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**SUPERIOR COURT OF THE STATE OF CALIFORNIA**

**COUNTY OF SACRAMENTO**

COUNTY OF SAN MATEO,

Petitioner,

vs.

DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES,

Respondent.

Case No. 34-2017-80002640

**MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR WRIT OF ADMINISTRATIVE MANDATE**

| | |
|---|---|
| Hearing Date: | April 27, 2018 |
| Time: | 11:00 a.m. |
| Location: | Sacramento County Superior Court<br>720 Ninth St<br>Sacramento, CA 95814 |
| Dept.: | 28 |
| Judge: | Hon. Richard K. Sueyoshi |

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## I. INTRODUCTION

The County of San Mateo operates outpatient federally qualified health centers ("FQHCs") dedicated to ensuring that Medi-Cal and indigent patients have access to primary care, including health promotion and disease prevention. The County of San Mateo contracts with the Health Plan of San Mateo (the "Plan") to provide all primary care services to Plan members assigned to the FQHCs for a fixed, capitated fee. The Plan has established a Pay for Performance ("P4P") incentive program to encourage the promotion of specific operational and care objectives, such as submitting documentation in a format that allows the Plan to better track care to its members, offering evening or weekend hours, performing annual well visits, diabetes testing, asthma action plans, women's health exams, referring patients to obstetricians, body mass index checks, and immunization registries. The Plan has established specific financial rewards for FQHCs and other primary care providers associated with meeting each P4P measure.

By law, the California Department of Health Care Services (the "Department") must ensure that each FQHC receive its pre-determined rate in full from Medi-Cal for each visit FQHCs render to Medi-Cal beneficiaries. When the Department delegates financial responsibility for services provided to a Medi-Cal beneficiary to a Medi-Cal managed care plan, such as the Plan, the Department must pay the FQHCs the difference between the amounts that the FQHCs were paid by the plans and the FQHCs' full per-visit Medi-Cal rate. However, to protect the value of a health plan's financial incentives to encourage specific behaviors, like the P4P incentive payments, formal federal agency guidance, state law and California's Medicaid State Plan all mandate that such financial incentives should be disregarded when calculating the supplemental payments made by the Department.

Notwithstanding this clear and consistent mandate, in this case, a Final Decision by the Chief Administrative Law Judge ("ALJ") of the Department's Office of Administrative Hearings and Appeals sought to reduce the Department's supplemental payments to its FQHCs by the amount of P4P incentives these FQHCs earned, $694,281 for this single year. The County of San Mateo respectfully requests this court to overturn this administrative decision, which overturns a well-reasoned Proposed Decision issued by the ALJ who presided over the administrative hearing

properly finding that consistent with the governing law, the P4P incentive payments at issue should be classified as "financial incentives."

The plain language definition of what constitutes a "financial incentive" as between a health plan and a provider is clear and not particularly subject to debate. The average person would understand that offers of remuneration above and beyond a provider's regular contracted payments associated with meeting specified targets, such as the performance of annual checkups or ensuring that diabetes patients' blood levels are within specified limits, are "financial incentives." This understanding is consistent with the federal regulation on point, which does not limit the scope of "any financial incentives" to be excluded when calculating the FQHCs' supplemental payment such that the P4P payments in this case would not constitute excluded financial incentives. Further, formal statements by the federal Centers for Medicaid and Medicare Services ("CMS") in the Federal Register (made after the administrative hearing in this case) confirm CMS' understanding of the broad scope of "financial incentive[s] related to meeting specified performance metrics" that should be excluded from the Department's calculation of supplemental payments. Both of these authorities on their face support an interpretation of "financial incentives" that encompasses the P4P incentive payments in this case.

However, the Final Decision rejects the Proposed Decision's sound legal reasoning by stretching the meaning of one sentence in a nearly twenty-year old CMS letter to exclude these P4P incentive payments from the category of "financial incentives." Specifically, from a single, dated, and informal reference describing certain financial incentives as "reduc[ing] unnecessary utilization of services or otherwise reduc[ing] patient costs," the Final Decision derives an absolute requirement that financial incentives must be supported by data demonstrating that the incentive reduced utilization or costs in order to be excluded from the calculation of supplemental payments. This is an unsupported conclusion contrary to the weight of legal authority.

This court should grant this motion for a writ of administrative mandate because:

- Both federal law and formal CMS interpretations broadly define financial incentives to encompass the P4P payments.

- The Final Decision's narrow definition of "financial incentives": (1) is directly contrary to federal law and CMS' formal interpretations; (2) negates the force of the Plan's financial incentives, contrary to CMS' intent; and (3) is based on supposed "expert" testimony on a question of legal interpretation.
- The Final Decision is based on an erroneous factual finding that the P4P incentive payments duplicate the capitated payments by the Plan. The evidence demonstrated that the FQHCs earn the P4P incentive payments for meeting specific targets, e.g., performing specific services subject to the timing and frequency established by the Plan, separate from the contractual obligations giving rise to capitated payments from the Plan.
- The Final Decision further relies on a faulty finding that the evidence did not demonstrate that the P4P incentive payments resulted in a reduction in costs or utilization because: (1) such a show is not required by law; (2) the Final Decision improperly shifts the burden of proof to the County of San Mateo; and (3) no evidence was presented to undermine the "axiomatic" connection between preventive services, on the one hand, and improvement in health status and reduction in health care service utilization and costs.
- The Final Decision erroneously determines that classifying P4P incentive payments as "financial incentives" would give rise to overpayments by the FQHCs because: (1) federal law requires the exclusion of the P4P incentive payments from the supplemental payment calculation, and thus, legally, there can be no overpayment; (2) the Final Decision makes no explicit factual findings to support this conclusion; and (3) to the extent the Final Decision relies on a speculative factual finding, that finding that the P4P payments duplicate the FQHCs' capitation payments is not supported by substantial evidence.

## II. RELEVANT MEDI-CAL BACKGROUND

### A. General Overview of the Medi-Cal Program

The Medicaid Act, 42 U.S.C. § 1396, et seq., authorizes federal financial support to states for medical assistance provided to certain low-income persons. (*Orthopaedic Hospital v. Belshe* (9th Cir. 1997) 103 F.3d 1491, 1493.) The program is jointly financed by the federal and state governments and administered by the states. (*Ibid*.; 42 C.F.R. § 430.0.) In order to receive

matching federal financial participation, states must agree to comply with applicable federal Medicaid law and regulations. (*See Alexander v. Choate* (1985) 469 U.S. 287, 289, fn. 1.)

California's Medicaid program ("Medi-Cal") is administered by the Department. (*See* Cal. Code Regs., tit. 22, § 50004; *see also* AR, Exh. 14, p. 16:6-13 [stipulation that the Department is the single state agency charged with administration of the Medicaid program, Medi-Cal].) The Medi-Cal program is responsible for establishing and complying with a state Medicaid plan (the "State 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 and 431.10.) The State Plan must be approved by the federal Centers for Medicare and Medicaid Services ("CMS") and describe the policies and methods to be used to set payment rates for each type of service included in the State Plan. (42 C.F.R. §§ 430.10 and 447.201(b).)

One way the Department administers Medi-Cal is through the fee-for-service program, under which the State pays providers for Medi-Cal covered services. (*Life Care Centers of America v. CalOptima* (2005) 133 Cal.App.4th 1169, 1174.) Another way the Department administers Medi-Cal is by contracting with various managed care plans to take on the responsibility for paying for the Medi-Cal-covered healthcare services utilized by the respective plan's enrollees. (*Ibid.*) The purpose of these Medi-Cal managed care plans is to "reduce costs, prevent unnecessary utilization, reduce inappropriate utilization, and assure adequate access to quality care for Medicaid recipients." (*Ibid.* [citation removed].) Medi-Cal managed care plans (like the Plan in this case) are "paid on a fixed, or 'capitated' basis for each Medi-Cal recipient, regardless of the level of services used by each recipient. In turn, the [Plan] assumes the financial risk of its members' care and pays health service providers directly." (*Ibid.*; *see also* Welf. & Inst. Code § 14087.6; AR, exh. 14, p. 92:3-15.)

**B. Medicaid/Medi-Cal Reimbursement to FQHCs**

The Medicaid Act requires each state Medicaid program to cover and pay for FQHC services. (42 U.S.C. § 1396a(a)(15).) Each state must establish a specific Medicaid "prospective payment system" ("PPS") reimbursement methodology for FQHCs. (42 U.S.C. § 1396a(bb).) PPS payments typically are calculated on a per-visit basis, based on a baseline estimate of the

reasonable cost of services for a baseline period, subject to certain adjustments. (42 U.S.C. § 1396a(bb)(3).)

Each state must ensure payment of the full PPS rate to a FQHC even when a Medicaid managed care entity pays the FQHC for the service, and the required additional payment is calculated based on the difference between the amount paid by the Medicaid managed care plan and the PPS rate. (42 U.S.C. § 1396a(bb)(5); see also 42 C.F.R. § 405.2469.)

Both California law and California's State Plan require the exclusion of financial incentives paid by Medi-Cal managed care plans from the calculation of supplemental payments. Specifically, Welfare and Institutions Code section 14132.100(h) supplemental payments to FQHCs must be calculated without including "managed care financial incentive payments that are required by federal law to be excluded from the calculation." Attachment 4.19-B, section L(3) to California's State Plan likewise requires that in calculating supplemental payments, "[p]ayments made to any FQHC… for FQHC… services under managed care contracts… will exclude any financial incentive payments to the FQHC… that are required by federal law to be excluded from the calculation…." (California Medicaid State Plan, Attachment 4.19-B, p. 6S, § L(3), available at http://www.dhcs.ca.gov/formsandpubs/laws/Documents/4.19B_6-6V.pdf; *see also* AR, exh. 7, p. 14.)

The parties agreed at the administrative appeal that the federal law defining the scope of financial incentives that should be excluded from the supplemental payment calculation is 42 C.F.R. section 405.2469. (Administrative Record ("AR"), exh. 2, p. 1; AR, exh. 3, p. 2.) That section at the time of this appeal[1] stated:

> Federally Qualified Health Centers under contract (directly or indirectly) with Medicare Advantage are eligible for supplemental payments for covered Federally Qualified Health Center services furnished to enrollees in Medicare Advantage plans offered by the Medicare Advantage organization to cover the difference, if any, between their payments from the Medicare Advantage plan and

[1] This regulation was amended, effective January 1, 2016, to reflect that no supplemental payment would be made where a Medicare managed care plan paid more than the Medicare FQHC rate to a FQHC. However, financial incentives continue to be excluded from the calculation of supplemental payments in current 42 C.F.R. section 405.2469(c). All references hereinafter to 42 C.F.R. section 405.2469 are to the version preceding the January 1, 2016, amendment.

> what they would receive under the cost-based Federally Qualified Health Center payment system.
>
> (a) Calculation of supplemental payment.
>
> (1) The supplemental payment for Federally Qualified Health Center covered services provided to Medicare patients enrolled in Medicare Advantage plans is based on the difference between –
>
> (i) Payments received by the center from the Medicare Advantage plan as determined on a per visit basis; or
>
> (ii) The Federally Qualified Health Center's all-inclusive cost-based per visit rate as set forth in this subpart, less any amount the FQHC may charge as described in section 1857(e)(3)(B) of the Act.
>
> (2) **Any financial incentives** provided to Federally Qualified Health Centers under their Medicare Advantage contracts, such as risk pool payments, bonuses, or withholds, are prohibited from being included in the calculation of supplemental payments due to the Federally Qualified Health Center.

(42 C.F.R. § 405.2469 (2015) [emphasis added].)

In a recent final rule governing Medicaid managed care, CMS reiterated that FQHCs are to receive financial incentive payments from Medicaid managed care plans on top of the full PPS payment resulting from the supplemental payment: "FQHCs and RHCs are required by statute to be reimbursed according to methodologies approved under the State plan. **In the event a particular financial incentive arrangement related to meeting specified performance metrics for these providers is part of the provider agreement with the managed care plan, those financial incentives must be in addition to the required reimbursement levels specified in the State plan.**" (Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27577 (May 6, 2016) [emphasis added].)

Historically, CMS also issued informal interpretive guidance related to payment for FQHC services in a State Medicaid Directors Letter ("SMDL") in 2000. In this SMDL, CMS explained that financial incentives offered by a Medicaid managed care organization ("MCO") should be excluded from Medi-Cal managed care payments in calculating a state's supplemental payments:

> Section 1902(a)(13)(C)(ii) of the Act requires States to make supplemental payments (at least quarterly) to FQHCs/RHCs that subcontract with MCOs representing the difference, if any, between

> the MCO's payment to the subcontracting FQHC/RHC and the payment to which the FQHC/RHC would be entitled for the services under the Act…. MCOs frequently use their own funds to include financial incentives in their contracts with subcontracting providers. Financial incentives provide the subcontractor with an incentive to reduce unnecessary utilization of services or otherwise reduce patient costs. Such incentives may be negative, such as withholding a portion of the capitation payments. If utilization goals are not satisfied, the subcontractor foregoes the withheld amount in whole or part. Incentives may also be positive, such as a bonus that is paid if desired utilization outcomes are achieved. In both cases, we believe these incentive amounts (whether positive or negative) are separate from the MCO's payment for services provided under the subcontract, do not include any additional Federal funding, and should not be included in the State's calculation of supplemental payments due the FQHC/RHC.
>
> Inclusion of incentive amounts (whether positive or negative) in calculating supplemental payments would negate the financial impact the incentive is designed to provide, since the FQHC/RHC would get the same total amount of money, regardless of whether it met the utilization or other goals set by the MCO. For this reason, we have determined that the State's quarterly supplemental payment obligation should be determined using the baseline payment under the contract for services being provided, without regard to the effects of financial incentives that are linked to utilization outcomes or other reductions in patient costs.

(CMS, SMDL 9/27/00, available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd092700.pdf [emphasis added]; AR Exh. J of Exh. 46.)

**C. Provider Audits and Appeals**

The Department conducts audits, including the settlement of cost reports and other audits of amounts paid for services to Medi-Cal beneficiaries. (*See*, *e.g.*, Welf. & Inst. Code §§ 14132.100(l), 14170.) Part of the cost report settlement for a FQHC is the calculation of the supplemental payments to a FQHC for services rendered to Medi-Cal managed care enrollees. A FQHC may appeal such an audit pursuant to Welfare and Institutions Code section 14171, which provides for an informal level hearing before a hearing auditor followed by a formal level hearing before an administrative law judge. (Welf. & Inst. Code § 14132.100(l).) Such appeals are governed by Code of California, title 22, sections 51016, et seq.

Pursuant to California Code of Regulations, title 22, section 51037, "[t]he Department has the burden of proof of demonstrating, by a preponderance of the evidence, that the audit findings were correctly made. Once the Department has presented such a prima facie case, the burden of

proof shifts to the provider to demonstrate, by a preponderance of the evidence, that the provider's position regarding disputed issues is correct."

## III. FACTUAL AND PROCEDURAL BACKGROUND

### A. The County of San Mateo's Provision of Health Care Services

The County of San Mateo is a political subdivision of the State of California. Counties like the County of San Mateo pull funding from various sources to provide health care services to their residents, not "as a profitable business model because it costs… three times as much to achieve the result than… we get compensated[.]" (AR, exh. 14, p. 193:21-23.) Approximately 90% of the patients receiving these health care services from the County of San Mateo are enrolled in Medi-Cal or indigent (i.e., without third-party coverage for health care). (*Id.*, pp. 193:16-194:3.)

As part of its mission to serve its citizenry, the County of San Mateo operates ten outpatient clinics that provide primary care services: Fair Oaks Family Health Center, Willow Clinic, North County Health Center, San Mateo Clinics – 30th Avenue, Daly City Youth Health Center, Coastside Health Center, Redwood City Youth Health Center, South San Francisco Health Center, Hoover Health Resources Center, and Edison Clinic. These clinics have been designated by the federal government as FQHCs, which means they receive specific grants to provide primary care services to the medically underserved. (42 U.S.C. § 254b(a)(1).) These FQHCs offer and provide certain outpatient services, including physician services, nurse practitioner, physician assistant, or certified nurse midwife services, clinical psychologist and clinical social worker services, and visiting nurse services. (*See* 42 U.S.C. §§ 1396d(l)(2), 1395x(aa)(1).)

### B. The Plan's Payments to the County of San Mateo

#### 1. Payment for Services

The Plan is the Medi-Cal managed care plan for San Mateo County. The Plan is an entity separate from the County of San Mateo. (AR, exh. 14, p. 135:20-22.) The Plan contracts for primary care services with the FQHCs owned and operated by the County of San Mateo. (*See* AR, exh. 14, pp. 135:12-136:4.)

During the time at issue, the Plan paid the County of San Mateo FQHCs on a capitated basis based on the capitated amounts that the Plan received from the State of California. (AR, exh. 14, pp. 136:10-137:13.) In other words, the Plan paid the FQHCs a "set rate each month based on the type of member." (*Ibid.*) In exchange for the payment, the FQHCs were required to meet a specified scope of work related to the provision of primary care services requested by members. (*Ibid.*) However, the FQHCs were reimbursed the same amount regardless of whether "a member goes to them for services or not, whether they provide individual services or not[.]" (*Ibid.*)

2. Pay for Performance Payments

Under a capitated model, the Plan became concerned about underutilization of services. (*See* AR, exh. 14, pp. 142:24-143:1.) The Plan considered creating financial incentives to ensure that its members were "receiving appropriate care at the appropriate time, … receiving the proper screenings, and to ensure that… their health care needs are identified and treated early on so that, down the line, they don't have diseases… or have hospitalizations or increased utilizations[.]" (*Id.* At p. 143:1-10.)

In response, in January 2008, the Plan established a P4P incentive program, which "consists of financial incentives designed to increase provider participation in quality of care activities, such as rendering or ensuring the completion of certain preventative care services." (AR, exh. H of exh. 46.) Testimony from the Plan below confirmed that the Plan established the P4P incentive program to change provider behavior "to focus them on certain preventive care measures that [the Plan] [developed] with the ultimate goal of improving quality of care and keeping our members healthy." (AR, exh. 14, pp. 139:22-140:6, 140:13-25, 144:7-10.) The Plan structured this program to provide immediate incentives for performing specific tasks, i.e., on a quarterly basis, to impact provider behavior in the present and to give providers the information they may need, like the number of women requiring women's health exams or diabetics requiring appointments or testing. (AR, exh. 14, pp. 144:7-145:11.) By tying P4P incentive payments to specific tasks, the Plan was also able to track the performance of individual providers and the effectiveness of the program. (AR, exh. 14, pp. 145:12-146:1.)

The Plan established the P4P incentives based on "measures that the plan wanted to improve quality on[.]" (AR, exh. 14, p. 141:12-142:3.) Indeed, many of the measures are also outcome measures for the Health Effect Data Information Center ("HEDIS"), which is the standard by which the State of California measures the quality of care rendered by the Plan to its members. The measures and incentives established by the Plan were:

| **P4P Measure** | **Incentive** | | **P4P Measure** | **Incentive** |
|---|---|---|---|---|
| Submit encounter forms for plans to track utilization | $3.00 paper/ $5.00 electronic | | Extended office hours | 10% of monthly capitation payment |
| Accept patient auto-assignment | 20% of monthly capitation payment | | Initial health assessment | $90 per claim |
| Annual child well visit | $90 per claim | | Annual teen well visit | $90 per claim |
| Women's health exam | $90 per claim | | Asthma action plan | $25 per claim |
| Postpartum exam by obstetrician ("OB") | $50 per claim | | Referrals by PCP to OB | $50 for each verification |
| OB visit | $100 for each verification | | Diabetes program | Varied incentives for specific tests/meeting specified lab results |
| Body mass index | $25 per claim | | Joining immunization registry | $500 incentive |

(AR, Exh. J of Exh. 46.)

The Plan developed each of these measures carefully to provide additional incentives for providers go beyond what was required under their capitation contracts. For example –

- Capitated providers have no incentive to submit any documentation of services rendered to the Plan because they receive the same payment regardless of whether a claim or an

encounter form is submitted. However, the submission of a claim or an encounter form allows the Plan to track the care that their members receive, in terms of utilization, type of care and quality, a tool to assist the Plan in providing better care. (AR, exh. 14, pp. 148:3-149:15.) By creating an increased incentive of $5.00 per electronic encounter form submission compared to $3.00 per paper encounter form submission, the Plan encourages providers to bill electronically. (*Ibid.*)

- Providers are not required to offer evening or weekend hours. However, recognizing the need to increase access for members who may not be available during business hours, the Plan has established a 10% bonus payment for providers to offer these extended hours. The Plan reasons that this incentive reduces costs for the Plan by offering primary care services during extended hours, without which members would be forced to seek more expensive care at hospital emergency rooms. (AR, exh. 14, pp. 149:16-150:7.)
- The incentive for auto-assignment encourages primary care providers to maintain an open panel so that new members can be automatically assigned to a physician to manage their care when they fail to select their own primary care physician. (AR, exh. 14, pp. 150:10-151:11.)
- The Plan also establishes financial incentives for primary care providers to perform specific services, such as an initial health assessment, an annual child well visit, an annual team well visit, a women's health exam, an asthma action plan, or a postpartum exam by an obstetrician. Regardless of whether the primary care providers actually rendered or arranged for this care, they would continue to receive payment under their capitation contracts. This financial incentive thus encourages providers to perform these services both timely and with the frequency expected by the Plan. (AR, exh. 14, pp. 151:19-153:19.)
- Because the Plan's own quality performance is measured based on achieving specific outcomes for diabetic patients, the Plan has established a diabetes program within the P4P incentive program to ensure "that our diabetics are seen by their primary care provider and they're getting these screen[ing] tests, at the very least, annually, and that they're

improving their actual outcomes it terms of their [Hb]A1C and LDL [levels]." (AR, exh. 14, pp. 153:20-155:10.) For example, the Plan establishes varied incentives for specific diabetes-related tests and screenings, and for achieving results for HbA1C and LDL-C tests within ranges established by the Plan. (AR, exh. 46, Provider's exh. J, pp. 4-5.)

As a contracted primary care provider, the County of San Mateo was also eligible to and did in fact receive P4P incentive payments for meeting these specific tasks. (AR, exh. 14, p. 158:9-11, 141:1-4.)

**C. The Department's Audit Adjustments**

The Department's auditor calculated the supplemental payments to the County of San Mateo's FQHCs by: (1) identifying the sum of all funds received by the FQHCs for services rendered to Medi-Cal managed care members, including P4P incentive payments and capitated payments; (2) identifying the aggregate PPS amount by multiplying each FQHC's PPS rate by the number of total visits; and (3) subtracting the total payment received for each FQHC from the aggregate PPS amount. (*See generally* AR, exh. 14, pp. 20:4-25:25, 30:3-39:21, 96:19-97:3; exh. 9.) The Department's audit reduced the supplemental payments to the County of San Mateo by $694,281 compared to the County of San Mateo's own estimates due to the inclusion of the P4P incentive payments in the County of San Mateo's managed care payments. (AR, exh. 14, pp. 14:16-16:5.)

**D. The Administrative Appeal**

1. <u>The Informal Level Appeal</u>

The County of San Mateo timely requested an informal level review of the Department's reduction in its supplemental payments associated with the inclusion of the P4P incentive payments in its Medi-Cal managed care payments, among other issues on April 16, 2014. (AR, exhs. 29, 30.) The Hearing Auditor denied the appeals related to the reduction in supplemental payments associated with the P4P incentive program at the informal level on October 29, 2014. (AR, Exh. 26.) However, it is important to note that the informal level is intended to resolve facts and issues in dispute, and not to determine the meaning of the law. (*See* Cal. Code Regs., tit. 22, § 51023(c).)

2. The Formal Level Appeal

The County of San Mateo timely requested a formal level appeal on November 25, 2014. (AR, exh. 25.) The formal hearing occurred on September 15, 2015, before ALJ Lewis F. Munoz.

At the hearing, the parties stipulated to use the 39th Avenue Clinic as the representative clinic for the appeal. (AR, exh. 7, pp. 2:23-3:6; exh. 14, pp. 12:25-14:1.) Pursuant to the stipulation, the "determination of the P4P issue as to the 39th Avenue Clinic will be applicable to Provider's remaining nine clinics." (*Ibid.*) The parties further stipulated that the total P4P amount in dispute is $694,281, and that the sole disagreement is whether the P4P incentive payments should be included in the managed care plan payment amount. (AR, exh. 14, pp. 14:16-16:5.)

At the hearing, the Department presented two witnesses: Jianfu Huang, the auditor who performed the audit and Marisa Ho, the audit supervisor. The County of San Mateo presented two witnesses: Nicole Ford from the Plan and Timothy Gray, a reimbursement consultant.

3. The Proposed Decision

On October 12, 2016, ALJ Munoz announced his Proposed Decision. (AR, exh. 7.) The Proposed Decision would have granted the County of San Mateo's appeal. First, the Proposed Decision finds that the P4P payments were financial incentives under the regulation, the objective of which was to "incentivize Providers' behavior and focus them on getting patients into their clinics for preventive health care." Second, the Proposed Decision finds that the inclusion of the P4P incentive payments in the supplemental payment calculation would undermine the purpose of having financial incentives. The Proposed Decision reasons that "if the financial incentive payments were included in the supplemental payment calculation, they would not provide any incentive because Provider's entire reimbursement would remain the same whether or not they met the criteria for receiving the financial incentives." Third, the Proposed Decision dismisses a concern raised by the Department that the exclusion of the P4P incentive payments in the supplemental payment calculation would result in double payment from Medi-Cal for the same service, by determining that the FQHCs were to receive their capitated payments from the Plan, their supplemental payments based on their capitated payments, and then the P4P incentive payments. The Proposed Decision notes that the State Plan "prohibits including financial

incentive payments in the calculation of the supplemental payment made to FQHCs[,]" without an exception for financial incentives paid with Medi-Cal source funds.

4. The Final Decision

On January 12, 2017, Chief ALJ Stevenson issued the Final Decision, rejecting the Proposed Decision. The Final Decision upholds the Department's inclusion of the P4P payments in the managed care payments used for calculating the County's supplemental payments.

First, the Final Decision determines that the Department had presented a prima facie case that its audit findings were correct, based on the Department's contention that the P4P incentive payments at issue were not of the type of financial incentives that should be excluded from consideration in calculating supplemental payments. Specifically, the Final Decision analyzes the examples by CMS in the SMDL based on "expert" testimony by the Department's staff to determine that CMS had intended to limit the types of financial incentives excluded from the supplemental payment calculation to those with the "shared goal of cutting costs or reducing utilization of services, coupled with benchmarks or measures used to determine if the goal has been reached." The Final Decision determines that the P4P incentive payments "serve the goal of encouraging providers to provide preventative care[,]" which the Final Decision concluded was "already required under their managed care contracts. ¶ While it is axiomatic that preventative care in the present can lead to healthier patients in the future, which could then in reduced costs or utilization, this contention… is speculative in that Provider has not offered data to support that result."

The Final Decision further determines that the County of San Mateo failed to meet its burden to prove that its position is correct based on the Chief ALJ's: (1) conclusion that the P4P incentive payments "are nothing more than additional reimbursement for specific services and incidental activities already covered under the Provider's MCO contract[;]" (2) determination, without evidentiary citation, that "it is pure speculation that a single instance of preventive care" can lead to better health outcomes that could reduce utilization of more costly services in the future; (3) conclusion that the Plan's structure of the P4P incentive payments rewards single instances of service, rather than a trend of preventative care for the Plan as a whole; (4)

understanding that CMS guidance and the Department's expert witnesses require financial incentives to meet goals or outcomes, such as lowered cost or reduced utilization; and (5) finding that the P4P incentive payments are not linked to reduction in utilization outcomes or reductions patient costs. Lastly, the Final Decision agreed with the Department's contention that excluding the P4P incentive payments would result in overpayments to the FQHCs.

## IV. STANDARD OF REVIEW

"Administrative mandamus under [CCP] section 1094.5 is appropriate to inquire 'into the validity of any final administrative order or decision made as the result of a proceeding in which by law a hearing is required to be given, evidence is required to be taken, and discretion in the determination of facts is vested in the inferior tribunal....' (Code Civ. Proc., § 1094.5, subd. (a).)" (*Conlan v. Bonta* (2002) 102 Cal.App.4th 745, 751 [citation in original].) "The inquiry in such a case shall extend to the questions whether the respondent has proceeded without, or in excess of, jurisdiction; whether there was a fair trial; and whether there was any prejudicial abuse of discretion. Abuse of discretion is established if the respondent 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(b).)

Where, as here, the appeal involves an interpretation of the law, the trial court exercises its independent judgment to "declare the true meaning and correct interpretation of statutes and regulations and must reject any erroneous agency interpretation." (*See Family Planning Associates Medical Group, Inc. v. Belshe* (1998) 62 Cal.App.4th 999, 1004; *see also Van Wagner Communications, Inc. v. City of Los Angeles* (2000) 84 Cal.App.4th 499, 508 [stating that a person aggrieved by an agency determination has a right to "independent judicial review" of questions of law and requesting agency interpretation of an ordinance].) As to questions of fact, "[t]he Department's decision is evaluated by the trial court under the substantial evidence test." (*Advanced Choices, Inc. v. Dept. of Health Services* (2010) 182 Cal.App.4th 1661, 1669 [citation omitted].)

Here, this court is tasked with determining the proper meaning of what managed care payments must be taken into consideration under 42 U.S.C. section 1396a(bb)(5) and 42 C.F.R.

section 405.2469. As the statute is ambiguous or silent as to how financial incentives should be addressed, this court must give strong weight to the interpretation by the agency tasked with the implementation of the statute, CMS. (*See Olszewski v. Scripps Health* (2003) 30 Cal.4th 798, 821; *Consejo de Salud de la Comunidad de la Playa de Ponce, Inc. v. Gonzalez-Feliciano* (1st Cir.) 695 F.3d 83, 97.) No deference should be afforded to the Department's litigating position in this case because it revolves around the interpretation of the requirement in federal law of the financial incentives that must be excluded when calculating the supplemental payment. (*Orthopaedic Hosp. v. Belshe* (9th Cir.) 103 F.3d 1491, 1495 [court reviews de novo agency's interpretation of federal statute without affording deference granted to federal agency's interpretation of its own statutes]; *Yamaha Corporation of America v. State Board of Equalization* (1998) 19 Cal.4th 1, 24, citing *Culligan Water Conditioning v. State Bd. Of Equalization* (1976) 17 Cal.3d 86 [no deference to agency's litigation position].)

## V. THE DEPARTMENT COMMITTED AN ABUSE OF DISCRETION BY UPHOLDING THE INCLUSION OF P4P INCENTIVE PAYMENTS WHEN CALCULATING THE FQHC'S SUPPLEMENTAL PAYMENTS

### A. The Final Decision Fails to Apply the Proper Law by Narrowly Defining of "Financial Incentives" Without Legal Basis

This court should issue a writ of administrative mandate overturning the Final Decision because the Final Decision improperly limits the types of financial incentives that must be excluded from managed care payments when calculating supplemental payments. Neither federal law, nor subregulatory guidance from CMS, nor state law, nor the Medicaid State Plan permits the Director to apply an arbitrary standard, e.g., that financial incentives cannot be excluded from the supplemental payment calculation unless they lower costs or reduce utilization on a plan level. Here, the P4P incentives acted to encourage specific behaviors by network providers that the Plan sought to encourage. These incentives fall within the scope of financial incentives that should be excluded from the supplemental payment calculation.

1. The Plain Language of the Law Broadly Defines the Scope of Financial Incentives to Include the P4P Incentive Payments

Federal law embodied at 42 C.F.R. section 405.2469(a)(2) broadly defines the scope of "financial incentives" to be excluded from the supplemental payment calculation. In determining the meaning of statute, the courts "look first to the words of the statute, giving the language its usual, ordinary meaning." (*Hunt v. Super. Ct.* (1999) 21 Cal.4th 984, 1000.) "Where the words of the statute are clear, we may not add to or alter them to accomplish a purpose that does not appear on the face of the statute or from its legislative history." (*Burden v. Snowden* (1992) 2 Cal.4th 556, 562.)

Specifically, 42 C.F.R. section 405.2469(a)(2) requires that "[a]ny financial incentives" provided to FQHCs under managed care contracts, "such as risk pool payments, bonuses, or withholds" are not considered when calculating supplemental payments to a FQHC. The everyday, plain language use of the term "financial incentive" is any monetary amount offered to encourage specific behaviors. By analogy, 42 C.F.R. § 438.6(a) defines an "incentive arrangement" in the context of Medicaid managed care as "any payment mechanism under which a [Medicaid managed care plan] may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract." Borrowing this understanding, a "financial incentive" in the context of 42 C.F.R. section 405.2469(a)(2) should be understood to include payment mechanisms under which a FQHC "may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract."

The use of the qualifier "any" before "financial incentives" in 42 C.F.R. section 405.2469(a)(2) clarifies any question that may arise as to the scope of "financial incentives." The term "any" is unambiguously inclusive, indicating CMS' intent to broadly define the scope of the financial incentives excluded from the supplemental payment calculation.

The phrase "such as" set forth in 42 C.F.R. section 405.2469(a)(2) relates back to the broad concept of "financial incentives," and the examples that follow after the phrase "such as" in that paragraph represent a nonexclusive list across a broad spectrum of approaches to encourage specific provider behaviors. The use of the phrase "such as" to illustrate the breadth of the

overriding concept was explained in *Shaddox v. Bertani* (2003) 110 Cal.App.4th 1406:

> [M]ost statutes must deal with untold and unforeseen variations in factual situations, and the practical necessities of discharging the business of government inevitably limit the specificity with which legislators can spell out "instances of a statute's intended application." [] As this Court recently stated: "To require that amount of detail would be inconsistent with the principle that legislation does not have to possess the exactness of mathematical formulae….
>
> The phrase "such as" is not a phrase of strict limitation, but is a phrase of general similitude indicating that there are includable other matters of the same kind which are not specifically enumerated.

(*Shaddox*, *supra*, 110 Cal.App.4th at 1413-14 [citations omitted].) Applying this constructive aid, the language "such as risk pool payments, bonuses, or withholds" is intended to provide exemplars of the general category of "any financial incentives," but not to act as strict limitations.

As found by ALJ Munoz in the Proposed Decision, "the objective of [the Plan's] P4P program was to incentivize Providers' behavior and focus them on getting patients into their clinics for preventive health care." (AR, exh. 7, p. 18:15-17.) Specifically, P4P incentive payments are "financial incentives… encouraging Providers to render specific preventive health care services, perform tasks, or undertake performance measures (i.e., using correct encounter forms, having extended office hours, performing annual well visits, diabetes testing, asthma action plans, women's health exams, referring patients to OB physicians, body mass index checks, and immunization registries.)" (*Id.* at p. 18:17-22.) These fall squarely within the broad scope of "financial incentives" required by law to be excluded from the supplemental payment calculation pursuant to Welfare and Institutions Code section 14132.100(h) and 42 C.F.R. section 405.2469(a)(2).

Considering the exemplars in the regulation, the P4P incentive payments are or are sufficiently similar to the concept of a "bonus" to be considered a "financial incentive." The plain language definition of the term "bonus" is "money or an equivalent given in addition to [one's] usual compensation[.]" (Merriam Webster at https://www.merriam-webster.com/dictionary/bonus.) Here, the Plan pays the County of San Mateo capitation under its contracts to provide all the primary care services that the Plan members request from their

assigned FQHCs. Like a bonus, the P4P incentive program provides additional payment on top of the capitated payment in order to create a financial incentive for the County of San Mateo's FQHCs to emphasize certain types of care or specific types of behaviors.

To the extent there was any ambiguity on this issue at the time this case was pending at the administrative level (which there was not), CMS has now made it clear in its Medicaid managed care final rule that the Department is not permitted to arbitrarily construe CMS' prior interpretations to exclude the P4P incentive payments. In the 2016 Federal Register, CMS unambiguously confirmed its longstanding interpretation of federal law that "[i]n the event a **particular financial incentive arrangement related to meeting specified performance metrics** for these [FQHC or RHC] providers is part of the provider agreement with the managed care plan, **those financial incentives must be in addition to** the required reimbursement levels specified in the State plan." (81 Fed. Reg. at 27577 [emphasis added].) Great deference by this court should be afforded these statements because: (1) CMS is the agency entrusted with the implementation of the Medicaid Act; (2) 42 U.S.C. section 1396a(bb)(5) is silent as to the treatment of financial incentives; and (3) CMS' interpretation is reasonable. (*See National Cable & Telecommunications Ass'n v. Brand X Internet Servs.* (2005) 545 U.S. 967, 981-1000 [adopting agency's formal interpretation of statute pursuant to *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.* (1984) 467 U.S. 837 because: (1) Congress had delegated implementation authority to the federal agency; (2) the statute did not address the precise question at issue; and (3) the agency's construction was reasonable].)

Here, the P4P is a financial incentive arrangement that is directly tied to meeting specified performance metrics, as described in section III.B.2. This formal interpretation by CMS prohibits the State of California from imposing an arbitrary requirement that such incentives be linked to reductions in utilization outcomes or reductions to patient costs on a plan level in order to be excluded from the supplemental payment calculation. (*See generally*, *Chevron U.S.A. Inc.*, *supra*, 467 U.S. 837.) Accordingly, the P4P incentive payments must be considered financial incentives excluded from the supplemental payment calculation.

2. The Final Decision Commits Legal Error by Improperly Narrowing the Scope of Financial Incentives

The Final Decision makes a number of illogical leaps to conclude that the P4P incentive payments should not be excluded for the purposes of calculating the FQHCs' supplemental payments, accepting the Department's position that it only needed to exclude financial incentives with the "shared goal of cutting costs or reducing utilization of services, coupled with benchmarks or measures [established on the health plan level] to determine if the goal has been reached." (AR, Exh. 1, pp. 23:11-24:10.) The Final Decision leaps too far by "seek[ing] hidden meanings not suggested by the statute…." (*People v. Knowles* (1950) 35 Cal.2d 175, 183.) There is nothing in 42 C.F.R. section 405.2469 or elsewhere that applies such a stringent definition to the "financial incentives" required by law to be excluded from the supplemental payment calculation.

Specifically, the Final Decision commits legal error in its definition of the scope of financial incentives excluded from the supplemental payment calculation because: (1) it narrowly defines "financial incentive" contrary to federal law and CMS' formal interpretations; (2) it applies a narrow definition in a manner that eviscerates CMS' intent; and (3) it relies on factual testimony to supercede the plain language meaning of the authorities governing this case to insert a "benchmark" evidentiary standard into the definition of a "financial incentive."

*a. The Final Decision's Limited Definition of Financial Incentives to Require a Relationship to the Reduction Costs or Utilization and Data Demonstrating Improvement Compared to a Benchmark at a Plan Level Contradicts 42 C.F.R. Section 405.2469 and Formal CMS Interpretations*

The Final Decision improperly reads the SMDL's single reference to financial incentives "to reduce unnecessary utilization of services or otherwise reduce patient costs" as requiring a direct linkage between a financial incentive and the reduction of utilization or patient costs. As a preliminary matter, this particular formulation of the scope of "financial incentives" is not found in any federal law or CMS statements. The Final Decision derives it solely from its own

interpretation, based largely on supposed "expert" testimony, discussed in further detail in section V.A.2.c below.

The County of San Mateo notes that the SMDL may be treated as a policy directive pursuant to *Skidmore v. Swift & Co.* (1944) 323 U.S. 134, garnering some level of respect from this court. However, formal CMS interpretations, such as the regulation at 42 C.F.R. section 405.2469(a)(2) and the Federal Register statements from 2016, are subject to *Chevron* deference. (*See Tibble v. Edison Intern.* (9th Cir. 2013) 729 F.3d 1110, 1122-23, *rev'd on other grounds* (2015) 135 S.Ct. 1823 ["we do not view the fact that the interpretation appears in a final rule's preamble as disqualifying it from *Chevron* deference… Though not a necessary condition, a notice-and-comment rule is virtually assured eligibility for *Chevron* deference].) To the extent any statement in the SMDL is relied upon to contradict the broad statements in CMS' formal interpretations, the formal interpretations must govern because *Chevron* requires greater deference than the respect afforded informal interpretations pursuant to *Skidmore*. (*Christensen v. Harris County* (2000) 529 U.S. 576, 587 [deferring to agency interpretation through formal rulemaking and not affording *Skidmore* respect to contrary agency interpretation in informal opinion letter]; *see also National Cable & Telecommunications Ass'n*, *supra*, 545 U.S. at 981 [agency inconsistency not a basis to decline to analyze an agency's interpretation under *Chevron*].)

As acknowledged in the Proposed Decision, the SMDL does not require the Final Decision's interpretation that a financial incentive does not exist unless the plan or FQHC can present data demonstrating a relationship between the financial incentive and reduced costs or utilization, as compared to a benchmark on an aggregate level. (*See* AR, Exh. 7, p. 19:18-26.) As an initial matter, the SMDL includes three mentions of utilization goals or outcomes, but only describes once the "reduc[tion in] unnecessary utilization of services." (AR, Exh. K of Exh. 46.) However, as explained in the Proposed Decision, "the CMS letter did not amend [section 405.2469] and did not create a new section of definitions. CMS simply explained its own understanding how financial incentives worked." (AR, exh. 7, p. 19:22-24.) The Final Decision illogically interprets this single mention of financial incentives to reduce unnecessary utilization of services as precluding an entire class of financial incentives: those associated with specific care or

actions that a Medicaid managed care plan may determine are beneficial for a myriad of reasons, such as plan management, long-term public health, or to avoid more expensive secondary care.

Here, the P4P incentive payments are generally linked to utilization outcomes, such as the provision of specific preventive services. "[M]ost of the [P4P] utilization outcome is that the service [i.e., the incentive task] is done." (AR, exh. 14, ap. 142:4-15.) In fact, the diabetes-related incentive payments are tied to proof that an additional outcome is actually achieved. (*Id.*) As acknowledged by ALJ Munoz, "[c]learly, the performance measures address the underutilization and overutilization of health care services with the objective of reducing the likelihood of patients requiring costlier future treatment." (AR, exh. 7, p. 18:22-24.)

Even to the extent that this single mention of incentives to "reduce unnecessary utilization of services" could be considered to limit the scope of the SMDL, such a narrow interpretation is impermissible in light of CMS' formal administrative acts in its 2005 adoption of 42 C.F.R. section 405.2469(a)(2) (Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2006, 70 Fed. Reg. 45764, 45872 (Aug. 8, 2005); *see also* Medicare Program: Establishment of the Medicare Advantage Program, 70 Fed. Reg. 4588, 4738 (Jan. 28, 2005)) and the 2016 adoption of the Medicaid managed care final rule. (Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27577 (May 6, 2016).) As discussed above, the scope of "any financial incentives" in 42 C.F.R. section 405.2469(a)(2) and a "financial incentive arrangement related to meeting specified performance metrics" in the 2016 Medicaid managed care final rule contain no limitation or condition that financial incentives must be tied to reductions in costs or utilization, supported by data compared to a benchmark on an aggregate level, in order to be excluded from the supplemental payment calculation. The P4P incentive payments would fall within the broad class of financial incentives described in either 42 C.F.R. section 405.2469(a)(2) or the Medicaid managed care final rule preamble. Accordingly, in the unlikely extent this court believes that the SMDL would suggest such a result, CMS' broad definition of financial incentives in its formal

administrative acts must be given greater deference. (*See Christensen v. Harris County*, *supra*, 529 U.S. at 587.)

*b. The Final Decision Improperly Narrowly Interprets the SMDL In a Manner that Undermines CMS' Intent*

The Final Decision's narrow interpretation of the SMDL violates fundamental rules of interpretation. A court should "not adopt a narrow or restricted meaning" "if it will result in an evasion of the evident purpose of a statute when a permissible, but broader, meaning would prevent the evasion and carry out that purpose." (*Copley Press, Inc. v. Super. Ct.* (2006) 39 Cal.4th 1272, 1291-92.) Here, the Final Decision would eviscerate CMS' policy in the context of the P4P incentive program.

From a policy perspective, CMS has expressed its "[support] of managed care plans incentivizing providers to meet performance metrics that improve the quality and efficiency of care." (81 Fed. Reg. at 27540.) In so doing, CMS has given Medicaid managed care plans broad flexibility to design how those financial incentives are structured. (*Ibid.* [describing the borrowed Medicare Advantage limitations on "physician incentive programs" as the "only explicit limitations" on like incentives for the Medicaid managed care program.) Consistent with this longstanding policy, CMS reasoned in the SMDL that the "[i]nclusion of incentive amounts (whether positive or negative) in calculating supplemental payments would negate the financial impact the incentive is designed to provider, since the FQHC/RHC would get the same total amount of money, regardless of whether it met the utilization or other goals set by the MCO." (AR, exh. K of Exh. 46, p. 2.)

The Final Decision's narrow interpretation would evade the purpose of this longstanding policy. As acknowledged in the Proposed Decision, "if the financial incentive payments were included in the supplemental payment calculation, they would not provide any incentive because Providers' entire reimbursement would remain the same whether or not they met the criteria for receiving the financial incentives." (AR, exh. 7, p. 21:9-13.) If allowed to stand, the Final Decision would negate any financial incentives for FQHCs to meet specified care or

organizational metrics identified by the Plan, in direct contravention of the stated intent of the SMDL.

By contrast, the reference to "an incentive to reduce unnecessary utilization of services" could be interpreted as simply an example of the broader scope of "utilization outcomes." The reasonableness of such an interpretation is embodied in the Proposed Decision authored by ALJ Lewis. (*See generally* AR, exh. 7.) Broadly interpreting "utilization outcomes" to apply to both the reduction of unnecessary utilization of services and the promotion of the utilization of beneficial services include the task-related performance metrics established by the Plan. In so doing, this broader interpretation would protect CMS' longstanding intent to permit Medicaid managed care plans the flexibility to establish incentive programs to meet their needs by continuing to preserve the financial incentives established by the Plan.

*c. The Final Decision Legally Erred by Relying on Factual Testimony To Supercede the Plain Language Interpretation of the Terms Financial Incentives, Risk Pool, Bonus and Withholds*

The Final Decision relies heavily on "expert" testimony from the Department "that common elements among risk pool payments, bonuses, and withholds… include the shared goal of cutting costs or reducing utilization of services, coupled with benchmarks or measures used to determine if the goal has been reached." (AR, exh. 1, p. 16:11-20, citing AR, exh. 14, pp. 49:21-25[2], 98:19-25.) It is well established that "[t]here are limits to expert testimony, not the least of which is the prohibition against admission of an expert's opinion on a question of law." (*People v. Nan Hui Jo* (2017) 15 Cal. App.5th 1128, 1176; *see also King v. State* (2015) 242 Cal.App.4th 265, 292 [expert not allowed to testify to legal conclusions in the guise of expert opinions].) To the extent that the Final Decision relies on the Department's supposed "expert" testimony as to the legal meaning of risk pools, bonuses and withholds, such reliance is impermissible.

[2] Indeed, the testimony by auditor Jianfu Huang as to the definition of these types of exclusions should be disregarded as it clearly falls outside the Department's designation of him as an expert in the area of health program auditing as it pertains to Medi-Cal cost reimbursement principles or cost reporting. (*See* AR, exh. 14, p. 29:11-23.)

Moreover, such "expert" testimony cannot outweigh the plain meaning of the terms financial incentives, and particularly the terms bonuses, and withholds, which can be discerned by their everyday use and the way in which they have been used by CMS. It is a logical stretch to think that any lay person's definition of a "financial incentive" would require any data demonstrating the impact of the measures to improved health measures across a population. The plain language concept of a "financial incentive" simply encompasses monies offered to encourage the meeting of specified targets.

This is consistent with the plain language understanding of the exemplars identified by CMS. For example, as discussed above, a "bonus" is well understood by a lay person to involve payments they receive in addition to set compensation, e.g., either a merit/production-based or discretionary bonus that an employee may receive at year end. Given the different forms that a bonus may take, there is no expectation that improvements on an aggregate basis be demonstrated as a prerequisite to a bonus.

This understanding of a bonus comports with CMS' consistent definition of the term "bonus" in the context of physician incentive plans, a subset of financial incentives offered by health plans. In those contexts, a "bonus" means "a payment [a health plan] makes to a physician or a physician group beyond the physician's set salary, fee-for-service payments, or capitation." (42 C.F.R. § 417.479; *see also* 42 C.F.R. § 422.208(a) [similar definition].) Indeed, CMS has historically acknowledged that while bonuses may be based a health plan's overall performance, they could also be based on actions by a physician or physician's group. (*See* Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 61 Fed.Reg. 13430-01, 13432 (Mar. 27, 1996).)

Similarly, a "withhold" simply means something that is "held back from[,]"[3] in this case, capitation. In this context, CMS' definition of a "withhold" in the context of Medicaid managed care is instructive. Pursuant to 42 C.F.R. § 438.6(a), a "withhold arrangement" is "any payment mechanism under which a portion of the capitation is withheld… and a portion of or all of the

[3] *See* Merriam-Webster Dictionary, available at https://www.merriam-webster.com/dictionary/withhold.

withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract." Again, nothing in this definition suggests the stringent standard applied in the Final Decision.

Based on the above, neither the plain language understanding nor CMS' own interpretation of the terms "bonus" or "withhold arrangement" require that these types of financial arrangements be tied to either cutting costs or reducing utilization of services, nor that they be tied to benchmarks established on a plan/aggregate level. On the contrary, the meaning of these terms based on the above is that they are financial incentives established to encourage doing something beyond the operational requirements of a provider's contract. Nothing in these definitions would require a provider or a plan to substantiate an incentive based on data showing improvement on a plan level compared to a benchmark, as the Final Decision purports to do here, solely based on supposed "expert" testimony. Accordingly, the Final Decision's reliance on "expert" testimony to define legal terms is erroneous.

**B. The Final Decision's Finding that the P4P Incentive Payments Were Additional Payments for Services Already Covered under the FQHCs' Capitation Contract Is Not Supported by Substantial Evidence**

An underlying premise of the Final Decision is the factual finding that "the P4P payments serve the goal of encouraging providers to provide preventative care already required under their managed care contracts." The Final Decision cites no evidence in support of this proposition.

In fact, the evidence presented in the administrative appeal demonstrated that, like the financial incentives in 42 C.F.R. section 405.2469 and the SMDL, the P4P incentive payments are separate and apart from the Plan's capitation payments to the FQHCs. (AR, exh. 14, pp. 158:5-11; 159:10-20.) Testimony from Nicole Ford, representing the Plan, demonstrated that "capitation is a rate that is paid to a provider regardless of whether a particular service is provided." (AR, exh. 14, pp. 142:16-143:10.) Ms. Ford further testified that the P4P incentive payments encourage the FQHCs to render specific types of care in the timeframes and under the frequency established by the Plan. (AR, exh. 14, pp. 151:19-153:19.) The P4P incentive payment program is an important

part of the Plan's efforts to improve outcomes for members. (AR, exh. H of exh. 46.) In other words, the P4P program "incentive[s] primary care and preventative care services… that otherwise may or may not be done by a provider." (AR, exh. 14, p. 151:12-18.) Ms. Ford that the P4P incentive payments for specific services are not requirements for the FQHCs to be paid under their capitation contracts. (AR, exh. 14, p. 142:4-15.)

The Department's evidence does not support the proposition that the capitation payments made by managed care plans covered the preventive care encouraged by the P4P incentive program. The only evidence cited by the Department in support of this proposition is evidence that the general scope of FQHC services as defined in the context of the Medi-Cal fee-for-service program include primary and preventive health services that are identified as tasks on the P4P schedule. (*See* AR, exh. 11, p. 10:16-11:3.) However, as discussed above, the Medi-Cal managed care program is separate from the Medi-Cal fee-for-service program. Accordingly, this evidence related to definitions in the fee-for-service program is completely irrelevant to whether the service is covered under the managed care capitation contract, which is the factual finding made in the Final Decision. Accordingly, the factual finding that the P4P payments duplicate requirements under the FQHCs' managed care contracts is not supported.

### C. The Final Decision's Finding that The P4P Incentive Payments Do Not Reduce Costs or Utilization Is Based on The Final Decision's Imposition of the Burden of Proof on the County of San Mateo and Not Supported by Substantial Evidence

In the Final Decision's analysis that the Department had met its burden of proof that its audit findings were correctly made, the Final Decision quizzically states that "[w]hile it is axiomatic that preventative care in the present can lead to healthier patients in the future, which could then result in reduced costs or utilization, this contention… is speculative in that Provider has not offered data to support that result. In addition, since each P4P payment is based on a *single instance* of providing care such as a well-baby checkup, it would be impossible to make such a determination…." (AR, exh. 1, p. 17:1-6.) As a preliminary matter, this factual finding is irrelevant to the final outcome in this case because the law does not require a demonstrated

connection between a particular financial incentive and healthier patients in the future on an aggregate level.

As acknowledged by the Final Decision, it is indeed "axiomatic" that "preventative care in the present can lead to healthier patients in the future[.]" Indeed, testimony by the Department conceded that "[i]n theory," preventative services could reduce the unnecessary utilization of services or reduce patient costs. (AR, exh. 14, p. 127:18-23.) Timothy Gray testified on behalf of the FQHCs that "we know that when you do these things [like render preventive care], people live longer; ER visits are… saved; better health outcomes; less cost; earlier, the better. Ounce of prevention is worth a pound of cure. And nobody has, necessarily, the scale to say is it a pound or a pound and a half or two pounds of cure. But we know that we get more – by spending an ounce, we get more in the end." (AR, exh. 14, pp. 189:10-190:3.) Moreover, the Plan established the P4P program with specific Plan-wide goals in mind, such as reducing expensive emergency room care (AR, exh. 14, pp. 149:16-150:7), increasing case management (*see* AR, exh. 14, pp.. 150:10-151:11), or managing chronic diseases like diabetes. (AR, exh. 14, pp. 153:20-155:10.) Many of the P4P targets are tied to specific quality standards imposed on the Plan by the Department. (AR, exh. 14:12-142:3.)

Yet, apparently disregarding this testimony, the Final Decision relies on the lack of evidence evaluating whether a single instance of providing care conclusively provides a long-term benefit for its factual finding that there is no such link. (AR, exh. 1, p. 17, n. 23, citing to AR, exh. 14, pp. 171:8-19; 172:9-10.) However, this does not provide sufficient evidentiary support for the factual finding in light of the "axiomatic" nature of preventive care leading to reduced utilization and costs, as well as the testimony provided as to the purpose of the P4P targets in hearing.

Moreover, the Final Decision improperly found against the County of San Mateo in the absence of any evidence presented by the Department in support of this proposition. The regulations governing provider audit appeals provides that the "Department has the burden of proof of demonstrating, by a preponderance of the evidence, that the audit findings were correctly made." (Cal. Code Regs., tit. 22, § 51037(i).) With respect to this particular finding, the Department provided no evidence to meet its burden of proof to demonstrate that the financial

incentives are not related to improved health outcomes. Accordingly, the Final Decision's finding improperly imposes the burden of proof to the County of San Mateo.

**D. To the Extent that The Final Decision is Based on Its Determination that the Exclusion of P4P Incentive Payments Would Lead to an Overpayment, This Determination is Legally Erroneous and Unsupported by Evidence-Based Factual Findings**

The heading of the last section of the Final Decision announces that "Exclusion of the P4P Payments Would Result In an Impermissible Overpayment and Could Implicate Principles of Payer of Last Resort." The section heading appears to be asserting an additional rationale in support of the Final Decision.

Here, an overpayment only exists to the extent that the FQHCs receive money to which they are not entitled. (*See* 42 U.S.C. § 1320a-7k(d)(4)(B).) However, state and federal law explicitly permit FQHCs to be paid a broad array of financial incentives above their PPS rates. (*See*, *e.g.*, Welf. & Inst. Code § 14132.100(h); 42 C.F.R. § 405.2469; *see also* California Medicaid State Plan, Attachment 4.19-B, p. 6S, § L(3).) To the extent the law requires the FQHCs to receive both their PPS rates and the P4P incentive payments for meeting the targets set forth by the Plan, there is legally no overpayment. (*See* AR, exh. 7, p. 23:12-14 [Proposed Decision finding that "this is not a double payment because Medi-Cal is obligated to make these payments under the law and is also obligated to reimburse the FQHCs one-hundred percent of their reasonable and allowable costs."].)

Moreover, the Final Decision does not base this determination on a concrete factual finding. In support of this section, the Final Decision simply states that "[i]f in fact a provider was compensated via a capitated payment from a Medi-Cal managed care plan for a service, such as a standard well-baby exam, and then was given a PPS supplemental payment to ensure that provider was fully compensated for the service, and thereafter received an *additional* payment for the same visit for the same patient on the same day, that would indeed result in an overpayment." This sentence is simply stated as speculation, not a factual finding. Accordingly, it cannot support the Final Decision's purported determination on overpayments.

Lastly, the purported factual finding is not supported by substantial evidence. Again, the Final Decision cites to no evidence to support this speculation. The evidence at the administrative level demonstrated that the P4P incentive payments do not duplicate capitated payments from the Plan to the FQHCs because the capitated payments pay for the FQHCs to render all services sought by the Plan's members during a month, while the P4P incentive payments encourage the FQHCs to meet specific targets, whether in terms of operational tasks or specific health care services. (AR, exh. 14, pp. 142:16-143:10; 151:19-153:19; 158:5-11; 159:10-20.) Accordingly, substantial evidence does not support the first clause that "[i]f in fact a provider was compensated via a capitated payment from a Medi-Cal managed care plan…."

## VI. CONCLUSION

For the reasons set forth above and presented at hearing, this court should grant the County of San Mateo's Motion for a Writ of Administrative Mandate.

Dated: February 27, 2018

**ROTENBERG & SZE, LLP**

By: _____

FELICIA Y SZE
Attorneys for Petitioner
COUNTY OF SAN MATEO

## PROOF OF SERVICE

**STATE OF CALIFORNIA, COUNTY OF SAN FRANCISCO**

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of San Francisco, State of California. My business address is 572 17TH Avenue, San Francisco, CA 94121.

On February 28, 2018, I served true copies of the following document(s) described as **MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR WRIT OF ADMINISTRATIVE MANDATE** on the interested parties in this action as follows:

Ashante L. Norton — Deputy Attorney General
Office of the Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 322-2197
Facsimile: (916) 324-5567
E-mail: Ashante.Norton@doj.ca.gov

____ **BY MAIL:** I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and placed the envelope for collection and mailing with the United States Postal Service, in a sealed envelope with postage fully prepaid. I am a resident or employed in the county where the mailing occurred. The envelope was placed in the mail at San Francisco, California.

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

Executed on February 28, 2018, at San Francisco, California.

Felicia Y Sze