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

ANSWER BRIEF ON THE MERITS

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STATEMENT OF THE ISSUE

Is the County of Santa Clara immune under the Government Claims Act (Gov. Code, § 810 et seq.) from an action seeking reimbursement for emergency medical care provided to persons covered by the County's health care service plan?

INTRODUCTION

When someone has a stroke or is injured in an accident, they often do not exercise meaningful, if any, choice over which emergency room will treat them. Real Parties in Interest Doctors Medical Center of Modesto, Inc. and Doctors Hospital of Manteca, Inc. (Plaintiffs) seek to exploit their resulting effective monopoly over such circumstances to pursue inflated sticker prices, known as billed charges, here, for medical services provided to three patients enrolled in Valley Health Plan (VHP).

VHP is a public-option plan operated by the County of Santa Clara (the County) offering enrollment to anyone who lives or works in Santa Clara County. The County reimbursed Plaintiffs in an amount it determined to be "reasonable and customary"—approximately twice of Plaintiffs' reported costs; Plaintiffs instead seek their full-billed charges, exceeding up to ten times costs.

The Court of Appeal correctly dismissed Plaintiffs' "reimbursement" claims that seek compensatory damages in quantum meruit, because their claims are barred by the Government Claims Act. The Government Claims

Act strictly reserves to the Legislature the prerogative to determine when claims for "money or damages" may be asserted against a public entity. Under the plain language of the Act, in Government Code sections 814 and 815, non-contractual claims for "money or damages" are broadly prohibited "except as otherwise provided by statute."

Each of these broad criteria for immunity is met here. *First*, the reimbursement claims are non-contractual. Plaintiffs do not challenge the Court of Appeal's ruling that their claims do not sound in contract.

Second, the claims are not "otherwise provided by statute." Plaintiffs argue that quantum meruit claims (sometimes called "implied-in-law" contract claims) are authorized by a provision of the Knox-Keene Act (Health & Saf. Code, § 1340 et seq.) requiring reimbursement of non-contracted providers at a "reasonable and customary" rate. But as the Court of Appeal correctly concluded—in analysis not meaningfully addressed by Plaintiffs—the cited provision does not authorize a private right of action and, thus, does not afford a cognizable statutory claim. By contrast, in the medical reimbursement cases cited by Plaintiffs, providers pressed *common law* claims or claims under the Unfair Competition Law (UCL) against private health plans. Plaintiffs do not challenge the Court of Appeal's ruling that neither a common law claim nor a claim under the UCL may be asserted against the County.

Third, Plaintiffs seek "money or damages." Reimbursement claims—the only type of claim at issue in this appeal—seek, as their primary objective, pecuniary relief in the form of an adjudication by a factfinder of a quantum of compensatory damages that effectively consists of alleged lost profits, based on concepts of value that are, in the medical reimbursement context, notoriously elastic.[1] Plaintiffs' reimbursement claims are thus quite distinct from the mandamus cases they cite, in which petitioners sought an order compelling compliance with a ministerial, statutory duty or payment of a civil penalty with no compensatory function.

Plaintiffs deepen their error by suggesting that immunity does not apply because this Court has purportedly read an extra-textual limitation into the Government Claims Act by holding that only claims traditionally considered to be "torts" are covered by immunity. Rather, this Court, like others, has used the term "tort" in this context as a shorthand for non-contractual claims for money or damages. This is in fitting with the Legislature's deliberate choice not to use the word "tort" in the Act, to strictly reserve to itself the determination whether a particular claim should fall outside of the reach of governmental immunity.

Plaintiffs' reimbursement claims also suffer from another fundamental problem, which renders their proposed amendments to the

[1] To be clear, Plaintiffs have never alleged that the County's reimbursement did not cover their costs, fell below national or state payment averages for all payors, or even differed significantly from Plaintiffs' contracted rates.

pleading futile. Plaintiffs do not and cannot dispute that selecting a reimbursement method entails the exercise of meaningful discretion: under the Knox-Keene Act, the "reasonable and customary" rate for a specific service is not a set amount and there is no fixed method for calculating the rate. Therefore, Plaintiffs' reimbursement claim does not fall within the narrow genre of statutory negligence claims authorized by Government Code section 815.6, because such claims are unavailable where, as here, fulfilling the statutory requirement entails the exercise of discretion. Mandamus similarly is not available to control the exercise of discretion by a public entity. Plaintiffs' claims, however framed, thus seek precisely the type of relief that is unavailable against a government entity.

Plaintiffs assert that a number of "sweeping" and "grave and chaotic" adverse effects might result if this Court does not reverse. (Opening Brief (OB) 39, 42.) But while a plaintiff's well-pled factual allegations are presumed to be true in assessing the sufficiency of a pleading, the same presumption does not apply to predictive assertions in briefing addressing public policy. This Court should therefore defer to the Legislature, as it has done in prior decisions, the burden of making predictive judgments about matters of health care policy—an arena in which, history readily illustrates, well-intentioned measures also have brought a host of complex and unintended consequences. In any event, were the Legislature ever to revisit the matter, it might well conclude that public policy is not served by permitting Plaintiffs to sue public plans for "reimbursement" of full-billed charges.

STATEMENT OF THE CASE

I. Background

Plaintiffs ask this Court to reverse based on their predictive assertions regarding the impact of the Court of Appeal's decision on health care access and affordability. (OB 11, 38–42.) The County therefore provides the following background as context for evaluating Plaintiffs' contentions, together with the related question whether the Legislature is the appropriate forum for vetting such predictive and value-laden judgments regarding health care policy.

A. The Broad Sweep and Transformative Impact of Public Health Plans

After over a half-century of study and debate, it is now widely accepted that the development and expansion of governmental health care programs in the United States have markedly increased lifespan and quality of life, particularly for elder Americans, vulnerable populations, women, and communities of color. (E.g., Lee et al., *Medicaid Expansion and Variability in Mortality in the USA: A National, Observational Cohort Study* (2022) 7 Lancet Pub. Health E48, E52–E54; Iglehart & Sommers, *Medicaid at 50: From Welfare Program to Nation's Largest Health Insurer* (2015) 372 New Eng. J. Med. 2152, 2155.)

Many early health plans, such as Blue Cross, were originally founded by physicians. (Paul Starr, *The Social Transformation of American Medicine* (1982) pp. 292, 294–96, 305–309 (hereafter Starr).) And more than fifty years ago, the American Medical Association (AMA) vehemently opposed the creation of Medicare and Medicaid, predicting at the time that it would "lead to the destruction of" the U.S. health care system. (E.g., Fee, *Signing the US Medicare Act: A Long Political Struggle* (2015) 386 Lancet Pub. Health 332, 332–33; see also Starr, *supra*, at p. 368; Cohen, *Reflections on the Enactment of Medicare and Medicaid* (1985) Health Care Fin. Rev. Ann. Suppl. 3, 4.) The AMA relented only after a compromise was struck, under which physician services would be separately included in these programs and private insurers like Blue Cross could administer claims and reimburse providers. (E.g., Giaimo, *Interest Groups, Think Tanks, and Health Care Policy: 1960–Present* in *U.S. Health and Health Care Policy* (Oliver edit., 2014) pp. 378–80; Starr, *supra*, at p. 369.)

California's Medicaid program, Medi-Cal, is the largest state Medicaid program in the nation, insuring approximately 14.8 million individuals[2]—one third of all Californians—after the program's expansion as part of the Affordable Care Act. (E.g., Kaiser Family Foundation, *Medi-*

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[2] Department of Health Care Services, *Medi-Cal Monthly Eligible Fast Facts* (Sept. 2022) p. 3, <http://bit.ly/3TZiUWH> [as of December 12, 2022] .

Cal Managed Care: An Overview and Key Issues (Mar. 2, 2016), <http://bit.ly/3tPFeaH> [as of December 12, 2022].) A distinguishing feature of Medi-Cal's managed care program is that different managed care models operate in different counties—a structure strongly influenced by counties' historical role in the delivery of primary care, public hospital services, mental health services, and care for indigent residents that arose in the nineteenth and early twentieth centuries. (*Ibid*.)

Plaintiffs note that, in California, there are about 7.4 million individuals enrolled in county-based health plans. (OB 12–13.) But as the source cited by Plaintiffs reflects, 95% of those enrollees are participants in Medi-Cal managed care programs—programs with reimbursement systems distinct from the "reasonable and customary" reimbursement scheme at issue here. (California HealthCare Foundation, *2019 Edition—California's County-Based Health Plans* (Aug. 12, 2019), <http://bit.ly/3ABeEWO> [as of December 12, 2022] ["California's County-Based Health Plans, 2019 — Data (ZIP)," Additional Notes, lines 81–83]; *supra* at 30.)

Together, Medi-Cal and Medicare provide the majority of net patient revenue for hospitals in California, using reimbursement methods not governed by the Knox-Keene Act. (*Supra* at 30; California HealthCare Foundation, *Medi-Cal Facts and Figures: Essential Source of Coverage for Millions* (Aug. 2021) p. 50 [relying on California Health and Human Services data].)

B. The Knox-Keene Act's Extensive Regulatory Apparatus to Ensure Efficient, Cost-Effective Care

The Knox-Keene Act is a "comprehensive system of licensing and regulation under the jurisdiction of the Department of Managed Health Care." (*Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 215 (*Bell*).) The Legislature sought to ensure the best possible health care "at the lowest possible cost by transferring the financial risk of health care from patients to providers" and to safeguard the "financial stability" of the health care system "by means of proper regulatory procedures." (Health & Saf. Code, § 1342, subds. (d) & (f); see also *Centinela Freeman Emergency Medical Associates v. Health Net of California, Inc.* (2016) 1 Cal.5th 994, 1005.)

Consistent with its purpose, the Knox-Keene Act focuses on dispute resolution and enforcement through efficient regulatory means, without the need to engage in litigation. In shaping the provisions of the Act, "the Legislature contemplated there may be disputes over the amounts owed to noncontracting providers," so it required each health plan—VHP included—to create "a dispute resolution mechanism that is 'fair, fast, and cost-effective,'" and authorized the DMHC, in that state agency's oversight role, to assess "monetary and other penalties" against any health plans engaging in unfair practices. (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 507, citing Health &

Saf. Code, §§ 1367, subd. (h)(2), 1371.37, 1371.38, subd. (a), 1371.39; see also Cal. Code Regs., tit. 28, § 1300.71.38.)[3]

The DMHC is a first-of-its-kind dedicated state agency, granted robust enforcement powers over managed health care to remedy perceived weaknesses in prior regulatory oversight. (E.g., Assem. Bill No. 78 (1998–1999 Reg. Sess.) § 1; California Department of Managed Health Care, *2018 Annual Report* (May 2019), p. 1; Enthoven & Singer, *The Managed Care Backlash and the Task Force in California* (1998) 17 Health Affs. 95, 106.) It "is the exclusive enforcement agency for violations of the Knox-Keene Act." (Request for Judicial Notice in Support of Answer Brief (RJN) Ex. G, at p. 21.)

The Knox-Keene Act regulates both health plans and providers. (RJN Ex. G, at p. 8, 20-22.) The DMHC may enforce the Knox-Keene Act and its implementing regulations by, among other serious remedies: issuing a cease-and-desist order; suspending or revoking a health plan's license; imposing civil penalties; and seeking injunctive relief in a civil action. (Health & Saf. Code, §§ 1386, subd. (a), 1387, subd. (a), 1390, 1391, subd. (a)(1).) Willful violations can be punished through criminal prosecution.

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[3] Plaintiffs err in suggesting that the DMHC does not report dispute resolution activities for "county-operated plans" such as VHP. (OB at 13–14.) The report cited references "county organized health system[s]" created to contract with the Medi-Cal program and subject to a different statutory scheme. (RJN Ex. C, at p. 5; see also generally Welf. & Inst. Code, § 14087.5.)

(Health & Saf. Code, § 1390.) The criminal, civil, and administrative remedies available to the DMHC may be combined in any manner deemed advisable by the DMHC to adequately enforce the Act. (Health & Saf. Code, § 1394.)

Where a county creates a separate public entity to operate a county plan, that new entity, the Legislature has specified, is, like the County, immune from claims for money or damages. (Welf. & Inst. Code, § 14087.38, subds. (i) & (j) ["The health authority, members of its governing board, and its employees, are protected by the immunities applicable to public entities and public employees governed by [the Government Claims Act], except as provided by other statutes or regulations that apply expressly to the health authority."].) This statutory language confirms what, as the County explains below, is also clear from the legislative history of the Government Claims Act: the Legislature did not intend to abrogate immunity merely by virtue of a public entity's participation in the health care system as plan or provider.

C. Reimbursement at the "Reasonable and Customary" Rate Under the Knox-Keene Act

Under the Knox-Keene Act, regulated health plans are generally required to reimburse providers for emergency services and certain post-stabilization services (i.e., health care services rendered after the emergency condition of the patient has stabilized). (Health & Saf. Code, §§ 1371.4, 1367, subd. (h)(2)).) The amount of reimbursement depends upon whether the hospital and plan have a contract in place: If they do, the plan must pay the agreed upon contractual rate (Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(A)); if they do not, the plan must pay the "reasonable and customary" rate (*id.*, subd. (a)(3)(B)). Reimbursement for Medi-Cal enrollees is governed by different statutes. (*Supra* at 30.)

A DMHC regulation requires health plans to craft their own reasonable reimbursement methodology for paying non-contracted providers a "reasonable and customary" rate, including consideration of six non-exclusive factors, as appropriate. (Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(b) (the "Reimbursement Regulation").) The reasonable and customary value should be "based upon statistically credible information that is updated at least annually" and, where appropriate, take six non-exclusive factors into consideration: "(i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case." (*Ibid.*)

To effectively resolve provider concerns about reimbursement rates, including individual or multiple claims for emergency services, DMHC created a Provider Complaint Unit and developed an informal dispute resolution process offering external review of the rationale for the reimbursement rate. (RJN Ex. A; Ex. D, at p. 17; Ex. E. at p. 8.) The DMHC's licensing, enforcement, and prosecutorial authority afford strong incentive for plans to resolve agency concerns without formal enforcement. The DMHC has also required corrective action to address failure to reimburse at a "reasonable and customary" rate through a consent agreement with the health plan, reopening claims for additional reimbursement. (RJN Ex. B, at pp. 1–3; Ex. F, at p. 2.)

Section 1371.4 of the Health and Safety Code was introduced at the urging of the California Medical Association (CMA), a provider group, because "CMA believe[d]" that the trend toward managed care increased incentives to deny care and reduce payments. (Sen. Ins., Claims & Corps. Com., Analysis of Sen. Bill No. 1832 (1993–1994 Reg. Sess.) as amended May 2, 1994, p. 3; Assem. Com. on Health, Analysis of Sen. Bill No. 1832 (1993–1994 Reg. Sess.) as amended June 16, 1994, p. 3.) The legislative history indicates that the author of the bill, Senator Marian Bergeson, was concerned that a small subset of plans might be under-reimbursing providers to retain excessive profits. (Senator Bergeson, letter to Governor Peter B. Wilson (1993–1994 Reg. Sess.) Sept. 9, 1994, Governor's chaptered bill files, ch. 614.)

The bill was intended to balance considerations of cost efficiency and quality of care. (E.g., Sen. Rules Com., Off. Of Sen. Floor Analyses, 3d reading analysis of Sen. Bill No. 1832 (1993–1994 Reg. Sess.) as amended Aug. 25, 1994.) The initial draft bill required reimbursement of non-contracted providers at the Medicare rate (Sen. Bill No. 1832 (1993–1994 Reg. Sess.) as introduced Feb. 24, 1994); this standard was replaced with a "reasonable and customary" rate after some health plans argued that, in certain instances, it was appropriate to pay less than the Medicare rate (e.g., James E. Randlett, letter to interested parties (1993–1994 Reg. Sess.) May 28, 1994, Author's bill file).

The draft bill also proposed placing a cap on the profits of health plans by mandating that a maximum of 15 percent of gross revenue be spent on "administrative costs and net profits." (Sen. Bill No. 1832 (1993–1994 Reg. Sess.) as introduced Feb. 24, 1994.) Federal law has since imposed this type of 15% cap on profits and administrative costs for most commercial health plans and other caps for Medicare and Medicaid plans. (Congressional Research Service, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress* (Jan. 2015) pp. 1, 3–4.)

D. The Current, Escalating Crisis Resulting from Hospital Pricing and Billing Practices

While health plan profits are now circumscribed by law, the same is not true for hospitals. The decades post-dating enactment of Section 1371.4 saw a wide-scale consolidation in hospitals and health plans, accompanied by drastically increased health care spending. (E.g., United States Congressional Budget Office, *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services* (Jan. 2022) p. 17 (hereafter Congressional Budget Office); Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses* (Sept. 2017) 36 Health Affs. 1530, 1533–36.) The consolidation of hospitals afforded significant bargaining leverage; according to the U.S. Congressional Budget Office and a commission appointed by the California Legislature, hospital prices are the largest contributing factor to increases in health care spending. (Congressional Budget Office, *supra*, at p. 1; Healthy California for All, *An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California* (Aug. 2020) pp. 56, 61–62, 65–67.)

Because hospital patient care involves relatively fixed costs, increases in billed charges can yield substantial incremental profits for hospitals. (E.g., Glied, *COVID-19 Overturned the Theory of Medical Cost Shifting by Hospitals* (June 2021) 2 J. Am. Med. Ass'n Health F. 1, 1–3; Complaint at 11–12, *SEC v. Tenet Healthcare Corp.* (Apr. 2, 2007),

<https://www.sec.gov/litigation/complaints/2007/comp20067.pdf> [as of December 12, 2022] [alleging steep escalation in billed charges by Plaintiffs and their parent company between 1999 and 2002].) Large, for-profit hospitals charge particularly high rates for emergency room services compared to other hospitals. (E.g., Henderson & Mouslim, *Hospital and Regional Characteristics Associated with Emergency Department Facility Fee Cash Pricing* (July 2022) 41 Health Affs. 1029, 1032.) The hospital facilities themselves, rather than physicians, are primary drivers of this increase in costs. (Cooper et al., *Hospital Prices Grew Substantially Faster Than Physician Prices for Hospital-Based Care In 2007–14* (Feb. 2019) 38 Health Affs. 184, 186–89.)

A hospital's "billed charges" are item-by-item pricing schedules unilaterally set by hospitals, which are notoriously "inflated" and bear little relationship to market rates or costs. (*Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 560.) Payors rarely, if ever, pay these billed charges, but hospitals in some instances seek to collect them from uninsured patients or non-contracted plans. (*Ibid*.)

Plaintiffs and their parent company, Tenet HealthCare Corporation (Tenet), have been identified in multiple analyses as frontrunners in the drastic run-up of full-billed charges by large, private hospitals. (E.g., Lagnado, *California Hospitals Open Books, Showing Huge Price Differences* (Dec. 2004), Wall Street J., <https://on.wsj.com/3ExP1Hk> [as of December 12, 2022] (hereafter *Open Books*) [2004 data]; Bai & Anderson, *Extreme Markup: The Fifty US Hospitals with the Highest Charge-to-Cost Ratios* (June 2015), 34 Health Affs. 922, 923–25 [2012 data] (hereafter Bai & Anderson); National Nurses United, *Fleecing Patients: Hospitals Charge Patients More Than Four Times the Cost of Care* (Nov. 2020), pp. 16, 20, 32–33, 51, 75–76 [2018 data].)[4] In one analysis, researchers found that the billed charge for a blood test was $97 for San Francisco General, but $1732.95 for Plaintiff Doctors Medical Center of Modesto (Doctors of Modesto)—17 times the price of the public hospital. (*Open Books*, table of charges.) Even versus other private hospitals, the billed charge for a brain scan was $881.90 for Scripps versus $6,599 for Doctors of Modesto. (*Ibid*.) Thus, on the rare occasions when Plaintiffs receive these billed charges, the payment is a windfall.

Billed charges are sometimes evaluated by comparing these charges to a hospital's reported, allowable costs, a metric known as the cost-to-charge ratio. According to the Plaintiffs' publicly available, regulatory submissions, their billed charges during the two years relevant to this dispute, 2016 and 2017, were over ten times their costs. (RJN Exs. I, J, K. L). At least one study found that, in the years preceding the disputes at issue here, Plaintiffs' cost-to-charge ratios were the highest in California

[4] (See also Certification of Interested Persons or Entities, filed by Plaintiffs on August 8, 2022 [identifying Tenet as Plaintiffs' parent company].)

and among the 50 highest in the country. (E.g., Bai & Anderson, *supra*, at pp. 923–25.) Plaintiffs' parent company, Tenet, explained that it declined to lower its sticker prices in the wake of a settlement with the federal government because billed charges are a useful "negotiating tool" providing leverage over commercial health insurance plans. (E.g., *Open Books*, *supra*.)

"Balance billing" (OB 41) is another practice that has been used by hospitals, in conjunction with maintaining high billed charges, to increase revenue and obtain greater bargaining leverage. (E.g., Cooper et al., *Out-of-Network Billing and Negotiated Payments for Hospital-Based Physicians* (Jan. 2020) 39 Health Affs. 24, 26–31.) Balance billing occurs when a plan pays only a portion of the billed amount and the provider bills the patient for the remaining balance of the full-billed charges, notwithstanding that the patient has health care coverage. (*Prospect Medical Group*, *supra*, 45 Cal.4th at p. 503.) This practice creates enormous hardship for individual patients and, in turn, places undue pressure on plans seeking to protect their enrollees from unexpected and potentially ruinous medical bills. (E.g., Sen. Rules Com., Off. Of Sen. Floor Analyses, 3d reading analysis of Assem. Bill No. 72 (2015–2016 Reg. Sess.) as amended Aug. 19, 2016, pp. 4–5; 7–8.; RJN Ex. G, at pp. 9–10, 13–17, 22, 26).

Provider groups have repeatedly argued, as they again suggest for the practices at issue here, that prohibiting balance billing would jeopardize emergency room care for the indigent and result in inadequate compensation. (E.g., *Prospect Medical Group*, *supra*, 45 Cal.4th at pp. 509–10.) The Legislature, Governor, and DMHC disagreed; and in an unsuccessful challenge to a regulation prohibiting the practice by provider groups, DMHC explained that balance billing is "contemptible" and a "malignant and unjust practice" inimical to the purpose of managed care. (RJN Exs. A, G at pp. 9–10, 13–17, 22, 26.)[5] Now, by law, providers are generally prohibited from balance billing patients covered by health plans irrespective of the outcome of this appeal. (Compare Cal. Code Regs., tit. 28, § 1300.71.39 and *Prospect Medical Group*, *supra*, at pp. 508–11 with OB 40–41.)

Since the enactment of Section 1371.4, the Legislature and the federal government have implemented numerous other measures to address health care affordability and reimbursement in this already highly regulated field—including further expanding Medi-Cal and creating an Office of Health Care Affordability to set and enforce cost targets for the health care industry. (E.g., Legis. Counsel's Dig., Sen. Bill No. 184, Stats. 2022, ch. 47 (2021–2022 Reg. Sess.) pp. 2–4.) Some of these initiatives have

[5] Numerical citations preceded by "App." refer to the Appendix filed in the Court of Appeal.

further limited the scope of what is governed by the Knox-Keene Act's "reasonable and customary" rate. Providers are now required, for instance, to accept their "average contracted rate" as reimbursement for out-of-network, non-emergency services provided at an in-network facility. (Health and Saf. Code, §§ 1371.31, 1371.9; Ins. Code, §§ 10112.8, 10112.81, 10112.82; 28 C.C.R. § 1300.71.31.) The "reasonable and customary" rate also does not apply, for example, to: (1) most services for Medi-Cal and Medicare enrollees (e.g., 22 C.C.R. § 51503; *Allied Anesthesia Med. Grp., Inc. v. Inland Empire Health Plan*, 80 Cal.App.5th 794, 812–13 (2022); *Dignity Health v. Loc. Initiative Health Care Auth. Of Los Angeles Cnty*., 44 Cal.App.5th 144, 162 (2020); (2) plans that have a contract with the provider covering the services (e.g., Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(A); and (3) certain types of commercial plans, known as PPO and POS plans (e.g., 28 C.C.R. § 1300.71 (a)(3)(C).)

E. The County's Stewardship Over Public Funds in Fulfillment of Sovereign Duties to Protect the Public Health, Provide for the Indigent, and Enhance Health Care Access

The County is responsible for providing medical care to indigent residents, preventing communicable disease, and protecting public health and safety. (Cal. Const., art. XI, § 7; Welf. & Inst. Code, § 17000 et seq.; Health & Saf. Code, § 101000 et seq.; Health & Saf. Code, § 120100 et seq.) The County's selection of methods for undertaking these functions necessarily entails making policy and operational choices specific to the County, taking into account its special mission and its distinct needs in operating a public health system serving the entire county, including a public health department covering 15 cities; a public option managed health plan; and a comprehensive system of public hospitals, pharmacies, and clinics. (See generally, e.g., County of Santa Clara, *County of Santa Clara Health System*, <https://health.sccgov.org/home> [as of Dec. 1, 2022].)

VHP is operated by and through the County. In addition to providing coverage to participants in government programs such Medi-Cal, VHP also offers coverage to anyone who lives or works in the County. (E.g., County of Santa Clara, Valley Health Plan, *Individual & Family Plan*, <https://www.valleyhealthplan.org/shoppers/shoppers/individual-family-plan> [as of Dec. 1, 2022].) The County operates VHP in service of its core governmental functions of protecting public health; enhancing resident access to high quality, affordable health care; and safeguarding the local pipeline of available health facilities and services. (Cal. Const., art. XI, § 7.)

II. PROCEDURAL HISTORY

A. This Lawsuit, Seeking Compensatory Damages for Alleged Lost Profits, After the County Refused to Pay Full-Billed Charges

In this civil lawsuit for monetary damages, Plaintiffs seek reimbursement of their full-billed charges for treatment of three VHP members, one of whom was also provided inpatient post-stabilization services, in Plaintiffs' facilities in Stanislaus and San Joaquin Counties. (App. 286, 290–92.) The operative Third Amended Complaint asserts as the lone cause of action a claim for breach of implied contract. (App. 293–94.) Plaintiffs alternatively allege that they were entitled to recoup their full-billed charges because there was no "rate set by law," or as the "reasonable and customary" rate under Section 1371.4. (E.g., App. 286–90. 469–70, 487–88.)

Plaintiffs amended the complaint three times, but never sought to bring a mandamus action or to plead a claim under Government Code section 815.6 (Section 815.6). Rather, Plaintiffs variously asserted claims for quantum meruit, unjust enrichment, open book account, intentional interference with contractual relations, intentional interference with prospective economic relations, breach of implied-in-fact contract, and negligent interference with prospective economic relations. (App. 467–96, 284–96.)[6]

Plaintiffs have not alleged that the County's reimbursement differed significantly from either average reimbursement across all payors or contracted rates. Nor do Plaintiffs contend that they are located in the

[6] Plaintiffs alleged that VHP tortiously interfered with Plaintiffs' ability to balance bill patients. (App. 470, 476–77, 492–94.) The County's demurrer argued, among other points, that Plaintiffs can neither balance bill patients nor sue plans for informing enrollees of their rights and benefits. (App. 11–12; *supra* at 28–29.)

geographical region in which VHP is required to maintain a contracted provider network. And they have not alleged that they submitted a complaint about the County's reimbursement to DMHC's Provider Complaint Unit.

Plaintiffs also never argued, in either the Superior Court or the Court of Appeal, that the Government Claims Act is inapplicable because Plaintiffs do not purport to seek "money or damages." Rather, Plaintiffs pled that they complied with the claim presentation requirements "as required by the Government Claims Act." (E.g., App. 290.) And, after meeting and conferring regarding planned demurrers and motion to strike, the parties stipulated to (a) the filing of a Second Amended Complaint that removed the quantum meruit claim; and (b) subsequently striking a claim that the County contended was untimely under the Act. (E.g., App.7–8, 201–05, 467, 480–90.)

The Superior Court sustained the County's demurrer to the Second Amended Complaint. (App. 281–83, 511–14.) The Court dismissed three of the four causes of action—tort claims—without leave to amend, finding that the County was immune from tort claims except as authorized by the Legislature. (App. 513–14.) The court dismissed the remaining cause of action for breach of an implied contract with ten days' leave to amend finding that, while Plaintiffs purported to rely on a provision of the Knox-

Keene Act, they had not pled a statutory cause of action with the required particularity. (App. 512–13.)

Plaintiffs filed a Third Amended Complaint referencing the Knox-Keene Act, but they did not argue in either court below that the claim invoked a purely statutory duty that had no common law analogue. Rather, in response to the County's immunity arguments, Plaintiffs argued that Government Code section 815's requirement that liability be "otherwise provided by statute" was satisfied where a statute "defines the tort in general terms" and is merely "declaratory of the common law." (E.g., App. 588–89.) Plaintiffs similarly did not seek leave in either court to file a writ petition. The Superior Court overruled the County's third demurrer to the Third Amended Complaint but granted a 30-day stay of discovery to permit the County to pursue writ relief. (App. 728.)

B. The Court of Appeal's Dismissal of the Action

The Court of Appeal granted the County's petition for writ of mandamus and reversed. (*County of Santa Clara v. Superior Court* (2022) 77 Cal.App.5th 1018, 1024.) The County, the Court of Appeal found, could not be held liable based solely on a common law claim for quantum meruit because section 815 of the Government Code eliminated common law liability for public entities. (*Id.*, at pp. 1028–29, citing *Sheppard v. North Orange County Regional Occupational Program* (2010) 191 Cal.App.4th 289, 314.) The cases cited by Plaintiffs, in which providers were permitted to bring a quantum meruit claim for reimbursement against private plans were inapposite, because they did not address public entity liability or indicate that the Knox-Keene Act authorizes providers to sue plans directly to enforce its obligations. (*Id*., at pp. 1029, 1031.)

Plaintiffs could not assert a claim under Government Code section 815.6, affording a statutory cause of action against a public entity for breach of a mandatory duty imposed by enactment, because Section 815.6 does not apply if the relevant statutory requirement is obligatory, but fulfilling that obligation involves the exercise of discretion. (*Id*., at pp. 1029–30.) Here, the Court of Appeal held, the County "is vested with discretion in determining" the reasonable and customary value of services under Section 1371.4. (*Id*. at p. 1030.)

And while immunity does not generally apply to contract claims, Plaintiffs' causes of action here were "tortious rather than contractual." (*Id*., at p. 1035.) Plaintiffs' allegations and their claims were grounded in an alleged breach of a statutory requirement rather than breach of a promise, as they did not allege breach of an obligation beyond the obligation already imposed by statute. (*Id*., at pp. 1033–34, citing *San Mateo Union High School Dist. v. County of San Mateo* (2013) 213 Cal.App.4th 418, 440.) Further, the County's authority to enter into contracts rests with its Board of Supervisors. (*Id*., at p. 1034.) Plaintiffs alleged only that County employees made "partial payment," which the

Court found insufficient to bind the Board of Supervisors to a contract. (*Ibid*.)

No other statute identified by Plaintiffs could serve as a predicate for asserting a civil claim for damages against the County. The Court reiterated that under section 815 of the Government Claims Act, public entity liability must be "provided by statute." (*Id*. at p. 1030.) Liability "must be based on a specific statute declaring them to be liable, or at least creating some specific duty of care." (*Ibid*., citing *Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.4th 1175, 1183.) The Court found that, here, the "provided by statute" standard would be satisfied if the Legislature intended to afford providers a private right of action to enforce Section 1371.4. (*Ibid*.)

But Plaintiffs conceded, and the Court agreed, that nothing in the express language of the Section 1371.4 affords a private right of action. (*Id*., at pp. 1030–31.) Nor was there any indication of "legislative intent to allow the Hospitals to sue directly under that statute to enforce the obligation" to reimburse under the Knox-Keene Act. (*Id*., at p. 1031.) The relevant provisions of the Knox-Keene Act stood in marked contrast, the Court observed, to statutes that, for example, provided that a party "has a cause of action" or "is liable" for reimbursement. (*Ibid*. [comparing section 1371.4 with Health & Saf. Code, § 1285, subd. (c) and Veh. Code, § 17001].)

The Court also rejected Plaintiffs' assertion that dismissing the action would leave the County with unfettered discretion to unilaterally underpay providers. (*Ibid*.) Plaintiffs, the Court found, could report an alleged unfair payment pattern to the DMHC, which the DMHC "shall review"; and the DMHC has regulatory authority over the County's resolution of disputes and can impose a range of serious sanctions. (*Id*., at pp. 1031–32, citing Health & Saf. Code, §§ 1371.39, subds. (a), (d), (h)(2); *id*., §§ 1386–92; Cal. Code Regs., tit. 28, § 1300.71.38.)

The Court thus rejected Plaintiffs' contention that this case is analogous to *Bell*, *supra*, 131 Cal.App.4th at p. 215, as, in that case, the defendant contended that it had no substantive obligation to pay a "reasonable and customary" rate. (*Id*., at p. 218.) Here, the County acknowledged its regulatory obligation to pay a "reasonable and customary" rate and the Court found that this obligation could be enforced by DMHC. (*County of Santa Clara v. Superior Court*, *supra*, 77 Cal.App.5th at p. 1031.) The Court of Appeal recognized that, under its reading of the Knox-Keene Act, Plaintiffs did not have the same remedies against public plans as it did against private plans. (*Id*., at p. 1032.) But it was for the Legislature, not the courts, to authorize statutory causes of action; because courts, the Court of Appeal concluded, have no power to rewrite the statutes that they are called upon to interpret. (*Ibid*.)

The Court ordered the Superior Court to sustain the County's demurrer and dismiss the complaint without leave to further amend. (*Ibid*.)

ARGUMENT

I. The Court of Appeal Correctly Found That Plaintiffs' Reimbursement Claims, No Matter How Styled, Fall within the Ambit of the Government Claims Act

Plaintiffs' reimbursement claims, however framed, fall within the scope of the immunity provisions of the Government Claims Act and thus must, as the Court of Appeal correctly determined, be authorized by statute to survive. The Act's substantive immunity provisions extend to any claims for "money or damages" other than contract claims and forbid such claims unless "otherwise provided by statute"—a limiting term preserving for the Legislature strict control over when damages claims may be asserted in civil suits against the state or its subdivisions. (Gov. Code, §§ 814, 815.) Unlike the mandamus cases cited in the opening brief, Plaintiffs here do not seek an order compelling the County to comply with a ministerial duty, but rather seek adjudication by a factfinder of a quantum of compensatory damages.

Indeed, Plaintiffs have never previously argued that they do not seek "money or damages." Should the Court nevertheless consider Plaintiffs' new arguments, they are incorrect: a reimbursement action asserts claims for "money or damages" within the meaning of the Act because it seeks, as its primary purpose, pecuniary, compensatory relief. And this Court has not, as Plaintiffs suggest, held that the Act's reach extends only to claims traditionally considered by courts to be "torts." Instead, this Court has held, consistent with the Act's plain language, that sovereign immunity applies to non-contractual claims for "money or damages."

A. Plaintiffs Did Not Argue in the Superior Court or Court of Appeal That They Do Not Seek "Money or Damages"

While Plaintiffs now urge that their proposed claims would not constitute causes of action for "money or damages," they advanced no such argument in the Superior Court or the Court of Appeal. Rather, Plaintiffs alleged that they timely presented claims and brought suit "as required by the Government Claims Act"—allegations that presuppose that the claims seek "money or damages." (E.g., App. 290.)

Plaintiffs also did not argue in either court below that immunity applies only to claims traditionally considered by courts to constitute "torts." Nor did Plaintiffs contend that they sought to vindicate a purely statutory obligation with no common law corollary. Thus, Plaintiffs failed to develop any of these points below. (*In re Joshua S.* (2007) 41 Cal.4th 261, 272, citing Rule 8.500(c)(1).) This Court should therefore decline to consider the belated and self-contradictory argument that Plaintiffs do not seek "money or damages" and related arguments about the scope of the Government Claims Act—although they are, as demonstrated below, incorrect in any event.

B. A Reimbursement Claim Seeks "Money or Damages" Because Its Primary Purpose Is to Obtain an Adjudication by a Factfinder of a Quantum of Compensatory Damages

Should the Court reach the issue, Plaintiffs' claims seek "money or damages" within the meaning of the Government Claims Act because a "reimbursement" action seeks, as its primary purpose, pecuniary, compensatory relief. The Government Claims Act reserves to the Legislature the sole prerogative to determine, within constitutional limits, whether and when damages claims asserted against a private party may also be asserted against a public entity. The Act refers to both "damages" and "money" with a limited set of exceptions identified by statute. (Gov. Code, § 905 [excluding, for example, claims for tax exemption and public assistance].)

Under the statute's plain language, all other claims seeking pecuniary relief fall within the scope of the phrase "money or damages." (*Ibid*.) Moreover, precedent establishes that "money or damages," used both in the Act's provisions addressing immunity and claims presentation (Gov. Code, §§ 814, 905), must be construed as "comprehensive in scope." (*Loehr v. Ventura Cnty. Cmty. Coll. Dist.* (1983) 147 Cal.App.3d 1071, 1079; see also *City of Stockton v. Superior Court* (2007) 42 Cal.4th 730, 739–40; *Stillwell v. State Bar* (1946) 29 Cal.2d 119, 123 [words or phrases should be given same scope and meaning within different portions of a law].)

The breadth of "money or damages" is, to the extent relevant, only further confirmed by the legislative history. (Recommendation Relating to the Presentation of Claims Against Public Entities (Jan. 1959) Cal. Law Revision Com. Rep. (1959) p. A17; Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) pp. 811–12.)[7] In reviewing the interpretation of various prior claims presentation provisions, the Law Revision Commission concluded that while "money" was typically understood to be broader than and inclusive of "damages," there were in some instances distinctions in how the two terms were understood. (Recommendation Relating to the Presentation of Claims Against Public Entities (Jan. 1959) Cal. Law Revision Com. Rep. (1959) pp. A44, A82–A83.) By including both "money or damages" within the scope of immunized claims, the Legislature adopted the broadest definition short of applying immunity to *all* claims, including those seeking injunctive relief.

Plaintiffs' reimbursement claims are "pecuniary" and fall within the broad scope of claims for "money or damages" because their "primary

[7] The Legislature largely adopted the comments of the Law Revision Commission, except where the recommended text was altered by the Legislature or as noted in the Assembly and Senate Committee Reports. (*Quigley v. Garden Valley Fire Protection Dist.*, *supra*, 7 Cal.5th 798, 804.)

purpose" is to obtain adjudication of a quantum of compensatory damages. (*Canova v. Trustees of Imperial Irrigation Dist. Employee Pension Plan* (2007) 150 Cal.App.4th 1487, 1493 (*Canova*).) The cases cited by Plaintiffs confirm this point. In *Canova*, for example, the court found that the portion of the pleading seeking compensation for an alleged breach of contract constituted a claim for "money or damages." *(Canova*, *supra*, 150 Cal.App.4th at p. 1493.) Only the request to compel defendants to invalidate the rollover of a pension plan fell outside the scope of a "damages" claim, because—unlike here—that claim sought adjudication of non-pecuniary issues that would only indirectly and incidentally have financial implications. (*Ibid*.)

In *Los Angeles Unified School Dist. v. Superior Court*, the court held that certain penalties are not "damages" because they apply irrespective of injury and do not serve a compensatory function. (*Los Angeles Unified School Dist. v. Superior Court* (2021) 64 Cal.App.5th 549, 566, review granted Sept. 1, 2021, S269608.) Similarly, in *Kizer v. County of San Mateo*, this Court held that immunity does not apply to civil penalties that have no "compensatory" function. (*Kizer v. County of San Mateo* (1991) 53 Cal.3d 139, 145.) Plaintiffs, by contrast, allege an injury and seek compensatory relief—not the imposition of a statutory penalty.

Plaintiffs argue that they seek only to vindicate a statutory duty. But the quantum of reimbursement fixed by a factfinder after a trial is based on an elastic factual inquiry that does not meaningfully speak to whether the County reasonably complied with statutory requirements in the first instance. (RJN Ex. H, at p. 4 [DMHC explanation that the Reimbursement Regulation sets forth "*minimum*" and non-exclusive criteria for compliance, which do not limit courts in adjudicating quantum meruit claims].) Indeed, as one Court of Appeal has keenly observed, "persons of common intelligence" would differ as to the reasonable and customary rate, such that it is "impossible" for a plan "to definitively know" the reasonable and customary value of emergency medical services that a jury might fix long after the fact, based on a different mix of information. (*Long Beach Memorial Medical Ctr. v. Kaiser Foundation Health Plan, Inc.* (2021) 71 Cal.App.5th 323, 346.) It is this weighing of new and different evidence after the fact to fix a quantum of damages that is the object of a reimbursement claim, not compliance with a regulatory obligation that only incidentally holds financial implications.

Plaintiffs also urge this Court to attribute significance to the use of the word "reimbursement" rather than "damages" in the Knox-Keene Act. (OB 27.) But Plaintiffs certainly seek "money," and it is unsurprising that the Legislature did not refer to "damages," as the relevant provisions of the Knox-Keene Act neither authorize nor focus on civil litigation. In any case, "reimbursement" is defined by the Reimbursement Regulation, which enumerates criteria intended to capture, in part, common law damages concepts. (*Children's Hospital*, *supra*, 226 Cal.App.4th at pp. 1271–72; see also Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(B).) The Knox-Keene Act and accompanying regulations in turn contemplate informal dispute resolution and, if necessary, an administrative enforcement action in which the DMHC requires a plan to craft its own compliant methodology—not litigation inviting a factfinder to displace the County's chosen methodology with a range of other criteria, without balancing the public policy and health care goals that the County is tasked with managing.

Plaintiffs also argue that they seek merely to recoup their costs to avoid a purported "shortfall," not to pursue damages. (E.g., OB 15; Petn. 13 ["a claim for reimbursement seeks no more than recompense for the claimant's expenditures on the health plan's behalf"].) The County does not understand the basis for this suggestion. Plaintiffs have never alleged that the County's reimbursement did not cover their costs, much less asserted a claim for costs. Rather, Plaintiffs seek their full-billed charges, either as the alleged "reasonable and customary" rate under the Knox-Keene Act or, alternatively, because there is no "rate set by law." (E.g., App. 286–90. 469–70, 487–88.)

Indeed, Plaintiffs' billed charges were, according to their own publicly available regulatory submissions, more than *ten times* their costs during the two relevant years. (RJN Exs. I, J, K, L.) If anything, Plaintiffs' allegation that the County paid 20% of their grossly inflated charges (OB 9, 15) reflects that the County reimbursed Plaintiffs at a more than adequate rate—it is the denominator that is the problem here, not the numerator.[8] In any event, courts have rebuffed parties' efforts to rely on evidence of costs in actions for reimbursement for emergency services. (E.g., *Children's Hospital*, *supra*, 226 Cal.App.4th at p. 1278 [reimbursement claim does not seek to measure costs].)

C. Plaintiffs' Claims Undisputedly Do Not Sound in Contract

Plaintiffs do not challenge the Court of Appeal's determination that their reimbursement claims do not sound in contract—and rightly so. (*County of Santa Clara v. Superior Court*, *supra*, 77 Cal.App.5th at pp. 1033–35.) As a threshold matter, Plaintiffs "implied-in-law contract" claim is not a contract claim at all. "Quantum meruit" and "implied-in-law contract" are synonymous terms. (*McBride v. Boughton* (2004) 123 Cal.App.4th 379, 388 fn. 6.) "The so-called 'contract implied in law' in reality is not a contract" because it is not "based on the apparent intention of the parties to undertake the performances in question, nor" is it a "promise." (*McBride*, at p. 388, fn. 6, quoting *Weitzenkorn v. Lesser* (1953) 40 Cal.2d 778, 794.) Thus, a quantum meruit claim does not fall

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[8] And despite comparing the County to the defendant in *Bell* (e.g., OB 36), Plaintiffs have not alleged, nor could they, that the County failed to reimburse Plaintiffs at the Medicare rate as Blue Cross did (nor anything remotely approaching that rate).

within the exception to immunity for contract claims set forth in Government Code section 814.[9]

Nor do Plaintiffs quarrel with the Court of Appeal's dismissal of their claims to the extent they were predicated on breach of implied-in-fact contract. As the Court correctly found, there can be no contract where neither party undertook an obligation to do anything beyond that which it was *already* required to do by statute. (*County of Santa Clara v. Superior Court*, *supra*, 77 Cal.App.5th at pp. 1033–35; see also Health & Saf. Code, § 1371.4 [referring to "non-contracted" providers]; Cal. Code Regs., tit. 28, §§ 1300.71, 1300.71.38 [same].)

In any case, Plaintiffs' allegations of partial payment and subsequent denial of administrative appeals (E.g., App. 290–93) do not demonstrate that there was ever a meeting of the minds as to the rate of payment. (*Allied Anesthesia Medical Group, Inc. v. Inland Empire Health Plan*, *supra*, 80 Cal.App.5th at pp. 808–10.) Further, as the Court of Appeal correctly found in an analysis unchallenged here, Plaintiffs' allegations of partial payment were insufficient to make out a claim for breach of contract, because the County is authorized to enter into contracts only through its Board of Supervisors. (*County of Santa Clara v. Superior*

[9] For avoidance of confusion and consistent with the Sixth District's analysis, the County will use the term "quantum meruit."

Court, *supra*, 77 Cal.App.5th at pp. 1033–35.) Plaintiffs made no allegation to demonstrate that the Board entered into a contract. (*Ibid*.)

D. The Legislature Did Not Limit the Scope of the Government Claims Act to Causes of Action Traditionally Considered by Courts to Be Torts

Plaintiffs err in suggesting—for the first time, in this Court—that the Government Claims Act can *only* apply to claims traditionally considered by courts to be torts. Rather, the plain language of the statute demonstrates that immunity applies to all claims for "money or damages" other than contract claims. (Gov. Code, §§ 814, 815.) While resort to legislative history is thus unnecessary, the legislative history discloses that the Legislature deliberately chose not to use the word "tort" to describe the scope of immunity, to ensure that only the express statutory language, rather than judicial classification of causes of action, would control the scope of immunity. (Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) p. 837.)

To be sure, courts sometimes use the word "tort" as a shorthand for the non-contractual damages claims covered by the Act. This shorthand appears to originate in case law indicating that, under the Government Claims Act, all non-contractual claims for money or damages are essentially treated as "torts." (E.g., *Arthur L. Sachs, Inc. v. City of Oceanside* (1984) 151 Cal.App.3d 315, 322 (*Sachs*)). In *Sachs*, for example, the appellate court explained that, in the context of the

Government Claims Act, "breach of a noncontractual duty" is considered "tortious." (*Ibid*.) The same analytical structure was applied by the Court of Appeal here. (*County of Santa Clara*, *supra*, 77 Cal.App.5th at p. 1035 [finding that claims were "tortious rather than contractual"].)[10]

But this Court has not, as Plaintiffs suggest, held that the metes and bounds of substantive immunity are set by common law definitions of "tort" rather than the express statutory language. To the contrary, this Court "adopt[ed] the practice of referring to the claims statutes as the 'Government Claims Act,' to avoid the confusion about the broad reach of encompassed claims, previously engendered by the informal short title 'Tort Claims Act.'" (*City of Stockton v. Superior Court*, *supra*, 42 Cal.4th at p. 734.)

The cases cited by Plaintiffs thus do not reflect judicial imposition of an extra-textual limitation on legislatively imposed sovereign immunity. Plaintiffs cite language from *City of Dinuba v. County of Tulare* for the proposition that the substantive immunity provisions of the Government Claims Act are "only concerned with shielding public entities from having to pay money damages for torts." (*City of Dinuba v. County of Tulare* (2007) 41 Cal.4th 859, 867 (*Dinuba*).) But the Court immediately

[10] Moreover, the legislative history suggests the Legislature understood the universe of claims for "money or damages" as limited, dichotomously, to either tort or contract claims. (E.g., Recommendation Relating to the Presentation of Claims Against Public Entities (Jan. 1959) Cal. Law Revision Com. Rep. (1959) pp. A43-A44.)

proceeded in the next sentence to explain what it meant: namely, that "liability based on contract or the right to obtain relief other than money damages is unaffected by the Act." (*Ibid*.)[11] *Dinuba* also addressed a very different type of claim. The petitioners there sought to correct clerical errors that had resulted in miscoding of tax parcels—relief that was conceded by all parties to require only ministerial acts by the public entity (*supra* at 64-65)—making the case appropriate for resolution via mandamus.

In *Quigley v. Garden Valley Fire Protection Dist.*, this Court addressed a tort claim against a public entity explicitly authorized by the Act. (*Quigley v. Garden Valley Fire Protection Dist.* (2019) 7 Cal.5th 798, 803.) It is in this context that the Court noted that Section 815 "makes clear that under the Government Claims Act, there is no such thing as common law tort liability for public entities"—a point that is, of course, true, but does not reach the question whether a claim that is not traditionally considered by courts to be a tort could nevertheless fall within the broader umbrella of "money or damages." (*Ibid*.)

And, again, while resort to legislative history is unneeded here, it is unsurprising that the Legislature concluded that the "practical effect" of

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[11] The sentence referring to "torts" relies on *Schooler v. State of California* (2000) 85 Cal.App.4th 1004, which in turn relies on *Arthur L. Sachs, Inc. v. City of Oceanside*. *Quigley v. Garden Valley Fire Protection Dist*, also cited by Plaintiffs, similarly relies on *Sachs*. (*Quigley v. Garden Valley Fire Protection Dist., supra*, 7 Cal.5th 798, 803.)

Section 815, considered together with Section 814, "is to eliminate any common law governmental liability for damages arising out of torts." (OB 24; see also Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) p. 837.) At the time of the Government Claims Act's passage, California law defined contracts rigidly to include only express and implied-in-fact contracts. (Civ. Code, §§ 1619, 1620, 1621; *Silva v. Providence Hospital of Oakland* (1939) 14 Cal.2d 762, 773.) The doctrine of quantum meruit—particularly as applied to actions involving government actors—was in its infancy and disfavored. (E.g., *Earhart v. William Low Co.* (1979) 25 Cal.3d 503, 515, fn. 10 [observing that "[m]ore adventurous courts" had gradually begun "turn[ing] to the idea of a 'contract implied in law'"]; see also Sloan, *Quantum Meruit: Residual Equity in Law* (1992) 42 DePaul L. Rev. 399, 447–48 ["actions based upon contracts implied in law" historically could "*not* be maintained against the government"].)

In the limited instances in which California courts discussed the doctrine of quantum meruit as applied to government entities, the disputes involved breach of an actual promise on the part of the government. (E.g., *Miller v. McKinnon* (1942) 20 Cal.2d 83, 88; *Los Angeles Dredging Co. v. City of Long Beach*, *supra*, 210 Cal. 348, 353; *Zottman v. City & County of San Francisco* (1862) 20 Cal. 96, 97.) Outside of that narrow context—in which the requests for quantum meruit relief were nevertheless denied—it does not appear that the notion of permitting quantum meruit recovery against government was contemplated by California courts.

So, to the extent the Legislature considered the existence of a quantum meruit claim brought against government when drafting the Government Claims Act, it would have understood such a claim as a non-contractual action for money or damages, and thus a "tort." In any case, the Legislature's intention was that any open questions about the scope of the Act be left to the "future study" of the Legislature, such that—consistent with the Act's default rule of immunity absent waiver by the sovereign—"liability may then be imposed," if appropriate, "by the Legislature within carefully drafted limits." (Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) pp. 809–12.)

Finally, neither party argues that Plaintiffs do not seek relief for an "injury" within the meaning of the Government Claims Act. (OB 33–34; Petn. 35 n.8; see also *Centinela Freeman Emergency Medical Associates v. Health Net of California, Inc.*, *supra*, 1 Cal.5th at p. 1002 [finding that failure to properly reimburse can give rise to a tort claim in narrow circumstances]; *Bell*, *supra*, 131 Cal.App.4th at p. [recognizing that providers can bring quantum meruit claims for "injuries"].)

II. The Court of Appeal Correctly Found That the County Is Immune from Plaintiffs' Quantum Meruit Claim Because the Claim Is Not "Otherwise Provided by Statute" Within the Meaning of the Government Claims Act

A. The Knox-Keene Act Does Not Provide a Private Right of Action at All, Much Less Authorize Assertion of Civil Damages Claims Against a Public Entity

Because Plaintiffs seek "money or damages," their reimbursement claims may be asserted only if "otherwise provided by statute" within the meaning of the Government Claims Act. (Gov. Code, § 815.) But as the Court of Appeal correctly recognized, Plaintiffs do not assert a cognizable statutory claim under the Knox-Keene Act. The Court of Appeal in this matter began its analysis by concluding that Plaintiffs cannot state a claim against a public entity based solely on the common law doctrine of quantum meruit. (*County of Santa Clara v. Superior Court*, *supra*, 77 Cal.App.5th at pp. 1028–29 [concluding that neither quantum meruit claim, nor claim under the Unfair Competition Law (UCL), may be asserted against a public entity].) Plaintiffs have not challenged that determination.

Rather, Plaintiffs now contend that they seek to enforce a purely statutory duty that "did not exist at common law." (OB 25.) But this Court has clarified that the "as otherwise provided by statute" language in Section 815 means that "direct tort liability of public entities must be based on a specific statute declaring them to be liable, or at least creating some specific duty of care" rather than on general liability statutes. (*Eastburn v.*

Regional Fire Protection Authority (2003) 31 Cal.4th 1175, 1183 [provision of Civil Code imposing duties of care and providing for civil liability did not authorize a cause of action against a public entity].)

The Knox-Keene Act does not supply a statutory, private right of action at all under the established standards for determining whether such a private right of action exists—and thus necessarily does not authorize a statutory claim against the County. (*County of Santa Clara v. Superior Court*, *supra*, 77 Cal.App.5th at pp. 1030–32.) On the contrary, the statutory scheme authorizes enforcement actions and criminal sanctions and provides that it does not preclude "otherwise available" remedies. (Health & Safety Code, § 1371.37, subd. (e).) This Court has, moreover, found that the Knox-Keene Act does not impose a tort duty of care except under limited circumstances inapplicable here. (*Centinela Freeman Emergency Medical Associates v. Health Net of California, Inc.*, *supra*, 1 Cal.5th 994, 1002.)

Where "neither the language nor the history of a statute indicates an intent to create a new private right to sue, a party contending for judicial recognition of such a right bears a heavy, perhaps insurmountable, burden of persuasion." (*Lu v. Hawaiian Gardens Casino, Inc.* (2010) 50 Cal.4th 592, 601, citing *Crusader Ins. Co. v. Scottsdale Ins. Co.* (1997) 54 Cal.App.4th 121, 133.) That the Legislative Counsel's Digest and other legislative materials did not recognize that the Knox-Keene Act created a new private remedy is "strong indication" that the Legislature did not intend to create such a right of action. (*Lu*, at p. 601.)[12]

Plaintiffs do not appear to argue otherwise. They do not attempt to evaluate their claim as statutory under the standards established by this Court—notwithstanding that it is Plaintiffs' burden to establish that the statute creates a private right of action. (*San Diegans for Open Government v. Public Facilities Financing Authority of City of San Diego* (2019) 8 Cal.5th 733, 739.) Plaintiffs instead contend that, because they allege violation of a statute, the Government Claims Act necessarily does not apply. (OB 28–29.) In making the argument, it is unclear if Plaintiffs mean to invite this Court to jettison the need for a cognizable statutory cause of action, or even threshold inquiry into legislative intent to create claims against public entities—or, rather, to implicitly concede that they do not really seek to assert an "implied-in-law" contract claim at all, but rather only a mandamus claim.

[12] A district court examining this legislative history found that Section 1371.4 does not authorize a private right of action, in one of the federal cases cited by Plaintiffs. (*California Pacific Regional Medical Center v. Global Excel Management, Inc.* (N.D. Cal., June 4, 2013, No. 13-CV-00540 NC) 2013 WL 2436602, at **6–8.) In another, *San Jose Neurospine v. Aetna Health of California, Inc*, the parties raised only fact-specific arguments on summary judgment about whether the defendant could pay a lower rate because of a billing code mistake. (*San Jose Neurospine v. Aetna Health of California, Inc.* (2020) 45 Cal.App.5th 953, 958.)

In any event, Plaintiffs' proposal ignores *Eastburn* and would, if countenanced, create a far *less* stringent standard for determining whether a claim for money or damages can be asserted against a public entity versus a private party—an outcome at odds with the Government Claims Act's core purpose of "rigidly" confining public entity liability. (*Eastburn v. Regional Fire Protection Authority*, *supra*, 31 Cal.4th 1175, 1183; *Zelig v. County of Los Angeles* (2002) 27 Cal.4th 1112, 1127–28; *Brown v. Poway Unified School Dist.* (1993) 4 Cal.4th 820, 829.) The provisions of the Act creating particular statutory causes of action would, moreover, be rendered surplusage if any statutory requirement presumptively imposes civil liability for money or damages on public entities. (E.g., Gov. Code, § 815.6; § 855 [imposing civil liability for violation of state regulations by public medical facility]).[13]

In recognizing that the Section 1371.4 does not authorize a private right of action, the Court of Appeal did not render the reimbursement obligation a "dead letter," as Plaintiffs appear to suggest—a limited circumstance that some courts have indicated might favor recognizing a

[13] As support for this novel proposal, Plaintiffs cite a federal district court decision that misconstrues California law. (OB 28–29, citing *Lonberg v. City of Riverside* (C.D. Cal. 2004) 300 F.Supp.2d 942, 946.) For example, the district court relied on reasoning in an appellate decision subsequently rejected by this Court. (*Compare ibid*., citing *Levine v. City of Los Angeles* (1977) 68 Cal.App.3d 481, 487, (*Levine*) with *Eastburn, supra,* 31 Cal.4th at p. 1183 [addressing the same Civil Code section as *Levine*]; see also App. 638–39.)

private right of action. (*Skov v. U.S. Bank National Ass'n* (2012) 207 Cal.App.4th 690, 698, citing *Mabry v. Superior Court* (2010) 185 Cal.App.4th 208, 218–19.) The Knox-Keene Act vests in the DMHC the power to enforce the statutory reimbursement obligation and providers remain free to sue private payors. (*County of Santa Clara v. Superior Court*, *supra*, 77 Cal.App.5th at pp. 1027, 1031–33.) In asserting that the County has "unfettered discretion" to pay an amount of its choosing (e.g., OB 37), Plaintiffs fail to address the Court of Appeal's findings regarding the DMHC's broad and significant enforcement powers—which include power that no private litigant could possess, that is, DMHC's authority to withdraw the plan's license to operate (Health & Saf. Code, § 1386, subd. (a)), and to pursue criminal penalties (Health & Saf. Code, § 1390).

B. In the Cases Relied upon by Plaintiffs, Providers Asserted Common Law Claims or Claims under the Unfair Competition Law

Plaintiffs stress that courts have recognized that claims for reimbursement may be asserted against private plans. (OB 19–22.) But the conclusion that a particular money or damages claim may be asserted against a private entity (i.e., that it constitutes an "injury") is merely a threshold predicate for undertaking an immunity analysis, as the Legislature's "very purpose" in enacting the substantive immunity provisions of the Government Claims Act was to reserve for itself the task of determining whether a claim for money or damages, that may be asserted against a private party, may also be asserted against government. (*Caldwell v. Montoya* (1995) 10 Cal.4th 972, 985.)

As the Court of Appeal correctly concluded, the cases cited by Plaintiffs, addressing claims against private plans, confirm that a claim for reimbursement for emergency services is a *common law* claim for quantum meruit. (*County of Santa Clara v. Superior Court* (2022) 77 Cal.App.5th 1018, 1029, citing *Bell*, *supra*, 131 Cal.App.4th at p. 216 [Section 1371.4 does not "*preclude* a private action under the UCL or *at common law* on a quantum meruit theory" (emphasis added)]; *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1273 [parties may seek relief from court via "*other common law or statutory remedies*" outside of the Section 1371.4 and its accompanying regulations (emphasis added)].)

Plaintiffs' reliance on the DMHC's amicus brief in *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211 is similarly misplaced. The DMHC made clear in a supplemental letter brief that the agency takes the same view as the Court of Appeal did here regarding available remedies: namely, that there are two potential remedies available to providers: (a) a common law claim under equitable principles, sounding in quantum meruit; and (b) a statutory claim under the UCL for violation of Section 1371.4. (RJN Ex. F, at pp. 2–3, 5.) Further, the DMHC explicitly acknowledged that a similar claim might not be available against a county, as public entities may not be sued under common law, equitable theories. (*Id*., at p. 3.)[14]

There is, moreover, no indication that the Legislature sought to abrogate immunity for public health plans in enacting the Knox-Keene Act. To the contrary, the Legislature took care to specify in enabling legislation that new local entities created to operate county plans are "protected by the immunities applicable to public entities and public employees." (Welf. & Inst. Code, § 14087.38, subds. (i) & (j).) Such provisions are in keeping with the Legislature's rejection of functional or transactional tests for immunity in enacting the Government Claims Act—legislation prompted in part by this Court's decision in a case in which the plaintiff had urged that operation of a public hospital was a proprietary function and thus not subject to immunity. (*Muskopf v. Corning Hospital Dist.* (1961) 55 Cal.2d 211, 213.)

III. The Court of Appeal Acted Within its Discretion in Denying Leave to Further Amend, after Inviting Supplemental Briefing Intended to Elicit Any Further Bases for Amendment

Neither of Plaintiffs' proposed amendments would cure the deficiencies in the complaint because they suffer from the same basic problem: namely, that they would ask the Court to impermissibly supplant

[14] Because *Bell* did not involve a public defendant, the DMHC had no reason to comprehensively address application of immunity. Its letter brief in that case referenced indigent care because the defendant had sought to rely on a case addressing indigent care. (*Ibid*.)

the exercise of discretion by a public entity. Section 815.6, a provision affording a narrow negligence claim for breach of a mandatory duty, cannot be used as a predicate for suing the County for its reimbursement determination because that statutory provision does not apply where fulfilling a statutory requirement involves the exercise of discretion.

For similar reasons, this case is very different from the mandamus cases cited by Plaintiffs, where the petitioners sought to compel compliance with a ministerial duty. Unlike the petitioners in those cases, Plaintiffs seek to control the outcome of a reimbursement decision that undisputedly entails the exercise of meaningful discretion—and requires fact-finding, not statutory interpretation, by the court.

A. Plaintiffs' Proposed Amendment, to Assert a Claim under Section 815.6, Would Impermissibly Seek to Supplant Discretionary Determinations by a Public Entity

Section 815.6 authorizes a narrow species of negligence claim against a public entity for breach of a mandatory duty to perform a non-discretionary action. (Gov. Code, § 815.6.) This type of claim is not available, however, where a statutory requirement, although obligatory, involves the exercise of discretion. (*Haggis v. City of Los Angeles* (2000) 22 Cal.4th 490, 499 (*Haggis*); see also *Mueller v. County of Los Angeles* (2009) 176 Cal.App.4th 809, 821.) A statutory requirement thus cannot serve as a predicate for this type of claim if determining whether the obligation was breached lends itself to "normative or qualitative debate" over whether the obligation was adequately fulfilled. (*State Dept. of State Hospitals v. Superior Court* (2015) 61 Cal.4th 339, 350.) These standards dovetail with one of immunity's core purposes: protecting the exercise of discretion by public officials. (E.g., Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963) pp. 812, 815, 817.)[15]

Plaintiffs do not and cannot dispute that determining the "reasonable and customary" amount of payment entails the exercise of significant discretion. Health and Safety Code section 1371.4 does not set a particular rate of reimbursement to providers but, instead, defers to health plans the task of crafting a reasonable and customary rate. And the Reimbursement Regulation supplies non-exhaustive factors to be considered by the plan in crafting a reimbursement methodology, but otherwise leaves fashioning the methodology to the plan's discretion. (Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(b).) Consideration of a host of potentially competing factors in determining how to best comply with a statute "is the hallmark of discretion." (*B.H. v. County of San Bernardino* (2015) 62 Cal.4th 168, 180–81.)

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[15] Even where a clear-cut, non-discretionary duty was breached, it is a complete defense to liability if the public entity can establish that it exercised reasonable diligence in seeking to perform the duty. (Gov. Code, § 815.6.) The availability of this defense further demonstrates that the Legislature intended to authorize a narrow negligence claim.

The subjectiveness of a reasonable value inquiry is also reflected in decisions addressing the methods that, in cases against private entities, may be used by a jury to fix a reasonable and customary rate. Courts have emphasized that the DMHC "refused to set specific amounts" (*Children's Hospital Central California v. Blue Cross of California*, *supra*, 226 Cal.App.4th at pp. 1272–76) and that there is no "mandatory" methodology for calculating reimbursement rates for emergency services (*NorthBay Healthcare Group - Hospital Division v. Blue Shield of California Life & Health Insurance* (N.D. Cal. 2018) 342 F.Supp.3d 980, 988.).

One appellate court held that, because market value could fluctuate and is intended to parallel the outcome of hypothetical and consensual transactions for the same services, prior transactions should be "treated as one of the colors in the prism of the 'wide variety of evidence' relevant to reasonable value." (*Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc.*, *supra*, 71 Cal.App.5th 323, 346.) These points also led the same court to conclude that a negligence claim for failure to adequately reimburse a negligence-based tort "would be both useless and impossible to comply with" and injunctive relief improper because "persons of common intelligence" would differ as to the reasonable and customary rate. (*Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc.*, *supra*, 71 Cal.App.5th at 339, 343.) A reimbursement claim is thus an even poorer fit for relief under Section

815.6, which is intended to carve out, rather supplant, discretionary determinations.

Plaintiffs urge that the requirement to reimburse is "mandatory" within the meaning of section 815.6 because the County does not have "complete discretion" to pay any amount. (OB 37.) But that is not the standard: rather, for a claim to be asserted under Section 815.6, the mandatory language in a statute must be intended by the Legislature to "foreclose" the exercise of discretion. (*Haggis*, *supra*, 22 Cal.4th at p. 499; see also *State Dept. of State Hospitals v. Superior Court* (2015) 61 Cal.4th 339, 350 [citing *Haggis* to find that statutory language specifying that "two" evaluators must be used "foreclose[s]" discretion as to the number of evaluators].)

The County acknowledges, and the Court of Appeal found, that the County is required to pay a reasonable and customary rate. But the County must, as the DMHC Reimbursement Regulation contemplates, exercise its discretion in determining how to satisfy this obligation. The Court of Appeal stood on firm ground in holding that juries and courts cannot step into the County's shoes to supplant its discretionary determinations or to displace the DMHC in its regulatory oversight and enforcement role.

B. A Mandamus Claim for "Reimbursement" Suffers from the Same Deficiencies as Plaintiffs' Other Claims

Plaintiffs' eleventh-hour suggestion that they may amend the pleading to assert a mandamus claim does not, if considered, warrant reversal. Mandamus cannot be used to control the exercise of discretion by a public entity, yet an adjudication that the County must pay a particular amount as the "reasonable and customary" rate—for a specific service as applied to a specific patient, no less—would do just that. And while the Government Claims Act does not as a general matter "immunize against or otherwise preclude mandamus review" (*Freeny v. City of San Buenaventura* (2013) 216 Cal.App.4th 1333, 1347), the converse is also true—reframing a damages claim as one for mandamus does not take the claim outside of the scope of the Act.

1. Mandamus Is Not Available to Control the Exercise of Discretion by a Public Entity

There is a fundamental mismatch between the form of relief sought here and the nature and purpose of mandamus. Mandamus may lie: (1) to compel the performance of a duty that is "purely ministerial in character"; or (2) to correct abuses of discretion. (*Morris v. Harper* (2001) 94 Cal.App.4th 52, 62; *Santa Clara Cnty. Counsel Attys. Ass'n v. Woodside* (1994) 7 Cal.4th 525, 539–40, superseded by statute on other grounds as stated in *Coachella Valley Mosquito & Vector Control Dist. v. Cal. Pub. Emp. Rels. Bd.* (2005) 35 Cal.4th 1072, 1077.) Because Plaintiffs are asking the Court to "compel the performance of an act"—specifically, "reimbursement" (OB 29–31)—the underlying statutory duty must be purely ministerial in nature. The writ "will not issue if the duty is not plain or is mixed with discretionary power or the exercise of judgment," as mandamus "will not lie to force the exercise of discretion in a particular manner." (*Inglin v. Hoppin* (1909) 156 Cal. 483, 491; *L.A. Cnty. Prof. Peace Officers' Ass'n v. County of Los Angeles* (2004) 115 Cal.App.4th 866, 869.)

Applying these principles, an appellate court concluded that mandamus could not issue to change the cause of death listed on a certificate because, while the coroner was required to designate a cause of death "in conformity with facts ascertained from inquiry, autopsy and other scientific findings," that obligation was not purely ministerial: the coroner has discretion to depart from the findings of the jury inquest based on the coroner's medical opinion. (*Morris v. Noguchi* (1983) 141 Cal.App.3d 520, 521–22, quoting Gov. Code, § 27491.5.) Here, too, the fact that the County has guidance regarding some of the factors to consider in exercising its discretion does not render the statutory obligation purely ministerial.

This is also not a case where plaintiffs simply seek to compel the performance of a ministerial duty that indirectly leads to recovery of a sum of money. (*Holt v. Kelly* (1978) 20 Cal.3d 560, 565–66, fn. 5.) In *City of Dinuba*, by contrast, plaintiffs sought to compel categorization of land according to mandatory provisions of the Revenue & Taxation Code, which would ultimately lead to the disbursement of additional tax revenues. (*City of Dinuba*, *supra*, 41 Cal.4th at pp. 862–63.) All parties agreed the requirement was purely ministerial and did not involve judgment or discretion. (E.g., Reply Br. at 14–17, 41 Cal.4th 859 (2007) (No. S143326), 2006 WL 439554; see also *Los Angeles County v. Riley* (1942) 20 Cal.2d 652, 657–62 [there was no dispute that calculating the amount of appropriated funds was ministerial].)

Here, on the other hand, Plaintiffs would ask the Court to step into the shoes of the County and exercise the County's discretion in calculating the "reasonable and customary value" of specific services, as well as to usurp the DMHC's regulatory role in determining whether a plan has adequately complied with the Reimbursement Regulation. (E.g., *Acosta v. Brown* (2013) 213 Cal.App.4th 234, 252–53 [mandamus could not issue because the "relief sought" would require "the court to interfere with and assume the responsibilities" of the Department of Labor]; *Cal. Ass'n for Health Servs. at Home v. Dep't of Health Servs.* (2007) 148 Cal.App.4th 696, 707–08 [similar]; see also OB at 31 [proposed mandamus claim would pursue "essentially similar relief" to the quantum meruit claim pled in the Third Amended Complaint].) Mandamus cannot issue.

This Court need not, and should not, address whether Plaintiffs could have contested, as an abuse of discretion, the County's methodology for calculating the "reasonable and customary value." Plaintiffs' petition, the order granting review, and opening brief identify the claim at issue as one for "reimbursement," which is fundamentally distinct from an "abuse of discretion" claim. (*See* Order Limiting Issues on Review; Petn. 13–14, 18, 31–33; OB 8–11, 29–33.) Such a claim would therefore fall outside of the scope of review.[16]

2. Claims for Money or Damages Fall Within the Ambit of the Government Claims Act When They Are Asserted as Mandamus Claims

Plaintiffs' arguments about mandamus should be rejected for the additional and independent reason that mandamus cannot be used as a vehicle for seeking "damage[s] predicated on acts for which the Government Code provides immunity." (*Hensler v. City of Glendale* (1994) 8 Cal.4th 1, 13–14, fn. 6., citing *HFH, Ltd. v. Superior Court* (1975) 15 Cal.3d 508, 518.) Plaintiffs therefore may not transfigure their covered claim for damages into a mandamus claim to circumvent the immunity

[16] At any rate, Plaintiffs have not proven that such a claim would be timely. Plaintiffs' complaint did not discuss the County's methodology, nor did it allege facts or injuries going to procedural questions. (*Norgart v. Upjohn Co.* (1999) 21 Cal.4th 383, 408–09 [amended claim must rest on the "same general set of facts," "involve the same injury," and "refer to the same instrumentality"]; *Klopstock v. Superior Court* (1941) 17 Cal.2d 13, 20–22 [amendment cannot "state facts which give rise to a wholly distinct and different legal obligation against the defendant"]; *Garrison v. Bd. of Directors* (1995) 36 Cal.App.4th 1670, 1678 [original complaint must have put defendants "on notice" of the amended claim].); cf. *City of Dinuba, supra*, 41 Cal.4th at p. 870 [noting plaintiffs sought mandamus relief in their original complaint].)

provisions of the Government Claims Act. (*Hensler*, *supra*, 8 Cal.4th at pp. 13–14, fn. 6; *cf. also TrafficSchoolOnline, Inc. v. Clarke* (2003) 112 Cal.App.4th 736, 739–42; *Loehr v. Ventura County Cmty. Coll. Dist.*, *supra*, 147 Cal.App.3d at pp. 1081–182.)

IV. Plaintiffs' Unsupported Public Policy Arguments Supply No Basis for Reversal

Plaintiffs' legal analysis begins and ends with public policy arguments predicated on unsupported speculation regarding the possible impact of the Court of Appeal's decision. But the heavy burden of balancing the public policy considerations that underlie immunity and other limitations on the liability of public entities rests, within constitutional limits, with the Legislature.

Courts are thus not "free to graft an equitable exception onto the Government Claims Act" based on speculation about the possible impact of application of immunity on the provision of health care. (*Tuthill v. City of San Buenaventura* (2014) 223 Cal.App.4th 1081, 1089.) This Court should therefore put aside the Plaintiffs' "suggestion that we can solve the societal and economic problems defined by their rhetoric." (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, *supra*, 45 Cal.4th 497, 510–11, citing *Bell*, *supra*, 131 Cal.App.4th at p. 222.)

In any event, were the Legislature to revisit such matters, it might well conclude that public policy does not support extending common law remedies to apply against public entities, in order to afford hospitals even *more* leverage to pursue ruinous pricing and billing practices. (Cf. *Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc.*, *supra*, 71 Cal.App.5th 323, 337 ["The hospitals have provided no evidence or argument suggesting that inadequate reimbursement for emergency medical services under the Knox-Keene Act is a widespread problem"].)

Plaintiffs' various arguments to the contrary are unsupported. Plaintiffs suggest, for example, that they *could*—to the extent possible—raise prices for non-emergency services as a result of the reimbursement rates paid by the County. (OB 41.) But assuming Plaintiffs were to raise their prices for other services, that hypothetical increase would not result from shifting costs left uncompensated by the County, but rather presumably to meet revenue targets as subsidiaries of a for-profit, publicly traded health care conglomerate. (See generally United States Securities Exchange Commission, *Form 10-K*, Tenet Healthcare Corporation, <https://sec.report/Document/0000070318-22-000013/thc-20211231.htm> [as of December 12, 2022] [reflecting that Tenet is publicly traded and reports income per share].) Plaintiffs' allegations demonstrate that the County's reimbursement more than covered Plaintiffs' reported costs. (*Infra* at 27, 44–45.)

The County acknowledges that application of governmental immunity may in some instances be "harsh" or even appear unfair, particularly from the vantage point of someone who is injured but cannot obtain compensatory relief. (Recommendation Relating to Sovereign Immunity (Jan. 1963) 4 Cal. Law Revision Com. Rep. (1963).) But even if equitable considerations allowed courts to disregard the Government Claims Act—and they do not—this case is simply not one of those concededly harsh situations. Plaintiffs' public policy arguments are but variations on the series of outsized threats and predictions that provider groups have historically and repeatedly foisted on courts and legislatures in pursuit of ratcheting their health care prices beyond all rational measure.

CONCLUSION

For all of the foregoing reasons, this Court should affirm the Court of Appeal's decision.

DATED: December 12, 2022

Respectfully submitted,

JAMES R. WILLIAMS
County Counsel

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CERTIFICATE OF COMPLIANCE

I, Susan P. Greenberg, certify that, pursuant to Rule 8.204(c)(1) of the California Rules of Court, the attached **ANSWER BRIEF ON THE MERITS** has a typeface of 13 points or more, and contains 13, 405 words, as determined by a computer word count.

DATED: 12/12/2022

By: DocuSigned by: Susan Greenberg F6B0E7284644468...
SUSAN P. GREENBERG
Deputy County Counsel

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 Jose, 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 **December 12, 2022**, I caused to be served, copies of the following:

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Susan Greenberg

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County of Santa Clara v. The Superior Court of Santa Clara

Case No. S274927

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12/12/2022

Date

/s/Susan Greenberg

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