CASE NO. B325070

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT, DIVISION ONE

PASADENA HOSPITAL ASSOCIATION, LTD., a California Nonprofit Public Corporation d/b/a Huntington Hospital,

Appellant and Petitioner,

v.

MICHELLE BASS*, in her official capacity as the Director of the California Department of Health Care Services,

Appellee and Respondent.

BRIEF OF AMICI CURIAE CALIFORNIA HOSPITAL ASSOCIATION, DIGNITY HEALTH AND DIGNITY COMMUNITY CARE, AND ADVENTIST HEALTH SYSTEM/ WEST IN SUPPORT OF APPELLANT PASADENA HOSPITAL ASSOCIATION

On Appeal from the Los Angeles County Superior Court
Case No. 21STCP03538, Hon. James C. Chalfant

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* The correct name spelling of the Director of the California Department of Health Care Services is Michelle Baass.

CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

Pursuant to Rule 8.208(e)(3) of the California Rules of Court, the undersigned certifies that it knows of no entity or person, other than the parties themselves, that either has a financial interest in the subject matter in controversy or in a party to the proceeding, or has a non-financial interest in that subject matter or in a party that could be substantially affected by the outcome of the proceeding.

DATED: November 13, 2023

HOOPER, LUNDY & BOOKMAN, P.C.

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Attorneys for California Hospital Association, Dignity Health and Dignity Community Care, and Adventist Health System/West

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INTRODUCTION

The California Hospital Association ("CHA"), Dignity Health and Dignity Community Care (together, "Dignity"), and Adventist Health System/West ("Adventist Health") (collectively, the "Amici") submit this brief in support of Appellant Pasadena Hospital Association, doing business as Huntington Hospital ("Huntington"). The Amici are filing this brief to elaborate for the Court the profound issue this case presents regarding the finality of Medi-Cal payment determinations on which hospitals may rely to make critical budgeting and expenditure decisions. This issue is of widespread concern to California hospitals, which operate on razor-thin, if not negative, margins, and for whom retroactive Medi-Cal payment revisions can materially upend their operations and ultimately limit patients' access to care.

Amici **CHA** is a non-profit association dedicated to representing the interests of California's hospitals. CHA is one of the largest hospital trade associations in the nation, serving more than 400 hospitals and health systems and 97 percent of the patient beds in California. CHA's members include general acute care hospitals, acute psychiatric hospitals, academic medical centers, county hospitals, and multi-hospital health systems. These hospitals furnish vital health care services to millions of the State's residents every year, including Medi-Cal beneficiaries and patients who otherwise require free or discounted care.

CHA is the largest advocacy organization for hospitals in California and provides its members with state and federal representation in the legislative, judicial, and regulatory arenas

in its continuing efforts to improve healthcare quality, access, and coverage. In order to help establish and maintain a financial and regulatory environment in which hospitals and health systems can continue to provide high-quality care to their patients—including and especially to Medi-Cal beneficiaries and other patients requiring financial support to access health care—CHA participates regularly as an *amicus curiae* in appeals that may have a substantial impact on hospitals and health systems. (See, e.g., *County of Santa Clara v. Superior Court* (2023) 14 Cal.5th 1034; *American Hospital Association v. Becerra* (2022) 142 S.Ct. 1896; *Gerard v. Orange Coast Mem'l Med. Ctr.* (2018) 6 Cal.5th 443; *Rashidi v. Moser* (2014) 60 Cal.4th 718; *Fahlen v. Sutter Cent. Valley Hosps.* (2014) 58 Cal.4th 655; *UFCW & Emp'rs Benefit Tr. v. Sutter Health* (2015) 241 Cal.App.4th 909; and *Sutter Health v. Superior Court* (2014) 227 Cal.App.4th 1546.)

Among its activities, CHA participates directly in the development of health care policy and related legislation, including policy analysis related to the Medi-Cal program. CHA is therefore well-situated to assist this Court in understanding the impact of California's Department of Health Care Services' (the "Department" or "DHCS") position if adopted by this Court.

Amici **Dignity Health** is a California nonprofit public benefit corporation with a principal place of business in San Francisco, California. Dignity Health operates acute care hospitals and care sites in California, Arizona and Nevada. Amici **Dignity Community Care** is a Colorado

nonprofit corporation which operates acute care hospitals and care sites in California, Arizona and Nevada.

Together, the **Dignity** organizations provide more inpatient bed days to Medi-Cal beneficiaries than any other health system in the State of California. As a result, they are uniquely reliant on and knowledgeable about Medi-Cal reimbursement. Dignity has a keen interest in their ability to predict future Medi-Cal payments and retain already-received Medi-Cal dollars, which allow the organization to make and maintain material operational decisions to carry out their mission of providing excellent, affordable health care services for patients, and to ensure those in need have access to quality care. Dignity is thus well-situated to assist this Court in understanding the impact of the Department's position particularly on California's Medi-Cal providers and beneficiaries.

Dignity organizations are also well-versed in the EHR incentive payments at issue in this case. Dignity providers participated in the same program as Huntington, spending millions of dollars to upgrade their electronic health records systems. Dignity qualified for and received these incentive payments, but now faces a similar recoupment effort by the Department. Dignity thus has a distinct understanding of the financial and operational importance of incentive payments and of the impact of retroactive removal of incentive payments on Medi-Cal providers and health systems.

Amici **Adventist Health** is a faith based nonprofit integrated healthcare system, headquartered in Roseville,

California. Adventist Health owns or operates 27 hospitals, 379 outpatient clinics, 15 home care agencies, eight hospice agencies, one continuing care retirement community, and three joint venture retirement centers. Adventist Health's operations are conducted through a workforce of over 37,000 physicians, allied health professionals, and support services associates.

Adventist Health provides care to millions of patients each year. In 2022, Adventist Health hospitals had nearly 130,000 inpatient admissions, over 700,000 emergency room visits, over 4,000,000 outpatient visits, and Adventist Health's clinics served nearly 2,500,000 patients.

Many of the communities in which Adventist Health operates are medically underserved, and Adventist Health facilities serve as safety net providers. In this capacity, Adventist Health provides free or discounted care to many of its patients. Additionally, Adventist Health puts money from operations back into the communities it serves in the form of community benefit. In 2022, Adventist Health maintained community benefit plans that included aid to the elderly, aid to the poor, subsidized community healthcare, community health improvement, and conducted education and research activities.

Adventist Health is thus similarly knowledgeable about charity care and the importance of Medi-Cal payments made to California providers. It is also similarly reliant on predictable Medi-Cal payments for its operations and its provision of health care. Adventist Health also has first-hand knowledge of the EHR incentive payments at issue in this case, having invested in their

electronic health record systems to qualify for the payments and subsequently facing similar recoupment efforts by the Department.

As a trade association representing most of the hospitals in California, and as two large nonprofit hospital systems caring for Medi-Cal recipients throughout the State in both urban and rural areas, the Amici have first-hand background and experience concerning the disruptions to hospital operations that necessarily arise when Medi-Cal payment determinations are substantially revised years after the periods to which the payments relate, and the specific disruption of the precise payment reversals at issue in this case. The Amici thus offer this brief to assist the Court in its understanding of the consequences that arise for hospitals operating on razor-thin margins of multiple year retroactive payment adjustments that could not have been reasonably anticipated.

STATEMENT OF THE CASE

Amici adopt by reference the statement of the case provided by Appellant Pasadena Hospital Association d/b/a Huntington Hospital.

STATEMENT OF FACTS

Amici adopt by reference the statement of facts provided by Appellant Pasadena Hospital Association d/b/a Huntington Hospital.

ARGUMENT

I. The Fiscal Circumstances Facing California Hospitals

Perhaps more than any other sector, California hospitals

face enormous financial challenges. These challenges, combined with the complex and demanding regulatory environment faced by hospitals and California hospitals' mission to ensure the availability of high-quality health care services to all Californians regardless of their individual circumstances, require that hospitals have available concrete fiscal information that allows them to engage in both short-term and long-term financial planning. Retroactive revisions of material payments from the Medi-Cal program that occur years after all necessary data has been submitted in accordance with DHCS's instructions and payments have been made based on that data upending hospitals' reasonable expectations, make it next to impossible for hospitals to make fully informed expenditure and operational decisions.

During calendar year 2022, more than one-half of California's hospitals (52%) had negative operating margins.[1] The health care consulting firm, KaufmanHall, concluded that one in five California hospitals are at risk of closure, and that "[g]rowing operating losses combined with declining cash balances and debt loads place many hospitals in unsustainable financial positions." KaufmanHall determined that California hospitals incurred $8.5 billion in losses during 2022, and $12.1 billion in losses during the prior two years.[2] The firm found that hospital operating margins on average were a negative 1.6%

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[1] See *Hospital Services at Risk Throughout California* (April 2023) KaufmanHall, available at https://www.kaufmanhall.com/sites/default/files/2023-04/CHA-Financial-Impact-Report.pdf, at 7.

[2] *Id.* at 3.

during 2022 (increasing to a negative 2.4% if one-time federal provider relief funding is not taken into account), and that fully 71% of California hospitals have "unsustainably low margins."[3]

The difficult financial circumstance facing hospitals has led to hospital bankruptcies and closures, particularly hospitals treating large numbers of Medi-Cal and other low-income patients, and hospitals in rural areas. Most recently, on January 3, 2023, Madera Community Hospital closed due to insurmountable financial difficulties, leaving the entire community without access to 24-hour emergency care. Earlier this year, Beverly Hospital, a 221-bed nonprofit community hospital located in Montebello, was forced to file bankruptcy. And in 2018, Verity Health System, a nonprofit 5-hospital health care system with prominent hospitals in Northern and Southern California, filed bankruptcy because of its $175 million in annual losses, resulting in a breakup of the system and a piecemeal sale of its facilities.[4]

The financial strain faced by California hospitals is likely to increase in the upcoming years. In October, Governor Newsom signed SB 525—which increases the minimum wage for many

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[3] *Id.* at 5.

[4] Eight California hospitals have closed since 2011, including Madera Community Hospital, St. Vincent Medical Center, Long Beach Community Hospital, Patient's Hospital of Redding, Pacific Gardens Medical Center, Olympia Medical Center, Menlo Park Surgical Hospital, and Adventist Health Feather River. Earlier closures of major medical centers include Robert F. Kennedy Memorial Hospital (2004) and Daniel Freeman Medical Center (2007).

hospitals to $25 per hour beginning in 2024. As labor makes up more than 50% of hospital costs, the impact of the resulting increase in operating costs will be substantial. However, there is no additional state funding, including Medi-Cal funding, to pay for the increased labor costs. In addition, California hospitals face a 2030 seismic safety compliance standard requiring very costly renovations to or replacements of many hospital buildings, again without state financial support. (Health & Saf. Code, § 130065.) Further, the legislature last year enacted legislation creating the Office of Health Care Affordability. (Health & Saf. Code, § 127501.12.) Among that Office's responsibilities is to develop health care expenditure targets for different sectors of the health care industry, including hospitals. This will undoubtedly place additional fiscal pressures on hospitals, as well as likely require them to provide short and long-term budgeting plans. The legislative and regulatory requirements are in addition to market conditions increasing hospital expenditures, particularly labor costs as hospitals experience shortages in the labor force.

While hospital expenditures continue to rise, payment levels, particularly Medi-Cal payment levels, have not kept pace. As of May 2023, about 16 million Californians are enrolled in Medi-Cal[5], which is about 40% of California's population. Medi-

[5] See *Department of Health Care Services (DHCS) Continuous Coverage Unwinding Dashboard* (May 2023), California Department of Health Care Services, available at https://www.dhcs.ca.gov/dataandstats/Documents/DHCS-Continuous-Coverage-Unwinding--May2023-Dashboard-07-06-

Cal accounts for about 20% of hospital revenue, although hospitals vary widely on their reliance on Medi-Cal. About one-fifth of California hospitals are "majority Medi-Cal", meaning that they receive more than 50% of their revenue from Medi-Cal. However, it is CHA's analysis that the Medi-Cal program on average covers only about 74% of hospital costs. This helps explain why the majority Medi-Cal hospitals typically run in the red, with a collective negative operating margin of -3.3%.[6]

One of the governmental initiatives for hospitals has been the adoption of electronic health records ("EHR") systems. These systems are extremely costly and complex, both to initially design and install, and to implement and upgrade on an ongoing basis. As discussed in Huntington's briefs, in order to provide incentives for hospitals to become meaningful users of EHR technology, Congress provided for EHR incentive payments under both Medicare and Medicaid. The amount of the payments is tied to Medicare and Medi-Cal utilization of the hospital, measured based on the percentages of Medicare and Medi-Cal inpatient days to total days. Given the challenging financial environment experienced by hospitals, these incentive payments are important to hospital decisions concerning the adoption of EHR technology. Further, the amount of the incentive payments is substantial,

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2023.pdf.

[6] This is based on CHA's analysis of data from Hospital Annual Financial Disclosure Reports submitted to and reviewed by the California Department of Health Care Access and Information. The data is available at https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables.

about $844 million as of 2020 in the aggregate under Medi-Cal alone, so that the payments have a substantial impact on hospital budgeting and expenditure decisions.[7]

Due to their thin financial margins and ever increasing fiscal, regulatory, and operational demands, it is essential that hospitals are able to budget and plan their expenditures very carefully, relying on accurate and predictable information. California's hospitals simply do not have financial cushions that would allow them to spend more than the revenue they will receive. It is critical that revenue be predictable and that hospitals not be surprised with bills seeking to recoup substantial sums years after the hospitals reasonably thought the payments they had received were final and could be relied on in making expenditure decisions. This is particularly so with respect to the Medi-Cal program, which comprises such a large portion of hospital activity and on which many hospitals depend for survival.

II. Congress, the California Legislature, and the Courts Have All Recognized the Importance of Timely and Final Payment Determinations

The Legislature has recognized the importance of finality in Medi-Cal reimbursement determination for more than fifty years. Beginning shortly after the federal Medicaid and California

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[7] California Department of Health Care Services, "Report to the Legislature: Medi-Cal Promoting Interoperability Program Fiscal Year 2019-20" (https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Medicaid-Promoting-Interoperability-Report-FY2019-20.pdf).

Medi-Cal programs were enacted, the Legislature imposed a time limit on the State's ability to audit Medi-Cal cost reports and similar data. (See former Welf. & Inst. Code, § 14105, Stats. 1969, ch. 21, § 38, p. 97.) In 1977, the audit limitation was amended and included in a new section of the Welfare and Institutions Code section 14170, where it remains today.

At the time Section 14170 was enacted, hospitals were reimbursed their reasonable costs of furnishing inpatient services under Medi-Cal. Interim payments based on estimated costs would be paid during the year. A hospital would submit a Medi-Cal cost report annually after the close of its fiscal year setting forth its costs and various other information. After it was filed, the cost report would be tentatively settled by reconciling the interim payments with the information on the filed cost report. The cost report would then be subject to audit and revision by the State, with a final settlement issued after the audit was completed.

The Legislature recognized that this process could result in a lengthy delay from the time a hospital furnished services and received interim payments to the time the cost report would be submitted, audited, and the hospital would know the amount of its final payment. The Legislature understood that this delay would create problems for hospitals, as they would need to know how much they would finally be paid for services relatively promptly in order to plan and operate. Accordingly, the Legislature in enacting Section 14170 required that cost reports and other data used for setting Medi-Cal payment rates would be

deemed true and correct if not audited within three years. While Huntington does not contend that the three-year audit limit applies directly to the meaningful use incentive payment audit at issue here, the enactment of Section 14170 underscores the Legislature's intent that payment determinations be made timely, as health care providers require timely and final payment determinations in order to operate and plan.

The same State of promoting finality in healthcare payment determinations is reflected elsewhere. A one-year time limit was imposed by a Department of Managed Health Care regulation adopted in 2003: pursuant to Title 28, California Code Regulations section 1300.71(b)(5), a health care service plan may request repayment of an overpayment only if it sends the provider a written request within 365 days of the date of payment.

Both Congress and the California Legislature have advanced national and state policies, respectively, that payment determinations should be predictable, and their final amount known timely. Congress enacted the Inpatient Prospective Payment System ("IPPS") in 1983 to reimburse hospitals for inpatient services under Medicare. In 2011, the California Legislature required the Department of Health Care Services ("DHCS") to develop and implement a prospective payment system under Medi-Cal (which it DHCS implemented on July 1, 2013). (See 42 U.S.C. § 1395ww(d); Cal. Welf. & Inst. Code, § 14105.28.) Under both systems, hospitals are paid fixed rates for each Medicare or Medi-Cal patient discharged depending on the

patient's condition and various other factors which determine the diagnosis related group to which the patient is assigned. These payment amounts are generally set in advance and so are known to providers and are predictable. IPPS replaced a "reasonable cost" reimbursement system, where payments were not final for many years after the close of the applicable fiscal period. The Medi-Cal prospective payment system replaced two reimbursement programs—one was a cost-based reimbursement system, the second was based on negotiated contracts between DHCS and providers. (Cal. Code. Regs., tit. 22, §§ 51536 – 51557; Cal. Welf. & Inst. Code, § 14081 et seq.)

The Centers for Medicare and Medicaid Services ("CMS"), the federal agency responsible for Medicare and Medicaid, has routinely opined—and various courts have agreed—that the idea that payment will be made at a predetermined, specified rate serves as the foundation of the prospective payment systems. (See, e.g., *Methodist Hosp. of Sacramento v. Shalala* (D.C. Cir. 1994) 38 F.3d 1225, 1232; *Anna Jacques Hosp. v. Burwell* (D.C. Cir. 2015) 797 F.3d 1155, 1169; *Skagit Cty. Pub. Hosp. Dist. No. 2 v. Shalala* (9th Cir. 1996) 80 F.3d 379, 386.) As the D.C. Circuit has noted "the Secretary's emphasis on finality protects Medicare providers as well as the Secretary from unexpected shifts in basic reimbursement rates" and permits hospitals to rely on the predetermined rates and resulting payments made thereunder. *Methodist Hosp., supra*, 38 F.3d at page 1232. The D.C. Circuit cited to the House Report concerning the Social Security Amendments of 1983 at 132, 1983 U.S.C.C.A.N. at 351, which

states "THE BILL IS INTENDED TO IMPROVE THE MEDICARE PROGRAM'S ABILITY TO ACT AS A PRUDENT PURCHASER OF SERVICES, AND TO PROVIDE PREDICTABILITY REGARDING PAYMENT AMOUNTS FOR BOTH THE GOVERNMENT AND HOSPITALS." (capitalization in original.) Similarly, the Eleventh Circuit commented in *Drs. Hosp., Inc. of Plantation v. Bowen* (11th Cir. 1987) 811 F.2d 1448, 1453:

> In order to fulfill the primary purpose of the Act in providing hospitals with predictability regarding payment amounts and to reform the financial incentive hospitals face, a hospital needs to know in advance how much it will receive under the PPS system during the transition period. To accept the Secretary's interpretation of the amendments would require an indeterminable wait before the rates could be appealed, and thus would add further uncertainty to the reimbursement procedure. The Secretary's interpretation thus frustrates the policy that Congress sought to implement.

Finally, and perhaps most importantly, the California Court of Appeal in *Fountain Valley Regional Hospital and Medical Center v. Bonta* (1999) 75 Cal.App.4th 316, 326 ("*Fountain Valley*") addressed the concept of finality in connection with the plaintiff hospital's laches argument:

> At some point, there must be finality to the Department's "final" reimbursement settlements. Otherwise, a hospital's financial planning and rational allocation

> of its resources will simply be impossible. Such a result is neither fair nor socially desirable. These considerations provide additional support for a rule which shifts the laches burden of proof to the Department when its own delay in revising a previously submitted "final reimbursement settlement" exceeds an analogous statute of limitations period.

III. Laches Should Apply Here to Bar DHCS's Recalculation of Huntington's Incentive Payments and Any Recovery of Funds from Huntington

A. Equitable Borrowing Applies to Shift the Burden to DHCS

There is no question that laches may apply in appropriate circumstances to bar administrative action, and DHCS does not question this proposition. (*Robert F. Kennedy Med. Ctr. v. Belshe* (1996) 13 Cal.4th 748, 760, fn. 9; *Fountain Valley Regional Hospital, supra*, 75 Cal.App.4th at pp. 323–24.) There is also no question that the state agency has the burden of demonstrating that a delay in taking administrative action was reasonable and that the party affected by the administrative action was not prejudiced where there is a statute of limitations governing an analogous action at law. (*Brown v. State Personnel Bd.* (1985) 166 Cal.App.3d 1151, 1159–60, *Fountain Valley*, *supra*, 75 Cal.4th at p. 324.)

The question of whether equitable borrowing applies to Medi-Cal payment determinations beyond the specific facts at issue in *Fountain Valley* is of great importance to hospitals and other Medi-Cal providers. This is an issue that has come up

frequently in the context of Medi-Cal administrative appeals, as DHCS often issues new reimbursement determinations many years after it had all the relevant information or had made an initial determination and reimbursed the provider based on that determination. In its final administrative decisions, DHCS typically takes a very narrow view of when a statute of limitations may be borrowed. Chief Administrative Law Judge Freeman did that here in rejecting the Proposed Decision issued by the Administrative Law Judge who presided over the appeal, which found that equitable borrowing applied, and DHCS's audit and attempted recovery were therefore barred, applying the doctrine of laches.

The question of whether unreasonable delay and prejudice have been demonstrated where equitable borrowing does not apply may be a question of fact to which some deference to the administrative decision might be appropriate. But the question of whether equitable borrowing should be applied in the first place would appear to be a question of law, to be decided *de novo* by the reviewing court (here this appellate court) without deferring to the administrative agency or an inferior court. *Cedars-Sinai Med. Ctr. v. Shewry* (2006) 137 Ca1.App.4th 964 ("Because pure questions of law were decided by the trial court upon undisputed facts in this mandamus proceeding, a de novo standard will apply on appeal."); *Fountain Valley*, *supra*, 75 Cal.App.4th at p. 323 (applying a de novo standard without affording deference to the administrative or trial court decision in deciding whether equitable borrowing applies).

As the parties have recognized, the key case in applying the concept of equitable borrowing here is *Fountain Valley*. At issue in that case was whether a revised Medi-Cal payment determination, or final settlement, was barred by laches. The court held that it was after concluding that "[t]here are several statutes of limitations in the Code of Civil Procedure ["CCP"] which are clearly applicable to the facts of this case." *Fountain Valley*, *supra*, 75 Cal.App.4th at page 325. The court determined that the applicable statutes of limitation include CCP sections 337 (four-year statute for actions based on a book account), 338(a) (three-year statute for actions based on a liability created by statute), and 338(d) (three-year statute for actions based on fraud or mistake).

The circumstances here are very much like those at issue in *Fountain Valley*. Huntington submitted cost report data to DHCS in accordance with DHCS's instructions. DHCS determined the aggregate amount of incentive payments due to Huntington over a four-year period in accordance with the data Huntington submitted and made payments based on that determination. Years later, DHCS decided to audit the data submitted by the hospital, and ultimately issued audit findings resulting in a revised payment determination or "settlement" which reduced substantially the previous payment determination. These facts are analogous to a claim based on a book account, a liability created by statute (here the federal statute setting forth the meaningful use payments and the companion state statutes), and/or on a mistake by DHCS in

instructing hospitals to include unpaid days and making payments based on data that included unpaid days. Accordingly, either a three- or four-year period should be borrowed, as Administrative Law Judge Rambo had concluded.[8]

DHCS' relies heavily on a footnote from *Fountain Valley* in which the court states "Because this case involves revised final reimbursement settlements, our decision should not be construed to mean that statutory periods of limitation may be borrowed when a hospital claims that the doctrine of laches should be applied to a delay by the Department in rendering an original final reimbursement settlement." (*Id*. at p. 325, fn. 8.) Indeed, DHCS routinely cites this footnote in brushing aside provider laches contentions arising from delayed Medi-Cal payment determinations.

There are several important points concerning the Fountain Valley footnote. First, the court does not state that equitable borrowing may not apply to a delay by DHCS in issuing an original final determination. Rather it only says that the court is not deciding that issue.

Second, a blanket rule that equitable borrowing does not

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[8] The statute of limitations for actions based on mistake commences on the date the claimant knew or should have known of the mistake. Here, DHCS should have known that it mistakenly instructed hospitals to include unpaid days in their total Medi-Cal days no later than October 2012 when CMS issued its directive in the form of Frequently Asked Questions (FAQ 7649, Respondent's Brief at 38) that unpaid days should not be included Medicaid days. DHCS both started and completed the audit of Huntington's EHR payment data more than 3 years after October 2012.

apply to delays in issuing final determinations would be contrary to California case law. Rather, if there is an analogous claim subject to a statute of limitations concerning an original final payment determination, equitable borrowing applies. Laches and its intertwined principle of equitable borrowing apply to delayed actions by administrative agencies, and the label given to the agency action does not matter if there is an analogous claim subject to a statute of limitations. See *Brown v. State Personnel Board* (1985) 166 Cal.App.3d 1151, 1158-61.

Third, although not necessary for equitable borrowing, the facts here are very similar to those presented in *Fountain Valley* for purposes of determining whether there is an analogous claim at law. Here, Huntington submitted data derived from a Medi-Cal cost report, the data was used to determine payments due to Huntington, payment was made to Huntington, DHCS later audited the data and revised its payment determination because it concluded DHCS had erroneously included unpaid days in Medi-Cal days, reducing the payments to the provider and seeking to recover substantial sums previously paid. Similarly, in *Fountain Valley*, DHCS had computed the Medi-Cal payments due to a provider based on cost report data furnished by the provider, made the payments that it determined to the provider, subsequently decided that it had made a mistake in computing the provider's payments and recomputed that amount of payments due to the provider after correcting the error, and sought to recover the resulting "overpayment" from the provider. There is no basis for concluding that DHCS's administrative

claim in *Fountain Valley* is analogous to claims based on book accounts, a liability based on statute, or a mistake but that DHCS's claim to recover meaningful use payments from Huntington is not analogous to such claims. The factual differences between this case and *Fountain Valley* may concern the calculation of the time period of the delay and whether DHCS demonstrated the delay was reasonable, but not whether a statute of limitations should be borrowed.

Fourth, it is important to remember that the question is not whether this case is analogous to *Fountain Valley* (although it is), but whether DHCS's administrative claims here are analogous to claims to which a statute of limitation applies. Clearly they are.

It cannot be disputed that DHCS maintains a book account with Huntington and other Medi-Cal providers, which is a "detailed statement which constitutes the principal record of one or more transactions between a debtor and a creditor, and shows the debits and credits in connection therewith, and against whom and in favor of whom entries are made . . . ." (Cal. Code Civ. Proc., § 337a.)

Similarly, the administrative claim here is analogous to a claim based on statute, as the claim is based on DHCS's view of the applicable federal statute and regulation, 42 U.S.C. § 1396b(t), 42 C.F.R § 405.310, and DHCS's audit authority under state law. (See Cal. Welf. & Inst. Code, §§ 14170 and 14046.1.)

If it is decided that DHCS is correct in its position that unpaid days may not be included in Medi-Cal days, it is evident

that DHCS made a mistake in instructing hospitals to use data that included unpaid days and then in calculating and paying incentive payments based on a factor that included them. Consequently, DHCS's claim to retroactively revise the amount of Huntington's EHR payments and to recover any overpayment that DHCS made is analogous to a claim for recovery based on mistake, and a three-year limitations period applies. (See fn. 8, p. 24.)

Accordingly, as in *Fountain Valley*, there is either a 3-year or 4-year limitation period that is applicable. DHCS's action here exceeded the borrowed limitations period regardless of whether it is a 3-year or 4-year period.

The following chronology sets forth the events relevant to an analysis of whether DHCS's delay in revising Huntington's incentive payments exceeded the applicable borrowed statute of limitations:

1. In 2009, Congress enacted the American Recovery and Reinvestment Act which included funding for an EHR meaningful use incentive program to be implemented by CMS under Medicare and Medicaid.

2. On September 9, 2011, DHCS submitted its State Medicaid Health Information Technology Plan ("SMHP") to CMS for review and approval.

3. On September 30, 2011, CMS approved California's SMHP.

4. At about this time, DHCS created a state level registry ("SLR") through which hospitals could register for the

incentive payment, submit the necessary attestations to participate, and complete a workbook that provided DHCS with the necessary data. DHCS created a Start Guide with the SLR that instructed providers to import specific cost report cells. These specified cells included unpaid days for Medi-Cal beneficiaries.

5. On December 5, 2011, Huntington submitted its initial application for attestation and enrollment in the EHR program. The initial application included the required Medi-Cal inpatient days data, which included unpaid days.

6. Shortly after Huntington's December 5, 2011 submission, DHCS determined that it was entitled to aggregate payments over a 4-year period in the amount of about $3.2 million, and paid the first period's installment to the hospital.[9][10]

7. On May 5, 2014, CMS approved DHCS's audit strategy under the EHR program.

8. On July 11, 2016, DHCS notified Huntington that it intended to audit its Year 1 attestation, including reported Medi-Cal inpatient days.

9. On June 2, 2017, DHCS issue a letter to Huntington transmitting its audit findings, which include a reduction in Medi-Cal inpatient days by 4,041 days, due primarily to the elimination of unpaid days.

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[9] These facts, which are not in dispute, are set forth in DHCS's Final Decision (JA051 – JA072).

[10] Huntington submitted attestations for years 2 through 4 on December 24, 2012, November 21, 2013, and November 25, 2014, receiving payments following each attestation.

As reflected above, more than 4 years elapsed from the time DHCS received Huntington's data until it initiated an audit of the data, and more than 5 years elapsed until the audit findings were issued, both well in excess of a 3 or 4 year borrowed limitations period.

If equitable borrowing were to apply, DHCS's principal argument is that the clock should not begin to run until CMS approved DHCS's audit strategy on May 5, 2014, and therefore, that the audit was initiated within a 3-year period. There are several fundamental flaws with this argument.

First, DHCS has failed to explain why it took so long for it to obtain CMS approval, assuming DHCS is correct in its assertion that it had to wait for CMS approval to commence the audit. DHCS was able to promptly submit and obtain CMS approval of its SMHP. The record reflects that DHCS had planned from the beginning to conduct audits, and DHCS contends that CMS required it to conduct audits. Further, by October 2012 when CMS issued its "frequently asked question" response concerning unpaid days, DHCS knew or should have known that unpaid days were included in Medi-Cal days. Moreover, state law required that the SMHP developed by DHCS and approved by CMS "Establish the audit and appeal process." (Cal. Welf. & Inst. Code, § 14046.1(b)(6).) Yet, DHCS did not obtain CMS approval of its audit strategy until more than two and one-half years had passed after CMS's approval of the SMHP. Accordingly, for purposes of applying laches, DHCS's unreasonable delay began at or around the time it obtained CMS

approval of its SMHP on September 30, 2011. The borrowed limitations periods were clearly exceeded, shifting the burden to DHCS. DHCS cannot be heard to argue in equity that, having unreasonably delayed obtaining audit authority from CMS, this delay should inure to its benefit by triggering a later date for the application of a borrowed limitations period.

Second, as Huntington notes in its Reply, the audit results were issued more than 3 years after CMS approved the audit strategy, which was beyond the borrowed limitations period under Code of Civil Procedure sections 338(a) and (d). DHCS asserts that the date it informed Huntington of the audit, and not the date of the audit findings, should control but provides no support for this proposition. It is the completion of the agency action, including here the issuance of audit findings, which must be done within a reasonable time to avoid the application of laches. If not, an agency could simply inform a regulated party that it intends to take an action and then delay indefinitely without finalizing the agency's action.

B. DHCS Has Not Rebutted the Presumptions of Unreasonable Delay and Prejudice

DHCS has not met its burden of showing its delay in auditing Huntington's data and revising the incentive payments due to Huntington was reasonable. DHCS's principal justification for the delay is that it could not audit until receiving CMS approval. As discussed above, however, DHCS has not provided any justification for the delay in obtaining CMS approval of its audit strategy. Nor has DHCS provided any justification for the more than three years it took to complete the

audit of Huntington's data after receiving CMS approval of the audit strategy.

DHCS also has failed to meet its burden of demonstrating that Huntington was not prejudiced by the delay. To do so, DHCS would have been required to demonstrate that the delay in auditing and revising the 2011 data, and the subsequent retroactive payment reductions, did not impact Huntington's budgeting and financial planning. DHCS did not make any such showing. Rather, as discussed in Huntington's Reply at 31-32, Huntington was prejudiced by DHCS's delay.

C. Additional Considerations Support a Finding of Laches

It is clear that finality in Medi-Cal payments is particularly important to hospitals, as discussed above. Many hospitals are financially stressed and do not have the means to deal with retroactive recoupments of substantial funds, especially when those recoupments occur several years after the payments were received, as is true of Huntington. This tilts the presumption further in favor of a finding that delays in payments to hospitals will result in prejudice.

Further, the federal and state governments have unquestionably recognized the importance to hospitals of finality and certainty in payment determinations so that hospitals may be able to budget and plan. This factor militates strongly in favor of shifting the burden of proof with respect to this issue to DHCS, a burden DHCS did not meet here.

Last, the equities here and the reasonableness of Huntington's expectations are further supported by the fact that

Huntington relied on DHCS's instructions (that had been approved by CMS) in providing the data to DHCS, including the Medi-Cal patient days data. DHCS's instructions to providers identified the specific cells from Medi-Cal cost reports from which the data should be taken. It is undisputed that the data in these cells include unpaid Medi-Cal days. As laches is an equitable concept, we urge the Court to consider this factor in adjudicating the equities.

IV. Medicaid Inpatient Days Include Unpaid Days

While the Amici have focused in this brief on the issue of laches, we emphasize that the Amici join in and support Huntington's position that Medicaid inpatient days as used in the incentive payment computation includes unpaid days for individuals enrolled in the Medi-Cal program on the unpaid day. In summary:

1. The plain language of the applicable statute requires that all patient days "attributable to" individuals who are receiving medical assistance under Medicaid be included in Medicaid days in the numerator of the Medicaid fraction. 42 U.S.C. § 1396b(t)(5). Individuals may be enrolled in Medicaid and receiving medical assistance regardless of whether a particular inpatient day is covered by the Medicaid program. An individual may well be receiving covered Medicaid services (such as physician services) on the same day that the inpatient day was not covered. If Congress wished to exclude unpaid days, it could have done so clearly.

2. To the extent there is any ambiguity in the statute,

the applicable federal regulation resolves the ambiguity, providing that Medicaid inpatient days used in the numerator of the Medicaid share fraction be "[t]he estimated number of acute-care inpatient-bed-days which are attributable to Medicaid individuals." An individual enrolled in Medicaid is a "Medicaid individual" regardless of whether Medicaid pays for an inpatient day for the individual. Note that the regulation does not require that the individual "be receiving" medical assistance under Medicaid on a patient day for the day to be include, only that the individual be a "Medicaid individual." CMS is of course bound by its own regulation.

3. The CMS Federal Register commentary on which DHCS relies is unclear, particularly as to its treatment of Medicaid fee-for-service days. Most importantly, it is not entitled to any weight where it is inconsistent with the plain language of the statute and regulations.

4. The October 2012 Frequently Asked Question document is entitled to no deference whatsoever as it was not adopted as a rule in accordance with the notice-and-comment rulemaking provisions of the Administrative Procedure Act and because it, too, is in conflict with the plain language of the controlling statute.

5. A comparison of the statute establishing the Medicare Share to the language establishing the Medicaid share makes it clear that unpaid Medicaid days should be included. The statute governing the Medicare Share, 42 U.S.C. § 1395ww(n)(2)(D), limits Medicare inpatient days to inpatient bed

days "which are attributable to individuals with respect to whom payment may be made under" the Medicare fee-for-service program. This language clearly limits the Medicare days included in the computation to paid days. No such payment language is in the statute establishing the Medicaid fraction, demonstrating the Congress did not intend Medicaid days to be limited to paid days.

For the foregoing reasons, unpaid inpatient days for individuals enrolled in Medicaid must be included in the Medicaid fraction. If the Court agrees, it need not reach the laches issue.

CONCLUSION

For the reasons stated herein and those articulated in Huntington's Opening and Reply Briefs, the Court should reverse the judgment of the superior court and instruct that it grant the petition for writ of administrative mandate.

Respectfully submitted,

DATED: November 13, 2023

HOOPER, LUNDY & BOOKMAN, P.C.

By: */s/ Lloyd A. Bookman*
LLOYD A. BOOKMAN

Attorney for California Hospital Association, Dignity Health and Dignity Community Care, and Adventist Health System/West

CERTIFICATE OF COMPLIANCE

Pursuant to California Rules of Court, rule 8.204(c), I hereby certify that this brief contains 6,523 words using 13-point Century Schoolbook font, including footnotes, which is less than the total words permitted by the California Rules of Court. In making this certification, I have relied on the word count of the computer program used to prepare the brief.

DATED: November 13, 2023

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PROOF OF SERVICE

I am over 18 years of age and not a party to this action. My business address is 1875 Century Park East, Suite 1600, Los Angeles, California 90067. My electronic service address is TReiss@hooperlundy.com.

On November 13, 2023, I served true copies of the attached Brief of *Amici Curiae* California Hospital Association, Dignity Health and Dignity Community Care, and Adventist Health System/West in Support of Appellant Pasadena Hospital Association by placing a true copy in a sealed envelope with first class postage prepaid in the United States mail upon the following:

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Los Angeles, CA 90012

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

Executed on November 13, 2023, at Los Angeles, California.

/s/ Tia Reiss
Tia Reiss

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Case Name: **Pasadena Hospital Association, LTD. v. Bass**
Case Number: **B325070**
Lower Court Case Number: **21STCP03538**

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

11/13/2023

Date

/s/Lloyd Bookman

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