B267012

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT, DIVISION ONE

SANJIV GOEL, M.D., INC.,

Plaintiff and Appellant,

v.

REGAL MEDICAL GROUP,

Defendant and Respondent.

APPLICATION OF CAPG and CALIFORNIA ASSOCIATION OF HEALTH PLANS (CAHP) TO FILE *AMICUS CURIAE* BRIEF IN SUPPORT OF RESPONDENT
And
AMICUS CURIAE BRIEF OF CAPG and CALIFORNIA ASSOCIATION OF HEALTH PLANS (CAHP) IN SUPPORT OF RESPONDENT

From a Judgment of the Los Angeles County Superior Court
Case No. BC543227
The Honorable Rolf Treu

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REQUEST FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

CAPG (formerly known as "California Association of Physician Groups") and California Association of Health Plans ("CAHP") respectfully request leave to file the attached *amicus curiae* brief in support of Respondent, Regal Medical Group, in the above-captioned matter. CAPG is the trade association for Regal Medical Group and represents capitated, delegated physician groups that pay downstream emergency medical service claims on behalf of health plans for the health plans' assigned HMO enrollees. CAHP is the trade association representing health care service plans who enter into capitated arrangements with delegated physician groups on behalf of their HMO enrollees. Both CAPG and CAHP members are subject to provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code § 1340 *et seq.*), and its implementing regulations, including, Title 28 C.C.R. section 1300.71(a)(3)(B). Moreover, many CAPG and CAHP members have been sued by Appellant Sanjiv Goel, M.D. (Goel) where Goel sought additional payment under theories of *quantum meruit* for the emergency cardiology services he has provided.

CAPG member physician groups and CAHP member health plans are profoundly affected by the fees that non-contracted emergency room providers charge for emergency room services. This is because CAPG physician groups and CAHP health plans are both required to pay non-contracted emergency room providers the "reasonable and customary value" pursuant to Title 28 C.C.R section 1300.71(a)(3)(B). It is vitally important to the entire healthcare industry, therefore, that the laws for determining the "reasonable and customary value" of non-contracted healthcare providers are correctly, consistently, and appropriately interpreted and applied consistent with the principles of *quantum meruit* valuation.

Most recently, the Appellate Court in *Children's Hospital Central California v. Blue Cross,* (2014) 226 Cal.App.4th 1260, addressed the intersection of Title 28 C.C.R. section 1300.71(a)(3)(B) and *quantum meruit* principles. This is a case that

the authors of this *amicus* brief are intimately knowledgeable about having been Blue Cross's lead trail attorneys. Unfortunately, Appellant Goel, attempts to reinterpret and apply the *Children's Hospital* decision in a manner that is not supported by the facts or holding of that case. As such, CAPG and CAHP submit this proposed *amicus* brief to provide an in-depth legal and factual analysis of the facts and circumstances of the *Children's Hospital* decision and its application to the facts presented in the current dispute between Goel and Regal Medical Group, and to future disputes between non-contracted healthcare providers and those entities responsible for paying the non-contracted provider.

This brief has been drafted entirely by CAPG and CAHP, without compensation or monetary contribution from any party or counsel for a party, and has been served on all parties (proof of service attached). Cal. R. Ct. 8.200(c)(3). CAPG and CAHP contend that most of the discussion, citations, and points made in the attached proposed are not presented by the parties in the case before the court.

Dated: January 5, 2017

Respectfully submitted,

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

California Cases

California Statutes and Regulations

Other Authority

INTRODUCTION

Amicus curiae CAPG (formerly known as California Association of Physician Groups) and California Association of Health Plans ("CAHP") submit this *Amicus* Brief to provide a broad perspective on the issues presented by Plaintiff and Appellant, Sanjiv Goel, M.D. Inc., ("Goel")[1] in his appeal from an adverse ruling favoring Defendant and Respondent, Regal Medical Group ("Regal"). First, it is untrue that the "decision of the Trial Court is at odds" with California law for determining the "reasonable and customary value" of a non-contracted healthcare provider's services. The trial court admitted all relevant evidence, and based on the particular facts and circumstances of Goel's case, determined the market value of his services. In short, the trial court concluded that the "amounts accepted" by Goel as full payment is not indicative of the "reasonable and customary value" of his services. It was a straight forward analysis of the relevant facts. The trial court also did *not* apply the law incorrectly, as Goel asserts. (*See,* Appellant's Opening Brief, p. 11; hereinafter "AOB.") Instead, Goel failed his burden of proffering statistically credible information of the relevant criteria (aside from what he accepts) so that the trial court could assess the "reasonable and customary value" of his services.

Goel argues that he "adhered to the *Children's Hospital* directive and simply produced the evidence of the empirical accepted payments history" because "*Children's Hospital* held that such actual payment history equates to 'actual market value.'" (AOB, p. 5.) But contrary to Goel's assertion, *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, ("*Children's Hospital*") does *not* hold that a trial court must limit its analysis when determining the market value of a non-contracted provider's services to the "amounts accepted."

[1] Plaintiff / Appellant is a medical corporation owned by Dr. Sanjiv Goel. Use of the name "Goel" in this Brief refers to both the corporation and the individual.

The case does not hold, state, or even imply that the "reasonable and customary value" of non-contracted medical services is measured exclusively by the amounts a provider accepts. Nor did *Children's Hospital* hold that the amount accepted by the provider is the only evidence for a "reasonable and customary valuation" of non-contracted services. *Children's Hospital* mandates no such bright-line rule. And neither Children's Hospital Central California nor Blue Cross ever sought such a bright-line requirement. Instead, *Children's Hospital* confirms that the amount owed to a non-contracted healthcare provider, like Goel, is the market value of those services based on quantum meruit principles. And the market value is determined by what a willing buyer would pay a willing seller in an arms-length negotiation.

Here, the evidence showed that Goel is not a willing seller. And the health payors who pay Goel's astronomical fees are not willing buyers. As a California cardiologist with staff privileges at Los Robles Hospital, Goel provides emergency cardiology services to patients entering the hospital through its emergency department. Because he provides emergency services, he is not required to either notify or obtain authorizations from the responsible health payors before treating the patients. Nor is he required to have a contract with any health payor.

His business model is predatory and opportunistic. Goel executes no written contracts with health payors before treating the health payors' members. He then bills the responsible health payor for his cardiology services demanding payment at rates that far exceed rates paid to cardiologists who execute written contracts through arms-length negotiations. Goel has no written contracts because health payors will not agree—through arms-length negotiations—to contract at Goel's unconscionable rates. Goel exploits the law barring health payors from requiring notification or authorization when emergency services are necessary, or mandating that only "in-network" providers be used. Although this law is based on sound public policy—

emergency services should not be delayed by either an authorization or in-network requirement—Goel abuses it. Goel obtains exceedingly high payments because he balance-bills the member and/or sues the responsible payor if his unconscionable fees are not paid.

After Goel treated four Regal members on four different days in Los Robles' Emergency Department, he sent bills to Regal totaling approximately $275,000. When Regal refused to pay Goel's outrageous charges, he sued for the quantum meruit value of his services. In a bench trial, the court correctly found that Regal's payments, not Goel's charges, reflected the "reasonable and customary value" of Goel's cardiology services. (AOB, p. 6.)

I. THE TRIAL COURT'S DECISION SHOULD BE AFFIRMED BECAUSE IT FOLLOWED *CHILDREN'S HOSPITAL* WHEN DETERMINING THE "REASONABLE AND CUSTOMARY VALUE" OF GOEL'S CARDIOLOGY SERVICES.

Goel argues that, "the *Children's Hospital* decision further clarified that this [reasonable and customary value] analysis would include ***only*** those payments which were 'accepted' by the medical provider." (AOB, p. 13.) (Emphasis Added.) Goel is correct in that *Children's Hospital* dictates how "reasonable and customary value" is determined for a non-contracted healthcare provider, but he is wrong to the extent he suggests: (1) *Children's Hospital* holds that the "amounts accepted" by non-contracted providers are the exclusive means for determining the market value of the provider's services; or (2) that common law quantum meruit principles are limited to "amounts accepted" when the dispute involves a non-contracted emergency room physician. Simply stated, Goel misses the significance of *Children's Hospital.*

In *Children's Hospital*, the plaintiff, Children's Hospital Central California ("CHCC"), specialized in providing medical services to children, most of whom qualified for the state's Medi-Cal program. In fact, 75 percent of the hospital's

patients were covered under Medi-Cal. (*Children's Hosp.*, at 1265.) Many of CHCC's patients received services pursuant to a written contract CHCC executed with the state Department of Health Care Services ("DHCS"). (*Id.*) For these patients, CHCC was paid based on an average California Medical Assistance Commission ("CMAC") rate. (*Id.*) Other patients were covered under Blue Cross's Medi-Cal managed care plan. (*Id.*, at 1265-66.) For these patients, DHCS paid a fixed monthly per person capitated rate to Blue Cross, who then paid CHCC. (*Id.*, at 1265.)

Through July 31, 2007, CHCC and Blue Cross had a written contract for the services CHCC provided to Blue Cross Medi-Cal managed care enrollees. (*Id.* at 1266.) That contract expired at midnight on July 31, 2007 and for the next ten months, the parties could not agree on the terms of a new Medi-Cal managed care agreement. (*Id.*) A new contract was eventually executed June 1, 2008. (*Id.*) During the 10-month non-contracted period, 896 Blue Cross Medi-Cal patients received emergency services followed by inpatient post-stabilization care at CHCC. (*Id.*, at 1267.) Blue Cross paid CHCC approximately $4.2 million for the care provided to these 896 Medi-Cal patients based on the average CMAC rate. (*Id.*)

The *Children's Hospital* dispute arose after CHCC claimed the average CMAC rate applied only to in-patient *pre*-stabilization emergency services, and CHCC was entitled to the "reasonable and customary value" for all inpatient *post*-stabilization services. (*Id.*, at 1266-67.) According to CHCC, Blue Cross had authorized the post-stabilization services when Blue Cross did not transfer the patients to a contracted hospital following notification from CHCC. (*Id.*, at 1267 and 1270.) Thus, an implied-in-fact contract existed whereby Blue Cross had authorized post-stabilization services at CHCC's "reasonable and customary" rate. (*Id.*) CHCC next argued that the "reasonable and customary value" of the post-stabilization services provided to Blue Cross members could only be determined using the six

factors listed in the Department of Managed Health Care ("DMHC") regulation, Title 28 Cal. Code of Reg. section 1300.71(a)(3)(B), (hereinafter, "1300.71(a)(3)(B)".) (*Id.,* at 1267-68.) CHCC argued that when these six factors were considered, the "reasonable and customary value" of CHCC's services was its full billed charges. (*Id.,* at 1268.) Although "less than 5 percent of [all] payors paid [CHCC] the full billed charges" rate, the trial court agreed with CHCC and barred Blue Cross from introducing any evidence that suggested the "reasonable and customary value" of CHCC's post-stabilization services was anything other than CHCC's full billed charges. (*Id.*, at 1265, 1268, 1277-78.) The jury awarded CHCC damages of $6,615,502: the difference between the CMAC rate paid by Blue Cross and CHCC's full billed charges. (*Id.,* at 1270.)

On appeal, the Appellate Court determined that Blue Cross did not receive a fair trial. (*Id.*, at 1265 and 1278.) The trial court's discovery orders, motions *in limine*, and jury instructions were prejudicial to Blue Cross because they curtailed the evidence upon which a determination of CHCC's "reasonable and customary value" could be based. (*Id.*, at 1279.) In reversing the judgment and ordering a new trial on damages, the Appellate Court provided two important instructions relevant to the current dispute between Goel and Regal. First, the Appellate Court instructed:

> All ***rates that are the result of contract or negotiation***, including rates paid by government payors, are relevant to the determination of reasonable value. In other words, applying quantum meruit principles, rates ***are relevant if they reflect a willing buyer and a willing seller*** negotiating at arm's length. (Emphasis added.) (*Id.*, at 1278.)

The Court made clear that the "rates are relevant" for determining the reasonable value of a non-contracted provider's services "*if*" those rates were agreed to in an arms-length negotiation. The corollary of course, is that "*if*" the rates were

not agreed to as part of a contract or negotiations, then the rates are *not* relevant to determining reasonable value. Stated differently, "*if*" Goel could not show that the amounts he accepts are the result of an arms-length negotiation, then his "amounts accepted" are not relevant to determining the reasonable value of his services. Accordingly, other evidence would be necessary to determine the value of Goel's services provided to the four Regal members.

The second significant take away from *Children's Hospital* is that the DMHC regulation, 1300.71(a)(3)(B), "established the minimum criteria for reimbursement of a claim, not the exclusive criteria." (*Id.*, at 1273.) Thus, the regulation is important because it sets the minimum measures necessary to determine the "reasonable and customary value" of a non-contracted healthcare provider's services. Section 1300.71(a)(3)(B) provides:

> For contracted providers without a written contract and non-contracted providers…: the payment of ***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… [Emphasis added.]

The DMHC adopted Knox Keene Act regulation 1300.71 to define reimbursement of a claim, based on *Gould v. Workers' Comp. Appeals Bd.* (1992) 4 Cal.App.4th 1059. (*Children's Hosp.*, at 1272.) The regulation requires analysis of "statistically credible information" that considers the "prevailing provider rates

charged in the general geographic area." Additionally, the regulation allows evidence of the economic aspects of the "medical provider's practice," and "any unusual circumstances." Thus, it was proper for Regal to introduce, and the trial court to consider, both statistical evidence of Regal's payments to other cardiologists, as well as evidence of Goel's business model when determining the "reasonable and customary value" of Goel's cardiology services.

A. The Amounts Goel Accepts are Not the Product of Arms-Length Negotiations, and Therefore, Not Relevant.

Goel has no written contracts with healthcare payors. Goel has been unable (or unwilling) to execute written contracts with health plans, health insurers, or capitated medical groups for emergency cardiology services based on prevailing market rates. Instead, Goel works in the emergency department treating patients who require emergency cardiology services. Both state and federal law require health payors to pay for emergency services, even when the emergency services are not authorized, and/or the emergency room physician does not have a contract with the responsible health payor. (*See,* Health and Safety Code § 1371.4; and 42 U.S.C. § 300gg-19a(b)[2].)

By refusing to contract at rates that are the product of arms-length negotiations, Goel is able to obtain significantly higher payments in comparison to other emergency room cardiologists who have executed written contracts. Goel obtains these higher payments because, as part of his business model, Goel threatens

[2] The Affordable Care Act ("Obama Care") reorganized, amended, and expanded Part A of Title XXVII of the Public Health Service (PHS) Act, adding, among other items, the patient protections provisions that appear in PHS Act Section 2719A. PHS Act section 2719A(b) says that, if a plan covers services in an emergency department, then the plan must cover emergency services in accordance with four standards. The first and second standard prohibit prior authorization requirements or that emergency services be provided from only in-network or "participating providers."

to, and does: (1) balance bill the patients if the health plan, health insurer, or capitated medical group does not pay his outrageously high charges; and (2) sues the health plan, health insurer, or capitated medical group if the responsible payor does not pay his outrageous fee. Goel's tactics succeed, mostly because health payors seek to protect their members from unanticipated and surprisingly large medical bills, and/or to avoid the cost of litigation. This results in after-the-fact health insurers and payors of Goel's cardiology services being coerced into making payments not reflective of the market, but based on concerns over balance billing, aggressive lawsuits, and other non-marketplace factors. Under this factual scenario, no trier of fact could ever conclude that the "amounts accepted" by Goel "reflect a willing buyer and a willing seller negotiating at arm's length." (*Children's Hosp.*, at 1275 and 1278.)

Given Goel's business model and the holding in *Children's Hospital*, the trial court had no option but to discount Goel's evidence of "amounts accepted." *Children's Hospital* holds that a healthcare provider's "rates that are the result of contract or negotiation…***are relevant if*** they reflect a willing buyer and a willing seller negotiating at arm's length." (*Id.*) Here, Goel's "amounts accepted" do not satisfy the conditional requirement for establishing relevance because they do not reflect what a willing buyer would pay a willing seller for cardiology services. And *Children's Hospital* clearly instructs that it is *only* those "rates that are the result of contract or negotiation" that "***are relevant if***" the product of arms-length negotiations. (*Id.*)

Goel ignores this *Children's Hospital* holding and argues that, "the trier of fact is to look to what has been paid and accepted." (AOB, p. 5.) But Goel could not, and did not, introduce evidence showing that the amounts he accepts are the product of "a willing buyer and a willing seller negotiating at arm's length." Because Goel failed to demonstrate that the amounts he accepts are the product of arms-length

negotiations, his "amounts accepted" were not relevant to determining the "reasonable and customary value" of his services under principles of quantum meruit and the instructions of *Children's Hospital*.

Finally, quantum meruit analysis contemplates a willing seller and a willing buyer. Most often, "willingness" is found when parties agree to rates before services are ever provided. It was for this reason that the payor contracts in *Children's Hospital* were so relevant. CHCC had many payor contracts that had been negotiated at arms-length before any services were provided. Goel, in contrast, has never negotiated an arms-length agreement. He instead concocted an unsavory scheme to bill commercial health payors, long after services are rendered, at rates far exceeding those accepted by his local counterparts.

B. Goel's "Amounts Accepted" Evidence Did Not Satisfy the Minimum Requirements of Title 28, C.C.R. Section 1300.71(a)(3)(B).

The DMHC enacted regulation 1300.71(a)(3)(B) in August 2003. Two years later, the Second Appellate District, in *Bell v Blue Cross of California* (2005) 131 Cal.App.4th 211, cited to the regulation in its decision allowing an emergency room physician to state a claim against a healthcare payor based on quantum meruit. (*Id.*, at 221 and 223.)

Dr. Bell, a non-contracted emergency room physician, sued Blue Cross alleging that Blue Cross was required to pay "a reasonable and customary amount for emergency services, not 'any amount it chooses, no matter how little.'" (*Id.*, at 214.) Thus, unlike Goel, Dr. Bell alleged that Blue Cross's payments were exceedingly low and were not reasonable. Blue Cross's demurrer was granted by the trial court. This Court reversed. In so doing, the Court first recognized that a health payor's duty to pay emergency room physicians "arises out of the providers' duty to render services without regard to a patient's insurance status or ability to pay," (*Id.*, at 220), where

"[f]ederal and state law both require that emergency services must be provided without first questioning the patient's ability to pay." (*Id.*, at 215.) In finding that Dr. Bell could state a claim under principles of quantum meruit, the *Bell* court looked to 1300.71(a)(3)(B) and acknowledged that "health care service plans must pay the reasonable and customary value" of a non-contracted provider's services "based upon statistically credible information that is updated at least annually and takes into consideration [the six listed factors]" (*Id.*, at 216.)

The California Supreme Court weighed in on the debate in 2009. In *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, the Supreme Court acknowledged that, "emergency room doctors do not have unfettered discretion to charge whatever they choose for emergency services." (*Id.*, at 508.) The Court explained that the responsible payor, however, had a duty to pay the non-contracted emergency room physician the "reasonable and customary value" of the provider's services. Referencing the six factors in section 1300.71(a)(3)(B), the Court explained:

> [T]he HMO has a duty to pay a reasonable and customary amount for the services rendered …. But how this amount is determined can create obvious difficulties. In a given case, a reasonable amount might be the bill the doctor submits, or the amount the HMO chooses to pay, or some amount in between. (*Id.*, at 505.) (Internal quotes, and citation omitted.)

While *Bell v. Blue Cross* and *Prospect Medical Group v. Northridge Emergency Medical Group* both recognized that 1300.71(a)(3)(B) requires health payors to pay a "reasonable and customary value" based on the six listed factors, it was *only* the trial court in *Children's Hospital* who ruled that section 1300.71(a)(3)(B) was the "*exclusive* standard for calculating the reasonable and customary rate" of a non-contracted provider's services. (*Children's Hosp.*, at 1269.)

The Appellate Court properly reversed, holding that, "in adopting section 1300.71(a)(3)(B), the DMHC established the *minimum* criteria for reimbursement of a claim, not the exclusive criteria." (*Children's Hosp.*, at 1273 and 1275.) Thus, contrary to Goel's argument that "only those payments which were 'accepted' by the medical provider" are relevant (AOB, p. 13), *Children's Hospital* holds that the six factors listed in 1300.71(a)(3)(B) are the *minimum* criteria for determining the "reasonable and customary value" of a non-contracted provider's services. (*Id*.) Here, Goel's evidence did not satisfy even the minimum criteria.

The first requirement of 1300.71(a)(3)(B) is that the data be based on "*statistically credible information that is updated annually*." Also important in this minimum analysis is the "*prevailing rates charged in the geographic area*." This fourth criteria squarely rejects Goel's argument that a court cannot consider rates charged by other local area cardiologists. (*See*, AOB p. 18.) Finally, the regulation contemplates that a trial court should consider the unique structure of Goel's business model. Criteria five and six require consideration of those "*aspects of the economics of* [*Goel's*] *medical practice*," and "*any unusual circumstances*" existing in the pending matter. The economics of Goel's medical practice is that he extracts higher than normal payments by balance billing patients and suing health payors that do not pay his outrageous fees. Both factors are to be considered under the regulation's minimum criteria for determining the "reasonable and customary value" of Goel's services. And as the trial court intuitively recognized, these facts cut against Goel's "amounts accepted" as a reasonable measure of the "reasonable and customary value" of his cardiology services.

1. Goel's "Amounts Accepted" Evidence is Not Based on Statistically Credible Information.

Regulation 1300.71(a)(3)(B) requires "statistically credible information" that

is "updated at least annually" when assessing the "reasonable and customary value" of a non-contracted provider's services. Goel argues that the trial court improperly rejected or afforded little weight to his proffered "empirical" data reflecting claims-paid and billed charges (AOB, p. 7), when the trial court granted Regal's objections for untimely data, selective data, lack of support documents, and an inadequate number of data entries. (Respondents' Brief, p. 7, 14, 16-17.) But consistent with the minimum requirements of 1300.71(a)(3)(B), the trial judge could reject Goel's evidence as statistically unreliable, and rely instead on Regal's statistically credible evidence.

Goel further argues there is no authority establishing a "threshold" number for payment data to determine the quantum meruit value of non-contracted services. (AOB, p. 8.) But here too, Goel is mistaken. Regulation 1300.71(a)(3)(B), requires the data to be "statistically credible information." A *fortiori*, statistically credible information updated annually means at a minimum, charges and/or payment data that is fair, accurate, complete and timely. (Accord, *Generally Accepted Accounting Principles*; and *Generally Accepted Auditing Standards.*) The protections afforded by 1300.71 (statistically credible data updated annually) for data sampling, extrapolation, completeness, and support documents were intended to act as a gate-keeper to exclude the very types of unreliable data that Goel proffered. (Respondent's Brief p. 28 ¶ 1.)

Accordingly, payment amounts accepted by Goel are the least relevant factor for the market value of his services. The trial court recognized this by finding that Goel lacked statistically credible evidence of the reasonable value of his cardiology services provided to Regal's members. Instead, the trial court relied on evidence of what other contracted cardiologists are paid. Indeed, there are many such commercial and government contracts with other cardiologists in Goel's same geographic market,

reflecting actual payment rates to better determine "reasonable and customary value."

In the end, Goel's "amounts accepted" evidence is more akin to CHCC's full billed charges evidence. But the California Supreme Court has explained that 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." (*Howell v. Hamilton Meats & Provisions, Inc.*, (2011) 52 Cal.4th 541, 564.). And in *Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311, the court recognized that "initial medical bills are generally insufficient on their own as a basis for determining the reasonable value of medical services." (*Id.*, at 1335.) Therefore, "a plaintiff who relies solely on evidence of unpaid medical charges will not meet his burden of proving the reasonable value of medical damages with substantial evidence." (*Id.*)

2. Goel's "Amounts Accepted" Evidence is Not Reliable in Comparison to the Other Criteria Listed in 1300.71(a)(3)(B).

Goel's "amounts accepted" is but one of six criteria listed in 1300.71(a)(3)(B). While criteria three allows for consideration of "the fees usually charged by the provider," it is neither exclusive, nor applies to the exclusion of all others. And because Goel could not establish the statistical reliability of the "amounts accepted," it was appropriate for the trial court to give greater consideration to the other remaining criteria. Here, the trial court gave greater weight to the fees that other cardiologists accept in the geographic region, as well as the unique characteristics and economic aspects of Goel's practice when it ruled in favor of Regal.

II. GOEL'S ATTEMPT TO REINTERPRET *CHILDREN'S HOSPITAL* MUST BE REJECTED BECAUSE IT IS INCONSISTENT WITH QUANTUM MERUIT PRINCIPLES.

In his Reply Brief, Goel tries to frame the issue as a black-or-white choice between the amounts accepted by Goel, or the rates accepted by other cardiologists

in the geographic region. Goel writes:

> Goel asks this Court to tell the parties whether or not, pursuant to the *Children's Hospital* decision, the quantum meruit value of emergency services is determined by: 1. Calculating the amounts the subject medical provider has accepted in payment for the subject services; or 2. Based on the amounts ***other*** medical providers in the geographic region have charged for the subject services. (Emphasis Original.) [Appellant's Reply Brief, p. 2; hereinafter "ARB".]

But *Children's Hospital* offered no bright-line rule on how to determine "reasonable and customary value" when a provider is non-contracted. Neither the holding in *Children's Hospital* nor California's well-settled law for valuing "services performed under circumstances disclosing that they were not gratuitously rendered," are as black-and-white as Goel argues. *Children's Hospital* never held that the amounts accepted by a non-contracted provider is the quantum meruit value of emergency services. Nor did *Children's Hospital* instruct that the quantum meruit value *is* determined exclusively by amounts other medical providers accept in the same geographic area. Instead, *Children's Hospital* made clear that*:*

> [T]he facts and circumstances of the particular case dictates what evidence is relevant to show the reasonable market value of the services at issue, i.e., the price that would be agreed upon by a willing buyer and a willing seller negotiating at arm's length. ***Specific criteria might or might not be appropriate for a given set of facts.*** (*Children's Hosp.,* at 1275.)

Children's Hospital could not be clearer. No two cases are the same. Non-contracted healthcare provider disputes must be decided on the "facts and circumstances" unique to each case. It is wrong, therefore, to argue that *Children's Hospital requires* a trial court to conclude that the market value of a non-contracted provider's services is either: (1) what the provider accepts, or (2) what other providers in the same region accept. Depending on the unique "facts and circumstances" of each

case, the reasonable value of a non-contracted provider's services could be: (1) what the provider accepts; (2) what other providers in the same geographic area accept; or (3) a range somewhere in between.

A. Neither *Children's Hospital* nor Quantum Meruit Principles Limit the Analysis to the "Amounts Accepted" by Non-Contracted Providers.

Goel argues that the sole "reasonable and customary" factor to be used by the trier of fact—pursuant to the *Children's Hospital* decision—is "what the subject medical provider has accepted in the past as payment." (ARB, p. 3.) Focusing on a single criterion, however, is precisely what CHCC argued to the trial court, which got the trial court reversed on appeal. CHCC convinced the trial court that the "reasonable and customary value" for non-contracted, in-patient post-stabilization services was singularly determined by CHCC's full billed charges. (*Children's Hosp.*, at 1268-1269.) The Appellate Court instructed that by limiting the evidence to only CHCC's billed charges, the trial judge committed reversible error. (*Id*.) Indeed, it was the exclusion of relevant evidence that prompted the Court of Appeal to reverse the jury verdict and remand for a new trial. A similar result would likely occur if a court relied exclusively on the "amounts accepted," to the exclusion of all other relevant evidence. Contrary to Goel's assertion, *Children's Hospital* does not limit the measure of damages in a quantum meruit claim to what a provider accepts from other payors for similar services.

More importantly, the Court in *Children's Hospital* provided a guideline for future courts assessing the "reasonable and customary value" of non-contracted healthcare providers' services under quantum meruit principles. This guideline does not support Goel's premise on appeal.

First, the Court recognized that reasonable market value must be based on

current market prices. (*Children's Hosp.*, at 1274.) Next, the Court explained that "[i]n determining value in quantum meruit cases, courts accept a wide variety of evidence." (*Id.*) Thus, relevant evidence would include the full range of fees that a hospital charges, what it accepts, or what a health plan pays for similar services. (*Id.*, at 1275 and 1277.) Thus, both amounts accepted by a provider as well as what other providers in the same geographic region are paid, is evidence a trier of fact can use to set the market value of a quantum meruit claim. Plaintiffs may offer testimony from the provider "as to the value of his services," or may offer expert testimony. (*Id.*, citing, *Culver Adjustment Bureau v. Hawkins Contr. Co.* (1963) 217 Cal.App.2d 143, 145.) Evidence of agreements to pay and accept a particular price can be considered. (*Id.*, citing *Oliver v. Campbell* (1954) 43 Cal.2d 298, 305.) In addition, "evidence of a professional's customary charges and earnings is relevant and admissible to demonstrate the value of the services rendered." (*Id.*, citing *Citron v. Fields* (1938) 30 Cal.App.2d 51, 61.) The full amount billed is also a factor to be considered. "Hospital's full billed charges were relevant to the issue of the reasonable and customary value of the services." (*Id.*) *Children's Hospital* emphasized that "the facts and circumstances of the particular case dictate what evidence is relevant to show the reasonable market value of the services, [and] .... Specific criteria might or might not be appropriate for a given set of facts." (*Children's Hosp.*, at 1275.) In sum, *Children's Hospital* held that market value is not set by any one consideration, but is best determined by analyzing "the full range of fees that Hospital both charges and accepts," together with "evidence of any other factors that are relevant to the situation." (*Id.)* Goel's position is contrary to California law.

Although Goel cites to *Children's Hospital*, he actually argues that most of the evidence *Children's Hospital* identified as being relevant to determine the fair market value of medical services, is irrelevant and inadmissible. Goel argues that the

testimony by Regal's expert, Dr. Miller, "flies in the face of the *Children's Hospital* rule and is thus directly at odds with California law." (AOB, p. 19.) Goel then asserts that "[p]ursuant to the criteria set forth in *Children's Hospital,* the reasonable market value of Dr. Goel's services at issue herein, is establish by the payments Dr. Goel has empirically accepted for such services." (AOB, p. 19.) Appellant's attempt to rely on the holding of *Children's Hospital* about how the reasonable value of medical services is to be determined, while rejecting the evidence specifically cited by that court for determining reasonable value, is at best disingenuous.

B. Applying Quantum Meruit Principles, the Determination of Reasonable and Customary Value Includes Consideration of both Medicare and Medi-Cal Payments.

Goel argues in his Opening Brief that it was improper for the trial court to consider Medicare or Medi-Cal payment rates he accepted for identical cardiology services when assessing the "reasonable and customary value" of his cardiology services. (AOB, pp. 16-18.) But Goel is wrong: "all rates that are the result of contract or negotiation, *including rates paid by government payors*, are relevant to the determination of reasonable value" (*Children's Hosp.,* at 1276-1277.) (Emphasis added). Moreover, Goel concedes he is both a contracted Medicare and contracted Medi-Cal cardiologist for non-emergency services in the Los Robles Ventura county area. (AOB, p. 7, fn.1.) To determine quantum meruit value, courts may accept a variety of evidence, including agreements to pay and accept a particular price. (*Children's Hosp.*, at 1274.) Accordingly, Appellant's *decision* to *also* work as a contracted emergency department cardiologist at Los Robles Hospital with both stabilized and non-stabilized patients, makes him "arms-length" with "full knowledge" of pertinent facts regarding his provider reimbursement from both Medicare and Medi-Cal payors. As such, these payment rates were also properly

weighed by the trial court in its assessment of the "reasonable and customary value" of Goel's services.

III. THE RELEVANT EVIDENCE IN *Goel v. Regal* IS SIGNIFICANTLY DIFFERENT FROM THE RELEVANT EVIDENCE IN *Children's Hospital* BECAUSE THE FACTS AND CIRCUMSTANCES OF THE TWO CASES ARE VERY DIFFERENT.

Children's Hospital emphasized that the "facts and circumstances of the particular case dictates what evidence is relevant to show the reasonable market value of the services at issue." (*Children's Hosp.*, at 1275.) There are three significant differences between Goel's claims, and those pursued by CHCC. These differences support the reversal of the trial court in *Children's Hospital*, and affirmance of the trial court below. First, unlike the trial court in *Children's Hospital*, the trial court below did ***not*** entirely exclude relevant evidence crucial to determining the value of Goel's services. Instead, the trial court allowed both parties to introduce their respective evidence of "reasonable and customary value," but assessed a lower level of credibility, weight, or reliability to the payment accepted data presented by Goel. Second, the evidence excluded in *Children's Hospital* was the hospital's contracted rates—negotiated at arms-length—with both Blue Cross and other payors. Goel has no arms-length-negotiated contracts. Finally, the dispute in *Children's Hospital* concerned the value of authorized, post-stabilization services after Blue Cross was notified that its members were stable, but failed to transfer the Medi-Cal beneficiaries to contracted facilities. Regal was never notified that any of its four members were stable for transfer prior to Goel providing emergency cardiology services, so there was no "deemed" authorization by Regal of Goel's services, nor any opportunity to negotiate a payment rate.

A. Goel was not Prejudiced by Trial Court Rulings Because he was Allowed to Introduce Alleged Evidence of the Reasonable Value of his Services.

In *Children's Hospital*, Blue Cross sought to introduce evidence of the CHCC's contracted rates with other health payors—both private insurers and government payors. Blue Cross also offered its contract rates agreed to with CHCC that existed both before and after the 10-month non-contracted period. According to Blue Cross, the hospital's contract rates reflected what a willing buyer would pay a willing seller in an arms-length transaction. Blue Cross argued that all such arms-length negotiated agreements were relevant in determining the market value of the hospital's services. The trial court disagreed, granting CHCC's motions *in limine* to "preclude Blue Cross from introducing evidence of the rates accepted by or paid to Hospital by other payors; the Medi-Cal and Medicare fee-for-service rates paid by the government; and Hospital's service specific costs." (*Id.*, at 1269). Thus, the trial court in *Children's Hospital* prohibited relevant evidence of the "reasonable and customary value" of CHCC's services. The trial court compounded this error by instructing the jury that neither "rates accepted by…or paid to Children's Hospital… [nor] rates paid by the government may…be considered in calculating the reasonable and customary value of services…" (*Id.*, at 1271.)

In contrast, the trial court below allowed both parties to introduce all evidence relevant to determining the reasonable value of Goel's services. Acting as the trier of fact, the trial court then assessed the reliability of the so-called "reasonable and customary value" evidence, including sums paid to Goel by other payors: "Dr. Goel…presented evidence of what Appellant had been paid by other payors for the same services at issue herein." (AOB, p. 4-5.) Similarly, Regal introduced evidence regarding the reasonable value of the Goel's services. At the conclusion of the bench trial, the trial court determined that the evidence proffered by Goel on "reasonable

and customary value" was less persuasive than the evidence submitted by Regal. Thus, there were no judicial errors here, unlike in *Children's Hospital*.

B. In *Children's Hospital* the Relevant Evidence Consisted of Payor Contracts that do Not Exist in Goel's Dispute with Regal.

In *Children's Hospital*, the hospital had many payor contracts and was only briefly non-contracted with Blue Cross. Blue Cross asserted at trial that the hospital's many payor contracts were relevant to determine the "reasonable and customary value" of the post-stabilization services. Blue Cross also argued that its contracted rates contained in the expired CHCC contract as well as the rates in the new agreement were relevant to determining the value of the post-stabilization services. In short, Blue Cross argued, and the Appellate Court agreed, that all contracted rates obtained through an arms-length negotiation were a better measure of market value for hospital services than full billed charges.

Here, Goel has no written contracts with commercial payors like Regal. This is not the situation where the parties were temporarily non-contracted. Thus, a significant factual distinction between the *Children's Hospital* case and the current dispute is that CHCC had many contracted payors, including contracts with Blue Cross, where amounts to be paid for emergency services had been negotiated at arms-length before the services were ever provided. Had the amounts Goel asserts he is owed been reflected in written contracts negotiated prior to providing emergency cardiology services—with Regal or any other payor—then Goel's proffered evidence to support his claim would be compelling. But, unlike *Children's Hospital*, Goel lacks such compelling evidence because no payor will agree to his outrageous rates that are only paid to protect a patient from receiving a balance bill and avoid litigation. Given that no payments were negotiated in advance through arms-length transactions, this distinguishes the payments assessed by the trial court below, from the disputed

payment rates in *Children's Hospital*. The trial court recognized this, rejecting Goel's evidence of other payments.

C. The Disputed Services in Children's Hospital Were "Authorized" Services, Unlike the Services Here Provided by Goel.

In *Children's Hospital,* CHCC had contacted Blue Cross when each of the patients had stabilized and sought authorization for post-stabilization services. At the time when Blue Cross elected not to transfer the patients to an in-network, contracted hospital, the post-stabilization services provided by CHCC were deemed authorized, and were payable by Blue Cross at the "reasonable and customary value." (*Id.*, at 1267.) In contrast, Goel never notifies or contacts any commercial payor *before* providing services. Nor does he allow payors to transfer the patients to contracted cardiologists whose rates are much more reasonable because they were negotiated at arms-length before services were required. Goel does not in advance seek authorization for his services, as he knows no health care payor will authorize his cardiology rates, which are magnitudes higher than what other cardiologists accept in his area. As such, there is never an opportunity to negotiate an arms-length agreement for his cardiology services.

CONCLUSION

The trial court decision in favor of Regal should be affirmed. With no reversible errors of law prejudicial to Goel, substantial evidence supports the trial court's broad discretion on evidentiary rulings on the "statistically reliable" evidence admitted on the "reasonable and customary value" of Goel's cardiology services. *Children's Hospital* holds that this "reasonable and customary value" assessment for non-contracted medical services should be based on the facts and circumstances of each case, using a wide range of statistically reliable market information, and cannot be based *solely* on the provider's billed charges or payments amounts the provider

elects to accept for non-contracted medical services.

For these reasons, the trial court's decision sitting as the trier of fact, should stand.

Dated: January 5, 2017

Respectfully submitted,

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CERTIFICATE OF WORD COUNT PURSUANT TO RULE 8.360

Pursuant to California Rules of Court, Rule 8.204(c)(1), I certify that this *Amicus Curiae* Brief consists of 6,275 words, not including the application, table of contents, table of authorities, the caption page or this certification page, as counted by the Microsoft Word program used to generate this brief.

Dated: January 5, 2017

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DECLARATION OF SERVICE BY MAIL

I am employed in the County of Sacramento, State of California. I am over the age of 18 years and not a party to the within action. My business address is 621 Capitol Mall, 25th Floor, Sacramento, CA 95814. On January 5, 2017, I served the document described as: **APPLICATION OF CAPG TO FILE *AMICUS CURIAE* BRIEF IN SUPPORT OF RESPONDENT and *AMICUS CURIAE* BRIEF OF CAPG IN SUPPORT OF RESPONDENT** on the interested parties in this action by placing a true copy thereof, enclosed in a sealed envelope, in the United States Mail at Sacramento, CA, addressed as follows:

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Clerk, Supreme Court of California 350 McAllister Street San Francisco, CA 94102-7303	*By electronic service*

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed January 5, 2017 at Sacramento, California.

/s/ Ileah Miller
ILEAH MILLER