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Supreme Court of California
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IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

No. ________

FAMILY HEALTH CENTERS OF SAN DIEGO,
Plaintiff and Appellant,

v.

STATE DEPARTMENT OF HEALTH CARE SERVICES,
Defendant and Respondent.

Court of Appeal of California
Third District
No. C089555

Superior Court of California
Sacramento County
No. 34201880002953
Hon. Steven Gevercer

PETITION FOR REVIEW

George E. Murphy (SBN 91806)
Murphy, Campbell, Alliston & Quinn
8801 Folsom Blvd, Suite 230
Sacramento, CA 95826

Douglas S. Cumming (SBN 88580)
Douglas Cumming Medical Law
1641 Stone Canyon Drive,
Roseville, CA 95661

Attorneys for Plaintiff and Appellant
Family Health Centers of San Diego

CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

This is the initial certificate of interested entities or persons submitted on behalf of Plaintiff and Appellant Family Health Centers of San Diego in the case number listed above.

The undersigned certifies that there are no interested entities or persons that must be listed in this Certificate under California Rules of Court, rule 8.208.

Dated: August 11, 2021 By: /s/ George Murphy

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Petition for Review

ISSUE PRESENTED

When a Federally Qualified Health Center[1] incurs costs to have an employee talk with medically at-risk individuals about how she/he/they may obtain health services, make appointments with a provider, or enroll in Medi-Cal where appropriate, do such person-to-person encounters constitute "advertising to the general public" under pertinent federal guidelines, to make the costs of those activities[2] not allowable for reimbursement under federal and state law?

IMMEDIATE REVIEW IS NECESSARY TO PROTECT THE HEALTH AND WELL-BEING OF THOUSANDS OF CALIFORNIANS

The published[3] decision of the appellate court[4] establishes a new, albeit erroneous, interpretation of federal law that will adversely affect critical health services for thousands of indigent Californians and review is therefore necessary under rule 8.500 (b)(1) of the California Rules of Court to settle an important question of law.

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[1] Hereinafter, "FQHC" or "health center."

[2] These activities are known as "outreach" in the context of this case.

[3] The appellate court's order certifying the decision for publication is attached hereto as Exhibit C.

[4] The appellate court's slip opinion is attached hereto as Exhibit A.

INTRODUCTION

The published decision in this case will drastically impair the ability of FQHCs[5] throughout California to fulfill their mandate of informing the neediest members of society about important healthcare services available to them at community clinics set up for their benefit. Family Health Centers of San Diego ("Family Health"), like approximately 2000 other FQHCs in California, provides health services under section 330 of the Public Health Service Act (42 U.S.C. § 201 et seq.) which include (1) services designed to assist patients in establishing eligibility for and gaining access to federal and state assistance programs (such as Medi-Cal), (2) services that enable individuals to use the health center's services (including outreach, transportation, and interpreter services), and (3) education regarding the availability and proper use of health services. (42 U.S.C. §§ 254b(b)(1)(A)(iii)-(v).) These health centers depend upon federal and state funding to provide for indigent, homeless and underserved individuals on the economic fringes of society. Pursuant to Medicare principles of cost reimbursement made applicable to FQHC reimbursement determinations by state law, various costs they incur are classified as allowable for inclusion

[5] "The purpose of FQHCs is to serve communities that may have financial disadvantages, language barriers, geographic barriers, or other specific needs. They serve high-need areas determined by the federal government that might be facing high levels of poverty, negative health outcomes, and limited access to health care services. FQHCs are usually located in rural areas or economically disadvantaged city areas, and provide services to all community members regardless of insurance status or ability to pay…. [¶] FQHCs and other safety net clinics play an important role in delivering health care services to those insured by MediCal." (Warrick, Anna,The Role of Federally Qualified Health Centers in Serving the Medi-Cal Population (Spring 2017) Occidental College Urban and Environmental Policy Student Scholarship.https://scholar.oxy.edu/uep_student/9. Footnotes omitted.)

in the rate setting cost reports they file with the Medicaid program. With oversight from the federal government, states reimburse health care providers for providing healthcare to low-income individuals who meet the criteria to be enrolled in the program.

The State Department of Health Care Services ("DHCS"), which oversees such programs in California, determined that costs associated with having clinic workers go into the community to inform such underserved individuals about medical services available to them and help them obtain healthcare are not allowable for inclusion in their rate setting Medi-Cal cost reports, relying primarily on a misreading of federal guidelines contained in the Provider Reimbursement Manual,[6] that make "advertising to the general public" not an allowable cost, with some exceptions. According to DHCS, and now the published decision in this case, talking to one or a few individuals in a homeless camp or other such setting about medical services is "akin to" disallowed "advertising to the general public."

Specifically, DHCS and the Court of Appeal, rely on section 2136.2 of the PRM, which provides, in pertinent part:

> "Costs of ***advertising to the general public*** which seek to increase patient utilization of the provider's facilities are not allowable." (AA 1405; emphasis added.)

When a health center's outreach worker talks with a person in a homeless shelter or encampment, on the street, in alleys, rescue missions, at a school,

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[6] The Provider Reimbursement Manual ("PRM," AA 1416-1418) consists of non-binding guidelines and interpretative rules promulgated by the U.S. Department of Health and Human Services to assist providers and intermediaries in the implementation of the Medicare regulations. (See, *Battle Creek Health Sys. v. Leavitt* (6th Cir. 2007) 498 F.3d 401, 404; *Catholic Health Initiatives v. Sebelius* (D.C. Cir. 2010) 617 F.3d 490, 491.) When used herein, "AA" refers to the Appellant's Appendix.

bar, bathhouse or park about accessing the health center's facilities,[7] those outreach efforts logically should increase "patient utilization" of the facility, and so DHCS argued, and the appellate court agreed, those individual interactions were "akin to" advertising to the general public for purposes of PRM 2136.2, rendering the cost for such activities unallowable. The Slip Opinion as originally filed, stated at page 14:

> "The regulations exclude costs that the program defines as not allowable, and the PRM makes clear that advertising costs "seek[ing] to increase patient utilization of the provider's facilities are not allowable." (PRM § 2136.2 (rev. 267, 09–82); 42 C.F.R.
>
> § 413.9(c)(3) (2021).) The evidence showed that plaintiff performed its outreach activities to "get the word out" about its various services and "develop[ ] awareness of each clinic's presence, resources, cultural competence, and desire to serve among members of [plaintiff's] target populations." It was not an abuse of discretion to find that *such activities had the purpose and effect of bringing in new patients and increasing utilization of plaintiff's facilities, making them akin to advertising*." (Exhibit A, hereto; italics added.)

Thus, the appellate court's analysis focused on the fact that outreach would bring new patients to the clinic (i.e., "increasing utilization") while ignoring the fact that for outreach costs to be disallowed such increase in patient utilization must be accomplished through "advertising to the general public" under the specific language of PRM 2136.2. It is clear from the undisputed evidence that Family Health's outreach activities did not involve advertising to the general public. To the contrary, outreach involved

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[7] AA 47:4-7, 48:7-9, 322:17-25.

interpersonal interactions, one or a few at a time, within a very small and unique segment of society---not in any way comparable to "advertising to the general public."

Family Health filed a Petition for Rehearing, bringing these factual and legal errors to the appellate court's attention. In response, the court of appeal slightly modified its decision in the context of denying rehearing[8] to add the words "to its audiences within the general public" after the words "various services," in the above quote from the decision. The added language compounded the court's erroneous analysis. Outreach workers do not have "audiences;" they have "individual interactions." (AA 269:16–17.) Often they go to locations frequented by homeless folks and other at-risk individuals, where public nurses will not even go. (AA 288:1–11.) Outreach is also conducted in culturally diverse areas, where different languages are spoken, exercising culturally sensitive communication skills. (AA 287:19–23.)

Suggesting that outreach workers address crowds of people is factually incorrect and contrary to the record. Further, inserting the words "general public" in the modified opinion does not cure the error. A conversation with one or two people is not transformed into an "advertisement to the general public" simply because that private conversation occurs in a place open to the public, such as a park or beach. The modification completely misses the point.

If the published appellate decision making the cost of outreach unallowable is not vacated, a vast number of indigent people in need of health care will go without it, because the decision's inevitable effect will be to decrease the flow of vital information reaching the homeless and other similarly situated people about how and where to receive health care. The

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[8] Attached hereto as Exhibit B is the Order Modifying Opinion and Denying Rehearing.

decision exacerbates a state-wide health crisis, potentially affecting hundreds of thousands of California residents, because FQHCs treat millions of California residents every year. "In 2019, California FQHCs served 5.6 million patients and generated 26.4 million patient visits, equating to increases of 40% in patients and 66% in visits over the seven-year review period. At the national level, FQHCs reported a 37% growth in patients and 43% rise in visits over the same timeframe, highlighting California FQHCs' relatively strong growth, particularly in visits."[9]

The unintended, harmful consequences of this erroneous appellate decision are vast. It has an immediate negative impact on the nearly 2,000 health centers in California trying to care for the needy (see fn. 9), but it has a more pernicious effect on the likely hundreds of thousands of would-be patients who will not learn of the health care they could be receiving. It is not an exaggeration to say that granting review to vacate this erroneous decision will save lives in California and significantly help countless sick and potentially infectious people throughout the state obtain needed medical services designed for them, including vaccinations[10] which help reduce the spread of disease throughout the general population.

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[9] California Federally Qualified Health Centers Financial & Operational Performance Analysis, 2016-2019, (2020) Capital Link and California Health Care Foundation, p. 2. https://www.caplink.org/images/California_Financial_and_Operational_Trends_Report.pdf

[10] Family Health worked with San Diego County to provide thousands of vaccines to homeless. (AA 288:2-4.)

BACKGROUND

A. Pertinent Law Regarding Federally Qualified Health Centers.

The federal government provides financial assistance to states to provide medical care to low-income individuals through the Medicaid program. (42 U.S.C.§ 1396 et seq.) California has implemented the program through Medi-Cal. (Welf. & Inst. Code, § 14000 et seq.; *Robert F. Kennedy Medical Center v. Belshé* (1996) 13 Cal.4th 748, 751 (*Kennedy*).) The DHCS is the state agency designated to administer the Medi-Cal program. (Welf. & Inst. Code, § 14203.) "Pursuant to Medi-Cal, participating health care providers, such as hospitals, receive reimbursement directly from the [DHCS] for providing medical care to Medi-Cal beneficiaries." (*Simi Valley Adventist Hospital v. Bontá* (2000) 81 Cal.App.4th 346, 348.) Providers are reimbursed for their allowable costs, as determined under Medicare/Medicaid standards and principles of reimbursement set forth in the Code of Federal Regulations and the PRM. (*Oroville Hospital v. Department of Health Services* (2006) 146 Cal.App.4th 468, 472; see also Cal. Code Regs., tit. 22, § 51536, subds. (a)(2) & (b)(4); *Community Care Foundation v. Thompson* (2006) 412 F.Supp.2d 18, 22–23 [PRM provisions are interpretations of the Medicare regulations].) In general, to be reimbursable, claimed costs "must be based on the reasonable cost of [covered] services" and "related to the care of beneficiaries." (42 C.F.R. § 413.9(a) (2021); see also PRM § 2100 (rev. 454, 09–12) ["All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries"].) These federal regulations are incorporated into state law and apply to Medi-Cal providers such as Family Health. (Welf. & Inst. Code, § 14132.100, subds. (e)(1) & (i)(2)(B)(ii).)

Under the federal regulations, a "[r]easonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs." (42 C.F.R. § 413.9 (c)(3).) "Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity." (42 C.F.R. § 413.9 (b)(2).

Advertising costs are allowable if they are "incurred in connection with the provider's public relations activities [and are] primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Examples are visiting hours information, conduct of management-employee relations, etc." (PRM § 2136.1 (rev. 267, 09–82).) However, "[c]osts of ***advertising to the general public*** which seeks to increase patient utilization of the provider's facilities are not allowable. . .. While it is the policy of the [relevant federal agencies] to promote the growth and expansion of needed provider facilities, general advertising to promote an increase in the patient utilization of services is not properly related to the care of patients." (PRM § 2136.2 (rev. 267, 09–82); emphasis added.)

"Consistent with [the] statutory authority [set forth in Welfare and Institutions Code section 14171], the regulations establish detailed appeal procedures applicable to the audit process, including an appeal from a final audit report. (Cal. Code Regs., tit. 22, § 51016 et seq.)" (*Kennedy*, *supra*, 13 Cal.4th at p. 758.) A Medi-Cal provider may request a hearing regarding disputed audit findings by submitting a statement of disputed issues to the DHCS. (Cal. Code Regs., tit. 22, § 51017.)

B. The Audit.

The dispute at issue started with a cost report audit performed by DHCS for fiscal year 2013, to set future-per visit rates for one of Family Health's clinic sites. (Welf. & Inst. Code, § 14132.100, subd. (i)(3)(c); AA 444 - 453.) The DHCS auditor reclassified $75,032 of salary and benefit expenses for community outreach services to a non-reimbursable cost center. (AA 470 - 478.) Family Health exercised all of its administrative appeal rights, leading to an evidentiary hearing in 2017, which included live testimony of several witnesses and various exhibits. None of the evidence about how Family Health conducted outreach was contravened by DHCS.

C. Evidence Regarding Family Health's Outreach Activities.

Family's Health's chief executive officer, Fran Butler-Cohen, testified about the nature of outreach activities and the fact that outreach is mandated by both federal and state regulations. For example, in reference to a training manual used by Family Health for its outreach workers,[11] she explained:

> "So these outreach workers go out; they find the people; they identify them; they give them education; they give them the enrollment; they make the appointments; they find out the other areas that they need addressing in their lives; then they make connections and referrals so that, that can get taken care of as well." (AA 321:2–8.)

The training manual for outreach workers identifies five steps to an "outreach encounter" with each individual, as follows:

[11] Family Health's exhibit Z. (AA 319:19-322:14, and 1150 et. seq.)

> "1. Observe: watch what is happening in the environment BEFORE you approach.
>
> 2. Approach: make conversation openers, attempt to get client's attention.
>
> 3. Engage and Identify Needs: move the conversation into client's needs;
>
> 4. Conduct: further explore behaviors related to the first and second needs.
>
> 5. Conclude and Follow-up: provide referrals, wrap up, revisit concerns later." (AA 1153.)

As this indicates, Family Health's outreach involves the outreach worker having a conversation with a potential patient, determining his or her needs and providing possible referrals. As such, outreach obviously is a highly individualized encounter. It does not involve an outreach worker addressing an "audience" of assembled listeners. It is not any form of mass communication to the general public.

Ms. Butler-Cohen explained that the outreach workers provide information to homeless individuals, for example, regarding his or her eligibility for benefits and the required documentation for the Department of Health Care Services. An outreach worked confronts various situations unique to each person eligible for, but not yet enrolled, in the Medi-Cal program, such as someone lacking a required divorce decree or citizenship or other eligibility issues. (AA 323:1–11.) Each outreach encounter is personal and unique. DHCS wants FQHCs to have "boots on the ground" for these outreach efforts because traditional methods of mass communication (like advertising to the general public) are not effective for this unique segment of society. (AA 323:22–23.)

She also explained that outreach is mandated by federal law. For example, provisions in the Code of Federal Regulations regulating FQHCs delineate services of outreach workers as a supplemental health service which, as she testified, “promote and facilitate optimal use of primary health services…” (AA283: 21–23) and quoting the regulation she stated:

> “[a] substantial number of individuals in the population served by the center are of limited English-speaking ability. The services of outreach workers and [other] personnel fluent in the language or languages spoken by such individuals [are required].” (AA 283:24–284:7.)

In that context she testified that the subject Family Health clinic is located in one of the most diverse areas of the country, which includes Sudanese, Somali, Latino and Ethiopian, and “the list goes on” from there. (AA 284:8–11.) Students at the middle school across the street from the clinic speak 57 different languages. (AA 284:11–13.) So, again, outreach cannot be conducted in the form of advertising to the general public. (AA 283–284.) Advertising to the general public about available healthcare through Medi-Cal programs would neither reach the needy people in this segment of society nor be effective. Reaching such medically underserved individuals requires the “boots on the ground” approach that is outreach. (AA 323:21–23.)

The testimony of Family Health’s CEO referenced a letter[12] from Sally Richardson, who at the time the letter was written in 1994 was the Director of the Medicaid Bureau of the Federal Department of Health and Human Services. (AA 284:19–285:3.) The letter identified Medicaid *outreach as an administrative cost necessary for the proper and efficient administration of the state plan.* (AA 284:24–285:3.) The CEO also discussed a document

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[12] Hearing exhibit J. (AA 789-797.)

from Title 42, of the Public Health and Welfare statute in reference to the federal mandate for outreach.[13] (AA 285:9–286:7.) Ms. Butler-Cohen elaborated that the federal government requires outreach and that Director Richardson indicated that state Medicaid directors will consider outreach an allowable service. (AA 286:1–7.) She also observed that the California Department of Health Care Services identified the homeless as being a particularly vulnerable population "that they wanted Community Based Organizations… and FQHCs to target and reach [them] to move them into the Medi-Cal program. Homeless are generally, as a population, very difficult to reach." (AA 287:8–14.)

Family Health's CEO testified that "this year [Family Health provided] healthcare to 35,000 unique homeless persons, and we have started shelters and we have mobile units." (AA 287:15–23.) She explained that she is very familiar with what it takes to reach homeless people and "you don't just build a building and tell them to come. You clearly must have culturally sensitive outreach to bring them into health care." (AA 287:20–23.)

Each Family Health outreach worker uses an activity log[14] listing location, hours and contacts conducted. (AA 633.) This form includes the name of the outreach worker, how many hours that person worked, the total number of *individual interactions* and the total number of materials distributed, as well as how many contacts were made for each particular area of service. (AA 269:10–20.) Again, the undisputed and overwhelming evidence is that outreach is a highly individualized activity involving unique individual interactions, within a narrow segment of society. It is not remotely akin to advertising to the general public.

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[13] Hearing exhibit K. (AA 798-804.)

[14] Hearing exhibit A. (AA 633-643.)

Ms. Butler-Cohen observed there is a significant level of accountability for each outreach worker. (AA 270:7–20.) It is not uncommon for potential patients of Family Health, including low-income people with limited English proficiency, teens, disabled, seniors and others in need, to be unaware that affordable healthcare or free healthcare services exist for them. (*Ibid*.) Consequently, Family Health's outreach workers go into the community, make these contacts, and set up appointments. Those appointments are notated to indicate whether the patients completed or missed the appointments. (*Ibid.*)

D. Decisions at the Administrative and Superior Court Levels.

The ALJ issued a proposed decision in favor of DHCS concluding, in pertinent part, that under the PRM guidelines regarding advertising, Family Health's outreach activities were non-reimbursable "patient recruitment." (AA 130.) The proposed decision was then adopted by the Chief ALJ. (AA 119.) A subsequent motion for reconsideration was denied on essentially the same basis. (AA 77–91.)

Family Health then filed a petition for writ of mandate in the Sacramento County Superior Court. (AA 3 – 8.) In denying mandate and rendering judgment in favor of DHCS, the trial court concluded that outreach costs are not allowable based on PRM §§ 2136.1 and 2136.2. Although some forms of advertising are considered "Allowable Advertising Costs" under 2136.1, others are deemed "Unallowable Advertising Costs" under 2136.2. The trial court seized upon the following language contained in 2136.2:

> "Costs of *advertising to the general public* which seeks to increase patient utilization of the provider's facilities are not

> allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective. While it is the policy of the Health Care Financing Administration and other Federal agencies to promote the growth and expansion of needed provider facilities, general advertising to promote an increase in the patient utilization of services is not properly related to the care of patients." (AA 1405; italics added.)

Family Health appealed to the Third District Court of Appeal, who initially issued an unpublished decision, concluding, in pertinent part:

> "We agree with the ALJ, the Chief ALJ, and the trial court that the DHCS did not abuse its discretion in finding that plaintiff's outreach costs were nonreimbursable. Plaintiff's outreach efforts involve going into public spaces such as on the street, at schools, business venues, beaches, and parks to attract new patients, provide counseling regarding eligibility for services, and make medical appointments for services. Such services may benefit the recipient by increasing awareness of care available through plaintiff and making the recipient feel more comfortable seeking care. And, such activities are required as part of plaintiff's role as a FQHC grant recipient. (42 U.S.C.§§ 254b(b)(1)(A)(iii)-(v), 1395x(aa)(4).) However, requiring plaintiff to perform such services as an FQHC grant recipient does not automatically make the associated costs reimbursable under Medicare (or Medi-Cal), even if they provide a benefit for the recipient.
>
> "The regulations exclude costs that the program defines as not allowable, and the PRM makes clear that advertising costs 'seek[ing] to increase patient utilization of the provider's facilities are not allowable.' (PRM § 2136.2 (rev. 267, 09–82); 42 C.F.R.§ 413.9(c)(3) (2021).) The evidence showed that plaintiff performed its outreach activities to 'get the word

> out' about its various services and 'develop[ ] awareness of each clinic's presence, resources, cultural competence, and desire to serve among members of [plaintiff's] target populations.' It was not an abuse of discretion to find that such activities had the purpose and effect of bringing in new patients and increasing utilization of plaintiff's facilities, making them akin to advertising." (Exhibit A: Slip opinion 13–14.)

The appellate decision was modified slightly in an order denying Family Health's Petition for Rehearing, with the appellate court inserting the words "to its audiences within the general public" after the words "various services," in the above quote from the decision. (Exhibit B: Order Modifying Opinion and Denying Rehearing, p. 2.) The appellate court subsequently granted the request of DHCS to certify the decision for publication. (Exhibit C: Order Certifying Opinion for Publication.)

LEGAL DISCUSSION

I. The Court of Appeal Misunderstood the Undisputed Facts Regarding Family Health's Outreach Activities, and Misread Pertinent Law

Section 2136.2 of the Provider Reimbursement Manual[15] ("PRM") provides, in pertinent part:

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[15] This consists of non-binding guidelines and interpretative rules promulgated by the U.S. Department of Health and Human Services to assist providers and intermediaries in the implementation of the Medicare regulations. (See, *Battle Creek Health Sys. v. Leavitt* (6th Cir. 2007) 498 F.3d 401, 404; Catholic Health Initiatives v. Sebelius (D.C. Cir. 2010) 617 F.3d 490, 491) See cms.gov/Regulations-and-Guidance/Guidance/Manuals /Paper-Based-Manuals-Items/CMS021929; pertinent excerpts at AA 57-60 and 1416-1418).

> "Costs of ***advertising to the general public*** which seek to increase patient utilization of the provider's facilities are not allowable." (AA 1405; emphasis added.)

The appellate court's analysis essentially ignored the words "advertising to the general public" at the beginning of PRM 2136.2 and seized upon the "increase patient utilization" language, in concluding as follows:

> "The regulations exclude costs that the program defines as not allowable, and the PRM makes clear that advertising costs 'seek[ing] to increase patient utilization of the provider's facilities are not allowable.' (PRM § 2136.2 (rev. 267, 09–82); 42 C.F.R.§ 413.9(c)(3) (2021).) The evidence showed that plaintiff performed its outreach activities to 'get the word out' about its various services and 'develop[ ] awareness of each clinic's presence, resources, cultural competence, and desire to serve among members of [plaintiff's] target populations.' *It was not an abuse of discretion to find that such activities had the purpose and effect of bringing in new patients and increasing utilization of plaintiff's facilities, making them akin to advertising*." (Decision p. 14; italics added)

The crucial point overlooked in the above analysis is that even if Family Health's outreach efforts had the purpose and effect of bringing in new patients and increasing utilization of plaintiff's facilities, those efforts are ***not subject to 2136.2 unless they constitute "advertising to the general public,"*** and as the undisputed evidence shows, none of Family Health's outreach activities were directed to the general public.

The evidence is not in dispute about how Family Health conducted its outreach activities. They are described in detail in appellant's opening brief at pages 23–30 and reply brief at pages 6–10. These were "boots on the ground" interpersonal encounters between a Family Health worker and one or a few individuals at a given time, otherwise described as "individual

interactions." (AA 323:22–23, 269:16–19.) Each individualized encounter was directed to a potential health center patient to assist in the delivery of medical care to improve that person's health outcomes. (AA 310:21–24.) Each encounter typically involved the outreach worker addressing the individual's particular medical needs and arranging an appointment, such as for a venipuncture, a pregnancy test, entry into the prenatal program, and so forth. (AA 271:5–19; 651.) By no stretch of imagination or linguistics can these individualized encounters be considered "akin to" advertising to the general public.

Family Health's outreach involved trained individuals going into the community to have direct "encounters" with individuals falling into specific at-risk categories, to help each person understand what medical care may be available to him or her and how to obtain it. These encounters occurred on the streets, in homeless shelters or other similar close-quarter settings. Even assuming they increased patient utilization, these kinds of outreach activities are not made unallowable by 2136.2 because they are *not* "advertising to the general public." Aside from the fact that outreach defies characterization as "advertising," the appellate decision overlooked or disregarded the requirement that for advertising costs to properly be classified as unallowable, the activities in question must be directed **to the general public**, which did not happen in this case.

Additionally, the commonly understood meaning of the term "advertising" connotes "'*widespread* promotional activities *usually directed to the public at large*,'…." (*Hyundai Motor M. Am. v. Nat'l Union Fire Ins. Co.* (9th Cir. 2010) 600 F.3d 1092, 1098; quoting, *Hameid v. National Fire Ins. of Hartford* (2003) 31 Cal.4th 16, 25. See *Bank of the West v. Superior Court* (1992) 2 Cal.4th 1254, 1262 ["most of the published decisions hold that 'advertising' means *widespread promotional activities directed to the public at large.*"] Italics added.) So, not only does PRM section 2136.2 use

the words "to the general public" to limit the scope of what is not an allowed cost, the term "advertising" itself encompasses that concept and is completely incompatible with the type of individualized encounters comprising Family Health's outreach activities.

Respectfully, the appellate court's decision is plainly incorrect.

II. The Court of Appeal Misstated the Law, Violated Fundamental Rules of Construction and Overlooked the Actual Facts in Concluding that Family Health's Outreach Efforts are "Akin to" Advertising to the General Public for Purposes of PRM 2136.2

As discussed, the undisputed facts establish that Family Health's outreach activities did not involve "advertising to the general public" and therefore, as a matter of law, PRM section 2136.2 does not make the outreach costs unallowable. However, the court of appeal side-stepped that fact in stating the following:

> "It was not an abuse of discretion to find that such activities had the purpose and effect of bringing in new patients and increasing utilization of plaintiff's facilities, making them *akin to advertising*." (Decision p. 14; italics added.)

Thus, the appellate decision disregarded the specific language of section 2136.2 that limits its applicability to "advertising *to the general public*" and disregarded the fact that Family Health's outreach activities were not directed to the general public by describing this form of outreach as "akin to advertising" because it had the effect of increasing patient utilization. Besides increasing patient utilization not being a dispositive issue (since

that outcome must be accomplished by advertising *to the general public*), the "akin to" construct employed by the court of appeal is incompatible with the facts and misstates the law.

"In the construction of a statute or instrument, the office of the Judge is simply to ascertain and declare what is in terms or in substance contained therein, *not to insert what has been omitted, or to omit what has been inserted*…." (Code Civ. Proc. § 1858; italics added.) A construction that renders a word surplusage should be avoided. (*City and County of San Francisco* v. *Farrell* (1982) 32 Cal.3d 47, 54; *California Mfrs. Assn.* v. *Public Utilities Com.* (1979) 24 Cal.3d 836, 844; *Delaney v. Superior Court* (1990) 50 Cal.3d 785, 798.) Where, as here, there is no ambiguity, then the language controls. (*Halbert's Lumber, Inc. v. Lucky Stores, Inc.* (1992) 6 Cal.App.4th 1233, 1238–1239; *In re Waters of Long Valley Creek Stream Sys.* (1979) 25 Cal.3d 339, 348.) By simultaneously ignoring the "to the general public" language in section 2136.2 and then inserting the "akin to" concept where it does not belong, the appellate court's decision violated these fundamental rules of construction to reach a conclusion which is both erroneous and incompatible with the facts.

It was error for the appellate court to treat as mere surplusage or otherwise ignore the words "advertising *to the general public*." (Italics added.) Those words must be given effect in the context of the facts of this case which most certainly do not involve advertising to the general public. And it was error to effectively insert the words "akin to" as the court did to alter the meaning of section 2136.2. When the correct legal principles are applied to the facts surrounding Family Health's outreach activities, it becomes inescapable that this case was wrongly decided. Family Health respectfully requests that this Petition for Review be granted to vacate the erroneous decision and issue this Court's own decision establishing the

correct statement of law regarding the allowability of outreach costs for FQHCs throughout California, and help protect the health of countless Californians.

CONCLUSION

Crucial flaws in the appellate court's analysis led to an erroneous decision. For a cost to be unallowable under PRM section 2136.2, it must be the result of "advertising *to the general public*." (Italics added.) The court ignored the "to the general public" component of 2136.2 to reach the erroneous conclusion that any activity resulting in increased patient utilization is "akin to advertising" and not allowed under section 2136.2. To the contrary, costs for an activity not directed to the general public are not properly disallowed by 2136.2, *even if it increases patient utilization.* Here, the activity at issue consisted of individualized outreach efforts in which a Family Health employee interacted on a personal basis with one or a few potential patients at a time about each person's medical needs. These high-risk individuals are often found in homeless shelters and encampments, on the streets, in bars and bathhouses and in a myriad of other places and situations where they cannot be reached by advertising to the general public. Instead, to inform them about available health services, a person-to-person approach is required, involving outreach workers going into in the places where such indigent people can be found, often beyond public view or awareness. Because those "boots on the ground" efforts are not "advertising to the general public," section 2136.2 does not render those outreach costs unallowable for purposes of reimbursement.

Unfortunately, because of this published decision, many destitute Californians will not get the health care needed to avoid serious illness or death. Nor will many receive vaccines which would help reduce the spread

of disease through the general population. Making outreach an unallowed cost for FQHCs, as this decision does, will result in less outreach being conducted and fewer people learning what medical services are available to them and/or how to go about obtaining those services. A vast number of vulnerable people will be adversely affected by this erroneous decision. This tragic outcome can be avoided only if this Court intervenes now to grant review, which is both justified and urgently needed.

Murphy, Campbell, Alliston & Quinn

Respectfully submitted,

Dated: August 11, 2021 By: /s/ George Murphy

Attorney for Plaintiff and Appellant
Family Health Centers of San Diego

CERTIFICATE OF COMPLIANCE

This brief is set using **13-pt Times New Roman**. According to TypeLaw.com, the computer program used to prepare this brief, this brief contains **5,410** words, excluding the cover, tables, signature block, and this certificate.

The undersigned certifies that this brief complies with the form requirements set by California Rules of Court, rule 8.204(b) and contains fewer words than permitted by rule 8.504(d) or by Order of this Court.

Murphy, Campbell, Alliston & Quinn

Dated: August 11, 2021 By: /s/ George Murphy

George E. Murphy

Plaintiff and Appellant, Family Health Centers of San Diego

Exhibit A

NOT TO BE PUBLISHED

California Rules of Court, rule 8.1115(a), prohibits courts and parties from citing or relying on opinions not certified for publication or ordered published, except as specified by rule 8.1115(b). This opinion has not been certified for publication or ordered published for purposes of rule 8.1115.

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

(Sacramento)

FAMILY HEALTH CENTERS OF SAN DIEGO, Plaintiff and Appellant, v. STATE DEPARTMENT OF HEALTH CARE SERVICES, Defendant and Respondent.	C089555 (Super. Ct. No. 34-2018-80002953-CU-WM-GDS) ORDER MODIFYING OPINION AND DENYING REHEARING [NO CHANGE IN JUDGMENT]

THE COURT:

It is ordered that the opinion filed on July 6, 2021, be modified as follows:

1. In the last partial paragraph starting at the bottom page 13 that begins with "We agree with the ALJ," delete the second sentence that begins with "Plaintiff's outreach efforts" and replace it with the following sentence:

Plaintiff's outreach efforts involve going into public spaces such as on the street, at schools, business venues, beaches, and parks to attract new patients from its audiences within the general public, provide counseling regarding eligibility for services, and make medical appointments for services.

2. Delete the first sentence in the first full paragraph on page 14 that begins with "The regulations exclude costs" and replace it with the following sentence:

The regulations exclude costs that the program defines as not allowable, and the PRM makes clear that "[c]osts of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable."

3. In the first full paragraph on page 14 that begins with "The regulations exclude costs," delete the sentence in the fourth line that begins with "The evidence showed" and replace it with the following sentence:

The evidence showed that plaintiff performed its outreach activities to "get the word out" about its various services to its audiences within the general public and "develop[ ] awareness of each clinic's presence, resources, cultural competence, and desire to serve among members of [plaintiff's] target populations."

This modification does not change the judgment.

The petition for rehearing is denied.

BY THE COURT:

ROBIE, Acting P. J.

HOCH, J.

KRAUSE, J.

Filed 7/6/21 Family Health Centers etc. v. State Dept. of Health Care Services CA3 (unmodified opinion)

NOT TO BE PUBLISHED

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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

(Sacramento)

FAMILY HEALTH CENTERS OF SAN DIEGO, Plaintiff and Appellant, v. STATE DEPARTMENT OF HEALTH CARE SERVICES, Defendant and Respondent.	C089555 (Super. Ct. No. 34-2018-80002953-CU-WM-GDS)

Plaintiff Family Health Centers of San Diego operates a federally qualified health center (FQHC) that provides various medical services to its patients, some of whom are Medi-Cal beneficiaries. Under section 330 of the Public Health Service Act (42 U.S.C. § 201 et seq.), FQHC's like plaintiff also may provide additional health services, including (1) services designed to assist patients in establishing eligibility for and gaining access to federal and state assistance programs (such as Medi-Cal), (2) services that

enable individuals to use the health center's services (including outreach, transportation, and interpreter services), and (3) education regarding the availability and proper use of health services. (42 U.S.C. §§ 254b(b)(1)(A)(iii)-(v).)

Section 330 of the Public Health Service Act authorizes grants to be made to FQHC's. (42 U.S.C. §§ 254b, 1395x(aa)(4).) In addition, FQHC's may seek reimbursement under Medi-Cal for certain expenses, including reasonable costs directly or indirectly related to patient care. Plaintiff appeals from the trial court's order denying its petition for writ of mandate seeking to compel the State Department of Health Care Services (DHCS) to reimburse plaintiff for money it expended for outreach services.

We reject plaintiff's contention that the trial court and the DHCS improperly construed and applied applicable guidelines in the Centers for Medicare & Medicaid Services Publication 15-1, The Provider Reimbursement Manual (PRM). We conclude that the monies spent by plaintiff were not an allowable cost because they were akin to advertising to increase patient utilization of plaintiff's services. We therefore will affirm the trial court's denial of the petition for writ of mandate.

BACKGROUND

1. *Statutory background*

The federal government provides financial assistance to states in order to provide medical care to low-income individuals through the Medicaid program. (42 U.S.C. § 1396 et seq.) California has implemented the program through Medi-Cal. (Welf. & Inst. Code, § 14000 et seq.; *Robert F. Kennedy Medical Center v. Belshé* (1996) 13 Cal.4th 748, 751 (*Kennedy*).) The DHCS is the state agency designated to administer the Medi-Cal program. (Welf. & Inst. Code, § 14203.)

"Pursuant to Medi-Cal, participating health care providers, such as hospitals, receive reimbursement directly from the [DHCS] for providing medical care to Medi-Cal beneficiaries." (*Simi Valley Adventist Hospital v. Bontá* (2000) 81 Cal.App.4th 346, 348.) Providers are reimbursed for their allowable costs, as determined under

Medicare/Medicaid standards and principles of reimbursement set forth in the Code of Federal Regulations and the PRM. (*Oroville Hospital v. Department of Health Services* (2006) 146 Cal.App.4th 468, 472; see also Cal. Code Regs., tit. 22, § 51536, subds. (a)(2) & (b)(4); see also PRM; *Community Care Foundation v. Thompson* (2006) 412 F.Supp.2d 18, 22-23 [PRM provisions are interpretations of the Medicare regulations].) In general, to be reimbursable, claimed costs "must be based on the reasonable cost of [covered] services" and "related to the care of beneficiaries." (42 C.F.R. § 413.9(a) (2021); see also PRM § 2100 (rev. 454, 09-12) ["All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries"].) These federal regulations are incorporated into state law and apply to Medi-Cal providers such as plaintiff. (Welf. & Inst. Code, § 14132.100, subds. (e)(1) & (i)(2)(B)(ii).)

Under the federal regulations, "[r]easonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable." (42 C.F.R. § 413.9(c)(3) (2021).) The regulations define necessary and proper costs as "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity." (42 C.F.R. § 413.9(b)(2) (2021).)

Advertising costs are allowable if they are "incurred in connection with the provider's public relations activities [and are] primarily concerned with the presentation

of a good public image and directly or indirectly related to patient care. Examples are: visiting hours information, conduct of management-employee relations, etc." (PRM § 2136.1 (rev. 267, 09-82).) However, "[c]osts of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. . . . While it is the policy of the [relevant federal agencies] to promote the growth and expansion of needed provider facilities, general advertising to promote an increase in the patient utilization of services is not properly related to the care of patients." (PRM § 2136.2 (rev. 267, 09-82).)

"The method by which the [DHCS] reimburses [Medi-Cal providers] is explained in detail in [*Kennedy, supra*, 13 Cal.4th 748]. Briefly stated, [Medi-Cal providers] receive interim estimated payments of Medi-Cal reimbursement during each fiscal year, with retroactive adjustments occurring at the end of each fiscal year when actual costs are known. (Cal. Code Regs., tit. 22, § 51536, subds. (c)(2) & (d).) Within four months of the end of each fiscal year, the [provider] submits a cost report based on actual costs. (42 C.F.R. § 413.24(f)(2)[ ].) The [DHCS] makes a tentative settlement based on the [provider's] unaudited cost report, making additional payments to the hospital if warranted. Following an audit which must be completed within three years (Welf. & Inst. Code, § 14170, subd. (a)(1)), the [DHCS] issues a final audit report and settlement." (*Little Company of Mary Hospital v. Belshé* (1997) 53 Cal.App.4th 325, 327, fn. omitted.)

"Consistent with [the] statutory authority [set forth in Welfare and Institutions Code section 14171], the regulations establish detailed appeal procedures applicable to the audit process, including an appeal from a final audit report. (Cal. Code Regs., tit. 22, § 51016 et seq.)" (*Kennedy, supra*, 13 Cal.4th at p. 758.) A Medi-Cal provider may request a hearing regarding disputed audit findings by submitting a statement of disputed issues to the DHCS. (Cal. Code Regs., tit. 22, § 51017.)

At the appeal hearing, the DHCS bears the burden of establishing by a preponderance of the evidence that its audit findings were correct. (Cal. Code Regs., tit. 22, § 51037, subd. (i).) After the DHCS has made a prima facie case, the burden shifts to the provider to demonstrate by a preponderance of the evidence that its position is correct. (*Ibid*.)

2. *Factual background*

a. *December 2016 audit and appeal*

In December 2016, the DHCS audited plaintiff's 2013 cost report and reclassified as nonreimbursable $78,032 in salary and benefit expenses that were for community outreach. The audit report noted (1) there was insufficient documentation demonstrating that the expenses were related to services and supplies incident to an FQHC visit, and (2) the expenses were not a covered benefit under Welfare and Institutions Code section 14132.100. The report further noted the documentation was insufficient under 42 Code of Federal Regulations parts 413.9, 413.20, and 413.24; PRM sections 2102, 2300, 2304, and 2328; sections 1395x(s)(2)(A), 1395x(AA)(1)(A)-(1)(C), 1396d(a)(2)(C), and 1396(d)(1)(2) of title 42 of the United States Code; and State Plan Amendments 09-001 and 09-015.

Plaintiff appealed the DHCS's determination in January 2017. After holding an informal hearing in March 2017, the hearing auditor upheld the adjustment in May 2017. The hearing auditor reasoned that Welfare and Institutions Code section 14132.100 defines the FQHC covered benefits reimbursable under the Medi-Cal program as physician services and services and supplies that meet the definition of being incident to an FQHC visit. The hearing auditor found that plaintiff had failed to demonstrate that its outreach encounters lead to an FQHC visit and a covered benefit under the Welfare and Institutions Code. In June 2017, plaintiff requested a formal hearing.

b. *October 2017 hearing*

During the October 2017 hearing, Jeff Cates, a health program auditor for the DHCS, testified first. At the time, Cates had worked for over 17 years at the DHCS and had conducted approximately 200 audits. He agreed with the report's conclusion and testified to the accuracy of the basis for reclassification of plaintiff's outreach costs as nonreimbursable. Cates had reviewed plaintiff's salary detail, job descriptions for those providing outreach services, and state plan amendments and regulations. In Cates's opinion, plaintiff's outreach costs were not allowable under the applicable regulations.

Plaintiff's chief executive officer, Fran Butler-Cohen, testified next. She explained that plaintiff served low-income and diverse populations that often are unaware of the existence of affordable or free health care services. Plaintiff required its outreach workers to go into the community and make medical appointments for people with whom they came in contact, such as an outpatient visit, a pregnancy test, or entry into the prenatal program. In her experience, patients contacted by outreach workers had a "very high show rate," typically between 75 to 85 percent. It is plaintiff's practice to track the appointment rates for individual outreach workers and actual services received. She provided a sample billing ledger that lists the services that occurred for some of the patients that were contacted by outreach workers.

Butler-Cohen testified that, in her opinion, FQHC's are mandated by the federal government and the state to perform outreach services, and therefore such costs were allowable. She cited several documents in support of her opinion. For example, the DHCS's grant application form for FQHC's lists "outreach" in the "required services provided" section. As reflected in the application, plaintiff provided outreach services directly. As part of its nonclinical outreach, plaintiff also provided counseling regarding eligibility for services, counseling regarding HIV-related issues, and counseling to teens regarding sexual education and health. In addition, plaintiff provided outreach "for the specific purpose of developing awareness of each clinic's presence, resources, cultural

competence, and desire to serve among members of [plaintiff's] target populations." Plaintiff performed these tasks "in the street, in schools, in agen[cies], business venues [such as LGBTQ bars and clubs, etc.], [and] other public venues such as beaches and parks." Butler-Cohen testified that the purpose of the company's efforts was to "get the word out, so to speak, for the various services we provide."

Butler-Cohen also cited a document published by the Health Resources and Services Administration (which regulates plaintiff) titled "Program Requirements," which lists outreach as a required service to be provided by a FQHC like plaintiff. The document explains that "[o]utreach services are a broad range of culturally and linguistically appropriate activities focused on recruiting and retaining patients from the target population/service area. [¶] At a minimum, these services must promote awareness of the health center's services and support entry into care. [¶] These services do not involve direct patient care where a provider is generating a face-to-face visit with a patient, documenting the care in a patient medical record, or exercising clinical judgment in the provision of services to a patient." The document references section 330(b)(1)(A)(iv) of the Public Health Service Act and 42 Code of Federal Regulations part 51c.102(j)(14). She further testified about a "Policy Information Notice" published by the Health Resources and Services Administration, listing nonclinical outreach as a service that may be (and often is) provided by FQHC's. The document explains that "[i]f it is the policy of the grantee that staff conduct outreach where no clinical services are offered, the grantee should list the activity as 'non-clinical outreach.' "

Butler-Cohen testified that a 1994 letter from Sally Richardson, the then-Director of the federal Medicaid Bureau at the Department of Health and Human Services, addressed to the state Medicaid director states that Medicaid outreach is " 'an administrative cost necessary for the proper and efficient administration of the state plan.' " In Butler-Cohen's opinion, Richardson's letter established that outreach is an allowable expense.

Butler-Cohen also cited legislation and regulations that she believed supported her opinion regarding reimbursement for outreach costs. She testified that 42 Code of Federal Regulations part 51c.102(j)(14) defines "[s]upplemental health services" to include "[s]ervices, including the services of outreach workers, which promote and facilitate optimal use of primary health services and [other] services . . . ." She further opined that outreach was a required primary health care service under section 254b, subdivision (b)(1)(A)(iv) of title 42 of the United States Code.

Butler-Cohen testified regarding the former "Expanded Access to Primary Care" (EAPC) program, a state program designed to expand access to and improve the quality of outpatient health care for medically indigent persons. The program information defined reimbursable versus allowable services. For example, outpatient visits were allowable and reimbursed under certain circumstances, while "information sessions for prospective recipients [and] health presentations to community groups" were not reimbursable.

Similarly, the May 2010 Affordable Care Act (ACA) encouraged assistance to low-income individuals to access and appropriately use health services, enroll in health coverage programs, obtain a regular primary care provider or a medical home, provide case management and care management, perform health outreach using neighborhood health workers (which plaintiff had), provide transportation, expand capacity, and provide direct patient care services.

Butler-Cohen also testified regarding a Medi-Cal timeline produced by the DHCS. The document indicates that when the ACA was adopted in 2010, California received $10 billion to implement health coverage for low-income and uninsured individuals, and to improve care for vulnerable populations. To get matching federal funds under the ACA, California "funneled" vulnerable individuals from the "Healthy Families Program" into Medi-Cal. Outreach was necessary to ensure that these individuals were moved to Medi-Cal.

Butler-Cohen also testified about a 2012 letter from then-director of the DHCS, Toby Douglas. The letter discussed an initial plan to implement the ACA in California, including transitioning the "Low Income Health Program" (LIHP) to ACA coverage options, with the goal of enrolling 450,000 to 500,000 individuals by December 31, 2013. The attachment to the letter stated that the DHCS intended to "develop and partner with local LIHP[']s, the [insurance exchange (Exchange)] and stakeholders on an outreach and communication strategy for the transition of LIHP enrollees to Medicaid or the Exchange. The outreach and communication effort will include general notification from the LIHP transition to enrollees during 2013 and information on any available transition assistance through the Exchange or the counties." This document was part of an effort by the DHCS to engage stakeholders such as plaintiff to make contact with eligible individuals and enroll them. Butler-Cohen testified there was "no question in [her] mind that the direction from the [DHCS] was clear in the utilization of [plaintiff's] outreach workers, because [they] were the boots on the ground." In Butler-Cohen's opinion, plaintiff could reach eligible individuals "far better" than the DHCS or even the county.[1]

c. *Decision by administrative law judge*

In May 2018, the administrative law judge (ALJ) issued a proposed decision finding that the " 'community outreach services' " did not involve patient care and instead were efforts to attract new patients and increase patient utilization of plaintiff's services. The ALJ noted that members of plaintiff's outreach staff were "tasked to 'promote awareness of the health center's services and support entry into care' of the new patients contacted." These tasks included "attempting to make new patients 'comfortable

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[1] DHCS requests we take judicial notice of the (1) California Medicaid State Plan, Attachment 4.19-B (as in effect in 2013); and (2) California Medicaid State Plan Amendments 05-006, 08-003, 09-015, 11-037a. We deny the request. (*People v. Preslie* (1977) 70 Cal.App.3d 486, 493.)

enough to seek care,' such as through repeated 'passes' of contact." The ALJ concluded that the evidence established that the disallowed amounts were spent for patient recruitment efforts not reimbursable with Medi-Cal funds.

In making its decision, the ALJ relied on part 413 of title 42 of the Code of Federal Regulations for the proposition that, to be reimbursable, costs must be reasonable and related to the care of beneficiaries. (42 C.F.R. § 413.9.) Per the PRM, reasonable costs include "all necessary and proper costs incurred in rendering the services," including both "direct and indirect costs of providers of services." (PRM §§ 2100, 2102.1 (rev. 454, 09-12).)

The ALJ reviewed the authorities submitted by plaintiff, but found them unconvincing. According to plaintiff, section 220.3 of the Medicare Benefit Policy Manual identified outreach as " 'non-reimbursable [but] nevertheless allowable.' " The ALJ noted that the cited section applied only to " 'preventative health services' provided 'by or under the direct supervision of a physician' and [said] nothing about outreach or patient recruitment." As such, even if plaintiff had provided such services at the specified locations, they would have been excluded from reimbursement by Medi-Cal.

The ALJ also rejected the idea that plaintiff should be reimbursed because it is required to provide outreach services in order to receive certain grants. The ALJ reasoned that the availability of these grants was not in question, nor did the grants necessarily require Medi-Cal to also reimburse plaintiff.

The ALJ further concluded that outreach activities are not reimbursable as case management under the 1994 letter to the state Medicaid director. The ALJ reasoned that the letter identified " 'Medicaid outreach' as one of the 'administrative costs necessary for the proper and efficient administration of the State plan,' it does not contemplate subcontracting this to FQHC clinics through cost basis reimbursement but merely cites to the Center for Medicare/Medicaid Services' . . . Medicaid Manual authorizing the State to spend Federal money on case management services. The Medicaid Manual in its current

form still authorizes such use of Federal Medicaid funds by the State, but does not discuss using FQHC clinics as outreach contractors or incorporating case management payments into FQHC per-visit rates."

With respect to the PRM, the ALJ rejected plaintiff's argument that outreach services were reimbursable because there was no provision that restricts it, such that general cost principles should be applied. The ALJ reasoned that outreach work is "performed specifically to bring new patients into the facilities." Although such activities are not prohibited, costs for patient recruitment are excluded under section 2136.2 of the PRM.

Given his conclusions, the ALJ declined to reach the DHCS's argument that the outreach costs were nonallowable due to insufficient documentation.

d. *Motion for reconsideration and petition for writ of mandate*

Plaintiff filed a petition for reconsideration. In July 2018, the Chief ALJ affirmed the ALJ's decision, finding that the outreach costs were really patient recruitment costs and therefore nonreimbursable.

In August 2018, plaintiff filed a petition for writ of mandate in the trial court. The trial court denied the petition in April 2019. Noting that outreach costs are not discussed in the PRM, the trial court agreed with the ALJ and the Chief ALJ and found that plaintiff's outreach services are similar to advertising intended to increase patient use of plaintiff's services. Given that the cost of advertising to increase utilization of the provider's facilities is not allowable under the PRM, the trial court held that the costs were not reimbursable.

DISCUSSION

1. *Standard of review*

Pursuant to Code of Civil Procedure section 1094.5, the trial court may review a Chief ALJ's final decision. (Welf. & Inst. Code, § 14171, subd. (j).) "When reviewing the denial of a petition for writ of administrative mandate under Code of Civil Procedure

section 1094.5, we ask whether the public agency committed a prejudicial abuse of discretion. 'Abuse of discretion is established if the [public agency] has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence.' [Citations.]" (*County of Kern v. State Dept. of Health Care Services* (2009) 180 Cal.App.4th 1504, 1510.)

Like the trial court, an appellate court's task is to "determine whether the [DHCS's] decision is supported by substantial evidence. [Citation.] [¶] 'As to questions of law, appellate courts perform essentially the same function as trial courts in an administrative mandate proceeding, and the trial court's conclusions of law are reviewed de novo.' " (*Hi-Desert Medical Center v. Douglas* (2015) 239 Cal.App.4th 717, 730.) With respect to questions of law, we apply the same rules governing interpretation of statutes to the interpretation of administrative regulations, with the fundamental goal of ascertaining the agency's intent and effectuating the purpose of the law. (*Pang v. Beverly Hospital, Inc.* (2000) 79 Cal.App.4th 986, 994-995.) We seek to "give the regulatory language its plain, commonsense meaning . . . , and we must read regulations as a whole so that all of the parts are given effect." (*County of Kern v. State Dept. of Health Care Services, supra*, 180 Cal.App.4th at p. 1512.) As this court recently explained, although state agencies such as the DHCS "may be entitled to deference in interpreting its *own* regulations and policies" (*Oak Valley Hospital District v. State Dept. of Health Care Services* (2020) 53 Cal.App.5th 212, 224), we do not extend such deference when it comes to the DHCS's interpretation of regulations and policies such as the PRM that are issued by federal agencies like the Centers for Medicare and Medicaid Services. (*Id.* at pp. 224-225.)

2. *Plaintiff's claims on appeal*

Plaintiff contends the trial court erred in concluding that outreach costs are not allowable under part 413.9 of title 42 of the Code of Federal Regulations. First, plaintiff argues that part 413.9(c)(3)'s requirement that costs must be "related to the care of

Medicare beneficiaries" should be interpreted under its broad, ordinary meaning. According to plaintiff, its outreach activities are related to patient care because they are "designed to inform indigent people about their healthcare options," and there is a "direct linear connection" between helping people obtain such information and providing the services.

Plaintiff also argues its outreach costs were "reasonable" (and allowable under part 413.9(a) of title 42 of the Code of Federal Regulations) because they were "necessary and proper" to the furnishing of those health care services. According to plaintiff, outreach is a crucial function in providing health care to indigent individuals. Plaintiff contends such costs should be allowable, given the broad scope of costs that are allowable under the regulations.

Finally, plaintiff argues the trial court erred in concluding that outreach was akin to advertising to the general public to increase patient utilization of its facilities and therefore unallowable per PRM section 2136.2. Plaintiff argues the PRM was created before the advent of FQHC's and was not intended to address their outreach activities. According to plaintiff, courts have defined advertising as " 'widespread promotional activities usually directed at the public at large,' " which is much different than plaintiff's targeted activity of sending trained individuals into the community to help at-risk individuals obtain health care. Plaintiff argues it is bad public policy to disallow outreach costs given its value to society and the communities plaintiff serves. We find no merit in plaintiff's arguments.

3. *Analysis*

We agree with the ALJ, the Chief ALJ, and the trial court that the DHCS did not abuse its discretion in finding that plaintiff's outreach costs were nonreimbursable. Plaintiff's outreach efforts involve going into public spaces such as on the street, at schools, business venues, beaches, and parks to attract new patients, provide counseling regarding eligibility for services, and make medical appointments for services. Such

services may benefit the recipient by increasing awareness of care available through plaintiff and making the recipient feel more comfortable seeking care. And, such activities are required as part of plaintiff's role as a FQHC grant recipient. (42 U.S.C. §§ 254b(b)(1)(A)(iii)-(v), 1395x(aa)(4).) However, requiring plaintiff to perform such services as an FQHC grant recipient does not automatically make the associated costs reimbursable under Medicare (or Medi-Cal), even if they provide a benefit for the recipient.

The regulations exclude costs that the program defines as not allowable, and the PRM makes clear that advertising costs "seek[ing] to increase patient utilization of the provider's facilities are not allowable." (PRM § 2136.2 (rev. 267, 09-82); 42 C.F.R. § 413.9(c)(3) (2021).) The evidence showed that plaintiff performed its outreach activities to "get the word out" about its various services and "develop[ ] awareness of each clinic's presence, resources, cultural competence, and desire to serve among members of [plaintiff's] target populations." It was not an abuse of discretion to find that such activities had the purpose and effect of bringing in new patients and increasing utilization of plaintiff's facilities, making them akin to advertising.

We disagree with plaintiff that we must disregard the PRM's clear guidance about advertising costs merely because the manual was drafted before the current FQHC program was implemented. Had the relevant agencies wished to change the manual to make FQHC outreach costs reimbursable, they would have done so. (See *City of Long Beach v. Workers' Comp. Appeals Bd.* (2005) 126 Cal.App.4th 298, 311 ["[i]f the language of the statute is unambiguous, we presume the Legislature meant what it said"].)

DISPOSITION

The judgment is affirmed. Costs on appeal are awarded to defendant. (Cal. Rules of Court, rule 8.278(a)(1), (2).)

KRAUSE, J.

We concur:

ROBIE, Acting P. J.

HOCH, J.

Exhibit B

Court of Appeal, Third Appellate District
Andrea K. Wallin-Rohmann, Clerk
Electronically FILED on 7/27/2021 by D. Welton, Deputy Clerk

NOT TO BE PUBLISHED

California Rules of Court, rule 8.1115(a), prohibits courts and parties from citing or relying on opinions not certified for publication or ordered published, except as specified by rule 8.1115(b). This opinion has not been certified for publication or ordered published for purposes of rule 8.1115.

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

(Sacramento)

FAMILY HEALTH CENTERS OF SAN DIEGO, Plaintiff and Appellant, v. STATE DEPARTMENT OF HEALTH CARE SERVICES, Defendant and Respondent.	C089555 (Super. Ct. No. 34-2018-80002953-CU-WM-GDS) ORDER MODIFYING OPINION AND DENYING REHEARING [NO CHANGE IN JUDGMENT]

THE COURT:

It is ordered that the opinion filed on July 6, 2021, be modified as follows:

1. In the last partial paragraph starting at the bottom page 13 that begins with "We agree with the ALJ," delete the second sentence that begins with "Plaintiff's outreach efforts" and replace it with the following sentence:

Plaintiff's outreach efforts involve going into public spaces such as on the street, at schools, business venues, beaches, and parks to attract new patients from its audiences within the general public, provide counseling regarding eligibility for services, and make medical appointments for services.

2. Delete the first sentence in the first full paragraph on page 14 that begins with "The regulations exclude costs" and replace it with the following sentence:

> The regulations exclude costs that the program defines as not allowable, and the PRM makes clear that "[c]osts of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable."

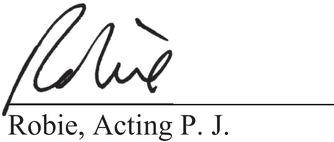
3. In the first full paragraph on page 14 that begins with "The regulations exclude costs," delete the sentence in the fourth line that begins with "The evidence showed" and replace it with the following sentence:

> The evidence showed that plaintiff performed its outreach activities to "get the word out" about its various services to its audiences within the general public and "develop[ ] awareness of each clinic's presence, resources, cultural competence, and desire to serve among members of [plaintiff's] target populations."

This modification does not change the judgment.

The petition for rehearing is denied.

BY THE COURT:



Robie, Acting P. J.

Hoch, J.

Krause, J.

IN THE

Court of Appeal of the State of California

IN AND FOR THE

THIRD APPELLATE DISTRICT

MAILING LIST

Re: Family Health Centers of San Diego v. State Department of Health Care Services
C089555
Sacramento County
No. 34201880002953CUWMGDS

Copies of this document have been sent by mail to the parties checked below unless they were noticed electronically. If a party does not appear on the TrueFiling Servicing Notification and is not checked below, service was not required.

Douglas S. Cumming
Douglas S. Cummings, Attorney
101 Parkshore Drive, Suite 100
Folsom, CA 95630

George E. Murphy
Murphy, Campbell, Alliston & Quinn
8801 Folsom Blvd, Suite 230
Sacramento, CA 95826

Kevin L. Quade
Office of the State Attorney General
P.O. Box 944255
Sacramento, CA 94244-2550

✓ Honorable Steven M. Gevercer
Judge of the Sacramento County Superior Court
720 Ninth Street
Sacramento, CA 95814

Exhibit C

Court of Appeal, Third Appellate District
Andrea K. Wallin-Rohmann, Clerk
Electronically FILED on 7/30/2021 by K. Peterson, Deputy Clerk

CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
THIRD APPELLATE DISTRICT
(Sacramento)

FAMILY HEALTH CENTERS OF SAN DIEGO Plaintiff and Appellant, v. STATE DEPARTMENT OF HEALTH CARE SERVICES, Defendant and Respondent.	C089555 (Super. Ct. No. 34-2018-80002953-CU-WM-GDS) ORDER CERTIFYING OPINION FOR PUBLICATION

APPEAL from a judgment denying a petition for writ of mandate of the Superior Court of Sacramento County, Steven M. Gevercer, Judge. Affirmed.

Douglas Cumming Medical Law, Douglas S. Cumming; Murphy, Campbell, Alliston & Quinn and George E. Murphy for Plaintiff and Appellant.

Xavier Becerra and Rob Bonta, Attorneys General, Cheryl L. Feiner, Assistant Attorney General, Niromi W. Pfeiffer, Gregory D. Brown, Marianne A. Pansa, and Kevin L. Quade, Deputy Attorneys General, for Defendant and Respondent.

THE COURT:

The opinion in the above-entitled matter filed on July 6, 2021, was not certified for publication in the Official Reports. For good cause it now appears that the opinion should be published in the Official Reports, and it is so ordered.

BY THE COURT:

Robie, Acting P. J.

Hoch, J.

Krause, J.

PROOF OF SERVICE

I declare:

At the time of service I was at least 18 years of age and not a party to this legal action. My business address is 8801 Folsom Blvd., suite 230, Sacramento, CA 95826. I served document(s) described as Petition for Review as follows:

By TrueFiling

On August 11, 2021, I served via TrueFiling, and no error was reported, a copy of the document(s) identified above on:

Supreme Court of California

Third District

Sacramento County County Superior Court

Douglas S. Cumming
(for Family Health Centers of San Diego)

Kevin L. Quade
(for State Department of Health Care Services)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: August 11, 2021 By: /s/ George Murphy

Supreme Court of California
Jorge E. Navarrete, Clerk and Executive Officer of the Court
Electronically FILED on 8/31/2021 by Florentino Jimenez, Deputy Clerk

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **Family Health Centers of San Diego v Department of Health Care Services**
Case Number: **TEMP-RDXV2P8K**
Lower Court Case Number:

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **varroyo@murphycampbell.com**

3. I served by email a copy of the following document(s) indicated below:

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

8/11/2021
Date

/s/George Murphy
Signature

Murphy, George (91806)
Last Name, First Name (PNum)

Murphy, Campbell, Alliston & Quinn
Law Firm