



March 17, 2009

Lucinda Ehnes
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. Ehnes:

For the reasons set forth below, the California Association of Physician Groups, Inc. ("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” 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 Governor promulgated Executive Order S-13-06, the courts decided the *Bell* and *Prospect* 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.

Executive Order S-13-06

On July 25, 2006, Governor Arnold Schwarzenegger issued Executive Order S-13-06, which directed the Director of the Department of Managed Healthcare to take a number of interrelated actions concerning payment for emergency services in California. The first one, as a result of the Department’s adoption of the Unfair Billing Pattern Regulation, 28 CCR §1300.71.39, and the Supreme Court’s decision in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, et al.*, (January 8, 2009, S142209) ___ Cal.4th ___, has been accomplished; balance billing of HMO enrollees for emergency services is illegal in California.

The resolution of the balance billing issue, however, highlights the importance of the Governor’s remaining directives, one of which was to “conduct a review of the current criteria used to determine the reasonable and customary value of non-contracted emergency services to ensure that it results in fair reimbursement for the provider, while not adversely affecting the financial viability of California’s healthcare delivery system.” The Executive Order clearly set forth the relationship between the issues of reasonable value and balance billing. If the enrollee is to be removed as a “bargaining chip” in disputes between payors and providers about payment for emergency services, providers must be able to obtain fair reimbursement for their services. This, in turn, requires appropriate criteria to determine reasonable and customary value. These criteria, however, must strike a balance between fair reimbursement and maintenance of the system’s financial viability.

The Decisions in the *Bell* and *Prospect* Cases Demonstrate that “Reasonable Value” will be 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.

Earlier this year, 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 provider’s 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 Regulation of the Department will likely be accorded great weight in these actions, as will interpretations by the Department such as its September 2, 2005 memorandum by Kevin Donohue, which purported to provide guidance for health plans, capitated providers, and contracted claims processing organizations in connection with a reasonable and customary payment methodology as defined under Section 1300.71(a)(3). To the extent that the Regulation enshrines in California law a standard for measuring reasonableness that is not supported by traditional 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.

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.

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.

The *Gould* case involved two police officers who sustained industrial psychiatric injuries during their employment as police officers 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 a single issue of how much of a showing, in a worker’s compensation appeal, must a provider 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

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 recently 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.*, (Case No. S142209, January 8, 2009) Slip Op. at 13.

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).

Reasonable Value

Under *quantum meruit*, if the “claim is based on quasi-contract” (or, implied-by-law), “the theory of recovery...is not for damages, but for restitution [and] is measured not by any loss suffered by the plaintiff, but by the gain or enrichment unjustly conferred on the defendant.” *Id.* at 485. Thus, in a *quantum meruit* situation, the measure of payment to a provider should be the value of the services to the patient and/or insurer. See also, *Iraola & CIA, S.A. v. Kimberly-Clark Co.*, 325 F.3d 1274, 1282 (2003) (“*Quantum meruit* claims measure the value of services to the recipient, rather than the costs to the provider, and therefore [plaintiff’s] alleged lost profits and costs are not recoverable.”). However, under either theory of recovery “[t]he reasonable market value of plaintiff’s services can be viewed as the correct remedy in most...cases...because...[t]he value of the plaintiff’s services measures the defendant’s gain when the defendant requests the work: the defendant’s benefit is receiving what he or she requested.” *New Baltimore* at 487.

California case law does not reveal any authority outlining the proper factors to be considered when determining the “reasonable value” of medical services supplied by non-contracted providers. It is clear, however, that reasonable value is not measured simply by the rate or price demanded. See *Arcade County Water District v. Arcade Fire District*, 6 Cal.App.3d 232 (where the court found an “implied agreement to pay not the

demanded price but a reasonable price.”). Further, in determining the reasonable value of the amount to be awarded on a *quantum meruit* claim, the Court may consider the “extent, character and value of the plaintiff’s services.” See *Arrison v. Information Resources, Inc.*, 1999 U.S. Dist. LEXIS 11471 (citing *George v. Double D. Foods, Inc.*, 155 Cal.App.3d 36, 46 (1984)). In addition “[a]ny competent evidence which reasonably tends to establish such value is admissible” 66 Am. Jr. 2d Restitution and Implied Contracts § 89 (1973).

The general result reached by California courts in *quantum meruit* cases, in which the measure of reasonable value is determined from the perspective of the recipient of the services as opposed to the service provider, is consistent with the methods for determining reasonable value utilized by other jurisdictions. For example, in *Temple University Hospital v. Healthcare Management Alternatives, Inc.* (“*Temple*”) a recent case in the Pennsylvania Superior Court (1003 PA Super. 332 (2003)), the court dealt with a situation in which a non-contracted provider claimed it was owed certain billed fees by a health plan. Under the equitable theory of unjust enrichment, the court found that where “there is no express agreement to pay, the law implied a promise to pay a reasonable fee for a health provider’s services...[t]hus, in a situation such as this, the defendant should pay for what the services are ordinarily worth in the community...[s]ervices are worth what people ordinarily pay for them.” *Id.* at Paragraphs 21-22. The court held that most “important question is what healthcare providers actually receive for [their] services.” *Id.* at Paragraph 23. Such “actual receipts” far more accurately than the provider’s billed charges indicate the value of the provider’s services.

An appellate court in Tennessee reached the same conclusion in a case regarding the reasonable value of an attorney’s services. In *Mitch Grissim & Assoc. v. Blue Cross & Blue Shield of Tennessee*, (2002) 14 S.W.3d 531, 538, the court held, “[r]ecovery under *quantum meruit* is not measured by the detriment to the plaintiff but by the benefit conferred on the defendant.” However, such benefit was not measured by the attorney’s stated charges. The factors employed, however, provide no guidance here, as they were drawn from principles of legal ethics as they relate to attorneys’ fees.

Case law from Louisiana similarly requires fact-specific analysis in *quantum meruit* cases, as “[t]here is no specific test which must be applied to determine the reasonable value of such services. It is a matter of equity depending on the circumstances of each case.” *Bieber-Guillory v. Aswell*, (1998) 723 So.2d 1145, 1151. However, in such situations, “Louisiana jurisprudence...has consistently applied a two-fold limitation to the recovery. First, the plaintiff cannot recover more than the actual value of his services and materials, plus a fair profit; and secondly, the plaintiff cannot recover more than defendant was enriched by plaintiff’s services.” *Id.* Reasonable value in Louisiana is capped at the value to the recipient of the services provided.

The above discussion demonstrates that the determination of reasonable value in a *quantum meruit* case is performed from the perspective of the payor (or patient) and not from the perspective of a provider of services. Simply stated, *quantum meruit* seeks to determine the value of the services to the recipient. As noted in *Iraola*, “*quantum meruit* claims measure the value of services to the recipient, rather than the costs to the provider, and therefore [plaintiff s] alleged lost profits and costs are not recoverable.” 325 F.3d at 1282.

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, 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 repealed.

Text of the Proposed Amendment

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

"(vi) average contract rates for the service of payors and providers in the general geographic area in which the service was provided;

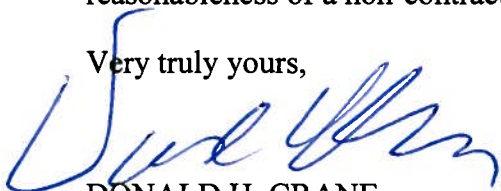
(vii) rates paid pursuant to established fee schedules by governmental payers (e.g., Medicare, MediCal, Healthy Families Programs) for the service;

(viii) average amount for the service paid to and accepted by non-contracted providers in the general geographic area in which the service was provided;"

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,



DONALD H. CRANE
President and CEO

DHC/mg
Attachment