No. S274927

IN THE SUPREME COURT OF THE STATE 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 BRIEFS

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INTRODUCTION

The five amicus briefs submitted to this Court,[1] considered together, confirm two fundamental points:

First, the damages claims that Plaintiffs seek to assert against a public entity are not statutorily authorized. Plaintiffs' amici commit the same fatal error as Plaintiffs: ignoring the plain language of the Government Claims Act. The Act states that immunity applies to all claims for "money or damages" other than contract claims. (Gov. Code, § 814.) Rather than engaging with the text, amici ask this Court to impose an extra-textual, torts-only limitation on the scope of the Act. To do so, however, would contravene not only the plain language of the Act but also the intent of the Legislature: The lynchpin of the Act is to confine government liability to rigidly delineated circumstances codified by statute, and the Legislature expressly forbade judicial expansion of liability. (Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) pp. 809–12, 814, 837.)

[1] Amicus briefs in support of the County were submitted by: (a) the California State Association of Counties (CSAC); (b) Local Health Plans of California (the "Local Health Plans"); and (c) National Health Economics and Policy Scholars (the "Health Economists"). Amicus briefs in support of Plaintiffs were submitted by: (a) The California Hospital Association and the California Medical Association (the "Provider Groups"); and (b) San José Healthcare System, L.P. and Good Samaritan Hospital, L.P. (the "HCA Hospitals"). The County refers to amici in support of Plaintiffs collectively as "Plaintiffs' amici."

Second, the public policy prognostications advanced in support of Plaintiffs are exceptionally speculative and, in any case, appropriately directed to the Legislature. As the Health Economists note, health care prices are already quite high; yet, the amounts Plaintiffs seek to recoup here are "so inflated and arbitrary in nature that almost no insurer or patient pays them." (Health Economists Br. 10–12.) The County's refusal to pay these inflated amounts "is not an anomaly and cannot reasonably be expected to lead to the kind of systematic underpayment described in the [Plaintiffs'] brief." (*Id.* at p. 19.) The cost-shifting assumptions underlying Plaintiffs' policy arguments are, moreover, contradicted by recent data and scholarship. (*Id.* at pp. 23–25.) Indeed, Plaintiffs emphasize in their reply brief that hospital costs have nothing to do with the issues before this Court. (Reply Br. 38.)

The Provider Groups purport to address the "real world" consequences of the ruling on review. But they raise more questions than they answer in contending that the emergency medical system depends on identical treatment of reimbursement claims against public and private entities. Both before the enactment of the Knox-Keene Act and continuing to this day, hospitals have voluntarily operated emergency departments knowing full well that a large segment of their services will be reimbursed via the Medi-Cal program or other public schemes, and other services will be reimbursed at varying rates, including contracted rates and individual

plan reimbursement rates regulated by the Department of Managed Health Care (DMHC) and subject to a range of dispute resolution mechanisms. The viability of the emergency medical system thus has not, as an empirical matter, depended on identical treatment of public and private health plans, nor even on identical treatment of different private health plans.

Plaintiffs' amici further err in arguing that the Sixth District's ruling somehow "bifurcates" regulatory enforcement of the Knox-Keene Act by the DMHC. As illustrated in the Local Health Plans brief, the ruling on review does the opposite: it recognizes that the County is subject to the Knox-Keene Act's full suite of statutory and regulatory requirements, and to robust enforcement of such obligations by the DMHC. Any complaints about the Legislature's chosen enforcement scheme supply no basis for recognizing extra-textual damages remedies against public entities. Rather, as CSAC correctly explains, the Government Claims Act mandates that any future expansion of public entity liability, if needed, be undertaken by the Legislature itself, within carefully drawn substantive and procedural limits.

I. Amici Identify No Statutory Support for the Damages Claims Asserted Here

A. The Government Claims Act Does Not Authorize a Quantum Meruit Claim

Should the Court elect to consider the new arguments raised by Plaintiffs and their amici regarding the scope of the Government Claims Act, the text of the Act, which was the product of extensive study and

debate, was intended by the Legislature to control such questions. (E.g., Answer Br. 47–48, 51; CSAC Br. 7–8, 12, 21.) The text of the Act refutes the contention that the Legislature intended to strictly limit substantive immunity to tort claims, in at least two ways. *First*, the opening section of the substantive immunity provisions, Government Code section 814, addresses the scope of immunity and, rather than limiting immunity to torts, specifies that immunity does not apply to claims for breach of contract or to requests for injunctive relief. Surely if the Legislature wished to strictly limit the scope of substantive immunity to causes of action traditionally considered by courts to be torts, it could and would have done so.

Second, the phrase "money or damages" on its face sweeps in all claims seeking pecuniary relief. The same phrase is used in both the Act's immunity provisions and its claims presentation provisions, which undisputedly apply to claims other than torts. (Gov. Code, §§ 814, 905.) Thus, "money or damages" is not, as Plaintiffs contend, limited to tort claims. If it were so limited, there would be no reason for Government Code section 905 to specifically exclude from the scope of claims for "money or damages" items related to public assistance, principal or interest on bonds, retirement benefits, and certain penalties and forfeitures.[2]

[2] Notably, section 905 states that the Act's presentation requirement extends to "all claims for money or damages" except for a list of exemptions, including claims for "reimbursement" of pupil fees if a school does not comply with certain statutory requirements, indicating that, absent

Although recourse to legislative history is not necessary given the clarity of the text, the Legislature surveyed pre-existing government immunity provisions that were expressly limited to tort claims and opted, instead, to apply immunity to all claims for "money or damages" other than contract claims. (Recommendation Relating to the Presentation of Claims Against Public Entities (Jan. 1959) Cal. Law Revision Com. Rep. (1959) pp. A43–44, A82–83.)[3] The legislative comments to Government Code section 815 confirm that, consistent with the text, the provision "abolishes all common law or judicially declared forms of liability for public entities, except for such liability as may be required by the state or federal constitution." (*Id.* at p. 837.) Quantum meruit is a form of common law liability, placing Plaintiffs' claims squarely within the ambit of the substantive immunity provisions.[4]

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an express carve out, the Legislature understood the phrase "money or damages" to include remuneration tied to the performance of statutory obligations. (Gov. Code., § 905, subd. (*o*); see also Ed. Code, § 49013.)

[3] Although the Legislature opined that the "practical effect" of the Act's immunity provisions is, largely, "to eliminate any common law governmental liability for damages arising out of torts," it made this statement only after observing that the lion's share of claims filed against government are tort claims. (Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) pp. 811, 837.) More importantly, the Legislature expressly declined to use the word "tort" in the Act's immunity provisions because it wished "to prevent the imposition of liability by the courts by reclassifying the act causing the injury." (*Id.* at p. 837.)

[4] The Provider Groups state that "[t]he hospitals in this case assert an implied-in-fact contract claim under section 1371.4 for quantum meruit."

1. The Proposed "Torts-Only" Rule Would Constitute Precisely the Form of Judicial Narrowing of Immunity That the Government Claims Act Sought to Prevent

Plaintiffs' amici do not offer a full-throated defense of Plaintiffs' contention that their reimbursement claims do not seek "money or damages" within the meaning of the Government Claims Act. Rather, Plaintiffs' amici focus on case law, as well as proposed rules already rejected by the Legislature, as support for a torts-only rule—notwithstanding that the Government Claims Act was enacted for precisely the purpose of preventing judicial expansion of public entity liability. (Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) pp. 809–12, 814, 837; see also Answer Br. 47–49, 51; CSAC Br. 28–29.) Reading an extra-textual torts-only rule into sections 814 and 815—while also presuming that "money or damages" means different things in the two parts of the Act—would undermine the Legislature's core purpose of rigidly confining public entity liability for damages claims and would run contrary to longstanding principles of statutory interpretation. (E.g., *Stillwell v. State Bar* (1946) 29 Cal.2d 119, 123; see also CSAC Br. 7–8, 12.)

(Provider Groups Br. 15 fn. 3.) The County understands this use of the phrase "implied-in-fact" to be a drafting error. At this stage, Plaintiffs assert as their sole cause of action an implied-in-law quantum meruit claim—they have not appealed the dismissal of their implied-in-fact contract claim. (Answer Br. 46.)

Plaintiffs' amici similarly run afoul of the Legislature's purpose in enacting the Government Claims Act by arguing that the County should be subject to damages claims based on functional or transactional criteria. The HCA Hospitals argue that the County "voluntarily" undertook to offer a public health care plan, and the Provider Groups argue that offering a public health plan requires a public entity to "delve deeper into the healthcare delivery system," suggesting that the function or transaction of offering a plan should strip the County of immunity. (HCA Hospitals Br. 16, 19; Provider Groups Br. 21.) But the Legislature intended for the Government Claims Act to reject such functional or transactional tests, and indeed was prompted in part by a decision finding that immunity did not apply to a public hospital. (Answer Br. 58, citing *Muskopf v. Corning Hospital Dist.* (1961) 55 Cal.2d 211, 213.) Rather than permitting courts to probe whether a government activity, on an intuitive level, seems of the type that ought to be shielded by immunity, the Legislature directed courts to apply immunity to all claims for money or damages other than contract claims, except as provided by statute. (Gov. Code, §§ 814, 815.)

In doing so, the Legislature recognized that counties have occupied a central and primary role in the delivery of health care for over a century as a core part of their exercise of governmental functions and fulfillment of constitutional duties. (E.g., Answer Br. 18, 30–31.) And counties continue to do so: the County offers care to anyone who needs it, regardless of

financial circumstances, at significant public cost, by operating the second largest major public health and hospital system in California, including three hospitals; a network of clinics offering emergency urgent, acute, preventative, and specialized care; and public pharmacies. (E.g., *ibid*.) The County's health care plan, Valley Health Plan, is one piece in this larger system of interrelated governmental operations through which the County seeks to protect the local pipeline of available providers and services and increase access to high quality care.

The County, it bears noting, thus has always delved deeply into the healthcare system and is, in turn, deeply invested in the viability of other providers within the county and surrounding areas. The closure of a nearby hospital, for example, would increase strain on the County's health system and disserve the County's core goals of protecting public health and access to care. (E.g., *Editorial: AG's Office Must Not Block Sale of Two Bay Area Hospitals* (Jan. 17, 2019), Merc. News <http://bit.ly/3KVhOZQ> [emphasizing differences between the County and for-profit hospital operators and the strain placed on public resources by hospital closures].) Reflecting this point, the County purchased two of its three hospitals out of bankruptcy to prevent such closures, including the only acute care hospital in a less densely populated area of the county (sometimes referred to as a "rural" hospital). (E.g., News Release, County of Santa Clara Office of Communication and Public Affairs, *County of Santa Clara to Assume*

Responsibility for Operating O'Connor and St. Louise Hospitals on March 1 (Mar. 1, 2019) <https://news.sccgov.org/news-release/county-santa-clara-assume-responsibility-operating-oconnor-and-st-louise-hospitals>; Press Release, U.S. Congresswoman Zoe Lofgren, *Santa Clara County Congressional Delegation Applauds Purchase of O'Connor and Saint Louise Hospitals* (Mar. 1, 2019) <https://lofgren.house.gov/media/press-releases/santa-clara-county-congressional-delegation-applauds-purchase-o-connor-and>.)

The choices made by a county about how to fulfill such interrelated duties and functions—whether by operating a hospital that "competes" for private patients, a health plan that "competes" for local enrollees while focusing on providing care through its public healthcare system, or some other participation in the healthcare market—thus do not, as the Legislature has recognized, supply a rationale for imposing extra-textual limitations on immunity. Indeed, the Legislature had before it, during the 1993-to-1994 legislative session, the question whether imposing a statutory requirement to reimburse emergency health care providers should waive government immunity. It opted instead to expand government immunity by extending it to special county health commissions and health authorities. (See 1994 Cal. Legis. Serv. Ch. 632 [SB 2092]; 1994 Cal. Legis. Serv. Ch. 642 [AB 2755]; 1994 Cal. Legis. Serv. Ch. 652 [AB 3221]; 1994 Cal. Legis. Serv. Ch. 614 [SB 1832].)

2. Plaintiffs' Open-Ended Damages Claims Are Not Comparable to Imposition of a Statutory Penalty or Mandamus Relief

The case law relied on by Plaintiffs' amici does not in any event support the novel expansion of public entity liability advocated here. For example, while Plaintiffs' amici cite case law addressing mandamus claims against a public entity to compel it to perform a purely ministerial duty (e.g., Provider Groups Br. 18, citing *City of Dinuba v. County of Tulare* (2007) 41 Cal. 4th 859), none of the amici write in support of Plaintiffs' argument that they should be granted leave to assert a mandamus claim.

Neither Plaintiffs, nor any of their amici, have argued, nor could they, that the County's reimbursement determinations are purely ministerial. Rather, Plaintiffs' amici emphasize that, in their view, the merits of Plaintiffs' claim turn on open-ended factual judgments to be made by a jury, presumably after a trial that airs evidence not before the County when it selected a reimbursement methodology. (E.g., HCA Hospitals Br. 25 ["whether the County paid too little, or the Hospitals charged too much, or both, is a question of fact"].) But a mandamus action is not a forum for second-guessing discretionary judgments made by public officials, as it is instead meant to either: (a) compel compliance with a purely ministerial duty; or (b) remand a matter to a public entity to exercise its discretion within lawful limits. (Answering Br. 63–66.) Courts have long understood that mandamus cannot lie to control the exercise of

discretion—it may only compel the release of government funds pursuant to a purely ministerial duty. (E.g., *Madera Community Hospital v. County of Madera* (1984) 155 Cal.App.3d 136, 146–49 [distinguishing *County of Sacramento v. Lackner* on the ground that, in that case, petitioners were owed a specific quantum of money incidental to the performance of a purely ministerial duty].)

The Provider Groups' heavy reliance on this Court's decision in *Kizer v. County of San Mateo* (1991) 53 Cal.3d 139 is similarly unavailing. In *Kizer*, this Court rejected an argument that a public entity was immune from a statutory penalty scheme, reasoning that application of immunity would result in a two-tiered system of enforcement. (Provider Group Br. 19, citing *Kizer*, at p. 148.) Here, however, the County has consistently emphasized that it *is* subject to an administrative enforcement scheme under the Knox-Keene Act—including penalties, as well as a range of other, potentially harsher sanctions—that the Legislature and Governor deemed sufficient to enforce the requirements of the Knox-Keene Act. (E.g., App. 19–20.)

Further, in *Kizer* this Court found that civil penalties fall outside of immunity because they apply irrespective of any showing of actual harm. (Provider Group Br. 19, citing *Kizer*, *supra*, 53 Cal.3d at pp. 146–47.) By contrast, Plaintiffs here seek compensatory damages for an alleged harm: The primary aim of this lawsuit is to obtain adjudication by a jury of the

alleged measure of purported harm occasioned by Plaintiffs' claimed loss in profits. (E.g., Answer Br. 41–45; cf. *NorthBay Healthcare Group v. Blue Shield of California Life & Health Insurance* (N.D. Cal. 2018) 342 F.Supp.3d 980, 983–84 [reimbursement claim must be "predicated on an incorrect reimbursement amount that causes [plaintiff] injury"].)

Kizer also reasoned that a penalty is intended to secure compliance with "some minimum health or safety standard" rather than to make plaintiffs whole. (Provider Group Br. 19 [*Kizer*, *supra*, 53 Cal.3d at pp. 146–47].) By contrast, in a quantum meruit action for reimbursement at a hypothetical and fluctuating market value, the factfinder is, as DMHC has recognized, not limited to criteria intended to establish whether a plan has met the minimum standard to comply with regulations. (Request for Judicial Notice (RJN), Ex. H, at p. 4.) Rather, the main point of such a lawsuit is to make the plaintiffs whole by determining a quantum of damages based on a mix of information, some of which was not and could not have been available to the plan when it crafted or implemented its reimbursement methodology. (Answer Br. 40–43.)

Thus, in marked contrast to a statutory penalty scheme (or a mandamus action), the reimbursement claims contemplated by Plaintiffs and Plaintiffs' amici would subject the County to open-ended financial exposure for damages claims based on elastic and largely uncircumscribed criteria—where concerns about such open-ended exposure prompted the

Legislature to sharply limit claims for money or damages against a public entity to those explicitly authorized by statute. (E.g., Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) pp. 817–18.) This point is only underscored by the allegations in the HCA Hospitals' brief, should the Court consider those allegations, as, per the HCA Hospitals, they seek over $270,000,000 in damages against the County, keyed off of their full billed charges. (HCA Hospitals Br. 5–6.)

3. The New Arguments Interjected by Plaintiffs' Amici, if Considered, Are Unavailing

a. Immunity Is Not Limited to Claims for Intentional Wrongdoing

The Provider Groups also make the novel argument that substantive immunity under the Government Claims Act is limited to "intentional wrongdoing." (Provider Groups Br. 28.) The Court should decline to consider this argument, which is not supported by cited authority and was not raised in the merits briefing. (E.g., *California Redevelopment Assn. v. Matosantos* (2011) 53 Cal.4th 231, 242 n. 2 [declining to consider legal arguments first raised by amici].)

In any event, the Legislature's creation of a narrow negligence claim under Government Code section 815.6 as an exception to immunity implicitly recognizes that, as a general matter, substantive immunity applies to negligence claims—not just claims predicated on intentional wrongdoing. And while the Provider Groups suggest that only intentional

wrongdoing is "tortious," they do not explain how this generalization comports with traditional tort standards such as strict liability and negligence. Nor do they grapple with the legislative history, which extensively discusses extending immunity to both negligence-based and intentional torts, with exceptions codified by statute. (E.g., Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) pp. 810–13, 830.)

b. Plaintiffs Have Conceded That They Seek Relief for an "Injury" Within the Meaning of the Government Claims Act

The HCA Hospitals argue that reimbursement claims do not fall within substantive immunity because they are not predicated on seeking recovery for an "injury" within the meaning of the Government Claims Act. (HCA Hospitals Br. 15–16, citing Gov. Code, § 815.) This argument was not advanced by the Plaintiffs in merits briefing (e.g., Opening Br. 33–34; Answer Br. 51), and thus should be disregarded. (*California Redevelopment Assn.*, *supra*, 53 Cal.4th at p. 242.)

Should the Court consider the argument, the HCA Hospitals err because the reference to "injury" in section 815 of the Government Claims Act is not intended to circumscribe immunity. Rather, the Legislature sought to make clear that, in setting forth various exceptions to immunity and in creating particular statutory causes of action against public entities, the Legislature did not intend to broaden public entity liability to

encompass damages claims for injuries to the type of interests that would not be compensable in a lawsuit against a private party. (Gov. Code, § 810.8; see also Cal. Law Revision Com. com., West's Ann. Cal. Gov. Code (2022 ed.) foll. § 810.8 ["The purpose of the definition is to make clear that public entities and public employees may be held liable only for injuries to the kind of interests that have been protected by the courts in actions between private persons."].) The reference to "injury" is thus intended to limit public entity *liability*, not to constrain *immunity*.

By contrast, in *City of Dinuba v. County of Tulare*, the plaintiff public entities sought a form of relief from a county—reallocation of tax revenue—that was only available against government entities, not private parties. (*City of Dinuba v. County of Tulare* (2007) 41 Cal.4th 859, 867.) Accordingly, the claim was properly asserted via mandamus and did not implicate the Government Claims Act. Here, the Sixth District confronted the inverse scenario, as Plaintiffs' arguments center on the premise that this Court should extend common law remedies already available against private parties to public entities—precisely the scenario addressed via the Government Claims Act. The HCA Hospitals' invitation to reinterpret the Act's reference to "injury" to constrain immunity for such damages claims

would run counter to legislative intent in referring "injury" in section 815, as well as the Legislature's core purpose of rigidly confining immunity.[5]

4. Government Code Section 815.6 Does Not Authorize Plaintiffs' Damages Claims

Plaintiffs' amici also argue that Plaintiffs' claims are authorized by Government Code section 815.6, which provides a negligence claim against a public entity for breach of a mandatory statutory duty. (E.g., Provider Group Br. 15, 28.) But, as the County has demonstrated, section 815.6 does not apply where fulfilling a statutory requirement involves the exercise of judgment, lending itself to a normative or qualitative debate about whether the requirement was satisfied. (Answer Br. 59–62.)

Rather than confront this point, Plaintiffs' amici, like Plaintiffs, seek to conflate two distinct questions: (a) whether a claim is adjudicable or amenable to judicial resolution, with (b) whether a judgment made by a public entity may be unseated via a claim under section 815.6. (E.g., HCA Hospitals Br. 20–23.) But the starting premise of the Government Claims Act is that there are meaningful differences between the claims that may be adjudicated between private parties versus those that may be brought

[5] The Provider Groups also implicitly concede that Plaintiffs seek relief for an "injury" in asserting that "Government Code section 815.6, and not the immunity of section 815, applies to any claim for reimbursement under Section 1371.4." (Provider Groups Br. 15.) Their reliance on section 815.6 also stands in considerable tension with Plaintiffs' argument, first asserted in this Court, that Plaintiffs do not seek "money or damages" within the meaning of the Government Claims Act.

against a public entity. (E.g., Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) p. 810 ["Government cannot merely be made liable as private persons are, for public entities are fundamentally different from private persons"].) That the judgments of a private plan might be revisited by a factfinder, whereas the same outcome would not be true for a public entity, comports with the Legislature's recognition that counties must be safeguarded from non-contractual claims for money or damages when fulfilling a range of governmental functions, including mandatory functions that require the exercise of discretion or judgment. (E.g., *ibid.*)[6]

The County agrees with CSAC that Plaintiffs also appear to be conflating the standard for determining whether a claim is cognizable under section 815.6—an issue that is determined as a matter of law at the pleading stage of a proceeding—with the standard for applying an affirmative defense under section 820.2 of the Government Claims Act for

[6] Plaintiffs' amici emphasize that courts have described section 1371.4 of the Knox-Keene Act as imposing a "mandatory" duty on health plans to reimburse providers for emergency care. (E.g., Provider Group Br. 26; HCA Hospitals Br. 17, 21–23, 25.) The phrase "mandatory duty," as used in the context of immunity and mandamus discussions, is a term of art focused on narrowing relief to ministerial matters, meaning matters that do not involve exercising judgment or discretion. The cases cited by Plaintiffs' amici do not purport to employ such terms of art, but rather address common law and statutory claims against private entities, in which the phrase "mandatory" has an ordinary, colloquial meaning. It is thus of no moment whether courts happened to use the word "mandatory" in the cases cited by Plaintiffs, as those courts did not purport to address governmental liability for non-ministerial determinations.

discretionary acts. (CSAC Br. 17–19.) As CSAC correctly observes, if an act is discretionary within the meaning of section 820.2, it presumably could not serve as a basis for a claim under section 815.6. (*Id*. at pp. 17–18.) But the converse is not true, as a claim under section 815.6 is available only where fulfilling a statutory requirement requires *no* judgment or discretion, a standard more protective of the public entity.

The County's adoption of a written policy to guide its "reasonable and customary rate" reimbursement determinations, as well as its implementation of that policy, plainly involve the exercise of judgment. Indeed, Plaintiffs challenge the County's fundamental policy choices in selecting a reimbursement policy. A plan's reimbursement methodology is set forth in a written document filed with the DMHC and applied across all reimbursement determinations.[7] A description of the County's current reimbursement methodology is available on the County's websites. (VHP, *Policy and Procedures: Operating Manual* <https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/documents/NCPR_0.pdf> [last visited Apr. 18, 2023]; VHP, *Claims Settlement Practices, Dispute Resolution Mechanism: Provider Notice*

[7] See generally DMHC, Letter of Agreement (Feb. 25, 2022) <https://wpso.dmhc.ca.gov/enfactions/docs/4135/1648224712620.pdf> [referencing filing of reimbursement methodologies with the agency]; *NorthBay Healthcare Group*, *supra*, 342 F.Supp.3d at p. 984 [noting that health plans file their plan-specific methodology with DMHC, which has the authority to address a non-compliant methodology via a range of disciplinary measures].

<https://www.valleyhealthplan.org/providers/forms-and-resources/claims-settlement-practices-dispute-resolution-mechanism> [last visited Apr. 18, 2023].)

As the description of the County's current reimbursement methodology posted on its website shows, the County's chosen policy reflects a series of judgments about how to balance competing criteria and incorporate the applicable regulatory factors, drawing from a range of sources, while ensuring that reimbursements approximate market rates for the relevant market measured as a multiple of the applicable Medicare rate. (*Ibid.*) Plaintiffs do not argue that the County misapplied its methodology or otherwise committed procedural error. Rather, Plaintiffs seek to unseat the County's basic policy choices in selecting a compliant reimbursement methodology, by replacing the County's methodology with a completely different payment method.

5. The Sixth District Correctly Found, in Analysis Unchallenged by Plaintiffs, That the Knox-Keene Act Does Not Afford a Private Right of Action for Reimbursement

The HCA Hospitals seek to interject an argument that the Knox-Keene Act affords private hospitals a private right of action for reimbursement—notwithstanding that Plaintiffs have abandoned this argument. (Compare HCA Hospitals Br. 17–19, with Reply Br. 30 ["The Hospitals do not purport to allege a private right of action under the Knox-

Keene Act."]) Should the Court nevertheless consider the argument, the Sixth District correctly found, and Plaintiffs conceded, that nothing in either the text or the legislative history of the Knox-Keene Act indicates that the Legislature intended to afford such a private right of action. (Answer Br. 36, citing *County of Santa Clara v. Superior Court* (2022) 77 Cal.App.5th 1018, 1030–31.) And the statutory language clarifying that the remedies afforded under the Knox-Keene Act do not preclude pursuit of "otherwise available" remedies (Health & Saf. Code, § 1371.37, subd. (e)) is incompatible with the HCA Hospitals' argument that the Knox-Keene Act creates such remedies.

The HCA Hospitals' novel argument that all pecuniary obligations give rise to a private, statutory right of action for civil damages claims is inconsistent with this Court's jurisprudence and would make little sense where the relevant pecuniary obligation is accompanied by an extensive enforcement scheme. (HCA Hospitals Br. 17–19.) In *Lu v. Hawaiian Gardens Casino, Inc.*, this Court found that a statutory provision entitling employees to gratuities—thus potentially imposing pecuniary obligations on the employer—did not afford a private right of action, observing that "we begin with the premise that a violation of a state statute does not necessarily give rise to a private cause of action." (*Lu v. Hawaiian Gardens Casino, Inc.* (2010) 50 Cal.4th 592, 603.)

The HCA Hospitals complain that the County cited this Court's decision in *Lu*, but did not address an intermediate appellate court decision, *Goehring v. Chapman University* (2004) 121 Cal.App.4th 353, distinguished at the end of a footnote in *Lu*, which found that a different statute created a private right of action. (HCA Hospitals Br. 19 ["the County ignores *Lu*'s specific discussion of *Goehring*"].) But *Goehring* addressed a statutory provision entitling students to a discrete sum—a refund of tuition—for violation of a statutory disclosure obligation. (*Goehring*, at p. 358.) That remedy is akin to a statutory penalty provision, as it sets forth payment of a specific sum as the means of enforcing a statutory obligation—not an extra-textual right to compensatory damages fixed by a jury. The court simply did not address the type of open-ended damages claim being asserted here.

Further, *Goehring* was grounded in the court's determination that the statutory provision would be rendered "nugatory" unless the Legislature intended to afford a private right of action. (*Goehring*, *supra*, 121 Cal.App.4th at p. 379.) Here, by contrast, both the Legislature and Governor contemplated that the DMHC's enforcement authority and dispute resolution mechanisms are sufficient to enforce the provisions of the Knox-Keene Act. (*Id*. at p. 378 [distinguishing this Court's decision in *Moradi-Shalal v. Fireman's Fund Ins. Companies* on the ground that, there, the statutory scheme afforded alternative enforcement remedies such as

cease and desist orders and penalties]; see also App. 19–20.) A statutory scheme that creates a pecuniary obligation but affords a robust enforcement scheme does not supply a rationale for implying a private right of action.

The Provider Groups' emphasis that the Knox-Keene Act is a comprehensive and carefully designed scheme (e.g., Provider Group Br. 11, 22–23) thus further supports the Sixth District's analysis. That comprehensive scheme, reflecting policy choices by the Legislature and Governor, affords no private right of action, instead focusing on administrative enforcement and other dispute resolution mechanisms. (E.g., App. 19–20.)

II. The Viability of the Emergency Medical System Does Not Depend on the Court's Adoption of a Novel Rule That Would Ignore the Many Differences Between Public and Private Participants in the Healthcare Market

A. Hospitals Do Not Operate Emergency Departments with the Expectation That They Will Receive the Same Reimbursement Rates Across Patients or Have the Same Remedies Against Public and Private Plans

Plaintiffs' amici, like Plaintiffs, urge this Court to adopt a rule that would afford them the same remedies against public and private plans. (E.g., Provider Group Br. 16, 29–30; HCA Hospitals Br. 8–15; Reply Br. 9–10.) But in the vast majority of instances in which Plaintiffs treat enrollees in public plans, the patient is participating in the Medi-Cal program, so that reimbursement will not be governed by the Knox-Keene Act. (Answer Br. 18.) As courts have recognized, it has long been the case

that hospitals choose to operate emergency departments knowing that a significant portion of the patients that they treat will be enrolled in public programs, such as Medi-Cal, that are governed by different reimbursement rates and regulatory schemes. (E.g., *Dameron Hospital Assn. v. AAA Northern California, Nevada, & Utah Ins. Exchange* (2014) 229 Cal.App.4th 549, 552, citing *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 552, 560 ["[d]epending on who pays the bill for emergency room services," payment "for the same treatment can vary substantially"]; see also DMHC, Amicus Brief, *Centinela Freeman Emergency Medical Association v. Health Net of California, Inc.* (Cal., No. S218497, Mar. 22, 2016) p. 7, https://www.dmhc.ca.gov/Portals/0/DataAndResearch/Archive/acbcremavhnoc.pdf ["Non-contracted emergency providers operate with full knowledge of the inherent financial risks associated with the very nature of emergency care"].)[8]

[8] Given that both Plaintiffs and the HCA Hospitals are subsidiaries of national healthcare conglomerates, it bears noting that the emergency medical system outside of California also does not operate under, much less depend upon, a singular reimbursement regime, notwithstanding the fact that rules requiring emergency departments to stabilize patients experiencing a medical emergency apply across the country. (E.g., 42 U.S.C. § 1395dd.)

For example, private civil suits for reimbursement in federal court, or in states other than California, are likewise in many instances either: (a) subject to mandatory, binding federal arbitration (e.g., 42 U.S.C. § 300gg-111(c)(5)(E)(i) [imposing binding dispute resolution process for

The Provider Groups thus are correct that "[t]his case does not involve reimbursement of emergency care to Medi-Cal enrollees." (Provider Groups Br. 29 fn. 4.) Yet while they purport to accordingly focus their amicus brief solely on non-Medicaid enrollees, the Provider Groups nevertheless repeatedly sweep Medi-Cal enrollees into their arguments. For example, the Provider Groups state that public plans cover "8.2 million enrollees . . . which represents 1 in 5 Californians," and enrollment in public plans "has seen a steady increase over the past decade," so the Court's decision in this case will "have substantial consequences on the market." (*Id.* at pp. 31–32.)

As explained in the County's answer brief, however, approximately 95% of those enrollees are participants in Medi-Cal managed care programs, placing them outside the scope of this dispute. (Answer Br. 18, citing California HealthCare Foundation, *2019 Edition—California's County-Based Health Plans* (Aug. 12, 2019) <http://bit.ly/3ABeEWO> [last visited Dec. 12, 2022] ["California's County-Based Health Plans,

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disputes with non-contracted providers in the absence of a state-law reimbursement scheme]); (b) precluded by administrative remedies applicable to public programs (e.g., *Doctors Medical Center of Modesto, Inc. v. Kaiser Foundation Health Plan, Inc.* (E.D. Cal. 2013) 989 F.Supp.2d 1009, 1015); or (c) barred by immunity under the Eleventh Amendment (S. Rep. 94-1240, 1976 U.S. Code Cong. & Admin. News, pp. 3-4 [discussing repeal, shortly after enactment, of provision that would have required states to waive immunity from suits by Medicaid providers as a condition of receipt of certain funds]; *Hospital Ass'n of New York State v. Toia* (S.D.N.Y. 1977) 435 F.Supp. 819, 826 [same]).

2019—Data (ZIP),” Additional Notes, lines 81–83].) And the recent increases in enrollment referenced by the Provider Groups largely stem from expansions in Medicaid eligibility found in laws such as the Affordable Care Act. (E.g., Answer Br. 17–18, citing Kaiser Family Foundation, *Medi-Cal Managed Care: An Overview and Key Issues* (Mar. 2, 2016) <http://bit.ly/3tPFeaH> [last visited Dec. 12, 2022].)

Thus, neither the Sixth District’s ruling, nor a reversal of that ruling, presumably could have the reverberating effects posited by Plaintiffs’ amici. The reliance by Plaintiffs’ amici on statistics for Medi-Cal enrollees, taken together with their urging that this Court adopt a broad rule regarding identical treatment of public and private plans, does, however, raise questions about whether providers anticipate utilizing some aspect of a favorable ruling by this Court to seek heightened reimbursement or new remedies for some portion of the patients enrolled in Medi-Cal, where their prior attempts to do so were unsuccessful. (E.g., *Allied Anesthesia Med. Grp., Inc. v. Inland Empire Health Plan* (2022) 80 Cal.App.5th 794, 812–13; *Dignity Health v. Loc. Initiative Health Care Auth. of Los Angeles Cnty*. (2020) 44 Cal.App.5th 144, 162.) The Sixth District’s decision as it currently stands does not, however, purport to address reimbursement under Medi-Cal.

B. Application of Immunity Does Not "Bifurcate" the DMHC's Robust Enforcement Authority over the County's Operation of a Licensed Health Plan

The Provider Groups and HCA Hospitals set up a strawman, insisting that the County is seeking to create a "bifurcated" or "two-tiered scheme of regulation divided between public and private health plans." (E.g., Provider Groups Br. 16; HCA Hospitals Br. 10.) The County seeks no such thing. All parties agree that the County is subject to the substantive requirements of the Knox-Keene Act and that the DMHC may use the full range of its powers to enforce the provisions of the Knox-Keene Act irrespective of whether a plan is public or private.

Plaintiffs' amici further assert that if the County prevails, it will pay hospitals arbitrary, random rates. (E.g., Provider Groups Br. 31, 34; HCA Hospitals Br. 11.) Not so. Although the County exercises discretion in determining the reasonable and customary amount it pays to an out-of-network hospital when that hospital provides emergency services to its members, the amount the County pays is far from random and certainly is not a wholly *ad hoc* determination. The County's reimbursement is governed by its reasonable and customary reimbursement methodology—a written policy that has been filed with DMHC and that must be applied across reimbursement determinations. (See *supra* pp. 26–27.)

The County's discretion is, moreover, guided and constrained by the parameters laid out in the DMHC's regulatory framework, and its

methodology is subject to multi-layered review by the DMHC. In addition to the DMHC's ability to issue or revise its regulations addressing the calculation of reasonable and customary rates, three aspects of DMHC authority stand out as notable. First, the DMHC conducts routine audits of each health plan every three to five years and initiates additional, non-routine audits as needed. (Health & Saf. Code, § 1382; Cal. Code Regs., tit. 28, § 1300.71(a)(3)(B); RJN, Ex. D, at pp. 26–27.) During these audits, the DMHC assesses a range of considerations, including whether the plan's methodology for determining reasonable and customary rates adequately accounts for the criteria laid out in the regulatory framework and is "based on statistically credible information that is updated at least annually." (DMHC Office of Financial Review, *Technical Assistance Guide: Claims Management and Processing* (2020) p. 5.) The audits "are a significant undertaking" that demand hours of preparation and participation on the part of plans, including during the period in which DMHC auditors appear "on site at the plan's offices, reviewing files and interviewing employees." (Local Health Plans Br. 16.)

Second, the DMHC Provider Complaint Unit has an established process for the submission and review of provider complaints, and the DMHC does not shy away from initiating investigations and enforcement actions based on complaints. (DMHC, *Provider Complaint Against a Plan* <https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPla

n.aspx> [last visited Mar. 24, 2023]; see also Local Health Plans Br. 19.) Indeed, in one such action involving a plan's methodology for calculating reasonable and customary rates, the plan agreed to revise its methodology, reprocess and repay claims submitted during a particular time frame, pay an administrative penalty, and submit compliance reports to the DMHC moving forward. (See generally RJN, Ex. B.)

Third, the DMHC can initiate investigations and enforcement actions sua sponte. (Local Health Plans Br. 22.) During such an investigation, the DMHC may issue subpoenas, obtain deposition-style testimony, and request answers to interrogatories. (Health & Saf. Code, § 1341.8; Gov. Code, §§ 11180, 11181.) If the DMHC uncovers regulatory violations—including an issue with a plan's methodology for calculating reasonable and customary rates—it may enforce the provisions of the Knox-Keene Act by, among other serious remedies: issuing a cease-and-desist order; suspending or revoking a plan's license; imposing civil penalties; ordering the remediation of payment deficiencies; ordering the submission of a corrective action plan; pursuing injunctive relief in a civil action; and, in cases involving willful violations, seeking criminal sanctions. (Health & Saf. Code, §§ 1386, subd. (a), 1387, subd. (a), 1390, 1391, subd. (a)(1); see also RJN, Ex. B.) DMHC reports indicate that, annually, plans pay millions of dollars in penalties stemming from DMHC enforcement actions.

(RJN, Exs. D, E [plans paid $165.1 million in 2020 and $177.8 million in 2021].)

There is no question that the DMHC "is equipped with the tools to prevent systemic underpayments to out-of-network hospitals" and puts those tools to good use. (Local Health Plans Br. 18.) Plaintiffs—who have not alleged that they ever submitted a complaint to the Provider Complaint Unit—insist that the DMHC lacks jurisdiction to adjudicate the issues raised in this dispute. (Reply Br. 25.) Neither of Plaintiffs' amici defend that position, and for good reason. The statute explicitly confers on the DMHC jurisdiction to enforce any requirement of the Knox-Keene Act, including the requirement to pay a reasonable and customary rate. (Health & Saf. Code, § 1341 [the DMHC "may exercise all powers necessary or convenient for the administration and enforcement of" the Knox-Keene Act]; see also *id.* §§ 1386, 1387, 1390, 1391, 1392 [authorizing the DMHC to use a range of enforcement tools to address any violation of the Knox-Keene Act].) Recent DMHC reports demonstrate that the agency understands it has jurisdiction to remedy shortcomings in a plan's reasonable and customary reimbursement methodology. (Local Health Plans Br. 16–17.) And the DMHC has, in fact, done so and ordered meaningful relief. (E.g., RJN, Ex. B.)

To be sure, the DMHC stated in an eighteen-year-old amicus brief, focused primarily on addressing the harms of balance billing, that the

agency lacks the authority to set specific reimbursement rates using quantum meruit-style damage calculations. (*Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1273; Reply Br. 25.) But this proposition only supports the County's argument that the relief Plaintiffs seek falls outside of the scope of the Knox-Keene Act, as the DMHC's enforcement authority covers all provisions of the Knox-Keene Act. Put differently, there is a tension between Plaintiffs' assertion that they have filed a purely statutory claim and their assertion that the DMHC lacks authority over this dispute. In any event, DMHC's more recent and consistent reports to the Legislature reflect that DMHC regularly and effectively resolves reimbursement disputes. (See *supra* p. 36; see also RJN, Ex. A [reflecting the Governor's expectation that the tools available to DMHC would be sufficient to ensure adequate reimbursement].)[9]

As Plaintiffs acknowledge, DMHC plainly has statutory jurisdiction to remedy "an unfair payment pattern" by a plan. (Health & Saf. Code, § 1371.31, subd. (a); see also Reply Br. 20–21.) But the DMHC also has

[9] Throughout the briefing, Plaintiffs have misapprehended the nature of their claims. The fact that their quantum meruit claims are predicated on a purported violation of the Knox-Keene Act does not transform their common law claims into statutory claims, just as an Unfair Competition Law (UCL) claim remains a UCL claim even if it is predicated on an alleged violation of the Knox-Keene Act. (E.g., *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 216 [providers may sue private plans for purported violations of section 1371.4 "at common law on a quantum meruit theory"].)

authority to remedy any other violation of the Act—including a failure to reimburse at a reasonable and customary rate—regardless of whether the violation stands on its own or as part of a pattern. (E.g., Health & Saf. Code, § 1386 [DMHC can suspend or revoke a plan's license if the plan "has violated or attempted to violate . . . any provision" of the Act]; *id.* § 1387 [DMHC can impose civil penalties on a person who "violates a provision" of the Act]; *id.* § 1390 [DMHC may seek criminal sanctions if a person "willfully violates any provision" of the Act]; *id.* § 1391 [DMHC may issue a cease-and-desist order prohibiting a plan or person from "engaging in any act or practice in violation" of the Act]; *id.* § 1392 [DMHC may seek injunctive relief "[w]henever it appears" that a person "has engaged, or is about to engage, in any act or practice constituting a violation" of the Act]; see also *id.* §§ 1387, 1386 [when the DMHC selects an appropriate remedy for a violation of the Act, it should consider whether "the violation is an isolated incident"]).

In short, it is plain that the Knox-Keene Act grants the DMHC comprehensive enforcement powers that give teeth to the Knox-Keene Act's requirements. Any complaints about the Legislature's chosen mode of enforcement should be directed to the Legislature, not this Court.

C. The Adequacy of the County's Contracted Network of Providers Is Subject to Robust Oversight by DMHC

The Provider Groups urge that unless the Court rules in favor of the Plaintiffs, the County will attempt to lower the rates it pays for emergency services by refusing to contract with out-of-network hospitals. (Provider Groups Br. 34.) Both courts and the Legislature have rejected similar, speculative arguments about plans' incentives to contract. (E.g., *Dignity Health, supra*, 44 Cal.App.5th at p. 165 [argument about claimed impact of ruling on incentives to contract is properly directed to the Legislature, not courts]; Assem. Com. on Health, Analysis of Assem. Bill No. 72 (2015-16 Reg. Sess.) Aug. 30, 2016, pp. 7, 13, 18, 20–21 [in response to provider group concerns, the Committee on Health observed, after considering input from DMHC, that existing regulatory oversight ensures the adequacy of health plans' contracted networks].) In any event, the Provider Groups' argument is based on the mistaken premise that public and private entities compete in the healthcare market in an identical manner—notwithstanding the many differences between public and private entities, including those recognized by the Legislature in making immunity the default rule and in excluding public entities from liability under the Unfair Competition Law.

The Provider Groups also have the perverse incentive argument backward. As explained by the Health Economists, a vanishingly small number of patients and plans pay a hospital's billed charges. (Health

Economists Br. 13–20.) If hospitals gain the ability to use the judiciary as a tool to force public plans to make payments that align more closely with the hospital's billed charges, it is the hospitals that will acquire a powerful incentive to remain outside the contracted network of public plans. (Cf. H.R. Rep. No. 116-615, 2d Sess., p. 53 (2020) ["[A] failure in the health care market causes providers . . . to have little or no incentive to contract to join a health plan's network due to a number of unique circumstances" including that the "providers face highly inelastic demand for their services because patients lack the ability to meaningfully choose or refuse care . . . during an emergency" and that providers "often hold substantial market power"].)

And, notably, there is a meaningful difference between the position of the Plaintiffs and that of the County. The County is legally obligated to maintain an adequate network of contracted providers. (Health & Saf. Code, §§ 1367.03, 1367.035; Cal. Code Regs., tit. 28, §§ 1300.51, 1300.67.2, 1300.67.2.1, 1300.67.2.2, 1300.97.2.3(a), 1300.67.8.) For example, the County must ensure that all plan enrollees live or work within 30 minutes or 15 miles of a contracted or plan-operated hospital that provides emergency health care services. (Cal. Code Regs., tit. 28, § 1300.51(d)(H)(ii).) The DMHC closely scrutinizes, on an annual basis, whether the County has met that and other network adequacy obligations. (E.g., DMHC, *Timely Access Compliance and Annual Network Report*

<https://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings/TimelyAccessReport.aspx> [last visited Mar. 20, 2023].) So, unlike the Plaintiffs, the County "cannot simply choose to forego contracting." (Local Health Plans Br. 24.)

To be sure, robust contracting in the healthcare space is a public good. And while the particular negotiating histories between the County and the HCA Hospitals are neither public nor properly before this Court, there are myriad reasons why the County seeks to contract with hospitals that will persist regardless of the outcome of this dispute, including the constitutional and statutory responsibilities discussed above as well as the desire for stability and certainty between entities that have frequent interactions. DMHC oversight ensures that the County's contracting decisions, whatever they may be with respect to individual healthcare facilities, will not undermine its responsibility to maintain an appropriately expansive network of contracted providers. That regulatory oversight is the proper forum for ensuring network adequacy—not litigation seeking damages in quantum meruit.

III. The Amicus Briefing Further Confirms the County's Point That the Various Other Public Policy Arguments Invoked Here Raise Complex Issues Best Considered, with Any Needed Additional Context, by the Legislature

Plaintiffs' amici, like Plaintiffs, purport to warn the Court of the "real-world consequences" that would "reverberate throughout the

marketplace" as a result of the Sixth District's decision. (Provider Group Br. 8, 29; see also HCA Hospitals Br. 8–15.) But, as the County urged in its answer brief, such predictive judgments are properly a matter for the Legislature. (Answer Br. 67–68.) In providing background to aid in demonstrating this point, the County did not, as Plaintiffs' amici contend, seek to preview a merits defense but, rather, to place Plaintiffs' policy arguments in context while speaking to the complex, multi-faceted, and important issues surrounding health care access and affordability that lie at the heart of the County's mission and operations.

The amicus briefing only further underscores that the arguments advanced in support of Plaintiffs' claims are not only misdirected, but also exceptionally speculative. For example, although Plaintiffs' amici invoke the plight of rural and "lower-charging" hospitals (HCA Hospitals Br. 26; Provider Groups Br. 12 fn. 2), neither Plaintiffs, nor the HCA Hospitals, can claim to fall within either of those categories or to speak on behalf of those hospitals. Plaintiffs' amici have not identified any connection between the special difficulties confronting such hospitals and quantum meruit lawsuits brought by subsidiaries of large, national healthcare conglomerates against a public health plan for full billed charges, so as to enable the County to respond.[10]

[10] The HCA Hospitals are subsidiaries of HCA Healthcare, Inc., one of the largest healthcare conglomerates in the country. (HCA Healthcare Inc.,

The suggestion by Plaintiffs' amici that this lawsuit (or the litigation by the HCA Hospitals) has anything to do with past or anticipated hospital costs associated with the pandemic, seismic upgrades, and changes to other public programs is similarly speculative and misguided. (E.g., Provider Groups Br. 12 fn. 2, 33–34, HCA Hospitals Br. 15.) Indeed, in their reply brief, Plaintiffs urged that discussion of cost had no place in this appeal. (Reply Br. 38.)

Any financial shortfalls as a result of the pandemic affecting *other* hospitals (to the extent they are not adequately alleviated by federal funding), have no bearing on this pre-pandemic dispute or the litigation brought by the HCA Hospitals, whose parent company (like Plaintiffs' parent company) operated at profit margins during most of the pandemic.

Form 10-k (2022), Ex. 21 <http://bit.ly/3L6r51a> [Delaware subsidiaries].) According to their publicly available regulatory submissions, the HCA Hospitals' billed charges during the years at issue in this appeal are based on cost-to-charge ratios comparable to, if not eclipsing, those of Plaintiffs. For example, in 2016, Regional Medical Center of San José reported a cost-to charge ratio of 12.26% and Good Samaritan Hospital, L.P. reported a cost-to-charge ratio of 13.47%, meaning the hospitals' billed charges represented approximately 12 or 13 times their claimed or "reported" costs. (Regional Medical Center of San José, *Summary Individual Disclosure Report* (2016) <http://bit.ly/3n2Q2lW>; Good Samaritan Hospital, *Summary Individual Disclosure Report* (2016) <http://bit.ly/3owa8FA>.) It is thus unsurprising that Plaintiffs' parent company, Tenet, identified HCA Healthcare, Inc. as a peer institution in its own SEC filing (Tenet Healthcare Corporation, *Form 10-k* (2022) pp. 34–35 <http://bit.ly/3V4JnEz>), nor is it surprising that the HCA Hospitals have been identified alongside Plaintiffs as hospitals with some of the highest billed charges in California. (E.g., National Nurses United, *Fleecing Patients: Hospitals Charge Patients More Than Four Times the Cost of Care* (Nov. 2020), p. 51 <http://bit.ly/3L3OoIP>.)

(See Hulver, Levinson, and Godwin, Kaiser Family Foundation, *Operating Margins Among the Largest For-Profit Health Systems Have Exceeded 2019 Levels for the Majority of the COVID-19 Pandemic* (Dec. 5, 2022) <http://bit.ly/3oqUYkR> [operating margins for HCA Healthcare and Tenet were positive and exceeded pre-pandemic levels for most of the pandemic]; HCA Healthcare, Inc., *HCA Healthcare Previews 2020 Third Quarter Results, Will Return Approximately $6 Billion in CARES Act Funding* (Oct. 8, 2020) <https://investor.hcahealthcare.com/news/news-details/2020/HCA-Healthcare-Previews-2020-Third-Quarter-Results/default.aspx> [announcement that HCA Healthcare would return federal relief funds]; Wang, Bai, and Anderson, *COVID-19 and Hospital Financial Viability in the U.S.*, 3 J. Am. Med. Ass'n Health F. 1, 1–7 [concluding that federal subsidies offset COVID-19 related losses for financially vulnerable hospitals, such as smaller or rural hospitals].)

The HCA Hospitals have it backward in suggesting that their anticipated need to meet healthcare affordability targets going forward is a rationale for permitting them to sue the County for hundreds of millions of dollars in billed charges. (E.g., HCA Hospitals Br. 15.) The affordability targets referenced will be implemented at the direction of the Legislature, as a reflection of the Legislature's conclusion that the amounts that hospitals are *currently* receiving for their services is already perilously high, placing untenable strain on the healthcare system and the economy

and even, in some instances, placing lives at risk by deterring Californians from seeking needed medical care. (E.g., Legis. Counsel's Dig., Sen. Bill No. 184, Stats. 2022, ch. 47 (2021-2022 Reg. Sess.) pp. 2–4; see also Shrank et al., *Health Costs and Financing: Challenges and Strategies for a New Administration* (Feb. 2021), 40 Health Affs. 235, 235–40 [noting that roughly half of U.S. adults have "delayed or avoided care because of cost" and explaining that health care costs have grown at "unsustainable" rates, which is growing the national debt, straining government budgets, stagnating wages, and generating financial insecurity for Americans].)

Nothing about this state of affairs suggests that the Legislature, were it to consider the matter, would conclude that anticipated future affordability targets warrant permitting hospitals to sue public plans for even higher reimbursement rates, much less hundreds of millions of dollars in billed charges. Nor in any event have amici demonstrated that anticipated reduced reimbursement would not be accompanied by greater efficiency or other cost-saving measures, preserving the generous profit margins reported by Tenet and HCA.

The Health Economists, by contrast, urge that Plaintiffs' cost-shifting arguments are not supported by current data and scholarship. (Health Economist Br. 23–25.) And these scholars conclude, after considering a variety of complex points about the healthcare market, that "the Court need not be concerned that affirming the Court of Appeal

decision below will lead to the public policy outcomes described by the Appellant Hospitals." (E.g., Health Economists Br. 25–26.) Ultimately, the resolution of such complex questions is, the amicus briefing thus confirms, properly undertaken, if needed and appropriate, by the Legislature.

IV. The HCA Hospitals' Unproven Allegations in Their Lawsuit Currently Pending Before the Sixth District Are Not Properly the Subject of Amicus Briefing

The HCA Hospitals repeatedly reference the facts of a dispute between them and the County that is currently pending before the Sixth District. (HCA Hospitals Br. 5–7, 23–25; see also *Regional Medical Center of San José v. County of Santa Clara* (Ct. App. Nov. 23, 2022, No. H050491) p. 1.) As the HCA Hospitals explain, the trial court's ruling in that case refers to and expands upon the reasoning of the decision on review. (HCA Hospitals Br. 5–6; see also *Regional Medical Center of San José v. County of Santa Clara* (Sup. Ct. Aug. 22, 2022, No. 20CV374697) p. 10.)[11] The County observes that arguments hinging on an entity's direct interest in the outcome of the litigation are not an appropriate subject of

[11] The HCA Hospitals are, however, mistaken in contending that the decision on review does not address post-stabilization care. (Compare HCA Hospitals Br. 7, 23–25, with App. 290–91 [allegations in Third Amended Complaint regarding inpatient treatment of stroke patient]). Further, while the HCA Hospitals urge that a plan is always notified before post-stabilization care is provided, Plaintiffs' allegations refute that contention; the operative pleading acknowledges that VHP was not contacted until after the patient was discharged. (App. 291, ¶ 38.)

amicus briefing, as the proper function of a friend of the court brief is "to advocate a position *not out of a direct interest in the litigation* but from [the entity's] views of what is legally correct and beneficial to the public interest." (*Connerly v. State Personnel Bd.* (2006) 37 Cal.4th 1169, 1183 [emphasis added].) The HCA Hospitals' attempt to insert legal issues from that case into this proceeding is not appropriate.[12]

In any event, the HCA Hospitals' emphasis on the alleged quantum of reimbursement purportedly owed by the County in its separate lawsuit, if considered—hundreds of millions of dollars in full billed charges—only further illustrates that such damages claims are not comparable to a mandamus action to compel a public entity to fulfill a ministerial duty by complying with the minimum standard imposed by statute or to the imposition of a discrete statutory penalty on a public entity.

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[12] As the HCA Hospitals acknowledge, their lawsuit raises allegations not relevant to the immunity issues currently before this Court. For example, the HCA Hospitals allege that the County paid "zero" for millions of dollars in claims. (HCA Hospitals Br. 24–25.) But here, the County paid roughly twice Plaintiffs' reported costs for the emergency services at issue. In any event, as the HCA Hospitals know, there are numerous reasons why a plan might lawfully pay zero in response to a claim, including that the patient was not enrolled in the plan or the claimed amount falls within the patient's co-pay obligation. Moreover, because the HCA Hospitals cite only to their own unproven allegations, this Court has no way of knowing whether the County in fact paid nothing on some or all of these claims, or whether some of the claims were later subject to adjustment, where appropriate and reasonable, as part of a dispute resolution process. Surely the HCA Hospitals do not suggest that, if the County paid zero on services worth millions of dollars, the DMHC would lack authority or jurisdiction to step in.

CONCLUSION

For the foregoing reasons, as well as those set forth in the County's answer brief, this Court should affirm the Court of Appeals' decision.

DATED: April 24, 2023

Respectfully submitted,

JAMES R. WILLIAMS
County Counsel

By: *__/s/ Susan P. Greenberg__*
SUSAN P. GREENBERG
Deputy County Counsel

Attorneys for Petitioner
COUNTY OF SANTA CLARA

CERTIFICATE OF COMPLIANCE

I, Susan P. Greenberg, certify that, pursuant to Rule 8.204(c)(1) of the California Rules of Court, the attached CONSOLIDATED ANSWER TO AMICUS BRIEFS has a typeface of 13 points or more, and contains 9,711 words, as determined by a computer word count.

DATED: April 24, 2023

/s/ Susan P. Greenberg
Susan P. Greenberg

CERTIFICATE OF SERVICE

I, Susan Greenberg, declare:

I am now and at all times herein mentioned have been over the age of eighteen years, employed in Santa Clara County, California, and not a party to the within action or cause; that my business address is 70 West Hedding Street, 9th Floor, San José, California 95110-1770. My electronic service address is: susan.greenberg@cco.sccgov.org. Participants who are registered with TrueFiling will be served electronically. Participants who are not registered with TrueFiling will receive hard copies via United States Postal Service. On **April 24, 2023**, I caused to be served, copies of the following:

CONSOLIDATED ANSWER TO AMICUS BRIEFS

to the people listed below at the following:

PLEASE SEE ATTACHED SERVICE LIST

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on **April 24, 2023.**

/s/ Susan P. Greenberg
Susan P. Greenberg

SERVICE LIST

County of Santa Clara v. The Superior Court of Santa Clara
Case No. S274927

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STATE OF CALIFORNIA
Supreme Court of California

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STATE OF CALIFORNIA
Supreme Court of California

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

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This proof of service was automatically created, submitted and signed on my behalf through my agreements with TrueFiling and its contents are true to the best of my information, knowledge, and belief.

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

4/24/2023

Date

/s/Susan Greenberg

Signature

Greenberg, Susan (318055)

Last Name, First Name (PNum)

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