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IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

In re **VERITY HEALTH SYSTEM OF CALIFORNIA, INC.,** Debtor,	Case No.: 2:19-cv-08762-JVS **APPELLANTS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES'S OPENING BRIEF** Courtroom: Santa Ana, 10C Judge: Hon. James v. Selna Appeal Filed: October 9, 2019

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INTRODUCTION

The bankruptcy court erred in ruling that the Debtors' Medi-Cal Provider Agreements (Provider Agreements) are licenses that can be sold free and clear of the tens of millions of dollars that the Debtor owes to Appellant California Department of Health Care Services (Department). In so ruling, the bankruptcy court erroneously reasoned that the Provider Agreements are not enforceable contracts because they lacked mutual consideration. In addition, the bankruptcy court improperly concluded a key feature of the executory contract is absent in the Provider Agreement – mutual obligations by the Debtors and the Department. Specifically, the bankruptcy court incorrectly analyzed that no obligation is imposed upon the Department by the Provider Agreements. Contrary to the bankruptcy court's incorrect analysis, the Provider Agreements demonstrates both mutual consideration between the parties and obligation upon the Department.

If the Debtors are allowed to sell, transfer, and assign the Agreements without requiring the Debtors to pay their HQA Fee liabilities and Medi-Cal overpayments or the buyer to assume those liabilities on joint and several liability, then Debtors and the buyer would be allowed to divorce the benefits from the burdens of the Provider Agreements and undermine the HQA Fee system.

Accordingly, the bankruptcy court's order rejecting the Provider Agreements as executory contracts (ECF No. 3372) must be reversed.

BACKGROUND

I. PROCEDURAL BACKGROUND

On August 31, 2018 (Petition Date), Debtors including St. Francis Medical Center, St. Vincent Medical Center, and Seton Medical Center (collectively, Debtors) filed their voluntary petitions for relief under chapter 11 of the United States Bankruptcy Code. Debtors' bankruptcy cases are jointly administered and, pursuant to 11 U.S.C. §§ 1107(a) and 1108, Debtors continue to operate their

businesses and manage their affairs as Debtors-in-Possession.

On January 17, 2019, Debtors filed the Motion for an order: (a) approving form of the Asset Purchase Agreement (APA) for the buyer, Strategic Global Management, Inc. (hereafter, Buyer SGM), and for prospective overbidders; (b) approving procedures related to the assumption of certain executory contracts and unexpired leases; and (c) to sell their property free and clear of any claims, liens, and encumbrances (Motion for the Sale). Mot. for the Sale, ECF No. 1279.

On January 25, 2019, the Department filed its Objection to Debtors' Motion for the Sale. Dept.'s Objection and Supporting Decl., ECF Nos. 1353 & 1353-1. On September 11, 2019, the Department filed its Supplemental Objection to Debtors' Motion for the Sale. Dept.'s Supp. Obj. and Supporting Decl., ECF No. 3043 & 3043-1.

On September 26, 2019, the bankruptcy court issued the Memorandum of Decision Authorizing Debtors to *Sell Medi-Cal Provider Agreements Free and Clear of Interests Asserted by the California Department of Health Care Services, Pursuant to §* 363(f)(5) (For Publication) (hereafter, Memorandum of Decision). Memo. of Decision, ECF No. 3146. On October 11, 2019, the bankruptcy court entered an Order Authorizing Debtors to Sell Medi-Cal Provider Agreements, Free and Clear of Interests Asserted by the California Department of Health Care Services, Pursuant to §§ 363(b) and (f)(5) (Order). Order, ECF No. 3372.

On October 9, 2019, the Department appealed the Order to the United States District Court. Notice of Appeal, ECF No. 3327.

On October 22, 2019, the bankruptcy court denied the Department's Emergency Motion for the Entry of an Order to Stay the Sale of Medi-Cal Provider Agreements Free and Clear of Interests and the Asset Purchase Provisions that Relate to Buyer SGM's Rights and Obligations under Debtors' Medi-Cal Provider Agreements (Emergency Motion). Em. Mot. and the Supp. Decl., ECF Nos. 3211

& 3211-1. The bankruptcy court entered an order denying the Emergency Motion. Order on the Em. Mot., ECF No. 3444.

II. STATUTORY AND REGULATORY BACKGROUND

A. Administration of the Medi-Cal System

The federal Medicaid Act, enacted in 1965 as title XIX of the Social Security Act, is a federal-state administered Spending Clause program designed to provide medical assistance to eligible low-income individuals. 42 U.S.C. §§ 1396a & b (2019). The financing and administration of the Medicaid program are a cooperative effort between the federal government and participating states, as authorized under a federally approved State Medicaid Plan. Title 42 U.S.C. §§ 1396 – 1396c authorize federal financial support to states for medical assistance provided to certain low-income persons. In California, this program is the California Medical Assistance Program, which is commonly known as Medi-Cal. Cal. Welf. & Inst. Code § 14063 (West 2019). The Department is the single state agency authorized to administer the Medi-Cal program. Cal. Welf. & Inst. Code § 10740 (West 2019); Cal. Code Regs. tit. 22, § 50004(b)(1) (2019).

B. Medi-Cal Financing

The costs of the Medicaid program are generally shared between states and the federal government based on a set formula. 42 U.S.C. §§ 1396b(a) and 1396d(b) (2019). Except for certain covered populations or discrete service expenditures specified in 42 U.S.C. §§ 1396b or 1396d, the federal government reimburses medical assistance expenditures under California's State Medicaid Plan at a rate of 50%. When the Department makes expenditures for medical assistance covered under Medi-Cal, the Department claims the appropriate federal share of those costs at the appropriate federal medical assistance percentage. *Id.*

Federal Medicaid law permits states to finance the non-federal share of

Medicaid costs through several sources, including but not limited to:

> Charges on Health Care Providers. Federal Medicaid law permits states to (1) levy various types of charges – including taxes, fees, or assessments – on health care providers and (2) use the proceeds to draw down FFP (federal financial participation) to support the non-federal share of state Medicaid expenditures. These charges must meet certain requirements and be approved by CMS (Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services) for revenues from these charges to be eligible to draw down FFP. A number of different types of providers can be subject to these charges, including hospitals.

42 U.S.C. § 1396b(w) (2019); 42 C.F.R. §§ 433.50 – 433.74 (2019).

The Hospital Quality Assurance Fee (HQA Fee) is a charge imposed by the Department on non-exempt hospitals to finance the non-federal share of specified Medi-Cal costs. Cal. Welf. & Inst. Code § 14169.51(*l*) (West 2019). The quarterly HQA Fee imposed upon non-exempt hospitals has been collected by the Department in similar form since 2009. The collected HQA Fees are used to support Medi-Cal expenditures and maximize available federal participation for Medi-Cal costs. 42 U.S.C. § 1396b(w) (2019); 42 C.F.R. §§ 433.50 – 433.74 (2019).

C. Delivery of Medi-Cal Services

The vast majority of Medi-Cal benefits are delivered through one of two systems: (i) the fee-for-service system and (ii) the managed care plan system. Cal. Welf. & Inst. Code § 14016.5(b) (West 2019). In the fee-for-service system, Medi-Cal contracts with and pays health care providers (such as physicians, hospitals, and clinics) directly for covered services provided to Medi-Cal beneficiaries. *Id.*, §§ 14131 – 14138 (West 2019).

The Department also administers Medi-Cal through various managed care plans operated by public and private entities under contract pursuant to various statutory authorities. *See generally* Cal. Welf. & Inst. Code §§ 14087.3-14089.8, 14200-1499.77. (West 2019). In the managed care system,

the Department contracts with managed care plans to provide the vast majority of covered services for enrolled Medi-Cal beneficiaries within a fixed geographic location. *See generally id*. at §§ 14087.3 – 14087.48 (setting forth standards governing contracts between the Department and managed care providers) and § 14169.51(ab) (West 2019) (defining "managed health care plan" for purposes of the HQA Fee program).

Medi-Cal managed care enrollees may obtain non-emergency services from contracted providers – including hospitals – that accept payments from their health plans. The Department develops and pays an actuarially sound (capitation) rate per Medi-Cal beneficiary enrollee per month to contracted managed care plans. Cal. Welf. & Inst. Code § 14301.1 (West 2019).

D. Payments to Hospitals for Medi-Cal Services

The Department provides payments to licensed general acute care hospitals. These hospitals are divided into three general categories (private hospitals, designated public hospitals (county and University of California), and non-designated public hospitals (district hospitals) based on whether the hospital is privately or publicly owned, and who operates the hospital. *Id*. Debtors are private hospitals.

Hospitals may receive several types of payments based on their participation in Medi-Cal, including direct payments from the Department, managed care payments from managed care plans, and supplemental payments from both the Department and managed care plans.

Direct payments are payments to providers such as Debtors for providing covered services to Medi-Cal beneficiaries through the fee-for-service system. Cal. Welf. & Inst. Code §§ 14131 – 14138 (West 2019). Managed care payments are payments from managed care plans to providers (including hospitals such as Debtors) for services delivered to Medi-Cal beneficiaries enrolled in these plans.

Cal. Welf. & Inst. Code § 14301.1 (West 2019). The plans receive funds from the Department to pay the providers.

Quality assurance payments are supplemental payments, supported by the HQA Fee revenue and federal matching funds, providing additional payments to Medi-Cal hospitals to supplement the Department's direct fee-for service payments and the managed care plans' payments to hospitals, including Debtors. Cal. Welf. & Inst. Code § 14169.53(b) (West 2019).

E. Statutory Basis for Collection of HQA Fees

California Welfare and Institutions Code section 14169.50 sets forth the legislative purpose and intent for the HQA Fee program. "It is the intent of the Legislature that funding provided to hospitals through a hospital quality assurance fee be continued with the goal of increasing access to care and to improving hospital reimbursement through supplemental Medi-Cal payments to hospitals." Cal. Welf. & Inst. Code § 14169.50(b) (West 2019). "It is [also] the intent of the Legislature to impose a quality assurance fee to be paid by hospitals, which would be used to increase federal financial participation in order to make supplemental Medi-Cal payments to hospitals, and to help pay for health care coverage for low-income children." Cal. Welf. & Inst. Code § 14169.50(d) (West 2019). California Welfare and Institutions Code section 14169.52(h) provides the Department with the statutory remedy to recover the unpaid HQA Fee debt from Medi-Cal payments until the entire debt is recovered (recoupment).

F. Reimbursement of Medi-Cal Overpayments

Medi-Cal makes interim payments to an authorized Medi-Cal provider after it renders services and submits claims for payment. The Department later audits the claims for Medi-Cal payment submitted by Medi-Cal providers. Cal. Welf. & Inst.

Code §§ 14133 and 14170 (West 2019). In that regard, the Department is statutorily authorized to audit and review a provider's cost report[1] within three years after the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later. Cal. Welf. & Inst. Code § 14170(a)(1) (West 2019).

If the audit indicates any overpayment, the provider must reimburse Medi-Cal for the overpayment. The Department may begin liquidation of any overpayment to a Medi-Cal provider sixty days after issuance of the first Statement of Accountability or demand for repayment. Cal. Code Regs. tit. 22, § 51047 (2019).

A provider can appeal the Department's audit findings. Cal. Code Regs. tit. 22, §§ 51016-51048 (2019). A Medi-Cal provider is entitled to a formal administrative hearing on any disputed overpayment. Cal. Welf. & Inst. Code § 14171 (West 2019).

III. JURISDICTION

This court has jurisdiction over this appeal pursuant 28 U.S.C. § 1331.

FACTUAL BACKGROUND

I. DEBTORS' HQA FEE DEBT TO MEDI-CAL

Debtor St. Vincent Medical Center, as of September 24, 2019, has HQA Fee liabilities for Phase V (January 1, 207 through June 30, 2019) in the amount of $6,575,330.03. Decl. of Hanh Vo in Support of the Department's Emergency Mot., ¶¶ 3-8, ECF No. 3211-1. Debtor Seton Medical Center, as of September 24, 2019,

[1] Cost reports and other data submitted by Medi-Cal providers are submitted to the Department for the purpose of determining reasonable costs for Medi-Cal services or establishing rates of Medi-Cal payment. Cal. Welf. & Inst. Code § 14170(a)(1) (West 2019).

has outstanding HQA Fee liabilities for Phase V in the amount of $16,714,870.24. *Id*. Debtor St. Francis Medical Center, as of September 24, 2019, has HQA Fee liabilities for Phase V in the amount of $13,528,354.37. *Id*.

II. MEDI-CAL OVERPAYMENTS TO DEBTORS

For July 1, 2016, through June 30, 2017, the Department's Audits Section – Los Angeles of the Financial Audits Branch determined that St. Francis Medical Center was overpaid $25,176,471 by Medi-Cal, which includes an overpayment recovery of $24,911.003. Emergency Mot. 10, ECF No. 3211; Declaration of Kenneth K. Wang, Ex. 1 (Declaration of Ginn Sampson in Support of Creditor California Department of Health Care Services's Opposition to Debtors' Request to Bifurcate ¶ 4) (concurrently filed herewith). There are cost reports for other fiscal years that still need to be reviewed and/or audited by the Department.

Further, for July 1, 2016, through June 30, 2017, the Department has determined, based on retroactive claim adjustments, that Seton Medical Center was overpaid $4,205.25 by Medi-Cal for hospital operations. Decl. of Hanh Vo in Support of the Dept.'s Supp. Obj., ¶ 16, ECF No. 3043-1.

Also, St. Francis Medical Center was overpaid by Medi-Cal in the amount of $662,327.67 in supplemental reimbursements under the Supplemental Reimbursement for Construction Renovation Reimbursement Program. Declaration of Shiela Mendiola, ECF No. 3043-2.

III. DEBTORS CONTINUE AS MEDI-CAL PROVIDERS POST PETITION

Since the Petition Date, Debtors have continued to provide Medi-Cal services, have continued to submit claims to Medi-Cal for payment, and have continued to receive millions of dollars in Medi-Cal payments. In other words, despite their bankruptcy filings, Debtors have remained in the Medi-Cal system, enjoying Medi-Cal provider benefits, such as direct payments from the Department, managed care payments from managed care plans, and supplemental payments

from both the Department and managed care plans.

ARGUMENT

I. THE BANKRUPTCY COURT ERRED IN REJECTING THE PROVIDER AGREEMENTS AS EXECUTORY CONTRACTS

The issue on appeal is whether Debtors' Medi-Cal Provider Agreements are executory contracts that must be assumed and assigned.

The Bankruptcy Code does not define the term "executory contract"; however, the legislative history of 11 U.S.C. § 365 leaves no doubt that an executory contract is one "in which neither side has fully performed at the commencement of bankruptcy." *In re Monsour Medical Center*, 8 B.R. 606, 612 (Bankr. W.D. Pa. 1981), aff'd 11 B.R. 1014 (W.D. Pa. 1981) (citing Fogel, *Executory Contracts and Unexpired Leases in the Bankruptcy Code*, 64 Minnesota Law Review 341, 344 (1980). The legislative history provides:

> Though there is no precise definition of what contracts are executory, it generally includes contracts on which performance remains due to some extent on both sides. A note is not usually an executory contract if the only performance that remains is repayment. Performance on one side of the contract would have been completed and the contract is no longer executory.

Id.

In other words, executory contracts include contracts where, to some extent, performance remains due from both parties. *In re Holland Enterprises, Inc*. (*In re Holland*), 25 B.R. 301 (Bankr. E.D. N.C. 1982) (citing *In re Rovine Corp*., 5 B.R. 402, 404 (W.D. Tenn. 1980).

A. Mutual Consideration for the Provider Agreement Included Successor Joint and Several Liability

Provider Agreements are enforceable contracts because of the mutual consideration.

To become entitled to receive Medi-Cal payments as Medi-Cal providers, the Debtors were required to enter into Provider Agreements with the Department. *In re Gardens Regional Hospital and Medical Center, Inc*. (*Gardens*), 569 B.R. 788,

792 (Bankr. C.D. Cal. 2017). Debtors' eligibility to participate in the Medi-Cal program is conditioned upon their consent to the terms of the Provider Agreements. *Gardens*, 569 B.R. at 796-97. In that regard, the Agreements specifically emphasize:

> **AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE.**

Decl. of Hanh Vo in Support of the Dept.'s Supp. Obj., Exs. 1 – 4 (Provider Agreements) (original emphasis), ECF No. 3043-1.

The bankruptcy court erred in assuming that the Provider Agreement is not an executory contract because it lacked mutual consideration. Mem. of Decision 7, ECF No. 3146. According to the bankruptcy court, the obligations in the Provider Agreements merely restate the Debtors' pre-existing obligations. *Id*. at 6-7. An agreement to comply with applicable law, bankruptcy court states, is a gratuitous promise, which does not provide consideration to make a contract enforceable. *Id*. 7, ECF No. 3146.

The order is incorrect because there is mutual consideration. As the bankruptcy court recognized in *Gardens*, a Provider Agreement entitles a health care professional or entity to Medi-Cal payment benefits. However, the Department, on behalf of Medi-Cal, does not have any pre-existing duty to authorize any health care professional or entity to become Medi-Cal providers or any pre-existing duty to execute the Provider Agreement with any health care professional or entity. Thus, the Department's agreement to execute the Provider Agreement with the Debtors to authorize them to become Medi-Cal Providers is sufficient consideration by the Department. There is also sufficient consideration by the Debtors. Under the Agreements, the Debtors receive the benefit of being

able to provide care to Medi-Cal beneficiaries and receive payment in the tens of millions of dollars. Consequently, there is an exchange of consideration sufficient to support the Department's position that the Provider Agreements are enforceable contracts.

The bankruptcy court's assumption also fails given the parties' consideration indicated in the Provider Agreements. The consideration includes the Debtors' agreement to successor joint and several liability in order to be approved as Medi-Cal providers and to receive Medi-Cal payment benefits. The Department made absolutely clear through its briefings below that the Debtors, by executing the Provider Agreements, agreed to every term and provision of the Provider Agreements. An explicit provision of the Provider Agreements mandated the successor joint and several liability:

> Assignability. Provider agrees that it has no property right in or to its status as a Provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that Provider may not assign its provider number for us as a Medi-Cal provider, or any rights and obligations it has under this Agreement except to the extent purchasing owner is joining this provider agreement with successor liability with joint and several liability.

Decl. of Hanh Vo in Support of the Dept.'s Supp. Obj., ¶ 7, Ex. 5 at 8, ECF No. 3043-1.

To the Department's knowledge, no federal or state statute or regulation mandates joint and several successor liability by the purchasing owner. As such, this significant provision was a condition imposed solely by the Department to which the Debtors must agree in order to contract with the Department, for enrollment in Med-Cal, and for receipt of Medi-Cal payment benefits. As such, there was consideration between the Department and the Debtors for the Provider Agreements to be enforceable contracts. Accordingly, the bankruptcy court erred in ruling that Provider Agreements are not enforceable contracts.

B. Provider Agreements Are Executory Contracts Because the Contracting Parties Have Mutual Obligations

Executory contracts are those in which performance remains due from both parties. *In re Holland,* 25 B.R. 301 (citing *In re Rovine Corp.*, 5 B.R. 402, 404 (W.D. Tenn. 1980). The bankruptcy court reasoned that Provider Agreements are not executory contracts in that they "impose no obligations upon the [Department]." Mem. of Decision 6, ECF No. 3146. The bankruptcy court added that the "only obligations spoken of in the Provider Agreements pertain to Debtors." *Id*. at 6 -7.

The bankruptcy court mistakenly concluded that the Provider Agreements only reference the Debtors' obligations. Mem. of Decision 6, ECF No. 3146. The Department's obligation to pay the Debtors, as Medi-Cal providers, is plainly stated in the Agreements. Paragraph 22 of the Agreement states that "payment received from the [Department] shall constitute payment in full. Decl. of Hahn Vo, Ex. 4 at 4, ECF No. 1353-1. Absent the Department's obligation to pay, the Debtors would not have entered into the Provider Agreements. There was no expectation that the Debtors would provide free services to Medi-Cal beneficiaries.

Also, the Department's obligation to pay Medi-Cal providers, such as the Debtors, is incorporated by reference into the Provider Agreements. The Provider Agreement, if unable to rely upon the shorthand of incorporation by reference, including the Department's obligations, "will swell in length from less than 10 pages to hundreds of pages." *Gardens*, 569 B.R. at 799. This is especially true given the fact that hospitals that are Medi-Cal providers may receive several types of payments based on their participation in Medi-Cal, including direct payments from the Department, managed care payments from managed care plans, and supplemental payments from both the Department and managed care plans.

C. Case Law Affirms that Medi-Cal Providers Have No Statutory Entitlement to Bill Medi-Cal

Participation in Medi-Cal allows providers to continue to bill and be paid by

Medi-Cal for services, as well as receive non-direct service payments, such as supplemental payments. These additional payments to Medi-Cal hospitals supplement the Department's direct fee-for service payments and the managed care plans' payments to hospitals, including Debtors. Cal. Welf. & Inst. Code § 14169.53(b) (West 2019).

The bankruptcy court erroneously reasoned that the Medi-Cal Provider Agreements are akin to licenses because the Debtors have a statutory entitlement to provide services and to receive reimbursement for such services. Memo. of Decision 8-9, ECF No. 3146. The bankruptcy court's analysis is unsupported because it only considered reimbursement for services provided. As authorized Medi-Cal providers pursuant to the Provider Agreements, the Debtors also receive tens of millions of dollars in supplemental payments under the HQA Fee program, which have no direct relationship to the service provided. The statutes do not set out any exclusive conditions under which the supplemental benefits must be paid or denied. *Goldberg v. Kelly*, 397 U.S. 254 (1970); *Arnett v. Kennedy*, 416 U.S. 134 (1974).

Further, the bankruptcy court ignored the fact that the disputed issue is about whether the Debtors have any statutory entitlement to remain in Medi-Cal such that they can transfer that right to Buyer SGM through the sale, not whether Debtors have any statutory entitlement to receive payment for services provided. Debtors do not have any statutory right to remain as Medi-Cal providers. In that regard, the Ninth Circuit has held that Medi-Cal providers do not have any ownership in their Medi-Cal provider status. Thus, they do not have any statutory entitlement to continue to remain in Medi-Cal and to continue to bill
Medi-Cal, which is the intended consequence of the transfer of Medi-Cal Provider Agreements from the Debtors to Buyer SGM.

In *Erickson v. United States Department of Health and Human Services*, the

district court granted an injunction to plaintiffs, a Medicare provider, to prohibit the Secretary of Health and Human Services from excluding them from federally-funded health care programs. On appeal, the Ninth Circuit followed the reasoning of the First and Tenth Circuits in *Koerpel v. Heckler*, 797 F.2d 858, 863-65 (10th Cir. 1986) and *Cervoni v. Secretary of Health, Education and Welfare*, 581 F.2d 1010 (1st Cir. 1978) and held that plaintiffs were not entitled to the continued participation in Medicare/Medicaid programs. Plaintiffs failed to show entitlement, including statutory entitlement, for continued participation in those programs; therefore, they have no property interest in continued participation in those programs. *Erickson v. United States Department of Health and Human Services*, 67 F. 3d 858, 862 (9th Cir. 1995). Similarly, the California Court of Appeal in *Lin v. State of California*, 78 Cal. App. 4th 931 (Cal. Ct. App. 2012) held that providers of Medicare and Medicaid services have no protected interests in continued participation in those programs. *Id*., at 935. In fact, the California Court of Appeal concluded that "the relationship between a Medi-Cal provider and the Department is 'contractual in nature.'" *Mednik v. State Department of Health Care Services* 175 Cal. App. 4th 631, 642 (Cal. Ct. App. 2009).

Consistent with the *Erickson* holding, the Debtors' Provider Agreements explicitly assert that no property interests exist in or to the Debtors' providers' status. Essentially, the Debtors have no property interest, including any purported statutory entitlement, in their Provider Agreements. Instead, the Agreements expressly state that any rights or obligations associated with the Provider Agreements may only be assigned and assumed with successor joint and several liability. Decl. of Hanh Vo in Support of the Dept.'s Supp. Obj. Ex 5 ¶ 37 at 8, ECF No. 3043-1.

Accordingly, contrary to the bankruptcy court's erroneous analysis, the Provider Agreements do not provide the Debtors with any statutory entitlement to

continue to remain in Medi-Cal and to continue to bill Medi-Cal, such that they can transfer such purported statutory entitlement to Buyer SGM through the sale. Mem. of Decision 8, ECF No. 3146.

D. *PAMC* and *Guzman* Do Not Provide the Debtors with a Statutory Right to Remain in Medi-Cal After the Sale

The bankruptcy court cited *PAMC, Ltd., v. Sebeli*us, 747 F.3d 1214 (9th Cir. 2014) and *Guzman v. Shewry*, 552 F.3d 941 (9th Cir. 2009) for the proposition that Medi-Cal Provider Agreements are not contracts because, upon joining Medicare, the hospitals receive a statutory entitlement, not a contractual right, to receive reimbursement services provided. Mem. of Decision 5-6, ECF No. 3146.

The bankruptcy court misinterpreted and misapplied *Guzman*. The relevant principle from that case is that a health care provider does not have a right to contract with the governmental assistance programs, such as Medi-Cal. In *Guzman*, Guzman argued that his temporary suspension denied him the ability to receive reimbursement for treating Medi-Cal beneficiaries; thus, he had been deprived of his right to contract with the State. *Guzman v. Shewry*, 552 F.3d at 954. Based upon the alleged deprivation of his right to contract with the State, Guzman further argued that he was deprived of the procedural guarantees of the Due Process Clause. *Id*. Guzman analogized his temporary suspension to bar from government contract bidding. *Id*.

The *Guzman* Court rejected the claimed liberty interest, ruling that one does not have a right to contract with the State to participate in its government assistance programs, "designed to provide benefits for a third party." *Id*. It was only in the context of whether Guzman had any guaranteed right to contract with the State that the Ninth Circuit noted that Guzman was entitled to receive payment for the services that he had already provided. *Guzman v. Shewry*, 552 F.3d at 955. Here, the issue is not whether the Debtors have any right to contract with Medi-Cal under the Provider Agreement. Rather, it is about whether the Debtors' Provider

Agreements constitute executory contracts in the bankruptcy context.

As for *PAMC*, it is entirely distinguishable. In that case, the provider failed to timely submit its quality data and was subject to a two percent reduction in its annual payment update. *PAMC, Ltd., v. Sebeli*us, 747 F.3d at 1216. The Medicare agreement did not include any provision regarding this issue. PAMC requested equitable relief. The Secretary of Centers for Medicare and Medicaid Services argued that she had published program procedures in the Federal Register and on the QualityNet Exchange website. *Id*. To resolve the disputed issue, the Ninth Circuit applied the regulatory scheme. The application of the regulatory scheme to resolve a disputed issue, in *PAMC*, does not negate the contractual nature of the Medi-Cal Provider Agreements.

Accordingly, the caselaw relied upon by the bankruptcy court does not demonstrate that the Debtors have a statutory entitlement to bill Medi-Cal.

II. THE DEBTORS CANNOT SELL THEIR AGREEMENT UNDER 11 U.S.C. § 363(F)

Aside from the fact that the Debtors have no property interests to continue to participate in the Medi-Cal system, 11 U.S.C. § 363(f) does not allow the Debtors to sell their Provider Agreements as property, free and clear of any debt or successor liability. Under 11 U.S.C. § 363(f), property can be sold free and clear of any interest in that property of an entity other than the estate, only if:

> (1) applicable nonbankruptcy law permits sale of such property free and clear of such interest;
> (2) such entity consents;
> (3) such interest is a lien and the price at which property is to be sold is greater than the aggregate value of all liens on such property;

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> (4) such interest is in bona fide dispute; or
> (5) such entity can be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest.

11 U.S.C. § 363(f).

Here, *Erickson* and the Provider Agreements specify that Medi-Cal providers, such as the Debtors, have no ownership interest in their Medi-Cal provider status. Given the binding Ninth Circuit precedent, the bankruptcy court mistakenly applied a broader definition of "interest . . . in property" to include "monetary obligations arising from the ownership of the property." Mem. of Decision 9, ECF No. 3146. The Debtors cannot meet the first through fourth criteria because they have no property ownership in their Medi-Cal provider status. Thus, they cannot have any monetary interest to sell based upon an agreement where there is no property interest.

For the fifth criteria, aside from the reasons above, the Department cannot be compelled to accept a money satisfaction in exchange for its rights to prevent a sale of the Debtors' Medi-Cal provider status or the Debtors' benefits, duties and obligations under the Agreements. There is no evidence that the Department may be compelled for less than the full payment of the debt. "By its express terms, Section 363(f)(5) permits lien extinguishment if the trustee can demonstrate the existence of another mechanism by which a lien could be extinguished without full satisfaction of the secured debt." *In re Terrace Chalet Apartments, Ltd.*, 159 B.R. 821, 829 (E.D. Ill, 1993). This especially holds true given the Department's right to recoup the Debtors' Medi-Cal debt on the Debtors' Provider Agreements, even after the sale. *Gardens*, 569 B.R. at 794-800. Buyer SGM will assume the Debtors' Provider Agreements after the sale. Equitable recoupment does not owe its legitimacy to anything in the Bankruptcy Code. *Sims v. United States Dept. of Health and Human Services*, 224 F. 1008, 1011 (9th Cir. 2000). Accordingly, the

Department, by equitable recoupment, can and will recoup Debtors' Medi-Cal debt on their Provider Agreements, even after the sale. *Gardens*, 569 B.R. at 794-800.

Accordingly, the Debtors cannot sell their Provider Agreements, free and clear of any debt under 11 U.S.C. § 363(f). The Provider Agreements can only be assumed and assigned with successor liability.

III. THIS BANKRUPTCY COURT'S RULING WILL CAUSE SEVERE, NEGATIVE RAMIFICATIONS

Bankruptcy courts should not be a haven for wrongdoers. *In re Berg*, 230 F.3d 1165, 1167 (9th Cir. 2000); *Lockyer v. Mirant Corp*., 398 F.3d 1098, 1107 (9th Cir. 2005). Similarly, bankruptcy courts should not be a mechanism through which a debtor is allowed to receive more favorable treatment, one that is strictly foreclosed for individuals or entities who are not in bankruptcy. Here, Medi-Cal providers, by the operations of their Provider Agreements, are required to transfer their Provider Agreements with successor joint and several liability. Yet, the bankruptcy court's ruling undermines that requirement and provides the Debtors with preferential treatment over Medi-Cal providers that are not in bankruptcy. Aside from the law, as a matter fairness and equity, Debtors should not be permitted to divorce the benefits of receiving millions of dollars from the burdens of their Provider Agreements.

As explained above, Medi-Cal makes interim payments to an authorized Medi-Cal provider after it renders services and submits claims to Medi-Cal for payment. The Department later audits the claims for Medi-Cal payment submitted by Medi-Cal providers. Cal. Welf. & Inst. Code §§ 14133 and 14170 (West 2019). The successor joint and several liability in the Provider Agreements comports with the nature and operations of the Medi-Cal system. A Medi-Cal provider, such as the Debtors, is only required to submit cost reports after the close of a fiscal year. Accordingly, the Debtors have yet to submit cost reports for the current fiscal year to the Department under California Welfare and Institutions Code section 14170,

which ends in June 2020.

Absent successor joint and several liability provided by 11 U.S.C. § 365 and given the bankruptcy court's ruling to authorize the Debtors to sell their Provider Agreements free and clear of the Department's claims, the Department will be foreclosed from recovering any Medi-Cal overpayments that are discovered after the sale solely because of the operations of the Medi-Cal system relative to the timing of the bankruptcy proceedings.

IV. DEBTORS' PROVIDER AGREEMENTS REQUIRE SUCCESSOR LIABILITY BY THE BUYER

Debtors and Buyer SGM cannot be allowed to divorce the benefits from the burdens of the Provider Agreements. Under the APA, SGM intends to "succeed to the quality history associated with the . . . Medi-Cal provider agreements." APA § 8.7, ECF No. 1279. Buyer SGM should not allowed to assume the benefits of the Provider Agreements without assuming the burdens thereon. In addition, if Buyer SGM does not assume the Debtors' obligations under the Provider Agreements, it should be barred from receiving any Hospital Quality Assurance Program payments (supplemental payments), after the sale, pursuant to the Debtors' Provider Agreements. APA § 1.9(j), ECF No. 1279. Similarly, under the Court's ruling, SGM must also be foreclosed from collecting on Debtors' Medi-Cal payment receivables after the sale. APA § 1.7(b), ECF No. 1279.

A party must accept the contract as a whole, meaning that a party cannot choose to accept the benefits of an agreement and reject its burdens to the detriment of the other party to the agreement. *Richmond Leasing Co. v. Capital Bank, N.A.*, 762 F.2d 1303, 1311 (5th Cir. 1985) (citing *In re Holland*, 25 B.R. 301). It is axiomatic that an assumed contract under 11 U.S.C. § 365 is accompanied by its provisions and conditions. *In re Holland*, 25 B.R. at 303 (citing *Atchison, Topeka & Santa Fe Ry Co. v. Hurley*, 153 F. 403 (8th Cir. 1907), aff'd 213 U.S. 126, 29 S.

Ct. 466, 53 L. Ed. 729 (1909)). "Assumption or rejection of an executory contract requires an all-or-nothing commitment going forward, and then a debtor cannot assume part of an executory contract in the future while rejecting another part." *In re St. Mary Hospital*, 89 B.R. 503, 509 (E.D. Pa. 1988).

An executory contract must be assumed or rejected *in toto*. *In re Holland*, 25 B.R. at 303. "To hold otherwise, would construe the bankruptcy law as providing a debtor in bankruptcy with greater rights and powers under a contract than the debtor had outside the bankruptcy." *Id*. (citing *In re Nashville White Trucks, Inc*., 5 B.R. 112, 117 (Bankr. M.D. Tenn.)).

> The Court remains cognizant of the legislative purpose behind section 365. This provision vests the bankruptcy court with a unique power designed to facilitate the rehabilitation of debtors. Nevertheless, a debtor may not retreat to this provision, derived from the inherent equitable powers of the bankruptcy courts, to avoid an obligation while it enjoys a benefit which arises in conjunction with that obligation.

In re Holland, 25 B.R. at 303.

Accordingly, if Buyer SGM assumes the Provider Agreements, then Buyer SGM will be held jointly and severally liable for any debt owed by the Debtors to the Department, including unpaid HQA Fees and any Medi-Cal overpayments to the Debtors, as Debtors' Provider Agreements specifically mandate. In addition, under the Provider Agreements, Buyer SGM will be subject to Department's recoupment for any unpaid HQA Fees and Medi-Cal overpayments owed by Debtors. 11 U.S.C. § 365. "It is hornbook law that a debtor cannot assume the benefits of an executory contract while rejecting the burdens." *In re Tidewater Memorial Hospital, Inc*., 106 B.R. 876, 884 n.9 (Bankr. E.D. Va. 1989) (citing *Richmond Leasing Co. v. Capital Bank, N.A.*, 762 F.2d at 1311).

If the Debtors are allowed to sell, transfer, and assign the Provider Agreements without requiring the Debtors to pay their HQA Fee liabilities or Buyer SGM to assume those liabilities on joint and several liability, then the Debtors and Buyer SGM would be allowed to divorce the benefits from the burdens of the

Agreements and undermine the HQA Fee system. Debtors and Buyer SGM would receive the benefits of the Debtors' Provider Agreements including Medi-Cal service payments as well as quality assurance payments, while disregarding the obligations of the same Provider Agreements, including successor liability for any debt incurred by the Debtors to the Department.

V. THE DEPARTMENT REQUESTS AN EXPEDITED APPEAL

To expedite the appeal, the Department hereby requests an order expediting the appeal and setting an early hearing date, pursuant to Federal Rules of Appellate Procedure Rule 2.

An expedited appeal should provide an appellate review and decision on the transfer of the Provider Agreements.

CONCLUSION

Given the foregoing, this Court should reverse the bankruptcy court's ruling and rule that the Provider Agreements are executory contracts that must be assumed by the Debtors and assigned to Buyer SGM.

Dated: December 9, 2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JENNIFER M. KIM
Supervising Deputy Attorney General

/s/ Kenneth Wang
KENNETH K. WANG
Deputy Attorney General
Attorneys for Appellant
California Department of Health Care Services

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Attorneys for Appellant
California Department of Health Care Services

IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

In re **VERITY HEALTH SYSTEM OF CALIFORNIA, INC.,** Debtor,	Case No.: 2:19-cv-08762-JVS **DECLARATION OF DEPUTY ATTORNEY GENERAL KENNETH K. WANG IN SUPPORT OF APPELLANT CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES'S OPENING BRIEF** Courtroom: Santa Ana, 10C Judge: Hon. James v. Selna Appeal Filed: October 9, 2019

I, Kenneth K. Wang, declare:

1. I am an attorney licensed to practice in the State of California and in the United States District Court, for the Central District of California. I am a Deputy Attorney General in the Health, Welfare, and Education Section of the Civil Division of the California Office of the Attorney General.

2. I represent Creditor California Department of Health Care Services (Department) in the instant appeal and in the related, jointly administered Chapter 11 cases.

3. I have personal knowledge of the matters and information stated herein.

4. Attached as Exhibit A hereto is a true and correct copy of the Declaration of Ginn Sampson in Support of Creditor California Department of Health Care Services's Opposition to Debtors' Request to Bifurcate, which was filed with the bankruptcy court, in bankruptcy court case number 2:18-bk-20151-ER.

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

Executed on this 9th day of December 2019, at Los Angeles, California.

Kenneth K. Wang

EXHIBIT A

XAVIER BECERRA
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Supervising Deputy Attorney General
KENNETH K. WANG
Deputy Attorney General
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Attorneys for Creditor
California Department of Health Care Services

IN THE UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA – LOS ANGELES DIVISION

In re:

VERITY HEALTH SYSTEM OF CALIFORNIA, INC., et al.,

Debtor and Debtors In Possession.

/x/ Affects All Debtors.
Affects Verity Health System of California, Inc.
Affects O'Connor Hospital
Affects Saint Louise Regional Hospital
Affects St. Francis Medical Center
Affects St. Vincent Medical Center
Affects Seton Medical Center
Affects O'Connor Hospital Foundation
Affects Saint Louise Regional Hospital Foundation
Affects St. Francis Medical Center of Lynwood Foundation

CASE NO. 2:18-bk-20151-ER

DECLARATION OF GINN SAMPSON IN SUPPORT OF CREDITOR CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES'S OPPOSITION TO DEBTOR'S REQUEST TO BIFURCATE

Hearing:	September 25, 2019
Time:	10:00 a.m.
Courtroom:	1568
Judge	Ernest M. Robles

Affects St. Vincent Foundation
Affects St. Vincent Dialysis Center, Inc.
Affects Seton Medical Center Foundation
Affects Verity Business Services
Affects Verity Medical Foundation
Affects Verity Holdings, LLC
Affects De Paul Ventures, LLC
Affects De Paul Ventures – San Jose Dialysis, LLC,

Debtors and Debtors in Possession.

I, Ginn Sampson, declare:

1. I am currently a Supervisor of the Audits Section – Los Angeles of the Financial Audits Branch (Audits Branch) of California Department of Health Care Services (Department). I have been employed by the Department since August 2000. In that capacity, I have personal knowledge of the matters stated herein.

2. My responsibilities as a Supervisor of the Audits Branch include management of the audits of Medi-Cal providers in Los Angeles County.

3. The Audit Branch audited St. Francis Medical Center's Medi-Cal cost report for fiscal year July 1, 2016, through June 30, 2017 (Audit). As a Supervisor, I directed and supervised the audit.

4. Based upon the audit, the Audit Branch determined that St. Francis was overpaid **$25,176,471** by Medi-Cal, which includes an overpayment recovery of $24,911,003. Attached as Exhibit 1 is a true and correct copy of the cover letter of the Department's Audit findings.

5. St. Francis Medical Center (St. Francis) has administratively appealed the Audit findings and the associated Medi-Cal overpayments pursuant to the administrative appeal process provided by California Welfare and Institutions Code section 14171.

6. Under California Welfare and Institutions Code section 14171(e)(1), the administrative appeal process provides an informal hearing, which must be

conducted no later than 180 days after the filing of a timely and specific statement of disputed issues by the Medi-Cal provider.

7. For any audit-related issues unresolved by the informal hearing, the provider may request a formal hearing under California Welfare and Institutions Code section 14171(e)(2). Under that statute, the formal hearing must be conducted no later than 300 days after the filing of a timely and specific statement of disputed issues by the provider.

8. To appeal the Audit findings, St. Francis, on July 11, 2019, submitted its statement of disputed issues related to the Audit findings and requested an administrative hearing regarding the Audit findings, which was accepted by the Office of Administrative Hearings and Appeals of the Department (OAHA). Attached as Exhibit 2 is a true and correct copy of OAHA's letter to Ms. Sze, dated July 19, 2019, accepting St. Francis's administrative audit appeal.

9. For its administrative appeal, St. Francis submitted its position paper to OAHA on August 21, 2019. Attached as Exhibit 3 is a true and correct copy of St. Francis's statement of disputed issues to OAHA (without the exhibits for protection of any potential confidential information), dated August 21, 2019.

10. On August 13, 2019, the Audits Branch submitted its position to OAHA. Attached as Exhibit 4 is a true and correct copy of the Department's position statement regarding the Audit (without the exhibits for protection of any potential confidential information), dated August 13, 2019.

11. The Informal Hearing was scheduled for and proceeded on August 29, 2019, in Van Nuys, California. Attached as Exhibit 5 is a true and correct copy of the notice of the Informal Hearing.

12. On August 29, 2019, St. Francis and its counsel requested and received an extension for additional time to submit post-Informal Hearing documentation and responses. Attached as Exhibit 6 is a true and correct copy of the Provider Extension of Time Agreement.

13. During the Informal Hearing, the parties agreed to extend the close of record for the submission of additional information and responses. Attached as Exhibit 7 is a true and correct copy of the letter by OAHA regarding the extension, dated September 6, 2019.

14. On September 11, 2019, pursuant to the extension agreement, the Audits Branch submitted its response to the additional information submitted by St. Francis. Attached as Exhibit 8 is a true and correct copy of the Department's response (without the exhibits for protection of any potential confidential information), dated September 11, 2019

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

Executed on this 24 th day of September 2019, at Los Angeles, California.

Ginn Sampson

EXHIBIT 1

REPORT ON THE COST REPORT REVIEW

ST. FRANCIS MEDICAL CENTER
LYNWOOD, CALIFORNIA
NATIONAL PROVIDER IDENTIFIERS: 1487697215
AND 1245227180

FISCAL PERIOD ENDED
JUNE 30, 2017

Audits Section—Los Angeles
Financial Audits Branch
Audits and Investigations
Department of Health Care Services

Chief: Maria L. Delgado
Audit Manager: Ginn Sampson
Auditor: Kwiho Park

DHCS

Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

May 15, 2019

Todd Schroder
Director of Reimbursement
Verity Health System
455 O'Connor Drive, Suite 150
San Jose, CA 95128

ST. FRANCIS MEDICAL CENTER
NATIONAL PROVIDER IDENTIFIERS (NPI): 1487697215 AND 1245227180
FISCAL PERIOD ENDED: JUNE 30, 2017

We examined the provider's Medi-Cal Cost Report for the above-referenced fiscal period. We made our examination under the authority of Section 14170 of the Welfare and Institutions Code and, accordingly, included such tests of the accounting records and other auditing procedures, as we considered necessary under the circumstances.

In our opinion, the audited combined settlement for the fiscal period due the State in the amount of $25,176,471, and the audited costs presented in the Summary of Findings represents a proper determination in accordance with the reimbursement principles of applicable programs.

This audit report includes the:

1. Summary of Findings
2. Computation of Medi-Cal Diagnostic Related Group Cost and Cost to Charge Ratio (DRG Schedules)
3. Computation of Medi-Cal Administrative Days Settlement (ADMIN DAYS Schedules)
4. Computation of Distinct Part Nursing Facility Per Diem (DPNF Schedules)
5. Audit Adjustments Schedule

The Statement of Account Status will include the audited settlement, which may reflect tentative retroactive adjustment determinations, payments from the provider, and other

financial transactions initiated by the Department. The State's fiscal intermediary will forward the Statement of Account Status to the provider. The Statement of Account Status will include instructions regarding payment.

This examination may affect future long-term care prospective rates. The Department's Fee-For-Service Rates Development Division will determine the extent of the rate changes.

Notwithstanding this audit report, overpayments to the provider are subject to recovery pursuant to Section 51458.1, Article 6 of Division 3, Title 22, California Code of Regulations.

The Welfare and Institutions Code, Section 14171 contains the procedures that govern an appeal. You may request a hearing for any disputed audit or examination finding by filing a Statement of Disputed Issues, as defined in the California Code of Regulations, Title 22, Section 51022. You must file the written request with the Department within 60 calendar days from the date you receive this letter.

Send the Statement of Disputed Issues and a copy of this letter to the following:

Chief
Department of Health Care Services
Office of Administrative Hearings and Appeals, MS 0016
3831 North Freeway Boulevard, Suite 200
Sacramento, CA 95834
(916) 322-5603

Please forward this audit report to your cost report preparer or financial consultant for review.

If you have questions regarding this report, you may call the Audits Section—Los Angeles at (213) 620-5911.

Maria L. Delgado, Chief
Audits Section—Los Angeles
Financial Audits Branch

Certified

EXHIBIT 2

DHCS

State of California—Health and Human Services Agency

Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

JUL 19 2019

Felicia Y. Sze, Esq.
Athene Law LLP
5432 Geary St., Suite 200
San Francisco, CA 94121

In The Matter Of:

ST. FRANCIS MEDICAL CENTER
IDENTIFIER NUMBER: 1487697215 &
1245227180
FISCAL PERIOD ENDED: 6/30/2017
CASE NUMBER: HA20-0617-058K-RD

DEPT. OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
MEDI-CAL PROGRAM

Dear Ms. Sze:

Your letter dated July 11, 2019, requesting a hearing in this matter, has been received and accepted as a valid appeal.

Your appeal has been assigned to Rose Disney, Hearing Auditor, at 3831 N Freeway Blvd, Suite 200, Sacramento, CA 95834.

We are requesting that the Audits & Investigations Division of the Department of Health Care Services prepare a position statement concerning the issues in dispute.

You will be notified by certified mail of the date, time, and location of the Informal Hearing at least 30 days prior to the scheduled date. ***The scheduling letter will also establish the time frames for submitting a position statement and additional documentation.***

Upon request, this notification will be made available in Braille, large print or computer disk. To obtain a copy in one of these alternate formats, please call or write to: Calendar Clerk, Office of Administrative Hearings and Appeals, 3831 N. Freeway Boulevard, Suite 200, Sacramento, CA 95834, Telephone Number (voice) (916) 322-5603, (TTY) California Relay 711/1-800-735-2929.

Please contact this office at (916) 322-5603 if you have any questions concerning this letter.

Sincerely,

Lisa Alder

Lisa Alder, Chief
Administrative Appeals

cc: Chief
Department of Health Care Services
Cost Report Tracking Section
MS 2109
P.O. Box 997413
Sacramento, CA 95899-7413
DHCSappeals-fab@dhcs.ca.gov

Marina Vinogradov, Chief
Department of Health Care Services
Third Party Liability & Recovery Division
P.O. Box 997425, MS 4720
Sacramento, CA 95899-7425
Marina.Vinogradov@dhcs.ca.gov

Chief
Department of Health Care Services
Safety Net Financing Division
P.O. Box 997436, MS 4518
Sacramento, CA 95899-7436
OahaNotices@dhcs.ca.gov

EXHIBIT 3

ATHENE LAW
5432 Geary Blvd. #200
San Francisco, CA 94121-2307
(415) 686-7531
www.athenelaw.com

August 21, 2019

Rose Disney, Hearing Auditor
Office of Administrative Hearings and Appeals
3831 N. Freeway Blvd., Suite 200
Sacramento, CA 95834

RE: PRE-INFORMAL CONFERENCE POSITION PAPER
ST. FRANCIS MEDICAL CENTER
NATIONAL PROVIDER ID.: 1487697215 & 1245227180
FISCAL PERIOD ENDED: 06/30/17
CASE NO.: HA20-0617-058K-RD

Dear Ms. Disney:

On behalf of St. Francis Medical Center (the "Provider"), we submit this position paper in preparation for the informal conference scheduled in the above-referenced matter on August 29, 2019.

Issue 1 **Adjustments 7, 8 and 9**
Elimination of Psychiatric Services from Provider's Cost Report
Revised est. reimbursement $3,000,000

In adjustment 7, the Department removed 9,272 psychiatric days from the Provider's Medi-Cal days from Worksheet D-1, Title V, line 9, column 1 ("Total Medi-Cal Inpatient Days"). The Total Medi-Cal Inpatient Days is derived from the sum of a number of other fields in the cost report, primarily from Worksheet S-3, Part I, column 7, line 1 (title XIX Adults & Peds). "Medicaid HMO days" are listed in Worksheet S-3, Part I, column 7, line 2. This is despite the inclusion of these days in the Paid Claims Summary Report. (Exh. A.)

A&I argues that it eliminated these psychiatric days and charges because the State Plan and Welfare and Institutions Code section 14105.28 does not include psychiatric services in the scope of services paid under the APR-DRG system. However, A&I's position ignores the definition in the State Plan that the cost-to-charge ratio used in the APR-DRG program "is calculated from a hospital's Medicaid costs (reported on Worksheet E-3, part VII, line 4) divided by Medicaid charges (reported on worksheet E-3, part VII, line 12)" "from a hospital's CMS 2552-10 cost report." (Exh. B, pp. 35, 52.) These cost reports are to be completed "in accordance with applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1." (Exh. B, p. 2.) The Department's own cost report instructions state that the 2552 form should be completed consistent with the CMS instructions in the PRM-2. (Exh. C.)

The instructions in the Provider Reimbursement Manual-2, chapter 40, section 4005.1 state:

> [Line 1 – E]nter the number of adult and pediatric hospital days excluding the SNF and NF swing-bed, observation bed, and hospice days. In columns 6 and 7, also exclude HMO days.... Labor and delivery days... must not be included on this line.
>
> Line 2 – ...Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 1, column 7.

(Exh. D, p. 3.) There is no instruction to exclude psychiatric days. The Provider notes that the psychiatric days do not constitute "Medicaid HMO days" because the State delegates the payment responsibility for inpatient psychiatric services to the County mental health plans. However, the County mental health plans are Prepaid Inpatient Health Plans, not "HMOs." (*See* Exh. E (42 U.S.C. §§ 300e, 300e-1); Exh. F (81 Fed.Reg. 27498, 27611 (May 6, 2016)); Exh. G (42 C.F.R. § 438.2); Exh. H (1915(b) Waiver Excerpt).)

Because county mental health plans are not "HMOs," Medi-Cal inpatient days that are paid by county mental health plans cannot be included in line 2 as "Medicaid HMO days." In the absence of any instruction in the PRM-2 that these days should be excluded in line 1 of Worksheet S-3, Part I, column 7, these days are properly listed in line 1. The auditor's removal of these days is unwarranted.

Issue 2 **Adjustments 7 and 8**
Treatment of NICU patients as nursery patients
Revised est. reimbursement $2,000,000

In adjustment 7, the auditor disregarded the cost reporting rules by reclassifying nearly 3,000 NICU bed days to nursery based on the hospital's use of revenue code 173 on the claims submitted for those patients. St. Francis operated a NICU consistent with the requirements of section 2202.7(II) of the Provider Reimbursement Manual 15-1 and as specified on its license. (Exh. I.)

Consistent with the requirements of section 2202.7(II) above, in the filed Medi-Cal cost report the Provider reported NICU in a special care cost center on Line 35.00. Routine nursery care was reported on Line 43.00 of the filed Medicare cost report. Documentation supporting this fact is enclosed in the following exhibits:

- Worksheet A Trial Balance of Expense (Exh. J.)
- Worksheet B-1 Cost Allocation Statistics (Exh. K.)
- Worksheet C Trial Balance of Revenue (Exh. L.)
- Worksheet S-3, Part I Census Days Summary (Exh. M.)
- Detail Listing of Nursery and NICU Patient Days – All Payors By Revenue Code (Exh. N.)
- Summary of Paid Medi-Cal Settlement Data Reported in the Filed Medi-Cal Cost Report Including Revenue Codes 170, 171, 173 and 174 (Exh. O.)

In the Medi-Cal audit report issued on May 15, 2019 the Department made no changes to the Provider's reported Nursery and NICU expense on Worksheet A, cost allocation statistics on Worksheet B-1, patient revenues on Worksheet C and total patient days reported on Worksheet S-3, Part II. This fact can be verified through a review of Schedule 4A (Program: DRG), Lines 1, 2, 3, 26, 27 and 28 of the Medi-Cal audit report. All of the values on these lines are the same in the reported and audited columns. However, in our view, the Department has erred by assigning revenue code 173 paid Medi-Cal days totaling 2,707 (2,433 + 274) to the Nursery cost center on Schedule 4A (Program: DRG), Line 4. Revenue code 173 paid Medi-Cal days were clearly reported in the NICU cost center on Schedule 4A (Program: DRG), Line 29 consistent with the reporting of costs, statistics, revenues and total patient days associated with these paid Medi-Cal revenue code 173 days. By moving paid Medi-Cal revenue code 173 days on Schedule 4A (Program: DRG), to Line 4 instead of Line 29, the Department has created a mismatch and misalignment of expense, statistics, revenue, total patient days and program days within the Medi-Cal audit report. This error creates improper Medi-Cal cost finding by shifting the Nursery and NICU costs to other payors so that the costs borne by the Medi-Cal program are less than they otherwise would have been. The practice of cost shifting is prohibited under 42 CFR 413.9.

Revenue code 173 is used to describe "sick babies" consistent with longstanding billing standards. The National Uniform Billing Committee defines revenue code 173 as reflecting "sick neonates who do not require intensive care, but require six to 12 hours of nursing each day." (Exh. P, p. 2.) These staffing ratios are consistent with the nursing standard for "intermediate care" NICU patients in the CCS Manual of Procedures, which consists of greater than eight but less than 12 hours of nursing care per day. (Exh. Q, p. 1.)

We dispute the Department's adjustments for the following reasons. Sometimes, the Provider's NICU treated sick babies whose claims included revenue code 173. However, the identification of these "sick babies" as being intermediate in terms of acuity does not change the fact that they received ICU-level services in the NICU. Section 2202.7(II)(A) states that "[i]f a neonatal unit qualifies as an intensive care type unit, the days are considered intensive care type days rather than nursery days." (Exh. I, p. 4.) Because the days coded with revenue code 173 were provided in the NICU, consistent with the admission criteria for the NICU, there is no justification for treating them as anything but "intensive care type days rather than nursery days" on its cost report.

Indeed, Verity's review of the patients with revenue code 173 anywhere in their detailed charges demonstrates that an overwhelming majority (70%) of these babies were critically ill during their inpatient stay, as demonstrated by the use of the revenue code 174 for certain periods of their stay. (Exh. R.)

A&I argues that it excluded patients with revenue code 173 based on the nurse staffing ratio. However, it provides no evidence that St. Francis provided less than 1 nurse to 2 or fewer

patients, as identified in PRM-1 section 2202.7.[1] St. Francis' nurse staffing data demonstrates that it provided ICU-level staffing for the period at issue. (Exh. S.)

CMS guidance likewise distinguishes a nursery as the location of care for "well babies" and a NICU as a location of care for "sick babies." Specifically, PRM-1, section 2202.7(II)(A) states that "[a] regular well baby nursery may not be considered an intensive care unit." (Emphasis added.) This reflects CMS' understanding that a "general care" newborns are "well babies" while "special care" babies for the purpose of classifying as NICU patients are "sick babies."

DHCS has acknowledged that babies billed with revenue code 173 are "sick babies" and not "well babies." For example, DHCS acknowledged in its FAQs governing the Medi-Cal APR-DRG program for 2015-16 that the revenue code is assigned based on the "severity of a baby's condition." (Exh. T, p. 2.) DHCS described revenue codes 170 and 171 as being associated with "well babies." By contrast, babies billed using revenue code 173 and 174 are not "well babies;" they are "sick babies." These "sick babies" required a higher level of care than nursery and received that higher level of care in the NICU. Accordingly, the NICU patient days should be remain classified as NICU patient days.

To the extent that the Department may reclassify these revenue code 173 babies as "nursery" patients, which it cannot, the Department improperly moved the patient days without moving either the costs or charges associated with these babies. This creates a mismatch of days, costs, and charges for the NICU and nursery cost centers, which has the impact of artificially reducing the hospital's cost-to-charge ratio. The artificial reduction of the hospital's cost-to-charge ratio violates the "fundamental tenet" of cost reporting prohibiting cost shifting between payors. (*See* 42 C.F.R. §§ 413.5(a), 413.9(b)(1); *see also Grossmont Hos. Corp. v. Sebelius*, 903 F.Supp.2d 39, 58 (D.C.D.C. 2012).)

Issue 3 **Adjustment 15, 16 and 17**
Outlier payment reconciliation
Est. reimbursement $25 million

The Department lacks the authority to reconcile the Provider's outlier payments as it did in adjustments 15, 16 and 17. First, the Legislature did not authorize the Department to impose a reconciliation process. In Welfare and Institutions Code section 14105.28, the Legislature commanded that the Department must "... design a new Medi-Cal inpatient hospital reimbursement methodology based on diagnosis-related groups that more effectively ensures ..." the "... administrative efficiency and minimize[ation] [of] administrative burdens on hospitals and the Medi-Cal program" and the "[s]implification of the process for determining and making payments to the hospitals." (Exh. U (Welf. & Inst. Code §§ 14105.28(a)(5), (7)).) These are the "legislative goals [that] establish[] a yardstick for the administrator[.]" (*People v. Wright*, 30 Cal.3d 705, 712 (1982).) The agency must implement the APR-DRG program consistent with

[1] A&I attempts to establish a much higher staffing ratio of 1 registered nurse to 2 or fewer patients, but there is no law that requires this a condition of payment. (*See* Cal. Code Regs., tit. 22, § 70217 [reference to licensed nurses].) Moreover, St. Vincent has a waiver as to the nurse staffing ratio it must meet. (Exh. ___.)

the purpose set forth by the Legislature.[2] (*Leftridge v. Sacramento* (1943) 59 Cal. App. 2d 516, 524.)

DHCS did the opposite. The Legislature was presumably aware that the vast majority of hospitals, including St. Francis, formerly contracted under the Selective Provider Contracting Program ("SPCP"). Through the SPCP, the contracted hospitals' cost reports no longer impacted their reimbursement. The application of a reconciliation process for outlier payments based on cost report auditing imposes new administrative burdens on these hospitals, decreases administrative efficiencies, and complicates the process for determining and making payments to these hospitals. The outlier reconciliation policy therefore violates the Legislature's stated direction to the Department: the creation of a hospital reimbursement methodology that is efficient, simple, and cost effective. As an action outside of the authority granted in Welfare and Institutions Code section 14105.28, the Department's reconciliation process is void. (*See Morris v. Williams* (1967) 67 Cal. 2d. 733, 737 [finding that administrative regulations that violate legislative acts are void because such acts "... must conform to the legislative will ..."].)

Moreover, even if the Department is arguably authorized to perform a reconciliation at all, which it is not, it cannot bait hospitals with 2014 cost report data and then switch to 2017 cost report data. Specifically, the Department implemented the APR-DRG program without specifying that the Department would replace the cost-to-charge ratio from the as-filed cost report with a cost-to-charge ratio from another year's audited cost report.[3] The Department implemented a change in the cost report year through the approval of State Plan Amendment 16-011[4] in June of 2016, which it then attempted to announce in a provider bulletin in November of 2017. (Exh. B, pp. 11-47 (original APR-DRG State Plan Amendment 13-004); Exh. B, pp. 48-63 (State Plan Amendment 16-011).) However, these changes in the APR-DRG program are unlawful because of the Department's failure to comply with the California Administrative Procedure Act's ("APA's") rulemaking requirements.

The APA is intended to advance "meaningful public participation in the adoption of administrative regulations by state agencies" and create "an administrative record assuring effective judicial review." [] In order to carry out these dual objectives, the APA (1) establishes "basic minimum procedural requirements for the adoption, amendment or repeal of administrative regulations" [] which give "interested parties an opportunity to present statements and arguments at the time and place specified in the notice and calls upon the agency to consider all relevant matter presented to it," and (2) "provides that any interested person may obtain a judicial declaration as to the validity of any regulation by bringing an action for declaratory relief

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[2] In the alternative, to the extent that the Department believes that the legislative intent is not binding on the Department, the absence of yardsticks set by the Legislature would result in the Legislature unconstitutionally delegating its authority to the Department without "effectively resolv[ing] the fundamental [policy] issues[.]" (*See People v. Wright*, 30 Cal.3d at 712.)

[3] The Department initially implemented of the APR-DRG program through State Plan Amendment 13-004. SPA 13-004 does not authorize such a change in base year data. Instead, SPA 13-004 simply states that [w]hen there is a material change between the reported CCR and the final audited CCR, outlier payments may be subject to recalculation based upon the audited CCR."

[4] SPA 16-011 specifies that: "Final Audited CCR shall be taken from the audited cost report which overlaps the hospital fiscal year meeting the material change parameters defined in Pre-Payment and Post-Payment Review...."

in the superior court." (*Voss v. Super. Ct.*, 46 Cal.App.4th 900, 908-09 (1996), citing *California Optometric Assn. v. Lackner*, 60 Cal.App.3d 500, 506 (1976) (citations removed).)

As background, the Legislature authorized the Department "... to design a new Medi-Cal inpatient hospital reimbursement methodology based on diagnosis-related groups..." (Welf. & Inst. Code § 14105.28(a).) The Legislature granted the Department two procedural alternatives to formal rulemaking under the APA for the implementation of the APR-DRG methodology: (1) an initial adoption and one readoption of emergency regulations pursuant to the California APA; or (2) "by means of provider bulletins, all-county letters, manuals, or other similar instructions, without taking regulatory action." (Welf. & Inst. Code § 14105.28(f).)

However, these waivers to the California APA applied only to the "implementation" of the APR-DRG program. Welfare and Institutions Code section 14105.28(b)(1)(A)(ii) established a deadline for this implementation of July 1, 2012, "or on the date upon which the director executes a declaration certifying that all necessary federal approvals have been obtained and the methodology is sufficient for formal implementation, whichever is later." As stated by the director in his declaration on May 3, 2013, the implementation date was July 1, 2013. The Department is barred from relying on the alternatives to formal APA rulemaking after this implementation date.

The Legislature did not grant the Department indefinite authority to regulate the APR-DRG payment methodology through the exceptions found in Welfare and Institutions Code section 14105.28(f). As a preliminary matter, Government Code section 11346(a) establishes that any statute superceding or modifying the requirements of the APA must state so expressly. (*See Voss v. Super. Ct.*, 46 Cal.App.4th 900, 909.) In other words, the presumption is that the APA requirements apply except when the Legislature expressly states otherwise.

Moreover, the Legislature's authorization for the Department to implement pursuant to provider bulletin in the "alternative" in Welfare and Institutions Code section 14105.28(f)(2) must be interpreted within the context of the limits imposed by the Legislature in Welfare and Institutions Code section 14105.28(f)(1). (*Ramirez v. City of Gardena*, 5 Cal.5th 995, 1000 (2018) ("'Because the statutory language is generally the most reliable indicator of legislative intent, we first examine the words themselves, giving them their usual and ordinary meaning and construing them in context.'").) The duration of an emergency adoption and a single read option pursuant to Welfare and Institutions Code section 14105.28(f)(1) would have a maximum duration of no more than 360 days. (Govt. Code § 11346.1(e).) The Legislature's permission for the Department to implement implementation by informal instruction "[a]s an alternative" suggests that it intended for DHCS' authority to be similarly limited toward the early implementation of the DRG system, not to permit changes DHCS sought to implement years after the fact.

Lastly, the audit findings cannot stand because the Department failed to raise the outlier adjustments to the hospital prior to and during the exit conference. The failure of the DHCS to both inform Provider of the proposed outlier adjustments resulted in Provider not being able to review or respond to these adjustments.

Pursuant to California Code of Regulations, title 22, section 51021, subdivision (a), the Department is required to afford the Provider "a reasonable opportunity to participate in an exit conference after the conclusion of any field audit or examination of records or reports of a provider, by or on behalf of the Department, and prior to the issuance of the Audit Report." Once DHCS adopted its own regulations, "... the regulations [they adopted] are presumptively valid and binding...." (*Tomlinson v. Qualcomm* 97 Cal.App.4th 934, 940 (2002).) The Department's failure to follow its own regulations with respect to the outlier adjustments invalidates those adjustments.

Moreover, the outlier adjustments are invalid because the Department's failure to grant the Provider a reasonable opportunity for an exit conference violates the Provider's right to due process. Specifically, the Provider has not been afforded a reasonable notice and opportunity to defend against the initial audit findings. This implicates the fundamental due process notions of a reasonable opportunity to respond to these initial findings. (*See Mathews v. Eldridge*, 424 U.S. 319, 335 (1974); *see also* Cal. Const. Art. I, § 7.)

* * * * *

We look forward to the hearing on August 29, 2019.

Sincerely,

Felicia Sze

Felicia Y Sze

Cc: Maria L. Delgado, Chief
Audits Section – Los Angeles
Financial Audits Branch/Audits Section – Los Angeles
311 South Spring St., Floor 10
Los Angeles, CA 90013

Assistant Chief Counsel
Department of Health Care Services
Office of Legal Services, MS 0010
P.O. Box 997413
Sacramento, CA 95899-7413

Glenn Bunting, Director
Moss Adams
2882 Prospect Park Dr., Suite 300
Rancho Cordova, CA 95670

EXHIBIT 4

DHCS

JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

GAVIN NEWSOM
GOVERNOR

August 13, 2019

Rose Disney
Hearing Auditor
Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 N. Freeway Blvd., Suite 200
Sacramento, CA 95834

APPEAL POSITION STATEMENT
ST. FRANCIS MEDICAL CENTER
NATIONAL PROVIDER IDENTIFIER: 1487697215
FISCAL PERIOD ENDED: JUNE 30, 2016
CASE NUMBER: HA20-0617-058K-RD

This is in response to the letter dated July 19, 2019, wherein our position statement was requested concerning the audit adjustment disputed as a result of our audit of the facility's Medi-Cal cost report for the above-referenced period.

The enclosed informal appeal package includes the Financial Audits Branch's position statement regarding the three issues in dispute, in addition to the documentary evidence. A copy of this package was transmitted to the provider.

If you have any questions in regard to the position statement and documentary evidence, Ginn Sampson, Supervisor, at (213) 620-5914.

Maria L. Delgado, Chief
Audits Section—Los Angeles
Financial Audits Branch

Enclosure
Certified

EXHIBIT 5

DHCS

Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

AUG 0 2 2019

CERTIFIED MAIL NO. 7018 1830 0000 6802 4817

Ms. Felicia Y. Sze, Esq.
Athene Law LLP
5432 Geary St., Suite 200
San Francisco, CA 94121

In The Matter Of:

ST. FRANCIS MEDICAL CENTER
NATIONAL PROVIDER ID.: 1487697215 & 1245227180
FISCAL PERIOD ENDED: 06/30/17
CASE NO.: HA20-0617-058K-RD

DEPT. OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
MEDI-CAL PROGRAM

Dear Ms. Sze:

We have scheduled the INFORMAL HEARING regarding your dispute of certain departmental review findings. In order to facilitate due process, postponements of the hearing from the scheduled date are not viewed favorably and may be granted only upon a showing of good cause.

The Informal Hearing is scheduled to be held at 15350 Sherman Way, Suite 100 in Van Nuys, California on Thursday, August 29, 2019, at 10:00 a.m.

The discussion will be limited to the issues previously raised in your written petition. Both parties are expected to be prepared to participate in a meaningful discussion of the issues at the Informal Hearing. To that end, the parties must present their respective positions supported by documentary evidence as necessary. If either party intends to introduce any documentation, one copy must be sent to this office and one copy sent to the other party by August 22, 2019. Any submissions postmarked or hand delivered after this date will not be included in the record unless the Hearing Auditor assigned to this case determines there is good cause to grant an exception.

The record in this matter will close at the conclusion of the Informal Hearing unless the Hearing Auditor determines that his or her decision, or the resolution of this case, will be facilitated by allowing post hearing submissions.

If you have any questions or comments regarding this notification, please contact me at (916) 322-5603.

Sincerely,

Rose Disney
Hearing Auditor

cc: Chief (electronic only)
Audits Section - Los Angeles
Financial Audits Branch
Department of Health Care Services
311 South Spring St., Floor 10
Los Angeles, CA 90013

Marla.Delgado@dhcs.ca.gov

EXHIBIT 6

State of California — Health and Human Services Agency

Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

Provider Extension of Time Agreement
Informal Level of Review (Informal Hearing)
Welfare and Institutions Code section 14171

In The Matter Of:

ST FRANCIS MEDICAL CENTER
NATIONAL PROVIDER ID.: 1487697215 & 1245227180
FISCAL PERIOD ENDED: 06/30/17
CASE NO.: HA20-0617-058K-RD

DEPT. OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
MEDI-CAL PROGRAM PROVIDER

RE: Extension of Time based upon Provider's Request to Postpone Close of Record for Informal Hearing

The undersigned agrees to extend the time limitations established by California Welfare and Institutions Code section 14171, subdivisions (e)(1) and (e)(2), applicable to the following:

1. Completing an Informal Hearing no later than 180 days after the filing of a timely and specific statement fo disputed issues, and
2. Conducting an Impartial Hearing no later than 300 days after the filing of a timely and specific statement of disputed issues.

The extension of time is necessary as the Provider, or the Provider's Representative, has requested additional time to submit post-Informal Hearing documentation and responses.

The extension of time shall be effective from August 29, 2019 to October 10, 2019

Provider or Provider's Representative — Felicia Sze, Title: Counsel for Provider — Date: 8/29/19

THE CLOSE OF RECORD WILL NOT BE POSTPONED UNLESS THIS EXTENSION OF TIME AGREEMENT IS SIGNED BY THE PROVIDER OR ITS REPRESENTATIVE.

EXHIBIT 7

State of California – Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

SEP 0 6 2019

Ms. Felicia Y. Sze, Esq.
Athene Law LLP
5432 Geary St., Suite 200
San Francisco, CA 94121

In The Matter Of:

ST. FRANCIS MEDICAL CENTER
NATIONAL PROVIDER ID.: 1487697215 &
1245227180
FISCAL PERIOD ENDED: 06/30/17
CASE NO.: HA20-0617-058K-RD

DEPT. OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
MEDI-CAL PROGRAM

Dear Ms. Sze, Esq.:

During the Informal Hearing, held on August 29, 2019, it was agreed that the record in the above cited case would remain open for the submission of additional information and responses. Therefore, the timeframes found in Welfare and Institutions Code section 14171, for the issuance of the Report of Findings and the scheduling of the Formal Hearing, have been extended.

The parties agreed to extend the close of record to allow for Audits' review of the Provider's position statement and exhibits, and for the Provider to respond. Audits agreed to submit a response to the Provider's position by September 12, 2019. The Provider agreed to either submit a response or decline to respond by September 26, 2019. In the case the Provider chooses to submit a response, Audits agreed to submit their final response by October 10, 2019. All submissions should be sent to both this office and the other party. If the requested documents are not received within the prescribed timeframe, the record will be closed and a decision will be issued based on the facts of the record. Please send all documents in electronic format only when possible.

If either party wishes to propose or agree to a revision, please include the adjustment number; cost center; and revision amount with your post hearing documents.

If you have any questions or comments regarding this notification, please contact me at (916) 322-5603.

Sincerely,

Rose Disney
Hearing Auditor

cc: Chief (electronic only) Maria.Delgado@dhcs.ca.gov
Audits Section - Los Angeles
Financial Audits Branch
Department of Health Care Services
311 South Spring St. FL 10
Los Angeles, CA 90013

Glenn Bunting, Director (electronic only) Glenn.Bunting@mossadams.com
Moss Adams

Ginn Sampson (electronic only) Ginn.Sampson@dhcs.ca.gov
Audit Supervisor

EXHIBIT 8

DHCS
State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

September 11, 2019

Rose Disney
Hearing Auditor
Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 N. Freeway Blvd., Suite 200
Sacramento, CA 95834

APPEAL POSITION STATEMENT
ST. FRANCIS MEDICAL CENTER
NATIONAL PROVIDER IDENTIFIER: 1487697215
FISCAL PERIOD ENDED: JUNE 30, 2016
CASE NUMBER: HA20-0617-058K-RD

This is in response to your letter dated August 21, 2019, wherein you requested a response to the additional documentation submitted by the provider subsequent to the informal hearing for the above-referenced period.

The enclosed statement summarizes the Financial Audits Branch's position with respect to the additional documentation submitted.

If you have any questions in regard to this Supplemental Appeal Position Statement, please contact Kwiho Park, Auditor, at (213) 620-5907.

Maria Delgado for

Ginn Sampson, Supervisor
Audits Section—Los Angeles
Financial Audits Branch

Enclosure
Certified

cc: Felicia Y. Sze, Esq
Athene Law LLP
5432 Geary St., Suite 200
San Francisco, CA 94121

PROOF OF SERVICE OF DOCUMENT

CASE NAME: In re Verity Health System of California, Inc.

CASE NUMBER: 2:19-cv-08762-JVS

I am over the age of 18 and not a party to this case or adversary proceeding. My business address is: 300 South Spring Street, Suite 1702, Los Angeles, CA 90013

A true and correct copy of the foregoing document entitled (*specify*):

APPELLANT CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES'S OPENING BRIEF

DECLARATION OF DEPUTY ATTORNEY GENERAL KENNETH K. WANG IN SUPPORT OF APPELLANT CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES'S OPENING BRIEF

will be served or was served in the form and manner stated below:

1. **TO BE SERVED BY THE COURT VIA NOTICE OF ELECTRONIC FILING (NEF).**

I hereby certify that on December 9, 2019, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system: I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

- Gary E. Klausner, gek@lnbyb.com; attorney for Strategic Global Management, Inc.;
- Tania M. Moyron, tania.moyron@dentons.com; attorney for Verity Health System of California, Inc.
- Sam R. Maizel, Samuel.maizel@dentons.com; attorney for Verity Health System of California, Inc.

☐ Service information continued on attached page

2. **SERVED BY UNITED STATES MAIL (COURTESY COPY)**:

On **December 9, 2019**, I served the following persons and/or entities with a courtesy copy of the above-referenced document at the last known addresses in this case or adversary proceeding by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows.

Gregory Allan Bray
Milbank, LLP
2029 Century Park East, 33rd Floor
Los Angeles, CA 90067

☐ Service information continued on attached page

3. SERVED BY EMAIL (COURTESY COPY).

On **December 9, 2019**, I served the following persons and/or entities by email with a courtesy copy of the above-referenced document.

Samuel Maizel, Esq. (on ECF)
Dentons US LLP
601 S. Figueroa Street, Suite 2500
Los Angeles, CA 90017
Samuel.Maizel@dentons.com

Gregory A. Bray, Esq.
Milbank, Tweed, Hadley & McCloy, LLP
2029 Century Park East, 33rd Floor
Los Angeles, CA 90067
gbray@milbank.com

Hatty Yip, Esq. (on ECF)
Office of the United States Trustee
915 Wilshire Boulevard, Suite 1850
Los Angeles, CA 90017
Hatty.Yip@usdoj.gov

4. SERVED BY PERSONAL DELIVERY: On **December 9, 2019**, I served the following persons and/or entities by personal delivery with a courtesy copy of the above-referenced document. Listing the judge here constitutes a declaration that personal delivery on, or overnight mail to, the judge will be completed no later than 24 hours after the document is filed.

Hon. Ernest M. Robles
United States Bankruptcy Court
255 East Temple Street
Courtroom 1568
Los Angeles, CA 90012

☐ Service information continued on attached page I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

December 9, 2019	Stacy McKellar	
Date	*Printed Name*	*Signature*