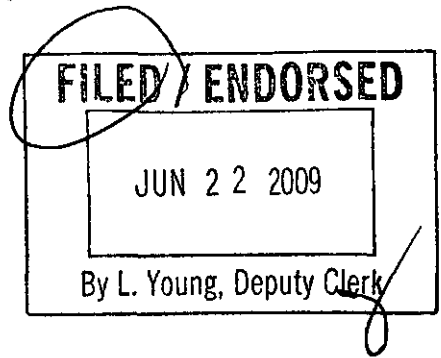


Department 29  
Superior Court of California  
County of Sacramento  
720 Ninth Street  
Timothy M. Frawley, Judge  
Lynn Young, Clerk



Hearing Held: Friday, June 12, 2009, 11:00 a.m.

<b>CALIFORNIA PRIMARY CARE ASSOCIATION; CLINICAS DEL CAMINO REAL, INC.; SOUTHERN TRINITY HEALTH SERVICES, INC.</b>	<b>Case Number: 34-2009-80000234</b>
v.	
<b>STATE OF CALIFORNIA, DEPARTMENT OF HEALTH CARE SERVICES</b>	

**Proceedings: Petition for Writ of Mandate and Complaint for Declaratory Relief**

**Filed By: Jennifer Dauer, Diepenbrock Harrison, and Elizabeth Saviano, Law Offices of Elizabeth C. Saviano, Attorneys for Petitioners/Plaintiffs**

The above-entitled cause came on for hearing on June 12, 2009, at 11:00 a.m., with counsel present as indicated on the record. The matter was argued and submitted. Having taken the matter under submission, the Court now rules as follows:

**RULING AFTER HEARING**

This action arises out of an urgency measure enacted by the Legislature to reduce public funding for health care services by excluding specific "optional benefits" from coverage under the Medi-Cal program.

In March of 2009, during its Third Extraordinary Session of 2009-10, the Legislature enacted Assembly Bill 5\_3X (AB 5), adding section 14131.10 to the California Welfare and Institutions Code. Subject to certain exceptions not relevant here, section 14131.10 provides that the following "optional benefits" are excluded from coverage under the Medi-Cal program (the "Excluded Benefits"): adult dental services, acupuncture services, audiology and speech therapy services, chiropractic services, optometric and optician services, podiatric

services, psychology services, and incontinence creams and washes. (Cal. Welf. & Instit. Code § 14131.10.)

Petitioners Clinicas Del Camino Real, Inc. ("Clinicas"), Southern Trinity Health Services, Inc. ("Trinity"), are a Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC), which provide health care services to Medi-Cal recipients, and Petitioner California Primary Care Association ("CPCA") is a non-profit corporation representing FQHCs, RHCs, and other non-profit community clinics. Clinicas, Trinity, and CPCA members provide one or more of the following Excluded Benefits which are currently being reimbursed under California's Medi-Cal program: adult dental, clinical psychology, chiropractic, optometric, and podiatrics. Respondent Department of Health Care Services ("DHCS") purportedly has indicated that, as a result of Welfare and Institutions Code section 14131.10, the State will no longer reimburse FQHCs and RHCs for patient visits at which the Excluded Benefits are provided.

In this action, Petitioners seek the issuance of a writ of mandate and declaration of law that FQHCs and RHCs are not subject to the exclusion of optional benefits under section 14131.10. Petitioners argue that because section 14131.10 was intended to exclude only "optional benefits," and because FQHC/RHC services are "mandatory" benefits, the Legislature could not have intended section 14131.10 to apply to services provided by FQHCs and RHCs. Petitioners claim that this argument is supported by the language of Welfare and Institutions Code section 14132.100, which continues to state that FQHC and RHC services shall be reimbursed on a per-visit basis in accordance with the definition of "visit" in section 14132.100, subdivision (g). Moreover, Petitioners argue that a contrary interpretation would conflict with the federal laws governing FQHC/RHC services.

Petitioners further argue that if section 14131.10 was intended to apply to FQHCs and RHCs, then section 14131.10 is invalid because it conflicts with federal law requiring States to reimburse FQHCs and RHCs for mandatory FQHC/RHC health care services.

#### Discussion

Petitioners seek declaratory and mandamus relief from DHCS' purported decision to apply section 14131.10 to deny FQHCs and RHCs reimbursement for patient visits at which the Excluded Benefits are provided.

DHCS contends that Petitioners' claims should be dismissed because they are not ripe; because Petitioners have failed to exhaust their available administrative remedies; and because Petitioners' exclusive remedy to challenge DHCS' decision(s) is by way of administrative mandamus. All of these arguments are rejected.

Administrative mandamus is not Petitioners' exclusive remedy because Petitioners are not seeking review of an administrative adjudication. Statutes provide for two types of review by mandate: traditional mandate, under Code of Civil Procedure section 1085, and administrative mandamus, under Code of Civil Procedure section 1094.5. Administrative mandamus is used to review the validity of quasi-adjudicatory decisions made as a 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 agency. (*DeCuir v. County of Los Angeles* (1998) 64 Cal.App.4th 75, 81; *Bunnett v. Regents of Univ. of California* (1995) 35 Cal.App.4th 843, 848.) Traditional mandamus under Civil Procedure Code § 1085 is used to review quasi-legislative determinations and quasi-judicial decisions made as a result of a proceeding in which a hearing was not required by law. (*Id.*)

The classification of administrative action as quasi-legislative or quasi-adjudicative "contemplates the function performed." As a general matter, a quasi-legislative act generally predetermines what the rules shall be for the regulation of future cases, while a quasi-adjudicatory act applies law to determine specific rights based upon specific facts ascertained from evidence adduced at a hearing. (*20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216, 275.)

In this case, Petitioners are not seeking review of an administrative adjudication, but of a quasi-legislative decision intended to govern future application of section 14131.10. Thus, traditional mandamus is the appropriate form of mandamus relief.

Petitioners' declaratory relief cause of action also is appropriate. Because declaratory relief may be used to review the validity of a quasi-legislative administrative decision, declaratory relief may be (and frequently is) joined with a petition for writ of traditional/ordinary mandate. (*See Greener v. Workers' Comp. Appeals Bd.* (1993) 6 Cal.4th 1028, 1045; *Pacific Legal Foundation v. California Coastal Com.* (1982) 33 Cal.3d 158, 168; 41 Cal. Forms of Pleading and Practice Ann. (2009) ch. 472B, Review of Agency Rulemaking, § 472B.13[3].)

Petitioners' declaratory relief cause of action is ripe for judicial review because the issues concerning DHCS' decision to deny FQHCs and RHCs reimbursement for patient visits at which the Excluded Benefits are framed with sufficient definiteness to enable the court to make a decree finally disposing of the controversy and the consequence of withholding court consideration would be lingering uncertainty in the law on a legal question of widespread public interest. (*Pacific Legal Foundation v. California Coastal Com.* (1982) 33 Cal.3d 158, 171 [controversy is ripe when it has reached, but not passed, the point at which the facts have sufficiently congealed to permit an intelligent and useful decision to be made].)

The parties dispute whether Petitioners' Second Cause of Action, for declaratory relief, should be heard concurrently with the First Cause of Action. The Court concludes that where, as here, the causes of action are essentially cumulative, seeking alternative remedies based on the same factual allegations and evidence, the causes should be decided concurrently based on the evidence and arguments presented.

The Court rejects DHCS' argument that the Court lacks jurisdiction because Petitioners failed to exhaust available administrative remedies under section 14132.100(l). Section 14132.100(l) only applies to an appeal of a "grievance or complaint concerning rate-setting, scope-of-service changes, and settlement of cost report audits." (Cal. Welf. & Instit. Code § 14132.100(l).) Because Petitioners are not pursuing a grievance or complaint concerning their per-visit rates and have not applied for a scope of service change, the Court is not persuaded that section 14132.100(l) applies to the instant circumstances. In any event, there is a recognized exception to the exhaustion requirement because pursuit of the administrative remedy would have been futile, and because the case involves important questions of public policy affecting the lives of many persons who are not parties to this action. (*Huntington Beach Police Officers' Assn. v. City of Huntington Beach* (1976) 58 Cal.App.3d 492, 499; *Lindeleaf v. Agricultural Labor Relations Bd.* (1986) 41 Cal. 3d 861, 870-871; see also *Hesperia Land Development Co. v. Superior Court* (1960) 184 Cal. App. 2d 865, 876.)

If the petition is not dismissed, DHCS argues that Petitioners' claims should be denied on the merits. According to DHCS, the plain language of section 14131.10 shows the Legislature intended the statute to apply to all Medi-Cal providers, including FQHCs and RHCS. DHCS contends this is not inconsistent with the provisions of federal law governing the Medi-Cal program.

The Court agrees with DHCS that the Legislature intended section 14131.10 to apply equally to all California Medi-Cal providers, including FQHCs and RHCs. The Court finds no merit in Petitioners' argument that the Legislature could not have intended section 14131.10's exclusion of optional benefits to apply to FQHCs and RHCs because FQHC/RHC services are "mandatory" under federal law.

While Petitioners are correct that federal law may require participating states to provide FQHC/RHC services, this does not mean – as Petitioners appear to assume – that all services provided by an FQHC or RHC are "required" FQHC/RHC services. And to the extent the services provided by FQHCs/RHCs are "optional" benefits, it is reasonable to conclude the California Legislature intended to address the State's fiscal crisis by excluding those optional benefits from the Medi-Cal program. The plain and unambiguous language of section 14131.10 supports this view in that it expressly supersedes all other relevant provisions of the Medi-Cal laws, including section 14132.100. (See Cal. Welf. &

Instit. Code § 14131.10(a) ["Notwithstanding any other provision of this chapter, . . . specific optional benefits are excluded from coverage under the Medi-Cal program."]; see also 42 CFR 440.240 [providing that services must be equally available to all individuals within a covered group].)

Further, if the Legislature had intended to create an exception to allow certain Medi-Cal providers, such as FQHCs and RHCs, to continue providing the Excluded Benefits, the Legislature could have so provided – as it did for beneficiaries under the EPSDT program and beneficiaries receiving long-term care in a nursing facility. (See Cal. Welf. & Instit. Code § 14131.10(c).) It did not.

Petitioners argue that the "notwithstanding" clause in section 14131.10 should not be construed to repeal or amend by implication the reimbursement provisions of section 14132.100. The Court, however, finds no irreconcilable conflict between the two statutes.

Section 14132.100, subdivisions (a) and (b) simply provide that the mandatory FQHC/RHC services described in 42 U.S.C. § 1396d(a)(2)(B) and (C) are covered benefits under Medi-Cal. As noted above, this simply begs the question of what FQHC/RHC services are required by federal law. If the State is required by federal law to reimburse the Excluded Benefits as mandatory FQHC/RHC services, it follows that section 14131.10 cannot exclude coverage for those benefits regardless of legislative intent. But if the State is not so required, section 14132.100, subdivisions (a) and (b) have no bearing on the proper interpretation of section 14131.10.

Section 14132.100, subdivision (c) merely provides that FQHC/RHC services "shall be reimbursed on a per-visit basis in accordance with the definition of 'visit' set forth in subdivision (g)." Petitioners argue that the term "visit" means a face-to-face encounter between an FQHC or RHC patient and any "physician," which is defined in subdivision (g) to include any medical doctor, osteopath, podiatrist, dentist, optometrist, or chiropractor. Thus, Petitioners argue, any services provided to a Medi-Cal patient by a medical doctor, osteopath, podiatrist, dentist, optometrist, or chiropractor in an FQHC/RHC setting is reimbursable under section 14132.100 subdivision (c).

However, section 14132.100, subdivision (g) is clear that it uses the term "physician" only to define "the professionals whose services are reimbursable on a per-visit basis," and not to define "the types of services that these professionals may render during these visits." (See Cal. Welf. & Instit. Code § 14132.100(g)(1).) Accordingly, the language in section 14132.100 does not support Petitioners' interpretation of section 14131.10.<sup>1</sup>

---

<sup>1</sup> In any event, the presumption against repeal by implication must yield where (i) the two acts are so inconsistent that there is no possibility of concurrent operation, or (ii) the later provision gives un-debatable evidence of an intent to supersede the earlier provision (*Prof Engineers in Calif.*

Neither does the language in the State Plan Amendment ("SPA") support Petitioners' interpretation. The SPA provides, at Section C.2 that a "visit" for purposes of reimbursing FQHC/RHC services includes a face-to-face encounter between an FQHC/RHC patient and a "physician." For purposes of defining a "visit," physician is defined to include doctors of medicine, osteopathy, podiatry, optometry, and dental surgery, and chiropractors. (Memorandum of Points and Authorities in Support of Verified Petition, Exh. B, pp.6B to 6C.) However, like section 14132.100, subdivision (g), the SPA explicitly states that inclusion of a professional category is solely for the purpose of defining the professionals whose services are reimbursable on a per-visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit. (*Id.*) In contrast, the FQHC/RHC services eligible for reimbursement are defined in Section C.1 of the SPA as the covered benefits described in Section 1905(a)(2)(C) and Section 1905(a)(2)(B) of the Social Security Act [which are codified at 42 U.S.C. § 1396d(a)(2)(B) and (C)].

(Moreover, even if there were a conflict between section 14131.10 and the existing SPA, it would not be an irreconcilable conflict. Section 14131.10, subdivision (d) provides that "this section shall only be implemented to the extent permitted by federal law." Presumably, this directive would include obtaining any federal approvals required to implement the section, including any necessary state plan amendments.)

This brings the Court to the heart of Petitioners' claims: that federal law prohibits denying FQHCs and RHCs reimbursement for the Excluded Benefits because they are "mandatory" services under federal law.

Under federal law, states must provide coverage for certain services, and have the option to choose whether to cover other types of services for program beneficiaries. The so-called "mandatory" health care services are set forth at paragraphs (1) through (5), (17) and (21) of Section 1905(a) of the Social Security Act [42 U.S.C. § 1396d(a)(1)-(5), (17), and (21)]. (42 U.S.C. §§ 1396a(a)(10).)

Included in the mandatory services are FQHC and RHC services. (See 42 U.S.C. §§ 1396a(a)(15), 1396a(bb), 1396d(a)(2)(B) and (C).) Specifically, federal law provides that a state plan must provide for payment of those FQHC and RHC services described in Sections 1905(a)(2)(B) and (C) of the Social Security Act [42 U.S.C. § 1396d(a)(2)(B) and (C)]. (See 42 U.S.C. § 1396a(bb).)

In regard to FQHCs and RHCs, Section 1905(a)(2) of the Act defines the required "medical assistance" to mean payment of all or part of the cost of the following care and services:

---

*Govt. v. Kempton* (2007) 40 Cal.4th 1016, 1038-1039, *Sacramento Newspaper Guild, etc. v. Sacramento County Board of Supervisors* (1968) 263 Cal.App.2d 41, 55 )

(B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the [State] plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the [State] plan. (42 U.S.C. § 1396d(a)(2)(B) and (C).)

Subsection (l)(1), in turn, defines the term "rural health clinic services" to have the meaning given such term in Section 1861(aa) [42 U.S.C. § 1395x(aa)]. Likewise, subsection (l)(2) defines the term "Federally-qualified health center services" to mean "services of the type described in subparagraphs (A) through (C) of Section 1861(aa)(1) [42 U.S.C. § 1395x(aa)(1)].

Section 1861(aa) defines "rural health clinic services" and "Federally-qualified health center services" to mean (among other services not relevant here) "physicians' services," and services furnished by a physician assistant, nurse practitioner, clinical psychologist, or clinical social worker. (42 U.S.C. § 1395x(aa)(1).)

Because "Federally-qualified health center services" are defined by reference only to the services described in Section 1861(aa)(1)(A) through (C), the definition of FQHC services for purposes of Medicaid is different than the definition of FQHC services for purposes of Medicare, which defines FQHC services to include the services described in subparagraphs (A) through (C), plus the services described in subparagraphs (qq) and (vv), plus the "preventative primary health services" required by section 330 of the Public Health Service Act [42 U.S.C. § 254b] (e.g., preventative dental services).

The key issue here is how to define the term "physicians' services" for purposes of determining what FQHC and RHC services are mandated by federal law.

Petitioners contend that because the Medicaid definitions of FQHC/RHC services incorporate the Medicare definitions of those terms, the Medicare definition of "physicians' services" should apply.

Medicare defines "physicians' services" to mean "professional services performed by physicians," and defines the term "physician" to mean:

- (1) a doctor of medicine or osteopathy . . . ,
- (2) a doctor of dental surgery or of dental medicine . . . ,
- (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a),

1832(a)(2)(F)(ii), and 1835 [42 USCS §§ 1395f(a),  
1395k(a)(2)(F)(ii), and 1395n] . . . ,

- (4) a doctor of optometry, but only for purposes of subsection (p)(1) and with respect to the provision of items or services described in subsection (s) . . . , or
- (5) a chiropractor . . . but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) [subsecs. (s)(1) and (s)(2)(A) of this section] and only with respect to treatment by means of manual manipulation of the spine . . . .

In the alternative, Petitioners contend the State law definition of a "physician" in Welfare and Institutions Code § 14132.100(g) should apply, which defines the term physician to include a medical doctor, osteopath, podiatrist, dentist, optometrist, and chiropractor. (Cal. Welf. & Instit. Code § 14132.100(g).)

DHCS contends that the Medicaid definition of "physician services" should control.<sup>2</sup> Medicaid defines "physicians' services" as services furnished by a "physician (as defined in section 1861(r)(1))," meaning the definition is limited to services furnished by a "doctor of medicine or osteopathy." (42 U.S.C. § 1396d(a)(5)(A), § 1395x(r)(1).)

While the Medicaid statute is drafted awkwardly, the Court agrees with DHCS that the Medicaid definition of "physician services" was intended to control the scope of FQHC/RHC services required under federal Medicaid law. The Court can conceive of no reason why the scope of required "physician services" at FQHCs/RHCs should be broader than the scope of physician services required at other Medicaid providers. (See 42 C.F.R. § 440.240.)

Therefore, the Court concludes that federal law does not preclude the California Legislature from denying FQHCs and RHCs reimbursement for the Excluded Benefits.

The petition for writ of mandate and Petitioners' requested declaratory relief are DENIED. The Court shall issue a declaratory judgment that section 14131.10 was intended to deny reimbursement to FQHCs and RHCs for the Excluded Benefits and that this is not inconsistent with federal law. Counsel for DHCS is directed to prepare a formal judgment consistent with this Court's ruling; submit it to opposing counsel for approval as to form; and thereafter submit it to the Court for signature and entry of judgment.

---

<sup>2</sup> DHCS also contends that, even if the Medicare definition of "physicians' services" applies, physicians' and dentists' services under Medicaid are provided "at the option of the state," and reimbursement is limited to RHC/FQHC services that are consistent with State law and included in the State plan (See 42 U S C § 1396d(a)(2)(B) and (C) ) For the reasons discussed below, the Court finds it unnecessary to address this contention

Case No. 34-2009-80000234

Name of Case: California Primary Care Association v. State of California, Department of Health Care Services

**CERTIFICATE OF SERVICE BY MAILING**  
**(C.C.P. Sec. 1013a(4))**

I, the undersigned deputy clerk of the Superior Court of California, County of Sacramento, do declare under penalty of perjury that I did this date place a copy of the above-entitled **RULING AFTER HEARING** a notice envelopes addressed to each of the parties or their counsel of record as stated below, with sufficient postage affixed thereto and deposited the same in the United States Post Office at Sacramento, California.

Jennifer L. Dauer  
Lawrence B. Garcia  
Diepenrock Harrison  
400 Capitol Mall, Suite 1800  
Sacramento, CA 95814

G. Mateo Munoz  
Deputy Attorney General  
Department to Justice  
1300 I Street, Suite 1101  
P.O. Box 944255  
Sacramento, CA 94244-2550

Elizabeth C. Saviano  
Law Offices of Elizabeth C. Saviano  
425 Market Street, 22<sup>nd</sup> Floor  
San Francisco, CA 94105

I, the undersigned Deputy Clerk, declare under penalty of perjury that the foregoing is true and correct.

Dated: June 23, 2009

SUPERIOR COURT OF CALIFORNIA  
COUNTY OF SACRAMENTO

By: L. YOUNG  
Deputy Clerk

