***Children's Hospital Central California v. Blue Cross of California*, 2014 Cal. App. LEXIS 503 (Cal. App. 5th Dist. June 10, 2014)**

The full range of fees that respondent hospital charged or accepted as payment for medical services rendered is relevant in determining the reasonable and customary value of such services.

FACTS AND PROCEDURAL POSTURE

Respondent Children's Hospital Central California (Hospital) provided 75% of its medical services to Medi-Cal patients enrolled in either a service plan or a managed care plan through its contract with the California Department of Health Care Services (DHCS). In a service plan, Hospital is paid the average California Medical Assistance Commission (CMAC) rate for the services it performs. In a managed care plan, the DHCS pays a fixed rate per person per month to the health plan, whether services are rendered or not.

Up until July 2007, Hospital and Blue Cross had a written contract setting rates for medical services provided to Blue Cross Medi-Cal beneficiaries. When the contract expired on July 31, 2007, the parties were unable to agree on a new contract until June 1, 2008. During the 10-month off-contract period, Hospital was still required to provide emergency services to Blue Cross beneficiaries under federal and state law. Blue Cross also had an obligation to pay for emergency services rendered. Once the emergency medical condition was determined stabilized, Blue Cross's obligation to pay ended and any payment for post-stabilization medical care required prior authorization.

Blue Cross paid over $4.2 million at the average CMAC rate to Hospital for post-stabilization services provided during the off-contract period. In July 2009, Hospital filed an action seeking additional payments based on *California Code of Regulations § 1300.71(a)(3)(B)*, alleging that it was entitled to the reasonable and customary value for the post-stabilization services. At discovery, Blue Cross requested admissions from Hospital claiming that Hospital's contracts with other health insurers indicated it had a history of accepting less than its full billed charges as payment. Blue Cross also asked in its interrogatories for Hospital to provide the number of patients from 2007 to 2008 receiving post-stabilization care for whom Hospital received its full billed charges as payment. Hospital objected to these requests and interrogatories on the ground that contracted rates and actual payments were irrelevant for determining the reasonable and customary value. Blue Cross moved to compel responses. The trial court denied the motions. Hospital filed several motions in limine limiting the scope of evidence that Blue Cross was permitted to present at trial to the six factors set forth in *§ 1300.71(a)(3)(B)*. The trial court granted the motions and confirmed that the exclusive standard for calculating the reasonable and customary value Blue Cross was required to pay for post-stabilization services was the six factor test. The jury, instructed to consider only the six factors, awarded Hospital damages of over $6.6 million—the amount of Hospital's full billed charges less the amount Blue Cross had already paid. Blue Cross appealed and the court of appeal reversed and remanded for a new trial on damages.

DISCUSSION

In determining the reasonable and customary value Blue Cross owed to Hospital for post-stabilization services, the court of appeal first established the Department of Managed Health Care (DMHC) is in charge of the administration and enforcement of laws relating to health care service plans.

According to the DMHC, the regulations are intended to set forth the minimum payment criteria for claims payments and dispute resolution standards. To the extent providers wish to pursue other common law or statutory remedies, they may seek redress in the courts. In adopting *§ 1300.71(a)(3)(B)*, the DMHC established the minimum criteria for reimbursement of a claim, not the exclusive criteria. The reasonable value of services is the reasonable market value, which 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." In determining this value, a wide variety of evidence is accepted. Therefore the market value for the post-stabilization services was not ascertainable from Hospital's full billed charges alone. The charges were relevant, but they were not determinative. Relevant evidence would have included the full range of fees that Hospital both charges and accepts as payments. The scope of the rates accepted by or paid to Hospital by other payors indicates the value of the services in the marketplace.

Because evidence of the range of fees that Hospital accepted was relevant to the reasonable value of services, the trial court erred in denying two motions filed by Blue Cross to compel discovery of Hospital's agreements with others regarding payments for post-stabilization services. For the same reason, the trial court also erred in granting Hospital's motions in limine to exclude evidence of the rates accepted by or paid to Hospital by other payors. Rates are relevant if they reflect a willing buyer and a willing seller negotiation at arm's length. Limiting the evidence available to the jury, that is not allowing rates paid to or accepted by Hospital, was also error. The trial court's errors in ruling that *§ 1300.71(a)(3)(B)* provided the exclusive standard for valuing the reasonable value of the post-stabilization services were prejudicial. Therefore Blue Cross was entitled to a new trial on damages, including additional discovery.