California Appellate Court Affirms Medi-Cal's Obligation To Pay FQHCs 100% Of Their Reasonable Costs

by Kathryn E. Doi

In a landmark victory for Federally-qualified health centers, a California Court of Appeal confirmed last October that federal and state law requires the State of California to pay FQHCs "100 percent" of their costs of furnishing core and other ambulatory services to Medi-Cal beneficiaries. (*Tulare Pediatric Health Care Center v. State Department of Health Care Services* (2nd Dist. 2019) 41 Cal.App.5th 163.)

The case involved an initial rate-setting cost report that Tulare Pediatric Health Care Center (the "Center"), an FQHC operated by Tulare County, submitted to the Department of Health Care Services ("DHCS") to establish its prospective payment system ("PPS") rate. At issue was the Center's contract with a physician, who agreed to provide necessary personnel to run the Center. It was undisputed that the Center agreed to pay and did pay the physician $106.00 per patient visit. When the Center submitted its rate-setting cost report, it incorporated the physician's fee of $106.00 per visit. The Center included its other reasonable and allowable costs and calculated a PPS rate of $167.85 per visit.

DHCS did not accept what the Center actually *paid* as the Center's actual *cost*. Instead, DHCS demanded the physician's records so it could determine his costs. As the Court noted, "This is akin to demanding cost reports from the subcontractor water company that resupplies the clinic's water cooler." In all, DHCS made audit adjustments that reduced the Center's costs of "Physician Services Under Agreement" from $2.3 million to $1.7 million, which, along with other adjustments, reduced the Center's PPS rate to $120.98.

The opinion does not describe what occurred at the administrative hearing on appeal, but apparently, the Center lost its administrative appeal, as it filed a writ petition with the superior court to require the State to set aside its adjustments to the Center's costs and to recalculate its payment rate accordingly. The superior court granted the Center's petition, finding federal law required the State to accept the Center's cost of paying the physician $106 per patient visit. The Court of Appeal agreed. In a remarkable series of findings, the Court rejected all of the State's arguments on appeal.

First, the Court declined to defer to the State's interpretation of the federal statute at issue. The Court rejected the State's argument that it was entitled to deference because the Centers for Medicare and Medicaid Services ("CMS") approved California's State Medicaid plan, noting, "[CMS] may have approved the State plan as a general matter, but there is no sign it approved the State's application of the State plan to Tulare Clinic, or even the State's application of the State plan in similar situations." In addition, the Court declined to deter to the State's interpretation of state law because "we do not defer to agency interpretations that are clearly erroneous, as the State's interpretation is here."

Instead, the Court found: "The plain language of [42 U.S.C. § 1396a(bb)] requires states to pay centers' full cost. … The statute is clear: the State must pay 100 percent of the center's costs for the defined services. We effectuate this plain meaning." The Court also found that State law is "in accord" with federal law.

The Court also admonished the State's conduct as inconsistent with Congress' intent. "Instead of adhering to subdivision (bb), the State tries to do exactly what Congress sought to avoid: pay a health center less than the center's full cost of treating Medicaid beneficiaries, creating a risk this clinic will use Public Health Services Act grant funds to subsidize Medicaid beneficiaries. … The State cannot shirk its responsibility to pay health centers' full costs."

Finally, the Court found that as a general rule, 42 C.F.R. Part 413 (Medicare reasonable cost principles) directs payment based on the actual costs of a provider rather than the costs of a contractor when an arms-length transaction is involved; Part 413 only directs payment based on the costs of a contractor rather than the costs of a provider where the provider and contractor are related by common ownership or control. The Court also rejected the State's position that 42 C.F.R. § 413.9(b)(1) allows the State to bring in every other Medicare rule that might favor its case. "The State plan's reference to part 413 does not allow the State to apply any Medicare regulation it sees fit. If the drafters of the State plan intended reasonable costs to be determined according to all Medicare regulations, it would have said so. Instead, those drafters specified part 413."

On its face, the *Tulare Pediatric* decision offers relief to FQHCs from adjustments to their cost reports that result in PPS rates that do not reflect reimbursement at 100 percent of the FQHCs' costs for providing core and other ambulatory services based on the Department's refusal to accept what FQHCs actually pay in arms-length transactions as actual costs or reliance on inapplicable Medicare rules. But only time will tell whether DHCS and its Office of Administrative Hearings and Appeals will accept and apply the letter and the spirit of the Court of Appeal's decision. Until that occurs, FQHCs who seek to challenge audit adjustments will continue to have to appeal the adjustments through the lengthy administrative appeal process and into the court system in order to obtain relief.

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