S274927

IN THE SUPREME COURT OF CALIFORNIA

COUNTY OF SANTA CLARA,
Petitioner,

v.

THE SUPERIOR COURT OF SANTA CLARA COUNTY,
Respondent,

DOCTORS MEDICAL CENTER OF MODESTO et al.,
Real Parties in Interest.

Sixth Appellate District
H048486

Application to File Amicus Curiae Brief; Brief of Amici Curiae San Jose Healthcare System, L.P., and Good Samaritan Hospital, L.P., in Support of Real Parties in Interest

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To the Honorable Patricia Guerrero, Chief Justice of California:

San Jose Healthcare System, L.P., which does business as Regional Medical Center of San Jose, and Good Samaritan Hospital, L.P., which does business as Good Samaritan Hospital (together, the San Jose Hospitals) respectfully apply to file as amici curiae the brief that follows, in support of real parties in interest (the plaintiff Hospitals).

The San Jose Hospitals are award-winning general acute care hospitals located in San Jose, the largest city in Santa Clara County (the defendant). But the County has not included either of them in its network of contracted providers of emergency services for patients enrolled in the County's Valley Health Plan. Nevertheless, the San Jose Hospitals still provide care to plan enrollees who present in need of emergency services, in keeping with their mission and what the law requires.

Like the plaintiff Hospitals, the San Jose Hospitals have an action pending against the County, doing business as Valley Health Plan, to obtain reimbursement required by Health and Safety Code section 1371.4 for out-of-network emergency services provided to plan enrollees who present to their emergency departments. (See *Regional Medical Center of San Jose et al. v. County of Santa Clara d/b/a Valley Health Plan* (Super. Ct., County of Santa Clara, No. 20CV374597).)

Citing the Court of Appeal's decision on review here, the trial court sustained without leave to amend the County's demurrer to the San Jose Hospitals' second amended complaint. (*Id.*, order filed Aug. 22, 2022; judgment filed Oct. 18, 2022.) The San Jose Hospitals

have appealed to the Court of Appeal for the Sixth Appellate District (H050891).

Unlike the plaintiff Hospitals—who are outside the County, and have claims here involving just three patients, and unpaid amounts totaling $115,500—the San Jose Hospitals are located in the largest city in the County, and have, over several years, received **thousands** of emergency visits from out-of-network patients enrolled in the County's commercial health plan, whose underpayments to date (including non-payments) **exceed $95,000,000**, and continue to grow.

Thus, the San Jose Hospitals are vitally interested in this case. Their own experiences with the County illustrate the disincentive for a publicly owned commercial health plan to include local hospitals in its contractual network, knowing they will render emergency and post-stabilization services regardless, when the public plan believes it can get away with paying whatever it likes—or pay nothing at all. Providing emergency care to all in need is not just a legal obligation; the San Jose Hospitals are committed to the care and improvement of human life.

Under heading B.1, we address the direct statutory exception to any immunity (even assuming Government Code section 815 would otherwise apply): Specifically, there is a direct right of action based on the liability for payment to providers that is imposed on health plans by Health and Safety Code section 1371.4, and Health and Safety Code section 1399.5 assures that public health plans are subject to such actions.

The action by the San Jose Hospitals also seeks statutorily required payment for post-stabilization services—involving **more than a thousand** claims for patients enrolled in the County's health plan, and

underpayments that exceed **another $175,000,000**. The action also involves zero pays by the County. The Court of Appeal's decision on review here did not address payments required for post-stabilization services—or zero pays—but the trial court nevertheless relied on the decision to dismiss claims for post-stabilization services and zero pays too. We address such claims under heading C.

The San Jose Hospitals are familiar with this case and are confident their briefing will be helpful to the Court.

March 3, 2023

Respectfully,

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BRIEF OF AMICI CURIAE
San Jose Healthcare System, L.P.,
and
Good Samaritan Hospital, L.P.

San Jose Healthcare System, L.P., doing business as Regional Medical Center of San Jose, and Good Samaritan Hospital, L.P., doing business as Good Samaritan Hospital (together, the San Jose Hospitals) support the points briefed by the real parties in interest (the plaintiff Hospitals) and ask the Court to consider also the points that follow.

A. Uneven treatment of public and private healthcare service plans operating in the commercial marketplace conflicts with the Legislature's statutory mandate and threatens to destabilize the healthcare system

The County must operate its plan according to the rules that govern Knox–Keene health plans—public and private alike—because the County voluntarily chose to operate a licensed Knox–Keene health plan.

The Legislature did not intend to upset merit-based competition in the market for health plans by giving publicly owned healthcare service plans (health plans/HMOs) an unearned competitive advantage of exemption from the rules applicable to all health plans. On the contrary, just like any other health plan, a public entity that wants to operate a commercial health plan in the marketplace must apply for a license to operate the health plan under the Knox–Keene Health Care Service Plan Act of 1975 (the Knox–Keene Act). (See Health & Saf. Code, §§ 1340–1399.847; *id.*, § 1340 [identifying div. 2, ch. 2.2 as Knox–Keene Act]; *id.*, § 1351 [licensing].)

When so licensed, the public plan is expressly subject to the provisions of the Knox–Keene Act—which apply even-handedly, across

the board, to both private and public plans. (Health & Saf. Code, § 1399.5.) As stated in the act:

> It is the intent of the Legislature that *the provisions of this chapter shall be applicable to any private or public entity or political subdivision* which, in return for a prepaid or periodic charge paid by or on behalf of a subscriber or enrollee, provides, administers or otherwise arranges for the provision of health care services, as defined in this chapter, *unless* such entity is *exempted from* the provisions of *this chapter* by, or pursuant to, Section 1343.

(*Id.*, § 1399.5, emphasis added.)

This provision is not undermined by an irrelevant provision for public entity and employee immunity, cited by the County, which is not located in the Knox–Keene Act, does not apply to the County, and relates to Medi-Cal. The County cites Welfare and Institutions Code section 14087.38, which simply applies the Government Claims Act to a "health authority" created—unlike the County's plan here—as "an entity *separate from* the county," with its own governing board, to support delivery of publicly assisted medical care for Medi-Cal beneficiaries. (Compare ABOM pp. 21, 58 with Welf. & Inst. Code, § 14087.38, subd. (a), (b), (c), (i), (j), (t) emphasis added.) Still, such a health authority is to obtain licensure under the Knox–Keene Act, and the statute expressly provides: "nor shall anything in this section be construed to reduce or otherwise limit the obligation of a health authority licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder." (Welf. & Inst. Code, § 14087.38, subd. (s), (t)(9).)

Section 1399.5 shows that the Legislature intended all health plans, whether privately or publicly owned, to operate on a level playing field. But the Court of Appeal did not appreciate the significance of this legislative directive. In fact, when quoting section 1399.5, the court's opinion cut off the last clause, which confines the ability of public plans to be exempted. (*County of Santa Clara v. Superior Court* (2022) 77 Cal.App.5th 1018, 1031 (*Santa Clara*); cf. Health & Saf. Code, § 1399.5 ["unless … exempted … by, or pursuant to, Section 1343"].)

Here, the County voluntarily operates a licensed Knox–Keene Act health plan, and it does not even argue that any of the inapplicable exemptions stated in section 1343 would apply.

The Court of Appeal's *Santa Clara* decision upends the level playing field established by section 1399.5 and disrupts the Knox–Keene Act's funding structure for emergency-medical services. A central element of the funding structure is that: "A health care service plan … shall reimburse providers for emergency services and care provided to its enrollees …." (Health & Saf. Code, § 1371.4, subd. (b).) As confirmed by this Court in *Prospect*, the reliable delivery of emergency services throughout the State requires that a number of interconnected elements mesh together. (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 504–508 (*Prospect*).) Among these: When a patient enrolled as a member of a health plan receives emergency care from noncontracting, out-of-network providers, the health plan must reimburse the providers the "reasonable and customary value" of the emergency services rendered; providers, in turn, may not bill the patient–member for the balance of any amount billed to but unpaid by the health plan; and payment disputes between a provider and the plan are to be decided by the trier of fact in court. (*Ibid.*

[no "balance billing"]; Health & Saf. Code, § 1371.4; Cal. Code Regs, title 28, § 1300.71, subd. (a)(3)(B).)

The Court of Appeal, however, would let publicly owned commercial health plans unilaterally decide to underpay, or not pay at all, for emergency services, by exempting them from reimbursement lawsuits by providers. Case law broadly recognizes that the Knox–Keene Act permits emergency providers to sue California-licensed health plans directly over billing disputes. (*Prospect*, *supra*, 45 Cal.4th at p. 506.) This Court and the Department of Managed Health Care (DMHC) also have recognized that: " ' "[D]enying emergency providers judicial recourse to challenge the fairness of a health plan's reimbursement determination[] allows a health plan to **systematically underpay** California's safety-net providers …." ' " (*Id.* at p. 508, emphasis added [quoting DMHC brief quoted in *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 218 (*Bell*)].) Dismantling the judicial recourse that providers have against publicly owned health plans, as the Court of Appeal would do here—letting public plans pay whatever they want, whether 100%, 50%, 10%, or just $1—is unlawful and unsound.

Because health plans licensed by DMHC under the Knox–Keene Act are the dominant form of healthcare coverage in California, rules applicable to those plans often have the most significant impact.[1] For hospital emergency services, the ability of providers to assure adequate reimbursement by health plans is particularly important. Providers must

[1] See DMHC Enrollment Summary Report – 2021, available at: https://www.dmhc.ca.gov/DataResearch/FinancialSummaryData.aspx [as of Feb. 15, 2023] compare Health Insurance Covered Lives Report, available at: http://www.insurance.ca.gov/01-consumers/110-health/coveredlivesrpt.cfm [as of Feb. 15, 2023].

render emergency services without questioning whether the patient can pay or is a member of an in-network versus out-of-network health plan. (See *Prospect*, *supra*, 45 Cal.4th at p. 504.) And California law confirms that they can pursue adequate compensation in the courts from the out-of-network health plans. (See *id.* at p. 506.)

But the Court of Appeal's decision would immunize an entire class of Knox–Keene licensed health plans—those owned by public entities—from judicial accountability, inviting those plans " ' "to systematically underpay California's safety-net providers …." ' " (*Prospect*, *supra*, 45 Cal.4th at p. 508.) Immunity from judicial accountability would be an "unjust windfall," as this Court and DMHC have warned. (*Ibid.*) "'"If providers are precluded from bringing private causes of action to challenge health plans' reimbursement determinations, health plans may receive an unjust windfall …."'" (*Ibid.* [quoting DMHC brief quoted in *Bell*, *supra*, 131 Cal.App.4th at p. 218].) The Legislature did not grant publicly owned health plans any such windfall.

The Court of Appeal's decision would confer a significant *unearned improper competitive advantage* on publicly owned plans—through an exemption not set forth in the Knox–Keene Act—and directly in conflict with the specific provisions set forth in Health and Safety Code section 1399.5. If not corrected, the problem of underpayments and non-payments in the commercial marketplaces where the County operates will grow, endangering the emergency services delivery system.

Under the Knox–Keene Act, a health plan "undertakes to arrange for the provision of health care services to … enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the … enrollees."

(Health & Saf. Code, § 1345, subd. (f)(1).) A "Plan contract" with an enrollee includes provision of "basic health care services," which includes "Emergency health care services[.]" (*Id.*, § 1345, subds. (b)(5) & (r).) A plan must maintain an adequate network of employed or contracted healthcare providers to assure timely care. (See *id.*, § 1367.03.)

But allowing public commercial health plans to dictate what they pay—and won't pay—to out-of-network providers creates strong *disincentives* for them to develop and maintain adequate networks of directly contracted emergency-medical facilities and professionals.

- The Court of Appeal's decision encourages public health plans to shift onto noncontracted, out-of-network emergency-room providers, the financial burden that these plans agreed to assume for emergency services—by underpaying at unilaterally set low rates that cannot be challenged.
- In San Jose, for example, the largest city in its service area, the County has not entered into network contracts with the San Jose Hospitals, despite the fact that over several years, they have received **thousands** of emergency visits from out-of-network patients enrolled in the County's commercial health plan, whose underpayments to date (including non-payments) **exceed $95,000,000** and continue to grow.

The decision also encourages public health plans to underfund non-emergency care, contracting with too few in-network hospitals and doctors, thus impeding enrolled patients from using scheduled services, driving enrollees to overuse emergency-room services. For example,

patients facing delays in scheduling appointments for treatment or even preventative care may resort to emergency care to get in to see a doctor.

Unchecked underpayments by licensed health plans owned by public entities would significantly deplete the financial resources for emergency-services providers in California. This is especially so in localities where publicly owned health plans, like the one in this case, are dominant or ascending. Systematic underpayment by these commercial health plans would undercut the financial viability of emergency-services providers, could drive emergency providers to other endeavors or practice areas, and would impede the ability of hospitals to maintain and expand their emergency-room care to meet the demand. In general, weaker hospitals will go out of business—as just occurred with Madera Community Hospital. (See Madera County posting at https://www.maderacounty.com/government/public-health/providers-health-orders/mch-closing [as of Feb. 17, 2023].)

The continuing availability of unreimbursed and under-reimbursed emergency services cannot be assumed. Not all hospitals have emergency rooms. 2021 statistics indicate about 72% (322) of California's then 447 (now 445 after two recent closures) licensed general acute care hospitals had emergency departments.[2] The flip side

[2] See Cal. Health & Human Services Agency, "2021 Hospital Emergency Department - Characteristics by Facility" (Excel file, "Data" & "Pivot" tabs) at: https://data.chhs.ca.gov/dataset/hospital-emergency-department-characteristics-by-facility-pivot-profile/resource/2ed730f2-0dcd-4d4e-9503-422d704ed969 [as of Feb. 15, 2023]. Compare Cal. Health & Human Services Agency, "Licensed Healthcare Facility Listing" current or Dec. 31, 2021 (Excel file, see col. O, sort A to Z, list of general acute care hospital licensees) https://data.chhs.ca.gov/dataset/licensed-healthcare-facility-listing [as of Feb. 15, 2023].

is that 28% did *not* have emergency departments—and history shows some hospitals will close their emergency rooms.

California hospitals are already under tremendous financial strain and face painful choices about where they must make cuts to continue to remain viable. (See Carmela Coyle, "Hospitals' Financial Peril Deepens" (California Hospital Association, June 2, 2022) https://calhospital.org/hospitals-financial-peril-deepens/ [referencing Kaufman Hall national report and noting pressures in California to complete more than $100 billion in seismic upgrades in little more than seven years and significantly reduce the rate of health care cost growth into the future].)

The availability of emergency services to Californians should not be undermined. But *Santa Clara* does exactly that by allowing publicly owned health plans to systematically underpay out-of-network providers for emergency services.

B. As a Knox-Keene Act licensed health plan, the County is not immune under the Government Claims Act from an action seeking reimbursement for emergency services provided to persons covered by the County's health plan

As shown in the briefs by the plaintiff Hospitals, Government Code section 815 does not immunize the County from an action seeking the amount owed by the County as a Knox–Keene Act health plan to a provider of emergency services and care rendered to patients enrolled in the County's health plan. Regardless of whether the action is deemed one for "money or damages" (see Gov. Code, § 814), it does *not* seek *tort* damages. The action does not concern an "injury" to the provider (cf. Gov. Code, § 815 ["not liable for an injury"]); it simply seeks to recover the amount owed.

As this Court explained with reference to immunity under Government Code section 860.2, the Government Claims Act is concerned with limiting governmental liability for an "injury"—within "the narrow meaning" of "injury" in Government Code section 810.8. (*City of Dinuba v. County of Tulare* (2007) 41 Cal.4th 859, 867 (*City of Dinuba*) ["defined in section 810.8 as 'death, injury to a person, damage to or loss of property, or any other injury that a person may suffer to his person, reputation, character, feelings or estate, of such nature that it would be actionable if inflicted by a private person' "].) Failure to pay the reimbursement due under Health and Safety Code section 1371.4 does not concern an "injury" for which immunity is provided.

Moreover, the County *voluntarily* undertook its obligation to pay providers, when it created its health plan under the Knox–Keene Act and enrolled patients—obligating itself to pay out-of-network providers whenever its enrolled patients obtain emergency services from those providers. (Health & Saf. Code, §§ 1345, subds. (b)(5) & (r) ["Plan contract" includes provision of "basic health care services," which include "Emergency health care services"], 1371.4 [requiring reimbursement].) An action to obtain proper reimbursement from a health plan for emergency services is not in the nature of a tort action for "injury" for which Government Code section 815 generally provides immunity to public entities.

Further, even where Government Code section 815 potentially applies otherwise, the immunity it can afford is restricted by its opening provision: "Except as otherwise provided by statute: …." Even if section 815 would otherwise apply, there are at least two important exceptions:

- While not developed by the plaintiff Hospitals, we first address what we consider the most direct statutory exception: the direct right of action based on the liability for payment to providers that is imposed on health plans by Health and Safety Code section 1371.4, which Health and Safety Code section 1399.5 assures is applicable to public health plans.

- Next, we review the right of action that exists pursuant to Government Code section 815.6 because of a mandatory duty: Under section 1371.4, any health plan, public or private, has a mandatory duty to reimburse providers for emergency services at the reasonable and customary value—a fact to be decided by the trier of fact—not by an exercise of discretion.

1. Section 1371.4 requires health plans to pay providers of emergency services, giving providers a private right of action against health plans—and section 1399.5 assures that public entity health plans are subject to such actions

By statute: "**A health care service plan** … **shall reimburse providers** for emergency services and care provided to its enrollees …." (Health & Saf. Code, § 1371.4, subd. (b), emphasis added; see *id.*, subd. (c) [exception—to deny "[p]ayment for emergency services and care"—where emergency services and care never performed].) Section 1371.4 thereby confers on the providers a private right of action against the health plan to recover the reimbursement owed.

A statute that entitles one party to payment by another confers on the party entitled to receive payment a private right of action against the party obligated to make the payment. (*Goehring v. Chapman University* (2004) 121 Cal.App.4th 353, 377–378 (*Goehring*).) In *Goehring*, a law school unsuccessfully argued that Business and Professions Code

section 6061 did not give students a private right of action against a law school that, having failed to make certain disclosures, failed to make refunds owed to students. Unlike other cases where a statute "did not expressly entitle individuals to a refund or any other type of payment," the court held that because "the Legislature unquestionably intended to bestow students or former students with individual monetary claims, it must have intended to give them private rights of action to pursue such claims." (*Ibid.*) Thus, "section 6061's refund language explicitly denotes a private right of action." (*Id.* at p. 378; see also Civ. Code, § 1428 ["An obligation arising from operation of law may be enforced in the manner provided by law, or by civil action or proceeding"].)

This Court endorsed *Goehring*'s analysis, and distinguished it, in *Lu v. Hawaiian Gardens Casino, Inc.* (2010) 50 Cal.4th 592, 603, fn. 8 (*Lu*), which involved a mere property right. Citing *Goehring*'s holding, this Court confirmed: "[Bus. & Prof.Code, § 6061's 'refund language explicitly denotes a private right of action'][.]" (*Ibid.*) And this Court underscored the payment obligation in section 6061 by citing it directly: "['If any school does not comply with these requirements, it *shall make a full refund of all fees paid by students* ' (italics added)]." (*Ibid.*) Distinguishing the statute before it, this Court explained that a mere property right was different: "In the present case, there is no such language 'expressly entitl[ing] individuals to a refund or any other type of payment for violation of the statute.' " (*Ibid.* [citing *Goehring*, *supra*, 121 Cal.App.4th at p. 377].) In *Lu*, this Court held that Labor Code section 351—declaring gratuities "to be the sole property of the employee or employees to whom it was paid, given, or left for"—did not give employees a private right of action against an employer regarding a tip-pooling arrangement. (*Id.* at pp. 595, 597–598.)

Lu is distinguishable here—for the same reason that *Lu* distinguished *Goehring*—because here, section 1371.4 obligates the health plan to pay the providers for emergency services. (See *Lu*, *supra*, 50 Cal.4th at 603, fn. 8.)

The County cites generic language in *Lu* that "when neither the language nor the history of a statute indicates an intent to create a new private right to sue," such a right is not likely to be found. (*Id.* at p. 601; ABOM p. 53.) But the County ignores *Lu*'s specific discussion of *Goehring*, that a statute imposing a payment obligation shows an intent to create a private right of action.

The obligation imposed on a health plan to pay for emergency services confers on the provider a private right of action against the health plan. By operating a health plan licensed under the Knox–Keene Act, the County voluntarily subjected itself to an action for reimbursement under Section 1371.4, which is contained within the Knox–Keene Act. (Health & Saf. Code, §§ 1340–1399.847; *id.*, § 1340 [identifying div. 2, ch. 2.2].) And as quoted above under heading A, the Legislature mandated that the provisions of the Knox–Keene Act apply to every health plan under the act, including those operated by any public entity or political subdivision—which includes the County. (Health & Saf. Code, § 1399.5.)

Subjecting the County to suit under section 1371.4 also accords with the statement the County cites (in part) from this Court's earlier decision in *Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.4th 1175: "In other words, direct tort liability of public entities must be based on a specific statute declaring them to be liable, or at least creating some specific duty of care, and not on the general tort provisions of Civil Code section 1714." (*Id.* at p. 1183 ["Otherwise, the

general rule of immunity for public entities would be largely eroded by the routine application of general tort principles"]; see Civ. Code, § 1714 ["want of ordinary care"]; ABOM pp. 36, 52–53 [citing *Eastburn*].) Here, section 1371.4 specifically provides that health plans are liable to pay providers. Actions to assure performance of that specific statutory obligation under the Knox–Keene Act *do not* risk erosion of the general immunity rule by "the routine application of general tort principles." Indeed, the Hospitals are not relying on tort theories at all.

Thus, even if immunity under Government Code section 815 were in the first instance to have been potentially applicable at some general level, Health and Safety Code sections 1371.4 and 1399.5, taken together, provide a statutory exception to immunity.

2. Section 815.6 also gives providers a right of action against public health plans because section 1371.4 imposes a mandatory duty on all health plans to pay reimbursement to providers of emergency services

Even if reimbursement had involved a tort action for "injury," for which Government Code section 815 would otherwise have provided immunity, Government Code section 815.6 contains another statutory exception. Section 815.6 creates a right of action against a public entity that fails to perform a mandatory statutory duty designed to protect against the risk of the particular kind of injury that occurred. (*Haggis v. City of Los Angeles* (2000) 22 Cal.4th 490, 499–500.) As discussed above under heading B.1, Health and Safety Code section 1371.4 creates a private right of action, and section 1399.5 assures that public health plans are subject to such actions. But even if they did not, the predicate statute imposing a mandatory duty—here, section 1371.4—need not

create a private right of action, because "section 815.6 [itself]… creates the private right of action." (*Ibid.*)

Health and Safety Code section 1371.4 imposes a mandatory duty: "A health care service plan … shall reimburse providers for emergency services and care provided to its enrollees …." (Health & Saf. Code, § 1371.4, subd. (b); see also subd. (j) ["A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for poststabilization care rendered to the enrollee …."].)

In fact, the Court of Appeal in this case acknowledged that under section 1371.4, "the duty to reimburse is mandatory …." (*Santa Clara*, *supra*, 77 Cal.App.5th at pp. 1029–1030.)

But the Court of Appeal inexplicably concluded, without any support, that because the implementing regulation directs reimbursement at "the reasonable and customary value" of the services rendered, a publicly owned health plan—and necessarily every other health plan—is somehow "vested with the discretion to determine the reasonable and customary value of the services," and thus has "discretion" to determine the amount of reimbursement owed. (*Santa Clara*, *supra*, 77 Cal.App.5th at p. 1030; see also Cal. Code Regs, title 28, § 1300.71, subd. (a)(3)(B).) Neither the statute nor the regulation says that the payment amount is discretionary.

To the contrary, the regulation merely provides criteria governing the amount of reimbursement. (Cal. Code Regs, title 28, § 1300.71, subd. (a)(3)(B).) These criteria help implement—not defeat—the Legislature's mandatory decree that a health plan "shall reimburse" for emergency services. (See Health & Saf. Code, § 1371.4, subd. (b).)

The amount of reimbursement—i.e., "the reasonable and customary value" of the services rendered—is a fact to be decided by a trier of fact. It is not some variable policy judgment—or as the County puts it, a "normative or qualitative debate" (ABOM p. 59)—to be undertaken every time that any patient enrolled in any health plan anywhere in the State obtains emergency services at any out-of-network hospital.

Private health plans do not have discretion to determine the reasonable and customary value. (*Prospect*, *supra*, 45 Cal.4th at p. 508; *Bell*, *supra*, 131 Cal.App.4th at p. 218.) Likewise, a public health plan faces the same nondiscretionary obligation. Section 1371.4 does not distinguish between them, and section 1399.5 confirms the same rules apply to private and public plans alike. When a health plan does pay the reasonable and customary value, then the trier of fact can say so. And when not, the trier of fact can make that finding. Either way, DMHC and case law confirm that the Knox–Keene Act permits emergency providers to sue California-licensed health plans directly over billing disputes. (*Prospect*, *supra*, 45 Cal.4th at p. 506.)

The consequences of fabricating a discretionary rather than a mandatory duty to pay the reasonable and customary value would be the same as denying a right of action before an objective trier of fact altogether: " ' "[D]enying emergency providers judicial recourse to challenge the fairness of a health plan's reimbursement determination[] allows a health plan to systematically underpay California's safety-net providers …." ' " (*Id.* at p. 508 [quoting DMHC brief quoted in *Bell*, *supra*, 131 Cal.App.4th at p. 218].)

A law requiring payment at "fair market value" does not give the payor discretion to set the amount. (E.g., Code Civ. Proc., §§ 1260.210, 1260.230, 1263.310–1263.330 [determination by trier of fact of "fair

market value" of property taken under eminent domain law].) Neither the plan nor the provider has unilateral rate-setting authority for emergency services. And when they disagree, the legal mechanism to resolve the dispute is trial in the courtroom.

The reimbursement required of all health plans by section 1371.4 is a mandatory duty. Thus, Government Code section 815.6 assures that providers of emergency services and post-stabilization care have a right of action against a public health plan to assure performance of its reimbursement obligations.

C. Public entity health plans are not immune from actions seeking reimbursement for post-stabilization care and for zero pays

The Court of Appeal's decision here did not address the related issue of actions seeking reimbursement for post-stabilization care. Nor did it address the problem of zero pays, where a health plan pays nothing on a claim for emergency or post-stabilization services.

The obligation of a health plan to pay for post-stabilization services results from choices made by the health plan, both by enrolling patients in the first instance and by choices made just before the start of post-stabilization care. When an enrolled patient receiving emergency services at an out-of-network hospital is stabilized but requires further (post-stabilization) care, the hospital notifies the health plan. (See Health & Saf. Code, § 1371.4, subd. (j), incorporating *id.*, § 1262.8.) The health plan then has 30 minutes to inform the hospital if it elects to transfer the enrolled patient to another hospital; otherwise, the health plan "shall reimburse the hospital for poststabilization care rendered to the enrollee …." (*Ibid.* [also requiring reimbursement if there is an unreasonable delay in a transfer and the noncontracting physician and surgeon determines that care is needed].)

All of the reasons why a public health plan is not immune from an action by an out-of-network provider to assure performance of the plan's obligation to pay for emergency services *also* foreclose immunity from an action to assure performance of the obligation to pay for post-stabilization care.

Further, the health plan is notified, giving it the opportunity to opt out and transfer its enrolled patient to another hospital of its choosing. Otherwise, the health plan "shall reimburse the hospital"—whether the health plan affirmatively authorizes post-stabilization care or simply fails to give notice of transfer within the time provided by law. (Health & Saf. Code, § 1371.4, subd. (j), incorporating *id.*, § 1262.8.) Thus, a provider's action for reimbursement of post-stabilization care is even further removed from the tort actions that are the subject of any immunity under the Government Claims Act and even more within the exclusion of immunity for "liability based on contract …." (Cf. *City of Dinuba*, *supra*, 41 Cal.4th at p. 867 ["the immunity provisions of the Act are only concerned with shielding public entities from having to pay money damages for torts"] [also citing "the narrow meaning" of "injury" in Gov. Code, § 810.8]; see also Gov. Code, § 814.)

The San Jose Hospitals' action and subsequent claims against the County include **more than a thousand** claims for post-stabilization care rendered to patients enrolled in the County's health plan, for cumulative underpayments that **exceed $175,000,000**. But the County aggressively asserts immunity from any action to assure performance of its reimbursement obligations, and the trial court agreed, citing the Court of Appeal's decision under review here.

Zero pays present another issue not addressed by the Court of Appeal. In many instances, the County has paid nothing on

reimbursement claims by the San Jose Hospitals. In its opinion here, the Court of Appeal held that the mandatory-duty exception to tort immunity did not apply based on its (unsupported) conclusion that the County has "discretion" to determine the *amount* of reimbursement. (*Santa Clara*, *supra*, 77 Cal.App.5th at pp. 1029–1030 [discussing exception under Gov. Code, § 815.6].) But the Court of Appeal admitted that "the duty to reimburse is mandatory under Health & Safety Code section 1371.4, …." (*Id.* at p. 1030.)

An action for reimbursement where the County has paid nothing clearly falls within the mandatory duty exception. While the County does *not*, in fact, have discretion to decide the amount of reimbursement—for the reasons addressed in the preceding section under heading B.2—in the case of zero pays, there is not the slightest basis to argue that discretion was exercised to determine the *amount*. Thus, the mandatory "duty to reimburse" forecloses any immunity against claims for zero pays.

D. The County's attack on the plaintiff Hospitals' charges raises issues of fact, not a basis for immunity

In an attempt at misdirection, the County portrays the plaintiff Hospitals as rapacious over-billing outliers, charging ten times their costs. (See, e.g., ABOM pp. 26–28 [including cite to 2004 news story].) This attack on the amount charged is irrelevant to the immunity question.

First, whether the County paid too little, or the Hospitals charged too much, or both, is a question of fact. Neither side has the unilateral right to avoid challenge. In *Bell*, the court held, in accordance with the position of DMHC, that a health plan does not have the authority to determine unilaterally the amount it will reimburse a noncontracting

provider. (*Bell*, *supra*, 131 Cal.App.4th at p. 217–218, 220.) In *Children's Hospital*, the court approved a jury instruction that "the reasonable and customary value," which the health plan was required to pay, "might be reflected by the bill submitted by [the] Hospital, or the amount [the health plan] paid, or some amount lesser than, greater than, or in between those amounts." (*Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1278 (*Children's Hospital*).) When disputed, the amount of reimbursement owed is a question of fact to be determined by the trier of fact.

Second, the County's cost arguments ignore that the County elsewhere admits that evidence of costs is inadmissible to determine reimbursement for emergency services. (See ABOM p. 45.) As explained in *Children's Hospital*—the case the County cites—"the costs of the services provided are not relevant to a determination of reasonable value." (*Children's Hospital*, *supra*, 226 Cal.App.4th at p. 1278 ["Quantum meruit measures the value of services to the recipient, not the costs to the provider"] [also noting that: "Parsing the costs for each service would be impractical"].)

Third, the County provides no basis to set policy based on billings by the particular plaintiff Hospitals here when the County itself describes those billings as outlier data, far exceeding what others charge. (See ABOM pp. 26–28.) If the plaintiff Hospitals charge more than others, this means others charge less. But the County's erroneous immunity argument would sweep up all these lower-charging hospitals. The County should not be underpaying in any event, and it should be accountable in every event.

Fourth, it should be noted that Medi-Cal and Medicare payments for emergency services do not cover costs.[3] And here, the exhibits cited by the County (I, J, K, and L to its request for judicial notice) show the overwhelming number of visits to the plaintiff Hospitals' emergency departments were by Medi-Cal, Medicare, and other indigent patients. Undoubtedly, commercial health plan and insurer reimbursements paid at the reasonable and customary value provide some offset of the cumulative underpayments for those patients.

[3] See, e.g., MedPAC, March 2022 Report to the Congress: Medicare Payment Policy, ch. 3, p. 69 ["In 2020, Medicare's payments to hospitals continued to be below hospitals' costs"] https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/ [as of Feb. 15, 2023]; Cal. Hospital Assn. (2023) summary [generally, Medi-Cal payments 26% below costs; Medicare payments 25% below costs] https://calhospital.org/wp-content/uploads/2023/01/How-Hospitals-Are-Financed-v14.pdf [as of Feb. 15, 2023].

E. Conclusion

The decision by the Court of Appeal, to give publicly owned health plans immunity from actions to assure performance of their reimbursement obligations to California's safety-net providers, is contrary to law—and it would have disastrous consequences for healthcare delivery in California.

This Court should reverse.

March 3, 2023

Respectfully,

King & Spalding LLP

by /s/ Paul R. Johnson
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CERTIFICATE RE LENGTH

I certify that the computer program with which the foregoing Application to File Amicus Curiae Brief; Brief of Amici Curiae San Jose Healthcare System, L.P., and Good Samaritan Hospital, L.P., in Support of Real Parties in Interest has been prepared has generated a total count (for headings, main text, and footnotes) of 6,098 words (excluding the cover, the tables, the signature blocks, and this certificate).

March 3, 2023

/s/ Paul R. Johnson

PROOF OF SERVICE

County of Santa Clara v. Superior Court, S274927, H048486
Underlying action: Superior Court, Santa Clara County, No. 19CV349757

I am a citizen of the United States, over 18 years of age, and not a party to the within proceeding. My business address is King & Spalding LLP, 633 W. 5th Street, Suite 1600, Los Angeles, California 90071.

On the date set forth below, I am serving the foregoing **Application to File Amicus Curiae Brief; Brief of Amici Curiae San Jose Healthcare System, L.P., and Good Samaritan Hospital, L.P., in Support of Real Parties in Interest** by causing true copies to be distributed as follows:

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Clerk, Court of Appeal
Sixth Appellate District
333 West Santa Clara Street
Suite 1060
San Jose, CA 95113

To the Respondent:

Hon. Maureen A. Folan
c/o Clerk, Superior Court
191 North First Street
San Jose, CA 95113

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To the Petitioner and to the Real Parties in Interest:

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Executed on March 3, 2023, at Los Angeles, California.

/s/ Paul R. Johnson
PAUL R. JOHNSON

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **SANTA CLARA, COUNTY OF v. S.C. (DOCTORS MEDICAL CENTER OF MODESTO)**
Case Number: **S274927**
Lower Court Case Number: **H048486**

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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.

3/3/2023

Date

/s/Paul Johnson

Signature

Johnson, Paul (115817)

Last Name, First Name (PNum)

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