IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

No. S270326

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. 34201880002953CUWMGDS
Michael P. Kenny

OPENING BRIEF ON THE MERITS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

Cases:

Statutes:

Other:

Opening Brief on the Merits

I. ISSUE PRESENTED

When a Federally Qualified Health Center[1] incurs costs to have an employee talk with an indigent individual—one or a few at a time---about how to obtain health services, or assist in making appointments with a provider, or enroll an at-risk person in Medi-Cal where appropriate, do such "outreach" activities constitute "advertising to the general public" under pertinent federal guidelines, so as to make the costs of those activities not allowable for reimbursement under federal and state law?

II. INTRODUCTION

The outcome of this case will directly impact the ability of FQHCs throughout California to fulfill their mandate[2] of informing the neediest members of society about important healthcare services available to them at community health centers established for their benefit—an activity known

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[1] Hereinafter, the term "Federally Qualified Health Center" is referred to by the acronym "FQHC."

[2] "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 Medi-Cal." (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.)

as "outreach." According to one study regarding California FQHCs, in the year 2019 "California FQHCs served 5.6 million patients and generated 26.4 million patient visits…."[3] In 2019 there were 1,963 FQHC delivery sites throughout California. (*Id*.) Hence, the outcome of this case will affect the health and well-being of a vast number of poor California residents. This case also has implications for the general population because infected people left untreated can spread disease to others. Indeed, for example, Plaintiff and Appellant Family Health Centers of San Diego ("Family Health") has worked with San Diego County to provide thousands of vaccines to homeless individuals. (AA 288:2–4.)[4] By December 30, 2021, California health centers like Family Health tested 65,332 patients for COVID-19 and vaccinated over 32,000 people.[5] The importance of this service has never been greater, given the ongoing pandemic.

Federal and State programs exist to make medical benefits available for disadvantaged individuals, but those people are often unaware of what the programs are, how to apply for benefits and where to go for needed medical help. Such individuals are typically unreachable through media such as television, radio, streaming services and social media. To inform them of what medical care is available, and how and where to obtain it, a more

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

[4] The designation "AA" refers to the Appellant's Appendix filed in the Court of Appeal. AA page references are to the Bates stamped page numbers, which differ from the pdf numbers.

[5] Health Resources & Services Administration, Health Center Program, "California Health Center COVID-19 Survey Summary Report," https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data/ca.

direct and personal approach is essential involving caring workers who engage them in their communities, on the streets and at facilities such at-risk individuals are known to frequent. These community directed efforts are called outreach, and the costs of these activities are what the State Department of Health Care Services ("DHCS") refuses to recognize as allowable in Medi-Cal rate setting cost reports filed by Family Health,[6]even though outreach is an activity encouraged by DHCS and mandated by Federal and State authorities. (AA 277:1–7.)

III. STANDARD OF REVIEW IS DE NOVO

In its ruling on Family Health's petition for writ of mandate, the trial court framed the issue before it as follows:

> "In this case, the costs at issue were incurred by Petitioner for 'outreach' efforts directed to persons who may be eligible to receive FQHC and/or Medi-Cal services, and to bring such persons to Petitioner's facilities. Thus, the issue is whether these costs are reimbursable." (AA 1402.)

The trial court noted that "[t]he issue here is the proper application of relevant laws and regulations…" presenting "a question of law which is reviewed de novo." (Citing, *Duncan v. Dept. of Pers. Admin.* (2000) 77 Cal.App.4th 1166, 1174; AA 1402.)

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[6] Family Health is a California FQHC which operates 57 delivery sites across San Diego County, including 23 primary care clinics, 16 behavioral health facilities, eight dental clinics, an outpatient substance use treatment program, three vision clinics, physical therapy departments, two mobile counseling centers, three mobile medical units and a pharmacy. https://www.fhcsd.org/about-us/

Indeed, the pertinent facts are not in dispute and the issue involves interpretation of law. The interpretation of statutes is a question of law subject to independent judicial review on appeal. (*Santa Ana Hosp. Med. Ctr. v. Belshé* (1997) 56 Cal.App.4th 819, 830; *Yamaha Corp. of Am. v. State Bd. Of Equalization* (1998) 19 Cal.4th 1, 7.) "In interpreting statutes, [the appellate court is] free to 'tak[e] into account' agency interpretations, but such agency interpretations 'are not binding or necessarily even authoritative.'" (*PG&E Corp. v. Pub. Utils. Com.* (2004) 118 Cal.App.4th 1174, 1195, citing *Yamaha Corp. of Am. v. State Bd. Of Equalization*, *supra*, at pp. 7–8.) "It is for the courts, not administrative agencies, to lay down the governing principles of law." (*Garamendi v. Mission Ins. Co.* (2005) 131 Cal.App.4th 30, 41.) Pure issues of law are always subject to independent appellate court determination. (*Stermer v. Bd. of Dental Exam'rs* (2002) 95 Cal.App.4th 128, 132–133.)

IV. LAW REGARDING MEDICAID, FQHCs AND ALLOWABLE COSTS

Except where otherwise indicated, the following ten paragraphs are quoted verbatim from *Tulare Pediatric Healthcare Center v State Dept. of Health Care Services* (2019) 41 Cal. App 5th 163, at pages166–168. The customary external quotation marks are not used.

Medicaid is a federal program subsidizing state spending on medical care for the poor. (42 U.S.C. § 1396–*1*; 42 C.F.R. § 430.0 (2019).) To get Medicaid funds, states must agree with the federal government to spend the funds in accord with federally imposed conditions. (42 C.F.R. § 430.10 (2019); see also *Armstrong v. Exceptional Child Ctr., Inc.* (2015) 575 U.S. 320….) And states must match federal dollars with their own, at a rate set by Congress. (42 U.S.C. §§ 1396a, 1396b.)

Federal regulations require each participating state to adopt a "State plan" outlining how it will follow federal Medicaid rules. (42 C.F.R. § 430.10 *et seq.* (2019)) States develop standards to determine who qualifies for medical assistance under their State plan. (42 U.S.C. § 1396a(a)(17).)

Medicaid beneficiaries are people getting medical assistance under a state plan (State plan).

Alongside Medicaid, a similar but independent federal program subsidizes health care by awarding grants to federally qualified health centers. This is under the aegis of the *Public Health Service Act. (*42 U.S.C. § 254b.) Health centers like [Family Health] qualify for grants by providing primary health services—immunizations, prenatal care, and the like—to medically underserved communities. (§ 254b.) Some in these underserved communities are also Medicaid beneficiaries. (See *Cmty. Health Care Ass'n of N.Y. v. Shah* (2d Cir. 2014) 770 F.3d 129, 136 *(Cmty. Health)*.)

When Congress authorized grants for health centers under the Public Health Service Act, it expected states to reimburse centers for all or part of the centers' cost of treating Medicaid beneficiaries. (See Pub.L. No. 94–63, § 330 (July 29, 1975) 89 Stat. 304; *Cmty. Health*, *supra*, 770 F.3d at p. 136[the grant program for health centers was established in 1975 as section 330 of the Public Health Service Act, now codified at 42 U.S.C. § 254b].) Congress heard testimony that, on average, states' payments covered less than 70 percent of the centers' cost of treating Medicaid beneficiaries. (H.R.Rep. No. 101–247, 1st Sess., p. 392 (1989), reprinted in 1989 U.S. Code Cong. & Admin. News, p. 2118; see also *Cmty. Health*, *supra*, at p. 136.)

Congress was concerned that, because Medicaid fell short of covering the full cost of treating its own beneficiaries, health centers would use Public Health Service Act grants to subsidize treatment of Medicaid

patients. (H.R.Rep. No. 101–247, 1st Sess., pp. 392–393 (1989), reprinted in 1989 U.S. Code Cong. & Admin. News, pp. 2118–2119.) This practice compromised the centers' ability to care for those without any public or private coverage whatsoever, who were the very people Congress sought to help when it passed the Public Health Service Act. (See *ibid.*) So Congress amended Medicaid rules to require states to pay health centers 100 percent of their costs for a defined list of services. (H.R.Rep. No. 101–247, 1st Sess., p. 393 (1989), reprinted in 1989 U.S. Code Cong. & Admin. News, p. 2119; see also *Three Lower Cntys. Cmty. Health Servs., Inc. v. Maryland* (4th Cir. 2007) 498 F.3d 294, 297–298 *(Three Lower Cntys.)*.)

This situation has created a complex payment structure: one funding source is a *combination* of federal and state funding, while another is *solely* federal. That is, a combination of federal and state funds support care for patients who are Medicaid beneficiaries. But federal funds alone support care for patients without any health coverage, because those monies come from Public Health Service Act grants, which are strictly federal in origin. (See *Alameda Health Sys. v. Ctrs. for Medicare & Medicaid Servs.* (N.D.Cal. 2017) 287 F.Supp.3d 896, 902.)

This scheme continues to the present day, with a modification for administrative purposes. The modification was in 2000, when Congress adopted a "prospective payment system" [PPS] to relieve health centers from the burden of providing new cost data every year. (*Three Lower Cntys.*, *supra*, 498 F.3d at p. 298.) Under this new [PPS] system, health centers that become federally qualified after 2000, including [Family Health], receive Medicaid payment equal to "100 percent of the costs of furnishing [defined] services" during their first year. (42 U.S.C. § 1396a(bb)(4).) In later years, payment is increased by a set percentage and is adjusted only to account for changes in the scope of the centers' services. (§ 1396a(bb)(3).)

Federal law gives states different ways of determining "100 percent of the costs of furnishing [defined] services" in the initial year. One option—the one pertinent here—is to determine the costs according to "the regulations and methodology" for centers federally qualified before 2000. (42 U.S.C. § 1396a(bb)(4).) That method requires states to pay "an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center … of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services." (§ 1396a(bb)(2).)

California incorporated these rules into its Medicaid program, which is Medi-Cal. (Welf. & Inst. Code, § 14063, § 14132.100, subd. (i)(3).) The State Department of Health Care Services administers Medi-Cal and audits payments to health centers. (§ 14100.1, § 14170, subd. (a)(1).)" [End of quotation from *Tulare Pediatric Healthcare Ctr. v. State Dept. of Health Care Servs.* (2019) 41 Cal.App.5th 163, 166–168.]

Pursuant to Welfare and Institutions Code sections 14132,100, subdivision (c), FQHCs are reimbursed by Medi-Cal on a per-visit basis. Subdivision (d) thereof provides that effective October 1, 2004, an FQHC's rate per visit shall be increased by an amount specified in the Medicare Economic Index for primary care services. Subdivision (e) (1) permits FQHCs to apply for an adjustment to its per visit rate based on a change in the scope of services ("COS") it provides. The balance of subdivision (e) describes the circumstances which constitute a qualifying COS. There is no dispute that a qualifying event for the COS at issue here occurred. Rather, the parties disagree as to whether outreach costs were properly included as allowable in Family Health's COS rate setting cost report.

Pursuant to section 14132.100, subdivision (e)(1), the allowability of costs included in an FQHC rate setting cost report is determined under the same reimbursement principles found in 42 Code of Federal Regulations part 413.

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).)

Of particular significance to this case is a set of federal guidelines known as the Provider Reimbursement Manual ("PRM"),[7] pursuant to which advertising costs are allowable if they are "incurred in connection with the provider's public relations activities [and are] primarily concerned

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[7] 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.) Pertinent portions of Chapter 21 of the PRM can be found in the record at AA pdf page numbers 80-92, or Bates stamp pages 57-69.) The entire PRM can be found online at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929. According to DHCS in this case, "the Department correctly relies on [the PRM] as guidance when determining allowable costs …, since the PRM is the federal Secretary of Health and Human Services' own interpretation of federal Medicare regulations" (RB 33) and "the PRM clearly applies to this matter and was appropriately relied on as guidance by the Department." (RB 50.)

with the presentation of a good public image and directly or indirectly related to patient care. Examples [of permitted advertising costs] 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 seek 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); italics and bolding added.)

V. STATEMENT OF THE CASE

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 pursuant to a COS. (Welf. & Inst. Code, § 14132.100, subds. (e)(1) and (2).; AA 444–453.) A DHCS auditor reclassified $75,032 total of salary benefit expenses for community outreach services to a non-reimbursable cost center. (AA 470–478.) Family Health then notified DHCS of its intent to appeal that determination and an "informal hearing" before a hearing officer resulted in sustaining the adjustment.[8] (AA 418–419.) Family Health followed by requesting a formal hearing, which was held on October 24, 2017. A proposed decision was issued on May 16,

[8] "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.)" (*Robert F. Kennedy Med. Ctr. v. Belshe* (1996) 13 Cal.4th 748, 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.)

2018, concluding outreach activities were not related to patient care, and therefore not properly included in determining the Medi-Cal rate. (AA 120–131.) In support of this conclusion, the administrative law judge (ALJ) invoked guidelines found in the PRM regarding advertising and characterizing Family Health's outreach activities as "patient recruitment." (AA 130.) The tentative decision was then adopted by the Chief ALJ on May 22, 2018. (AA 119.) Family Health's petition for reconsideration resulted in an "Order and Decision Upon Reconsideration" dated July 2, 2018, affirming the ALJ's decision. (AA 77–91.)

On August 13, 2018, Family Health filed a petition for writ of mandate in the Sacramento County Superior Court. (AA 3–8.) After briefing was completed, a tentative decision was issued on March 28, 2019, denying the petition for writ of mandate. (AA 1400–1407.) The parties waived argument and the tentative decision became final. (AA 1398.) Counsel for DHCS was directed to prepare a formal order and a separate judgment incorporating the court's ruling. (AA 1398.) Judgment was entered on April 22, 2019 (AA 1408–1409) and Notice of Entry of Judgement was served by mail on May 8, 2019. (AA 1421–1422.) Family Health filed its notice of appeal from judgment on May 15, 2019. (AA 1437–1438.)

DHCS argued on appeal that outreach costs were not allowable because (1) they were not "related to" the care of Medicare beneficiaries for purposes of 42 C.F.R. 413.9,[9] and (2) outreach constituted advertising to the

[9] Subdivision (a) of 42 C.F.R. § 413.9 provides that "[a]ll payments to providers of services must be based on the reasonable cost of services covered under Medicare and *related to* the care of beneficiaries." (Italics added.) The term "reasonable cost" is defined therein to include "all necessary and proper costs incurred in furnishing the services…." (*Id.*) Subdivision (b) explains that "[t]he regulations in this part take into account both direct *and indirect costs* of providers of services." (Italics added.) Subdivision (c)(3) indicates that "reasonable costs" are not limited to the medical services themselves, but broadly "includes *all* necessary and proper

general public and therefore unallowable pursuant to PRM section 2136.2. The Court of Appeal adopted the second argument, basing its affirmance exclusively on the perceived applicability of PRM section 2136.2. (*Family Health Ctrs. of San Diego v. State Dept. of Health Care Servs.* (2021) 67 Cal.App.5th 356, 368 *(Family Health Ctrs.)*.)

In opposing DHCS's argument that outreach was not "related to" the medical services to which outreach pertained, Family Health emphasized that in determining legislative intent courts begin by looking at the language employed with the assumption that its ordinary meaning accurately expresses the legislative purpose. (*Morales v. TWA* (1992) 504 U.S. 374, 383.) The words "relating to" are universally given a broad meaning, such as "'to stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with,' Black's Law Dictionary 1158 (5th ed. 1979 - - and the words thus express a broad…purpose." (*Ibid.*) As stated in *Coregis Ins. Co. v. Am. Health Found.* (2d Cir. 2001) 241 F.3d 123:

> "The term 'related to' is typically defined broadly and is not necessarily tied to the concept of a causal connection. Webster's Dictionary defines 'related' simply as 'connected by reason of an established or discoverable relation.' Webster's Third New International Dictionary [1986] at 1916. The word 'relation' in turn, as 'used especially in the phrase "in relation to,"' is defined as a 'connection' to or a 'reference' to." (*Id*. at p.129.)

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expenses incurred in furnishing services, *such as* administrative costs, maintenance costs, and premium payments for employee health and pension plans." (Italics added.) Necessary and proper costs "are usually costs that are common and accepted occurrences in the field of the provider's activity." (Subd. (b)(2).)

Given the broad meaning of the words "related to," Family Health argued on appeal, *inter alia*, that at a bare minimum there is "some relation" or "connection" between informing specific individuals how to obtain medical services (outreach) followed by those same people obtaining those medical services, necessarily making outreach "related to" those services for purposes of 42 C.F.R. § 413.9.

In the end, the Court of Appeal did not reject Family Health's argument that outreach communications about available medical services are "related to" providing those same services for purposes of 42 C.F.R. § 413.9. Instead, the Court based its affirmance solely on the erroneous application of PRM section 2136.2, asserting that outreach was "akin to advertising" to the general public, as follows:

> "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." (PRM § 2136.2 (rev. 267, 09–82); see *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 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." 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*." (*Family Health Ctrs.*, *supra*, 67 Cal.App.5th at pp. 368–369; italics added.)

Following the denial of Family Health's Petition for Rehearing (also modifying the original slip opinion), and order certifying of the opinion for

publication, Family Health timely filed a Petition for Review in the California Supreme Court, which was granted by order dated November 17, 2021.

VI. PERTINENT FACTS REGARDING FAMILY HEALTH'S OUTREACH

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,[10] 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 Family Health training manual for outreach workers identifies five steps to an "outreach encounter" with each individual, as follows:

> "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;

[10] Hearing exhibit Z. (AA 319-322:14 and 1150 et seq.)

> 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 if possible, providing appropriate 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 worker 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" (AA283/306) 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 Family Health clinic site at issue is located in one of the most diverse areas of the country, which includes people of Sudanese, Somali, Latino and Ethiopian origin, and "the list goes on" from there. (AA 283.) Students at the middle school across the street from the clinic speak 57 different languages. (*Id*.) So, again, effective outreach cannot be conducted in the form of mass communication to the general public. (AA 283–284.) Advertising to the general public about available healthcare through Medi-Cal programs would neither reach the vulnerable people in this segment of society nor be effective. Reaching such medically underserved individuals requires the "boots on the ground" approach that constitutes outreach. (AA 323:21–23.)

The testimony of Family Health's CEO referenced a letter[11] 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 284:24–285:3.) 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 from Title 42, of the Public Health and Welfare statute.[12] She elaborated in reference to both exhibits that "[t]he federal government requires outreach and the direction from Sally Richardson says that state Medicaid directors will consider outreach an allowable service and the Community Health Center Fund, which is appropriated by Congress through the Department of

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

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

Health and Human Services, states how money will be transferred to the Community Health Center Program." (AA 286:1–7.) She noted that exhibit K indicates what primary health services are required, one of which is "services that enable individuals to use the services of the health center (*including outreach*…)." (AA 286:23–25; 800–801; italics added.) She 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 healthcare." (AA 287:20–23.)

Each Family Health outreach worker used an activity log[13] listing location, hours and contacts conducted. (AA 633.) This form includes the name of the particular 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 very limited segment of society. It is not remotely akin to advertising to the general public.

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

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

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.*)

VII. LEGAL ARGUMENT

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

As noted, section 2136.2 of the PRM 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.)

The appellate court's analysis essentially ignored the words "advertising to the general public" at the beginning of PRM 2136.2 and seized only 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*." (*Family Health Ctrs.*, *supra*, 67 Cal.App.5th at pp. 368–369; italics added.)

The crucial point overlooked in the above analysis is that even if Family Health's outreach efforts resulted in new patients utilizing its 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 outreach. These were "boots on the ground" interpersonal encounters between a Family Health worker and one or a few individuals at a given time. They were "individual interactions." (AA 269.) 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. Each encounter typically involved the outreach worker addressing the individual's particular medical needs and arranging an appointment, involving, for example, a venipuncture, a pregnancy test, entry into the prenatal program and a host of other procedures and activities. (AA 271:5–19; 651.) By no stretch of imagination or linguistic twist can these individualized encounters properly 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 them and how to obtain it. These encounters occurred on the streets, in homeless shelters or other similar close-quarter settings. If these outreach efforts succeeded in drawing impoverished people to clinics to receive healthcare services, their costs are not made

unallowable by 2136.2 because they do not consist of "advertising to the general public." Aside from the fact that Family Health's outreach activities defied 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.

Further, 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. Nat'l 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.

B. Pertinent Rules of Statutory Construction Compel a Rejection of the Appellate Court's Analysis and DHCS's Position

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*." (*Family Health Ctrs.*, *supra*, 67 Cal.App.5th at p. 369.)

Thus, the appellate decision disregarded both the specific language of section 2136.2 that limits its applicability to "advertising *to the general public*" and the fact that Family Health's outreach activities were not directed to the general public, by describing them as "akin to advertising" because they had the effect of increasing patient utilization. Besides the fact that increasing patient utilization is not a dispositive issue (since that outcome must be accomplished by advertising *to the general public* to be disallowed), 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 & Cnty. of San Francisco v. Farrell* (1982) 32 Cal.3d 47, 54; *California Mfrs. Assn. v. Pub. Utils. 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 words "to the general public" 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 in this case, which 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 by the Court of Appeal. Therefore, Family Health respectfully requests that its erroneous judgment be reversed.

VIII. CONCLUSION

Crucial flaws in the appellate court's analysis led to an erroneous decision. The record establishes that the individualized outreach activities at issue, conducted on a one-on-one basis with Medi-Cal eligible individuals, did not constitute "advertising" in any sense of the word. Moreover, 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 conclude 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. The at-risk individuals to whom outreach was directed were 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 the costs unallowable for purposes of reimbursement.

Disallowing FQHC outreach costs would 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. Thus, the position of DHCS, adopted by the Court of Appeal, excluding outreach costs from an FQHC's rate setting determination, would leave many destitute Californians without the healthcare needed to avoid serious illness or death.

For the reasons stated, and on the authorities cited hereinabove, Family Health respectfully urges this Honorable Court to reverse the judgment of the Court of Appeal.

Murphy, Campbell. Alliston & Quinn

Respectfully submitted,

Dated: January 21, 2022

By: /s/ George E. Murphy

George E. Murphy

Attorney for Plaintiff and Appellant
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Murphy, Campbell, Alliston & Quinn

Dated: January 21, 2022

By: /s/ George E. Murphy

George E. Murphy

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California Court of Appeal, Third District

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