S274927

IN THE SUPREME COURT OF CALIFORNIA

COUNTY OF SANTA CLARA,
Petitioner,
v.
THE SUPERIOR COURT OF SANTA CLARA,
Respondent,
DOCTORS MEDICAL CENTER OF MODESTO et al.,
Real Parties in Interest.

AFTER A DECISION BY THE COURT OF APPEAL, SIXTH APPELLATE DISTRICT
CASE NO. H048486

CONSOLIDATED ANSWER TO AMICUS CURIAE BRIEFS

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CONSOLIDATED ANSWER TO AMICUS CURIAE BRIEFS

INTRODUCTION

Real parties in interest Doctors Medical Center of Modesto, Inc. and Doctors Hospital of Manteca, Inc. (the Hospitals) answer the amicus curiae briefs supporting the County that were filed by California State Association of Counties (CSAC), Local Health Plans of California (LHP), and National Health Economics and Policy Scholars (the Scholars).

CSAC and LHP offer no cogent response to the Hospitals' showing that the Government Claims Act does not immunize County of Santa Clara (the County) from the Hospitals' action seeking reimbursement for emergency medical care provided to enrollees in the County's health plan. Contrary to these amici's arguments, (1) the Hospitals' reimbursement claim is not a disguised common law claim, (2) the Hospitals' claim does not implicate statutory or other limitations on the County's contracting authority, and (3) the general rule that private parties may not sue public entities in quantum meruit does not apply here because the rationale behind that rule—to protect and limit a public entity's contractual obligations—is absent. The Hospitals base their claim on statutes, not on a contractual obligation undertaken by the County.

Additionally, like the County, the amici emphasize the Department of Managed Health Care's (Department) enforcement powers and dispute resolution mechanisms. That focus is misplaced. The Department disclaims any power to

resolve individual reimbursement disputes such as those involved here, and the dispute resolution mechanisms are voluntary, nonbinding, seldom used, and ineffective to prevent or remedy underpayment of reimbursement.

Unlike CSAC and LHP, the Scholars do not address any legal issues. They focus on hospital economics. For reasons we discuss, the Court need not wade into that thicket.

Additionally, the Scholars rest their presentation on the false premise that the Hospitals' are seeking to recoup their billed charges in full. In fact, the Hospitals are seeking to recoup the reasonable and customary value of the emergency services they provided, whether that value be the amount they billed or a lesser amount.

LEGAL ARGUMENT

I. The Hospitals are not alleging a disguised common law claim. Their claim is grounded on statutes, not equitable considerations.

Amicus curiae CSAC contends the Government Claims Act abolished all common law liability of public entities (Amicus Curiae Brief of CSAC (CSAC ACB) 7) and that the Hospitals' claim for reimbursement is simply a "reclassif[ied]" common law claim (CSAC ACB 9, 15). This contention is flawed.

CSAC's argument depends on mislabeling the Hospitals' claims as common law quantum meruit claims against a public entity. (CSAC ACB 15; see CSAC ACB 16–17, 19 ["what remains are common law quantum meruit claims"], 20 ["permitting Real Parties to proceed with a common law claim for quantum meruit

would completely undermine the Government Claims Act"].) CSAC misunderstands the role of quantum meruit here.

Common law quantum meruit claims are grounded in equity. Under the common law theory, " 'a contract to pay for services rendered is implied by law for reasons of justice.' " (*Newport Harbor Ventures, LLC v. Morris Cerullo World Evangelism* (2016) 6 Cal.App.5th 1207, 1222, affd. (2018) 4 Cal.5th 637.)

Here, the Hospitals are not asking the Court to imply a contract "for reasons of justice." They are asking the Court to enforce their right to reimbursement under the Knox-Keene Act.

CSAC's misunderstanding may stem from the fact that courts use the term "quantum meruit" in several different ways.

First, courts refer to quantum merit as an equitable *remedy* or *measure* of relief. (See, e.g., *Tenzer v. Superscope, Inc.* (1985) 39 Cal.3d 18, 28, fn. 6 [referring to "recovery in quantum meruit" as a "traditional equitable remed[y]"]; *Earhart v. William Low Co.* (1979) 25 Cal.3d 503, 506 ["the remedy of quantum meruit"]; *Palmer v. Gregg* (1967) 65 Cal.2d 657, 660 ["[t]he measure of recovery in quantum meruit"]; see also Rest.3d Restitution and Unjust Enrichment (2011) § 49, com. f, p. 182 ["[l]iability in restitution for the market value of goods or services is the remedy traditionally known as quantum meruit"].)

Second, courts refer to quantum meruit as a distinct *claim* or *cause of action*. (See, e.g., CSAC ACB 19–20 [quoting cases that refer to a " 'claim' " or " 'action' " for quantum meruit].)

Third, courts refer to the *doctrine* or *theory* of quantum meruit. (See, e.g., *Sheppard, Mullin, Richter & Hampton, LLP v. J-M Manufacturing Co., Inc.* (2018) 6 Cal.5th 59, 88 ["the equitable doctrine of quantum meruit"]; *Hedging Concepts, Inc. v. First Alliance Mortgage Co.* (1996) 41 Cal.App.4th 1410, 1419 ["Quantum meruit is an equitable theory which supplies, by implication and in furtherance of equity, implicitly missing contractual terms"].)

Here, the Hospitals seek the *remedy* of quantum meruit, the measure of relief being that mandated by the Knox-Keene Act and implementing regulations: the reasonable and customary value of the Hospitals' emergency services. The Hospitals are not pursuing a *common law claim* for quantum meruit; they are not asking the Court to imply a contract in the interests of justice. The Legislature has already considered those interests. The fruits of the Legislature's consideration are reflected in the Knox-Keene Act, which imposes on the County the reimbursement obligation the Hospitals seek to enforce. The Legislature decided that (1) hospitals *must* provide emergency services to all persons requesting and requiring emergency care, and (2) the County *must* reimburse hospitals for those services. (OBOM 12–14.)

Further, CSAC's position would fail even if the Hospitals were pursuing a quantum meruit claim (rather than a quantum meruit remedy) because the Government Claims Act does not immunize public entities from liability under rules imposed by the Legislature, here, the reimbursement rule imposed by the Knox-Keene Act. The Government Claims Act may have

"abolished all common law or judicially declared forms of liability against public entities" (CSAC ACB 19), but the Hospitals' claims do not rely on the common law or on judicially declared forms of liability.

Contrary to CSAC's understanding, the Hospitals' claims do not "reference the Knox-Keene Act as a basis for an *equitable* argument." (CSAC ACB 27, emphasis added.) Rather, the Hospitals cite the Knox-Keene Act as the basis for a *legal* argument. The Hospitals allege that, as a matter of law (not equity), the County is obligated to comply with that Act and related regulatory directives to reimburse the Hospitals for the reasonable and customary value of their emergency services. The theory of quantum meruit may properly be invoked in service of an emergency provider's claim to reimbursement under the Knox-Keene Act. (See *Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc.* (2021) 71 Cal.App.5th 323, 334–335 [emergency provider may seek amounts due under the Knox-Keene Act by pleading a quantum meruit claim]; *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 218 (*Bell*) [agreeing with Department that emergency room doctor could pursue quantum meruit claim "based on the implied-in-law contract created by Dr. Bell's statutory duty to provide stabilizing medical care, and Blue Cross's concomitant statutory duty to pay for emergency services rendered to its enrollees"]; RBOM 13–14.)

Finally, CSAC's position fails because Government Code section 815.6 authorizes the Hospitals' claim against the County based on its failure to comply with its statutory duty. (OBOM

33–38; RBOM 30–36.) This statutory claim is not available to an emergency provider who seeks reimbursement from a private health plan. No matter how this claim is characterized—even if informally called a claim for quantum meruit—it is based on section 815.6, not on the common law.

Because the Hospitals are not alleging a common law quantum meruit claim, "reclassif[ied]" or otherwise (CSAC ACB 9), the main thrust of CSAC's argument collapses.

II. The Hospitals' claim does not implicate "public entity contract law."

CSAC argues that to permit the Hospitals to proceed on their quantum meruit, i.e., implied-in-law contract, theory would violate "public entity contract law," which imposes "statutory restrictions on a public entity's contracting authority." (CSAC ACB 23.) CSAC's argument does not bear scrutiny. It confuses implied-in-fact contracts with implied-in-law contracts.

An implied-in-fact contract is like an express contract, the only difference being that "the promise is not expressed in words but is implied from the promisor's conduct." (*Weitzenkorn v. Lesser* (1953) 40 Cal.2d 778, 794 (*Weitzenkorn*).) Both implied-in-fact and express contracts depend on the parties' mutual intent, that is, a meeting of the minds. (*Silva v. Providence Hospital of Oakland* (1939) 14 Cal.2d 762, 773; *Blaustein v. Burton* (1970) 9 Cal.App.3d 161, 179 (*Blaustein*).)

Implied-in-law contracts, on the other hand, are not contracts at all. (*Weitzenkorn*, *supra*, 40 Cal.2d at p. 794.) They are obligations imposed on the parties by law, regardless of the

parties' intention to form or not to form a contract. (*Ibid.*; *Blaustein*, *supra*, 9 Cal.App.3d at p. 179; *Arcade County Water Dist. v. Arcade Fire Dist.* (1970) 6 Cal.App.3d 232, 236 ["An 'implied-in-law' contract is actually not a contract at all, but merely an obligation imposed by the law"].) On this point, the Hospitals and the County agree. (See ABOM 45.)

Confusion can arise because "contracts implied-in-fact and implied-in-law . . . are not infrequently confused by the judiciary" (1 Bruner & O'Connor on Construction Law (July 2022) § 2:10) and because "courts have permitted recovery on implied contract or quantum meruit for services rendered, without always clearly indicating whether the contract was implied in fact or implied in law" (1 Witkin, Summary of Cal. Law (11th ed. 2022) Contracts, § 1072, p. 1120).

This much is clear: while implied-in-fact and express contracts may implicate statutory or other legal limitations on a public entity's contracting authority, implied-in-law contracts do not. The obligations arising under implied-in-law contracts may be enforced regardless of whether the parties had a meeting of the minds.

Here, the Legislature, not the parties, established their legal relationship. The relationship is quasi-contractual, that is, akin to a contract, because the Knox-Keene Act and implementing regulations require the County to pay for services rendered by the Hospitals, as though the parties had actually contracted for the services. But because the Legislature, not the County, established the relationship and mandates the

reimbursement, the Hospitals' claim against the County arises from governing law and thus does not implicate any restrictions on the County's authority to voluntarily enter a contract.

CSAC cites cases for the proposition that "[w]here a public entity's legal authority to enter into a contract is restricted by statute, and an implied contract would disregard those restrictions, courts have consistently denied claims against public entities based on quantum meruit, implied-in-law, or quasi-contract theory." (CSAC ACB 23–24.) According to CSAC, the principle underlying these decisions is that the law will not imply an obligation to do that which the law forbids the party to do. (CSAC ACB 24.)

None of the cited cases is apposite.

Three of the cited cases did not even involve a quantum meruit theory.[1] The other cases involved plaintiffs who asserted a quantum meruit theory against a government entity in the face of "an invalid or unenforceable express contract." (1 Witkin, Summary of Cal. Law, *supra*, Contracts, § 1072, p. 1120 ["whenever there is an invalid or unenforceable express contract, and recovery is nevertheless allowed, the basis of the recovery is quasi-contractual"].)

The plaintiffs in those cases alleged a quantum meruit theory to *circumvent* statutory or contractual limitations on the entity's contracting authority by inviting the court to *imply* a

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[1] See *Authority for California Cities Excess Liability v. City of Los Altos* (2006) 136 Cal.App.4th 1207; *Janis v. California State Lottery Com.* (1998) 68 Cal.App.4th 824; *Los Angeles Equestrian Center, Inc. v. City of Los Angeles* (1993) 17 Cal.App.4th 432.

payment obligation. (See *Reams v. Cooley* (1915) 171 Cal. 150, 153–154 [contractor on school construction project could not maintain quantum meruit claim for plaster work not within contract's scope of work but performed at the request of a board that failed to comply with statutory contracting requirements]; *Fairview Valley Fire, Inc. v. Department of Forestry & Fire Protection* (2015) 233 Cal.App.4th 1262, 1271 [vendor who responded to government dispatcher's request for assistance at fire scene but who had no valid contract with government could not recover under quantum meruit theory]; *Sheppard v. North Orange County Regional Occupational Program* (2010) 191 Cal.App.4th 289, 295, 313–314 [part-time instructor employed by government entity could not maintain quantum meruit claim to recover compensation for preparation time not covered by contract]; *P&D Consultants, Inc. v. City of Carlsbad* (2010) 190 Cal.App.4th 1332, 1340–1342 [where plaintiff's contract with city permitted extra work only when authorized in writing, plaintiff could not maintain quantum meruit claim for extra work performed at oral request of project manager]; *Katsura v. City of San Buenaventura* (2007) 155 Cal.App.4th 104, 108–109 [plaintiff could not maintain quantum meruit claim against city for extra work performed at request of city employee and consultant who lacked authority to request the work]; see also *Russell City Energy Co., LLC v. City of Hayward* (2017) 14 Cal.App.5th 54, 69, 71–73 [distinguishing several of the cases cited by CSAC and allowing plaintiff to amend complaint to allege a quasi-contractual restitution claim against public entity;

"In seeking quasi-contractual relief, Russell is not attempting to imply the existence of an extra-contractual agreement, nor is Russell attempting to enforce the invalid provision of the agreement"].)

Unlike the plaintiffs in those cases, the Hospitals here did not *choose* to provide goods or services to the County—they were legally bound to provide emergency services to the County's enrollees. Nor do the Hospitals seek to *circumvent* any statutory or other restrictions on the County's contracting authority—they seek to recover the reimbursement to which the Legislature has deemed them entitled.

And unlike the plaintiffs in the cited cases, the Hospitals are not asking the Court to *imply* any payment obligation in the interests of equity or justice. They are asking the Court to enforce the obligation that the Knox-Keene Act and implementing regulations *expressly* impose on the County.

The Knox-Keene Act applies to public and private health plans alike. (Health & Saf. Code, § 1399.5; see OBOM 12.) In 1994, when it added the reimbursement mandate to the Act, the Legislature laid the foundation for the implied-in-law contract at issue here. (OBOM 19.) Under CSAC's erroneous view of the law, statutory restrictions on the County's contracting authority ensure that the implied-in-law contract established by the Legislature will rarely if ever be enforced. It's fair to assume, however, that the Legislature did not intend the 1994 amendment to be an idle, pointless act as applied to public health

plans. (Civ. Code, § 3532 ["The law neither does nor requires idle acts"].)

In sum, this case has nothing to do with any contract voluntarily entered into between the County and the Hospitals and thus does not implicate any "restrictions on a public entity's contracting authority." (CSAC ACB 23.)

III. The general rule that private parties may not sue the government in quantum meruit should not apply here because the rationale for the rule is absent.

To be sure, a number of cases include the broad statement that, "*As a general rule*, a public entity cannot be sued on an implied-in-law or quasi-contract theory, because such a theory is based on quantum meruit or restitution considerations which are outweighed by the need to protect and limit a public entity's contractual obligations." (*Lundeen Coatings Corp. v. Department of Water & Power* (1991) 232 Cal.App.3d 816, 831, fn. 9 (*Lundeen*), emphasis added; see CSAC ACB 19–20.)

The Court of Appeal here relied on that general rule (*County of Santa Clara v. Superior Court* (2022) 77 Cal.App.5th 1018, 1028–1029 (*Santa Clara*)), and the amici curiae supporting the County invoke that general rule in their briefs (CSAC ACB 19–20, 24; Amicus Curiae Brief of LHP (LHP ACB) 8, 25–26).

However, "[w]hen the reason of a rule ceases, so should the rule itself." (Civ. Code, § 3510.) The reason behind the general rule of public entity nonliability for implied-in-law contracts—"to protect and limit a public entity's contractual obligations" (*Lundeen*, *supra*, 232 Cal.App.3d at p. 831, fn. 9)—is not

implicated here. As explained above, this case does not involve any contract the County chose to enter or not to enter. Because the rationale behind the general rule is absent, applying the general rule here would simply shield the County from its legal obligation—a windfall—without serving any countervailing public purpose.

LHP cites *Orthopedic Specialists of Southern California v. Public Employees' Retirement System* (2014) 228 Cal.App.4th 644 (*Orthopedic Specialists*). (LHP ACB 25.) But that case actually confirms the Hospitals' point that the general rule does not apply here.

In *Orthopedic Specialists*, an out-of-network health care group, OSSC, chose to provide non-emergency medical services to an enrollee in a public health plan based on the plan's "implied oral promise" to pay OSSC for the services. (*Orthopedic Specialists*, *supra*, 228 Cal.App.4th at p. 649.) When the plan later paid less than the amount to which OSSC believed it was entitled, OSSC filed an action against the plan alleging a claim for quantum meruit, among others. (*Id.* at p. 646.) The Court of Appeal affirmed an order sustaining a demurrer to the quantum meruit claim, explaining that "an oral promise cannot be enforced against a government agency." (*Id.* at p. 649.) The court cited the general rule that a private party cannot sue the government in quantum meruit. (*Id.* at pp. 649–650.)

But that case is distinguishable because it involved non-emergency services. Unlike OSSC, the Hospitals here were legally obligated to provide emergency services. And the

Hospitals did not need the County's express or implied promise of reimbursement. The Hospitals have a statutory right to reimbursement. The Court of Appeal in *Orthopedic Specialists* specifically *distinguished* cases like this one:

> OSSC relies on two cases, which do not assist it. In both *Prospect Medical Group, Inc. v. Northridge Emergency Medical* (2009) 45 Cal.4th 497 [(*Prospect Medical*)], and *Bell*[, *supra*,] 131 Cal.App.4th 211, the courts held that out-of-network emergency room physicians could assert claims directly against health care service plans for payments the physicians deemed too low, *because such physicians are required by law to render services to all emergency room patients without regard to the patient's insurance status or ability to pay* [citation]. While OSSC acknowledges that these cases only apply to emergency room physicians, it argues that "the logic and reasoning are the same here." Not true. Unlike emergency room physicians, *who must treat all patients seeking emergency care*, OSSC is free to pick and choose its patients and focus on those with the greatest ability to pay its charges. OSSC can also find out, in advance of treatment, how much it will be reimbursed by CalPERS and how much it must recover from the patient. *Emergency room physicians have none of these advantages*.

(*Orthopedic Specialists*, *supra*, 228 Cal.App.4th at pp. 648–649, emphasis added.)

LHP also cites *Green Valley Landowners Assn. v. City of Vallejo* (2015) 241 Cal.App.4th 425. (LHP ACB 26.) The court there simply recited the general rule that a city cannot be sued under an implied-in-law or quasi-contract theory because

" 'contracts that disregard applicable code provisions are beyond the power of the city to make.' " (*Green Valley*, at p. 438.)

As explained, that rule does not apply here because the Hospitals are not asking the Court to enforce any contract in disregard of statutory or other restrictions on the County's contracting authority. The Hospitals' claim does not implicate those restrictions because it does not rest on any contract the County had authority to make or not to make.

IV. The Hospitals are not seeking an equitable exception to the Government Claims Act.

CSAC misunderstands the Hospitals to be seeking an equitable exception to the Government Claims Act. (See CSAC ACB 25–27.) Not so. No exception is needed because the Act does not apply to the Hospitals' action, which does not seek to recover damages in tort. (OBOM 22–29; RBOM 10–19.)

CSAC notes that when the Law Revision Commission proposed what became the Government Claims Act, the Commission was motivated by concerns over the government's exposure to " 'unascertainble tort obligations' " and " 'the danger of tort liability.' " (CSAC ACB 12.) This case poses no such exposure or danger. Government Code section 815 does not apply.

Moreover, even if the Act were to govern, Government Code section 815.6, not principles of equity, would provide an exception that applies to this case. (OBOM 33–38; RBOM 30–36; *Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.4th 1175,

1180 ["Government Code section 815.6, makes a public entity directly liable for its breach of a statutory 'mandatory duty' "].)

V. The Legislature's treatment of county "health authorities" sheds no light on the question presented: whether the County is immune from the Hospitals' action.

Amicus Curiae LHP argues that when the Legislature allowed counties to establish special county health commissions, or "health authorities," to support the state's Medi-Cal program, the Legislature endowed the newly formed public entities with "the same immunities as the counties themselves." (LHP ACB 9; see LHP ACB 8–13.)

Welfare and Institutions Code section 14087.38, on which LHP largely bases its discussion (LHP ACB 9, 11–13), does not apply to Valley Health Plan, the County health plan in this case. That statute applies the Government Claims Act to a health authority created as "an entity separate from the county" with its own governing board. (Welf. & Inst. Code, § 14087.38, subds. (a)(1)–(2), (c), (j)(2).) Those health authorities are "created to contract with the Medi-Cal program and [are] subject to a different statutory scheme." (ABOM 20, fn. 3.) Valley Health Plan "was not formed pursuant to these statutes" (LHP ACB at 9, fn. 3) and "is not an independent legal entity from the County" (vol. 2, exh. 14, p. 302). Rather, Valley Health Plan "is a division of Santa Clara County." (Vol. 3, exh. 23, p. 605.)

But in any event, to say that county health authorities enjoy the same immunities as the counties themselves begs the

question presented here: what immunities *do* the counties enjoy? LHP does not purport to answer that question.

VI. The Department's enforcement powers and voluntary, nonbinding dispute resolution mechanism are inapposite and, in any event, ineffective to prevent or correct underpayment of reimbursement.

LHP, like the County (ABOM 19–23, 44), highlights the Department's enforcement powers and its Independent Dispute Resolution Process (IDRP). (LHP ACB 13–23.) The gist of the argument seems to be that there are alternatives to judicial enforcement of the Knox-Keene Act's reimbursement requirement, so dissatisfied emergency providers need not seek relief from the courts. The Hospitals have explained the fallacy in that argument: the issue here is not whether the Hospitals *need* to seek judicial relief but whether they *can*. (RBOM 20–22.)

Even on its own terms, LHP's argument does not hold up. The Department's enforcement powers and its voluntary, nonbinding (RBOM 7–8) dispute resolution mechanism are ineffective to prevent or correct underpayment of reimbursement in individual cases.[2]

As the Hospitals have explained, the Department is empowered to review health plans' *methodologies* for calculating the reasonable and customary value of emergency services.

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[2] LHP admits the IDRP is "seldom used" to resolve disputes over reimbursement for emergency services. Only 16 such disputes have been resolved through the IDRP in the last 10 years, including only 1 in the last 4 years. (LHP ACB 20–21 & fn. 14; see LHP ACB, exh. 1.)

(RBOM 24–25 & fn. 5; see LHP ABC 16–19.) Violations may result in settlements with the Department in which the offending health plan agrees to pay an administrative penalty or to correct a deficient methodology. (LHP ACB 16; RJN, exh. D, p. 30; see, e.g., vol. 3, exh. 26, pp. 693–700 [consent agreement between Department and health plan].)

While the Department may be "equipped with the tools to prevent *systemic* underpayments to out-of-network hospitals" (LHP ACB 18, emphasis added), the Department itself disclaims any authority to resolve *non*systemic—particular—disputes between a health plan and an emergency provider over the reasonable and customary value of emergency services (RBOM 20–21). The fact that the Department may compel a health plan to pay a fine or modify its methodology is no remedy for an emergency provider who believes it has been underpaid on a particular claim seeking reimbursement for emergency services.

LHP emphasizes the Department's "exacting" (LHP ACB 16) and "aggressive" (LHP ACB 17) enforcement efforts, designed to ensure health plans "comply with regulatory requirements, including the regulation at issue here requiring payment for non-contracted emergency services at the reasonable and customary value" (*ibid.*).

The Department's efforts are commendable, but manifestly insufficient. Disputes between health plans and emergency providers over the amount of reimbursement for emergency services are common (OBOM 13–14), and they are on the rise. According to the Department, "[t]he reporting full service health

plans received 1,710,506 provider disputes during the 2021 reporting period. This represents a 23% percent increase in the total amount of claims processed, and a 21% increase in disputes over the 2020 reporting period." (Dept. of Managed Health Care, *Health Care Service Plans' Provider Dispute Resolution Mechanisms, 2021 Annual Report* (Mar. 25, 2022) p. 6 <https://tinyurl.com/DisputeResolution2021Plan> [as of Apr. 12, 2023].) Notably, claims payment disputes "primarily involve claims of inadequate reimbursement." (*Ibid.*)

Citing the Department's annual reports, LHP asserts that, as a result of Department enforcement efforts, health plans pay many millions of dollars each year to physicians and hospitals. (LHP ACB 17; see RJN, exh. D, p. 1; exh. E, second unnumbered page after Table of Contents ["$177.8 MILLION dollars in payments recovered to physicians and hospitals"].) LHP does not inform us how much, if any, of that total represents reimbursement to providers for *emergency* medical services as distinct from, for example, poststabilization or other routine medical services. Nor does LHP disclose how much health plans *refuse* to pay each year.

VII. As long as the County's reimbursement payments to noncontracted hospitals are immune from judicial scrutiny, the County has no incentive, but powerful disincentives, to contract with additional emergency providers.

The Hospitals have explained that insulating public health plans' reimbursement decisions from judicial review creates a perverse incentive for plans *not* to contract with emergency

services providers, to avoid committing themselves in advance to a fixed reimbursement schedule or formula. (OBOM 40.) Several amici curiae echo the Hospitals' concern. (See Amicus Curiae Brief of the California Medical Association and the California Hospital Association 34 (CMA ACB) ["Insulating county health plans from fair reimbursement obligation to out-of-network providers can also create perverse incentives against building robust provider networks"]; Brief of Amici Curiae San Jose Healthcare System, L.P., and Good Samaritan Hospital, L.P. (San Jose ACB) 6, 13 ["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"].)

LHP responds that health plans are legally "required to maintain an adequate network of providers by entering into contracts sufficient to meet regulatory standards of access to care, including contracts with hospitals providing emergency services." (LHP ACB 24, emphasis omitted.) Thus, according to LHP, "[p]ublic sector health plans cannot simply choose to forego contracting and rely on out-of-network hospitals." (*Ibid.*)

LHP paints an incomplete picture. True, public sector health plans cannot forgo *all* contracts and rely entirely on out-of-network hospitals. The health plans must contract with a sufficient number of geographically diverse emergency providers to satisfy regulatory standards of access. (See, e.g., Cal. Code Regs., tit. 28, §§ 1300.51, subd. (d)(H)(ii), 1300.67.2, subd. (c).)

But the plans are not required to contract with all emergency providers—and in fact they don't, as this case illustrates.

The County has not contracted with two of the amici curiae, Regional Medical Center of San Jose and Good Samaritan Hospital, which are sizeable facilities operating in the County's largest city, San Jose. (San Jose ACB 5, 13.) The County's decision not to contract with these hospitals has not stopped Valley Health Plan enrollees from requesting emergency services from these hospitals. Over several years, these hospitals "have received thousands of emergency visits" from Valley Health Plan enrollees. (San Jose ACB 13, boldface omitted.) These hospitals report that the County's underpayments, and even nonpayments, for those emergency services "exceed $95,000,000 and continue to grow." (*Ibid.*, boldface omitted.)

As long as the County's reimbursement payments to noncontracted hospitals are immune from judicial scrutiny, and the Department disclaims authority to adjudicate particular disputes, the County has no incentive, but powerful disincentives, to contract with additional emergency providers. The County knows it can decline to contract with emergency providers without jeopardizing its enrollees' access to emergency care. State and federal law guarantee enrollees the emergency services they need, whether or not the County has a contract with the emergency provider. (OBOM 12–14.) Absent access to the courts, emergency providers are essentially left at the mercy of the County and other noncontracting health plans to honor their obligations under the Knox-Keene Act.

VIII. The Court need not consider the economics of emergency medical services.

Amici curiae the Scholars do not purport to address any legal issues, let alone the legal issue before this Court. They limit their brief to a discussion of hospital economics, and how those economics bear on certain public policy concerns the Hospitals have raised. (Amicus Curiae Brief of the Scholars (Scholars ACB) 7.)

Whether hospitals are currently being overpaid or underpaid for their services is disputed. (Compare ABOM 25–30, 68 ["ruinous pricing and billing practices"] and Scholars ACB 11 ["spending on hospitals is already high" (original formatting omitted), and hospital spending is "one of the largest sectors of the U.S. economy"][3] with CMA ACB 12, fn. 2 ["California hospitals and emergency care providers operate on thin margins and have been forced out of business due to persistent under-compensation in the managed care marketplace"] and San Jose ACB 15 ["California hospitals are already under tremendous financial strain and face painful choices about where they must make cuts to continue to remain viable"].)

This Court, however, need not and should not wade into the thicket of hospital pricing and billing practices.

First, those practices, and the economics behind them, have no bearing on the purely legal question before the Court: whether the County is immune from the Hospitals' action. (See RBOM

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[3] Nowhere do the Scholars quantify spending on *emergency* medical services, the subject of the dispute in this case.

37–38.) If and when this case is remanded to the superior court and proceeds on its merits, the County will have ample opportunity to argue that evidence of hospital economics in general, or these Hospitals' economics in particular, should be considered by the trier of fact when determining the reasonable and customary value of the Hospitals' emergency services.

Second, the Legislature has already considered the economics of emergency medical services and related public policy. (See CMA ACB 12–15.) The Legislature has mandated that every health plan—both private and public (Health & Saf. Code, § 1399.5)—reimburse emergency medical service providers "for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee" (*id.*, § 1371.4, subd. (b)). The governing regulation specifies that for "non-contracted providers," such as the Hospitals, reimbursement means "the payment of the reasonable and customary value for the health care services rendered," as determined based on statistical information and specified factors. (Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(B).) That is the declared public policy of this state. The Scholars should not be heard to advocate for other policies that may not be consistent with the Legislature's chosen scheme.

IX. The Hospitals seek reimbursement for the reasonable and customary value of their emergency services, whether that value be the billed amount or a lesser amount.

The Scholars' economic arguments rest on the premise that "the amounts that the Hospitals seek to recover from the County

are list prices, known as 'billed charges.' " (Scholars ACB 10; see Scholars ACB 12–23 [section titled, "Hospitals' Billed Charges are Arbitrary Amounts that Do Not Reflect Prices or Costs" (original formatting omitted)].) That premise is false, hence the Scholars' argument collapses like a house of cards.

The Hospitals do not allege the County's failure to pay their billed charges in full violated the Knox-Keene Act or its implementing regulations. Rather, the Hospitals allege the County " 'failed to fully reimburse the [Hospitals] for the services rendered to the Patients *at reasonable and customary rates as required by the Knox-Keene Act*.' " (*Santa Clara*, *supra*, 77 Cal.App.5th at pp. 1025–1026, emphasis added; see vol. 2, exh. 12, pp. 293–294 [third amended complaint].)

Whether the reasonable and customary value will prove to be the amount the Hospitals billed, the amount the County paid, or an amount in between remains to be determined by the trier of fact. (See *Prospect Medical*, *supra*, 45 Cal.4th at p. 505 ["In a given case, a reasonable amount might be the bill the doctor submits, or the amount the HMO chooses to pay, or some amount in between"].)

The Scholars are equally mistaken when they assert "billed charges" are "at the center of [the Hospitals'] public policy arguments." (Scholars ACB 23.) The Hospitals' public policy arguments do not mention billed charges. (See OBOM 38–43.) Rather, the Hospitals discuss the potential consequences of a decision to shield public health plans from emergency providers'

actions seeking "to recoup the reasonable value of their emergency services." (OBOM 41.)

The Scholars assert "the research demonstrates that hospitals' billed charges neither reflect the prices that insurers pay to hospitals for a given service, or the cost of the service." (Scholars ACB 13.) The County may present these arguments when this case returns to the superior court and the County is required to address the merits of the Hospitals' reimbursement claims. At this point in the case, however, the Scholars' assertion has no apparent relevance.

If anything, the Scholars' presentation tends to confirm that, when a health plan *contracts* with a provider, the plan ends up paying a much higher percentage of the hospital's billed charges than the percentage the County paid the noncontracted Hospitals in this case. (Scholars ACB 15.) The Scholars' presentation thus tends to validate the Hospitals' argument that health plans have a financial incentive *not* to contract with emergency providers, when that is an option, to preserve the plans' ability to unilaterally pay less for medical services than they would pay under negotiated contracts with the providers.[4]

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[4] Figures provided by the Scholars for the year 2011 show that insurers who contracted with hospitals paid, on average, the following percentages of billed charges for the indicated medical services (rounded to the nearest percentage point): inpatient, 48 percent of billed charges ($14,020 of $28,969); hip replacement, 48 percent of billed charges ($24,565 of $51,458); knee replacement, 49 percent of billed charges ($24,059 of $49,327); Cesarean delivery, 48 percent of billed charges ($8,258 of $17,194); vaginal delivery, 51 percent of billed charges ($5,465 of

The Scholars conclude: "[T]he County's decision to pay the Appellant Hospitals an amount that is substantially less than the Hospital's billed charges is not an anomaly and cannot reasonably be expected to lead to the kind of systemic underpayment described in the Hospitals' brief." (Scholars ACB 19.) Again, Scholars misunderstand the Hospitals' position.

The Hospitals do not suggest that a health plan's reimbursement in an amount less than full billed charges is an "anomaly" or evidences "systemic underpayment." Rather, the Hospitals claim that a public health plan's reimbursement in an amount less than the reasonable and customary value of the emergency services is unlawful, and that the Government Claims Act does not immunize the public health plan from an emergency provider's action to collect the amount to which the Legislature has decided the provider is entitled—be it the billed charge or something less.

$10,612); PTCA (percutaneous transluminal coronary angioplasties), 41 percent of billed charges ($25,395 of $61,382); colonoscopy, 59 percent of billed charges ($1,834 of $3,123); and lower limb MRI, 53 percent of billed charges ($1,343 of $2,546). (Scholars ACB 15.) By contrast, in this case, the County paid the Hospitals *about 20 percent* of their billed charges for the emergency services at issue. (OBOM 15.) That disparity is no accident.

CONCLUSION

Amici curiae CSAC and LHP offer no persuasive response to the Hospitals' showing that the County is not immune under the Government Claims Act from the Hospitals' action seeking reimbursement for emergency medical services provided to enrollees in the County's health care service plan. Amici curiae the Scholars do not address that legal issue.

April 21, 2023

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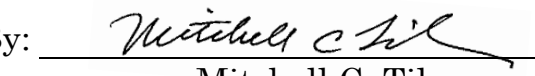
By: 
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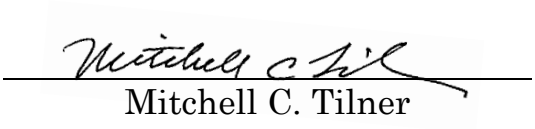

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PROOF OF SERVICE

County of Santa Clara v. The Superior Court of Santa Clara (Doctors Medical Center of Modesto et al.)
Case No. S274927

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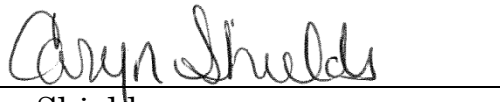

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STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

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Case Number: **S274927**
Lower Court Case Number: **H048486**

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