No. S270326

# In the Supreme Court of the State of California

FAMILY HEALTH CENTERS OF SAN DIEGO,
*Plaintiff and Appellant,*

v.

STATE DEPARTMENT OF HEALTH CARE SERVICES,
*Defendant and Respondent.*

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

## ANSWER BRIEF ON THE MERITS

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## INTRODUCTION

The Medicaid program, operated in California as Medi-Cal by the state Department of Health Care Services, reimburses healthcare providers for certain services they provide to patient beneficiaries, in accordance with federal law. The burden is on the provider to establish that a claimed cost is eligible for reimbursement. The issue presented here is whether the Department must reimburse plaintiff and appellant Family Health Centers of San Diego (Family Health) for the costs associated with what Family Health describes as "outreach." The relevant federal guidance in this area, the Provider Reimbursement Manual (PRM), does not use the term "outreach" or directly address whether expenditures designated by a provider as outreach costs are eligible for reimbursement. But the PRM does include an extensive and detailed discussion regarding whether and when a healthcare provider's costs for "advertising costs" are "allowable"—that is, reimbursable.[1]

Under these provisions of the PRM, which the parties agree governs this dispute, advertising costs are allowable in some, but not all, instances. Whether costs are allowable depends primarily on the content and context of the advertising. For example, "[a]dvertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a

[1] A copy of the PRM is available at https://tinyurl.com/4cck862d [as of March 23, 2022]. The PRM provisions most relevant to this case are reproduced in the appendix to this brief.

good public image and directly or indirectly related to patient care." (PRM § 2136.1.) But the "[c]osts of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable." (*Id.* § 2136.2.) Determining whether a provider's costs are allowable under these principles requires a nuanced, case-specific analysis of the advertising communications at issue, requiring the provider to present sufficiently detailed documentation to establish that its claimed costs are eligible for reimbursement.

In this case, however, that is not the approach Family Health took. It sought blanket reimbursement for all of the salary and benefit costs of its outreach workers. Family Health provided the general job descriptions of these workers and documented the number of outreach interactions each worker had, but it offered minimal evidence regarding the content and context of the outreach communications themselves. And the evidence indicated that the purpose of the communications was to bring new patients into Family Health's system—that is, to increase the utilization of its facilities, contrary to what the PRM allows. Under these circumstances, it was not an abuse of discretion for the Department's chief administrative law judge to conclude that Family Health had failed to show that its outreach costs were eligible for reimbursement.

There is no question that the work Family Health does is vital. It is a federally qualified health center (FQHC)—a type of healthcare provider that offers primary care services in disproportionately low-income and at-risk communities, and that

receives special federal grants to help fund its operations. That does not mean, however, that all of Family Health's outreach costs are eligible for reimbursement. Some may be with proper documentation, and nothing in the decision below or the ALJ's ruling prevents Family Health or other providers from seeking reimbursement for the costs of specific types of outreach that are allowable under the PRM provisions governing advertising costs. And for outreach costs that cannot be reimbursed under Medi-Cal, FQHCs have access to separate federal grants and state appropriations that may be used to pay for these activities. Thus, while the Department correctly denied Family Health's claim for reimbursement on the particular evidentiary record in this case, other avenues will remain available for FQHCs and other Medi-Cal providers to conduct appropriate community outreach.

## LEGAL BACKGROUND

### A. Medicaid and Medi-Cal

Medicaid is a cooperative federal-state program that provides medical care for those in need, including low-income, aged, blind, and disabled persons. (*Nat. Fed. of Independent Business v. Sebelius* (2012) 567 U.S. 519, 541.) The voluntary program is administered by States but funded in substantial part by the federal government. (*Id.* at pp. 541-542.) States that choose to participate receive federal funds to reimburse healthcare providers that furnish services to program beneficiaries, conditioned on the States' meeting a variety of federal statutory and regulatory requirements. (See *Robert F. Kennedy Medical Center v. Belshé* (1996) 13 Cal.4th 748, 751; 42 U.S.C. § 1396a.)

In order to receive funding, a State must submit a State Medicaid Plan for approval to the Centers for Medicare and Medicaid Services (CMS), an agency within the federal Department of Health and Human Services (HHS). A State must comply with the provisions of its approved State Plan, as well as applicable federal Medicaid laws and regulations. (See 42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 431.1, 431.10.) The Medicaid Act requires that all State Plans: (1) delineate the nature and scope of services covered in the State's Medicaid program; (2) reimburse providers for furnishing covered services under the State Plan to eligible beneficiaries in compliance with federal reimbursement standards; and (3) provide for audits to ensure only proper and necessary reimbursement payments are made to providers for those covered services under the State Plan. (See 42 U.S.C. §§ 1396a(a)(10), (a)(27), (a)(30)(A), (a)(42); 42 C.F.R. § 413.9; *Physicians & Surgeons Laboratories, Inc. v. Dept. of Health Services* (1992) 6 Cal.App.4th 968, 983.)

In California, the Department of Health Care Services is the state agency responsible for administering Medi-Cal, the State's implementation of the federal Medicaid program. (Welf. & Inst. Code, § 14203.) The Department reimburses healthcare providers for the costs of providing care to Medi-Cal beneficiaries in accordance with the Medicare/Medicaid reimbursement principles set forth in the Code of Federal Regulations and the Provider Reimbursement Manual (PRM), which define what costs are "allowable." (Welf. & Inst. Code, § 14132.100, subds. (e)(1) & (*i*)(2)(B)(ii); see Cal. Code Regs. tit. 22, § 51536, subd. (a)(2);

*Oroville Hospital v. Dept. of Health Services* (2006) 146 Cal.App.4th 468, 472.)[2] The PRM sets forth CMS's interpretations of the pertinent federal regulations. (See *Community Care Found. v. Thompson* (D.D.C. 2006) 412 F.Supp.2d 18, 22-23.)

Under federal law, in order for a cost to be allowable, 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).) "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." (*Id.* § 413.9(c)(3).) The regulations further define "necessary and proper costs" as "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." (*Id.* § 413.9(b)(2).)

When a provider seeks reimbursement for costs related to the care of beneficiaries, "[t]he burden of proof is on the provider seeking reimbursement to demonstrate whether a cost is eligible for reimbursement." (*Visiting Nurse Ass'n v. Thompson* (1st Cir. 2006) 447 F.3d 68, 77, citing 42 C.F.R. §§ 413.20, 413.24; see also, e.g., *Pac. Coast Med. Enterprises v. Dept. of Benefit Payments* (1983) 140 Cal.App.3d 197, 212.) In so doing, the provider

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[2] As a technical matter, reimbursement is generally made through a fixed "per-visit" rate, which is calculated by adding together all of a provider's allowable costs in the year before the rate setting, then dividing that amount by the provider's total number of Medi-Cal patient visits in that year. (See 42 U.S.C. § 1396a(bb)(1)-(3).)

generally must present evidence—in the form of documents, witness testimony, or both—showing that the claimed costs fall within one of the categories designated as allowable under the federal regulations and the PRM. (See, e.g., *Oroville Hospital*, *supra*, 146 Cal.App.4th at pp. 471-477.)

While the federal regulations themselves do not directly address whether provider outreach or advertising costs qualify for reimbursement, the PRM specifies that "advertising costs" are allowable in some—but not all—instances. (PRM §§ 2136-2136.2.) Under the PRM, "[t]he allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining, and furnishing covered services" to beneficiaries, in light of the particular "facts and circumstances of each provider situation" and whether the costs are "common and accepted occurrences in the field of the provider's activity." (*Id.* § 2136.) Specifically, "[a]dvertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care." (*Id.* § 2136.1.) "Examples are: visiting hours information, conduct of management-employee relations, etc." (*Ibid.*)

In contrast, "[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.) The PRM explains that "[s]ituations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients," and thus is not an

allowable cost. (*Ibid.*) In these instances, "[a]n analysis . . . of the advertising copy and its distribution may then be necessary to determine the specific objective." (*Ibid.*) "While it is the policy" of the federal government "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." (*Ibid.*)

Apart from these categories of advertising costs expressly designated as allowable, the PRM generally advises that the "[c]osts of advertising for any purpose" not specifically addressed as non-allowable in the PRM "may be allowable if they are related to patient care and are reasonable." (PRM § 2136.1.)

### B. Federally qualified health centers

Federally qualified health centers (FQHCs) are healthcare providers that receive grants under the Federal Public Health Service Act because they provide primary care services in underserved areas and to individuals who might otherwise be unable to afford or access care. (See generally 42 U.S.C. §§ 254b, 1395x(aa)(4).) To qualify as an FQHC, an entity must provide services to "a population that is medically underserved," such as "migratory and seasonal agricultural workers, the homeless, and residents of public housing" (*id.* § 254b(a)(1)), as well as "low-income populations, the uninsured, [and] individuals with limited English proficiency" (74 Fed. Reg. 66207, 66207 (Dec. 9, 2009)).

As a condition of receiving federal grant funding, FQHCs must provide certain "required primary health services," and may provide additional services as well. (42 U.S.C. § 254b(a)(1)(A)-

(B).) Required primary health services generally include "basic health services" such as "family medicine, internal medicine, pediatrics, obstetrics, or gynecology." (*Id.* § 254b(b)(1)(A)(i).) FQHCs must also provide referrals for specialty and other health services, including substance abuse and mental health services, as well as "patient case management services," "outreach and transportation services," and "education of patients and the general population served by the health center regarding the availability and proper use of health services." (*Id.* § 254b(b)(1)(A)(ii)-(v).)

Congress has established a "dual funding mechanism" for FQHCs, allowing them to receive both federal grants and Medicare and Medicaid reimbursement. (*Community Health Care Assn. of N.Y. v. Shah* (2d Cir. 2014) 770 F.3d 129, 136 (*Shah*).) When FQHCs treat patients who are beneficiaries of those programs, FQHCs receive reimbursement from the government for allowable costs. (*Ibid.*) The grants FQHCs receive are separate from Medicare and Medicaid reimbursement, and may be used to fund activities that do not qualify for reimbursement or to provide care to individuals who are not Medicare or Medicaid beneficiaries. (*Ibid.*; see 42 U.S.C. § 254b(e).)

## STATEMENT OF THE CASE

Family Health Centers of San Diego (Family Health) operates an FQHC that provides medical services to its patients, some of whom are Medi-Cal beneficiaries. (Appellant's Appendix (AA) 145.) The dispute in this case arose when the Department

conducted an audit of Family Health's cost report for the 2013 fiscal year. (AA 467-476; see Welf. & Inst. Code, § 14132.100, subd. (*i*)(3)(C).) After evaluation, the Department's auditor reclassified as non-reimbursable costs in the amount of $78,032 for salary and benefit expenses for employees engaged in what Family Health described as "Outreach Services." (AA 503-506.) The auditor reviewed the materials Family Health submitted in support of its claim, including the job description for the relevant positions and salary details. (AA 503.) He determined that the expenses were not allowable because Family Health had provided "insufficient documentation that the costs of the outreach services" were "incident to a[n] FQHC visit"; thus, Family Health had not shown that the outreach costs were related to patient care under the reimbursement principles set forth in federal regulations and the PRM. (AA 506.)

Family Health filed an administrative appeal and requested a formal hearing, which was held in October 2017. (AA 424-434, 441-442; see AA 257-400 [hearing transcript].) At the hearing, Family Health's CEO Fran Butler-Cohen provided some limited additional information regarding the costs at issue. (AA 289-359.) She testified generally that Family Health's outreach workers "go into the community" and "are required to make medical appointments for the people they come into contact with." (AA 293.) The workers must "invest[] the necessary time and attention to those patients to get them into the system." (*Ibid.*) Ms. Butler-Cohen introduced records showing the number of interactions for each outreach worker and whether those

contacts resulted in medical appointments. (AA 292-295; see AA 658-721.)

Following that hearing, an administrative law judge issued a proposed decision agreeing with the auditor's determination that the costs were not allowable (AA 159-173), and in May 2018 the chief ALJ adopted that proposed decision as the Department's final decision (AA 142-157). The chief ALJ noted that the evidence showed that the "outreach" costs for which Family Health sought reimbursement "involve a broad range of activities, taking place 'in the street, in schools, in agencies, business venues,'" as well as "bars, bathhouses, clubs," and "other public venues such as beaches and parks." (AA 145-146.) The costs entailed "[o]utreach staff" seeking to "promote awareness of the health center's services and support entry . . . of the new patients contacted" into Family Health's facilities. (AA 146.) Based on this evidence, the chief ALJ found that "[t]he 'community outreach services' in question are efforts to attract new patients and increase patient utilization of [Family Health's] available services among the community, but do not involve direct patient care." (AA 145.)

The chief ALJ reasoned that while "the PRM does not speak to patient recruitment efforts under the label of 'Outreach,' it does address them under the broader heading of 'Advertising Costs.'" (AA 153.) Applying those provisions of the PRM, "[b]ecause [Family Health's] outreach work is performed specifically to bring new patients into the facilities, it is not reimbursable as part of the Medi-Cal rate." (*Ibid.*) The chief ALJ

further observed: "This is not to say that it is an impermissible activity or that it does not serve a purpose—indeed, it appears that [Family Health] has received funding from other sources" for such outreach, "but it is outside the scope of . . . Medi-Cal reimbursable activities." (*Ibid.*)

Family Health sought reconsideration (AA 124-126), but the chief ALJ denied that request (AA 100-117). In that ruling, she specifically addressed Family Health's argument that its outreach costs are allowable under the provisions of the PRM governing advertising costs. She explained that "even if this tribunal were to accept this argument," Family Health still bore the burden of "demonstrating that its outreach costs are 'primarily concerned with the presentation of a good public image and directly or indirectly related to patient care.'" (AA 112, quoting PRM § 2136.1.) But Family Health "was unable to offer sufficient documentation to establish that its outreach activities were aimed at the goal of presenting a good public image or were directly or indirectly related to patient care. Instead, these costs were centered on patient recruitment." (*Ibid.*)

In August 2018, Family Health filed a petition for writ of mandate in superior court. (AA 26-34.) The court denied that petition in March 2019 on essentially the same grounds as those reflected in the Department's final decision. (AA 1434-1443.) The court agreed that the provisions of the PRM regarding advertising costs apply in this context (AA 1438) and concluded that "[b]ased on the examples listed in the PRM," Family

Health's "outreach activities are unallowable advertising costs and therefore not reimbursable" (AA 1439). "The testimony presented during the administrative proceedings shows that the outreach activities were designed to attract *new* patients" and thus constituted non-allowable costs. (*Ibid.*)

The court of appeal affirmed in a July 2021 decision. (Modification Order 2; Slip Opinion (Opn.) 15.)[3] The court explained that under the PRM, "[a]dvertising 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.'" (Opn. 3-4, quoting PRM § 2136.1, alterations omitted.) "However, 'costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable.'" (Opn. 4, quoting PRM § 2136.2, alterations omitted.)

Applying these principles, the court of appeal "agree[d] with the ALJ, the Chief ALJ, and the trial court" that the costs were not allowable based on the evidence Family Health presented. (Opn. 13.) That evidence showed that Family Health's "outreach efforts involve going into public spaces such as on the street, at schools, business venues, beaches, and parks to

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[3] The court of appeal issued its opinion on July 6, 2021 and issued an order modifying that opinion (without changing the judgment) on July 27, 2021. (See Petition for Review, Exs. A-B.) On July 30, 2021, the court of appeal ordered that the opinion be published. (See *id.*, Ex. C.)

attract new patients from its audiences within the general public," as well as to "provide counseling regarding eligibility for services" and to "make medical appointments." (Modification Order 1-2; Opn. 13.) The court concluded that "[i]t was not an abuse of discretion" for the administrative law judges and the trial court "to find that such activities had the purpose and effect of bringing in new patients and increasing utilization of [Family Health's] facilities, making them akin to advertising." (Opn. 14.) The court noted that federal law requires FQHCs to engage in community outreach and that such outreach may be beneficial, but these considerations "do[] not automatically make the associated costs reimbursable under Medicare (or Medi-Cal), even if they provide a benefit for the recipient." (Opn. 13-14.)

This Court granted Family Health's petition for review on November 17, 2021.

## ARGUMENT

In administering the Medi-Cal program, the Department reimburses healthcare providers for activities related to the medical care of beneficiaries. Federal regulations and agency guidance—specifically the PRM, which the parties agree applies here—specify that a healthcare provider's advertising costs are allowable in some, but not all, instances. Advertising generally qualifies for reimbursement under the PRM if it seeks to (for example) foster a good public image, educate Medi-Cal beneficiaries about the services the program offers, or provide important information such as a provider's operating hours. But the costs of advertising to the general public seeking to increase

utilization by new patients of the provider's facilities are not allowable.

As the PRM expressly contemplates, the distinction between allowable and non-allowable advertising costs typically requires a nuanced factual analysis of the content and context of a provider's advertising to determine whether its costs are allowable. A provider bears the burden of offering documentation sufficient to establish that its claimed costs are allowable. In this case, two ALJs concluded that Family Health had failed to carry this burden, and the trial court and court of appeal upheld that ruling. Family Health sought reimbursement for the salaries and benefits of its outreach workers under the theory that outreach costs are categorically allowable, but the PRM does not support that blanket approach. The limited evidence Family Health presented regarding the content and context of its outreach indicated that the communications at issue sought to bring new patients into its system—that is, to increase the utilization of its facilities. And there was no evidence that some or all of the communications served any other purpose. Under the particular circumstances of this case, the Department did not abuse its discretion in determining that the costs at issue were not allowable.

Family Health and its amici raise a significant policy concern, namely that denying reimbursement for the costs at issue here will cause FQHCs to reduce their community outreach activities. The Department agrees that outreach by FQHCs is important, given the populations they serve, but this concern

does not provide a sound basis for reversing the judgment below. Some forms of outreach, if properly itemized and documented by the provider, will constitute allowable costs under the PRM. FQHCs also receive other funding, through federal and state grants and appropriations, that may be used to pay for the costs of advertising or outreach activities that do not qualify for Medicare or Medicaid reimbursement. Thus, while the Department correctly denied Family Health's claim for reimbursement here, FQHCs and other healthcare providers will continue to have access to funding that can be used to raise awareness among Medi-Cal beneficiaries of the healthcare services available to them.

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

### A. Standard of review

Where, as here, a party seeks a writ of administrative mandamus, an "[a]buse of discretion is established" if the 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." (Code Civ. Proc., § 1094.5, subd. (b).) Unless the trial court "is authorized by law to exercise its independent judgment on the evidence," the agency's factual findings must be upheld if "supported by substantial evidence in the light of the whole record." (*Id.*, subd. (c); see *State Bd. of Chiropractic Examiners v. Superior Court* (2009) 45 Cal.4th 963, 977.) In cases governed by the substantial-evidence standard, an appellate court "reviews not the trial court's ruling," but rather

the agency's "final administrative decision." (*TG Oceanside, L.P. v. City of Oceanside* (2007) 156 Cal.App.4th 1355, 1370.)

Here, because the trial court was not authorized to exercise independent-judgment review, the Department's factual findings are reviewed for substantial evidence, "resolving all conflicts in the evidence and drawing all inferences in support of" the agency's finding. (*Golden Day Schools, Inc. v. Office of Admin. Hearings* (2017) 8 Cal.App.5th 1012, 1020.) Legal questions receive de novo review. (*City of Marina v. Bd. of Trustees of Cal. State Univ.* (2006) 39 Cal.4th 341, 355-356.)[4]

### B. Family Health's reimbursement claim is governed by the provider reimbursement manual's provisions regarding advertising

As noted, federal regulations provide that a healthcare provider's costs are allowable for Medicare and Medicaid reimbursement purposes if the costs are "based on the reasonable cost of [covered] services" and "related to the care of beneficiaries." (42 C.F.R. § 413.9(a); see *ante*, p. 14.) But the

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[4] Because the PRM is federal (not state) regulatory guidance, the Department does not contend that its interpretation of the PRM provisions at issue here is entitled to any type of formal administrative deference. (See *Oak Valley Hospital Dist. v. State Dept. of Health Care Services* (2020) 53 Cal.App.5th 212, 224-225.) Nonetheless, even absent formal deference, the Department respectfully submits that this Court should approach the issue with "due regard for the agency's expertise and special competence" and that the Department's interpretation should be adopted because of its persuasive force. (*Alvarado v. Dart Container Corp.* (2018) 4 Cal.5th 542, 559; see *id.* at pp. 561-568 [adopting agency position notwithstanding lack of formal deference].)

federal regulations on their own are insufficient to resolve this case. The open-ended textual provision "related to the care of beneficiaries" provides limited guidance because "as many a curbstone philosopher has observed, everything is related to everything else." (*Maracich v. Spears* (2013) 570 U.S. 48, 60.)

The issue presented in this case is whether Family Health adequately established that the full costs of a provider's "'outreach' activities"—here, the costs of the salaries and benefits of employees who make in-person contacts with individuals in the provider's community regarding the healthcare services the provider offers—are allowable for purposes of Medi-Cal reimbursement. (Opening Brief on the Merits (OBM) 6.) Neither the federal regulations nor the PRM discuss outreach costs. But Chapter 21 of the PRM does contain extensive guidance regarding whether and when a provider's "advertising costs" are allowable. (PRM §§ 2136-2136.2.) The court of appeal, the trial court, and the ALJs all focused principally on these provisions. (Opn. 3-4, 14; AA 1438-1439 [trial court]; AA 112, 153 [ALJ rulings].) Family Health likewise agrees that these provisions should guide the Court's analysis here. (OBM 13-14 & fn. 7.)[5]

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[5] Amici Health Centers suggest that the PRM does not apply to FQHCs. (Health Centers Amicus Letter (Aug. 27, 2021) 6.) Family Health, however, agrees that the PRM should guide the analysis in this case. (See OBM 13-14 & fn. 7, 22-26.) Because the argument that the PRM does not apply to FQHCs is raised only by an amicus, this Court should decline to consider it. (See, e.g., *Prof. Engineers in Cal. Govt. v. Kempton* (2007) 40 Cal.4th 1016, 1047, fn. 12.) In any event, amici Health Centers are wrong in arguing that the PRM does not apply. As the court

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And California courts routinely rely on the PRM to resolve Medi-Cal reimbursement disputes. (See, e.g., *Oak Valley Hospital Dist. v. State Dept. of Health Care Services* (2020) 53 Cal.App.5th 212, 225-236; *Oroville Hospital*, *supra*, 146 Cal.App.4th at pp. 473-477.)

The PRM's guidance regarding advertising costs is particularly relevant because the concepts of outreach and advertising are closely related. To "advertise" is "to make known to (someone)" or "give notice to." (Webster's Third New International Dictionary (2002) 31; see also *ibid.* [alternatively defining "advertising" as "the action of calling something (as a commodity for sale, a service offered or desired) to the attention of the public, esp[ecially] by means of printed or broadcast paid announcements"]; Black's Law Dictionary (11th ed. 2019) [defining advertising as "[t]he action of drawing the public's attention to something to promote its sale"].) Those definitions overlap significantly with Family Health's description of its outreach activities, which it says are designed to "inform[] the medically underserved population of the availability of health care services" and "to bring patients . . . into the health care delivery system." (AA 37-38; accord OBM 7.) And in many

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of appeal correctly recognized (Opn. 3), California law governing reimbursement of FQHCs expressly incorporates "Medicare reasonable cost principles," cross-referencing the federal regulations that the PRM interprets. (Welf. & Inst. Code, § 14132.100, subds. (e)(1), (e)(3)(B); see also Cal. Code Regs. tit. 22, § 51536, subds. (a)(2), (b)(4); *ante*, pp. 13-14.)

contexts, the terms "advertising" and "outreach" are used in tandem or interchangeably. (See, e.g., *Orange Citizens for Parks & Recreation v. Superior Court* (2016) 2 Cal.5th 141, 154.) In the absence of any regulatory guidance expressly covering outreach activities, the PRM provisions regarding advertising costs offer the most detailed, apposite, and reliable source of law to apply in this context.

### C. Family Health's evidence failed to establish that the costs of its outreach activities were allowable advertising costs

Family Health did not attempt to make the case below, and does not contend now, that the outreach costs at issue here fall within any of the specifically defined categories of allowable advertising costs set forth in PRM section 2136.1. (See OBM 22-27.) It is possible that certain forms of outreach, if properly documented, may be allowable under section 2136.1—for instance, if "the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care." (PRM § 2136.1; see *post*, pp. 38-41.) But as the chief ALJ observed, Family Health made no effort to show that its outreach activities at issue here, in whole or in part, meet that standard. (AA 112.)

While the PRM contains a catch-all provision that allows for other advertising costs that are "related to patient care and are reasonable[,]" that provision applies only where the cost is not expressly excluded as non-allowable. (PRM § 2136.1.) The key exclusion at issue here is for a provider's "[c]osts of advertising to the general public which seeks to increase utilization of the

provider's facilities"; these costs "are not allowable." (*Id.* § 2136.2.) Such costs are excluded because "general advertising to promote an increase in the patient utilization of services is not properly related to the care of patients." (*Ibid.*; see also, e.g., *Gosman v. United States* (Ct. Cl. 1978) 573 F.2d 31, 38 [the costs of attracting new patients are "only tangentially or speculatively related to the actual care of . . . beneficiaries"].)

In practice, drawing the line between allowable and non-allowable advertising requires a careful factual analysis of the advertising at issue to determine whether that standard is met. The PRM recognizes as much, explaining that "[s]ituations may occur where advertising which appears to be in the nature of the provider's public relations activities is, in fact, an effort to attract more patients," and an "analysis . . . of the advertising copy and its distribution may then be necessary to determine the specific objective." (PRM § 2136.2.) As discussed below, based on the limited evidence Family Health presented regarding the context and content of its outreach communications, the Department did not abuse its discretion in determining that the activities at issue constituted advertising to the general public seeking to increase utilization of Family Health's facilities.

**1. The activities at issue constitute advertising**

There is no factual dispute regarding the nature of the outreach activities for which Family Health seeks reimbursement. (See OBM 23.) The activities involved Family Health's outreach workers "going into public spaces such as on the street, at schools, business venues, beaches, and parks" and having in-person

interactions with members of the public in order to "attract new patients from its audiences within the general public, provide counseling regarding eligibility for services, and make medical appointments for services." (Modification Order 1-2; Opn. 13; see AA 145-146.) As the ALJ found, "[o]utreach staff are tasked to 'promote awareness of the health center's services and support entry into care' of the new patients contacted." (AA 146.) These activities fit comfortably within the definitions of "advertising" discussed above: they seek to "give notice to" prospective new patients of Family Health's services (Webster's Third New International Dictionary, *supra*, at p. 31) and to "draw[] the public's attention" to those services (Black's Law Dictionary, *supra*).

Family Health contends that these activities "def[y] characterization as 'advertising'" because "the commonly understood meaning of the term 'advertising' connotes '*widespread* promotional activities *usually directed to the public at large*.'" (OBM 24.) Family Health is correct that advertising often includes messages transmitted widely through media such as television and newspapers. But other types of activities, while more targeted, still constitute advertising—such as a contractor mailing flyers to homeowners in a particular zip code, or a food-truck owner passing out discount coupons to workers in a particular building.

This Court has recognized that the definition of "advertising" is context-dependent. For instance, it may include "one-to-one statements of salespeople" to prospective customers. (*Ford*

*Dealers Assn. v. Dept. of Motor Vehicles* (1982) 32 Cal.3d 347, 362.) In *Ford Dealers*, the Court upheld a DMV regulation that defined advertising to include such communications, because "[h]istorically . . . the terms advertising and 'advertisement' have been held to be broad enough to include oral representations made on a one-to-one basis." (*Id.* at p. 359, quoting *Feather River Trailer Sales, Inc. v. Sillas* (1979) 96 Cal.App.3d 234, 248; see *id.* at pp. 356-362.) Likewise, California courts have "repeatedly" held that "oral statements made to individual members of the public" constitute advertising for purposes of the False Advertising Law, Business & Professions Code section 17500. (*Id.* at p. 358.)[6]

Family Health's narrower definition of "advertising" (see OBM 24) relies on a line of cases from the insurance-coverage context where the term has a specialized meaning—most notably *Hameid v. National Fire Insurance of Hartford* (2003) 31 Cal.4th 16. In these cases, courts considered whether a business's insurance company had a duty to defend the business, under the "advertising injury" provision of a commercial general liability policy, in a lawsuit brought by a competitor of the business for soliciting the competitor's customers. (*Id.* at p. 19.) This Court,

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[6] See, e.g., *Chern v. Bank of America* (1976) 15 Cal.3d 866, 870-871, 875-876 [oral statement made by bank employee to prospective customer regarding loan terms]; *People v. Superior Court (Jayhill Corp.)* (1973) 9 Cal.3d 283, 286-288 [door-to-door solicitations by encyclopedia salesmen]; *People v. Conway* (1974) 42 Cal.App.3d 875, 878 [oral representations made by car salesmen].

following the majority rule, concluded that "one-on-one solicitation of a few customers does not give rise to the insurer's duty to defend the underlying lawsuit." (*Ibid.*; see *id.* at pp. 22-30.)

But "a word may have different legal meanings in different contexts" (*Richmond v. Shasta Community Services Dist.* (2004) 32 Cal.4th 409, 422), and the rationale courts offered in the cases Family Health cites for adopting a narrower interpretation of "advertising" does not readily translate outside of the unique context of insurance-coverage litigation. In the "insurance context" in particular (*Hameid*, *supra*, 31 Cal.4th at p. 28), courts have "reasoned that defining 'advertising' to include customer solicitations would stretch too far" because "'[i]f the act of contacting potential customers is advertising for the purposes of the policy, then any dispute related to economic competition among businesses is covered by the policy provision for advertising injury'" (*id.* at p. 24, quoting *Select Design Ltd. v. Union Mutual Fire Ins. Co.* (Vt. 1996) 674 A.2d 798, 803). *Hameid* and other courts also voiced concern that adopting a broader reading of "advertising" in the insurance context "would encourage litigation" and "eliminate the clarity and certainty that is essential to the insurance industry." (*Id.* at p. 29.)

Those industry-specific policy considerations do not apply in the Medi-Cal reimbursement context, where "advertising" is best understood to carry its broader, commonly understood meaning that encompasses individualized solicitations. Many of the examples of advertising discussed in the PRM—such as providing

"visiting hours information," "recruiting medical, paramedical, administrative, and clerical personnel," and "professional contacts with physicians, hospitals, public health agencies . . . and similar groups and institutions, to apprise them of the availability of the provider's covered services" (PRM § 2136.1)—would often be delivered in mailings, email, or orally to one person or a defined group. The specific PRM provision at issue here, moreover, focuses on whether a provider's communications "seek[] to increase patient utilization of the provider's facilities." (*Id.* § 2136.2.) As this case illustrates, new patients can be recruited to increase provider utilization not only through mass media, but through one-on-one solicitations as well. (Cf. *Ford Dealers*, *supra*, 32 Cal.3d at pp. 358-359 [noting that "false and misleading statements to the public" can readily be transmitted orally and in a targeted way, not just disseminated widely through print or broadcast media].)

Family Health also faults the court of appeal for describing its outreach activities as being "akin to" advertising (as opposed to actually being advertising). (OBM 25.) But the outcome in this case should not depend on whether one views the activities as literally being advertising or as merely being "akin to" advertising. Either way, the court of appeal was right to follow the PRM's guidance regarding advertising costs, in light of the significant overlap between outreach and advertising. (See *ante*, pp. 27-28.) Indeed, Family Health apparently does not dispute that outreach activities in fact *are* akin to advertising. (See OBM 25.) But a healthcare provider cannot avoid its burden of

establishing that its advertising costs qualify for reimbursement under the PRM merely by characterizing them as categorically allowable "outreach" costs. (Cf. *United States v. Calhoon* (11th Cir. 1996) 97 F.3d 518, 528-529 [upholding federal false-statement conviction for healthcare executive who sought reimbursement for non-allowable advertising expenses by labeling them "outreach" costs].)

**2. The advertising was directed to the general public**

Substantial evidence supports the Department's factual finding that the advertising activities at issue were directed "to the general public." (PRM § 2136.2.) The evidence showed that the communications at issue involved outreach workers visiting places frequented by the general public, such as "bars, bathhouses, clubs" and "other public venues such as beaches and parks," and talking to individuals they encountered there. (AA 146; see also AA 293 [Family Health's CEO testifying that outreach workers "go into the community"].) These efforts sought to publicize Family Health's "available services among the community." (AA 145.)

Dictionaries define "general public" as "ordinary people in society, rather than people who are considered to be important or who belong to a particular group."[7] Case law confirms that

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[7] Macmillan English Dictionary, https://tinyurl.com/bpajkuxp [as of March 23, 2022]; accord Cambridge Dictionaries Online, https://tinyurl.com/nzxu4jw8 [as of March 23, 2022] [defining "general public" as "ordinary people, especially all the people who are not members of a particular organization or who

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"general public" ordinarily refers to the broad mass of people who lack some salient characteristic—for instance, in the context of pharmaceutical price regulation, customers paying the "prevailing retail price" as opposed to those covered by third-party insurers. (*United States v. Bruno's, Inc.* (M.D.Ala. 1999) 54 F.Supp.2d 1252, 1257; see also, e.g., *First Nat. Bancshares Corp. II v. Bd. of Governors* (6th Cir. 1986) 804 F.2d 54, 57 [regulation defined "debt held by the general public" as "debt held by parties other than institutions, officers, directors, and principal shareholders of banking organizations"].)

In the context of healthcare provider advertising to patients, the most natural understanding of "general public" is that the term distinguishes a provider's existing patients from "the community at large." (See *St. Francis Hospital v. Califano* (D.D.C. 1979) 479 F.Supp. 761, 764 [denying reimbursement for costs of operating telephonic health information service whose use "was not restricted to the [provider's] patients"].) The basic principle that costs must be "related to patient care" in order to be allowable (PRM § 2136.1) suggests a distinction between individuals who are already patients of a provider and those who are not. And here, there is no dispute that Family Health's

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do not have any special type of knowledge"]; cf. Webster's Third New International Dictionary, *supra*, at p. 944 [defining "general" as "applicable or relevant to the whole rather than to a limited part, group, or section"].

outreach entailed communications with prospective "new patients." (AA 146.)

Family Health suggests that its outreach did not involve the general public because it consisted of "interpersonal encounters between a Family Health worker and one or a few individuals at a given time." (OBM 23.) But the term "general public" entails a qualitative distinction, not a quantitative one. A single person or a small group picked at random from a public place still consists of members of the general public. Moreover, adopting an interpretation of "general public" that depends on the number of people a communication reaches would create difficult line-drawing problems. If a provider representative addresses a crowd of 100 people at a community event, or mails flyers to 1,000 residents in its neighborhood, does that constitute advertising to the general public? Family Health's theory offers no guidance on such questions. Nor does it accord with the PRM's distinction between public relations activities related to patient care and increasing utilization of a particular provider's services.[8]

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[8] Family Health argues that the court of appeal improperly "ignor[ed] the words 'to the general public'" in the PRM. (OBM 25.) That is not correct. While the court of appeal initially omitted that phrase from one part of its analysis, the opinion as modified recognizes that the "'costs of advertising *to the general public* which seeks to increase patient utilization of the provider's facilities are not allowable.'" (Modification Order 2, quoting PRM § 2136.2, italics added, alteration omitted; see Opn. 14; see also Opn. 4 [legal background section of initial opinion discussing the same PRM provision].)

### 3. The advertising sought to increase utilization by new patients of Family Health's facilities

Substantial evidence also supports the Department's finding that the outreach sought "to increase utilization of [Family Health's] facilities." (PRM § 2136.2.) The chief ALJ found that "[t]he 'community outreach services' in question are efforts to attract new patients and increase utilization of [Family Health's] available services among the community, but do not involve direct patient care." (AA 145; see also AA 153 [the "outreach work is performed specifically to bring new patients into the facilities"].) As the chief ALJ further explained in denying rehearing, Family Health "was unable to offer sufficient documentation to establish that its outreach activities were aimed at the goal of presenting a good public image or were directly or indirectly related to patient care. Instead, these costs were centered on patient recruitment." (AA 112.)

Family Health does not appear to dispute that factual finding in this Court. (See OBM 22-26.) Nor could it, because the finding that the outreach sought to increase utilization of Family Health's facilities is amply supported by the evidence presented to the Department. Family Health's CEO testified that outreach workers "are required to make medical appointments for the people they come into contact with." (AA 293.) The workers must "invest[] the necessary time and attention to those patients to get them into the system." (*Ibid.*) The CEO also testified that "somewhere between 75 and 85 percent" of prospective new patients contacted by outreach workers ultimately show up at Family Health's facilities for their appointments. (AA 295.) That

outcome may well be desirable as a policy matter, and as discussed below (*post*, pp. 38-41, 45-49), there are avenues available for Family Health and other FQHCs to receive funding for such outreach activities. But this evidence supports the Department's finding that the purpose of Family Health's outreach activities was to increase utilization of its facilities by new patients and therefore was non-reimbursable.

### D. Provider outreach costs may be allowable in other instances, but not in this case based on the evidence Family Health presented

To be clear, the Department does not contend that a healthcare provider's outreach or advertising costs are *never* allowable for Medi-Cal reimbursement purposes. On the contrary, many types of outreach may qualify for reimbursement under the PRM, in whole or in part.

First, the costs of outreach to a provider's existing patients are very likely allowable. Among other things, such outreach would not constitute advertising "to the general public." (PRM § 2136.2; see *ante*, pp. 34-36.) Outreach to existing patients regarding that patient's medical needs—for example, calling a patient to recommend a consultation for a particular type of procedure—likely would be "related to patient care," and thus the costs would be allowable so long as they are reasonable. (PRM § 2136.1; see also *id.* §§ 2102.1-2102.2.)

Second, even when outreach targets prospective new patients, some types of outreach costs may still qualify for reimbursement under the PRM, provided the provider makes an appropriate evidentiary showing. Reasonable outreach costs

"incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care." (PRM § 2136.1.) "Examples are: visiting hours information, conduct of management-employee relations, etc." (*Ibid.*) Even if outreach does not fit this description, its costs may still be allowable under the PRM's catch-all provision so long as the costs are "reasonable," "related to patient care," and not specifically defined as non-allowable. (*Ibid.*)

A variety of forms of outreach may be eligible for reimbursement under these provisions. For instance, the costs of maintaining a website that provides information to the public about the provider's services, or posting a flyer containing similar information on a bulletin board at a homeless shelter, may well be allowable, if properly documented. (See PRM § 2136.1; cf. *Metro. Med. Ctr. & Extended Care Facility v. Harris* (8th Cir. 1982) 693 F.2d 775, 788 [costs of hospital outreach seeking to "familiarize people with the services and staff available" at the provider's facilities and "build goodwill in the community" may be allowable].) Indeed, it is possible that some portion of Family Health's outreach costs at issue here may have qualified for reimbursement on this ground. But as the chief ALJ found, Family Health "was unable to offer sufficient documentation to establish that its outreach activities" met that standard. (AA 112.) That conclusion aligns with decisions of the federal Provider Review Reimbursement Board, which has explained

that "while coordination, education and liaison, and certain forms of advertising activities are allowable for reimbursement purposes," the provider must "present[] sufficient documentation" to establish that the claimed costs are allowable. (*Harriet Holmes Health Care Services, Inc. v. Blue Cross & Blue Shield Assn.* (P.R.R.B. Apr. 7, 1997) 1997 WL 256897, at *11-12.)

In addition, some advertising might be viewed as having two or more purposes, some of which are allowable and some of which are not. For instance, certain types of advertisements may seek "to increase utilization of the provider's facilities" (PRM § 2136.2) while also having a valid public-relations purpose and relating to patient care (see *id.* § 2136.1). In these instances, on appropriate proof, the Department may deem reasonable advertising costs allowable, in whole or in part. (See, e.g., *Superior Home Health Care of Middle Tenn., Inc. v. Secretary of Health & Human Services* (6th Cir. Oct. 13, 1999) 194 F.3d 1314 [table], 1999 WL 970342, at *3 [affirming agency's decision to award 50% reimbursement for yellow pages advertisements that were intended "in part" to "promote the utilization of [the provider's] facilities" and partly for other purposes]; *Sacred Heart Hospital v. Bowen* (E.D.Pa. 1986) 652 F.Supp. 171, 181-182 [affirming agency's decision that cost of newspaper ad was not reimbursable where "primary purpose" was to aid provider in litigation]; see also *Advanced Health Systems, Inc. v. Schweiker* (D.Colo. 1981) 510 F.Supp. 965, 969-970 [allowing reimbursement for advertising costs that related to patient care even though the

advertising sought in part to increase facility utilization].)[9] Whether reimbursement is allowed for these costs may depend in part on the relative weight or importance of each purpose the advertising serves.

Here, Family Health presented only summary and general evidence about its outreach activities, and sought full reimbursement of its outreach workers' salaries and benefits without any attempt to separate out potentially reimbursable activities. In these circumstances, substantial evidence supports the Department's factual finding that the only proven purpose of Family Health's outreach activities was to increase utilization of Family Health's facilities by new patients. (*Ante*, pp. 37-38.)

## II. THE REMAINING ARGUMENTS ADVANCED BY FAMILY HEALTH AND ITS AMICI LACK MERIT

Apart from their interpretation of the relevant PRM provisions, Family Health and its amici raise both legal and

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[9] In *Advanced Health Systems*, a district court allowed for reimbursement of radio and television advertising costs by a provider that exclusively treated alcoholics; the advertising was designed to convince prospective patients that they in fact had a disease and persuade them of the need for treatment. (510 F.Supp. at p. 966.) In that case, the provider established that the "public outreach" was not designed simply to recruit new patients, but was "directly related to the diagnosis and treatment of alcoholism" and "common and accepted in the field of alcoholism treatment[.]" (*Id*. at p. 968; see also *id*. at p. 969.) The Department expresses no view on whether *Advanced Health Systems* was correctly decided. Family Health did not attempt to establish in this case that its outreach was integral to specialized treatment or that its outreach practices were common and accepted as part of such treatment.

policy arguments in support of their view that the outreach costs at issue are allowable. None of these arguments is persuasive.

### A. The legal authorities cited by Family Health and its amici do not suggest that the outreach costs at issue here are allowable

In the background section of its brief, Family Health references a 1994 letter written by the then-director of the Medicaid Bureau of the federal Department of Health and Human Services. (OBM 20; see AA 816-823.) Family Health asserts that that letter "identified Medicaid outreach as an administrative cost necessary for the proper and efficient administration of the state plan." (OBM 20.) That one-line reference in a nearly 30-year-old agency policy statement indicates only that "Medicaid outreach" is a type of cost "necessary for the proper and efficient administration of [a] State plan," which is a document prepared *by a State* and submitted to CMS for approval. (AA 817; see generally 42 C.F.R. §§ 430.10-430.25.) The letter is most naturally read as advising States to consider outreach regarding Medicaid to residents eligible to enroll in the program, not as a suggestion that any cost incurred by a provider that might be characterized as "outreach" to Medicaid beneficiaries is allowable. And regardless, agency letters and policy statements of this kind "lack the force of law" and "do not warrant *Chevron*-style deference." (*Wos v. E.M.A. ex rel. Johnson* (2013) 568 U.S. 627, 643.)

Amici Health Centers cite a 2001 question-and-answer document provided by the federal Health Care Financing Administration. (Heath Centers Amicus Letter (Aug. 27, 2021) 4-

5.) The document explains that in determining whether a "change in the scope of services" has occurred, a State "must add on the cost of new . . . services even if those services do not require a face-to-face visit" with a provider, "e.g., laboratory, x-rays, drugs, outreach, [etc.]." (*Id.* at p. 5.)

For several reasons, this document is inapposite. Its apparent purpose is to address changes in the scope of services, not to define what services a State must include in its plan in the first instance. The document's cursory reference to "outreach" is thus best understood as specifying that the cost of whatever outreach a State Medicaid plan covers must be added to a provider's newly calculated reimbursement rate when such outreach occurs. A question-and-answer document of this kind, discussing changes in the scope of services, would be a highly unusual place for the federal agency to purport to announce a requirement that States must reimburse all costs that a provider characterizes as "outreach." In addition, there is no indication that the document's reference to "outreach" encompasses (as in this case) outreach to prospective new patients seeking to increase utilization of a provider's facilities. The other listed services—such as laboratory services, x-rays, and drugs—would presumably be provided only to existing patients; the same may well be true of the "outreach" the document contemplates. Finally, like the 1994 letter Family Health references, the 2001 question-and-answer document lacks the force of law and does not qualify for *Chevron* deference. (*Wos*, *supra*, 568 U.S. at p. 643.)

Amici Health Centers also contend that the court of appeal's decision in this case "is at odds" with the Second District Court of Appeal's opinion in *Tulare Pediatric Health Care Center v. State Department of Health Care Services* (2019) 41 Cal.App.5th 163. (Health Centers Amicus Letter 6.) But there is no conflict between the court of appeal's analysis in this case and *Tulare Pediatric*. That case addressed whether the State must reimburse a clinic "the full amount the *clinic* paid to a contractor," or "an amount equal to only the *contractor*'s underlying costs." (*Tulare Pediatric*, *supra*, at p. 166.) But that question—i.e., what portion of a provider's allowable costs must be reimbursed—is separate from the question of what kinds of costs are allowable in the first place. The costs at issue in *Tulare Pediatric*—for patient visits (*id.* at p. 169)—were quintessentially allowable, whereas in this case, the parties dispute whether the costs at issue are allowable to begin with. And *Tulare Pediatric* had nothing to do with advertising, outreach, or the PRM provisions at issue here.[10]

Amici Health Centers' argument that the court of appeal's decision overlooks federal statutory law (Health Centers Amicus

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[10] While *Tulare Pediatric* noted that federal regulations use "broad and inclusive phrases when outlining reasonable costs" (41 Cal.App.5th at p. 174), that general principle provides scant guidance here. That is particularly true because the federal regulations do not directly address whether advertising is an allowable cost; only the PRM does. And unlike in *Tulare Pediatric* (see *id.* at p. 175), all parties here—and the court of appeal—agree that the PRM applies. (*Ante*, pp. 26-27, fn. 5.)

Letter 6-7) is misplaced for similar reasons. The Health Centers contend that treating the activities at issue here as non-allowable costs would violate the requirement that States must reimburse providers "in an amount . . . that is equal to 100 percent" of the average reasonable costs of furnishing the services at issue. (42 U.S.C. § 1396a(bb)(2).) That provision was at the crux of the dispute in *Tulare Pediatric* (41 Cal.App.5th at p. 168), but it sheds no light on the separate question here—which is *what costs* are allowable, not *what portion* of allowable costs must be reimbursed.

### B. The policy arguments advanced by Family Health and its amici overlook the variety of funding sources available for Medi-Cal outreach

Family Health also raises an important policy concern: It contends that "[d]isallowing FQHC outreach costs would result in less outreach being conducted and fewer people learning what medical services are available to them," thereby "leav[ing] many destitute Californians without the healthcare needed to avoid serious illness or death." (OBM 27.) Family Health's amici raise similar concerns. (See Health Centers Amicus Letter 2; Cal. Primary Care Assn. Amicus Letter (Aug. 19, 2021) 5.)

The Department agrees that outreach is a critical tool for ensuring that Medi-Cal beneficiaries are able to access the healthcare services available to them. For two principal reasons, however, these policy considerations do not warrant reversing the judgment below and treating the outreach costs at issue here as allowable. First, as discussed, many forms of outreach may be eligible for reimbursement, particularly if providers offer

adequate documentation regarding the content and context of that outreach—which Family Health failed to do in this case. (*Ante*, pp. 20, 38-41.)

Second, even where outreach costs are not allowable under Medicaid, FQHCs like Family Health have access to federal and state grants and appropriations that may be used to offset the costs of those outreach efforts. As the chief ALJ observed, a determination that the costs for outreach are not reimbursable "is not to say that" such outreach "is an impermissible activity or that it does not serve a purpose," only that "it is outside the scope of . . . Medi-Cal reimbursable activities." (AA 153.) And as the ALJ also noted, "it appears that [Family Health] has received funding from other sources" for such outreach. (*Ibid.*) That is correct. The federal government and the State have created other funding mechanisms for FQHC outreach. Indeed, filling gaps left by Medicare and Medicaid reimbursement is one of the core purposes of the FQHC grant program. The approach policymakers have chosen—declining to reimburse providers through Medicare or Medicaid for outreach or advertising that seeks to bring in new patients, but rather subsidizing such activities through grants where needed—is a sensible one.

Providers like Family Health are designated as FQHCs 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. (See, e.g., 42 U.S.C. §§ 254b(a)(1), 1395x(aa)(4); *Shah*, *supra*, 770 F.3d at p. 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. (42 U.S.C. § 254b(a)(1), (k)(3).) And they must provide a variety of statutorily enumerated "primary health services" (*id.* § 254b(a)(1)(A)), including "services that enable individuals to use the services of the health center," such as "outreach and transportation services" (*id.* § 254b(b)(1)(A)(iv)), as well as "education of patients and the general population served by the health center regarding the availability and proper use of health services" (*id.* § 254b(b)(1)(A)(v)).

Under the "dual funding mechanism" Congress has created, FQHCs have two primary sources of revenue. (*Shah*, *supra*, 770 F.3d at p. 136.) They "receiv[e] direct grants from the United States to provide primary and other health care services" to underserved communities, and at the same time they "can also bill for providing Medicare or Medicaid services" to beneficiaries of those programs. (*Ibid.*) An FQHC's acceptance of federal grant money obligates it to provide the "required primary health services" set forth in the statute (see 42 U.S.C. § 254b(b)(1)(A), (e)(2), (k)(2), (k)(3)), even though not all of those services will always qualify for Medicare or Medicaid reimbursement. FQHCs are expected to use their federal grant money to cover the costs of such services. (See *Shah*, *supra*, at p. 136.) Outreach costs not eligible for reimbursement under the PRM are among the services funded primarily through these federal grants.

In addition, state funds are also available for outreach to Medi-Cal patients. In 2019, for example, the Legislature appropriated more than $59 million over three fiscal years to fund county and community-based outreach to assist with Medi-Cal enrollment and access to healthcare services. (See AB 74 (2019-2020 Reg. Sess.), Stats. 2019, ch. 23, § 2.) The Department's website provides additional information about these funds and details on how counties and community-based organizations (including FQHCs) can apply for funding.[11] The Legislature has made similar appropriations for Medi-Cal outreach in prior years. (See, e.g., AB 82 (2013-2014 Reg. Sess.), Stats. 2013, ch. 23, § 71.)[12]

Funding this type of outreach through fixed grants rather than through Medicaid reimbursement offers several advantages. It allows federal and state policymakers to set an overall outreach budget, allocating outreach funds specifically to FQHCs and other providers that disproportionately serve disadvantaged communities, while preserving Medicare and Medicaid dollars for activities more closely related to patient care. Family Health's theory, in contrast, apparently would allow healthcare providers

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[11] See Dept. of Health Care Services, Medi-Cal Health Enrollment Navigators Project, https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/NavigatorsProject.aspx [as of March 23, 2022].

[12] In addition, a recently proposed Assembly bill would create a "Community Health Navigator Program" to provide grants to community-based organizations for targeted outreach and other activities. (See AB 2680 (2021-2022 Reg. Sess.).)

of all stripes—not just FQHCs—to seek full reimbursement for the costs of their outreach to Medicare and Medicaid patients, even where the only purpose of such outreach is to increase utilization by new patients of the provider's facilities. That would create problematic incentives for providers, potentially imposing a significant burden on public healthcare finances and effectively subsidizing providers' advertising budgets.

Family Health asserts that the proposition that FQHC outreach is funded through separate grants is "without any support in the record" and was not presented below. (Reply to Answer to Petition for Review 5.) That is not correct. The Department has consistently maintained that the outreach costs at issue are "funded . . . by the Federal government through non-Medi-Cal grants" (AA 109), and the chief ALJ acknowledged that point (AA 153). In any event, this is not primarily a record-based argument. As just discussed, federal law expressly provides for grants to FQHCs to fund required primary health services, including outreach, regardless of whether the costs of such services are allowable for reimbursement purposes. Those grants, as well as the resources the State provides for outreach to Medi-Cal beneficiaries, will continue to enable FQHCs and other healthcare providers to educate members of the community about the publicly funded healthcare services available to them.

## CONCLUSION

The judgment of the court of appeal should be affirmed.

Respectfully submitted,

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March 24, 2022

## CERTIFICATE OF COMPLIANCE

I certify that the attached Answer Brief on the Merits uses a 13-point Century Schoolbook font and contains 9,923 words.

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March 24, 2022

# Appendix

CHAPTER 21

COST RELATED TO PATIENT CARE

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2100. PRINCIPLE

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 or, in the case of acute care hospitals, the prospective payment system (PPS). (See Chapter 28 on PPS.) Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

2102. DEFINITIONS

2102.1 Reasonable Costs.--Reasonable costs of any services are determined in accordance with regulations establishing the method or methods to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. The objective is that under the methods of determining costs, the costs for individuals covered by the program are not borne by others not so covered and the costs for individuals not so covered are not borne by the program.

Costs may vary from one institution to another because of scope of services, level of care, geographical location, and utilization. It is the intent of the program that providers are reimbursed the actual costs of providing high quality care, regardless of how widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors. Utilization, for this purpose, refers not to the provider's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., its patient mix - age of patients, type of illness, etc.).

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (See §2103.) If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

In the event that a provider undergoes bankruptcy proceedings, the program makes payment to the provider based on the reasonable or actual cost of services rendered to Medicare beneficiaries and not on the basis of costs adjusted by bankruptcy arrangements.

2102.2 Costs Related to Patient Care.--These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

2102.3 Costs Not Related to Patient Care.--Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.

Such costs are not allowable in computing reimbursable costs and include, for example:

- Cost of meals sold to visitors;
- Cost of drugs sold to other than patients;
- Cost of operation of a gift shop;

- Cost of alcoholic beverages furnished to employees or to others regardless of how or where furnished, such as cost of alcoholic beverages furnished at a provider picnic or furnished as a fringe benefit;

- Cost of gifts or donations;

- Cost of entertainment, including tickets to sporting and other entertainment events;

- Cost of personal use of motor vehicles;

- Cost of fines or penalties resulting from violations of Federal, State, or local laws;

- Cost of educational expenses for spouses or other dependents of providers of services, their employees or contractors, if they are not active employees of the provider or contractor;

- Cost of meals served to executives that exceed the cost of meals served to ordinary employees due to the use of separate executive dining facilities (capital and capital-related costs), duplicative or additional food service staff (chef, waiters/waitresses, etc.), upgraded or gourmet menus, etc.; and

- Cost of travel incurred in connection with non-patient care related purposes.

2102.4 Donations to a Provider of Produce, Supplies, Space, Etc.--If a provider receives a donation of produce, supplies, the use of space owned by another organization, etc., the provider may not properly impute a cost for the value of the donations and include the imputed cost in allowable costs. If an imputed cost has been included in the provider's costs, that amount is deleted in determining allowable costs. If the provider and donor organization are both part of a larger organizational entity, such as units of a state or county government, costs related to the donations are includable in the allowable costs of the provider. For example, if a county home health agency is given space to use in the county office building, costs related to that space may be included in the agency's costs, e.g., depreciation, costs of janitorial services, maintenance and repairs.

## 2136. ADVERTISING COSTS--GENERAL

The allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining, and furnishing covered services to Medicare beneficiaries by providers of services. In determining the allowability of these costs, the intermediary should consider the facts and circumstances of each provider situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions. To be allowable, such costs must be common and accepted occurrences in the field of the provider's activity.

2l36.l Allowable Advertising Costs.--Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is 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. Costs connected with fund-raising are not included in this category (see § 2l36.2).

Costs of advertising for the purpose of recruiting medical, paramedical, administrative and clerical personnel are allowable if the personnel would be involved in patient care activities or in the development and maintenance of the facility.

Costs of advertising for procurement of items or services related to patient care, and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price.

Costs of advertising incurred in connection with obtaining bids for construction or renovation of the provider's facilities should be included in the capitalized cost of the asset (see Chapter I, §l04.l0).

Costs of advertising incurred in connection with bond issues for which the proceeds are designated for purposes related to patient care, i.e., construction of new facilities or improvements to existing facilities, should be included in "bond expenses" and prorated over the life of the bonds.

Costs of activities involving professional contacts with physicians, hospitals, public health agencies, nurses' associations, State and county medical societies, and similar groups and institutions, to apprise them of the availability of the provider's covered services are allowable. Such contacts make known what facilities are available to persons who require such information in providing for patient care, and serve other purposes related to patient care, e.g., exchange of medical information on patients in the provider's facility, administrative and medical policy, utilization review, etc. Similarly, reasonable production and distribution costs of informational materials to professional groups and associations, such as those listed above, are allowable if the materials primarily refer to the provider's operations or contain data on the number and types of patients served. Such materials should contribute to an understanding of the role and function of the facility as a provider of covered health care in the community.

Costs of informational listings of providers in a telephone directory, including the "yellow pages," or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry.

Costs of advertising for any purpose not specified above or not excluded below may be allowable if they are related to patient care and are reasonable.

2l36.2 Unallowable Advertising Costs.--

Costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable.

Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are not allowable. See section 2136.1 for allowability of professional contact costs and costs of advertising for the purpose of recruiting physicians as members of the provider's salaried staff.

Costs of advertising incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered as reductions in the proceeds from the sale and, therefore, are not allowable.

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

2l38. MEMBERSHIP COSTS--GENERAL

Providers customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary provider operating costs.

# DECLARATION OF ELECTRONIC SERVICE

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

I declare:

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

On March 24, 2022, I served the attached **ANSWER BRIEF ON THE MERITS** by transmitting a true copy via this Court's TrueFiling system:

George E. Murphy
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Sacramento, CA 95826
gmurphy@murphycampbell.com

Douglas S. Cumming
Douglas Cumming Medical Law
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Roseville, CA 95661
dsc@dougcummingmedical-law.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 March 24, 2022, at San Francisco, California.

| Joshua Patashnik | /s/ Joshua Patashnik |
|---|---|
| Declarant | Signature |

**STATE OF CALIFORNIA**
Supreme Court of California

## *PROOF OF SERVICE*

**STATE OF CALIFORNIA**
Supreme Court of California

Case Name: **FAMILY HEALTH CENTERS OF SAN DIEGO v. STATE DEPARTMENT OF HEALTH CARE SERVICES**
Case Number: **S270326**
Lower Court Case Number: **C089555**

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

2. My email address used to e-serve: **Josh.Patashnik@doj.ca.gov**

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

Title(s) of papers e-served:

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|---|---|
| BRIEF | S270326 Answer Brief on the Merits |

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This proof of service was automatically created, submitted and signed on my behalf through my agreements with TrueFiling and its contents are true to the best of my information, knowledge, and belief.

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

3/24/2022

Date

/s/Joshua Patashnik

Signature

Patashnik, Joshua (295120)

Last Name, First Name (PNum)

Office of the Attorney General

Law Firm