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(3d Dist. Ct of Appeal No. C089555)

IN THE SUPREME COURT OF THE STATE OF CALIFONRIA

FAMILY HEALTH CENTERS OF SAN DIEGO,
PLAINTIFF AND APPELLANT
V.
STATE DEPARTMENT OF HEALTH CARE SERVICES,
DEFENDANT AND RESPONDENT

APPEAL FROM THE SUPERIOR COURT OF CALIFORNIA
SACRAMENTO COUNTY
NO. 34201880002953CUWMGDS
THE HON. STEVEN M. GEVERCER

APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE BRIEF* IN SUPPORT OF PLAINTIFF-APPELLANT; *AMICUS CURIAE* BRIEF OF THE CALIFORNIA PRIMARY CARE ASSOCIATION

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APPLICATION FOR PERMISSION TO FILE *AMICUS CURIAE* BRIEF AND STATEMENT OF INTEREST

Pursuant to Rule 8.520(f) of the California Rules of Court, the California Primary Care Association ("CPCA") respectfully requests permission to file the attached *amicus curiae* brief in support of Plaintiff-Appellant Family Health Centers of San Diego ("FHCSD").

CPCA is the federally designated Primary Care Association ("PCA") for California, representing more than 1,370 nonprofit community health centers and regional clinic associations that provide comprehensive health care services to the state's low-income, uninsured, and underserved residents. As the PCA for the State, CPCA is responsible for providing training, support, and technical assistance to all its member clinics, most of which are federally qualified health centers ("FQHCs").[1] CPCA's member clinics serve patient populations that are uninsured, on Medi-Cal, or otherwise vulnerable. Accordingly, CPCA's member clinics all rely heavily on compensation through the Medi-Cal Prospective Payment System ("PPS") for significant portions of their revenue.

Although CPCA generally avoids court-based advocacy on behalf of its members, the issues raised in this matter are

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[1] For convenience, this application and its accompanying brief uses the terms "federally qualified health centers" and "FQHCs" to refer to health centers that receive grant funding under section 330 of the Public Health Service Act ("PHSA"), or that are designated as FQHC look-alikes, entities that meet the same stringent requirements as PHSA grant recipients but do not have a PHSA grant.

immensely important not only to CPCA's members, but also to the one in five Californians currently served by FQHCs and the many other residents of this State who depend on FQHC outreach services to learn that they are eligible to receive care at FQHCs. CPCA seeks to submit the attached *amicus curiae* brief to assist this Court in its consideration of the critical role FQHC outreach services play in the delivery of healthcare in this State, and the complexities governing of FQHCs are reimbursed under Medi-Cal.

This application is timely. Under Rule 8.520(f) of the California Rules of Court, an application to file an *amicus curiae* brief is due within thirty days after all briefs that the parties may file have been filed. FHCSD filed its reply brief on April 12, 2022. CPCA is filing its application on May 12, 2022.

No party to this action has provided support in any form about the authorship, production, or filing of this brief. CPCA requests an order granting it leave to file an *amicus curiae* brief in this matter.

DATED: May 12, 2022.

Respectfully submitted,
DJR García, APC
By

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Association

SUMMARY OF THE ARGUMENT

The appellate court's decision to exclude costs associated with an FQHC's individualized outreach activities as allowable costs under Medi-Cal's PPS rate setting process creates incredibly harmful precedent, is contrary to well-established state public health and fiscal policies, and must be reversed.

CPCA believes the appellate court's decision is flawed from its premise to its conclusion because it is based on standards found in non-binding, interpretative guidance intended to regulate activities and providers that are inapposite to the activities of the Plaintiff-Appellant. By applying inapplicable standards to the question at hand, the appellate court ignored a more fundamental issue presented in the underlying case and inevitably came to the erroneous conclusion that an FQHC's federally mandated, individualized outreach efforts aimed at helping the most vulnerable people in the State are "akin to" advertising to the general public and therefore not reimbursable through the Medi-Cal PPS rate.

Given both the expansive reach and ambiguity of the appellate court's "akin to" standard, CPCA is deeply concerned that the appellate court's decision will have a dramatic chilling effect on FQHC outreach activities statewide, to the detriment of thousands of individuals living in designated underserved areas or communities and who do not know about, or otherwise do not have access to, affordable healthcare.

ARGUMENT

I. The appellate court decision overlooks state and federal law that requires Medi-Cal to cover 100 per cent of FQHCs' costs in providing primary care to Medi-Cal patients, including outreach activities designed to identify and enroll new Medi-Cal beneficiaries.

The appellate court, DHCS, and Plaintiff-Appellant have devoted considerable discussion to the question of whether costs associated with Plaintiff-Appellant's individualized outreach services are allowable reimbursable costs under specified provisions of the Medicare Provider Reimbursement Manual ("PRM"). CPCA will express its view on that issue in *Section II* of this brief. However, as the federally designated statewide association representing more than 1,370 FQHCs statewide, CPCA is more concerned with the lack of discussion regarding the State's obligation under both state and federal law to ensure that FQHCs are reimbursed through the Medi-Cal program for 100 percent of the costs of caring for Medi-Cal patients. (42 U.S.C. §1396a(bb)(4); Cal. Welf. & Inst. Code §§14132.100(i)(2)(B), 14132.100(i)(3)(C), (D); Cal. Dept. of Health Care Services, Medicaid State Plan, Attachment 4.19B, 6-11, pp. 6K-6L, Section J(3)(b).)

To be clear, FQHCs are tasked under federal law with providing primary health services to medically underserved populations. (42 U.S.C. §254b(a)(1).) As noted by the appellate court, in addition to "substantive" health care services, FQHCs are required to provide other services aimed at "increasing awareness of and utilization of the health center's resources." (*Family Health Ctrs. of San Diego v. State Dept. of Health Care*

Servs. (2021) 67 Cal.App.5th 356, 368; *see also* 42 U.S.C. §254b(b)(1)(A)(iv).) As a service that is essential to ensuring the provision of care to an FQHC's medically underserved patients (including Medi-Cal eligible patients) outreach is clearly a reasonable cost that must be compensated as part of the costs of providing primary care services to Medi-Cal patients.

The appellate court's decision largely ignores this issue. But DHCS maintains FQHC outreach costs are sufficiently covered through federal and state grants and assumes that these other moneys are intended to supplement or otherwise pay for entirely the costs of outreach efforts designed identify and enroll Medi-Cal patients. (Resp't-Appellee's Answer at 46.) Indeed, DHCS goes so far as to suggest, but offers no evidence to support, that FQHCs receive so much separate grant funding for outreach activities that requiring Medi-Cal to reimburse FQHCs for these activities would be "duplicative." (Resp't-Appellee's Answer at 11, fn. 4).

DHCS' position is belied by the record established at the administrative hearing, which makes clear that Plaintiff-Appellant designed its individualized outreach activities with the intent of identifying and enrolling Medi-Cal eligible patients into the Medi-Cal program. (Pet'r-Appellant's Reply at 9; Appellant's Appendix ("AA") 281:7-9; AA 321:2-8; AA 322:17-25). When FQHC outreach efforts are designed to identify and enroll Medi-Cal patients, these activities must become Medi-Cal allowable costs for purposes of PPS rate setting. To hold otherwise would require FQHCs to subsidize outreach efforts that ultimately

benefit Medi-Cal eligible patients with moneys designed for other purposes (namely, to benefit patients who are ineligible for the Medi-Cal program).

Such an outcome would not only be contradictory to state and federal law; it would illustrate the exact harm that Congress sought to prevent when it required states to reimburse FQHCs through their Medicaid programs at a rate that covers 100 percent of their costs in rendering primary care services to Medicaid patients. (H.R.Rep. No. 101-247, 1st. Sess., p. 393 (1989), reprinted in 1989 U.S. Code Cong. & Admin. News, p. 2119; *see also Tulare Pediatric Health Care Center v. State Department of Health Care Services* (2019) 41 Cal.App.5th 163, 168.) Congress made clear that DHCS cannot do what it suggested in its Answer Brief it wants to do; that is, look to other funding sources to subsidize the costs of care for an FQHC's Medi-Cal patients. (*Id.*)

II. **Medicare interpretative guidance governing hospital advertising costs should not be used to assess whether federally mandated, individualized FQHC outreach activities are allowable costs under the Medi-Cal PPS rate setting process.**

Because the appellate court avoided the question of whether state and federal law require FQHC outreach efforts directed at Medi-Cal eligible patients to be reimbursed through Medi-Cal's PPS rate setting process, the underlying case on appeal and related briefs focus entirely on whether the Plaintiff-Appellant's activities qualify as allowable advertising costs under Medicare's hospital PRM guidelines.

Without conceding that this is the appropriate framework to review DHCS' decision to disallow Plaintiff-Appellant's outreach costs, CPCA wishes to express its view for this Court's consideration on (1) whether PRM guidelines governing hospital advertising costs should apply to FQHC outreach activities generally; and (2) whether outreach activities directed at underserved individuals in an FQHC's catchment area constitute advertising to the general public.

a. *PRM Sections 2136.1 and 2136.2 do not apply to FQHC outreach activities.*

The PRM is, by its own description, a body of interpretative guidance written primarily for hospitals providing inpatient services. [2] It should be used to aid in the day-to-day application of extremely complex standards and principles of reimbursement under the Medicare program, and be applied with thoughtful and informed discretion on a case-by-case basis. Importantly, the PRM is not intended to serve as the basis for creating binding, unyielding rules of law.[3]

And, while the PRM and other bodies of Medicare guidance are often looked to by both regulators and courts to aid in matters outside the context of hospital inpatient services and even beyond

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[2] The Forward to the PRM states, "[t]he provisions of the law and the regulations are accurately reflected in this manual, b**ut it does not have the effect of regulations**. . . . **The rulings do not have the force and effect of a statute or regulations, but provide illustrative case material useful in interpreting and applying policies and procedures contained in instructional issuances."** Emphasis added.

[3] *Id*.

just the Medicare program, the PRM is by no means considered binding on or universally applicable to FQHCs.[4] CPCA notes with substantial concern the lack of discussion on this point in the parties' briefs and in the appellate court's decision.

While CPCA does not dispute that those federal regulations commonly referred to as Part 413[5] are incorporated into state law and apply to FQHC Medi-Cal reimbursement rules under Section 14132.100(e)(1) and (i)(2)(B)(ii) of the California Welfare and Institutions Code, CPCA is not aware of any case law or state or federal statute or regulation compelling the application of the PRM on Medi-Cal reimbursement rules applicable to FQHCs. As will be explained below, just because the PRM is intended to aid in the interpretation of Medicare regulations generally, it does not necessarily follow that the PRM is well-suited or even appropriate to aid in the interpretation of federal regulations as they are applied to unique provider types like FQHCs.

For example, state law requires DHCS to evaluate PPS rate changes based on change in scope of service requests in alignment with Part 413. (Cal. Welf. & Inst. Code §§ 14132.100(e)(1) and (i)(2)(B)(ii)). Neither state nor federal law, however, requires DHCS to adhere to the PRM in interpreting Part 413 as part of its evaluation. In the underlying case

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[4] *Tulare Pediatric Health Care Ctr. v. State Dept of Health Care Servs.*, 41 Cal. App. 5th 163, 175, 253 Cal. Rptr. 3d 895, 904 (2019), rejecting the State's application of Medicare guidelines in the PRM to an FQHC because the PRM provisions governed how costs are determined for hospital inpatient services, not FQHCs.
[5] See Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations.

between the parties, DHCS *elected* to rely on the PRM when determining allowable costs "since the PRM is the federal Secretary of Health and Human Services' own interpretation of [Part 413] and . . . clearly applies to this matter." (Pet'r-Appellant's Opening Brief at 13, fn. 7).

CPCA disagrees. Unless incorporation of the PRM is mandated by law (and with respect to the question raised in the immediate case, it is not), the indiscriminate and automatic application of the PRM to any and every provider type or Medi-Cal reimbursement question is not appropriate. And for providers like FQHCs, which are subject to complex federal payment structures and are uniquely mandated to seek out and aid patients in underserved areas and populations, the presumptive application of PRM guidelines to PPS rate setting questions seems particularly misguided.

By way of illustration, in the instant case both DHCS and, by implication, the appellate court, seem to naturally assume that PRM Sections 2136.1 and 2136.2 ("PRM Sections") were appropriate for assessing the allowability of Plaintiff-Appellant's outreach activity costs. But these PRM Sections are intended to identify examples of when Medicare dollars can be used to reimburse hospitals for costs associated with various types of advertising activities. To the extent hospital advertising activities are not directly or indirectly related to patient care, the PRM generally states that such costs are not allowable. (*See* PRM §§ 2102.2 and 2012.3.) More specifically, if a provider's costs in "advertising to the general public seeks to increase

patient utilization of the provider's facilities, those costs are not allowable" under PRM Section 2136.2. (*Family Health Ctrs. of San Diego v. State Dept. of Health Care Servs*. (2021) 67 Cal.App.5th 356, 368.)

CPCA does not believe these PRM Sections are appropriate to assess costs associated with FQHC outreach efforts. Hospital advertising to the general public is motivated by the desire to increase an entity's market share. (*See* Davis & Connolly, *San Francisco Bay Area: Regional Health Systems Vie for Market Share*, California Health Care Almanac, California Health Care Foundation, April 2021, p. 5; Finnochio & Paci, *Sacramento Area: Large Health Systems Grow in a Pricey and Tumultuous Market*, California Health Care Almanac, California Health Care Foundation, April 2021, p. 1; Davis & Connolly, *San Diego: Competing, Collaborating, and Forging Ahead with Population Health*, California Health Care Almanac, California Health Care Foundation, April 2021, pp. 5-6.) In California, where hospital market share is divided by an increasingly small number of large national corporate entities competing against each to retain the same healthcare providers and to treat the same patients,[6] this motivation weighs heavily in favor of the benefiting the bottom line of the entity that owns the hospital - not patient care.

But this type of self-interested motivation does not apply to FQHCs engaged in federally mandated outreach services. By virtue of their certification as an FQHC, they are already located

[6] Gudiksen, Gu, & King, *Markets or Monopolies? Considerations for Addressing Health Care Consolidation in California,* California Health Care Foundation, December 2021, p. 1.

in a designated underserved area or serving a medically underserved population and charged with seeking out and identifying underserved individuals in need of care. (42 U.S.C. §§254b(a)(1), 254b(k)(3)(G)(iii)(I).) Further, FQHCs are required under their Public Health Service Act ("PHSA") grants to establish and maintain collaborative relationships with other health care providers in their catchment areas to better meet the needs of their shared underserved patient populations. (42 U.S.C. §254b(k)(3)(B).) Indeed, FQHCs are required to assess the *unmet* need for health services in their designated area or population – not to divert patients away from care they are receiving elsewhere. (42 U.S.C. §254b(k)(2)(A)).

As the appellate court's decision erroneously ratifies DHCS' application of these inapplicable PRM Sections whenever it assesses FQHC costs associated with outreach activities, this Court should reverse the appellate court's decision and remand to DHCS to reassess Plaintiff-Appellant's change of scope of service request without relying on the aforementioned PRM Sections.

b. *Even if Section 2136.2 does apply to FQHC outreach activities, the appellate court's "akin to" standard constitutes a troubling expansion of this standard and should be revised.*

Notwithstanding the above and assuming, *arguendo*, it was appropriate for DHCS to look to the PRM Sections for guidance concerning allowable FQHC outreach costs, the appellate court still erred in concluding that Plaintiff-Appellant's individualized outreach efforts were not related to patient care and were "akin to" advertising to the general public under Section 2136.2.

Under the PRM Section 2136.1, hospital advertising costs are considered allowable "if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care." Examples of allowable advertising costs include advertising that provides visiting hours information; information on the conduct of management-employee relations; information that apprises other physicians, hospitals, and related professional institutions or organizations of the availability of a provider's covered services; and informational listings in a telephone directory consistent with accepted industry practice. (PRM §2136.1.) By contrast, unallowable advertising costs, which are described in Section 2136.2, include "costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities."

The appellate court struggled to fit Plaintiff-Appellant's federally mandated outreach activities into the description found in Section 2136.2, which resulted in the court's creation of a new and overly broad "akin to" standard. (*Family Health Ctrs. Of San Diego v. State Dept. of Health Care Servs.* (2021) 67 Cal.App.5th 356, 369.) This standard, if allowed to stand, *broadens* the PRM's definition of unallowable advertising costs because it includes not just the activities described in Section 2136.2, but also activities that are similar enough (in the subjective eyes of whoever is making the assessment) to what is described in Section 2136.2 to somehow warrant inclusion.

As demonstrated amply in both parties' briefs, the appellate court's "akin to" standard incorporates a new flexibility into

Medicare's allowable advertising cost guidance - the limits of which are not defined. This expansive new standard injects uncertainty into the FQHC cost reimbursement, rate establishment, and audit processes, making it difficult for either DHCS or FQHCs to know or reasonably guess what activities might be considered akin to advertising and subject to the PRM's allowable advertising cost policies.

In addition to the lack of clarity regarding the scope of the appellate court's standard itself, the nature of supporting documentation required to show an allowable advertising cost is also uncertain. Plaintiff-Appellant provided extensive support to describe and explain the outreach activities its workers undertook. (AA 321:2-8, AA 1153, AA 323: 1-11, AA 321:22-23; *see also* hearing exhibit Z, FHCSD's outreach worker training manual.) DHCS' Answer Brief dismisses this supporting evidence, claiming instead that Plaintiff-Appellant "offered minimal evidence regarding the content and context of the outreach communications themselves." (Resp't-Appellee's Answer at 11.)

DHCS appears to take the position that every individual outreach communication must be documented and supported to justify reimbursement of the costs of outreach workers and outreach services. The individualized strategies and one-on-one approaches undertaken by Plaintiff-Appellant's outreach workers, as described by Plaintiff-Appellant's chief executive officer Fran Butler-Cohen, as well as the volume of potential

patient interactions undertaken, plainly show this supporting evidence requirement to be utterly infeasible.

To supply line-by-line support showing the content and context of every individual outreach communication would amount to a requirement that each outreach worker's workday be essentially memorialized in detailed minutes. Requiring such documentation not only would create an immense, new recordkeeping obligation, but would also raise privacy concerns given the individualized nature of the outreach workers' conversations with potential patients as well as the potentially sensitive medical subject matter of those conversations.

CPCA is very concerned that imposing an ambiguous new standard with unclear supporting documentation requirements on FQHCs will create a chilling effect on FQHC outreach efforts across the state. The importance of providing clear regulatory guidance and standards is well documented and indisputable. (*Kisor v. Wilkie* (2019) 139 S. Ct. 2400, 2413-2414.) There is immeasurable value in providing enough clarity in law to ensure consistent regulatory enforcement and predictability for the regulated community. (*U.S. v. Zhi Yong Guo* (9th Cir. 2011) 634 F.3d 1119, 1122-1124.) Without clear documentation requirements and standards for what constitutes compensable costs associated with outreach services (and what does not), FQHCs take a risk every time they engage in mandated outreach activities – even those directed at potential Medi-Cal eligible individuals.

III. **The appellate court's decision will chill effective FQHC outreach efforts, which are essential to support and**

advance the State's fiscal and public health policy objectives.

Beyond it being federally required (as discussed in *Section I*) – there are several compelling policy reasons why Medi-Cal should compensate FQHCs for effective outreach activities through the PPS rate setting process.

CPCA is troubled that, in its answer brief, DHCS suggests that while the individualized communication strategies employed by Plaintiff-Appellant were not allowable costs for PPS rate setting, costs associated with maintaining a website with information about an FQHC's services or posting a flyer on a homeless shelter bulletin board would be considered reimbursable outreach. (Resp't-Appellee's Answer at 39.) These suggestions ignore the diverse needs and economic challenges that many individuals in FQHC catchment areas face.

Indeed, in making these suggestions, DHCS presumes that all individuals in an FQHC's catchment area will have the same level of internet access, have a common base level of language and reading competency, and have access to homeless shelter resources. But even a cursory understanding of what FQHCs do and the patients they serve would reveal that these presumptions are not realistic.

FQHCs are required to provide primary health services to medically underserved populations, which includes migratory and seasonal agricultural workers, the homeless, and residents of public housing. FQHCs' patients are made up of diverse populations from different cultural backgrounds, who often reside in different areas with unique access and transportation

challenges and have very different life circumstances. (42 U.S.C. §254b(a)(1).) The majority of the 7.2 million patients served by California's FQHCs are poor, with 52 percent having income levels below the federal poverty level. (CPCA, *Community Health Centers 2021 State Profile* (2021), p. 2.) Thirty-one percent have limited English proficiency, and eighty-one percent identify as non-white. (*Id*. at 1.) And FQHC patients often have barriers to access related to living situations; FQHCs served 329,680 patients experiencing homelessness and 844,324 agricultural workers. (*Id*.)

Truly *effective* FQHC outreach strategies, therefore, must be innovative, creative, and individualized - just like those utilized by the Plaintiff-Appellant, and just like those that are now at risk of going unfunded because of the ambiguous and expansive new "akin to" standard established by the appellate court.

The importance of effective outreach is indisputable. Healthcare providers and policy makers nationwide recognize that outreach services improve patient use of primary and preventive care, while preventive care helps manage and avoid larger, costlier medical interventions. (Yue D., et al. *Enabling Services Improve Access to Care, Preventive Services, and Satisfaction Among Health Center Patients*, Health Affairs, 2019;38(9) <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05228>; Starfield B., Shi L., Macinko J. *Contribution of primary care to health systems and health*, Milbank Q, 2005;83(3):457–502 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/>.)

Preventive care has been shown to be able to avert more than two million deaths annually in the United States. (Maciosek, M., et al. *Greater Use of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost*, Health Affairs, 2010;29(9) < https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0701>.) Outreach efforts are a critical first step in getting hard-to-reach, vulnerable populations connected with primary and preventive care that can improve health outcomes and reduce healthcare costs down the line.

And with respect to keeping healthcare costs down, CPCA is compelled to point out that nearly two-thirds of all FQHC patients in California are Medi-Cal patients. (Newman, M. & Paci, J., *2021 Edition—California's Health Care Safety Net*, California Health Care Foundation, https://www.chcf.org/publication/2021-edition-californias-health-care-safety-net/ .) Medi-Cal provides coverage to approximately one-third of all Californians, making FQHCs the primary care provider for approximately 20 percent of all California residents. (*Medi-Cal Eligibility*, DHCS < https://www.dhcs.ca.gov/dataandstats/Pages/Medi-Cal-Eligibility-Statistics.aspx> (as of May 6, 2022).) And despite caring for 30 percent of all Medi-Cal patients, Medi-Cal expenditures on FQHC services make up a disproportionately small 2.8 percent of the total Medi-Cal budget. (CPCA, *All California District Profiles* (2017), p. 1.) In fact, the preventive care provided by FQHCs costs Medi-Cal 22 percent *less* than other provider types. (*Id.*) Thus, by supporting FQHC outreach activities through the Medi-

Cal PPS rate setting process, the State can not only improve health outcomes for California's medically underserved but can also save the Medi-Cal program money through ensuring patients know about and have access to less-costly preventive and primary care.

CONCLUSION

By establishing an ambiguous and precedential standard with unclear supporting documentation requirements, the appellate court decision would bring life-and-cost-saving FQHC outreach services to a chilling halt. The appellate court's decision would require an FQHC's costs in performing federally mandated outreach services to be reviewed by DHCS under the Medicare PRM's interpretive, non-binding, and inapplicable guidance for hospital allowable advertising costs. This requirement, in addition to being ill-fitting for benevolent outreach activities, misses the more critical point that federal law simply requires all Medicaid programs, like Medi-Cal, to reimburse FQHCs for 100 percent of their costs in providing primary health care services to Medi-Cal patients. Finally, in addition to the clear congressional mandate to cover outreach costs, there are significant public health and fiscal policy interests advanced by reimbursing FQHCs through the PPS rate for costs associated with outreach activities. For these reasons, CPCA respectfully requests this Court to reverse the decision of the appellate court.

DATED: May 12, 2022

Respectfully submitted,

DJR García, APC

By:
/s/Deborah J. Rotenberg
Deborah J. Rotenberg
Attorneys for Amicus Curiae
California Primary Care Association

CERTIFICATE OF COMPLIANCE PURSUANT TO CAL. R. CT. 8.204 AND 8.520

Pursuant to California Rules of Court 8.204 and 8.520(b), (c), and (h), and in reliance on the word count feature of the software used to prepare this document, I certify that the foregoing Amicus Curiae Brief (excluding cover page, tables, application, proof of service, certificate of compliance, and signature blocks) of the California Primary Care Association contains 3,698 words, exclusive of those materials not required to be counted under Rule 8.520(c)(3). The typeface is Century Schoolbook, 13 points.

DATED: May 12, 2022

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/s/Deborah J. Rotenberg
Deborah J. Rotenberg

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California Court of Appeal, Third District

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

Dated: May 12, 2022 By: /s/Mallory S. Petterelli____
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/s/Deborah Rotenberg
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