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The Supreme Court
State of California

Family Health Center of San Diego

Plaintiff and Appellant,

v.

State Department of Health Care Services

Defendant and Respondent.

On Review From The Court Of Appeal For the Third Appellate District,
Division One, 3rd Civil No. C089555

After An Appeal From the Superior Court For The State of California,
County of Sacramento, Case Number 34201880002953CUWMGDS, Hon. Steven M. Gevercer

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Application for Leave to File *Amicus Curiae* Brief in Support of Plaintiff-Appellant Family Health Centers of San Diego; *Amicus Curiae* Brief of Amici Health Centers

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Application For Leave To File Amicus Curiae Brief

A.
Application

Pursuant to rule 8.520(f) of the California Rules of Court, the following eleven (11) California federally-qualified health centers ("FQHCs" or "Health Centers") request an order granting leave to file an amicus curiae brief in this matter: Avenal Community Health Center, Eisner Health, Golden Valley Health Centers, Innercare, La Maestra Community Health Centers, Neighborhood Healthcare, Open Door Community Clinic, Ravenswood Family Health Network, Shasta Community Health, TrueCare, and WellSpace Health (collectively, the "Amici Health Centers"). The proposed amicus curiae brief is in support of the plaintiff-appellant Family Health Centers of San Diego ("FHCSD"). The proposed brief is attached to this application.

Counsel for the Amici Health Centers have represented health centers in connection with rate-setting and reimbursement issues for many years. Ms. Doi has represented health centers at all stages of rate-setting appeals before the Department of Health Care Services Office of Administrative Hearings and Appeals ("OAHA"), as well as in superior court writ actions challenging

OAHA decisions, and in discussions and negotiations with the Medi-Cal program. She was also the lead attorney in the case *California Association of Rural Health Clinics v. Douglas*, 738 F.3d 1007 (9th Cir. 2013), which enforced the provisions of the Medicaid Act defining the scope of FQHC and rural health center ("RHC") services required to be covered by State Medicaid programs.

Ms. Boyle is the former legal counsel for the California Primary Care Association ("CPCA"), the trade association for FQHCs in California. In that capacity she played a lead role in drafting and negotiating most of California's Medicaid statutes relating to reimbursement of Federally Qualified Health Centers and Rural Health Clinics, including Senate Bill 36 (Chesbro) (Stats. 2003, ch. 527 § 2), which was sponsored by CPCA, and which implemented Section 1396a(bb) of Title 42 of the United States Code, which transitioned FQHC and RHC Medicaid reimbursement from a retrospective cost-based methodology to a prospective cost-based methodology, as set forth in Welfare & Institutions Code § 14132.100. She also played a lead role in drafting and negotiating Assembly Bill 2674 (Stats. 2002 ch 756 § 1), also sponsored by CPCA, modifying Welfare & Institutions

Code§ 14087.325, to eliminate a provision of State law that, among other things, impermissibly required FQHCs/RHCs to waive their federal statutory right to be reimbursed at the cost-based all-inclusive per visit rate, if they entered into capitated or at-risk Medi-Cal managed care agreements. She consulted with Kathryn Doi in the case *California Association of Rural Health Clinics v. Douglas*, 738 F.3d 1007 (9th Cir. 2013), and, since 2005, has represented individual FQHCs on a wide variety of legal issue.

The concurrently-filed amicus brief addresses important legal issues not addressed by the parties to this matter, namely the background and history of the community health center program and the FQHC benefit, as well as the limitations on the application of Medicare reasonable cost principles not found in Part 413 of 42 C.F.R. to FQHC Medi-Cal rate-setting and the proper application of Part 413 reasonable cost principles to a provider's necessary and proper costs. The Amici Health Centers submit that the brief will assist this Court in its consideration of the issues presented.

This application is timely. FHCSD filed its reply brief on April 12, 2022. An application to file an amicus curiae brief is due

within thirty days of all briefs on the merits that the parties may file. (Cal. Rules of Court, rule 8.520(f).) This application is filed and served on May 12, 2022.

The Amici Health Centers certify that no person or entity other than the Amici Health Centers and their counsel authored or made any monetary contribution intended to fund the preparation or statement of the proposed brief (See Cal. Rules of Court, rule 8.520(f)(4).)

B.
Statement of Interest

The Amici Health Centers are California Health Centers designated by the federal government as FQHCs. FQHCs are non-profit outpatient health care providers whose mission is to provide primary care services to medically underserved populations in California, including the poor, homeless, and migrant populations.

The Amici Health Centers and the over 150 other FQHCs in this state,[1] as well as the millions of indigent and Medi-Cal

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[1] As of 2020, there were 175 FQHCs in the State of California, and 26 California FQHC Look-Alikes, providing services at a total of 2,472 health care delivery sites. (https://data.hrsa.gov/topics/health-centers)

patients that they collectively serve, will be directly and adversely impacted under the now published Court of Appeal decision, which allows the Department of Health Care Services to refuse to reimburse health centers for outreach activities that they are required by federal law to undertake as a precondition to participating in Medicaid based on application of inapplicable Medicare reasonable cost principles.

The Amici Health Centers request an order granting them leave to file an amicus curiae brief in this matter to address this critical issue that affects FQHCs state-wide.

Respectfully submitted,

DATED: May 12, 2022 HANSON BRIDGETT LLP

By: /s/ Kathryn E. Doi
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DATED: May 12, 2022 LAW FIRM OF REGINA M. BOYLE

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I.
SUMMARY OF ARGUMENT

A Federally-qualified health center ("FQHC") is an entity receiving or eligible to receive direct grants from the United States (specifically, the federal Health Resources and Services Administration ("HRSA") under section 330 of the Public Health Service Act[2]) to provide primary and other health care services to indigent, homeless, and migrant populations not eligible for Medicaid. As a condition to receiving the Section 330 grant, FQHCs are required to provide health care services to anyone who seeks them, regardless of insurance status. In addition to receiving the Section 330 grant, an FQHC is required to enroll in Medicaid, and to charge and collect payment for providing Medicaid services.[3] This dual funding mechanism is intended to

[2] The federal grant program for FQHCs was established in 1975, as Section 330 of the Public Health Services Act. See Special Health Revenue Sharing Act of 1975, Pub.L. 94–63, § 501, 89 Stat. 304, now codified at 42 U.S.C. § 254b. (See *Community. Health Care Ass'n of N.Y. v. Shah*, 770 F.3d 129, 136 (2d Cir. 2014).)

[3] 42 U.S.C. § 254b(k)(3)(E)-(F); *see also* S. Rep. 94-29, at 5--6, reprinted in 1975 U.S.C.C.A.N. 469, 472—73, initially adding this language to address concerns of the Ford Administration that Medicaid and Medicare underpayments for "covered" services under their programs would result in the siphoning off of health center grant funds.

allow FQHCs to allocate their direct grant dollars towards treating those who lack even Medicaid coverage. For this dual funding mechanism to work, the Medicaid program must pay its fair share of the costs of the FQHC for providing services to Medicaid patients.

The criteria used to establish the rates paid by the California Medicaid program (called "Medi-Cal") to FQHCs is at the heart of this appeal and was also addressed in *Tulare Pediatric Health Care Center v. State Department of Health Care Services*, 41 Cal. App. 5th 163 (2nd Dist. 2019) ("*Tulare Pediatric*") In both cases, the State of California Department of Health Care Services ("DHCS" or the "Department"), which is charged with setting Medi-Cal reimbursement rates for California FQHCs, eliminated costs from an FQHC's rate-setting cost report used to determine its per-visit rate, purportedly based on the application of Medicare reasonable cost principles.

The issues that deserve this Court's attention are (1) whether the Department can disallow a reasonable cost that is otherwise allowable under the Medicare reasonable cost principles found in Part 413 of title 42 of the Code of Federal Regulations

("Part 413") and Generally Accepted Accounting Principles ("GAAP") in the absence of a validly adopted rule requiring such disallowance, and (2) whether the costs associated with the "required primary health services" that an FQHC must provide to retain its Medicaid FQHC designation and participate in Medicaid are "necessary and proper costs" within the meaning of Part 413 for FQHC rate-setting purposes.

In the absence of such guidance, the Department will continue to misapply these principles to FQHC cost reports in rate-setting, resulting in the payment to FQHCs of less than their actual and reasonable costs, in violation of federal law, and the improper subsidization of the Medi-Cal program by federal grant dollars that are intended to be used to provide health care to uninsured indigent populations in California.

II.
HISTORY OF THE COMMUNITY HEALTH CENTER PROGRAM AND THE FQHC BENEFIT

In 1989, Congress established FQHCs as a new provider type and mandated coverage and reimbursement by State

Medicaid Agencies for specified "FQHC services".[4] An FQHC, as defined by Medicaid in 42 U.S.C. § 1396d(*l*)(2), is an entity either receiving, or determined to meet the requirements permitting it to receive, direct grants from the United States (specifically, HRSA) under its Health Center Program as described in 42 U.S.C. § 254b (also known as Section 330 of the Public Health Service Act[5]).

In order to be eligible to receive a Section 330 grant, and thus meet Medicaid's definition of an FQHC, an entity must provide the "required primary health services" described in 42 U.S.C. § 254b(b)(1), including the outreach and other specified services described in § 254b(b)(1)(A)(iv) "that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the

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[4] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6404, 103 Stat. 2106, 2264; *see also* 42 U.S.C. §§ 1396d(*l*)(2) for the Medicaid definition of an "FQHC", and 1396d(a)(2)(C) for the Medicaid definition of "FQHC services" that must be covered by states and reimbursed in the manner described in 42 U.S.C. § 1396a(bb).

[5] The federal grant program for FQHCs was established in 1975, as Section 330 of the Public Health Services Act. See Special Health Revenue Sharing Act of 1975, Pub.L. 94–63, § 501, 89 Stat. 304, now codified at 42 U.S.C. § 254b. (See *Community. Health Care Ass'n of N.Y. v. Shah*, 770 F.3d 129, 136 (2d Cir. 2014).)

individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals)". These are generally referred to as "enabling" services.

FQHCs, unlike most other types of providers, must enroll in Medicaid, Medicare and other specified federal programs, or must have made "every reasonable effort" to enroll in such programs.[6] They must also make and continue to make every reasonable effort to collect appropriate reimbursement for their costs in providing health services from Medicaid and other programs,[7] and are prohibited from denying health care services to any patients "due to an individual's inability to pay for such services".[8]

To qualify for enrollment as an FQHC in the Medicare and Medicaid programs, an FQHC must be approved by the Centers for Medicare and Medicaid Services ("CMS"), following a recommendation by HRSA or the issuance of a Section 330 grant

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[6] 42 U.S.C. § 254b(k)(3)(E).

[7] 42 U.S.C. § 254b(k)(3)(F).

[8] 42 U.S.C. § 254b(k)(3)(G).

to the entity. (CMS Pub. 45, State Medicaid Manual, Ch. 4, ¶ 4231(C), Request for Judicial Notice, Exh. A.) Consistent with the identical Medicare and Medicaid definitions of the term "FQHC", CMS guidance states that certification as an FQHC obligates the entity to "meet **all** Section 330 of the PHS requirements" [Emphasis in original].[9] As noted, one of the requirements of Section 330 is the obligation to provide outreach and other enabling services.[10]

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[9] 42 U.S.C. §§ 1395x(aa)(4) and 1396d(*l*)(2); *see also* CMS FQHC Fact Sheet, p. 5; accessed on May 5, 2022 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/fqhcfactsheet.pdf, Request for Judicial Notice, Exh. B; *see also* CMS State Operations Manual, Publ. 100-07, Ch. 2, § 2825-2826H https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf describing FQHC certification requirements in more detail.

[10] 42 U.S.C. § 254b(a), defining a "health center" as, in pertinent part, "an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements . . . (A) required primary health services (as defined in subsection (b)(1))" and § 254b(b)(1)(A)(iv), describing outreach services as a "required primary health service".

III.
THE COST OF OUTREACH AND OTHER ENABLING SERVICES MUST BE ALLOWED UNDER PART 413, THE MEDICARE REASONABLE COST PRINCIPLES APPLICABLE TO FQHC RATE-SETTING

State Medicaid Agencies, including the Department, are required to reimburse FQHCs on a per-visit basis in the manner described in 42 U.S.C. § 1396a(bb).[11] The general formula for establishing the per-visit rate is to take the total of an FQHC's reasonable costs and divide this total amount by the total number of all patient visits regardless of insurance coverage. Medi-Cal's fair share of the cost of providing FQHC services to Medi-Cal beneficiaries is determined by taking this overall average per-visit cost and multiplying it by the number of visits with Medi-Cal beneficiaries to ensure that the total compensation for Medi-Cal services only reflects Medi-Cal's fair share of the FQHC's total costs. Given that FQHCs are not-for-profit entities that cannot pass budgetary shortfalls onto owners or other payers, Congress was particularly concerned that states might indirectly use Public

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[11] 42 U.S.C. §§ 1396a(a)(10)(A) (mandating that State Medicaid plans include coverage of the FQHC services described in §§ 1396d(a)(2)(C)) and 1396a(a)(15) (mandating that State Medicaid plans provide for payment for services described in § 1396d(a)(2)(C) in accordance with § 1396a(bb)).

Health Service grants under 42 U.S.C. § 254b (which are paid entirely by the federal government) to subsidize state Medicaid costs (which are paid in part by the states). (See H.R.Rep. No. 101-247, 1st Sess., pp. 392–393 (1989), reprinted in 1989 U.S. Code Cong. & Admin. News, pp. 2118–2119 ("Congress was concerned that, because Medicaid fell short of covering the full cost of treating its own beneficiaries, health centers would use Public Health Services Act grants to subsidize treatment of Medicaid patients. … This practice compromised centers' ability to care for those without any public or private coverage whatsoever, who were the very people Congress sought to help when it passed the Public Health Services Act.").)

Under the FQHC reimbursement methodology, rates are prospectively established at 100 percent of the costs of the FQHC to furnish "FQHC services" based on "such other tests of reasonableness as the Secretary prescribes in regulations" under 42 U.S.C. § 1395l(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under 42 U.S.C. § 1395*l*(a)(3). (42 U.S.C. § 1396a(bb)(2), (4) and (6).)

Under California's State Medicaid plan, as approved by CMS, DHCS represents that it "determines all rates in accordance with cost reimbursement principles in 42 C.F.R. Part 413, and with Generally Accepted Accounting Principles." (Cal. State Medicaid Plan, Attachment 4.19-B, p. 6F, ¶ E(1)(a), Request for Judicial Notice, Exh. C.) 42 C.F.R. Part 413 is a set of regulations developed under 42 U.S.C. § 1396*l*(a)(3) for the Medicare program.[12]

Part 413 describes the Medicare reasonable cost principles for a broad range of provider types including hospitals, critical

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[12] To date CMS has never promulgated Medicaid FQHC reimbursement regulations, and the statute and the agency's practice both indicate that the Medicare regulations should apply until such regulations are promulgated. In the 1992 Medicare FQHC regulations, CMS indicated that "[r]elated Medicaid rules are being developed in a separate rulemaking document." 47 F.R. 24961, 24961 (June 12, 1992). By 1996, CMS acknowledged that the Medicaid FQHC rules were still not complete. 61 F.R. 14640, 14641 (April 3, 1996). As of today, no Medicaid FQHC reimbursement regulations have been promulgated.

Furthermore, California has not adopted any regulations that define its understanding of the "reasonable cost" of providing FQHC services, other than the references to Part 413 in Welfare & Inst. Code § 14132.100(e)(1), (e)(3)(B), (i)(2)(B)(ii), (*l*)(3)(E) and (m)(3)(E), each of which relates to scope of service rate adjustments, which are at issue in the case on appeal.

access hospitals, skilled nursing facilities, home health agencies, end-stage renal disease facilities, organ procurement organizations and histocompatibility laboratories. (42 C.F.R. § 413.1.) The regulatory requirements applicable to these provider types, and the types of services customarily offered, vary widely, and thus the reasonable cost of providing critical access hospital services, for example, would vary significantly from the cost of providing FQHC services.

Part 413 reflects the flexibility required for such broad applicability, requiring treatment of a broad range of direct and indirect costs as "reasonable" thus allowable costs. The rules recognize that -

> The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors. 42 C.F.R. § 413.9(c)(2).

Uniformly allowable costs include not only the direct cost of providing Medi-Cal covered services, but a wide variety of indirect

costs, including but not limited to, executive compensation,[13] pension and fringe benefits,[14] the value of services of nonpaid workers,[15] depreciation,[16] rent and leasing costs,[17] educational costs,[18] insurance,[19] interest expense,[20] legal fees,[21] janitorial costs,[22] taxes,[23] and professional and civic membership costs.[24] "Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans." (42 C.F.R. § 413.9(c)(3).)

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[13] 42 C.F.R. § 413.102.

[14] 42 C.F.R. § 413.5(c)(7).

[15] 42 C.F.R. § 413.5(c)(4).

[16] 42 C.F.R. §§ 413.9, 413.130, 413.134, 413.139, 413.149.

[17] 42 C.F.R. § 413.130(a)(3).

[18] 42 C.F.R. § 413.5(c)(1) and 413.85.

[19] 42 C.F.R. §§ 413.100(b)(2) and 413.40(g)(3).

[20] 42 C.F.R. §§ 413.130(a)(7), (f) and (i) and 413.157.

[21] See *Dyna Care Home Health, Inc. v. Shalala*, 1999 U.S. Dist. LEXIS 10583 (N.D. Ill. July 6, 1999) holding that while there are no specific regulations dealing with legal expenses, Medicare reimburses such expenses when they are reasonable and otherwise meet the criteria of 42 C.F.R. § 413.9 and 42 U.S.C. § 1395(v)(1)(A).

[22] 42 C.F.R. §§ 413.9(a), (c)(3).

[23] 42 C.F.R. §§ 413.100(c)(2)(vi) and 413.130(a)(2).

[24] *Cong. of Cal. Seniors v. Catholic Healthcare W.*, 87 Cal. App. 4th 491, fn. 7 (2001).

Section 413.9 further provides that “necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider’s activity.” (42 C.F.R. § 413.9(b)(2).)

DHCS admits that “the federal regulations themselves do not directly address whether provider outreach or advertising costs qualify for reimbursement”. (DHCS Answer Brief on the Merits, p. 15.) Therefore, under Section 413.9, the question is whether these costs are “appropriate and helpful in developing and maintaining the operation of patient care facilities and activities” and “costs that are common and accepted occurrences in the field of the provider’s activity.” (42 C.F.R. § 413.9(b)(2).)

As relevant here, FQHCs are required to provide outreach services as a prerequisite to qualification as such according to Medicaid’s definition of an FQHC. Outreach services were determined by Congress to be sufficiently necessary and appropriate for the provision of health care services in medically underserved areas such that they were mandated to be provided by all health centers under 42 U.S.C. § 254b(b)(1)(A).

Furthermore, Congress defined the types of entities qualified as an "FQHC" for purpose of the Medicaid program as entities complying with the requirements described in 42 U.S.C. § 254b.

Not only are the provision of outreach and other enabling services "common and accepted occurrences in the field of the provider's activity" – the provision of these services is required for the FQHC to qualify as such under Medicaid. (42 U.S.C. § 1396d(*l*)(2)(B).)

Thus, under the current Medicaid FQHC payment provision, state Medicaid agencies are required to pay FQHCs at a rate that includes Medicaid's fair share of outreach costs their per-visit rate for each visit of a Medicaid beneficiary. The determinations below to the contrary were incorrect and must be overturned.

IV.
THE PROVIDER REIMBURSEMENT MANUAL APPLIED BY THE COURT OF APPEAL IS NOT APPLICABLE TO FQHC RATE-SETTING

The Court of Appeal's decision below rested on application of CMS Publication 15-1, The Provider Reimbursement Manual ("PRM") to find that the provider's outreach costs were not allowable costs because they were akin to advertising costs, which

are not allowable under the PRM. (See *FHCSD*, 67 Cal.App.5th at 360 ("Providers are reimbursed for their allowable costs, as determined under Medicare/Medicaid standards and principles of reimbursement set forth in the Code of Federal Regulations and the PRM.")

Nothing in the CMS-approved State plan or the federal or state laws or regulations applicable to FQHCs provides for the application of the PRM to FQHC rate-setting.

Both the State plan and the California Welfare and Institutions Code, section 14132.100(e)(1) [Appendix at 606] reference and adopt for California FQHC rate setting purposes only the Medicare regulations contained in 42 C.F.R. Part 413, and not Parts 405 and 415. Notably, 42 C.F.R. Part 415 (not Part 413) requires application of the PRM, which the Department and the lower courts relied upon here.

The *Tulare Pediatric* court noted, "The State plan's reference to part 413 does not allow the State to apply any Medicare regulation it sees fit. If the drafters of the State plan intended reasonable costs to be determined according to all Medicare

regulations, it would have said so. Instead, those drafters specified part 413." (*Tulare Pediatric, supra*, 41 Cal.App.5th at 175.)

Both the Court of Appeal below and the State in *Tulare Pediatric*, cited *Oroville Hospital v. Dept. of Health Services*, 146 Cal.App.4th 468 (2006) ("*Oroville Hospital*") for the proposition that allowable costs are determined in accordance with the PRM. But the *Tulare Pediatric* court aptly noted that *Oroville Hospital* involved a hospital and a regulation that expressly applies Medicare standards and the PRM to hospital inpatient services. (*Id*. at 492; 22 C.C.R. § 51536.) As noted by the *Tulare Pediatric* court, that regulation (22 C.C.R. § 51536) does not apply to FQHCs. Nor is there anything in state statute or regulation, or the State plan, that adopts or incorporates Part 415 and the PRM into the FQHC rate setting process.

The approach taken by the *Tulare Pediatric* court with respect to application of the PRM is the correct one. The State should be applying Part 413 Medicare reasonable cost principles and GAAP to FQHC cost reports and not Part 415 and the PRM.

V.
CONCLUSION

As noted by the *Tulare Pediatric* court, "the State has ample ways to attack health center costs that indeed are unreasonable. … But the State cannot reduce payment based on regulations that do not apply, with no other showing of unreasonableness. That is what the State seeks to do here."

Pursuant to the express provisions of the Medicaid State Plan and Welfare and Institutions Code section 14132.100, FQHC allowable costs are to be determined based on the Medicare reasonable cost principles set forth in Part 413 of Title 42 of the Code of Federal Regulations and Generally Accepted Accounting Principles, and not the provisions of Part 415 and the Provider Reimbursement Manual.

Application of Part 413 prevents the Department of Health Care Services from categorically excluding costs associated with the provision of the "required primary health services" defined in 42 U.S.C. § 254(b)(1), including the so-called "enabling services,"

which FQHCs are required to provide to qualify as FQHCs and to participate in the Medicaid program.

DATED: May 12, 2022 HANSON BRIDGETT LLP

By: /s/ Kathryn E. Doi
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DATED: May 12, 2022 LAW FIRM OF REGINA M. BOYLE

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CERTIFICATE OF WORD COUNT

(Cal. Rules of Court 8.520(c))

This brief (excluding the caption, tables, application, proof of service and this certificate) contains 5,119 words, as calculated by Microsoft Word, the word processing program used to generate the brief. The typeface is Century Schoolbook, 13 points.

PROOF OF SERVICE

Family Health Centers of San Diego v. Department of Health Care Services
Supreme Court Case No. S270326
Court of Appeal No. C089555
Sacramento County Superior Court
No. 34201880002953CUWMGDS

STATE OF CALIFORNIA, COUNTY OF SACRAMENTO

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of Sacramento, State of California. My business address is 500 Capitol Mall, Suite 1500, Sacramento, CA 95814.

On May 12, 2022, I served true copies of the following document(s) described as

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFF-APPELLANT FAMILY HEALTH CENTERS OF SAN DIEGO; AMICUS CURIAE BRIEF OF AMICI HEALTH CENTERS

on the interested parties in this action as follows:

SEE ATTACHED SERVICE LIST

BY MAIL: (Superior Court and Court of Appeal) I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and placed the envelope for collection and mailing, following our ordinary business practices. I am readily familiar with Hanson Bridgett LLP's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid.

BY TRUE FILING ELECTRONIC TRANSMISSION: Using the True Filing Service option on all counsel

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

Executed on May 12, 2022, at Sacramento, California.

/s/ Jessica L. Walker

Jessica L. Walker

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<u>Family Health Centers of San Diego v. Department of Health Care Services</u>
Supreme Court Case No. S270326
Court of Appeal No. C089555
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No. 34201880002953CUWMGDS

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Electronically FILED on 5/18/2022 by Celia Wong, Deputy Clerk

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **FAMILY HEALTH CENTERS OF SAN DIEGO v. STATE DEPARTMENT OF HEALTH CARE SERVICES**
Case Number: **S270326**
Lower Court Case Number: **C089555**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

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Title(s) of papers e-served:

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

5/12/2022

Date

/s/Kathryn Doi

Signature

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Last Name, First Name (PNum)

Hanson Bridgett LLP

Law Firm