No. S270326

In the Supreme Court of the State of California

FAMILY HEALTH CENTERS OF SAN DIEGO,
Plaintiff and Appellant,

v.

STATE DEPARTMENT OF HEALTH CARE SERVICES,
Defendant and Respondent.

Third Appellate District, Case No. C089555
Sacramento County Superior Court, Case No. 34-2018-80002953
The Honorable Steven M. Gevercer, Judge

CONSOLIDATED ANSWER TO AMICUS CURIAE BRIEFS

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INTRODUCTION

Medi-Cal reimburses healthcare providers for the costs of providing care to program beneficiaries. The core focus of this reimbursement is for the costs of patient visits to providers, but Medi-Cal also reimburses for certain other costs that are "related to patient care." (42 C.F.R. § 413.9.) These include, for example, specified operating expenses, administrative costs, and similar items—including, as relevant here, some limited communications to members of the public who are not already patients of the healthcare provider. The provisions of the Provider Reimbursement Manual (PRM) discussing advertising costs set forth guidance for determining when these kinds of expenses are allowable for reimbursement purposes. The PRM provides a framework for determining whether Family Health may obtain full reimbursement for its claimed "outreach" expenses—specifically, the salary and benefits of its employees tasked with performing that outreach.

Amici Health Centers and the California Primary Care Association (CPCA) disagree that the PRM's provisions regarding advertising apply here. They contend that the PRM and the regulations it interprets were drafted with hospitals in mind, not federally qualified health centers (FQHCs) like Family Health that operate in traditionally underserved communities. But while FQHCs are a unique and important category of healthcare provider, the principles governing FQHC reimbursement—generally referred to as "Medicare reasonable cost principles"—are materially the same as those that apply to other kinds of

providers. And the PRM offers reasoned guidance regarding how these principles apply to specific categories of expenses. Notably, apart from the PRM, neither Family Health nor its amici have pointed to any other analytical framework for determining whether outreach expenses are "related to patient care." (42 C.F.R. § 413.9.)

Amici's arguments do not establish that Family Health was entitled to reimbursement based on the evidence it presented to the Department. While some FQHC outreach costs may well be eligible for reimbursement, Family Health made no effort to demonstrate that its specific outreach activities fit within the parameters of allowable advertising costs under the PRM. Instead, Family Health sought reimbursement for all its outreach expenses—including those incurred in encouraging members of the public to become new patients at Family Health. While that type of outreach is certainly permissible, and may serve important purposes, it is properly funded through the federal grants FQHCs receive and other outreach-specific grant programs—not through Medi-Cal's FQHC prospective payment system reimbursement.

ARGUMENT

I. THE DEPARTMENT DID NOT ABUSE ITS DISCRETION IN DENYING REIMBURSEMENT FOR FAMILY HEALTH'S OUTREACH COSTS

Both amici urge this Court, albeit for different reasons, not to consider the PRM. Even if the Court were to entertain amici's arguments—which Family Health has not advanced—they are wrong. The provisions of Chapter 21 of the PRM discussing

provider advertising are relevant to determining whether the costs for outreach to persons who are not already patients are allowable. Applying the principles set out in the PRM, the Department did not abuse its discretion in determining that Family Health failed to establish that its outreach costs are allowable, based on the evidence it presented.

A. The PRM provides reasoned guidance regarding what costs are "related to patient care"

At the outset, it bears emphasis that at its core, Medicaid reimburses providers for the cost of "medical services provided to needy individuals." (*Wilder v. Va. Hospital Assn.* (1990) 496 U.S. 498, 502; see generally 42 U.S.C. § 1396a(a)(10).) Of course, in order to provide those services, healthcare providers must incur certain basic operating expenses—for example, the costs of staffing and equipping a medical facility. (See 42 C.F.R. § 413.9(c)(3); *Tulare Pediatric Health Care Center v. State Dept. of Health Care Services* (2019) 41 Cal.App.5th 163, 169 [reimbursement includes the direct cost of patient visits plus certain "other costs, like office and printing supplies and so forth"].) State Medicaid programs reimburse providers for these kinds of operating expenses, but only insofar as the expenses are "related to patient care." (42 C.F.R. § 413.9.) The further removed a particular type of cost is from the actual provision of medical care to a program beneficiary, the less likely it is to be allowable for reimbursement purposes. (See, e.g., *Everhealth Found., Inc. v. Dept. of Health Services* (1985) 168 Cal.App.3d 708, 722-724 [housing expenses for provider administrators were not related to patient care].)

The PRM sets forth the reasoned guidance of the Centers for Medicare and Medicaid Services (CMS) regarding what specific types of provider costs are allowable for reimbursement purposes. As the Department explained in its Answer Brief on the Merits, the PRM's provisions regarding provider advertising costs should guide this Court's analysis of whether "outreach" to the public and other activities designed to bring in new patients are reimbursable. (See ABM 25-28 & fn. 5; PRM §§ 2136-2136.2.) Amici disagree and offer three interrelated arguments for why this Court should depart from that approach and reject the PRM as relevant guidance here. But these arguments are not persuasive.

First, amici contend that the PRM should not apply to FQHCs because CMS issued the manual primarily to apply in the context of reimbursement to hospitals. (See CPCA Br. 13-17; Health Centers Br. 20-21.) But CPCA acknowledges that the PRM is "often looked to by both regulators and courts to aid in matters outside the context of hospital inpatient services and even beyond just the Medicare program." (CPCA Br. 13-14.) And amici have not pointed to any statute or regulation indicating that the principles set forth in the PRM are inapplicable to FQHCs. On the contrary, the federal Medicaid statute specifies that FQHCs are reimbursed for costs that are "reasonable and related to the cost of furnishing . . . services" to beneficiaries. (42 U.S.C. § 1396a(bb)(2).) The Medicare program, similarly, reimburses FQHCs for "medically necessary primary health

services and qualified preventive health services from an FQHC practitioner."[1]

These principles are similar to those governing reimbursement to other types of providers. CPCA argues that the PRM should not be applied to FQHCs because they supposedly lack the kind of "self-interested motivation" that leads other types of providers to try to increase capacity utilization and market share. (CPCA Br. 16.) But neither Congress, nor CMS, nor the Department has endorsed that theory or enacted any law or regulation specifying that Medicaid reimbursement operates differently for FQHCs than for other types of providers.

CPCA argues that this Court should not follow the PRM because it is not "mandated by law" to do so. (CPCA Br. 15.) The Department agrees that the Court is not required to follow the PRM; indeed, the PRM itself makes clear that it "does not have the effect of regulations" but rather "provide[s] illustrative case material useful in interpreting and applying" those statutes and regulations. (*Id.* at p. 13, fn. 2, quoting Foreword to the PRM.) This Court should look to the PRM not because it is required to do so, but because the PRM is the most detailed and on-point guidance available regarding what types of provider costs are related to patient care. That is why courts in California and elsewhere have frequently relied on the PRM in resolving

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[1] Centers for Medicare & Medicaid Services, Medicare Learning Network Booklet: Federally Qualified Health Center (Jan. 2021), p. 6, <https://tinyurl.com/2p9xwuse> (as of June 14, 2022).

Medicare and Medicaid reimbursement disputes even though it lacks the force of law. (ABM 13-14, 27; see, e.g., *Oak Valley Hospital Dist. v. State Dept. of Health Care Services* (2020) 53 Cal.App.5th 212, 225-236.)

Neither Family Health nor its amici have offered any alternative framework for determining whether and when provider outreach costs are related to patient care. Indeed, the Health Centers acknowledge that there is no other federal or state regulatory guidance on point. (Health Centers Br. 20, fn. 12.) It would make little sense for the Department and courts to ignore the useful guidance provided in the PRM, particularly when Family Health and its amici are unable to identify any other analytical approach for resolving the central issue in this case.[2]

Second, amici Health Centers argue that the PRM does not apply because California statutes and regulations do not reference it. Instead, the Health Centers assert, California law references only "the Medicare regulations contained in 42 C.F.R.

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[2] In its reply, Family Health asserts that the Department in its answer "incorrectly" stated that Family Health "agree[d] that PRM sections 2136 et seq. should guide the court's analysis here." (RBM 12-13.) Family Health now says that "outreach is not advertising and so the PRM provisions regarding advertising do not pertain." (RBM 13.) But Family Health's Opening Brief on the Merits stated that those provisions of the PRM are "[o]f particular significance to this case." (OBM 13.) And apart from its discussion of the advertising provisions of the PRM (see OBM 22-26; RBM 14-18), Family Health has offered no other legal argument for why its outreach costs should be deemed to be related to patient care for reimbursement purposes.

Part 413, and not Parts 405 and 415," which the Health Centers contend are the federal regulations to which the PRM pertains. (Health Centers Br. 25; *see id.* at pp. 24-26.)[3] The Health Centers are wrong in suggesting that the PRM does not provide guidance regarding Part 413, which is the portion of CMS's regulations directly relevant to this case. Both Chapter 21 of the PRM (which contains the provisions regarding advertising) and 42 C.F.R. section 413.9 (which is encompassed within Part 413) are entitled "cost related to patient care." The overarching "principle" appearing at the beginning of Chapter 21 mirrors the "[p]rinciple" set forth at the beginning of section 413.9(a): "All payments to providers of services must be based on the reasonable cost of services . . . and related to the care of beneficiaries[.]" (PRM § 2100; compare 42 C.F.R. § 413.9(a).) And California courts have often applied the PRM in cases involving Part 413. (See, e.g., *Oroville Hospital v. Dept. of Health Services* (2006) 146 Cal.App.4th 468, 472; *Redding Medical Center v. Bonta* (1999) 75 Cal.App.4th 478, 480-481.)

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[3] Parts 405, 413, and 415 are all components of CMS's regulations governing Medicare and Medicaid. Part 405 is entitled "Federal Health Insurance for the Aged and Disabled." Part 413 is entitled "Principles of Reasonable Cost Reimbursement" (followed by other sub-headings). Part 415 is entitled "Services Furnished by Physicians in Providers, Supervising Physicians in Teaching Settings, and Residents in Certain Settings." Current Part 413 was formerly labeled Part 405. (*Redding Medical Center v. Bonta* (1999) 75 Cal.App.4th 478, 480-481.)

Similarly, the Health Centers also argue that the PRM does not apply because the state "regulation that expressly applies Medicare standards and the PRM" governs only hospital inpatient services and "does not apply to FQHCs." (Health Centers Br. 26, citing Cal. Code Regs., tit. 22, § 51536; see also CPCA Br. 13.) But Welfare & Institutions Code section 14132.100—which *does* apply to FQHCs, as the Health Centers recognize—incorporates "Medicare reasonable cost principles, as set forth in Part 413." (Welf. & Inst. Code, § 14132.100, subd. (e)(1).) Indeed, the Health Centers agree that this case is governed by "Part 413 Medicare reasonable cost principles." (Health Centers Br. 26.) There is no basis for the Health Centers' suggestion that Chapter 21 of the PRM—which addresses that very subject—is somehow inapposite here.

Third, amici argue that *Tulare Pediatric* supports their view that the PRM does not apply here. (Health Centers Br. 25-26; CPCA Br. 14, fn. 4.) But *Tulare Pediatric* is distinguishable. (See ABM 44-45.) The issue in that case was whether the State had to reimburse a healthcare clinic for "the full amount the *clinic* paid to a contractor," or rather "an amount equal to only the *contractor*'s underlying costs." (*Tulare Pediatric*, *supra*, 41 Cal.App.5th at p. 166, italics in original.) The court explained that there was a federal statute directly on point, specifying that the State had to reimburse providers "'*100 percent*'" of the costs of "a defined list of services.'" (*Ibid.*, quoting 42 U.S.C. § 1396a(bb)(4).) As a result, the court reasoned that the State could not rely on arguments grounded in the PRM as a basis for

reimbursing the provider only the amount of the contractor's underlying costs. (See *id.* at pp. 175-176.)

Here, in contrast, there is no statute or regulation that speaks to the question of whether the types of outreach expenses at issue are allowable in the first place, making it appropriate to look to the PRM for guidance. *Tulare Pediatric* did not hold that it is *never* appropriate to rely on the PRM in the context of FQHC reimbursement, even when (as here) there is no statute or regulation that would resolve the reimbursement question. And *Tulare Pediatric* does not speak to the specific argument the Department advances here—that Chapter 21 of the PRM is relevant because it sets forth CMS's view regarding what costs are "related to patient care" under Part 413, which is the central issue in this case. (42 C.F.R. § 413.9(a); see *Tulare Pediatric*, *supra*, 41 Cal.App.5th at p. 175; see also, e.g., *People v. Lonergan* (1990) 219 Cal.App.3d 82, 93 ["A case does not stand as precedent for an issue not considered by it."].)

B. No statute or regulation entitles FQHCs to Medi-Cal reimbursement for all costs related to outreach to prospective new patients

The Department in this case did not abuse its discretion in determining that Family Health's generalized evidence concerning its outreach work failed to satisfy its burden of establishing that these costs were eligible for reimbursement. (See ABM 28-38.) The Health Centers and CPAC disagree and argue that Family Health's outreach costs should have been classified as allowable, but their arguments lack merit.

The Health Centers assert that because "FQHCs are required to provide outreach services" as a condition of receiving federal Section 330 grants, the costs of such outreach must be allowable for purposes of Medicaid reimbursement. (Health Centers Br. 23; *see id.* at pp. 23-24; 42 U.S.C. § 254b(b)(1)(A)(iv) [specifying that FQHCs must provide "services that enable individuals to use the services of the health center," including "transportation services," language services, and certain types of "outreach"].) But the Health Centers offer no authority to support their theory that simply because FQHCs are required to engage in *some* forms of outreach, the costs of *all* outreach are automatically allowable for Medicaid reimbursement purposes. To be sure, some types of outreach may well qualify for Medicaid reimbursement (see ABM 38-41), but for the reasons outlined in the PRM, outreach to the general public "to promote an increase in the patient utilization of services is not properly related to the care of patients." (PRM § 2136.2; see 42 C.F.R. § 413.9(a).)

Relatedly, the Health Centers argue that because FQHC outreach is required, it necessarily qualifies as a "'common and accepted occurrence[] in the field of the provider's activity'" and constitutes an allowable cost on that basis. (Health Centers Br. 24, quoting 42 C.F.R. § 413.9(b)(2).) But again, even if that is true of *some* outreach, Family Health made no effort to establish that it is true with respect to the particular outreach activities at issue in this case—which involved Family Health's workers going out into public spaces and approaching individuals to encourage them to become new patients at Family Health. (See ABM 19;

AA 145-146.)[4] And even if it were true that the outreach at issue here is common and accepted for FQHCs, the Health Centers overlook—indeed, they do not even mention—the separate requirement that allowable costs must be "related to the care of beneficiaries," (42 C.F.R § 413.9(a)); that requirement is the focus of the parties' dispute in this case.

CPCA contends that denying reimbursement in this case violates "the State's obligation . . . to ensure that FQHCs are reimbursed through the Medi-Cal program for 100 percent of the costs of caring for Medi-Cal patients." (CPCA Br. 10.) That argument rests on a faulty premise. In fact, FQHCs are entitled to reimbursement in an amount equal to 100 percent of their average per-visit rate multiplied by the number of visits by Medi-Cal beneficiaries. (See 42 U.S.C. § 1396a(bb)(2)-(4); Welf. & Inst. Code, § 14132.100, subds. (c)-(e); see also *Tulare Pediatric*, *supra*, 41 Cal.App.5th at p. 168.) And an FQHC's per-visit rate is calculated using "Medicare reasonable cost principles, as set forth in Part 413" (Welf. & Inst. Code, § 14132.100, subd. (e)(1)), including 42 C.F.R. section 413.9 and the PRM, which account for the direct costs of medical care plus facility overhead. (*Ante*, pp. 10-12.) So the fact that FQHCs are entitled to reimbursement under a formula based on 100 percent of their average per-visit

[4] Some confusion has arisen regarding the page numbering of the Appellant's Appendix, many pages of which contain two separate sets of Bates numbers. (See OBM 7, fn. 4.) All of the Department's citations refer to the larger, bolded set of Bates numbers, which appear on every page of the Appellant's Appendix.

rate sheds no light on the separate question of whether the type of outreach costs at issue here are properly deemed to be allowable for purposes of calculating that per-visit rate in the first place.

CPCA also suggests that the evidence presented by Family Health was sufficient to establish that the outreach costs at issue are allowable. (See CPCA Br. 11, 19.) As the Department explained, however, Family Health in this case sought reimbursement for *all* of its outreach expenses, primarily in the form of the salary and benefits of outreach workers. (ABM 18, 41.) The evidence presented showed that those workers' activities consisted of going out into public places and approaching members of the public to encourage them to utilize Family Health's facilities. (AA 145-146.) The costs of this kind of generalized public outreach are not categorically allowable for purposes of Medi-Cal reimbursement. While on an appropriate showing, Family Health may well be entitled to reimbursement for some portion of its outreach expenses—for instance, the costs of outreach to its existing patients, or outreach that qualifies as allowable under the relevant provisions of the PRM—Family Health presented no evidence showing what portion of its outreach costs fell within these categories, as opposed to outreach to the general public to increase the utilization of its facilities. (See ABM 38-41.) The Department thus properly denied Family Health's claim on the evidence before it.

II. AMICI'S CHARACTERIZATIONS OF THE CONSEQUENCES OF AFFIRMING THE DECISION BELOW ARE UNFOUNDED

Amici also assert that were this Court to affirm the court of appeal's judgment, leaving the Department's longstanding reimbursement practices in place, a variety of negative consequences would follow. But amici fail to substantiate those claims.

A. Applying the PRM will not create uncertainty or unfairly prevent FQHCs from obtaining reimbursement for allowable outreach costs

Echoing arguments advanced by Family Health, CPCA contends that treating the outreach activities in this case being "akin to" advertising "injects uncertainty" into the reimbursement process, "making it difficult . . . to know or reasonably guess what activities might be considered akin to advertising and subject to the PRM's allowable advertising cost practices." (CPCA Br. 19; see also RBM 18-19.) But the Department is not advancing any "'akin to' standard" for applying the PRM's provisions regarding advertising. (CPCA Br. 18.) Although the phrase "akin to advertising" appeared in the Court of Appeal's opinion, Family Health and its amici read far too much into it, and this Court may affirm the judgment below without adopting that phrase. The key point is simply that, in order for Family Health's outreach expenses to be eligible for reimbursement, they must fit into some recognized category of allowable costs—and the PRM's provisions regarding advertising provide the most relevant framework. Based on the evidence in the record, the costs of Family Health's outreach communications to prospective new patients are properly considered non-

allowable under a straightforward application of those provisions. (See Opn. 14; ABM 29-36.)

Indeed, it is Family Health and its amici, not the Department, who are proposing a standard that would create uncertainty. They offer no guidance or framework that would allow the Department, healthcare providers, or courts to determine when outreach costs are "related to the care of beneficiaries." (42 C.F.R § 413.9(a); see *ante*, p. 10.) The Department's view, in contrast, is that CMS's extensive and considered discussion of advertising costs in the PRM should guide the analysis of that question. Any uncertainty that may exist regarding how the relevant provisions of the PRM apply to a particular set of facts is far less than the uncertainty that would exist *absent* the PRM's guidance.

CPCA next asserts that the Department "appears to take the position that every individual outreach communication must be documented and supported to justify reimbursement of the costs of outreach workers and outreach services," which would "create an immense, new recordkeeping obligation" preventing FQHCs from obtaining reimbursement. (CPCA Br. 19, 20; see *id.* at p. 20 [suggesting that the Department believes "line-by-line support" for each outreach communication is required].) But the Department has never suggested that every individual outreach communication must be documented in order for an FQHC to obtain reimbursement. On the contrary, providers may submit summary evidence that captures, to a reasonable degree of accuracy, what portion of outreach workers' time is spent on

allowable forms of outreach. For example, duty statements are a common source of documentation submitted to the Department during FQHC audits to justify salary and personnel costs. An outreach worker's duty statement may indicate the approximate percentage of his or her time that is spent communicating with Family Health's existing patients about their health care needs, or spent engaging in types of communication to prospective new patients that is allowable under the PRM. Moreover, Family Health could have offered testimony to that effect during the administrative hearing. Here, however, Family Health submitted no such evidence to support its reimbursement claim. Rather, it proceeded on the unsupported theory that outreach costs are categorically allowable. (*Ante*, p. 16.) That is why the Department denied Family Health's claim, not because it failed to present line-by-line documentation of every single outreach communication

B. Amici's assertions of harm to FQHCs' outreach activities are overstated

Family Health and its amici also contend that a rule that fails to allow reimbursement for all communications and activities designed to bring new patients to FQHCs "will chill effective FQHC outreach efforts[.]" (CPCA Br. 9, 20; *see id.* at pp. 20-24; *see also* OBM 27.) That is doubtful. For one thing, the Department's longstanding policy is *not* to reimburse the kinds of FQHC outreach costs at issue here. Affirming the decision below will simply keep that status quo approach in place. Moreover, as the Department has explained, some FQHC outreach costs are likely to be allowable if properly documented (ABM 45-46), and

nothing prevents FQHCs from using other grant money for non-reimbursable outreach or applying for state funds earmarked for Medi-Cal outreach (ABM 46-49).

Both the Health Centers and CPCA argue that denying reimbursement for Family Health's outreach costs at issue in this case will result in the "improper subsidization of the Medi-Cal program by federal grant dollars that are intended to be used to provide health care to uninsured indigent populations in California." (Health Centers Br. 14; accord CPCA Br. 12.) That is not correct. The Section 330 grants FQHCs receive may be used to cover FQHC costs that are not eligible for Medicare or Medicaid reimbursement. (See, e.g., *Community Health Care Assn. of N.Y. v. Shah* (2d Cir. 2014) 770 F.3d 129, 136.) While providing care to the uninsured indigent population is certainly one of the main purposes FQHC grants serve, it is not the only one. To the extent FQHCs wish to engage in outreach whose costs are not allowable for reimbursement, other sources of funding may be used. Indeed, Family Health does not deny that it could use its FQHC grant money for that purpose. (RBM 26-28.)

Notably, Family Health and its amici fail to rebut the Department's argument that allowing reimbursement for all FQHC outreach costs would create problematic incentives for providers, encouraging them to invest potentially very large sums of public money in outreach to prospective new patients designed to increase the utilization of provider facilities. (ABM 49.) For outreach costs to be allowable, it is sensible to require providers

to establish that the outreach at issue was designed to benefit Medi-Cal patients, not just the provider.

CONCLUSION

The judgment of the court of appeal should be affirmed.

Respectfully submitted,

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June 15, 2022

CERTIFICATE OF COMPLIANCE

I certify that the attached Consolidated Answer to Amicus Curiae Briefs uses a 13-point Century Schoolbook font and contains 4,071 words.

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June 15, 2022

DECLARATION OF ELECTRONIC SERVICE

Case Name: **Family Health Centers of San Diego v. Department of Health Care Services**
Case No.: **S270326**

I declare:

I am employed in the Office of the Attorney General and am a member of the California State Bar. I am 18 years of age or older and not a party to this matter. I am familiar with the business practice at the Office of the Attorney General for collecting and processing electronic correspondence. In accordance with that practice, correspondence that is submitted electronically is transmitted using the TrueFiling electronic filing system. Participants who are registered with TrueFiling will be served electronically.

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I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on June 15, 2022, at San Diego, California.

Joshua Patashnik	/s/ Joshua Patashnik
Declarant	Signature

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

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Case Number: **S270326**
Lower Court Case Number: **C089555**

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