CAPG
The Voice of Accountable Physician Groups

August 12, 2014

Shelley Rouillard
Director
California Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725

Re: DMHC Claims Settlement Regulation and *Quantum Meruit* Recovery

Dear Ms. Rouillard:

For the reasons set forth below, CAPG hereby submits this petition for amendment of the Claims Settlement Practices Regulation promulgated by the California Department of Managed Health Care (codified at Title, 28, Section 1300.71 of the California Code of Regulations (the "Regulation")), which became effective on August 23, 2003. Specifically, CAPG requests that the Department amend or repeal Section 1300.71(a)(3)(B), which purports to prescribe the method for determining the reasonable and customary value of healthcare services rendered by non-contracted providers and providers without a written contract on the ground that an exclusively charge-based system (as opposed to a method that takes into account prevailing payment rates as well as prevailing charges) is contrary to controlling case law. CAPG is submitting this petition pursuant to Section 11340.6 of the California Administrative Procedure Act, Cal. Gov. Code § 11340 *et seq.* (the "APA"). The complete text of the proposed amendment is set forth below.

Section 1300.71(a)(3)(B) states, that for contracted health care providers without a written contract and non-contracted providers, reimbursement of a claim should be:

> "the payment of the *reasonable and customary value* of the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provide; (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 aspect of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case." Regulation 1300.71(a)(3)(B) (emphasis added).

The considerations relevant to the determination of "reasonable and customary value" detailed in the Regulation are not an accurate reflection of the "reasonable value" standard under California law. Specifically, the references to "the fees *charged* by the provider" and the "prevailing provider rates *charged* in the general geographic area in which the services were rendered," without corresponding references to amounts paid to or accepted, are not supported by either statute or case law. Accordingly, CAPG believes that the Regulation violates the consistency requirement under the APA.

Further, as a result of legal developments since the Regulation was adopted, its importance in California's delegated model has grown significantly, while its intrinsic limitations have become more manifest. Since the Regulation was adopted, the courts decided the *Bell, Prospect* and *Children's Hospital Central California* cases and the Workers Compensation Appeals Board has had an opportunity to apply the *Gould* case itself. As set forth below, these developments require the Regulation to be re-examined.

The Decisions in the *Bell* and *Prospect* Cases Demonstrate that "Reasonable Value" is the Single Legal Issue to be Resolved Between Payors and Non-contracted Providers

The California Court of Appeals, in *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, recognized that an implied-in-law contract exists between providers of emergency medical services and those responsible for payment (i.e. plans or delegated groups) by virtue of the legal obligation imposed on the provider to treat emergency patients without regard to their ability to pay and on the plan or delegated group to pay for emergency services regardless of the contract status of the provider of such services. The Court of Appeals held that this implied-in-law contract confers on non-contracted providers the right to seek payment from

the plan or delegated group directly and entitles the provider to payment equal to the reasonable value of the services rendered on a *quantum meruit* theory.

In early 2009 the California Supreme Court held that although non-contracted providers of emergency services are entitled to be paid the reasonable value of their services, they are not entitled to balance bill enrollees in order to collect amounts exceeding the initial amount paid by the HMO or IPA. In so holding, the Court recognized both the implied-in-law contract between the provider of emergency services and the health plan and the providers' right to be paid the reasonable value of their services that had been set forth by the Court of Appeals in *Bell*. The Supreme Court remanded the case to the trial court to determine the remaining issue between the parties, i.e. the reasonable and customary value for the healthcare services rendered by the emergency room physicians.

Following *Bell* and *Prospect*, it is clear that under California law both non-contracted providers and the applicable payors have standing to litigate the reasonableness of the rates charged by non-contracted providers and the reasonableness of the payments made by the payors. The Regulations of the Department will likely be accorded great weight in these actions. To the extent that the Regulation enshrines in California law a standard for measuring reasonableness that is not supported by controlling formulations of *quantum meruit*, providers and payors who choose to litigate the issue of reasonableness will do so burdened by an incorrect standard. The portion of the Regulation adopting the *Gould* factors should be amended for this reason alone.

As addressed in detail below, the shortcomings of the *Gould* factors as the exclusive method of determining reasonable value was recently addressed by the Court of Appeal in *Children's Hospital Central California v. Blue Cross of California*, 226 Cal.App.4th 1260, 1275 (2014) ("Thus, while the *Gould* court set forth a comprehensive set of factors for the situation presented there, those factors are not exclusive or necessarily appropriate in all cases.")

The Purported Case Law Basis for the Regulation

Gould v. Workers' Compensation Appeals Board

In *Gould v. Workers' Compensation Appeals Board*, 4 Cal.App.4th 1059 (1992) the court addressed the issue of what constitutes a "reasonable fee" in the context of a workers' compensation claim. Pursuant to California Labor Code §5307.1, a physician may charge an employer or workers' compensation carrier a fee in excess of the "Official Medical Fee Schedule" so long as, among other things, the fee is "reasonable." According to *Gould,* in deciding "reasonableness" of fees charged *in excess of* the fee schedule rate, the Workers' Compensation Board may consider evidence regarding:

- the physician's training, qualifications and length of time in practice;
- the nature of the services provided;
- the fees usually charged by the medical provider;
- the fees usually charged in the geographic area in which the services were rendered;
- other aspects of the economics of the physician's practice that are relevant; and
- any unusual circumstances of the case.

Gould at 1071.

The Gould Case – Distinguished

The factors included in the Regulation were clearly imported directly from the *Gould* case. However, DMHC's reliance on *Gould* is unwarranted. *Gould* was decided as it was solely because of its workers' compensation context. The unique nature of the workers' compensation

payment system requires that the case's reach be limited to that context. *Children's Hospital*, 226 Cal.App.4th at 1275.

The *Gould* case involved two police officers who sustained industrial psychiatric injuries during the course of their employment by the city of Los Angeles. The officers obtained treatment from a psychiatrist, Dr. Sam Gould. Under Labor Code Section 5307.1, there is an official medical fee schedule containing unit values for specified procedures adopted by the administrative director of the Division of Industrial Accidents (now called the Division of Workers' Compensation) (Cal. Code. Regs., Tit. 8, Ch. 4.5, Section 9791.1 [Rule 9791.1]) In California Code of Regulations, Title 8, Chapter 4.5, Section 9792 (Rule 9792), conversion factors are specified. When the unit values for specified procedures, such as psychotherapy (the service at issue in the *Gould* case), are multiplied by the conversion factor for the pertinent section of the schedule, the recommended fee is obtained. Although Labor Code Section 5307.1 provided that the Schedule was to be revised "no less frequently than biennially," the Schedule and Rule 9792, at the time the *Gould* case was decided, had not been amended in at least five years.

The fee schedule amount for a 45 – 50 minute psychotherapy session was $98.40. Dr. Gould presented evidence that he should receive a higher fee because he had extensive experience in treating police officers, psychiatrists in West Los Angeles generally charged much more than $98.40 per session, and the cost of doing business in West Los Angeles required that a higher fee be allowed. The Workers' Compensation Appeals Board rejected Dr. Gould's appeal, holding that a finding of "extraordinary circumstances" was necessary before the fee schedule amount could be varied in a particular case. The Court of Appeal reversed and remanded, holding that in order for the Workers' Compensation Appeals Board to augment the fee schedule amount in a particular case, it was not necessary for the petitioner to show extraordinary circumstances, but only to show, utilizing the factors set forth above, that the fee schedule amount should be augmented in a particular case.

The *Gould* case thus decided the single issue of how much of a showing, in a worker's compensation appeal, a provider must make in order to overcome the presumptive

reasonableness of the workers' compensation fee schedule. The case did not, and did not purport to, set forth a list of factors to be considered more generally in assessing the reasonableness of a provider's charges. In the non-industrial context, it hardly needs to be said that there is no statewide fee schedule that enjoys a statutory presumption of reasonableness. Non-contracted providers are entitled to "the reasonable and customary value" of the services they render. (28 CCR § 1300.71(a)(3)(B)). In this context, however, payors do not have the luxury of a statutory or regulatory benchmark against which to measure non-contracted providers' billed charges.

Prior to the Department's adoption of the *Gould* factors in the Regulation, *Gould* had only been applied outside the context of a workers' compensation claim in one instance. In *Van Ness v. Blue Cross of California*, 87 Cal. App. 4364 (2001), the Court of Appeal cited *Gould* to support the proposition that relative value studies can be used in determining the reasonableness of medical charges for industrial injuries. Again, prior to the Department's adoption of the *Gould* factors, the case's influence was limited to the industrial arena.

Finally, *Gould* itself undercuts a reliance on charges to evidence reasonableness. The *Gould* court specifically stated that "[e]vidence that a physician has charged a fee similar to fees charged for the same service in the geographical area in which the physician practices does not itself mean that the physician's fee is reasonable." *Gould* at 1069. To the extent that the *Gould* formulation of a reasonable fee employs two elements that are explicitly charge-based and none that relate to prevailing payment rates (which would be unnecessary in a fee schedule environment), the factors are inconsistent with a traditional common law "*quantum meruit*" formulation of "reasonable value."

The *Quantum Meruit* Standard-*Children's Hospital Central California v. Blue Cross.*

Quantum meruit, which means "as much as he or she deserved" is utilized as a measure of recovery in "situations in which one person is accountable to another on the ground that otherwise he would unjustly benefit or the other would unjustly suffer loss." *California Emergency Physicians Medical Group v. Pacificare of California*, 111 Cal.App.4th 1127, 1136 (2003) (citing the Restatement of Restitution, general scope note, p.1.); see also, *Bell v. Blue*

Cross of California, 131 Cal.App.4th 211 (2005). This position was confirmed by the California Supreme Court in the *Prospect* case: "Emergency room doctors *are* entitled to reasonable payments for emergency services rendered to HMO patients." *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, et al.*, 45 Cal.4th at p. 509.

The classic formulation concerning the measure of recovery in *quantum meruit* is found in *Palmer v. Gregg*, (65 Cal.2d 657 (1967)). In *Palmer*, Justice Mosk, writing for the court, said: "[t]he measure of recovery in *quantum meruit* is the *reasonable value* of the services rendered provided they were of direct benefit to the defendant." Id. at p. 660. *See also, Producers Cotton Oil Co. v. Amstar Corp.*, 197 Cal.App.3d 638, 659 (1988). The burden is on the person making the *quantum meruit* claim to show the value of the services. *Miller v. Campbell, Warburton, Fitzsimmons, Smith, Mendel & Pastore*, 162 Ca.App.4th 1331, 1344 (2008).

Although a long line of California cases, including the California Supreme Court's *Prospect* decision, have stated that a non-contracted provider is entitled to "*quantum meruit*" compensation, i.e., compensation equal to the reasonable and customary value of the services, California cases have provided very little guidance on how reasonable and customary value was to be determined. As a result, 28 CCR §1300.71(a)(3)(B) constituted the only available guidance to plans and delegated groups confronted with a non-contracted provider claim.

On June 10, 2014 the California Court of Appeal for the Fifth Appellate District ruled unambiguously that billed charges do not constitute reasonable and customary value for purposes of non-contracted provider claims. *Children's Hospital Central California v. Blue Cross of California*, 226 Cal. App. 4th at 1275. The court found in favor of Blue Cross of California in a dispute with Children's Hospital Central California regarding post-stabilization medical services provided during a ten-month period during which the parties did not have a contract in place. The hospital's billed charges were $10.8 million; Blue Cross had paid the hospital the Medi-Cal rate of $4.2 million. (The Blue Cross plan was a Medi-Cal managed care plan.) The trial court had held that Blue Cross was required to pay the Hospital's full billed charges for services rendered during the non-contracted period and set damages at $6.6 million. Blue Cross appealed

and placed squarely before the Court of Appeal the issue of what *quantum meruit* requires in the context of non-contracted provider charges.

Because the *Gould* factors included "the fees usually charged by the provider" and "prevailing provider rates charged in the general geographic area in which the services were rendered" but did not include any factors relating to payments accepted by the provider for the same services, Children's Hospital successfully argued to the trial court that evidence relating to the amount that it accepted under contracts with payors was irrelevant, and the trial court did not permit Blue Cross to present evidence regarding amounts that Children's Hospital actually accepted for the services. Similarly excluded was evidence regarding Medi-Cal rates for the services. The trial court concluded that the *Gould* factors were the exclusive method to determine reasonable and customary value. Therefore, the only evidence of value the jury was allowed to consider was the hospital's full billed charges. The Court of Appeal held that this was reversible error. 226 Cal.App.4th at 1277.

The Court of Appeal reviewed the history of §1300.71(a)(3)(B) and determined that the Department had not intended to supplant the common law of *quantum meruit*. The court noted that the "'reasonable value' of the services [sought to be valued] has been described as the 'going rate' for the services (*Maglica v. Maglica* (1998) 66 Cal.App.4th 442, 446) or the 'reasonable market value at the current market prices." (*Punton v. Sapp Bros. Construction Co.* (1956)143 Cal.App.2d 696, 701." 226 Cal.App.4th at 1274. Further, "[r]easonable market value, or fair market value, is the price that ' a willing buyer would pay to a willing seller, neither being under compulsion to buy or sell, and both having full knowledge of all pertinent facts.' *(Alameda County Flood Control & Water Conservation Dist. v. Department of Water Resources* (2013) 213 Cal. App.4th 1163, 1174-1175, fn. 9)." Id.

The Children's Hospital court held that in determining value in *quantum meruit* cases courts accept a wide variety of evidence, including evidence of "agreements to pay and accept a particular price. (*Oliver v. Campbell* (1954) 43 Cal.2d 298, 305; *Watson v. Wood Dimension, Inc.* (1989) 209 Cal.App.3d 1359, 1365 (*Watson*)." Id. Accordingly, a written contract providing for an agreed price is admissible in evidence in an action to determine the reasonable value of services. *Parker v. Maier Brewing Co.*, 180 Cal.App.2d 630, 635 (1960). Therefore,

"while the *Gould* court set forth a comprehensive set of factors, for the situation presented there, those factors are not exclusive or necessarily appropriate in all cases." Id.

In the *Children's Hospital* case, the court held that the reasonable value of the hospital's services (i.e., the market value) is not ascertainable from the hospital's full billed charges alone. The court quoted the California Supreme Court when it noted "[A] medical care provider's billed price for particular services is not necessarily representative of either the cost of providing those services or their market value." 226 Cal.App.4th at 1275, quoting *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal.4th 541,564 (2011). The court also noted, as had the Supreme Court in *Prospect*, that the reasonable value might be the charges, or the amount the payor chooses to pay, or some amount in between the two. 226 Cal.App.4th at 1275, quoting *Prospect, supra,* 45 Cal.4th at p. 505). The court held that "relevant evidence would include the full range of fees that Hospital both charges and accepts as payment for similar services. The scope of the rates accepted by or paid to Hospital by other payors indicates the value of the services in the marketplace. From that evidence, along with evidence of any other factors that are relevant to the situation, the trier of fact can determine the reasonable value of the particular services that were provided, i.e., the price that a willing buyer will pay and a willing seller will accept in an arm's length transaction." 226 Cal.App.4th at 1275.

In the wake of *Children's Hospital Central California v. Blue Cross of California* it is clear that determination of reasonable and customary value requires evidence of amounts accepted by the non-contracted provider for similar services, even if those amounts are paid pursuant to a contract. The non-contracted provider's billed charges are also relevant, but a payor will be permitted discovery regarding how often the provider actually receives its billed charges. Although not specifically addressed in the *Children's Hospital* case, it seems likely that evidence relating to payments accepted by other providers in the area would also be relevant to the issue of value of services in the marketplace.

This conclusion is entirely consistent with the application of the *Gould* factors by California's Workers' Compensation Appeals Board. In *Kunz v. Patterson Floor Coverings, Inc.*, et al., 67 Cal.Comp.Cas 1588 (en banc 2002), the Board was called upon to determine the reasonable value of ambulatory surgery center services, because surgery centers are not covered by the workers' compensation fee schedule. In this respect, non-contracted surgery center

services are very similar to all non-contracted provider services in a non-industrial context: no fee schedule is available to provide customary payment (as opposed to charge) information.

In *Kunz*, the Board applied the *Gould* factors, but applied them to explicitly include not only charges, but also payment accepted by the provider:

> "We emphasize that the 'usual fee' to which we refer is the fee usually *accepted*, not the fee usually *charged*, because that is an aspect of the economics of a medical provider's practice in the current market."

Unfortunately, the plain meaning of the language employed in *Gould* does not clearly signal the way the factors are to be employed in a non-fee-schedule environment. As the application in the *Kunz* case shows, and as the court explicitly held in *Children's Hospital*, the factors, although facially limited to charges, should include also customary payment data when the services at issue have no applicable fee schedule amount. Because the Regulation itself does not indicate its context, the *Gould* language should be revised so that it will be applied in a manner consistent with common law *quantum meruit* principles, i.e., to include within its scope factors relating to prevailing payments as well as billed charges.

The Regulation Violates the Consistency Standard for Regulations

The APA requires that regulations adopted by state agencies must be consistent with law. *See* Gov. Code § 11439.1. "Consistency" means being "in harmony with, and not in conflict with or contradictory to existing statutes, court decisions, or other provisions of law." Gov. Code § 11349(d). For the reasons set forth above, the Regulation conflicts with existing court decisions governing the measurement of *quantum meruit* claims. Accordingly, the Regulation violates the consistency standard for regulations under the APA and should be amended to conform to applicable law.

Text of the Proposed Amendment

CAPG proposes that Section 1300.71(a)(3)(B) be amended to add the following factors as items (vi) and (vii), and that the factor currently listed as item (vi) ("any unusual circumstances in the case") be re-numbered as item (viii):

> "(vi) average contract rates for the service of payers and providers in the general geographic area in which the service was provided;
>
> (vii) average amount for the service paid to and accepted by non-contracted providers in the general geographic area in which the service was provided, including payments made by both commercial and governmental payors (e.g., Medicare and Medi-Cal Programs) ;"

These factors, when considered in conjunction with the six factors currently listed in the Regulation, will make the Regulation consistent with prevailing law, and will provide appropriate guidance to payors, providers and dispute resolvers in this area.

For the reasons set forth above, CAPG respectfully requests that the Department amend the Regulation to the extent that it establishes a charge-based test to determine the reasonableness of a non-contracted provider's charges.

Very truly yours,

William Barcellona

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