



**California Medical Association**  
*Physicians dedicated to the health of Californians*

April 15, 2009

**VIA ELECTRONIC MAIL**

Suzanne Chammout, Chief of Regulations  
Office of Legal Services  
Department of Managed Health Care  
980 9th Street, Suite 500  
Sacramento, CA 95814

**RE: The California Association of Physician Groups' Petition to Amend 28 C.C.R.  
§1300.71(a)(3)(B)**

Dear Ms. Chammout:

The California Medical Association (CMA) appreciates the opportunity to comment on the California Association of Physician Groups' (CAPG) petition dated March 17, 2009 (the Petition) to amend Title 28, Section 1300.71(a)(3)(B) of the California Code of Regulations (the Gould criteria). CMA strongly opposes the Petition because it in essence is an attempt to systematically and artificially depress non-contracted provider reimbursement rates that HMOs and delegated risk-bearing organizations, like CAPG's members, are required to pay by law. CAPG offers nothing new in asking the Department of Managed Health Care (DMHC) to amend the Gould criteria because they purportedly are inconsistent with prevailing law.<sup>1</sup> CAPG once again complains that the existing Gould criteria are an "exclusively charge-based system" because they include the following two factors (among six broad factors): "the fees charged by the provider" and the "prevailing provider rates charged in the geographical area in which the services were rendered."<sup>2</sup> This Petition is baseless and raises the same arguments that have been raised in the recent past, without success. The DMHC did not act on the request to amend the Gould criteria not long ago, and there is no reason to treat CAPG's request this time any differently. CAPG's Petition should be summarily dismissed.

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<sup>1</sup> The California Administrative Procedure Act requires all regulations to be "in harmony with, and not in conflict with or contradictory to, existing statutes, court of decisions, or other provisions of law." Govt. Code §11349.

<sup>2</sup> Read in full, section 1300.71(a)(3)(B) requires reimbursement of non-contracted providers at "the reasonable and customary value for 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 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."

## I. CAPG's Proposed New Factors for the Gould Criteria.

The heart of CAPG's request does not come until the last page of its Petition, with the proposal of three new Gould factors. The Petition very well could have been one page because the first eight pages are dedicated to recounting background developments (that bear little relevance) and an over-generalized and unhelpful discussion of *quantum meruit* (that primarily relies on non-California sources). Notwithstanding the inaccuracies of CAPG's self-serving description of *quantum meruit* (for which CMA will briefly correct), the proposed new Gould factors do not comport even with CAPG's own view of *quantum meruit*. CAPG in fact offers no explanation how the proposed factors could remedy any alleged inconsistency between the existing Gould criteria and prevailing law. Of course, there is no such explanation because CAPG's proposed Gould factors are anathema to any conception of what is "reasonable and customary." Rather than get distracted with the ancillary issues of *quantum meruit*, CMA will focus directly on CAPG's proposed new Gould factors.

### A. Government-Set Rates Pursuant to Social Health Programs

Rates paid by the Medicare, Medi-Cal or Healthy Family programs are not an appropriate basis to determine reimbursement for non-contracted physicians who rendered services to Knox-Keene enrollees. There is no better way to say it – CAPG wishes to compare apples and oranges.

The Gould criteria are intended to help determine the reasonable and customary value that private Knox-Keene plans and their delegated risk-bearing organizations (including CAPG's members) must pay to out-of-network physicians for rendering services to their enrollees in the private sector. Medicare, Medi-Cal and Healthy Families, on the other hand, are government-funded social programs with preset fee schedules that are universally recognized to be well below free market rates. Government fee schedules are constantly subject to budgetary constraints and in no way reflect what is reasonable or customary in a commercial market setting. Furthermore, to the extent physicians participate in government-funded health programs, they accept lower reimbursement rates for the public good. Given these considerations, it would defy logic to use government social health program rates to determine reasonable and customary rates to be paid by private plans and insurers or their delegates.

Indeed, the DMHC acknowledged on numerous occasions during the initial rulemaking period for AB 1455 (the law under which the Gould criteria were promulgated) that rates under government social health programs have no place in the Gould criteria: "The Department recognizes that these (Medicare or Medicaid) government programs are not designed to reimburse the provider for the fair and reasonable value of the services rendered and are, therefore, an inappropriate criterion" for determining reasonable and customary value of non-contracted provider services. *See* Response No. 62, Second Comment Period. Additionally, in Response No. 10 in the Third Comment Rulemaking Period, the DMHC stated:

Following extensive comments from stakeholders, the Department has determined that the reimbursement of non-contracted providers based solely on Medicare and Medi-Cal payment rates would be inconsistent with California law. Non-contracted providers are entitled to compensation equivalent to the reasonable value of the services rendered. Thus, *DMHC has properly rejected these fee schedules as a consideration when determining reasonableness and see no sound rationale to reconsider them today.* (emphasis added)

The DMHC has already resoundingly rejected CAPG's proposal to include Medicare, Medi-Cal and Healthy Families rates in the Gould criteria. Nothing CAPG raises in the Petition justifies a different reaction now.

### *B. Contracted Discount Rates*

CAPG's second proposed new Gould factor – contract rates imposed by HMOs – also is an ill-conceived standard to measure the reasonable and customary value of non-contracted services in the free market. CAPG has blurred the distinction between non-contracted and contracted and, in so doing, betrays a fundamental presumption of the Gould criteria – *i.e.* the Gould criteria are intended to measure the reasonable and customary value of professional services that non-contracted physicians offer in the out-of-network context, free from the constraints of HMO-imposed contract rates. Contract rates therefore are completely irrelevant.

Contract rates by design, and in practice, are categorically lower than actual market rates. Contract rates represent a discount on customary rates that physicians offer to be part of an HMO's network of providers, in exchange for specific benefits to the physician. When deciding whether to enter into a managed care contract with a payor, physicians look at a number of factors including, but not limited to, the number of patients involved, payor utilization management requirements, payor billing rules and the administrative burden associated with getting paid, payor solvency, referral patterns, and the physician's relationship with the hospitals in which the physician practices. These considerations have an economic value that are worthy of the discounted fee. *See HCA Health Services of Georgia, Inc. v. Employer's Health Insurance Company*, 240 F.3d 982 (11th Cir. 2001). As was discussed in a Workers' Compensation Appeals Board decision in California, *Garbini v. Macy's West*, W.C.A.B. No. SJ0-0228626:

[T]here are important reasons they [*i.e.* contracted fees] are lower than a fair fee payable when there has been no prearrangement of the fee to be charged. For one thing, the provider knows in advance what payments are being offered in a provider or network arrangement, and decides whether to accept those fees or decline to provide services on the proffered basis. Co-relatively, the provider that agrees to accept these fees can rely on the prompt payment of the negotiated fee . . . Finally, there is generally an express or implied agreement in the preferred provider network arrangement that the payors or their clients will refer patients to those in the network, often including financial concessions to the patients for using "in network providers."

The discount that an HMO has obtained under a provider contract can provide no guidance in an assessment of what is reasonable and customary in the non-contracted marketplace. CAPG offers no explanation to counter this basis to reject its proposal.

### *C. Amounts Accepted by Providers*

Finally, there is no valid reason to accept CAPG's proposal to insert into the Gould criteria the "average amount for the service paid to and accepted by non-contracted providers." Such amounts are misleading and fail to take into account the numerous underlying reasons why a physician accepted a particular payment. These reasons do not operate in the commercial marketplace. CAPG's third proposal, as with all of CAPG's proposed new Gould factors, represents an artificial construct that cannot accurately reflect the true reasonable and customary value of out-of-network services.

There are many reasons why an out-of-network physician may accept payment that is less than the reasonable and customary value of his or her services. Many physicians, who have long term relationships with their patients and/or have deep commitments to their local community, will allow their patients a discount due to financial hardship, on a case by case basis. Business & Professions Code section 657(c) expressly recognizes that physicians can give discounts when they have “reasonable cause to believe [the patient] is not eligible for, or is not entitled to, insurance reimbursement, Medi-Cal or coverage by a health care service plan.” CAPG’s Petition would seek to take advantage of a physician’s charity and misconstrue these discounts out of context to suggest that the discounted rates reflect the physician’s reasonable and customary rate. The law expressly prohibits such a stratagem: “Any discounted fee granted pursuant to this section shall not be deemed to be the health care provider’s usual, customary or reasonable fee for any other purposes.” *Id.* Physicians may also give discounts for prompt payment or may ultimately accept less than their just reimbursement because they do not have the energy or resources to appeal unilateral and persistent underpayments by HMOs and their delegated payors. The Supreme Court in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 45 Cal. 4th 497, 508 (2009), emphasized that “an HMO does not have unfettered discretion to determine unilaterally the amount it will reimburse a noncontracting provider.” Certainly this statement means that HMOs cannot unilaterally refuse to pay a provider’s bill, engage in unyielding stalling tactics until the physician capitulates and then claim that the physician’s acceptance of whatever the HMO paid in the first place represents that physician’s reasonable and customary rate. That is an absurd contention, and one that CAPG has in fact made with its proposal to insert accepted payments into the Gould criteria. There is no valid reason to accept this proposal.

## **II. The Proposed New Gould Factors Are Not Consistent With California Law on *Quantum Meruit*.**

CAPG’s Petition supposedly is premised on the principle of *quantum meruit*. But by proposing the foregoing three new Gould factors, CAPG demonstrates a complete misunderstanding of (or a disregard for) the equitable concept. CAPG’s proposals betray the foundations of *quantum meruit*, which arise out of the simple notion of fairness to compensate someone for the full and reasonable value of a service rendered. This common law principle is well established in California law, and it is not necessary or relevant to look to out-of-state authority (upon which CAPG primarily relies to advance its skewed definition of *quantum meruit*). California law certainly does not support CAPG’s assertion that *quantum meruit* is measured “from the perspective of the recipient of the services.” Petition at p. 7 (citing state court cases from Tennessee, Louisiana and Pennsylvania).

*Quantum meruit* refers to the well-established principle that “the law implies a promise to pay for services performed under circumstances disclosing that they were not gratuitously rendered.” *Long v. Rumsey*, 12 Cal. 2d 334, 342 (1938). To recover in *quantum meruit*, a party must show the circumstances were such that “the services were rendered under some understanding or expectation of both parties that compensation therefor was to be made.” *Estate of Mumford*, 173 Cal. 511, 523 (1916). Thus, the proper inquiry for measuring quantum meruit, relevant to the health care context, is what the patient would pay the out-of-network physician based on their understanding at the time services would be rendered. Certainly, such an understanding would not include payment based on the out-of-network physician’s Medi-Cal reimbursement rate, the physician’s contracted rate or past discounts applied to specific patients on a case-by-case basis.

The most concise calculation of *quantum meruit*, which conforms most faithfully to its purpose, is the free market comparison. The Ninth Circuit Court of Appeals, applying California law on *quantum meruit*, specifically endorsed this view. The court in *Chodos v. West Publishing Co., Inc.*, 92 Fed.

Appx. 471, 473, 2004 WL 385675 (9th Cir. 2004), confirmed that under *quantum meruit* recovery, “[i]n assessing the reasonable value of plaintiff’s time and effort, you may evaluate what he would have been paid if the parties had bargained for plaintiff’s services in the open market.”

On the other hand, California courts have held that the measure of *quantum meruit* must exclude the non-market factors that CAPG hopes to introduce into the Gould criteria. The court in *Maglica* made clear that the measure of *quantum meruit* is not dependent on the value of the services from the perspective of the recipient of those services. See *Maglica v. Maglica*, 66 Cal. App. 4th 442, 449 (1998) (“It is one thing to require that the defendant be benefited by services, it is quite another to *measure* the reasonable value of those *services* by the value by which the defendant was ‘benefited’ as a *result* of them”) (emphasis in original). Not only did the *Maglica* court disabuse the notion that *quantum meruit* is measured from the perspective of the recipient, it also specifically rejected the notion (which CAPG proposes) that a *quantum meruit* calculation should include contract rates. The court held that “[c]ontract price and the reasonable value of services rendered are two separate things; sometimes the reasonable value of services exceeds a contract price.” *Id.* at 450. Thus, according to the court, *quantum meruit* cannot be used “to impose a highly generous and extraordinary contract that the parties did not make.” *Id.* at 451; see also 21 A.L.R. 3d 30 (2009) (discussing and citing cases holding that the price for services fixed in a contract cannot provide the measure of damages in *quantum meruit*).

As noted previously, there is no common sense or valid rationale to adopt CAPG’s proposed new Gould factors. Contrary to CAPG’s assertions in the Petition, the law of *quantum meruit* also lends no support to, but rather contravenes, CAPG’s proposals.

### **III. CMA Requests that DMHC Issue Fines for All Health Plans Who Violated the Gould Criteria When They Relied on Ingenix.**

It is well documented and publicized that Ingenix – the primary databases relied upon by the health plan and insurance industry to calculate “usual and customary fees” for non-contracting physicians – is severely flawed. The New York Attorney General’s (NYAG) investigation of Ingenix revealed numerous flaws in the databases, and some of these flaws are the very data points that CAPG hopes to introduce into the existing Gould criteria:

- a) The Ingenix databases lack information about the provider’s training and qualifications, the type of facility where the comparative service was provided;
- b) Ingenix manipulates the databases by deleting valid high charges and by deleting proportionately more high charges than low charges;
- c) Ingenix deletes from the database charges that have modifiers to indicate procedures or services with complications;
- d) Ingenix fails to correct information affecting the value of the service, such as whether the service was performed by someone other than a physician.
- e) Ingenix pools data from dissimilar providers (such as nurses, physician assistants, and physicians) for use in the Ingenix database;
- f) Ingenix contains outdated information;

- g) Ingenix fails to audit the data it receives from data contributors to ensure that they have submitted all appropriate data and have not included negotiated or discounted rates;
- h) Some data contributors delete higher charges from the data they submit to the Ingenix database, thereby skewing reimbursement rates downward; and
- i) Ingenix uses the defective data in the databases, and a deficient methodology, to “derive” additional charges. The use of defective data to formulate a rate for other charges means that the resulting rate is itself defective.

Rather than adopt the factors that CAPG proposes, which contributed to the NYAG’s conclusion that the Ingenix databases systematically understated out-of-network UCR rates, the DMHC should reject CAPG’s Petition out of hand. Furthermore, rather than open proceedings on CAPG’s baseless Petition, the DMHC should look into how many California consumers were harmed by Knox-Keene plans that used Ingenix. Congress is undertaking an investigation of Ingenix and United Healthcare to determine if consumers were cheated. As the regulator of the same industry from which Ingenix and United operated, the DMHC should focus attention on this growing national issue.

CMA respectfully urges the DMHC to summarily reject CAPG’s Petition. If any regulatory action needs to be taken, it is not to open rulemaking proceedings on this Petition, but rather to investigate and take enforcement action if necessary to determine whether Knox-Keene HMOs and PPOs cheated physicians and consumers by their use of Ingenix. Should you have any questions, please do not hesitate to contact Armand Feliciano directly at (916) 444-5532 or email at [afeliciano@cmanet.org](mailto:afeliciano@cmanet.org).

Respectfully Submitted,



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