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.

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

ANSWER TO PETITION FOR REVIEW AND *AMICUS CURIAE* LETTERS IN SUPPORT OF REVIEW

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August 31, 2021

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INTRODUCTION

Family Health Centers of San Diego (Family Health) asserts that the decision below "establishes a new, albeit erroneous, interpretation of federal law that will adversely affect critical health services for thousands of indigent Californians[.]" (PR 7.) In fact, this case involves a simple and straightforward application of the federal regulations that govern the State's Medicaid reimbursement.

Family Health operates a federally qualified health center (FQHC). It receives both federal grant funding and Medicaid reimbursement for providing health services to medically underserved patients, including Medicaid beneficiaries. In addition to providing health services, it engages in community outreach to assist prospective patients and raise awareness of the availability of services.

Family Health seeks Medicaid reimbursement for the cost of its outreach. But—as the Court of Appeal correctly held—federal regulations preclude reimbursement under Medicaid because—as the administrative law judge (ALJ) found based on the evidence presented—Family Health's outreach does not involve patient care and is, instead, aimed at bringing new patients into the health center. Further, FQHCs like Family Health are required to provide these outreach services as a condition of their receipt of federal grant funding, and are allocated money for them. Thus, contrary to Family Health's assertion, outreach services will continue to be provided.

What Family Health seeks, and what the Court of Appeal's decision denying reimbursement precludes, is *double funding*, from both the federal FQHC grant program and Medicaid. Federal law correctly prohibits such additional reimbursement for the type of costs at issue in this case. The law is uniform and clear, and there is no basis for this Court's further review.

LEGAL BACKGROUND

The Department of Health Care Services (Department) is the state agency designated to administer Medi-Cal, California's implementation of the federal Medicaid program. (Welf. & Inst. Code, § 14203.) It reimburses participating providers for the "allowable" costs of providing care to Medi-Cal beneficiaries, as determined by the Medicare/Medicaid reimbursement principles set forth in the Code of Federal Regulations and the Provider Reimbursement Manual (PRM). (See *Oroville Hospital v. Dept. of Health Services* (2006) 146 Cal.App.4th 468, 472.) Reimbursement is made through the Prospective Payment System (PPS), which uses a "per-visit" reimbursement rate, calculated by adding together all of a provider's "allowable" costs, then dividing that amount by the provider's total number of Medi-Cal patient visits in a year. (See *Three Lower Counties Community Health Services, Inc. v. Maryland* (4th Cir. 2007) 498 F.3d 294, 298-299 (*Three Lower Counties*); see also 42 U.S.C. § 1396a(bb)(2); Welf. & Inst. Code, § 14132.100, subd. (e)(2)(A).)

In order for a cost to be "allowable" (factored into the PPS rate calculation), it "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).) "Reasonable 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." (42 C.F.R. § 413.9(c)(3) (2021).) These "necessary and proper expenses" are defined as "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." (42 C.F.R. § 413.9(b)(2) (2021).)

The PRM, which catalogs the Centers for Medicare and Medicaid Services' interpretations of federal reimbursement regulations (see *Community Care Foundation v. Thompson* (D.D.C. 2006) 412 F.Supp.2d 18, 22-23), explains that certain forms of advertising costs are allowable if they relate to patient care or a provider's public relations activities. (PRM § 2136.1 (rev. 267, 09-82).)[1] Examples include advertising of visiting hours information or the conduct of management-employee relations. (*Ibid.*) The PRM makes clear, however, that the "[c]osts of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable." (PRM § 2136.2 (rev. 267, 09-82).) The manual explains that, although it is general government policy to promote the growth and expansion of provider facilities, "general

[1] The regulation interpretations pertinent to this appeal can be found in Chapter 21 of the PRM, accessible online at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929> (as of Aug. 30, 2021).

advertising to promote an increase in the patient utilization of services is not properly related to the care of patients." (*Ibid.*)

STATEMENT OF THE CASE

This case arose from the Department's reclassification of $78,032 in salary and benefit expenses incurred by Family Health for community outreach as non-reimbursable under Medi-Cal. (AA 268, 467-476.)[2] On administrative appeal, after a formal hearing, an administrative law judge (ALJ) upheld the removal of these costs from Family Health's Medi-Cal reimbursement calculation, explaining that the outreach activity sought to bring new patients into the health center and was not directed at patient care. (AA 143, 149-154, 159.) When Family Health sought reconsideration, the Chief ALJ likewise determined that the outreach costs were non-reimbursable because patient recruitment efforts did not involve direct or indirect patient care. (AA 100-117.)

Family Health filed a petition for writ of mandate in the superior court. (AA 26-34.) After briefing, the court rejected Family Health's arguments, finding that efforts to bring new patients into the facilities were outside the scope of activities reimbursable under Medi-Cal. (AA 1434-1440.)

On appeal in the Third Appellate District, the Court of Appeal maintained this consensus. In concluding that Family Health's community outreach is non-reimbursable, the court likened these activities to advertising to the general public, which

[2] "AA" refers to the Appellant's Appendix below.

the PRM deems non-reimbursable because it seeks to increase patient utilization while bearing no sufficient connection to patient care. (Opn. 13-14.)

WHY REVIEW SHOULD BE DENIED

I. THE OPINION WILL NOT CURTAIL COMMUNITY OUTREACH BY FQHCS, WHICH IS REQUIRED BY AND PAID FOR THROUGH FEDERAL GRANTS AND HAS NEVER BEEN A BASIS FOR MEDICAID REIMBURSEMENT

Family Health asks this Court to grant review based on its assertion that the Court of Appeal's decision—holding that Family Health's community outreach services are not reimbursable under Medi-Cal—will curtail community outreach by FQHCs to the detriment of California's vulnerable population. (PR 7, 11-12; see also California Primary Care Association (CPCA) Amicus Ltr. (CPCA Ltr.) 5; Avenal Community Health Center, et al. (Amici Health Centers) Amicus Ltr. (AHC Ltr.) 2, 4.) That assertion is demonstrably incorrect. As the Court of Appeal noted (Opn. 1-2), these FQHC community outreach services are already funded through a separate federal grant program, which requires FQHCs to provide such services as a condition of their grant funding.[3] What Family Health seeks

[3] Though not relevant to the underlying appeal, which relates to Medi-Cal reimbursement to FQHCs through PPS rates, the Department notes that there are separate Medi-Cal programs and legislative appropriations that provide funding towards outreach and enrollment efforts of counties and community-based organizations. (See, e.g., Welf. & Inst. Code, § 14132.47; Assembly Bill No. 82 (2013-2014 Reg. Sess.) §§ 70-71; Senate Bill No. 18 (2013-2014 Reg. Sess.) § 1.)

here is an *additional* recovery for outreach services that is quite appropriately prohibited under the applicable federal Medicaid regulations because such services do not relate to patient care.

Providers like Family Health are designated as FQHCs precisely because they receive direct grants from the United States to provide primary health care and other related services to underserved communities in accordance with the Public Health Services Act. (42 U.S.C. §§ 254b(a)(1), 1395x(aa)(4); *Community Health Care Assn. of New York v. Shah* (2d Cir. 2014) 770 F.3d 129, 136.) FQHCs must be located in medically underserved areas or provide care to medically underserved populations, including migratory or seasonal agriculture workers, the homeless, or residents of public housing. (*Three Lower Counties*, *supra*, 498 F.3d at p. 297; see 42 U.S.C. § 254b(a)(1), (k)(3).) Though FQHCs often serve Medicaid beneficiaries, and are reimbursed through Medicaid for 100 percent of the costs of caring for these patients (*Three Lower Counties*, at pp. 298-299, citing 42 U.S.C. § 1396a(bb)(2); see Welf. & Inst. Code, § 14132.100, subd. (i)(1)(C)), the FQHC grant structure is independent from the Medicaid program.

As a condition of federal grant money under the Public Health Services Act, FQHCs are required to provide various health services, including family and internal medicine; pediatrics; obstetrics and gynecology; and well-child services. (42 U.S.C. § 254b(b)(1)(A)(i).) In addition to substantive health care services, FQHCs must also provide a variety of services aimed at increasing awareness of and utilization of the health center's

resources. This mandated "outreach" includes: patient case management services designed to assist in establishing a prospective patient's eligibility for and access to federal and state assistance programs; services that enable individuals to use a health center's resources (including outreach, transportation, and interpreter services); and education of patients and the general population of the availability and proper use of health services. (42 U.S.C. § 254b(b)(1)(A)(iii)-(v).)[4]

Family Health, CPCA, and the Amici Health Centers acknowledge that acceptance of FQHC grant money obligates a provider to engage in the type of outreach at issue here. (See PR 8; CPCA Ltr. 2, 3, 5; AHC Ltr. 4, fn. 8.) Federal grant money received by an FQHC is allocated to facilitate, among other things, the grantee's compliance with its obligation to provide "required primary health services," which include community outreach. (See 42 U.S.C. § 254b(b)(1)(A), (e)(2), (k)(2), (3).) The Court of Appeal's opinion in this case thus will have no appreciable effect on the ability of FQHCs like Family Health to

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[4] Family Health and CPCA imply that the Department is hostile to community outreach in California's medically underserved communities. (See PR 9-10; CPCA Ltr. 4.) This is not the case. It is undoubtedly beneficial when more Californians, especially those most vulnerable and in need of assistance, utilize available health care resources as demonstrated by the programs California has instituted to aid in this effort. (See *ante*, fn. 3.) But this cases concerns a far more narrow (and uncontroversial) question, whether the community outreach required of FQHCs and paid for through separate grant funding, warrants duplicative funding via Medi-Cal reimbursement under the applicable federal regulations.

inform and engage with vulnerable Californians in medically underserved communities.

The opinion does not change longstanding practices. Indeed, the status quo is and always has been that community outreach costs of the type at issue in this appeal are not reimbursable under Medi-Cal. The Department has long viewed the applicable federal regulations, which prohibit reimbursement for costs not sufficiently related to patient care (42 C.F.R. § 413.9 (2021)), to bar consideration of activities like community outreach when calculating a provider's PPS rate. The Court of Appeal's opinion merely affirms this well-established application of federal regulations. Contrary to Family Health and amici's arguments, the decision will not decrease Medi-Cal reimbursement or require that outreach to vulnerable communities be diminished or discontinued because the cost of these activities has never factored into the PPS rate. The effect of the Court of Appeal's decision is simply to deny FQHCs *additional payment*, via Medi-Cal reimbursement, for these outreach costs that are already funded through a separate federal grant.[5]

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[5] CPCA's letter distinguishes FQHCs from what it calls "look-alike[] Community Health Centers." (CPCA Ltr. 1, internal quotation marks and parenthesis omitted.) Apart from the difference in name, however, CPCA identifies no relevant legal distinction between the two types of health care provider. According to CPCA, Community Health Centers, like FQHCs, are legally obligated to provide various services, including outreach, to medically underserved populations under the Public Health Services Act grant program. (See CPCA Ltr. 5, citing 42 U.S.C. § 254b(a)(1), (b)(1)(A)(iv), (v).)

Accordingly, Family Health and the amici's warnings that review is necessary to prevent wide-sweeping devastation to the health of California's medically underserved communities ring hollow.

II. THE OPINION CREATES NO CONFLICT IN CASE LAW, AND THERE IS NO LEGAL ISSUE OF STATEWIDE IMPORTANCE WARRANTING THIS COURT'S FURTHER REVIEW

As to the legal issue at the heart of this case, Family Health and CPCA argue that review is necessary because the Court of Appeal erred when applying the federal Medicaid reimbursement regulations to claims for community outreach expenses. (PR 21-26; CPCA Ltr. 4.) But mere error correction of the sort suggested (and there is no error here) is not a ground for review. (See Cal. Rules of Court, rule 8.500(b)(1).)

Family Health can establish no other basis for review. There is no conflict among any authorities on this issue. Neither Family Health nor CPCA identify, and the Department is not aware of, any court in any jurisdiction that has found these types of outreach service costs to be reimbursable under the Medicaid reimbursement regulations.

The Amici Health Centers submit that the Court of Appeal's denial of Medicaid reimbursement for outreach costs is "at odds" with *Tulare Pediatric Health Care Center v. State Dept. of Health Care Services* (2019) 41 Cal.App.5th 163, 174 (*Tulare Pediatric*), which described part 413's standards for reimbursement as "broad and inclusive." (AHC Ltr. 6.) That characterization, however, occurred in an entirely different context, the court's consideration of how much reimbursement is required, not what

type of costs are reimbursable. (See *Tulare Pediatric*, at p. 171.) In fact, the *Tulare Pediatric* court, in holding that the State was required to fully reimburse an FQHC for its reported costs, repeatedly noted that the applicable statutes and regulations contemplated reimbursement for actual treatment of Medicaid beneficiaries. (*Id.* at pp. 171, 174.) There is no conflict here, with *Tulare Pediatric* or any other case.[6]

Moreover, this case does not present any important unanswered questions of law that would warrant this Court's intervention. Indeed, the law governing reimbursement here is simple, straightforward, and settled, and was correctly applied by the ALJ, Chief ALJ, trial court, and a unanimous panel of the Court of Appeal. Under governing federal regulations, a provider's costs cannot be factored into the Medicaid reimbursement rate unless they are "related to the care of beneficiaries." (42 C.F.R. § 413.9(a) (2021).) Federal agency guidance from the PRM illustrates how this principles is applied, highlighting advertising to the general public, which seeks to

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[6] The Amici Health Centers also cite *Tulare Pediatric* for the proposition that the Court of Appeal did not consider whether the exclusion of outreach costs is consistent with the federal requirement that FQHCs be reimbursed for 100 percent of the cost of services provided. (AHC Ltr. 6-7, citing *Tulare Pediatric*, *supra*, 41 Cal.App.5th at p. 166; see also 42 U.S.C. § 1396a(bb)(4).) But under part 413, and consistent with *Tulare Pediatric*, the Court of Appeal's conclusion that Family Health's outreach costs did not relate to patient care and, thus, were non-reimbursable, necessarily does not violate the requirement of full repayment for *reimbursable* services.

increase utilization of a provider's services, as non-reimbursable because it does not relate to patient care. (PRM § 2136.2 (rev. 267, 09-82).)

The Amici Health Centers argue that review is warranted because the Court of Appeal did not consider other federal regulatory guidance, a 2001 question-and-answer document from CMS's predecessor agency concerning changes in the scope of FQHC services. (AHC Ltr. 4-5.) That guidance explains that a change in scope occurs when a center adds or drops a service that meets both the definition of an FQHC service under section 1905(a)(2)(B) and (C) of the Social Security Act, and qualifies as a covered service under the a state's Medicaid plan. (AHC Ltr. 5.)[7] As allegedly relevant here, "outreach" is listed as a service potentially subject to reimbursement after a change in scope. (See AHC Ltr. 5.)

But this guidance has no application here. Initially, as noted, this question-and-answer addresses changes in scope of services, whereas Family Health's challenge to the Department's reclassification concerns an initial rate-setting audit. More importantly, although the agency guidance appears to contemplate that states *may elect* to include services like outreach in their federally-approved plan, California has not done so. (See Respondent's Motion for Judicial Notice (RMJN) 12-13 [California's plan limiting reimbursable services to those

[7] Section 1905 of the Social Security Act is codified at 42 U.S.C. section 1396d.

described in section 1905(a)(2)(C) of the Social Security Act]; see also 42 U.S.C. § 1395x(aa)(1) [describing services provided by physicians and other health professionals].) In fact, the state plan's language on changes in scope of services largely tracks the question-and-answer guidance, while notably omitting any reference to "outreach" in the examples of covered services. (See RMJN 24-25.) This federal guidance thus has no bearing on and does not undermine the Court of Appeal's determination that outreach is not reimbursable under California's implementation of Medicaid.

As the ALJ, Chief ALJ, trial court, and Court of Appeal all determined, the outreach services in question are not related to Medi-Cal patient care and are instead analytically akin to general public advertising because they aim to increase awareness and utilization of health center services. (See AA 100-117, 143-154, 1434-1440; Opn. 13-14.) Family Health, CPCA, and the Amici Health Centers fail to show any error in these determinations, let alone that this case raises any unsettled issues of statewide importance, particularly given that these outreach services are already funded by separate FQHC grant money.[8] The issue here is not whether health care outreach

[8] In repeatedly focusing on the "general public" component of the PRM's exclusion of advertising from Medicaid reimbursement, Family Health and CPCA provide a distorted framing of the legal issue. As explained, advertising to the general public is not excluded under part 413.9 because it concerns a large-scale broadcast to "crowds of people" (PR 11), but rather, because it aims to increase utilization of health

(continued…)

services to California's vulnerable communities will be provided and funded, but whether FQHCs will be paid for them not only through federal grant funding, but also through Medicaid reimbursement. Further review of that question is unwarranted.

CONCLUSION

For these reasons, the petition for review should be denied.

Respectfully submitted,

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(…continued)

services, a task with insufficient connection to individual patient care. (PRM § 2136.2 (rev. 267, 09-82).)

CERTIFICATE OF COMPLIANCE

I certify that the attached **ANSWER TO PETITION FOR REVIEW AND *AMICUS CURIAE* LETTERS IN SUPPORT OF REVIEW** uses a 13 point Century Schoolbook font and contains 2,939 words.

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August 31, 2021

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Attachment A

Filed 7/27/21 Family Health Centers etc. v. State Dept. of Health Care Services CA3

NOT TO BE PUBLISHED

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

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.

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.

DECLARATION OF ELECTRONIC SERVICE AND SERVICE BY U.S. MAIL

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, which is the office of a member of the California State Bar, at which member's direction this service is made. 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 and physical correspondence. In accordance with that practice, correspondence placed in the internal mail collection system at the Office of the Attorney General is deposited with the United States Postal Service with postage thereon fully prepaid that same day in the ordinary course of business. Correspondence that is submitted electronically is transmitted using the TrueFiling electronic filing system. Participants who are registered with TrueFiling will be served electronically. Participants in this case who are not registered with TrueFiling will receive hard copies of said correspondence through the mail via the United States Postal Service or a commercial carrier.

On August 31, 2021, I electronically served the attached **ANSWER TO PETITION FOR REVIEW AND AMICUS CURIAE LETTERS IN SUPPORT OF REVIEW** by transmitting a true copy via this Court's TrueFiling system and via electronic mail. Because one or more of the participants in this case have not registered with the Court's TrueFiling system or are unable to receive electronic correspondence, on August 31, 2021, I placed a true copy thereof enclosed in a sealed envelope in the internal mail collection system at the Office of the Attorney General at 1300 I Street, Suite 125, P.O. Box 944255, Sacramento, CA 94244-2550:

Sacramento County Superior Court The Honorable Steven M. Gevercer Department 27 Gordon D. Schaber Courthouse 720 Ninth Street Sacramento, CA 95814	Third Appellate District Stanley Mosk Library and Courts Building 914 Capitol Mall, 4th Floor Sacramento, CA 95814

George Murphy Murphy, Campbell, Alliston & Quinn varroyo@murphycampbell.com *Representing Appellant*	Douglas S. Cumming Law Offices of Douglas S. Cumming dsc@dougcummingmedicallaw.com *Representing Appellant*
Deborah Rotenberg DJR Garcia Health & Wellness Law deborah@djrgarcia.com	

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 August 31, 2021, at Sacramento, California.

T. Routt	**/s/ *T. Routt***
Declarant	Signature

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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. STATE DEPARTMENT OF HEALTH CARE SERVICES**
Case Number: **S270326**
Lower Court Case Number: **C089555**

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Date

/s/Laurie Lozano
Signature

Quade, Kevin (285197)

Last Name, First Name (PNum)

DOJ Sacramento/Fresno AWT Crim

Law Firm