IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

Physician Anesthesia ASSOCIATION, INC., P.S.,	)	No. 66942-7-I
	)	DIVISION ONE
Respondent and Cross Appellant,	)	
v.	)	UNPUBLISHED OPINION
MOLINA HEALTHCARE OF WASHINGTON, INC.,	)	
Appellant and Cross Respondent.	)	FILED: June 11, 2012

Schindler, J. — Molina Healthcare of Washington Inc. is a managed health care organization (MCO). Molina contracts with the Washington State Department of Social and Health Services (DSHS) to provide health care to Medicaid-eligible clients enrolled in the "Healthy Options" program. Physician Anesthesia Association Inc. P.S. (PAA) filed a lawsuit against Molina to obtain reimbursement for the difference between its billed rates and the amount Molina paid for anesthesiology services provided to Healthy Options patients at Yakima Valley Memorial Hospital. On cross motions for summary judgment, the trial court ruled that based on the parties' undisputed course of dealing from 2003 until November 26, 2007, PAA agreed to accept reimbursement from

Molina at the DSHS/fee-for-service (FFS) rates for anesthesiology services provided to Healthy Options patients. However, the court ruled that after PAA objected to paying the DSHS/FFS rates on November 26, 2007, PAA was entitled to recover the difference between its billed rate and the DSHS/FFS rates for anesthesiology services provided to Healthy Options patients on an open account theory. Molina contends the court erred in ruling that PAA is entitled to reimbursement on an open account theory. Molina asserts that because PAA continued to accept reimbursement for anesthesiology services provided to Healthy Options patients at the DSHS/FFS rates, the court erred in denying summary judgment dismissal of PAA's claims for reimbursement after November 26, 2007. PAA cross appeals dismissal of its claims for reimbursement before November 26, 2007. We affirm the decision to dismiss the claim for reimbursement before November 26, 2007, reverse the determination that after November 26, 2007 PAA was entitled to reimbursement on an open account theory, and remand.

FACTS

Title XIX of the Social Security Act creates the Medicaid program. Medicaid is a cooperative federal and state program that provides health care resources for low income individuals and families. Social Security Act, ch. 531, 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. §§ 301-1397mm); Harris v. McRae, 448 U.S. 297, 308, 100 S. Ct. 2671, 65 L. Ed. 2d 784 (1980).

DSHS administers the Medicaid program in Washington. State law authorizes DSHS to enter into a "Core Provider Agreement" (CPA) with hospitals and other health

care providers to provide health care to Medicaid patients. Under the CPA, the provider must accept reimbursement payments at rates established by DSHS (DSHS/FFS rates).[1]

DSHS also administers the managed care Healthy Options program.[2] State law authorizes DSHS to contract with a MCO to provide health care services to Medicaid recipients.[3] DSHS pays a MCO for providing health care services at a set monthly premium rate for individuals and families eligible for the Medicaid Healthy Options program.[4] The MCO is responsible for providing medical services to the Healthy Options enrollees.

PAA is a group of physicians that provide anesthesiology services to patients at Yakima Valley Memorial Hospital (Hospital). PAA contracts with DSHS to provide anesthesiology services to Medicaid patients. Dr. Ross Katz, the PAA doctor responsible for negotiating contracts on behalf of PAA, testified that one third of the anesthesiology services PAA provides are for Medicaid patients.

PAA independently establishes a billed rate for anesthesiology services on an annual basis. PAA office manager Karen Beard testified that without regard to whether "PAA has negotiated different reimbursement rates with different insurance companies, commercial or Healthy Options plans, . . . [e]verything goes out billed at the same rate"

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[1] See WAC 388-502-010.

[2] A third program administered by the Washington State Health Care Authority (HCA), the "Basic Health Plan" (BHP) program, provides health care resources for low income individuals who do not qualify for Medicaid. The HCA also contracts with MCOs to provide coverage for the BHP. RCW 70.47.005, 010.

[3] See WAC 388-538-067.

[4] See former WAC 388-538-070(1) (1997) (allowing DSHS to pay for managed care services using a "capitated system").

in order to track "write-offs."[5]

In January 1998, Qual-Med, a MCO in Yakima, entered into an agreement with DSHS to provide health care services to Healthy Options program enrollees. Qual-Med did not enter into a written agreement with PAA to provide anesthesiology services to Healthy Options patients at the Hospital. There is no dispute that PAA accepted reimbursement from Qual-Med for anesthesiology services at the DSHS/FFS rates without objection.[6]

Molina purchased Qual-Med in January 2000.[7] Molina is a for-profit MCO that provides health care to low income families and individuals. Molina entered into a contract with DSHS to provide health care services to eligible Medicaid clients enrolled in the Healthy Options program. The contract with DSHS for the Healthy Options enrollees requires Molina to maintain an "appropriate provider network" and enter into written agreements with hospitals and other providers to provide health care services to Healthy Options members. But the contract does not require Molina to enter into a written agreement for ancillary services such as anesthesiology.[8] If there is no written agreement, the DSHS contract for Healthy Options enrollees provides that the cost to "the enrollee . . . is no greater than if the services were provided by participating providers."

Molina entered into written agreements with the Hospital, as well as individual physicians and physician groups in Yakima to provide primary and surgical care to

[5] The record does not contain a copy of any of PAA's invoices.

[6] PAA admits that Qual-Med paid DSHS/FFS rates.

[7] In 2004, Molina contracted with the HCA to provide coverage to BHP members.

[8] The only reference to anesthesiology services in the DSHS contract with a MCO for Healthy Options enrollees relates to coverage for emergency and post stabilization services.

Healthy Options enrollees. Molina did not enter into a written agreement with PAA. Molina typically requires preauthorization for nonemergency care at the Hospital. However, Molina does not require preauthorization for services such as ancillary anesthesiology services.

After Molina acquired Qual-Med, PAA continued to provide anesthesiology services to Molina Healthy Options patients and continued to accept payment at the DSHS/FFS rates. In July 2003, the Hospital entered into an agreement with PAA that designated PAA as "the exclusive provider of anesthesiology services at Hospital."

During contract negotiations in 2007 with another MCO, Dr. Katz learned for the first time that PAA did not have to accept the DSHS/FFS reimbursement rates for Healthy Options patients. Dr. Katz directed the office manager Karen Beard to determine whether PAA was providing anesthesiology services to other patients enrolled in the Healthy Options program with other MCOs. Beard discovered that PAA provided anesthesiology services to Molina patients enrolled in the Healthy Options program, and that in recent years, the number had significantly increased. Beard also learned that PAA had accepted reimbursement from Molina at the DSHS/FFS rates and did not have a written agreement with Molina. Beard said that "nobody realized" PAA could enter into a contract with Molina. According to Beard, the office staff believed reimbursement for "Healthy Options was like Medicaid, and so it was paid the same." Beard testified, in pertinent part:

> A: [Dr. Katz] asked me to find out who else we were seeing that had Healthy Options patients.
> Q: And what did you do?
> A: Went back to the office to find out who had Healthy Options contracts, checked with the billing staff, ran some numbers to try and

figure out what percentage of our billing it constituted.

Q: And what did you find out?

A: Basically that the percentages of Molina was increasing and that we didn't have a contract with them. And the reason was is that nobody realized that we could have a contract with them. The people in the office had been led to believe that it was, you know, state funded.

Q: When you say the people in the office had been led to believe that it was state funded, what do you mean by that?

A: When I asked the office staff what Healthy Options was, that was the explanation that they gave me.

Q: Who was the staff that gave you that?

A: That was actually Debbie Radtke who does the billing for state funded.

Q: What did she say precisely?

A: She said the Healthy Options was like Medicaid, and so it was paid the same.

Q: Paid the same as what?

A: As Medicaid.

Q: And did she say where she got that belief from?

A: No.

Q: Did you talk to anyone else in the office staff about the reimbursement rates for Healthy Options?

A: No.

On November 26, 2007, PAA contacted Molina for the first time about entering into a written agreement to provide anesthesiology services to its Healthy Options enrollees. In a letter to Molina dated January 15, 2008, PAA states that it did not have to accept payment at the DSHS/FFS rates and demanded reimbursement based on its billed rate "for services rendered to your patients in 2007." The letter states, in pertinent part:

> This letter is to inform you of a balance due to [PAA] for services rendered to your patients in 2007. We do not have a contract with Molina Healthcare and are therefore under no obligation to accept a reduced amount for the services provided in good faith. We have attempted to make contact with Molina in regards to initiating a contract, but to date have not received a response from anyone in contracting.

In response, Molina informed PAA that it was not obligated to pay more than 100

percent of DSHS/FFS rates for Healthy Options enrollees, and until the parties agreed otherwise, it would continue to reimburse PAA at those rates. The January 22 letter

from Molina to PAA states, in pertinent part:

> With regard to reviewing claims and payment history payment for your group: We are not obligated to pay more than 100% of DSHS rates to providers that are not contracted with us for Medicaid lines of business. We discussed this on our phone call and you seemed to understand that point. Please help me understand the rationale you are using to expect that we should be paying your billed charges for these state funded programs. We would be available to meet with your Executive Committee if they continue to have questions.
>
> . . . .
>
> Once this issue is resolved we would be happy to continue discussing the possibility of contracting with [PAA]. In the meantime, we will continue to pay 100% of DSHS rates for any services provided to a Molina member that falls under Washington State's [CPA].

In a letter to Dr. Katz dated March 7, Molina rejects PAA's proposal for reimbursement at 150 percent of DSHS/FFS rates, and reiterates that it will continue to reimburse PAA at the same DSHS/FFS rates. The March 7 letter states, in pertinent part:

> Per our discussion I presented the rate proposal you presented to me during our phone call on February 21, 2008 to our committee. I explained your position and rationale for the rate structure. You made it very clear to me in our telephone conversation that you are not open to any counter proposal on rates and in fact that you would not accept any counter proposal at this time.
>
> Your proposed Rate Structure:
>
> Healthy Options: 150% of DSHS rates
> BHP [(Basic Health Plan)]: 100% of Total Charges
> BHP+, SCHIP [(State Children's Health Insurance Program)]: 100% of DSHS Rates
> No Blended Rates
> Three Year Contract with 6% increase per year
>
> I regret to inform you that we cannot agree to your proposed rates. Molina . . . will honor it's [sic] responsibilities in payment to [PAA] under the same structure that we currently pay you. . . . Dr. Katz we are interested in coming to a mutually acceptable agreement.

Although the parties did not enter into a written agreement, PAA continued to provide nonemergency anesthesiology services to Molina Healthy Options patients and sent invoices to Molina at the billed rate. Molina continued to reimburse PAA at DSHS/FFS rates.[9]

In April 2009, PAA filed a lawsuit against Molina to obtain reimbursement for the difference between payments received for nonemergency anesthesiology services provided to Healthy Options patients and its billed charges from 2003 to 2008.[10] PAA claimed it was entitled to the balance owed based on an open account theory or in the alternative, restitution in an amount equal to the difference between what Molina paid and billed charges.

Molina filed an "Answer and Affirmative Defenses to Plaintiff's First Amended Complaint, and Counterclaim for Declaratory Relief." Molina asserted that it "consistently approved and paid covered, eligible claims submitted by [PAA] at the DSHS/Medicaid [FFS] rates for Healthy Options, not the billed rates from [PAA]." Molina alleged that PAA accepted payment at the DSHS/FFS rates and "continued to provide medical services to Healthy Options enrollees."

Molina also alleged that PAA was "on express notice" that it would only pay DSHS/FFS rates, yet continued to provide services to its Healthy Options patients. Molina claimed PAA's "conduct constitutes performance of [Molina]'s offer to pay only at DSHS/Medicaid rates" by accepting "payment, creating a unilateral contract

[9] Molina paid PAA its full billed charges for services to BHP members.

[10] PAA also demanded reimbursement from Molina for anesthesiology services provided to patients in the BHP. Before the lawsuit was filed, Molina and PAA entered into a "Release of Claims and Settlement Agreement" for claims related to BHP members. According to Molina, it agreed to pay PAA at its billing rate because of the small number of patients and the concern that PAA would "attempt to balance bill Molina's [BHP] members" covered by Molina's plan.

recognized under Washington law."

In the counterclaim for declaratory relief, Molina asserts that under the unilateral contract between Molina and PAA, PAA accepted reimbursement at the "DSHS/Medicaid [FFS] rates with respect to medical services [provided by PAA] to enrolled Healthy Options members." Molina also asserts that the contract between DSHS and PAA required PAA to accept reimbursement at DSHS/FFS reimbursement rates.

Molina filed a motion for summary judgment dismissal on the grounds that the course of dealing established the existence of a series of unilateral contracts between Molina and PAA. PAA filed a cross motion for partial summary judgment. PAA argued that Molina was liable for the unpaid balance due on an open account theory, and that PAA's contract with DSHS did not require it to accept DSHS/FFS reimbursement rates from Molina.

The trial court dismissed PAA's reimbursement claims for the period beginning in 2003 until November 26, 2007. The court ruled that the course of dealing established the existence of a series of unilateral contracts between PAA and Molina for that time period. The court concluded that the undisputed evidence showed that PAA knew that Molina only paid DSHS/FFS rates for anesthesiology services provided to Healthy Options patients but continued to provide anesthesiology services to Healthy Options patients at the DSHS/FFS rates, and that PAA accepted reimbursement at that rate

without objection until November 26, 2007.

> As I see it, there was an implied in fact contract between the parties up until November of '07 for the services provided. We call it unilateral contract or implied in fact contract. It is probably an implied in fact contract.
>
> Plaintiff knew what they were going to receive for reimbursement.

However, as to PAA's claims for reimbursement after November 26, 2007, the court ruled that Molina was liable for the difference between the DSHS/FFS rates and the billed rates charged by PAA on an open account theory. Accordingly, the court did not reach PAA's claim for restitution. The court also ruled that the contract between PAA and DSHS did not govern rates for reimbursement to Molina for nonemergency anesthesiology services provided to the Healthy Options patients.[11] In order to expedite the appeal, PAA and Molina entered into a stipulated judgment.[12] Molina and PAA filed a petition for review in the supreme court.[13] The supreme court denied the petition and transferred the case to this court.

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[11] The order states, in pertinent part:

1. Plaintiff's Motion for Partial Summary Judgment is granted with respect to:
    a. Defendants' counterclaim for a declaratory judgment; and
    b. The Open Account claim for the period November 26, 2007 forward.

    Plaintiff's Motion is denied as to the Open Account claim for the period prior to November 26, 2007.
2. Defendant Molina Healthcare of Washington Inc.'s Motion for Summary Judgment is granted with respect to:
    a. The Open Account claim for the period prior to November 26, 2007.
    b. The Restitution claim for the period prior to November 26, 2007. The Court does not reach the Restitution claim for the period subsequent to November 2007.
    c. The Consumer Protection Claim for the period prior to January 22, 2008.

Defendant's motion is otherwise denied.

[12] As part of the stipulated judgment, PAA dismissed its claim that Molina violated the Consumer Protection Act, chapter 19.86 RCW.

[13] Community Health Plan of Washington, a non-profit MCO, and DSHS each filed an amicus brief.

ANALYSIS

Molina contends the court erred in ruling that after November 26, 2007, PAA was entitled to reimbursement on an open account theory for the difference between PAA's billed rate and the DSHS/FFS rates. Molina claims the court erred in denying its motion for summary judgment on the grounds that the record establishes the existence of unilateral contracts after November 26, 2007. PAA cross appeals, arguing that the trial court erred in dismissing its claims for reimbursement before November 26, 2007.

We review an order granting summary judgment de novo. Failor's Pharmacy v. DSHS, 125 Wn.2d 488, 493, 886 P.2d 147 (1994). Summary judgment is proper if the pleadings, depositions, answers, and admissions, together with the declarations, show that there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. CR 56(c). We consider the facts and all reasonable inferences from those facts in the light most favorable to the nonmoving party. Failor's, 125 Wn.2d at 493.

PAA's Claim for Reimbursement from 2003 to November 26, 2007

PAA contends the trial court erred in ruling that it entered into a series of unilateral contracts with Molina during the period beginning 2003 until November 26, 2007.

The law recognizes two kinds of contracts: bilateral and unilateral. Cook v. Johnson, 37 Wn.2d 19, 23, 221 P.2d 525 (1950). The essential distinction between a bilateral and a unilateral contract is the method of acceptance. Multicare Med. Ctr. v. DSHS, 114 Wn.2d 572, 584, 790 P.2d 124 (1990), overruled in part by statute on other

grounds as stated in Neah Bay Chamber of Commerce v. Dep't of Fisheries, 119 Wn.2d 464, 832 P.2d 1310 (1992). A bilateral contract is formed by an exchange of promises. Govier v. N. Sound Bank, 91 Wn. App. 493, 499, 957 P.2d 811 (1998). By contrast, a unilateral contract consists of a promise of the offeree and acceptance by performance. In a unilateral contract,

> "the offer or promise of the one party does not become binding or enforceable until there is a performance by the other party, whereas, [in a bilateral contract], it is not performance which makes the contract binding, but rather the giving of a promise by the one party for the promise of the other."

Multicare, 114 Wn.2d at 584[14] (quoting Higgins v. Egbert, 28 Wn.2d 313, 317-18, 182 P.2d 58 (1947)). For purposes of a unilateral contract, "consideration consists of the offeree performing the requisite terms of the offer." Multicare, 114 Wn.2d at 584.

The party asserting the existence of a unilateral contract has the burden to prove each essential element of the contract. Multicare, 114 Wn.2d at 584 n.19 (citing Johnson v. Nasi, 50 Wn.2d 87, 91, 309 P.2d 380 (1957)). Washington follows the objective manifestation theory of contracts. Multicare, 114 Wn.2d at 586. "To determine whether a party has manifested an intent to enter into a contract, we impute an intention corresponding to the reasonable meaning of a person's words or acts." Multicare, 114 Wn.2d at 587. The unexpressed subjective intent of the parties is irrelevant. Hearst Communs., Inc. v. Seattle Times Co., 154 Wn.2d 493, 503-04, 115 P.3d 262 (2005). "[M]utual assent of the parties must be gleaned from their outward manifestations." Multicare, 114 Wn.2d at 587.

Here, the undisputed course of dealing between the parties from 2003 until

[14] (Alteration in original.)

November 26, 2007 establishes the existence of a series of unilateral contracts between Molina and PAA. See Puget Sound Fin., L.L.C. v. Unisearch, Inc., 146 Wn.2d 428, 434, 436, 47 P.3d 940 (2002); Multicare, 114 Wn.2d at 587-88. PAA admits that from 2003 until November 26, 2007, it knew Molina would only pay reimbursement at the DSHS/FFS rates for Healthy Options patients. Dr. Katz admitted that PAA accepted payment from Qual-Med and then Molina at DSHS/FFS rates and never challenged or objected to the amount paid.

> Q. Well, you accepted the reimbursements in 2003 without any challenge, correct?
> A. Correct.
> Q. And you were on notice that that was what Molina was going to be paying for reimbursements on Medicaid patients in its Healthy Options plan, correct?
> A. Correct.
> Q. And you continued to provide services to Molina plan members throughout 2003 knowing that that is what you were going to be receiving from Molina, correct?
> A. Correct.

The record also shows that PAA agreed to accept payment at the DSHS/FFS rates based on its independent misunderstanding. Until 2007, PAA did not know that it could enter into an agreement with Molina, and believed that the reimbursement rate for Healthy Options patients was the DSHS/FFS rates. PAA learned for the first time in the fall of 2007 that it did not have to accept the FFS rates and a contract with Molina. Thereafter, on November 26, 2007, PAA contacted Molina about entering into a contract at a different reimbursement rate.

We conclude that the parties' course of dealing from 2003 to November 26, 2007 established a series of binding unilateral contracts and that PAA agreed to accept

reimbursement at the DSHS/FFS rates for the anesthesiology services provided to Molina Healthy Options patients.

Claims for Reimbursement after November 26, 2007

Molina contends the trial court erred in ruling that after November 26, 2007, PAA was entitled to reimbursement at its billed rate on an open account theory.

PAA has the burden of establishing the existence of an open account. Card v. W. Farmers Ass'n, 72 Wn.2d 45, 49, 431 P.2d 206 (1967). An open account is " '[a]n account that is left open for ongoing debit and credit entries by two parties and that has a fluctuating [account] balance until either party finds it convenient to settle and close.' " Tingey v. Haisch, 129 Wn. App. 109, 111-12, 117 P.3d 1189 (2005), rev'd on other grounds, 159 Wn.2d 652, 152 P.3d 1020 (2007)[15] (quoting Black's Law Dictionary 20 (8th ed. 2004)). An open account is similar to a line of credit. To establish an open account, PAA must show the parties' intent to treat the individual transactions in the account as a connected series, rather than as independent of each other.

> [S]ubject to a shifting balance as additional debits and credits are made, until one of the parties wishes to settle and close the account, and where there is but one single and indivisible liability arising from such series of related and reciprocal debits and credits. . . . Thus, an open account is similar to a line of credit.

1 Am. Jur. 2d Accounts and Accounting § 4 (1962).

The record does not support the conclusion that PAA is entitled to recover for anesthesiology services provided to Molina Healthy Options patients on an open account theory. There is no evidence that the parties treated the anesthesiology services provided to Molina Healthy Options patients as a single running account subject to a shifting balance until "one of the parties wishes to settle and close the account." The record also shows that PAA wrote off the difference between billed

[15] (First alteration in original.)

charges and what it received and did not rebill. And if Molina overpaid, Beard testified that PAA "recouped those overpayments by reducing the amount paid to PAA on other claims that were unrelated to the original service for which the overpayment was made. These kinds of adjustments are routine in medical billing." See Chicago, Milwaukee & St. Paul Ry. Co. v. Frye & Co., 109 Wash. 68, 75, 186 P. 668 (1919) (no open account where invoices paid separately and no credit extended). We conclude the court erred in ruling that PAA was entitled to reimbursement from Molina after November 26, 2007 on an open account theory.

Molina argues that because PAA knew Molina would only pay DSHS/FFS rates yet continued to perform anesthesiology services for Healthy Options patients, the court erred in rejecting its argument that PAA entered into unilateral contracts after November 26, 2007.[16] Molina claims that PAA's objection to reimbursement at DSHS/FFS rates has no legal effect on the formation of unilateral contracts. Molina relies on Multicare; St. John Medical Center V. DSHS, 110 Wn. App. 51, 38 P.3d 838 (2002); and Cascade Auto Glass, Inc. v. Progressive Casualty Insurance Co., 135 Wn. App. 760, 145 P.3d 1253 (2006), to argue that PAA had the right to refuse to treat Molina Healthy Options patients under the terms of the contract with the Hospital.

PAA claims that its independent contractual obligation precludes the determination that a unilateral contract exists. PAA asserts that because its contract with the Hospital required PAA to provide anesthesiology services to Healthy Options patients, Molina cannot establish mutual intent or consideration.

[16] Molina does not appeal dismissal of its counterclaim that the contract between PAA and DSHS required it to accept DSHS/FFS rates.

As a general rule, performance of a preexisting legal obligation cannot constitute consideration for a unilateral contract. Multicare, 114 Wn.2d at 585. And here, unlike in Multicare, St. John, and Cascade, a third party contract—the contract between PAA and the Hospital—is implicated, and the parties dispute whether the provisions in the contract require PAA to provide anesthesiology services to Molina Healthy Options patients.[17] The contract between PAA and the Hospital states, in pertinent part:

> Exclusivity and Payer Contracting. Subject to its meeting the elements of this Agreement, PAA shall be the exclusive provider of anesthesiology services at Hospital. . . . In the event that Hospital notifies PAA of a date for such additional coverage needs, then PAA shall respond to Hospital within ten (10) days as to its intent to provide coverage. PAA agrees to provide services to the patients insured by all payers which contract with Hospital for surgical services, provided said payers agree to pay PAA on the basis of customary and prevailing rates as provided by other payers within Eastern Washington. PAA agrees to negotiate payments in good faith with all payers that contract with Hospital in an attempt to maintain a contract with such payers. Hospital agrees to provide services to the patients insured by all payers which contract with PAA for anesthesiology services, provided said payers agree to pay Hospital on the basis of customary and prevailing rates as provided by other payers. Hospital agrees to negotiate payments in good faith with all payers that contract with PAA in an attempt to maintain contract with such payers.

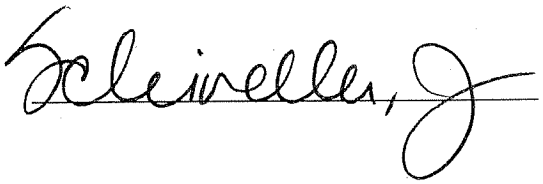
Viewing the evidence in the light most favorable to PAA, there are material issues of fact as to whether the contract with the Hospital required PAA to provide anesthesiology services to Healthy Options patients, and whether the parties entered into unilateral contracts after November 26, 2007.

CONCLUSION

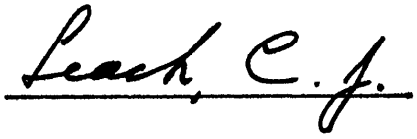
We affirm the decision to dismiss PAA's claims for reimbursement against Molina from 2003 until November 26, 2007. We reverse the determination that after

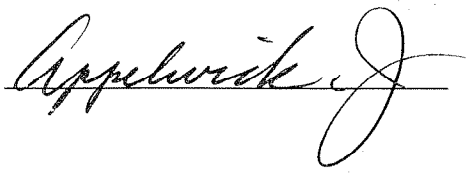
[17] The parties also dispute PAA's ethical obligations to provide anesthesiology services to patients.

November 26, 2007, PAA was entitled to reimbursement at its billed rates on an open account theory. Because there are material issues of fact as to whether the parties entered into unilateral contracts after November 26, 2007, we remand. If the court determines that the parties did not enter into unilateral contracts after November 26, 2007, both parties agree the court should address whether PAA is entitled to reimbursement on an unjust enrichment theory.[18]



WE CONCUR:





[18] PAA objects to consideration of Molina's "Third Statement of Additional Authorities" on the grounds that it does not comply with the requirements of RAP 10.8. We agree and did not take into consideration the Third Statement of Additional Authorities.