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

BRIEF OF AMICUS CURIAE LOCAL HEALTH PLANS OF CALIFORNIA IN SUPPORT OF PETITIONER COUNTY OF SANTA CLARA

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I. INTRODUCTION: IMPORTANCE OF ISSUE AND INTEREST OF AMICUS

Local Health Plans of California ("LHPC") is a statewide trade organization consisting of all 16 local, public sector Medi-Cal health plans. Together, LHPC member plans serve approximately 70 percent of all Medi-Cal beneficiaries totaling over 7.5 million Californians. LHPC's members are mission-driven, community-based organizations committed to providing access to quality, affordable, and comprehensive health care services for all Californians. LHPC's public sector health plan members are not motivated by profit. They reinvest in the local community through grants and incentive payments, work with consumer advisory committees to gain insight into member needs, and contract with safety-net providers to ensure these providers have the financial resources to continue to serve the indigent and uninsured.

Like the County's public sector health plan in this case, most LHPC member plans are licensed under the Knox-Keene Health Care Service Plan Act of 1975 (the "Knox-Keene Act") (Health and Safety Code sections 1340 et seq.) and regulated by the Department of Managed Health Care ("DMHC").

LHPC has a vital interest in the issue this case presents—whether public sector health plans are immune from quasi-contractual claims pursued by non-contracted emergency service providers seeking higher payment for care provided to those plans' members. Like other forms of local government, public sector health plans rely on the immunities granted under the Government Claims Act. Through this action, Real Parties in Interest Doctors Medical Center of Modesto, Inc. and Doctors

Hospital of Manteca, Inc. ("Plaintiffs") are asking this Court to create an exception to this statutory immunity specific to public sector health plans for quantum meruit claims brought by out-of-network emergency services providers.

This Court should decline to create a judicial exception and should instead affirm the Court of Appeal's determination that the County of Santa Clara ("County") is immune under the Government Claims Act (Cal. Gov't Code section 810 et seq.) from an action seeking additional payment for emergency medical care provided to persons covered by the County's public sector health plan. There is no basis to strip public sector health plans, as Plaintiffs in this action argue, of some (but apparently not all) of the basic immunities of local government, specifically the immunity against claims for money or damages under a quantum meruit theory. Importantly, the Legislature weighed in on the issue almost 30 years ago when it enacted legislation allowing for the creation of public sector health plans.

At the time it enacted these laws, the Legislature had the opportunity to qualify the immunity of these public sector health plans. The Legislature could have narrowed such immunity in the same manner Plaintiffs ask this Court to narrow such immunity. However, rather than set any limitations on immunity, the Legislature allowed for the creation of public sector health plans with all the same immunities of other local governments, while also requiring them to be licensed under the Knox-Keene Act and allowing them to compete in the marketplace with private health plans.

Plaintiffs use scare tactics to justify their request for the creation of a judicial exception to the Government Claims Act's immunity provisions. If governmental immunity were upheld here, they argue, public sector health plans would be "free to systematically underpay emergency health care providers." Opening Brief on the Merits ("OB") 11. They threaten that this result "would adversely affect California's emergency health care delivery system." *Id.* However, this fear is misplaced because public sector health plans are regulated by DMHC, and, notwithstanding Plaintiffs' alarmist threat, DMHC has the authority to quash any potential systematic underpayment before it happens.

II. ANALYSIS

A. The Legislature intended public sector health plans to have the same immunities as other local government agencies.

It is well-established that local government agencies are entitled to immunity from quasi-contractual claims under the Government Claims Act. Cal. Gov't Code §§ 811.2, 815; *Sheppard v. N. Orange Cnty. Reg'l Occupational Program*, 191 Cal. App. 4th 289, 314 (2010) ("a private party cannot sue a public entity on an implied-in-law or quasi-contract theory, because such a theory is based on quantum meruit or restitution considerations which are outweighed by the need to protect and limit a public entity's contractual obligations") (quoting *Janis v. Cal. State Lottery Comm'n*, 68 Cal. App. 4th 824, 830 (1998)). Plaintiffs seek an exception to this immunity for public sector health plans. Such

an exception would be contrary to the intent of the Legislature. When the Legislature established the ability for counties to create public sector health plans almost 30 years ago, it made clear that the grant of full immunity, without exception, would coexist with the requirements of being a health care service plan licensed under the Knox-Keene Act.

In 1994, to support the state's Medi-Cal program, the Legislature enacted a series of statutes allowing counties to establish special county health commissions or health authorities for the specific purpose of contracting with the state as public sector health plans. These new laws were contained primarily in three bills, Assembly Bill ("AB") 2755 and AB 3221, and Senate Bill ("SB") 2092, and largely mirrored similar statutes that were in place at the time.[1] 1994 Cal. Legis. Serv. Ch. 632 (SB 2092); 1994 Cal. Legis. Serv. Ch. 642 (AB 2755); 1994 Cal. Legis. Serv. Ch. 652 (AB 3221).[2] The statutes required the newly-formed public sector health plans to obtain a license under the Knox-Keene Act and granted them the same immunities as the counties themselves.[3]

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[1] *See, e.g.*, Cal. Welf. & Inst. Code §§ 14087.35 (Alameda), 14087.36 (San Francisco), 14087.31 (Tulare and San Joaquin), 14087.96 et seq. (Los Angeles). The legislation was largely county-specific, but AB 2755 also added Welfare and Institutions Code section 14087.38 to allow the state to choose various unnamed counties to participate. Cal. Welf. & Inst. Code § 14087.35(a)(1) ("counties selected by the director").

[2] The full legislative history of all three bills from the 1993-94 session can be found at http://www.leginfo.ca.gov/bilinfo.html.

[3] The County's public sector health plan was not formed pursuant to these statutes. Regardless, as a public-option plan formed and operated by county government, Valley Health Plan is similarly situated, particularly when it comes to local government immunity.

The first analyses of AB 2755 and AB 3221 in April 1994 conducted by the Assembly Committee on Health explained that, at the time, current law permitted Santa Barbara and San Mateo Counties to establish health care commissions to function as public sector health plans and gave such commissions the same "immunities available to counties," and that these bills were "modeled after the existing commission language." Assembly Comm. on Health, Analysis of AB 2755, Apr. 5, 1994, p. 2; *see also* Assembly Comm. on Health, Analysis of AB 3221, Apr. 12, 1994, p. 2; Assembly Comm. on Health, Analysis of SB 2092, Jul. 5, 1994, p. 3.[4]

When the two Assembly Bills made their way to the Senate in June 1994, the Senate Committee on Health and Human Services pointed out in the bill analyses that the California Association of Hospitals and Health Systems ("CAHHS") (an affiliate of the California Hospital Association) said its "member hospitals [were] concerned that they and similar providers may be uncompensated if the county managed care programs became bankrupt." Senate Comm. on Health and Human Svcs., Analysis of AB 2755, Jul. 6, 1994, p. 3; *see also* Senate Comm. on Health and Human Svcs., Analysis of AB 3221, Jun. 29, 1994, p. 2.

Notably, the California Medical Association ("CMA") did not appear to share the concerns of CAHHS as CMA was a supporter of the bill by July 1994. *See* Senate Comm. on Health and Human Svcs., Analysis of AB 2755, Jul. 6, 1994, p. 3; *see also*

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[4] SB 2092 originated in the Senate and therefore was analyzed by the Assembly a few months later in 1994.

Assembly Comm. on Health, Analysis of SB 2092, Jul. 5. 1994, p. 3 (showing CMA in support of SB 2092).

Neither CAHHS nor CMA sought any limitation or exception to the immunity being granted to these public sector health plans. Instead, CAHHS sought a stop-loss insurance requirement. Senate Comm. on Health and Human Svcs., Analysis of AB 2755, Jul. 6, 1994, p. 3 ("CAHHS is seeking additional financial protections, including a requirement for stop-loss insurance"); *see also* Senate Comm. on Health and Human Svcs., Analysis of AB 3221, Jun. 29, 1994, p. 2 (amendment "would require the state to provide stop-loss insurance"). The final bills included a stop-loss requirement for the start-up phase. *See, e.g.*, Cal. Welf. & Inst. Code § 14087.38 (1994) (original version contained this language). CAHHS eventually became a supporter of the bill. Senate Fl. Analysis, AB 2755, Aug. 24, 1994, pp. 1-2; *see also* Senate Fl. Analysis, AB 2755, Aug. 26, 1994, pp. 1-2; Senate Fl. Analysis, SB 2092, Aug. 25, 1994, pp. 3-4.

In August 1994, the Senate Floor Analysis acknowledged that the public sector health plans would both "be Knox-Keene licensed" and have the "immunities available to a county." Senate Fl. Analysis, AB 2755, Aug. 24, 1994, pp. 1-2; *see also* Senate Fl. Analysis, AB 2755, Aug. 26, 1994, pp. 1-2; Assembly Fl. Analysis, SB 2092, Aug. 19, 1994, pp. 2-3. These statutes cleared the way for the formation of the majority of LHPC's current public sector health plan members, most of which have been in operation since the mid-1990s or earlier.

This history is relevant to show that the Legislature established public sector health plans without creating an exception to the immunities being granted, the same immunities possessed by other local public agencies. *See, e.g.*, Cal. Welf. & Inst. Code § 14087.38 (1994), subdiv. (b) ("immunities vested in a county … shall be vested in the health authority"); *id.*, subdiv. (f) ("health authority shall be deemed to be a public agency that is a unit of local government …"); *id.*, subdiv. (i) ("[a]ll claims for money or damages against the health authority shall be governed by [the Government Claims Act]"); *id.*, subdiv. (j) ("health authority, members of its governing board, and its employees, are protected by the immunities applicable to public entities and public employees…").[5] By the time the three bills were enacted, both CAHHS and CMA were supporters. Senate Fl. Analysis, AB 2755, Aug. 24, 1994, pp. 1-2; *see also* Senate Fl. Analysis, AB 2755, Aug. 26, 1994, pp. 1-2; Senate Fl. Analysis, SB 2092, Aug. 25, 1994, pp. 3-4.

Although these laws were primarily aimed at creating public sector health plans to participate in the Medi-Cal program, this framework contemplated, from its inception, that these public sector health plans would serve a broader membership, including Medicare enrollees, individuals "employed by public agencies or private businesses, and uninsured or indigent individuals." *Compare* Cal. Welf. & Inst. Code § 14087.38(b) (1994 version) *with* Cal. Welf. & Inst. Code § 14087.38(b)

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[5] The current version of section 14087.38 contains all these same provisions. *See* Cal. Welf. & Inst. Code § 14087.38.

(current version); *see also* Cal. Welf. & Inst. Code §§ 14087.35(d) (Medicare enrollees "and individuals and groups employed by public agencies and private businesses"), 14087.36(e)(1) (Medicare enrollees, "individuals employed by public agencies and private businesses, and uninsured or indigent individuals"), 14087.31(b)(2) (Medicare enrollees, " individuals and groups entitled to coverage under other publicly supported programs, individuals and groups employed by public agencies or private businesses, and uninsured or indigent persons"), 14087.967 (Medicare enrollees, "individuals employed by public agencies and private businesses, and uninsured or indigent patients").[6]

In other words, the Legislature granted public sector health plans all the immunities of local government while enabling them to compete in the commercial health care market with private sector health plans.

B. Health care in California is a heavily regulated industry, ensuring that upholding immunity from provider claims will not adversely affect the health care delivery system.

The amicus curiae letters urging the Court to take this case have an apocalyptic tone. The California Hospital Association ("CHA") called the Court of Appeal's decision "a crisis in the making," while CMA asserted that the decision "could destabilize the marketplace[.]" CHA Amicus Letter in Support of Petition for Cert at p. 1; CMA Amicus Letter in Support of Petition for Cert

[6] The language "Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code" in each of these statutes is a reference to the Medicare program.

at p. 1. CMA referred to governmental immunity provided in the Government Code as "a loophole" when applied here. CMA Letter at p. 6.

First and foremost, such cries for change should be directed at the Legislature rather than this Court. *See Kim v. Reins Int'l California, Inc.,* 9 Cal. 5th 73, 90, n.6 (2020) ("policy arguments that the statute should have been written differently are more appropriately addressed to the Legislature"); *Dignity Health v. Local Initiative Health Care Authority of Los Angeles Cnty.*, 44 Cal. App. 5th 144, 165 (2020) ("policy considerations are for the Legislature to address"). But more importantly, DMHC's regulatory control over Knox-Keene Act licensed health plans, including public sector health plans, ensures that the health care delivery system will be well-protected.

The Knox-Keene Act requires health plans to pay for emergency care rendered to their members by non-contracted providers. Cal. Health & Safety Code § 1371.4(b). The DMHC regulations specify the manner in which the amount of payment is to be determined, requiring health plans to determine "the reasonable and customary value for the health care services rendered," taking "into consideration" the following six factors:

> (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 ….

28 C.C.R. § 1300.71(a)(3)(B).

The regulations do not provide a specific fee schedule or dictate a particular methodology.[7] DMHC has explained that "no universal formula has been established for these rates." *See* DMHC Office of Financial Review Division of Financial Oversight, Technical Assistance Guide, Claims Management and Processing (2020) ("TAG") pp. 31-32.[8] Instead, plans are charged with developing their own methodologies within the parameters of the regulatory framework and subject to DMHC oversight, as discussed in more detail below. Plans are thus required to exercise independent business judgment in formulating a reasonable and customary rate methodology.[9]

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[7] By contrast, there is a specific fee schedule/methodology for emergency services provided to Medi-Cal beneficiaries. When paying for emergency services provided by non-contracted providers, plans are required to pay what the State would pay if it were directly paying for those same emergency services. *See* 42 U.S.C. § 1396u-2(b)(2)(D) (Section 6085 of the Federal Deficit Reduction Act of 2005 (Rogers Amendment)); Cal. Welf. & Inst. Code § 14105.28.

[8] The TAG is available at https://www.dmhc.ca.gov/Portals/0/Docs/OFR/Claims%20TAG%20Revised%201_31_2020.pdf.

[9] Plaintiffs complain that public sector health plans can pay non-contracted hospitals "any amount they choose." Reply at 10. To be clear, both private health plans and public sector plans alike exercise discretion in determining the amounts they pay out-of-network hospitals when those hospitals provide emergency services to their members. They do not, however, choose random or arbitrary amounts. The payment amount is derived from the independent business judgment required to be exercised pursuant to section 1300.71(a)(3)(B).

The reasonable and customary rate methodology plans develop is subject to exacting review by DMHC. *See* Cal. Health & Safety Code § 1382; *see also* Request for Judicial Notice in Support of County of Santa Clara's Answer Brief ("RJN"), Exh. D (DMHC Annual Report 2020) pp. 26-27 ("DMHC conducts routine financial examinations of each health plan every three to five years and initiates non-routine financial examinations as needed."). These reviews or audits are a significant undertaking for plans. They involve DMHC auditors on site at the plan's offices, reviewing files and interviewing employees, necessitating hours of preparation and participation by plans. One of the many aspects of a health plan's claims payment compliance that the auditors review is the plan's methodology for developing reasonable and customary value. *See* TAG No. 1.2.4, p. 5.

Regulatory violations discovered during audits, as well as written complaints submitted by providers, among other things, can serve as the impetus to informal and formal enforcement actions by DMHC. Informal settlements regularly occur in the form of a plan paying an administrative penalty and/or remediating claims payment deficiencies, among other things.[10] If DMHC and the plan are unable to resolve the matter informally, DMHC can initiate a formal enforcement action. These actions can result in DMHC issuing cease and desist orders, imposing administrative penalties, freezing enrollment, and requiring corrective actions. Cal. Health & Safety Code §§ 1386, 1390, *et. seq*.

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[10] The DMHC searchable Enforcement Actions database can be found at https://wpso.dmhc.ca.gov/enfactions/actionSearch.aspx.

When necessary, DMHC may even pursue litigation to ensure health plans follow the law. *See, e.g.*, RJN, Exh. D (DMHC Annual Report 2020) p. 30. As a result of these actions, DMHC reports annually that plans pay millions of dollars each year to physicians and hospitals and in administrative fines. *See, e.g.*, *id.* at p. 1 (payments of $165.1 million to physicians and hospitals; $83.6 million assessed against health plans that violated the law); *id.*, Exh. E (DMHC Annual Report 2021 stating $177.8 million in payments to physicians and hospitals).

Moreover, beginning January 1, 2023, the Legislature increased the size and number of penalties that DMHC may assess against plans, necessitating a significant increase in funding for enforcement activities. Cal. Health & Safety Code § 1387 (increasing penalties from $2,500 per violation to $25,000 per violation); *see also* Sen. Rules Comm., Off. of Sen. Floor Analyses, Analysis of SB 858, Aug. 22, 2022 (amended Aug. 18, 2022), p. 5 (DMHC cost estimates included $3.9 million in the first year, $12.4 million in the second year, and over $9.2 million per year thereafter to pay for, among other things, "enforcement referrals … addressing civil and administrative penalty assessments and procedures to ensure compliance; funding for expert witness contracts, trial-related costs …").

DMHC is responsible for "the execution of the laws of this state relating to health care service plans and the health care service plan business[.]" Cal. Health & Safety Code § 1341(a). DMHC's regulatory approach is aggressive, necessitating that health plans employ full time individuals dedicated to regulatory

compliance. DMHC regulates health plans with the singular focus that health plans comply with regulatory requirements, including the regulation at issue here requiring payment for non-contracted emergency services at the reasonable and customary value. In short, as set forth in more detail below, DMHC performs sufficient oversight of the claims payment practices of the public sector health plans and is equipped with the tools to prevent systemic underpayments to out-of-network hospitals.

1. Financial examinations.

DMHC conducts financial examinations of Knox-Keene Act licensed health plans at regular intervals. Such routine examinations involve detailed audits of a plan's fiscal and administrative affairs to "assess the overall fiscal soundness, financial viability and claims management of each plan, as well as to verify the plan's compliance with the Knox-Keene Act and related Rules." TAG, Forward. Because a plan is required to establish its non-contracted rates pursuant to a DMHC regulation, DMHC's financial audits review a plan's methodology for compliance with the regulation. One question specifically addressed in a financial audit concerns the soundness of the plan's reasonable and customary rate methodology:

> Pursuant to Rule 1300.71(a)(3)(B), does the health plan's information system calculate reasonable and customary rates based on statistically credible information that is updated at least annually and take the following into consideration: a. Provider characteristics such as training, qualifications, time in practice, etc.? * * * b. Nature of the services provided? * * * c. Fees usually charged by the provider? * * * d. Prevailing provider rates

> charged in the general geographic area in which the services are rendered? * * * e. Other economic aspects or unusual circumstances?

TAG p. 5, No. 1.2.4.

Thus, plans are not free to implement any payment methodology they choose. The reasonable and customary methodology of health plans, including public sector health plans, is subject to stringent scrutiny by DMHC.

2. Provider complaints.

DMHC includes a detailed provider complaint process on its website.[11] Providers regularly use this process to submit complaints to DMHC's Provider Complaint Unit. DMHC offers this process to ensure plans are paying providers promptly and accurately, and DMHC acts on complaints received from providers. DMHC investigates each provider complaint to determine whether there is non-compliance with the Knox-Keene Act, including looking for common types of payment issues. The results of a provider complaint investigation can lead to investigative discovery, enforcement actions, and non-routine financial examinations.

DMHC has formally investigated plans' reasonable and customary payments. In one example, the investigation resulted in a consent agreement in which the plan agreed to revise its methodology, reprocess non-contracted provider claims submitted during a particular time frame, pay an administrative penalty, and submit compliance reports. RJN, Exh. B.

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[11] Information regarding DMHC's Provider Complaint process is available at https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan.aspx and https://www.dmhc.ca.gov/FileaComplaint/FrequentlyAskedQuestions.aspx#providers.

3. Emergency Services Independent Dispute Resolution Process.

In addition to investigating provider complaints, the Provider Complaint Unit administers the Independent Dispute Resolution Process ("IDRP"), designed to resolve payment disputes for non-contracted emergency services claims like those at issue here. IDRP provides a procedure to determine the narrow issue of the reasonable and customary value of the emergency services provided using a decision process similar to "baseball style" arbitration where the reviewer is required to decide whether the provider's billed charges or the payor's paid amount is most representative of the reasonable and customary value of the emergency services that were rendered. The process is efficient, resulting in a decision within 60 days.[12]

Although the process is voluntary and nonbinding, as Plaintiffs point out, it is seldom used.[13] In the last 10 years, IDRP has resulted in only 16 decisions, and only one in the last

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[12] *See* DMHC Emergency Services Independent Dispute Resolution Process, available at https://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/EmergencyServicesIndependentDisputeResolutionProcess.aspx.

[13] If either the Legislature or DMHC saw a need for mandatory IDRP in these circumstances, it would likely establish one. There is a mandatory IDRP process in place for payment disputes between health plans and out-of-network providers providing non-emergency services at in-network facilities. *See* Cal. Health & Safety Code § 1371.30(a)(3) ("If either the noncontracting individual health professional or the plan appeals a claim to the department's independent dispute resolution process, the other party *shall* participate in the appeal process as described in this section") (emphasis added).

four years.[14] Although providers have prevailed in 14 of the 16 cases, one reason it is seldom used is because most providers' billed charges have increased substantially in recent years, and few, if any, are indicative of reasonable market value. *See State Farm Mutual Automobile Ins. Co. v. Huff*, 216 Cal. App. 4th 1463, 1471 (2013) ("the full amount billed by medical providers is not an accurate measure of the value of medical services"). Billed charges are unilaterally set by providers and bear little or no relation to a provider's costs or other market conditions. *Howell v. Hamilton Meats & Provisions, Inc.,* 52 Cal. 4th 541, 561 (2011) ("hospital bills have been called insincere, in the sense that they would yield truly enormous profits if those prices were actually paid"). Unlike health plans that must determine the reasonable and customary value according to a regulatory framework, hospitals may charge whatever amount they choose, untethered to any value-based methodology.

As mentioned above, DMHC does not shy away from initiating investigations based on provider complaints. If DMHC received a high volume of IDRP requests regarding a particular health plan's methodology for paying the reasonable and customary value for emergency services, DMHC would surely investigate that plan's practices regardless of whether that plan is a public sector health plan.

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[14] On December 29, 2022, LHPC's counsel submitted a Public Records Act request to DMHC seeking the decisions resulting from the IDRP process over a 10-year period. In response to that request, DMHC provided the summary attached as Exhibit 1.

4. DMHC investigations and enforcement proceedings.

Like all state agencies, DMHC is vested with the authority to conduct investigations. Cal. Health & Safety Code § 1341.8; Cal. Gov't Code § 11180. This allows DMHC to issue subpoenas, to propound interrogatories, and to obtain sworn testimony of witnesses in a deposition-like proceeding. Cal. Gov't Code § 11181. DMHC uses this authority routinely, often in response to provider complaints. DMHC will open an enforcement matter prior to initiating such discovery, and health plans, including public sector health plans, are required to respond to this investigative discovery even if no formal accusation has been filed. DMHC often combines two or more enforcement matters in order to broaden the scope of its investigation.

DMHC has discretion to take formal action against plans it has reason to believe have violated the Knox-Keene Act and/or its implementing regulations. *See People v. Alorica Inc.*, 77 Cal. App. 5th 60, 66 (2022) ("An agency has the power to investigate a matter within its jurisdiction 'merely on suspicion that the law is being violated, or even just because it wants assurance that it is not.'") (quoting *Brovelli v. Superior Ct. of Los Angeles Cnty.,* 56 Cal. 2d 524, 529 (1961)). The tools at its disposal include requiring the payment of penalties, remediation of provider claims, and implementation of corrective action plans, among other things.[15] Cal. Health & Safety Code §§ 1386, 1390 et seq.

[15] The DMHC enforcement database shows DMHC enforcement activity that results in penalties or settlements. *See* https://wpso.dmhc.ca.gov/enfactions/actionSearch.aspx.

If a public sector health plan were "systematically underpay[ing] emergency health care providers," as Plaintiffs fear would be the result of applying immunity in this case, DMHC would undoubtedly receive an overwhelming number of provider complaints and would promptly launch a full-scale investigation. Such behavior would not go unchecked under the California regulatory regime for health plans.

5. DMHC Rulemaking.

DMHC enacts new regulations and reviews current regulations as a central component of its regulatory oversight responsibilities.[16] Cal. Health & Safety Code § 1341. As recently as 2015, DMHC reviewed the reasonable and customary rate regulation with a focus on non-contracted emergency services.[17] This review was prompted by a petition to reopen the regulation in light of recent case law and a request to investigate regulatory violations. DMHC required both health plans and providers to submit data so that DMHC could evaluate payment methodology trends and determine whether the regulation needed to be revised. Ultimately, DMHC determined that there was "no standard methodology" among health plans and, with no apparent reason to amend the law, elected to leave the regulation unchanged.[18]

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[16] Information about DMHC rulemaking activity is available at https://www.dmhc.ca.gov/aboutthedmhc/lawsregulations.aspx.

[17] A PowerPoint presentation explaining the review is available at: https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/racp031815.pdf?ver=WO42MXugjpmu99qGibtgTw%3d%3d.

[18] DMHC's determination is reflected in publicly available minutes from a meeting of its Financial Solvency Standard Board, at https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/Meetings/M061715.pdf.

C. Network adequacy requirements ensure plans will continue to contract with providers, regardless of whether immunity is upheld.

Another baseless fear pushed by Plaintiffs is that upholding public entity immunity here would "destabilize California emergency medical services delivery system by incentivizing publicly operated health care service plans to *avoid* contracts with providers fixing the rates of reimbursement for emergency services." OB at 40 (emphasis in original). This allegation ignores the fact that health plans, including public sector health plans, are *required* to maintain an adequate network of providers by entering into contracts sufficient to meet regulatory standards of access to care, including contracts with hospitals providing emergency services. Cal. Health & Safety Code §§ 1367.03, 1367.035; 28 C.C.R. § 1300.51(d)(H)(ii) ("In the case of a full-service plan, all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a *contracting or plan-operated provider of all emergency health care services*") (emphasis added); 28 C.C.R. § 1300.67.2.2.

Public sector health plans cannot simply choose to forego contracting and rely on out-of-network hospitals. DMHC regulations require health plans to contract with hospitals that provide emergency services. Thus, despite public sector health plans' immunity from quasi-contractual civil claims, all Knox-Keene Act-regulated health plans remain highly incentivized,

and indeed, required by law, to negotiate and maintain contracts with hospitals.[19]

D. Immunity extends to quantum meruit actions.

Plaintiffs went to great lengths arguing that the current state of local government immunity is that it only applies to common law torts, ignoring the landscape of case law applying immunity to quantum meruit claims along with a host of other common law claims that fall outside of traditional tort claims.[20] Courts have consistently applied Government Claims Act immunity in circumstances involving quantum meruit or implied-in-law contact claims. *See, e.g.*, *Orthopedic Specialists of S. Cal. v. Cal. Public Emps.' Ret. Sys.*, 228 Cal. App. 4th 644, 649 (2014) (rejecting claim for quantum meruit because "an oral promise cannot be enforced against a government agency, like CalPERS" and citing the Government Claims Act); *Sheppard v. N. Orange Cnty. Reg'l Occupational Program*, 191 Cal. App. 4th 289, 314

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[19] The Court of Appeal in *Dignity Health v. Local Initiative Health Care Authority of Los Angeles Cnty.*, 44 Cal. App. 5th 144, 165 (2020), correctly rejected a similar argument regarding the potential effect on the financial incentives for plans to contract because "policy considerations are for the Legislature to address."

[20] Plaintiffs support their theory anecdotally by suggesting in a footnote that the Government Claims Act was, at one time, referred to as the "Tort Claims Act." OB at 23, n.4. Plaintiffs ignore that more than a decade ago, the Legislature, taking its cue from this Court, sought to eliminate the confusion that the Government Claims Act applied only to torts by codifying its name officially as the "Government Claims Act." Cal. Gov't Code § 810(b); *see also* Assembly Comm. on Judiciary, Analysis of AB 2690, May 8, 2012 (citing *City of Stockton v. Superior Court*, 42 Cal. 4th 730, 742 n.7 (2007)). The legislative history of AB 2690 from the 2011-2012 session can be found at http://www.leginfo.ca.gov/bilinfo.html.

(2010) (citing section 815 of the Government Claims Act and holding that "[t]he trial court properly sustained the demurrer to the quantum meruit claim because such a claim cannot be asserted against a public entity."); *Lundeen Coatings Corp. v. Dep't of Water & Power*, 232 Cal. App. 3d 816, 835 (1991); *see also Green Valley Landowners Ass'n v. City of Vallejo*, 241 Cal. App. 4th 425, 438 (2015).

Public sector health plans rely on this immunity in the same manner as other local government agencies. There is simply no support for the notion that the Government Claims Act applies only to traditional common law tort actions and not to quantum meruit claims. Further, there is no basis to create an exception to this fundamental public entity immunity merely because the local public entity operates as a public sector health plan.

E. The mandatory duty exception does not apply.

The appellate court correctly determined that the mandatory duty exception found in section 815.6 does not apply here. Plaintiffs, however, mischaracterize the nature of the duty here. The Knox-Keene Act mandates that health plans, including public sector health plans, "reimburse providers for emergency services and care provided to its enrollees …." Cal. Health & Safety Code § 1371.4(b). The mandatory statutory duty is to pay. The amount of payment is not mandated by statute or by regulation.

The amount of payment is not a specific figure. Rather, as discussed above, DMHC promulgated a regulation to provide guidance to the health plans in their determination of the

amount. *See* 28 C.C.R. § 1300.71(a)(3)(B). This form of payment requires the health plan to make an informed business decision taking into account six factors. By definition, this requires the exercise of discretion by the plan. Such discretion is to be exercised within the legal parameters provided by DMHC. Thus, the Court of Appeal correctly decided that the discretion required in determining the payment amount renders section 815.6's immunity exception inapplicable here.[21]

III. CONCLUSION

For the foregoing reasons, this Court should affirm the Court of Appeal's decision that the County of Santa Clara is immune from an implied contract action seeking additional payment for emergency medical care provided to persons covered by the County's public sector health plan.

Dated: March 3, 2023 DAPONDE SIMPSON ROWE PC

By: /s/ Michael J. Daponde
MICHAEL J. DAPONDE
DARCY L. MUILENBURG
Attorney for Amicus Curiae
LOCAL HEALTH PLANS
OF CALIFORNIA

[21] Similarly, a writ of mandate may only be used to enforce a mandatory duty. *Los Angeles Cnty. Prof. Peace Officers' Assn. v. Cnty. of Los Angeles,* 115 Cal. App. 4th 866, 869 (2004) (explaining that a writ of mandate "seeks to enforce a mandatory and ministerial duty to act on the part of an administrative agency or its officers"). A writ cannot issue for any obligations that require the exercise of discretion. *Id*. ("[m]andate will not issue if the duty is not plain or is mixed with discretionary power or the exercise of judgment"). The reasonable and customary value regulation requires the exercise of judgment, and therefore would not be subject to a writ of mandate.

CERTIFICATE OF WORD COUNT

Pursuant to Rule 8.204(c) of the California Rules of Court, I hereby certify that this brief contains 5,506 words, including footnotes. In making this certification, I have relied on the word count of the computer program used to prepare the brief.

Dated: March 3, 2023 DAPONDE SIMPSON ROWE PC

By: /s/ Michael J. Daponde
MICHAEL J. DAPONDE
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Attorney for Amicus Curiae
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EXHIBIT 1

Please see the table below for all decisions rendered as a result of the Emergency Services Independent Dispute Resolution Process (EMTALA IDRP) closed by year from January 1, 2012 through November 30, 2022.

Emergency Services Independent Dispute Resolution Process (EMTALA IDRP) Application Outcomes Closed by Year			
Year	Favorable to Provider	Favorable to Payor	Totals
2012	3	0	3
2013	2	0	2
2014	2	1	3
2015	1	1	2
2016	0	0	0
2017	1	0	1
2018	4	0	4
2019	0	0	0
2020	0	0	0
2021	1	0	1
2022*	0	0	0
Totals	14	2	16

*Through November 30, 2022

Please note the numbers above represent applications, not individual claims.

PROOF OF SERVICE

I am a citizen of the United States and employed in Sacramento County, California. I am over the age of eighteen years and not a party to the within-entitled action. My business address is 500 Capitol Mall, Suite 2260, Sacramento, California.

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Honorable Maureen A. Folan
SANTA CLARA COUNTY SUPERIOR COURT
191 North First Street, Dept. 6
San Jose, CA 95113-1006

Trial Court Judge

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

Executed on March 3, 2023, at Sacramento, California.

/s/ Kate Moore
KATE MOORE

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

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

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Date

/s/Kate Moore

Signature

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