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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION TWO

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| COUNTY OF VENTURA,<br><br>Plaintiff and Appellant,<br><br>v.<br><br>JENNIFER KENT, as Director, etc.,<br><br>Defendant and Respondent. | B284988<br><br>(Los Angeles County Super. Ct. No. BS164067) |

APPEAL from a judgment of the Superior Court of Los Angeles County. Amy D. Hogue, Judge. Affirmed.

Hooper, Lundy & Bookman, Eric D. Chan and Tracy A. J. Hale for Plaintiff and Appellant.

Xavier Becerra, Attorney General, Julie Weng-Gutierrez, Assistant Attorney General, Jennifer M. Kim and Alyson Reed Parker, Deputy Attorneys General, for Defendant and Respondent.

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This case concerns adjustments made by the California Department of Health Care Services (Department) during its audit of four federally qualified health centers (FQHC's) operated by the County of Ventura (County) for the fiscal year 2011 (FY 2011). According to the County, the audited per-visit rates for three of the FQHC's are too low because the Department imposed a "productivity standard" that artificially inflated the number of visits for the clinics for FY 2011 that the Department used in the denominator of the calculation to establish the clinics' "per-visit" rate going forward. For the fourth clinic, the County contends that the Department improperly disallowed its entire building expense for FY 2011, thereby reducing its per-visit rate.

The County appealed the audit findings. After an informal hearing and then a formal hearing before an administrative law judge (ALJ), a final decision was issued by the Department, upholding the audit adjustments. The County appealed the final decision through a petition for writ of mandate. The trial court denied the petition and entered judgment in favor of the Department.

The County appeals, largely raising the same arguments it raised below. We affirm.

## FACTUAL AND PROCEDURAL BACKGROUND

### I. *The parties and relevant statutory context*

#### A. The parties

The County offers a comprehensive range of health care services to County residents. Among other things, it operates a network of ambulatory clinics. At issue in this appeal are four of the County's FQHC's: Fillmore Family Medical Group (Fillmore), Magnolia Family Medical Clinic (Magnolia), the Piru Family Medical Center (Piru), and Santa Paula Hospital Clinic (Santa

Paula). Each of these clinics provided health care services to Medi-Cal beneficiaries during the period of July 1, 2010, through June 30, 2011, and were entitled to reimbursement by the Medi-Cal program.

Jennifer Kent is the Director of the Department, the single state Medicaid agency charged with administering the Medi-Cal program. (Welf. & Inst. Code, § 14000 et seq.; Cal. Code of Regs., tit. 22, § 50000 et seq.)

B. The California Medicaid Program

Title XIX of the Social Security Act, the Medicaid Act, authorizes federal financial support to states for medical assistance to certain low-income persons. The Medicaid program is administrated by a single state agency, in California—the Department, which is charged with the responsibility of establishing and complying with a state Medicaid plan that, in turn, must comply with the provisions of the applicable federal Medicaid law. (42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 430.10 & 431.10.)

Among the types of services covered under the Medi-Cal program are those offered by FQHC's, defined as community-based health care providers that receive federal grant funding for the purpose of providing primary care services in underserved areas. (42 U.S.C. § 1396d(a)(xvii)(1)(2)(A)-(B).)

FQHC's that participate in the Medi-Cal program are reimbursed for services on a "per-visit" basis. (Welf. & Inst. Code, § 14132.100, subd. (c) (section 14132.100).) FQHC's can choose one of three methods to calculate their fixed per-visit reimbursement rate: The first two methods set the reimbursement rate based on the average per visit rate for surrounding FQHC's. (§ 14132.100, subds. (i)(1)(A) & (B).) The

third method is to have the Department set the rate using a statutory formula based on the actual and allowable cost per visit during the FQHC's first year of operation. (§ 14132.100, subd. (i)(1)(C).)

To set the reimbursement rate under this system, the FQHC determines its cost "per visit" by calculating its total cost for the year and dividing it by the number of total patient visits. Then the Department audits this figure both to substantiate the claimed costs and to adjust the FQHC's reported costs "[b]ased on actual and allowable cost per visit." (§ 14132.100, subd. (i)(3)(C).)

Once determined, an FQHC's per-visit rate is carried forward and applies prospectively for services rendered in subsequent fiscal periods. For this reason, according to the County, "it is critically important for FQHCs that the 'base period' per visit rate determined by the Department for the facilities accurately reflects the level of services the clinics provide, and the costs incurred in providing those services."

According to federal law, FQHC's may only be reimbursed for reasonable costs. (see 42 U.S.C. § 1396a(bb)(4), § 1396a(bb)(2); 42 C.F.R. §§ 413.9(a), 405.2468(b), 405.2468(e).) California's Medicaid program, Medi-Cal, is required to comply with these federal authorities and only reimburse reasonable costs. (42 U.S.C. § 1396a(b).) In fact, the reasonableness requirement is built into the Welfare and Institutions Code: an FQHC's reimbursement rate "shall be evaluated in accordance with Medicare reasonable cost principles." (§ 14132.100, subds. (e)(1), (i)(2)(B)(ii).)

The Centers for Medicare and Medicaid Services (CMS) determine what costs are "allowable" or reasonable. With regard to "allowable costs," federal law provides that "limits on

payments may be set by [CMS], on the basis of costs estimated to be reasonable for the provision of such services." (42 C.F.R. § 405.2468(e).) CMS may establish "[t]ests of reasonableness" with respect to costs, which include, but are not limited to, screening guidelines and payment limits. (42 C.F.R. § 405.2468(c).) And "[c]osts in excess of amounts established by the guidelines are not included unless [the clinic or center] provides reasonable justification." (42 C.F.R. § 405.2468(d).)

In determining whether an FQHC's costs are reasonable, the Department's auditors may employ a screening guideline referred to as a "productivity standard." (§ 14132.100, subds. (e)(1), (i)(1)(C) & (i)(3)(D) ["The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs . . . as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code," which permits "other tests of reasonableness"].) Productivity standards are a screening guideline that the Department's auditors use to compare the number of patients seen by each physician per year to a minimum baseline, under the theory that physicians must see enough patients to justify their expense. This reasonableness test adopted by CMS estimates that an average FQHC physician should be able to see approximately 4,200 patients per year.

Productivity standards prevent artificial inflation of an FQHC's per visit rate. For example, if FQHC physicians see less than 4,200 patients per year, the denominator (number of visits) in the per-visit cost calculation is lower, artificially boosting the per visit rate for later years as the FQHC's productivity increases. Therefore, during a prospective rate-setting audit, the Department may adjust the denominator to prevent an FQHC from receiving a windfall as its productivity increases.

Also, only substantiated costs are allowable. Thus, all Medicare providers must "maintain sufficient financial records and statistical data for proper determination of costs payable under the program." (42 C.F.R. § 413.20(a).) And, in order to receive reimbursement for claimed costs, Medicare providers must substantiate those costs by providing adequate cost data records. (42 C.F.R. § 413.24(a).) To be "adequate," cost data must be capable of being audited. (42 C.F.R. § 413.24(c).) Adequate cost data and information "is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis." (42 C.F.R. § 413.24(c).)

C. Procedure

Pursuant to Welfare and Institutions Code section 14171, the Department established an administrative appeal process to review grievances or complaints of providers arising from findings of an audit or examination made pursuant to Welfare and Institutions Code section 14170. (see also Cal. Code Regs., tit. 22, § 51017 [implementing Welf. & Inst. Code, § 14171].) Initially, FQHC's have an opportunity to dispute the audit results at an exit conference before the findings are final. (Cal. Code Regs., tit. 22, § 15021, subd. (a).) The purpose of the exit conference is to discuss the audit findings and to give the provider an opportunity to provide additional information.

If a provider disagrees with the final audit findings, it may request an informal hearing for "any disputed audit or examination finding." (Cal. Code Regs., tit. 22, § 51022, subd. (a).) After the informational hearing, the Department's hearing officer must serve a written report or order explaining the results of the informal level of review. (Cal. Code Regs., tit. 22, § 51022, subd. (e).)

If a provider disagrees with the hearing officer's reports, it may request a formal hearing, presided over by an ALJ. (Cal. Code Regs., tit. 22, § 51024, subd. (a).) The decision of the ALJ is reviewable by the Director, who must issue a final decision. The final agency determination of the Director is reviewable pursuant to Code of Civil Procedure section 1094.5 and Welfare and Institutions Code section 14171.

II. *Background facts of this case*

During FY 2011, the County began operating a group of FQHC's: Magnolia, Fillmore, Piru, and Santa Paula. In order to receive reimbursement, the County elected to have the Department audit the clients' cost reports, pursuant to section 14132.100, subdivision (i)(1)(C), and set a prospective per visit reimbursement rate.

A. The audit

After auditing the County's cost reports, the Department disallowed unreasonable and unsubstantiated costs, and calculated a prospective reimbursement rate based upon allowable costs. Relevant to this appeal, the Department made the following two adjustments to the County's claimed costs.

First, the auditor elected to apply a screening guideline, the productivity standard, to the physicians working in three of the County's clinics (Fillmore, Piru, and Santa Paula) to determine the reasonableness of their claimed costs. Specifically, if a physician saw less than 4,200 patients during the FY 2011 without proper justification, the Department's auditor changed the number of visits in the cost per visit equation to 4,200.

Second, the auditor disallowed some unsubstantiated costs related to the building housing the Magnolia clinic. The Magnolia clinic operated out of a suite in Oxnard, California.

The County claimed certain building costs, but was unable to substantiate them with documentation. Because of the lack of documentation, the Department denied reimbursement for those building costs.

B. Exit conference

After his initial findings, the Department's auditor requested specific source documents to substantiate the Magnolia building costs. The County did not "respond or give [the auditor] any documents" in response to his requests.

The Department held an exit conference on December 3, 2013, prior to the issuance of a final audit report.

C. Informal appeal

In May 2014, the County initiated the informal appeal process, and the informal appeal was held on July 24, 2014. In a letter dated December 10, 2014, the hearing officer declined to decide whether productivity standards applied to independent contractors, and upheld the exclusion of costs related to the Magnolia building because the County failed to provide loan documents or specific invoices, as requested by the auditor.

D. Formal appeal and administrative hearing

The County appealed the findings of the informal hearing, thereby triggering a formal appeal. The three issues identified by the County for review were: (1) Whether the Department could apply productivity standards to independent contractor physicians or only employed physicians; (2) Whether the Department could apply productivity standards to physicians who did not render services on a "regular, scheduled" basis; and (3) Whether the Department could exclude reimbursement for unsubstantiated building costs reported for the Magnolia clinic.

An administrative hearing was scheduled before ALJ Vince J. Blackburn.

On the first day of the hearing, and two years after the Department's repeated requests for substantiating documentation, the County produced the alleged source documents for the disputed Magnolia costs. But, the Department's auditor was unable to testify about the documents because they were first presented to him during cross-examination.

After a thorough evidentiary hearing, ALJ Blackburn issued a final decision upholding the audit in full. ALJ Blackburn concluded that the Department acted within its discretion in applying productivity standards to independent contractors. He noted that if the productivity standards did not apply, there would be a "hole in the regulatory scheme within which there would be little if any methodology to evaluate the reasonableness of charges to governmental programs."

As for adjustments to Magnolia's building expense, ALJ Blackburn determined that the County's evidence did not substantiate the claimed amount for the alleged costs and was submitted too late for the auditor to review and for the "necessary exchange" to occur.

ALJ Blackburn's decision was adopted as the final decision of the Director.

E. Petition for writ of mandate

In August 2016, the County filed a petition for writ of mandate, raising the same three issues that it raised in connection with the formal hearing. In addition, the County introduced several purportedly new arguments that were never raised in the administrative forum. As is relevant to the issues

raised on this appeal, the County asserted that (1) the Department may not interpret section 14132.100 to permit productivity standards, and (2) the 4,200-visit standard is unreasonable.

On June 14, 2017, the trial court denied the County's petition for writ of mandate. It held that (1) the Department did not abuse its discretion in applying productivity standards to both independent contractors and part-time staff, (2) substantial evidence supported the Department's decision to exclude Magnolia's costs; and (3) the County had failed to exhaust its administrative remedies with respect to all arguments not raised during the administrative hearing.

F. Judgment and appeal

Judgment was entered, and this timely appeal ensued.

## DISCUSSION

*I. Standard of review*

Administrative decisions are reviewed for prejudicial abuse of discretion. (Code Civ. Proc., § 1094.5, subd. (b).) An agency abuses its discretion if it does not proceed as required by law, the decision is not supported by the findings, or the findings are not supported by the evidence. "The standard for review on appeal from a proceeding under Code of Civil Procedure section 1094.5 is dependent upon the standard of review utilized at the trial level. Thus, where a trial court is authorized to exercise its independent judgment on the evidence taken as a whole, the appellate court has only to determine whether there is substantial evidence to support the trial court's findings. [Citations.] But if the substantial test governed at trial, the appellate court must answer the same question that faced the trial court, that is whether the *agency's findings* were supported

by substantial evidence. [Citations.]" (*Pacific Coast Medical Enterprises v. Department of Benefit Payments* (1983) 140 Cal.App.3d 197, 207, fn. 2.)

*II. The trial court properly denied the County's petition for writ of mandate*

A. Productivity standards

The trial court properly upheld the Department's application of productivity standards. Section 14132.100, subdivision (i)(1)(C), expressly provides that FQHC's are reimbursed "based on actual and allowable cost per visit." Unreasonable costs are not allowable. (42 U.S.C. § 1396a(bb)(2); § 14132.100, subds. (e)(1) & (i)(3)(C); 42 U.S.C. § 1395x(v).) It follows that the Department may employ tests of reasonableness to eliminate unreasonable, or unallowable, costs. In fact, the Department's interpretation adheres to the "limits on payments" set by CMS, as authorized by the Code of Federal Regulations in the Medicare Benefit Policy Manual: the productivity standard screening guideline. (42 C.F.R. § 405.2468(e).)

1. *Statutory authority to use productivity standards*

In urging us to reverse, the County argues that the Department did not have the authority to alter the definition of a "visit." A "visit" is defined as a "face-to-face encounter between an FQHC . . . patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse." (§ 14132.100, subd. (g).) According to the County, the statute's plain language prohibits the Department from using a productivity standard to alter the number of actual face-to-face visits that occurred. We cannot agree, for both procedural and substantive reasons.

a. Exhaustion of administrative remedies

First, the County forfeited this argument by failing to raise it in the administrative proceedings. (*Abelleira v. District Court of Appeal* (1941) 17 Cal.2d 280, 292 ["where an administrative remedy is provided by statute, relief must be sought from the administrative body and this remedy exhausted before the courts will act"].) It is well-established that courts have no authority to grant relief based on a legal theory never presented during the administrative proceedings. (*NBS Imaging Systems, Inc. v. State Bd. of Control* (1997) 60 Cal.App.4th 328, 337.)

Here, the County never raised the issue of whether the Department could "alter the definition of a 'visit'" during the administrative proceedings. As set forth above, to dispute the results of an audit, providers must file a statement of disputed issues specifically listing "each issue as are in dispute" and "setting forth the provider's contentions as to those issues." (Cal. Code Regs., tit. 22, § 51022, subds. (a) & (d).) The County directs us to no record citation showing that it did so here. (Cal. Rules of Court, rule 8.204(a)(1)(C); *Guthrey v. State of California* (1998) 63 Cal.App.4th 1108, 1115.)

In its reply brief, the County claims that it did raise the issue of the Department's statutory authority and, in support, points to portions of ALJ Blackburn's decision that allegedly address the issue. The County mischaracterizes what it argued below and the scope of ALJ Blackburn's decision. Certainly ALJ Blackburn considered and evaluated section 14132.100; that was what he was asked by the parties to do. But he never considered whether the statutory definition of the term "visit" could be altered by the 4,200 productivity standard. Accordingly, as the

trial court correctly found, the County has waived this argument on appeal.

b. The Department may use productivity standards

Regardless, on the merits, the County's argument fails. As set forth above, in order to assess whether a cost is "reasonable," and therefore "allowable," the Department may use productivity standards. If we were to adopt the County's argument, the Department could be compelled to reimburse providers for all costs of every face-to-face visit without any "reasonableness" or "allowable" qualifier, rendering words in the statutory scheme surplusage. (*California Mfrs. Assn. v. Public Utilities Com.* (1979) 24 Cal.3d 836, 844 [statutory interpretation rendering words void or surplusage is "to be avoided"].)

2. *Underground regulation*

A regulation is defined as "every rule, regulation, order, or standard of general application . . . by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure." (Gov. Code, § 11342.600.) Government Code section 11340.5, subdivision (a), provides that "No state agency shall issue, utilize, enforce, or attempt to enforce any guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation as defined in [Government Code] Section 11342.600, unless the guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule has been adopted as a regulation and filed with the Secretary of State pursuant to this chapter."

"A regulation found not to have been properly adopted is termed an 'underground regulation.' '"An underground

regulation is a regulation that a court may determine to be invalid because it was not adopted in substantial compliance with the procedures of the [Administrative Procedure Act].'" [Citations.]" (*People v. Medina* (2009) 171 Cal.App.4th 805, 813–814.)

The County argues that because the Department never formally promulgated a regulation adopting the productivity standards, the policy of applying productivity standards amounts to an impermissible underground regulation. In support, it contends that it "is undisputed that productivity standards are a long-standing rule that the Department always applies to initial rate-setting audits for FQHCs." We disagree.

As pointed out by the Department, the auditor, Nicholas Lui, testified that the productivity standard does not always need to be applied. Even the County's attorney admitted in his opening statement that the productivity standards do not always "come[] into play" and that they are "never mandatory."

Thus, we conclude that the Department interpreted the law, as opposed to adopting a new regulation. (*Aguilar v. Association for Retarded Citizens* (1991) 234 Cal.App.3d 21, 26 [discussing "[t]he difference between interpreting a regulation to enforce it and adopting a new regulation"].) The Department is the agency charged with enforcing another agency's regulations, namely CMS. (42 U.S.C. § 254b(k)(3)(E).) In setting a reimbursement rate to FQHC's, the Department may only reimburse "allowable" costs. (§ 14132.100, subd. (i)(1)(C).) A federal regulation governing reimbursement to FQHC's expressly allows the use of reasonableness tests established by CMS to determine allowable costs by FQHC's. (42 C.F.R. § 405.2468(b) & (c).) The regulation permits the use of screening guidelines as a

reasonableness test to determine allowable costs. One screening guideline is provided by CMS in its Medicare Benefit Policy Manual, namely a 4,200-visit productivity standard. By applying that productivity standard to the reimbursement rate to FQHC's in California, the Department interpreted the law; it did not adopt and enforce a new regulation.

3. *Reasonableness of productivity standard*

To the extent the County argues that the productivity standard employed here (4,200 visits per physician) is unreasonable, we deem that argument waived. The County did not raise this argument in the administrative proceedings. Had it done so, the Department would have had an opportunity to explain and present evidence in support of its contention that the standard is reasonable.

4. *Productivity standards are applicable to independent contractor physicians*

Finally, the County argues that productivity standards, even if allowable, are not applicable to independent contractor physicians. In support, the County directs us to the Medicare Manual, which provides: "Physician services under agreements are not subject to the productivity standards. Instead of the productivity limitation, purchased physician services are subject to a limitation on what Medicare would otherwise pay for the services (under the Physician Fee Schedule), in accordance with 42 C.F.R. § 405.2468(d)(2)(v)." According to the County "physician services 'under agreements'" includes services by independent contractor physicians as opposed to employee physicians. Like the ALJ and the trial court, we reject this interpretation.

As the trial court found, there is "no plausible policy reason why the productivity standards should be rejected based on the nature of the contractual relationship with the physicians that ordinarily staff the FQHCs. As the ALJ pointed out, this would create a hole in the regulatory scheme. The FQHC's could easily avoid the productivity standards that would otherwise apply by drafting documents designed to structure its relationships with regularly engaged physicians as independent [contractors]."

Moreover, the phrase "[s]ervices provided through agreements" is defined as "other" "specialized" services that "are not available at the clinic." (42 C.F.R. § 491.9(d).) For example, as the ALJ explained, these might include services of a phlebotomist who came to work as an independent contractor. But nothing in the statutory scheme suggests that independent contractor physicians must be excluded from productivity standards.

B. Reimbursement of Magnolia building costs

Substantial evidence supports the trial court's finding that the County failed to submit sufficient documentation to justify reimbursement of its Magnolia clinic building costs. Magnolia was required to provide "adequate cost data" that is "capable of verification by qualified auditors." (42 C.F.R. § 413.24(a.) But the County never provided source documents for the claimed costs. Rather, the appellate record shows that the Department requested, but never received, "source documents . . . , like, the purchasing agreement for the building" and "the loan agreement or the interest payments." In fact, the auditor testified that the County did not provide a single document that was not prepared by the County itself.

In urging reversal, the County argues that the exclusion of *all* of Magnolia's capital costs was not supported by the evidence because some documentation provided to the Department before the formal hearing "was more than sufficient to support" some of the costs ($154,111.19). In other words, it was an abuse of discretion for the ALJ to have found $154,111.19 in costs, but then decide to disallow reimbursement for all costs.

The County mischaracterizes the ALJ's findings and the appellate record. As noted by the ALJ, the County requested reimbursement for $163,208 in capital costs. Thus, he was tasked with determining "whether Magnolia [could] demonstrate by a preponderance of the evidence that its reported Capital Cost of $163,208 [was] correct." And, it could not do so. The two documents offered by the County to substantiate the total capital cost were Exhibit G, a depreciation schedule, which was "only a summary and calculation rather than a source document," and Exhibit H, which was a source document but was not submitted until the day of the hearing. Examining the two documents together, ALJ Blackburn determined that the amounts set forth therein could only be "approximately correlated", for a capital cost of "$154,111.19, which does not correlate with $163,208 despite being relatively close." Ultimately, ALJ Blackburn found that he "need not reach additional matters such as the integrity of Exhibit G's calculations or the authenticity of Exhibit H. Magnolia's evidence lends credence to the proposition that it has incurred chargeable building costs, but does not substantiate them at the claimed amount. Were these documents presented to an auditor during the audit there would have been time for additional questions and discussions that should have resulted in a substantiated, claimable amount of building capital costs, be

that $163,208 or another number. Exhibit H was simply submitted too late in the process for the necessary exchange to occur. Magnolia has not met its burden to show that its calculation of capital costs was correct."

In light of ALJ Blackburn's express statements, we disagree with the County's contention that the ALJ found sufficient documentation to support at least $154,111.19 in reimbursable costs.

**DISPOSITION**

The judgment is affirmed. The Department is entitled to costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS.

_____, J.
ASHMANN-GERST

We concur:

_____, P. J.
LUI

_____, J.
CHAVEZ