e.g.*, RCW 34.05.558 (judicial review generally confined to agency record); RAP 9.1 (delineating the composition of the record on review).

II. COUNTER-STATEMENT OF THE ISSUES

1. Did the Review Decision and Final Order (“Final Order”) from HCA’s Board of Appeals correctly hold that Chehalis failed to establish by clear, cogent, and convincing evidence that equitable estoppel should not prevent HCA from recovering the overpayment of approximately \$74,000, when (a) Chehalis concedes it was overpaid; (b) the Legislature forgave nearly two-thirds of the overpayment; (c) Chehalis did not reasonably rely on any expectation of never being subject to an audit by HCA; (d) it would not be a manifest injustice to require Chehalis to repay money that it concedes it was not entitled to receive in the first instance; and (e) applying equitable estoppel would impair HCA’s exercise of its governmental functions to ensure compliance with federal law regarding proper levels of Medicaid payments?

2. Is Chehalis entitled to attorneys’ fees and costs on appeal, when (a) the Final Order should be affirmed; and (b) Chehalis did not comply with RAP 18.1 by explaining any applicable law under which it allegedly would be entitled to fees and costs?

III. STATEMENT OF THE CASE

A. The Medicaid Program and Its Funding

Under the original version of Medicaid enacted in 1965, Congress “offers federal funding to States to assist pregnant women, children, needy

families, the blind, the elderly, and the disabled in obtaining medical care.” *Nat’l Fed’n of Indep. Bus., et al., v. Sebelius*, 132 S. Ct. 2566, 2581, 183 L. Ed. 2d 450 (2012) (citing 42 U.S.C. § 1396a(a)(10)). In the Patient Protection and Affordable Care Act of 2010, Congress expanded Medicaid to cover anyone with an income below 133% of the federal poverty level. *Nat’l Fed’n*, 132 S. Ct. at 2601, 2605.

To receive federal funding, the State must comply with federal Medicaid law. *See generally Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1382, 191 L. Ed. 2d 471 (2015); *Cal. Ass’n of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1010 (9th Cir. 2013). One requirement is to submit a “State Plan” describing how the State will administer Medicaid and assuring compliance with federal law. *Armstrong*, 135 S. Ct. at 1382; 42 U.S.C. § 1396a(a); 42 C.F.R. § 430.12. The federal Centers for Medicare and Medicaid Services (“CMS”) must approve the State Plan and any amendments. *See* 42 C.F.R. §§ 430.10, 430.14; *Douglas*, 738 F.3d at 1010.

Once the federal government approves its State Plan, a state is eligible to receive federal matching funds. *See generally* 42 U.S.C. § 1396b(a); 42 C.F.R. § 430.1. The federal CMS wields a considerable financial stick, because it can withhold all or a portion of a state’s Medicaid funding if it concludes the state is out of compliance with

federal requirements. *See* 42 U.S.C. § 1396c; 42 C.F.R. §§ 430.1, 430.35(a), 430.40(a), 430.42(a), 447.304(c); *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2604. The amounts add up quickly, since the federal government funds at least 50 percent of a state's Medicaid expenditures. *See* 42 U.S.C. § 1396b(a)(1); *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2606.

HCA is designated in the State Plan as Washington's "single State agency" for its administration and supervision. *See* 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10(b)(1). HCA has been Washington's Medicaid agency since July 1, 2011. *See* RCW 74.09.530(1)(a); Final Order, Conclusion of Law ("CL") 2; Clerk's Papers ("CP") at 21. Before that date, the Department of Social and Health Services was the Medicaid agency. *Samantha A. v. Dep't of Soc. & Health Servs.*, 171 Wn.2d 623, 630, 256 P.3d 1138 (2011).

The Legislature has explicitly instructed HCA to take all steps necessary to ensure the State receives federal Medicaid matching funds. *See* RCW 74.04.050(3), 74.09.500.

B. The State Must Have Written Agreements With Medicaid Providers

As another condition of receiving federal Medicaid funding, HCA must have written agreements with medical providers who choose to

participate in Medicaid. *See* 42 U.S.C. § 1396a(a)(27); 42 C.F.R. § 431.107; *Banks v. Sec’y of Ind. Family & Soc. Servs. Admin.*, 997 F.2d 231, 234 (7th Cir. 1993). In turn, Washington law allows HCA to enter into those contracts. *See* RCW 74.09.120(5). The contracts are known as a “Core Provider Agreement.” *MultiCare Med. Ctr. v. State*, 114 Wn.2d 572, 575-76, 790 P.2d 124 (1990); *St. John Med. Ctr. v. State*, 110 Wn. App. 51, 55, 38 P.3d 383 (2002).

C. Medicaid Clients Can Receive Healthcare Services From Managed Care Organizations

Medicaid clients can receive their medical care through either a “fee-for-service” system or a “managed care” system. *See* 42 U.S.C. § 1396u-2(a)(1)(A); 42 C.F.R. § 438.1(a)(6); *G. v. State of Hawaii Dep’t of Human Serv.*, 703 F. Supp. 2d 1078, 1084 (D. Haw. 2010). Under the traditional fee-for-service model, “the state contracts directly with and pays healthcare providers, . . . for services they provide to Medicaid beneficiaries.” *Hawaii*, 703 F. Supp. 2d at 1084. Under the managed care model, the state enters into contracts with managed care organizations that assume responsibility for furnishing Medicaid services “through their own employees or by contracting with independent providers[.]” *Id.*

In Washington, the majority of Medicaid clients receive their healthcare through managed care organizations, rather than under the fee-

for-service system). *See* RCW 74.09.522(2), (6). During the time period relevant to this case, Washington's Medicaid managed care program was called "Healthy Options." *St. John*, 110 Wn. App. at 56.

D. HCA Must Offer Medicaid Services Through Rural Health Clinics and Pay the Clinics Under Certain Methodologies

Another condition of receiving federal Medicaid funding is that the State must allow Medicaid clients to receive services from health centers known as "Rural Health Clinics." *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(2)(B); 42 C.F.R. §§ 440.20(b), 440.210(a)(1); *Douglas*, 738 F.3d at 1010.

The federal statute specifies the manner in which HCA must pay rural health clinics for their Medicaid services. *See* 42 U.S.C. § 1396a(bb)(1); *Pee Dee Health Care, P.A. v. Sanford*, 509 F.3d 204, 207 (4th Cir. 2007). The general payment methodology is known as the "Prospective Payment System." *Id.* The rate that results from the Prospective Payment System is often called the "encounter rate." *See, e.g.,* Final Order, Finding of Fact ("FF") 13-14, CP at 14. A clinic's Prospective Payment System rate for calendar year 2001 was based on the clinic's reasonable costs from 1999 and 2000. *See* 42 U.S.C. § 1396a(bb)(2). The rates for each subsequent year are the clinic's 2001

rates plus an inflation factor and any adjustments based on changes in the scope of the clinic's healthcare services. *See* 42 U.S.C. § 1396a(bb)(3).

HCA and a clinic can agree to use an "Alternative Payment Methodology" to replace the Prospective Payment System. *See* 42 U.S.C. § 1396a(bb)(6); *Pee Dee Health*, 509 F.3d at 207. The resulting payment under the Alternative Payment Methodology must be at least equal to what the Prospective Payment System rate would have been. *See* 42 U.S.C. § 1396a(bb)(6)(B); *Pee Dee Health*, 509 F.3d at 207.

Furthermore, the State must make a "supplemental payment" to a health clinic if (1) the State contracts with managed care organizations to provide services to Medicaid clients and (2) the clinic has a contract with any such organization. *See* 42 U.S.C. § 1396a(bb)(5)(A). The purpose of the supplemental payment is to make sure that the clinic, through the combination of the managed care organization and the State, gets paid the amount it would have received under the Prospective Payment System. *Id.* The State's supplemental payment is often called an "enhancement payment." *See, e.g.*, Final Order, FF 8, CP at 12-13.

To ensure that the amounts of the enhancement payments are correct, HCA performs a "reconciliation" of the payments made each calendar year. *See* Final Order, FF 11, FF 20, CP at 13. The purpose of the reconciliation is to compute what a clinic received in both its encounter

payments from the managed care organizations and its enhancement payments from HCA. *See* Final Order, FF 13, CP at 14. At the end of the process, HCA needs to make sure that a clinic is paid at the level it would have received under the Prospective Payment System. *Id.*; *see also* 42 U.S.C. § 1396a(bb)(5)(A).

E. Chehalis is a Rural Health Clinic That Provides Services to Medicaid Clients

Chehalis is a rural health clinic. *See* Final Order, FF 1, CP at 11. Chehalis has a contract with HCA (the Core Provider Agreement) to provide healthcare services to Medicaid clients. *Id.* Chehalis also has contracts with managed care organizations so it can provide healthcare services to Medicaid clients who are enrolled with those organizations. *See, e.g.*, Final Order, FF 26, CP at 17.

For the services provided under the Core Provider Agreement, Chehalis chose to be paid under an Alternative Payment Methodology rather than the Prospective Payment System. *See* Final Order, FF 10, CP at 13. Since Chehalis also provided services to managed care clients, it received enhancement payments from HCA on top of the encounter payments it received from the managed care organizations. *See* Final Order, FF 16, CP at 15.

HCA performed a reconciliation to ensure the level of Chehalis's enhancement payments for calendar year 2009 was correct. *See* Final Order, FF 2, CP at 11. Through this process, HCA determined it had overpaid Chehalis by \$216,336. *Id.*

In 2014, the Legislature inserted a proviso in the operating budget for the fiscal biennium ending June 30, 2015, that forgave Chehalis and other rural health clinics for nearly two-thirds of their overpayments pertaining to the 2009 reconciliation. *See* Third Engrossed Substitute S.B. 5034, § 213 (46) (2014) (specifying the dollar amount of the write-off), CP at 110; *see also* Final Order, FF 2, CP at 11. As a result of the Legislature's write-off and one other minor adjustment, Chehalis's overpayment dropped from \$216,336 to \$74,634. *Id.*

F. Chehalis Challenged HCA's Notice Regarding the Reduced Overpayment Amount

Chehalis requested an adjudicative proceeding to contest HCA's notice that it repay the reduced overpayment amount of \$74,634. *See* Final Order, FF 3, CP at 11. An administrative law judge applied the principle of equitable estoppel to prevent HCA from collecting the overpayment. *See* Initial Order, §§ 5.28, 6.1, 6.2, CP at 48-50.

HCA sought administrative review of the initial decision, and Judge King of HCA's Board of Appeals reversed, finding that Chehalis

had failed to establish, by clear and convincing evidence, three of the five elements of equitable estoppel. *See* Final Order, CL 18-28, CP at 27-30. In declining to apply equitable estoppel, Judge King relied on federal Medicaid law, guidance from CMS, HCA's regulations, and written communications from HCA to Chehalis explaining that the amount of the enhancement payments and encounter payments must exactly match what Chehalis would have received under the Prospective Payment System. *See, e.g.*, Final Order, CL 14, 19, CP at 27-28.

On judicial review, the Thurston County Superior Court affirmed the Final Order. *See* CP at 122-25. Chehalis then filed this appeal. *See* CP at 126-27.

IV. ARGUMENT

A. Standard of Review and Burden of Proof

The Court's review of the Final Order is governed by the Administrative Procedure Act ("APA"). *Hardee v. Dep't of Social and Health Servs.*, 172 Wn.2d 1, 6, 256 P.3d 339 (2011); *Tapper v. Emp't Sec. Dep't*, 122 Wn.2d 397, 402, 858 P.2d 494 (1993). Chehalis has the burden of proving the Final Order is invalid. *See* RCW 34.05.570(1)(a); *Hardee*, 172 Wn.2d at 6.

When, as here, the challenged action is an agency order, the Court reviews the findings and conclusions of the final decision-maker for the

agency, not the initial decision-maker. *Verizon Nw., Inc. v. Emp't Sec. Dep't*, 164 Wn.2d 909, 915, 194 P.3d 255 (2008). This Court “sits in the same position” as the Superior Court, “applying the standards of the [APA] directly to the record before” the Board of Appeals. *Tapper*, 122 Wn.2d at 402. The Court may reverse the Final Order if it is (1) based on an error of law; (2) depends on findings not based on substantial evidence; or (3) reflects an arbitrary or capricious exercise of discretion. *Id.*; *see also* RCW 34.05.570(3); *Campbell v. Emp't Sec. Dep't*, 180 Wn.2d 566, 571, 326 P.3d 713 (2014).

The Court “review[s] questions of law and an agency’s application of the law de novo, but [gives] an agency’s interpretation of the law great weight where the statute is ambiguous and is within the agency’s special expertise.” *Snohomish Cty. v. Pollution Control Hearings Bd.*, 187 Wn.2d 346, 357, 386 P.3d 1064 (2016); *see also Port of Seattle v. Pollution Control Hearings Bd.*, 151 Wn.2d 568, 593-95, 90 P.3d 659 (2004). Similarly, the Court gives substantial weight “to an agency’s interpretation of rules that the agency promulgated.” *Verizon*, 164 Wn.2d at 915.

The Court reviews findings of fact under the “substantial evidence” standard and will uphold a finding if it is supported by “evidence that is substantial when viewed in light of the whole record before the court[.]” *See* RCW 34.05.570(3)(e); *see also King Cty. Pub.*

Hosp. Dist. No. 2 v. Dep't of Health, 178 Wn.2d 363, 372, 309 P.3d 416 (2013). This standard is highly deferential to the fact-finder. *ARCO Prods. Co. v. Wash. Utils. & Transp. Comm'n*, 125 Wn.2d 805, 812, 888 P.2d 728 (1995). The evidence is viewed in the light most favorable to the party who prevailed at the final administrative forum, and the Court must accept the fact-finder's determinations of credibility and the weight to be given to reasonable but competing inferences. *City of Univ. Place v. McGuire*, 144 Wn.2d 640, 652, 30 P.3d 453 (2001). The Court should uphold a finding if there are sufficient facts from which a reasonable person could make the same finding as the agency, even if the Court would make a different finding based on its reading of the record. *Callecod v. Wash. State Patrol*, 84 Wn. App. 663, 676 n.9, 929 P.2d 510 (1997). An appellate court "[does] not weigh witness credibility or substitute [its] judgment for the agency's findings of fact." *Goldsmith v. Dep't of Social & Health Servs.*, 169 Wn. App. 573, 584, 280 P.3d 1173 (2012).

"[U]nchallenged findings [of fact] are treated as verities on appeal." *Darkenwald v. Emp't Sec. Dep't*, 183 Wn.2d 237, 244, 350 P.3d 647 (2015).

B. Summary of Argument

Chehalis does not challenge the conclusion that it was overpaid by more than \$212,000 and that the final amount owed to the State is more

than \$74,000. *See* Final Order, CL 16, CP at 26-27; Brief of Appellant (“Br. Appellant”) at 2. Instead, Chehalis tries to avoid the repayment by relying on equitable estoppel. *See* Br. Appellant at 15-17. However, Chehalis has not established by clear, cogent, and convincing evidence that (1) it reasonably relied on any statute, rule, or agency guidance that it would not need to repay an overpayment; (2) a manifest injustice would occur if it had to repay the money; or (3) HCA’s governmental functions of ensuring compliance with federal law would not be impaired if the overpayment is not collected.

Chehalis has not cited to any contract or other binding obligation under which the State promised to pay the clinic more than what it was entitled to receive under the Prospective Payment System. Similarly, Chehalis does not deny receiving direct communications from HCA, stating explicitly that the amount of the encounter payments and enhancement payments must exactly match what Chehalis would have received under the Prospective Payment System.

C. Chehalis Has Not Met Its Burden of Proving That the Findings of Fact Are Unsupported by Substantial Evidence

Chehalis alleges that five Findings of Fact in the Final Order “are incorrect.” *See* Br. Appellant at 8-11. Chehalis has the burden of proving error. *See* RCW 34.05.570(1)(a); *Cornelius v. Dep’t of Ecology*,

182 Wn.2d 574, 585, 344 P.3d 199 (2015). As explained below, under the substantial evidence standard, Chehalis has not met its burden.²

1. Finding of Fact 8

Relying on the testimony of HCA's Rural Health Clinic program manager, Judge King made findings describing the process by which HCA makes enhancement payments to Chehalis and other clinics. *See* Final Order, FF 8, CP at 12-13. Chehalis claims the description is incorrect. *See* Br. Appellant at 9-11.

However, Chehalis does not challenge the basic premise of the factual finding, which is that enhancement payments are made to Chehalis by HCA in addition to the negotiated payments (or encounter rates) that Chehalis receives from managed care organizations. *See* Final Order, FF 8, CP at 12-13. As explained above, this basic premise is spelled out in federal Medicaid law. *See* 42 U.S.C. § 1396a(bb)(5)(A) (CP at 107-08).

Chehalis claims Judge King made "an obvious and fatal error" by holding that the State has the legal right to recoup a portion of the enhancement payments if the amount paid by HCA exceeded what Chehalis was entitled to receive. *See* Br. Appellant at 9. First, Chehalis is

² Chehalis contends it "finds error in other Findings of Fact and Conclusions of Law" in the Final Order but concedes that it "does not cite those errors" in its brief. *See* Br. Appellant at 2. Nonetheless, Chehalis claims it "does not admit as verities" any of those findings or conclusions. *Id.* Chehalis offers no citation to authority for the proposition that unchallenged findings are not verities on appeal.

making a legal argument in the context of challenging a factual finding. Second, the argument overlooks the plain language of the federal statute governing enhancement payments:

In the case of services furnished by a . . . rural health clinic pursuant to a contract between the . . . clinic and a managed care entity . . . , the State plan shall provide for payment to the . . . clinic by the State of a supplemental payment *equal to the amount (if any)* by which the amount determined under [the Prospective Payment System] exceeds the amount of the payments provided under the contract [between the clinic and the managed care entity].

See 42 U.S.C. § 1396a(bb)(5)(A) (emphasis added).

There is nothing in the plain language of this statute authorizing Chehalis to keep any portion of the enhancement payments that exceeds what it should receive under the Prospective Payment System. Chehalis is entitled to what it would have received under the Prospective Payment System. *Id.* No more, no less.

2. Finding of Fact 11

Again relying on the testimony of the Rural Health Clinic program manager, Judge King explained the process and methodology of how HCA performs the “annual reconciliation” of the amounts Chehalis received in encounter payments from managed care organizations and enhancement payments from HCA. *See* Final Order, FF 11, CP at 13.

Chehalis again masks a legal argument under the guise of challenging a factual finding. *See* Br. Appellant at 10.

Chehalis argues that the Court must reject the reconciliation and allow Chehalis to keep the overpayment because HCA did not complete the process in 2010 (the year following the period at issue). *Id.* There is nothing in the federal statute requiring HCA to comply with the constricted timeframe that Chehalis advocates. As explained above, the requirement is to pay Chehalis precisely what it is entitled to receive under the Prospective Payment System. *See* 42 U.S.C. § 1396a(bb)(5)(A); Final Order, CL 13, CP at 26. Federal law imposes no timeframe on determining the accuracy.

Furthermore, a primary component of the reconciliation process is that it compares the enhancement payments and encounter payments that a clinic had received in any given calendar year. HCA fulfills the requirement for an “annual reconciliation” by comparing the amounts that a clinic had received in that calendar year. The law does not govern *when* the process must be completed; the law governs *what* is included in the process.

Moreover, by failing to even challenge the amount of its overpayment, Chehalis concedes it has in fact received nearly \$75,000 more than it was entitled to receive and therefore should not be entitled to

keep. Chehalis's argument over what "annual" means in this context is beside the point and does not negate the otherwise unchallenged finding that it was overpaid.

3. Finding of Fact 12

Again relying on the testimony of the Rural Health Clinic program manager, Judge King explained the intent of enhancement payments and the possibility of HCA recouping any overpayments. *See* Final Order, FF 12, CP at 13-14. Chehalis does not cite to any federal or state law to support its contention that it is entitled to *more than* the amount it would have received under the Prospective Payment System. *See* Br. Appellant at 10-11. Indeed, Chehalis ignores the plain language of 42 U.S.C. § 1396a(bb)(5)(A) (CP at 107-08).

Instead, Chehalis relies only on one phrase in a cover letter to HCA from a local CMS official. *See* Br. Appellant at 10-11. The letter advised HCA of CMS's approval of a State Plan Amendment. *See* CP at 117. However, the letter does not purport to present binding federal law or guidance and, in any event, Chehalis overlooks the plain language of the State Plan Amendment itself. *See* CP at 118-21.

The State Plan Amendment explains that the enhancement payments "will be paid in amounts necessary to ensure compliance with Section 1902(bb)(5)(A)" of the Social Security Act, which is 42 U.S.C.

§ 1396a(bb)(5)(A). *See* CP at 121. As mentioned, in order to comply with the statute, HCA makes enhancement payments at a level to ensure the clinic's overall payments are "equal to" what it would have received under the Prospective Payment System.

The State Plan Amendment further explains that HCA will "ensure that the *appropriate amounts* are being paid to each clinic" under the Medicaid statute and that, therefore, "the State will perform an annual reconciliation and verify that the enhancement payments made in the previous year were *in compliance with* Section 1902(bb)(5)(A)." *See* CP at 121 (emphasis added). Chehalis does not argue that HCA's determination of the overpayment was incorrect or that HCA is violating the statute.

If HCA fails to comply with the statute or the State Plan, it would endanger the State's receipt of federal Medicaid funding. *See, e.g.*, 42 U.S.C. § 1396c; 42 C.F.R. §§ 430.35(a), 430.40(a), 430.42(a); *Armstrong*, 135 S. Ct. at 1382; *Douglas*, 738 F.3d at 1010. Also, the Legislature explicitly instructed HCA to take all steps necessary to ensure the State receives federal Medicaid funds. *See* RCW 74.04.050(3), 74.09.500. Chehalis has not argued or proven that CMS has taken any adverse action against HCA in connection with HCA's adherence to the statute and the State Plan.

In addition, the Court should defer to CMS's interpretation of the federal Medicaid statutes, as contained in the language of the State Plan instructing HCA that payments to health clinics must comply with 42 U.S.C. § 1396a(a)(bb)(5)(A). *Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235, 1247-48 (9th Cir. 2013) (deference under *Chevron U.S.A., Inc. v. Nat. Res. Def. Coun., Inc.*, 467 U.S. 837 (1984), applies to CMS approvals of State Plan Amendments).

Furthermore, even if it is arguing that language in the State Plan Amendment or the CMS cover letter supports its position, Chehalis does not have any legal right to pursue an action on that basis. *Developmental Servs. Network v. Douglas*, 666 F.3d 540, 548-49 (9th Cir. 2011) (no private right of action to enforce State Plan Amendments). In any event, the plain language of 42 U.S.C. § 1396a(bb)(5)(A), as applied by Judge King, supports HCA's position.

4. Finding of Fact 20

Similar to Finding of Fact 11, Judge King relied here on the testimony of the Rural Health Clinic program manager to explain the "annual reconciliation" process of comparing the amounts of the enhancement payments and encounter payments. *See* Final Order, FF 20, CP at 16. As with Finding of Fact 11, Chehalis objects because the process was completed in 2014, not 2010. *See* Br. Appellant at 11. As explained

above with respect to Finding of Fact 11, Chehalis's argument misses the point that the law governs the accuracy of the calculation of the overpayment, not the precise timing of the determination.

5. Finding of Fact 30

In this finding, Judge King summarized the testimony of a Chehalis executive, Jenise Mugler, regarding her understanding of how the clinic is paid for its Medicaid services. *See* Final Order, FF 30, CP at 19. Ms. Mugler ultimately stated that she thought enhancement payments were "an additional source of income" to Chehalis. *Id.* Judge King concluded that her beliefs were "not reasonable" in light of the weight of the evidence. *Id.*

Chehalis does not dispute its own executive's testimony but instead argues that Judge King reached an incorrect conclusion. *See* Br. Appellant at 11. As explained above, Judge King is correct because enhancement payments are only intended to ensure that Chehalis receives an amount "equal to" what it would have received under the Prospective Payment System. *See* 42 U.S.C. § 1396a(bb)(5)(A); Final Order, CL 13, CP at 26. And, again, Chehalis does not dispute that it was, in fact, overpaid. *See* Final Order, CL 16, CP at 26-27.

D. Chehalis Has Not Established That HCA Should Be Equitably Estopped From Recouping the Overpayment

Chehalis claims that principles of equitable estoppel should prevent HCA from recouping the Medicaid funds to which the clinic is not entitled. *See* Br. Appellant at 15-17. Chehalis disputes Conclusions of Law 13-15, 19-21, and 23-28. *See* Br. Appellant at 11-17. Chehalis has not satisfied its burden of proving that Judge King committed an error of law, as required by RCW 34.05.570(3)(d).

“[E]quitable estoppel prevents a party from taking a position inconsistent with a previous one where inequitable consequences would result to a party who has justifiably and in good faith relied.” *Wash. Educ. Ass’n v. Dep’t of Ret. Sys.*, 181 Wn.2d 212, 226, 332 P.3d 428 (2014) (citation omitted). Equitable estoppel has the following five elements:

1. A statement, admission, or act by the party to be estopped, which is inconsistent with its later claims;
2. The asserting party acted in reliance upon the statement or action;
3. Injury would result to the asserting party if the other party were allowed to repudiate its prior statement or action;
4. Estoppel is necessary to prevent a manifest injustice; and
5. Estoppel will not impair governmental functions.

Wash. Educ. Ass’n, 181 Wn.2d at 226; Final Order, CL 17, CP at 27.

As the party asserting estoppel, Chehalis has the heavy burden of proving each of the elements by clear, cogent, and convincing evidence. *Kramarevcky v. Dep't of Soc. & Health Servs.*, 122 Wn.2d. 738, 744, 863 P.2d 535 (1993). “Courts should be most reluctant to find the government equitably estopped when public revenues are involved.” *Id.*

Judge King found that Chehalis had established the first and third elements. *See* Final Order, CL 18, CP at 27; CL 22, CP at 28. However, Judge King declined to apply equitable estoppel because Chehalis did not establish the second, fourth, and fifth elements. *See* Final Order, CL 19, CP at 27-28 (second element); CL 23-26, CP at 28-30 (fourth element); CL 27, CP at 30 (fifth element). Chehalis argues that it satisfied all of those elements. *See* Br. Appellant at 15-17. Chehalis is incorrect.

1. Chehalis has not established that it acted with reasonable reliance

Despite substantial evidence to the contrary, Chehalis argues it was unaware that HCA, in the reconciliation process, might recoup the amounts of the enhancement payments exceeding what Chehalis was entitled to receive. *See* Br. Appellant at 13 (challenging Conclusions of Law 19-21). Chehalis has not shown by clear, cogent, and convincing evidence that it reasonably relied on any expectation of never being subjected to an audit.

Instead, as Judge King described, Chehalis was fully aware of the governing federal statute, instructions to HCA from the federal government, and communications from HCA's Director to health clinics about the reconciliation process and the need to ensure that enhancement payments did not exceed what Chehalis should receive under the Prospective Payment System. *See* Final Order, CL 19-21, CP at 27-28 (and exhibits cited therein). Indeed, Chehalis does not deny that it was aware of the statute, the federal instructions, and the letter from HCA's Director. The statute was in effect before 2009, the CMS instructions were issued before 2009, and the letter was sent before 2009. *Id.* Therefore, it is not plausible for Chehalis to contend it had any reasonable belief that the mere receipt of an enhancement payment meant that HCA would never audit the payment to ensure accuracy.

This conclusion also follows from the fact that Chehalis cannot base a defense on its claim that it was unaware of the law that would govern its transactions with the State, since "every person is presumed to know the law and is bound thereby[.]" *Maynard Inv. Co. v. McCann*, 77 Wn.2d 616, 624, 465 P.2d 657 (1970).

2. Chehalis has not established that equitable estoppel is necessary to prevent a manifest injustice

Chehalis also contends it would be a manifest injustice to require it to repay the money that it was not entitled to receive in the first instance. *See* Br. Appellant at 13-14 (challenging Conclusions of Law 23-26). It is worth noting again that Chehalis does not challenge the factual finding that it was overpaid. *See* Final Order, CL 16, CP at 26-27.

Chehalis claims it would be a manifest injustice for HCA to recoup the money because the clinic allegedly did not know “the enhancements were paid incorrectly[.]” *See* Br. Appellant at 13. Even if Chehalis did not know, it is irrelevant, because the State has the right to audit its Medicaid payments to ensure accuracy and secure any overpayments. *See, e.g.*, RCW 41.05A.070 (right to recover overpayments); RCW 74.09.200 (providers must allow HCA “to inspect and audit all records”); RCW 74.09.220 (providers must repay amounts to which they are not entitled, regardless of intent); RCW 74.09.290 (HCA’s authority to audit). Indeed, auditing Medicaid payments is a federal requirement, as part of the State Plan. *See* 42 U.S.C. §§ 1396a(a)(27)(B), 1396a(a)(37)(B).

In addition, Chehalis presented no evidence to counter Judge King’s conclusion that both the clinic and HCA understood that the amount of the enhancement payments “was an approximate figure which

would be reconciled later.” *See* Final Order, CL 24, CP at 29. Judge King based his conclusion on the fact that HCA’s payments to Chehalis hinged on monthly enrollment figures that HCA received from the managed care organizations. *Id.* Based on the timing of the transmittal of the information and the making of the enhancement payments, Chehalis “knew the funds given by [HCA] were an approximate payment which would be reconciled later.” *Id.*

Furthermore, as Judge King noted, it cannot be a manifest injustice to repay the remaining amount when the Legislature already has forgiven two-thirds of the clinic’s obligation. *See* Final Order, CL 23, CP at 28-29; CL 26, CP at 30. Chehalis has been treated more than fairly.

3. Chehalis has not established that estoppel will not impair governmental functions

Chehalis argues that applying equitable estoppel would not impair HCA’s exercise of its governmental functions. *See* Br. Appellant at 14-15 (challenging Conclusion of Law 27) (“There is no federal law requirement that HCA recoup any part of the enhancement payment.”). It would be a meaningless act to perform the reconciliations if HCA would essentially do nothing with the results, which is what Chehalis advocates.

Estoppel would impair the governmental function of reconciling the clinic’s payments. As noted, HCA is obligated under federal and state

law to ensure its Medicaid payments are made in accordance with Medicaid requirements. Barring HCA from recovering identified overpayments would directly contradict those requirements. This is especially true in the present case, where Chehalis concedes it was overpaid.

Chehalis contends that “CMS does not request or require any repayment for any of the enhancement funds[.]” *See* Br. Appellant at 15. Judge King correctly discounted this argument. *See* Final Order, CL 27, CP at 30. The argument also ignores 42 U.S.C. § 1396a(bb)(5)(A) (requiring payments from HCA “equal to” the amounts calculated under the Prospective Payment System) and 42 C.F.R. § 433.312 (requiring HCA to refund identified overpayments to CMS). Chehalis has not established by clear, cogent, and convincing evidence that HCA’s obligations under federal Medicaid law would not be impaired by allowing Chehalis to avoid responsibility for repaying the money to which it is not entitled.

4. Chehalis has not established any error of law in any other challenges to Judge King’s conclusions of law

Chehalis also challenges Conclusion of Law 13 and 14, although not specifically in the context of trying to prove the elements of equitable estoppel. *See* Br. Appellant at 11-12. Instead, Chehalis simply repeats its

contention that it is allowed to keep more Medicaid funding than it would have received under the Prospective Payment System. As Judge King noted, and as explained above, Chehalis's interpretation of the federal statute is incorrect. *See* Final Order, CL 13-14, CP at 26.

In addition, Chehalis challenges Conclusion of Law 15, under which Judge King noted that he did not need expert testimony from an accountant in order to apply federal Medicaid law. *See* Final Order, CL 15, CP at 26; Br. Appellant at 12. There is nothing erroneous with a judge holding that applying a federal law does not need expert input from an accountant. The issues are legal, not financial.

Finally, Chehalis challenges Judge King's conclusion, after lengthy analysis, that it has not established all the elements of equitable estoppel. *See* Br. Appellant at 15-17 (challenging Conclusion of Law 28). As explained above, Judge King accurately held that Chehalis had not proven three of the elements by clear, cogent, and convincing evidence. Chehalis did not reasonably rely on its initial receipt of the enhancement payments; it would not be a manifest injustice to require Chehalis to repay the remaining amount; and preventing HCA from carrying out its federal and state Medicaid requirements would clearly impair its governmental functions.

E. Chehalis is Not Entitled to Fees and Costs

Chehalis requests payment of its attorneys' fees and costs in connection with this appeal. *See* Br. Appellant at 18. The Court should reject the request because, as discussed above, the Final Order should be affirmed. In addition, Chehalis did not “devote a section of its opening brief to the request for the fees or expenses[,]” *see* RAP 18.1(b), or cite to any “applicable law” under which it would be entitled to fees and costs, *see* RAP 18.1(a). *Hedlund v. Vitale*, 110 Wn. App. 183, 188, 39 P.3d 358 (2002).

V. CONCLUSION

The Court should affirm the Final Order because Chehalis has not met its burden of proving that the Board of Appeals committed any legal errors. Chehalis is not entitled to keep Medicaid funding that it concedes it should not have received.

RESPECTFULLY SUBMITTED this 18th day of April, 2017.

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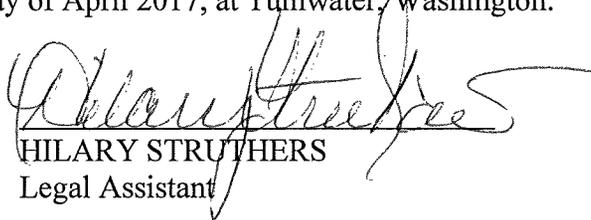
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I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 18th day of April 2017, at Tumwater, Washington.


HILARY STRUTHERS
Legal Assistant

WASHINGTON STATE ATTORNEY GENERAL
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