

Filed 10/9/26

CERTIFIED FOR PUBLICATION
IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION SIX

HARDIE B. PHILLIP,
Individually and as Trustee,
etc., et al.,

Plaintiffs, Cross-
complainants and
Respondents,

v.

MICHELLE BAASS, as
Director, etc.,

Defendant, Cross-defendant
and Appellant.

2d Civ. No. B341853
(Super. Ct. No. 17CV-0261)
(San Luis Obispo County)

California participates in the federal Medicaid program through the Medi-Cal Act. (Welf. & Inst. Code,¹ § 14000 et seq.) The Department of Health Care Services (the Department) is tasked with administering Medi-Cal. Here we interpret Welfare and Institutions Code section 14009.5, which requires the

¹ Undesignated statutory references are to the Welfare and Institutions Code.

Department to seek reimbursement from the estates of deceased Medi-Cal members in “an amount equal to the payments for the health care services received.” (*Id.*, subd. (b).)

Similar to premiums, capitation² payments are monthly prospective payments paid by Medi-Cal to managed care plans to cover the projected cost of a member’s health care services. Because these payments are not tethered to a member’s “health care services received” as required by section 14009.5, we conclude capitation payments exceeding the amount paid for those health care services received (excess capitation) do not qualify for estate recovery. We also conclude the Department’s implementing regulation is void. We affirm.

FACTS AND PROCEDURAL HISTORY

The Phillip litigation

Theodosia³ Phillip was a recipient of Medi-Cal benefits and lived in a nursing care facility from October 2010 until her death in 2015. The Department made \$261,957.40 in capitation payments to CenCal Health, Theodosia’s managed care plan. To maintain Medi-Cal eligibility, Theodosia paid a monthly “share of cost,” totaling \$188,697 during her enrollment. The share-of-cost system allows members with too much income to qualify for Medi-Cal. (§§ 14054, subd. (a), 14005.4, 14005.7.)

² “‘Capitated basis’ ” means a “fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided.” (Cal. Code Regs., tit. 28, § 1300.76, subd. (d).)

³ Due to the shared Phillip surname, we use first names for ease of reference. No disrespect is intended.

While CenCal received \$261,957.40 in capitation payments from the Department, CenCal paid Theodosia's health care providers only \$106,672.71 for Medi-Cal services.⁴ But after Theodosia's death, the Department sought \$407,774.41 in estate recovery, comprised of \$261,957.40 for capitation payments, \$5,852.30 for Medicare Part B premiums, and \$139,964.71 in interest.

Theodosia's trustee challenged the estate recovery claim, and the Department filed a lawsuit after the parties could not resolve the claim. On behalf of themselves and others similarly situated, Hardie Phillip and Jennifer Phillip, two of Theodosia's beneficiaries, cross-complained against the Department, asserting causes of action for breach of implied-in-law contract/quasi-contract and declaratory relief.⁵ The Phillips also petitioned for a writ of mandate seeking to compel the Department to recalculate certain estate recovery claims, limiting them to the amounts paid by the managed care plans for "health care services received" by Medi-Cal recipients.

Procedural history

The trial court certified a class of Medi-Cal recipients and their estates where the Department sought to recover excess capitation. The court held two hearings on four stipulated issues, two of which are relevant to this appeal: (1) whether the Department is lawfully permitted to assert an estate recovery

⁴ Theodosia's estate does not dispute the Department's right to recover a slightly higher amount, \$106,901.12.

⁵ The trial court summarily adjudicated the Phillips' breach of implied-in-law contract/quasi-contract causes of action in the Department's favor.

claim for excess capitation, and (2) if not, whether such a ruling constitutes a change in the law, thereby allowing reprocessing of estate recovery claims.

The court concluded the Department's excess capitation estate recovery violated section 14009.5 and title 42 United States Code section 1396p(b)(1) and concluded its ruling applied retroactively. It entered judgment in favor of the Department on the complaint, awarding it capitation reflecting the amount paid by Theodosia's managed care plan for her health care services received plus prejudgment interest. On the cross-complaint, the court entered a declaratory judgment in favor of the Phillips and the certified class, and issued a writ of mandate requiring the Department to reform its estate recovery practices, cease collecting excess capitation, and reprocess certain class estate recovery claims.

DISCUSSION

The Department contends it can recover excess capitation pursuant to section 14009.5; title 22, section 50961 of the California Code of Regulations (regulation 50961); and federal law.⁶ We are not persuaded.

This dispute requires us to review de novo section 14009.5, California's estate recovery statute, and employ fundamental

⁶ The Department's notice of appeal does not purport to appeal the ruling on the motion for class certification. Nevertheless, the Department requests we reverse and remand with instructions to the trial court to vacate its order granting class certification. Because it offers no argument in support, we decline to do so. Points perfunctorily asserted without argument are not properly raised. (*Gardner v. County of Sonoma* (2003) 29 Cal.4th 990, 999, fn. 6.)

statutory interpretation rules. (*City of Saratoga v. Hinz* (2004) 115 Cal.App.4th 1202, 1212.) “To determine the Legislature’s intent and effectuate the statute’s purpose, we first examine the ‘statute’s words and give them their usual and ordinary meaning.’” (*Harmon v. Superior Court* (2026) 117 Cal.App.5th 1236, 1246.) “If a statute’s language is clear, then the Legislature is presumed to have meant what it said, and the plain meaning of the language governs” and there is no need to examine legislative intent. (*Kizer v. Hanna* (1989) 48 Cal.3d 1, 8; *Lungren v. Deukmejian* (1988) 45 Cal.3d 727, 735.) But if the statute’s language “permits more than one reasonable interpretation, courts may consider other aids, such as the statute’s purpose, legislative history, and public policy.” (*Coalition of Concerned Communities, Inc. v. City of Los Angeles* (2004) 34 Cal.4th 733, 737.)

Medi-Cal’s estate recovery scheme and managed care plan model

Medicaid is a federal medical assistance program for low-income individuals, enacted by Congress in 1965 as Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.). (*Daniel C. v. White Memorial Medical Center* (2022) 83 Cal.App.5th 789, 800.) States participating in Medicaid “must comply with federal requirements and administer its Medicaid program through a plan approved by the federal Centers for Medicare and Medicaid Services (CMS).” (*Dignity Health v. Local Initiative Health Care Authority of Los Angeles County* (2020) 44 Cal.App.5th 144, 152 (*Dignity Health*); see 42 U.S.C. § 1396a(a)(1)–(87).) While states’ participation in Medicaid is optional, a participating state “must develop and implement a state plan that conforms to federal law.” (*Daniel C.*, at p. 800.)

Applicants may qualify for Medicaid benefits if they are “aged, blind, or disabled,” and lack sufficient income and resources to afford health care. (42 U.S.C. § 1396-1.) An applicant over the age of 55 will have their principal residence excluded when determining eligibility, allowing elderly applicants to qualify for Medicaid despite having a valuable asset. (42 U.S.C. § 1382b(a)(1); see also *California Advocates for Nursing Home Reform v. Bonta* (2003) 106 Cal.App.4th 498, 508 & fn. 4 (*California Advocates*); § 14006, subd. (c); Cal. Code Regs., tit. 22, § 50425, subd. (c).) In exchange, federal law requires participating states to recover all or a portion of the Medicaid benefits paid during the member’s lifetime from their estate at death.⁷ (42 U.S.C. § 1396p(b)(1).) Since 1993, estate recovery has been “mandatory.” (*California Advocates*, at pp. 508–509; 42 U.S.C. § 1396p(b)(1).)

California implemented the Medi-Cal Act (§ 14000 et seq.) to participate in Medicaid. (*California Medical Assn. v. Brian* (1973) 30 Cal.App.3d 637, 642.) The Department is tasked with administering Medi-Cal in accordance with the state plan,⁸ applicable Welfare and Institutions Code provisions, and Medi-Cal regulations. (Cal. Code Regs., tit. 22, § 50004; see also

⁷ There are exceptions to the Department’s estate recovery scheme, including statutory exemptions under section 14009.5, subdivision (b), as well as hardship waivers. These exceptions are not relevant here.

⁸ A state plan is “a comprehensive written statement submitted by the [Department] describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity” with federal law. (42 C.F.R. § 430.10.)

Santa Rosa Memorial Hospital, Inc. v. Kent (2018) 25 Cal.App.5th 811, 815–816.) Section 14009.5 was enacted as an urgency measure and became effective June 28, 1981 (Assem. Bill No. 251 (1980–1981 Reg. Sess.); Stats. 1981, ch. 102, § 101, p. 738). (*Kizer v. Hanna, supra*, 48 Cal.3d at p. 4.) It “enables Medi-Cal to help those persons in need when they have such need, yet ensures that when the need no longer exists by virtue of the recipient’s death, the benefits paid can be recouped. The Medi-Cal benefits thus recouped can be used to assist others in need.” (*Id.* at p. 6.)

Medi-Cal does not directly provide medical care to its members. Instead, Medi-Cal reimburses participating health care providers in one of two ways: via a fee-for-service, or a managed care plan. (*Dignity Health, supra*, 44 Cal.App.5th at p. 152.) As of 2025, over 10 million Medi-Cal members in all 58 counties, representing approximately 95 percent of all members, received health care through a capitated managed care model.

In a managed care system, the Department contracts with managed care plans to provide health coverage to members. The Department pays the managed care plans a monthly predetermined capitation payment for each member, regardless of costs and whether or not the member receives health care services. (*Dignity Health, supra*, 44 Cal.App.5th at p. 152; *Lackner v. Department of Health Services* (1994) 29 Cal.App.4th 1760, 1762, fn. 2 [“Unlike the fee-for-service plan, a managed care plan does not pay for services actually rendered; instead, the state pays a fixed rate per person per month to the health plan. This payment is made *whether or not services are rendered* and is accepted as payment in full for all covered services performed” (italics added)].)

The fixed amount paid by the Department “is calculated on a per capita basis, with a flat rate paid for each individual enrolled in the plan during a particular time period.” (*Solorzano v. Superior Court* (1992) 10 Cal.App.4th 1135, 1141; see also § 14499.74 [explaining how capitation payments are determined].) The member then obtains medical services from a provider within the managed care plan’s network. (*Dignity Health, supra*, 44 Cal.App.5th at p. 152.) Capitation payments thus constitute a “risk-sharing arrangement” between Medi-Cal and managed care plans under which the plans “assume[] the full risk for the cost of [those] contracted services without regard to the type, value[,] or frequency of services provided” to the members. (*Centinela Freeman Emergency Medical Associates v. Health Net of California, Inc.* (2016) 1 Cal.5th 994, 1004, fn. 8; Cal. Code Regs., tit. 28, § 1300.76, subd. (d).)

Excess capitation estate recovery under section 14009.5

Section 14009.5 outlines California’s estate recovery⁹ scheme. The Department’s estate recovery formula is determined by the version of this statute in effect when the member died. For Medi-Cal members who died prior to January 1, 2017 (including Theodosia), the Department claims a right to recover “the full amount of managed care capitation remitted by [the Department] to the member’s . . . managed care plan.” And for

⁹ An estate recovery claim contains: (1) Medicare Part A premiums; (2) Medicare Part B premiums; (3) Medi-Cal Dental premiums; (4) capitation payments made by the Department to managed care plans; and (5) fee-for-service amounts the Department paid to providers. While the Department sought components (2) and (4) from Theodosia’s estate, only component (4)—the capitation payment—is relevant in this appeal.

those who died after January 1, 2017, the Department claims a right to “the full amount of” capitation, “up to the full estate value,” which it estimates by “apportioning capitation payments between allowable and nonallowable categories of service across Medi-Cal recipients.” Under both formulas, the Department pursues estate recovery for excess capitation. Because the class includes members who died prior to, and after January 1, 2017, we examine both versions of the statute.

We first turn to section 14009.5, former subdivision (a): “Notwithstanding any other provision of this chapter, the department shall claim against the estate of the decedent . . . an amount equal to the payments for the health care services received.” Section 14053 defines “‘health care services’” as the benefits set forth in sections 14021 and 14131 through 14138. Those sections define “‘health care services’” as specific benefits. (See *Pottgieser v. Kizer* (9th Cir. 1990) 906 F.2d 1319, 1324 (*Pottgieser*).) For example, section 14021 provides that certain “mental health and substance use disorder services” constitute “health care,” as do “[d]rug Medi-Cal outpatient substance use disorder services” (*id.*, subd. (c)), “[i]npatient hospital services in an institution for mental diseases” (*id.*, subd. (d)), and “[o]ther diagnostic, screening, preventive, or remedial rehabilitative services for the maximum restoration of an individual to the best possible functional level” (*id.*, subd. (e)). Section 14021 does not mention premiums, excess capitation to managed care plans, or capitation payments at all.

Sections 14131 through 14138 also include specific benefits available to Medi-Cal members. Section 14131.05 references hearing aid benefits. Section 14132 mentions outpatient services (*id.*, subd. (a)), inpatient hospital services (*id.*, subd. (b)), nursing

facility and subacute care services (*id.*, subd. (c)), dialysis services (*id.*, subd. (e)), anesthesiologist services (*id.*, subd. (f)), and so on. And while certain sections reference managed care plans (see, e.g., § 14132.07), none of the sections reference premiums, excess capitation, or provide that capitation payments constitute “health care services.” In sum, sections 14131 through 14138 define “health care services” as specific benefits. Because excess capitation is not included among those benefits, “[t]he negative implication . . . is that the Legislature did not intend” for them to be included: *expressio unius est exclusio alterius*. (*Clark v. Burleigh* (1992) 4 Cal.4th 474, 489.)

We next examine the current version of section 14009.5, which became effective on June 27, 2016. (§ 14009.5, subd. (g) [2016 amendments apply to individuals who die on or after Jan. 1, 2017]; Sen. Bill No. 833 (2015–2016 Reg. Sess.) Stats. 2016, ch. 30, § 22 (Senate Bill 833).) The Legislature amended section 14009.5 to limit Medi-Cal estate recovery to only “those services required to be collected under federal law.” (§ 14009.5, subd. (a)(1).) Section 14009.5 defines “‘health care services’” as “only those services required to be recovered under Section 1396p(b)(1)(B)(i) of Title 42 of the United States Code.” (§ 14009.5, subd. (f)(4).) And section 1396p(b)(1)(B)(i) provides that the Department “shall seek . . . recovery” “only for medical assistance consisting of[:] [¶] (i) nursing facility services, home and community-based services, and related hospital and prescription drug services.” (42 U.S.C. § 1396p(b)(1)(B)(i).) Neither premiums nor excess capitation are among the recoverable “‘health care services’” specified in the federal statute.

We conclude that excess capitation is not recoverable as “health care services” under section 14009.5. Under its plain and unambiguous language, the Department is only entitled to recover “an amount equal to the payments for the health care services received.” (*Id.*, subd. (b).) To draw a contrary conclusion would require us to rewrite the statute to add more than it currently contains. We cannot do so. The statute speaks to estate recovery in “an amount equal to the payments for the health care services received.” (*Ibid.*) And capitation may or may not pay for health care services received. As the Department concedes, under a managed care plan model, Medi-Cal pays managed care plans a “predetermined amount for each beneficiary per month, whether or not the beneficiary actually receives services.” Thus, a member may receive health care services in an amount *less than* the capitation rate the Department paid to the managed care plan.

The Department nevertheless contends “the most natural reading of the statute” is that references to “payments” refer to “those made by the Department itself—rather than those made by the patient or other unnamed third-parties.” But this contention ignores the language before and after the word “payments.” Both versions of the statute require the Department to pursue estate recovery in “an amount equal to the payments for the health care services received.” (§ 14009.5, former subd. (a); § 14009.5, subd. (b).) The word “payments” cannot be read in isolation. We must read the statute “in context, as part of a comprehensive legislative scheme.” (*McMahon v. City of Los Angeles* (2009) 172 Cal.App.4th 1324, 1332.) Under the last antecedent rule, “‘qualifying words, phrases and clauses are to be applied to the words or phrases immediately preceding and

are not to be construed as extending to or including others more remote.’” (*Renee J. v. Superior Court* (2001) 26 Cal.4th 735, 743.) We cannot read the word “payments” in isolation. The word “received” modifies “services,” not “payments.”

Our conclusion that excess capitation falls outside section 14009.5 is supported by *Pottgieser, supra*, 906 F.2d 1319. There, the Department paid insurance premiums on behalf of Cecilia Pottgieser. (*Id.* at p. 1320.) After Cecilia died, the Department sought to recoup these premiums through estate recovery contending that “‘medical assistance’” included “‘payment of part or all of the cost’” of those services. (*Ibid.*) Cecilia’s heirs argued that the federal statute, title 42 United States Code section 1396d(a), did not include “premiums” under the definition of “‘medical assistance.’” (*Pottgieser*, at p. 1320.) Rather, the statute permitted the Department to recover “medical assistance *correctly paid*.” (*Id.* at p. 1321, quoting 42 U.S.C. § 1396p(b)(1).)

The District Court agreed, and the Ninth Circuit affirmed, noting that “under the plain language of the statute, costs of service are different than premiums, and premiums are not included in the definition of ‘medical assistance.’” (*Pottgieser, supra*, 906 F.2d at p. 1322.) The statute defined “‘medical assistance’” as “payment of part or all of the cost of the following care and services” of certain specified services including, as the court noted, “inpatient hospital services [etc.]” (*Ibid.*, citing 42 U.S.C. § 1396d(a), italics omitted.) *Pottgieser* held that the phrase “‘payment of all or part of the cost’” of services did not include premiums, and concluded there was “no clear expression of Congressional intent contrary to [its] conclusion that the estates of recipients should not be charged” the premiums. (*Pottgieser*, at pp. 1322–1323.)

Pottgieser also concluded its interpretation was consistent with section 14009.5's limitation on estate recovery: "California's state code similarly authorizes recovery from an estate for specific costs. Only 'when a decedent has received health care services' may the state make a claim in 'an amount equal to the payments for the health care services received.' 'Health care services' are defined in terms of specific benefits. [¶] Both the federal regulations and the state statute are consistent with our reading of the federal statute that payment of the cost of 'medical assistance' does not include premiums." (*Pottgieser, supra*, 906 F.2d at pp. 1323–1324, italics omitted.)

The Department contends its interpretation of section 14009.5 is supported by a Minnesota Supreme Court case, *In re Estate of Ecklund* (Minn. 2025) 20 N.W.3d 351. We disagree. There, the court held that the Minnesota Department of Health Services (DHS) was entitled to recover the value of the capitation payments it attributed to health care services. (*Id.* at pp. 360, 363.) Not only did *Ecklund* not discuss California law (*Robertson v. Saadat* (2020) 48 Cal.App.5th 630, 649), DHS did "not seek to recover the *entire* amount of capitation payments" made to Ecklund's managed care plan. (*Ecklund*, at p. 353, fn. 3.) Rather, DHS pursued estate recovery of "only the actuarially-limited portion that relates exclusively to the cost of [Ecklund's] long-term care services." (*Ibid.*) Here, the Department seeks to recover excess capitation that is untethered to "the health care services received" by Theodosia.

Section 14009.5's legislative history

The Department also contends section 14009.5 is ambiguous, requiring that we resort to extrinsic evidence to decipher the Legislature's intent. (*Lungren v. Deukmejian*,

supra, 45 Cal.3d at p. 735; *City of Sacramento v. Public Employees' Retirement System* (1994) 22 Cal.App.4th 786, 794.) Even if the statute were ambiguous, we would still conclude that excess capitation is not permitted. Section 14009.5's legislative history does not mention estate recovery for excess capitation.

Rather, legislative history only indicates that estate recovery would be permissible under the new statute. (Legis. Counsel's Dig., Assem. Bill No. 251 (1981–1982 Reg. Sess.) 4 Stats. 1981, Summary Dig., p. 32 [noting “[e]xisting law does not permit the state” to recover Medi-Cal payments from deceased members, and the new statute “would provide that recovery may be made” from decedents' estates]; see also Cal. Dept. of Finance, Enrolled Bill Rep. on Assem. Bill No. 251 (1981–1982 Reg. Sess.) undated, p. 1 [noting that the new statute would “[a]uthorize[] the Department . . . to recover the costs of Medi-Cal services from the estate of a deceased beneficiary”].)

Section 14009.5 has also been amended six times but none of the amendments include reference to premiums or excess capitation. The most recent 2016 amendments sought to limit, rather than expand, what the Department may seek in estate recovery. Senate Bill 833 required the Department assert estate recovery claims “only in specified circumstances for those health care services that the state is required to recover under federal law.” (Legis. Counsel's Dig., Sen. Bill No. 833 (2015–2016 Reg. Sess.) 30 Stats. 2016, Summary Dig., pp. 1022–1023.) Senate Bill 833 also limited claims against the member's estate to the member's assets in probate; deleted the requirement that the Department make a claim upon the death of the member's surviving spouse; prohibited the Department from asserting a claim if the member had a surviving registered domestic partner;

and required the Department to waive its estate recovery claim when the estate is “a homestead of modest value, as defined.” (*Id.* at p. 1023.) Estate recovery of excess capitation is not discussed.

The Department additionally contends other statutes enacted before section 14009.5 “defined health care services to refer generally to the full spectrum of Medi-Cal benefits available to members.” (Italics omitted.) But these statutes refer to specific services constituting “health care services,” not premiums. (See Stats. 1965, 2nd Ex. Sess., ch. 4, § 2, pp. 110–111, [enacting § 14053, which defined “‘[h]ealth care and related remedial or preventive service’” as including “[i]npatient hospital services,” “[o]utpatient hospital services,” and “[l]aboratory and X-ray services”]; Stats. 1971, ch. 577, § 24, p. 1116 [amending § 14053 to add other benefits constituting “‘health care services,’” including “[s]killed nursing home services,” “[p]hysicians’ services,” “[m]edical care,” “[h]ome health care services,” etc.]; Stats. 1978, ch. 429, § 243, p. 1474 [version of § 14053 in effect when Legislature enacted § 14009.5, identifying “‘health care services’” as “the benefits set forth in Article 4 (commencing with Section 14131) of this chapter and in Section 14021”].)

None of the Department’s extrinsic evidence supports the Department’s contention that the Legislature included excess capitation or premiums as “health care services.” Instead, the Legislature was specific and explicit in its identification of certain medical benefits that constituted “health care services”: inpatient services, outpatient services, and the like.

Regulation 50961

The Department also contends the relevant implementing regulation resolves any statutory ambiguity and is “consistent” with section 14009.5. Because regulation 50961 is “unambiguous,” the Department contends it is valid. We are not persuaded.

Despite its explicit reliance on section 14009.5, the Department concludes that its own regulation 50961 (Cal. Code Regs., tit. 22, § 50961) is unambiguous, consistent with, and does not conflict with section 14009.5. But regulation 50961 was enacted to carry out the purpose of section 14009.5, not the other way around. Because we must evaluate whether the regulation is consistent with section 14009.5, the appropriate analysis begins with the statute, not the regulation. (See *In re Gadlin* (2020) 10 Cal.5th 915, 926.) The final responsibility for interpreting a statute rests with the courts. (*Diablo Valley College Faculty Senate v. Contra Costa Community College Dist.* (2007) 148 Cal.App.4th 1023, 1034.)

The Department has authority to administer the Medi-Cal Act. Section 14124.5 provides the Department director with specific rulemaking powers, including the power to adopt “reasonable rules and regulations as may be necessary or proper to carry out the purposes and intent of this chapter.” (See §§ 10720 [defining “department” and “director”], 10725 [director’s power to adopt regulations]; see also Gov. Code, § 11342.600 [defining “regulation”].) But no regulation is valid or effective unless it is “reasonably necessary to effectuate the purpose of the statute” and does not conflict with the statute. (Gov. Code, § 11342.2.) A regulation that is inconsistent with a statute, alters or amends the statute, or enlarges or impairs its scope is

void. (*PaintCare v. Mortensen* (2015) 233 Cal.App.4th 1292, 1306.)

Here, regulation 50961, subdivision (c) provides that the Department's estate recovery claim "shall include all payments made by the Medi-Cal program on behalf of the decedent, including . . . payments to managed care plans." (Cal. Code Regs., tit. 22, § 50961, subd. (c).) On its face, regulation 50961, subdivision (c) includes excess capitation because it is paid to managed care plans. But this enlarges the scope of section 14009.5, which does not authorize the Department to recoup excess capitation. Because it impermissibly allows the Department to recover payments that are not "equal to the payments for the health care services received," we conclude the regulation is void.

Federal law

The Department contends federal law requires it to recover excess capitation payments. We again disagree.

Federal law limits mandatory estate recovery to specified categories of "medical assistance" in title 42 United States Code section 1396p(b)(1)(B)(i). Excess capitation is not among those specified services.

The Department also asserts it must include excess capitation payments pursuant to "unambiguous directions" from the Centers for Medicare & Medicaid Services (CMS) set forth in the State Medicaid Manual (the Manual). (See *Family Health Centers of San Diego v. State Dept. of Health Care Services* (2023) 15 Cal.5th 1, 12–13.) The Manual is informal agency guidance, however, and the Department may not rely on the Manual to implement a rule inconsistent with the unambiguous language in section 14009.5. Additionally, the Department cannot evade the

Administrative Procedure Act (APA) (Gov. Code, § 11340 et seq.) by adopting rules and regulations, including reliance on the Manual, to carry out the Medi-Cal Act. (See § 14124.5; *Union of American Physicians & Dentists v. Kizer* (1990) 223 Cal.App.3d 490, 496 [§ 14124.5 “explicitly makes the Department’s rule making subject to the provisions of the APA”]; *California Advocates, supra*, 106 Cal.App.4th at p. 532.)

Furthermore, the Manual is nonbinding federal guidance because it was not promulgated through federal notice and comment rulemaking. (See *Family Health Centers of San Diego v. State Dept. of Health Care Services* (2023) 15 Cal.5th 1, 12 [CMS manual is “an informal guidance document; it does not ‘have the force and effect of law’ ”]; *Ramey v. Reinertson* (10th Cir. 2001) 268 F.3d 955, 963 [“the State Medicaid Manual does not have the force and effect of law, nor is it binding on this court”].) Thus, we reject the Department’s contention that federal law requires excess capitation estate recovery.

The Department’s remaining arguments

The Department also cites third-party liability statutes in the Welfare and Institutions Code, asserting that the Legislature is intentional as to when the Department should recover the value of services rather than the capitation rate. (See, e.g., § 14124.71, subd. (a).) It also relies on section 14124.70, subdivision (c), which provides a detailed definition of the “ ‘reasonable value of benefits’ ” where a member received treatment for third-party injuries under a managed care plan. Because the Legislature did not use similarly detailed language in section 14009.5, the Department contends it did not intend to limit estate recovery to the value of services actually received and must have intended to include capitation payments as a

component of estate recovery. We are not persuaded. If the Legislature required the Department to recover excess capitation, it would have said so in drafting or amending the statute.

The Department additionally contends that allowing the judgment to stand would lead to “catastrophic and unintended consequences.” It asserts it “will need to ‘recover’ third-party health-care payments” exceeding the Department’s premium expenses; people whose decedents’ medical care costs exceeded the capitation payments “would be required to pay the full cost of their loved ones’ end-of-life medical care”; and because “capitation premiums are the only amount ‘actually paid’ by the Department, the Phillips necessarily demand that the Department bill heirs for payments made by someone else.”

But in the trial court proceedings, the Department stipulated that it only pays a capitation rate to a managed care entity for each member “in exchange for the managed care plan undertaking the obligation to arrange for or provide all medically necessary services covered under the contract for the member, *regardless of whether the cost of furnishing these services to the Medi-Cal member is less than or exceeds the amount of the capitation payments under the contract.*” (Italics added.)

If our conclusion portends chaotic results in the realm of managed care, the Department is free to consult with the Legislature. As the Department concedes, section 14009.5 “was written before managed care existed in its current form.” But we are not in the business of making policy. We must interpret the statute as written to avoid any encroachment on the province of the Legislature to declare public policy. (*Hartt v. County of Los Angeles* (2011) 197 Cal.App.4th 1391, 1399; *Green v. Ralee Engineering Co.* (1998) 19 Cal.4th 66, 71.)

We conclude the Department may not recover excess capitation because it is not “an amount equal to the payments for the health care services received.”

DISPOSITION

The judgment is affirmed. The Phillips shall recover their costs on appeal.

CERTIFIED FOR PUBLICATION.

BALTODANO, J.

We concur:

CODY, P. J.

YEGAN, J.

Tana L. Coates, Judge

Superior Court County of San Luis Obispo

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