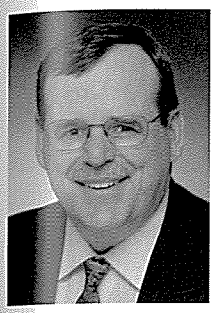
APPELLATE CASE SUMMARIES



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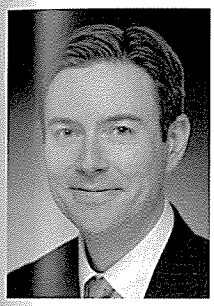

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H&S CODE § 1799.110'S EXPERT WITNESS REQUIREMENT APPLIES ONLY TO MEDICAL STANDARD OF CARE ISSUES

Stokes v. Baker (May 30, 2019, B279241) ___ Cal.App.5th ___ [2019 WL 2296490]

Health and Safety Code section 1799.110, subdivision (c), imposes limits on the expert testimony that may be offered in medical negligence actions against hospital-based emergency medicine physicians. To testify in such a case, an expert must have had substantial professional experience (within the last five years) while assigned to provide emergency care in a hospital emergency department.

In this case, Clara and Vaughn Stokes sued Dr. Ellen Baker, alleging that her negligent failure to diagnose a subarachnoid hemorrhage when treating Ms. Stokes in the emergency department caused serious personal injuries. The trial court granted Dr. Baker's motion for summary judgment, ruling that plaintiffs' causation expert—a board certified neuro-interventional surgeon—was ineligible to testify under section 1799.110 because he lacked five years' experience in an emergency department.

Deciding an issue of first impression, the Court of Appeal reversed—though it acknowledged that the trial court's interpretation of section 1799.110 was consistent with its plain meaning. The Court of Appeal rejected that plain meaning because the statute's context and legislative history reflected a contrary Legislative purpose: to ensure that jurors hold emergency room doctors to a practical *standard of care* reflecting the unique challenges of an emergency room. But that consideration doesn't apply to expert testimony on *causation and damages* issues, which were at stake in this case. Further, adopting a literal construction of 1799.110 would conflict with Evidence Code section 720, which broadly imposes a more lenient standard for expert testimony. Also, a literal construction of 1799.110 could require expert emergency room physicians to render opinions far outside their expertise (in this case, neurointervention, as it relates to subarachnoid hemorrhage) that they are not qualified to give under Evidence Code section 720. The Court of Appeal therefore feared that adopting the statute's plain meaning would create the absurd result of barring a plaintiff's lawsuit whenever emergency physicians lack the qualifications to testify about complex causation and damages issues. Therefore, the court construed the experience requirement in section 1799.110 as limited to standard of care issues, and accordingly held that the trial court erred in striking the plaintiff expert's causation declaration and granting summary judgment.

ORDER ENFORCING MEDICAL BOARD SUBPOENA OF MEDICAL RECORDS NOT STAYED PENDING PHYSICIAN'S APPEAL

Kennedy v. Superior Court (June 14, 2019, A157089) ___ Cal.App.5th ___ [2019 WL 2484008]

The Medical Board of California issued a subpoena demanding that Dr. Ron

Kennedy produce the medical records of three minor patients for whom he had provided vaccination exemptions. When Dr. Kennedy refused to comply, the Board filed a petition in the superior court under Government Code section 11187 to compel compliance. The superior court granted the petition and ordered Dr. Kennedy to produce the records, then denied Dr. Kennedy's request to stay that order pending appellate review. Dr. Kennedy appealed and filed a petition for a writ of supersedeas seeking a stay of the production order pending appeal.

The Court of Appeal filed a published order denying supersedeas. Relying on the usual statutes governing stays in Code of Civil Procedure sections 916 to 918, Dr. Kennedy argued he was entitled to a stay pending appeal upon posting a bond in an amount fixed by the trial court. But the court rejected that argument, holding that swath of the Code of Civil Procedure inapplicable to a "special proceeding" like the Government Code section 11187 production order. In addition, the Board's duty to investigate complaints against physicians would be hindered if physicians could force the Board to obtain court orders enforcing its subpoenas, then automatically stay those orders pending appeal.

The Court of Appeal explained that Dr. Kennedy can seek a discretionary stay by showing that his appeal raises substantial questions, and that disclosure of the records will cause irreparable harm. Here, however, the superior court acted within its discretion in finding the Board's interest in obtaining vaccination records outweighed the patients' privacy rights. Accordingly, the court declined to issue a discretionary stay.

HOSPITAL'S ATTEMPT TO TETHER AN UNTIMELY MEDI-CAL REIMBURSEMENT CHALLENGE TO ITS TIMELY ADMINISTRATIVE APPEAL REJECTED

Hoag Memorial Hospital Presbyterian v. Kent *(June 17, 2019, A153742) __Cal. App.5th __ [2019 WL 2499606]*

The California Department of Health Care Services prepared a Medi-Cal audit of Hoag Hospital's 2009 cost report, determining that Hoag had to pay more than $2.4 million in reimbursements mandated by Assembly Bills (AB) 5 and 1183, which reduced the amount of certain Medi-Cal payments. Hoag filed a timely administrative appeal contesting the legality of the Assembly bills and the reimbursement deductions based on federal and state laws and constitutions. Hoag later filed a second appeal requesting that its existing appeal also address an alleged $620,903 calculation error to be corrected if AB 5 and 1183 were lawful. The ALJ dismissed Hoag's first appeal for lack of jurisdiction and dismissed its calculation error appeal as untimely.

Hoag filed a petition for writ of administrative mandate seeking to reverse the ALJ's dismissal order. The superior court denied Hoag's petition regarding the calculation error, and remanded the main petition for the ALJ's reconsideration in light of recent authority. Hoag appealed the portion of the judgment affirming the dismissal of its calculation error administrative appeal.

The Court of Appeal affirmed, explaining that, under the controlling regulations, Hoag was required to specify each issue it was challenging within 60 days after receipt of the audit results. The court rejected Hoag's contention that the calculation error issue simply " 'elaborat[ed] on' " the legality of the reimbursement reduction. The court concluded "the reality [is] that the 'math issue' was a completely new and distinct challenge." Accordingly, Hoag's calculation error appeal was untimely because Hoag had failed to set forth its contentions as to that issue within the 60-day time frame set forth in the governing regulation.

DHCS'S MEDI-CAL LIEN ON PATIENT'S TORT RECOVERY IS NOT PREEMPTED AND IS BASED ON THE COST OF CARE

Lomeli v. State Dept. of Health Care Services *(June 25, 2019, B290608) __Cal. App.5th __*

Ethan Lomeli's guardian sued medical care providers for his birth injuries. Through Medi-Cal, the California Department of Health Care Services paid for his medical care before and during the lawsuit. After Lomeli settled with defendants for $4 million, the Department moved to impose a $267,159.60 lien on the settlement, seeking reimbursement for the care it provided. The trial court granted the motion, and Lomeli appealed.

The Court of Appeal affirmed, rejecting Lomeli's argument that certain provisions of the Social Security Act preempt state Medicare liens. The purpose of Welfare

and Institutions Code sections 14124.72 and 14124.76, which allow the Department to seek repayment for the costs of medical care, is to ensure that Medicaid beneficiaries do not receive a windfall by recovering (as damages in a tort action) medical costs they did not bear. The Court followed Tristani ex rel. Karnes v. Richman (3rd Cir. 2011) 652 F.3d 360, which interpreted the federal statutes as containing implied exceptions to provisions that otherwise seemed to bar the liens.

The Court of Appeal also affirmed the trial court's "reality-based" lien calculation approach. To determine the proper lien amount, the trial court began with the sum of actual medical costs, then subtracted attorney fee and litigation cost adjustments (required by statute). The court rejected Lomeli's "best-case scenario" approach, which divides the "amount of actual settlement" by a "hypothetical best-case scenario" for Lomeli's tort suit, and then multiplies this fraction by the amount of the Department's medical cost expenditures. The court criticized this approach as resting on an unjustified hypothetical number rather than an actual one, and as inequitably diminishing the Department's recovery to benefit Lomeli at the expense of others who need the Department to cover their medical care.

DHCS MUST MAKE 90% OF MEDI-CAL ELIGIBILITY DETERMINATIONS WITHIN 45 DAYS OF APPLICATION DATE

Rivera v. Kent *(June 27, 2019, A147534) _ Cal.App.5th _ [2019 WL 2706732]*

For various reasons, the Department of Health Care Services (DHCS) experienced significant delays in processing hundreds of thousands of applications for Medi-Cal benefits in 2013 and 2014. Several Medi-Cal applicants and a nonprofit organization filed a petition for writ of mandate seeking to compel DHCS to make all Medi-Cal eligibility determinations within 45 days of the application date. The trial court issued a preliminary injunction and partially granted the petition. The trial court ordered DHCS to determine eligibility within 45 days unless certain exceptions applied (the main one being disability-based applications). In cases where the deadline was not met, DHCS could comply with the injunction by providing provisional benefits to likely eligible applicants and issuing a notice of hearing rights to others. DHCS appealed, arguing (1) the trial court should have abstained in deference to federal oversight of the Medi-Cal program, and (2) DHCS was not legally required to make Medi-Cal eligibility determinations within 45 days of the application date.

The Court of Appeal affirmed in part and reversed in part. The appellate court began by rejecting DHCS's first argument, explaining that the trial court did not abuse its discretion by declining to abstain. The court's order merely directed DHCS to comply with a ministerial duty (making eligibility determinations within 45 days) without dictating the process by which DHCS should achieve that end or exercise its oversight role.

The Court of Appeal did, however, reverse the trial court's order compelling DHCS to make eligibility determinations within 45 days. It concluded that certain statutory provisions do not impose a clear ministerial duty on DHCS to make all eligibility determinations within 45 days. (See Welf. & Inst. Code, §§ 10000, 15926; Cal. Code Regs., tit. 22, § 50177; 42 C.F.R. § 435.912.) Rather, "under the intricate statutory and regulatory scheme . . . the 45-day deadline the plaintiffs wish to enforce is merely a target, not an absolute requirement." Under the controlling performance standard (Welf. & Inst. Code, § 14154), DHCS is required to meet that target deadline at least 90% of the time. Because plaintiffs failed to submit evidence that DHCS was not meeting the 90% performance standard, it was error to grant writ relief enforcing a 45-day deadline in all cases.

RESIDUE OF A SPECIAL NEEDS TRUST MUST REIMBURSE DHCS FOR MEDI-CAL PAYMENTS TO DECEASED BENEFICIARY

Gonzalez v. City National Bank *(June 24, 2019, B284521) __ Cal.App.5th __ [2019 WL 2576537]*

After Brenda Gonzalez suffered birth injuries, a medical malpractice suit brought on her behalf yielded a $2.4 million settlement. A court placed the settlement funds in a special needs trust, thereby preserving Brenda's eligibility for Medi-Cal benefits while sheltering money to meet any special needs not covered by Medi-Cal. Brenda died while there was still about $1.6 million left in the trust. The Department of Health Care Services (DHCS) filed a nearly $4 million creditor's

claim with the probate court to recoup Brenda's Medi-Cal expenses. Brenda's parents (plaintiffs) then petitioned the probate court for an order denying DHCS's claim and, instead, directing the trustee to distribute the funds to them. The probate court ruled that federal and state law required the trustee to reimburse DHCS for Brenda's Medi-Cal expenses before disbursing funds to her heirs. Plaintiffs appealed.

The Court of Appeal affirmed. Plaintiffs had argued that—under Shewry v. Arnold (2004) 125 Cal.App.4th 186, as well as former Welfare and Institutions Code section 14009.5, and Probate Code section 3605, subdivision (b)—the trustee was prohibited from reimbursing DHCS's Medi-Cal payments since Brenda was under age 55 at the time of her death. But the Court of Appeal followed Herting v. State Dept. of Health Care Services (2015) 235 Cal.App.4th 607, which had reached the opposite conclusion from Shewry. Under 42 U.S.C. § 1396p(d)(4)(A), states should not consider the assets in a special needs trust when determining Medicaid eligibility if the state will receive reimbursement for Medicaid payments upon the beneficiary's death. Congress enacted section 1396 to prevent Medicaid recipients from receiving taxpayer-funded health care as they shelter their own assets for their own benefit. As Herting concluded, section 1396 does not limit DHCS reimbursements to services provided to beneficiaries older than 55, and construing Probate Code section 3605 to impose that limitation would render the statute preempted by section 1396. Further, public policy favors reimbursing DHCS to maximize the funds it can provide to others in need. Finally, requiring reimbursement was consistent with the language of the trust itself, which anticipated paying remaining assets to a state agency that had provided Brenda medical assistance.

NURSING HOME RESIDENTS MAY SUE DHCS UNDER SECTION 1983 TO ENFORCE SUCCESSFUL NURSING HOMES TRANSFER AND DISCHARGE DECISIONS

Anderson v. Ghaly, *__ F.3d __, 2019 WL 3227461 (9th Cir. July 18, 2019)*

The Federal Nursing Home Reform Amendments (FNHRA) impose various requirements on nursing homes receiving reimbursement under Medicaid. As pertinent here, they require a nursing home that transfers, discharges, or refuses to readmit a hospitalized resident to inform the resident of his or her right to appeal that decision. The state-established appeals process must provide a "fair mechanism" by which residents may challenge a decision. Medi-Cal's appeals process allows residents contesting a transfer or discharge to appeal the nursing home's decision to the California Department of Health Care Service (DHCS). Either party may file a petition for writ of administrative mandate in the superior court to contest a DHCS decision. However, while the superior court may order DHCS to vacate the hearing decision, no provision expressly allows the court to order compliance with its decision.

Three former nursing home residents sued the DHCS under 42 U.S.C. § 1983 for violating FNHRA. They alleged that their nursing homes engaged in "dumping" by sending them to a hospital for medical treatment and then refusing to readmit them; that they prevailed at DHCS hearings challenging those readmission decisions; that their nursing homes nevertheless refused to readmit them; and that the DHCS declined to enforce its own readmission decision. The residents' lawsuit sought to compel DHCS to enforce their FNHRA right to an enforceable administrative readmission decision. The district court dismissed their complaint, ruling that they had no rights under FNHRA that were enforceable under § 1983.

The Ninth Circuit reversed, holding that FNHRA's provisions requiring states to "provide for a fair mechanism . . . for hearing appeals on transfers and discharges of residents" create a statutory right to appropriate redress after a favorable administrative appeal—a right that is enforceable in a § 1983 action. The Ninth Circuit rejected the district court's conclusion that FNHRA created no private rights because it imposes duties primarily on states. In addition, the Ninth Circuit found the right to enforce a favorable administrative decision was not too vague to enforce under § 1983, and that FNHRA unambiguously imposes a binding obligation on states to provide a "fair mechanism" for an administrative hearing regarding transfer and discharge decisions using language that is "mandatory, not precatory." The Ninth Circuit also rejected the DHCS's argument that, in the

FNHRA and other state law, Congress and California legislated comprehensively, impliedly foreclosing actions under § 1983.

Having cleared a procedural path for the residents to sue, however, the Court ultimately concluded that the residents' complaint did not plausibly allege a violation of their FNHRA rights. The residents complained of the lack of a state agency to enforce readmission, but they failed to allege that California law provided no mechanism whatsoever for enforcing administrative transfer, discharge, and readmission decisions. California could provide an enforcement mechanism other than agency enforcement, in the court's view. Accordingly, the Ninth Circuit vacated the dismissal and remanded to allow the residents to replead.

H&S CODE § 1418.8'S USE OF INTERDISCIPLINARY TEAM TO MAKE HEALTHCARE DECISION FOR UNBEFRIENDED INCAPACITATED NURSING HOME RESIDENTS SATISFIES DUE PROCESS WHEN NOTICE PROVISIONS ARE IMPLIED

California Advocates for Nursing Home Reform, et al. v. Smith *(July 22, 2019 A147987) __ Cal.App.5th __ [2019 WL 3283218]*

Health and Safety Code § 1418.8 requires an interdisciplinary team (IDT) to make healthcare decisions for "unbefriended" nursing home residents who lack capacity to make those decisions. A nursing home resident, a taxpayer, and the California Advocates for Nursing Home Reform petitioned for a writ of mandate against the Director of the Department of Public Health (Department) challenging the constitutionality of section 1418.8. The superior court granted the petition, ruling that section 1418.8 was unconstitutional because it (1) facially violated due process by failing to require notice to a resident of a physician's determination that the resident lacks capacity, has no surrogate decisionmaker, needs a recommended medical intervention, and has a right to judicial review; (2) violated due process when applied to authorize an IDT to make decisions about administering antipsychotic medication; and (3) violated the patient's privacy rights regarding end of life withdrawal of care decisions. The court entered judgment and prohibited enforcement of section 1418.8 to the extent it conflicted with those rulings. Both parties appealed.

The Court of Appeal mostly reversed, in the process expressly disagreeing with portions of Rains v. Belshe (1995) 32 Cal.App.4th 157 regarding the constitutionality of section 1418.8 as enacted. The Court of Appeal agreed with the superior court's determination that section 1418.8 would be unconstitutional on its face if it failed to require notice to a resident that he or she had been found to lack decision making capacity and that no surrogate was available before initiating medical intervention. However, to preserve the statute's constitutionality, the appellate court construed section 1418.8 to require specific oral and written notice to the resident and "at least one competent person whose interests are aligned with the resident." That notice must specify the incapacity decision and lack of a surrogate, proposed treatment decisions by an IDT, and the resident's right to judicial review of IDT decisions. The court further held that "an essential feature of the IDT process that saves it from constitutional infirmity" is the inclusion of a patient representative on the IDT who is independent of the nursing home. Finally, the court rejected the petitioner's as-applied challenges to section 1418.8, holding that the IDT process was appropriate for administering antipsychotic medication in nonemergency situations, and for decisions regarding life-sustaining treatment or hospice care to a terminally ill patient—provided the patient receives notice of the decisions and the IDT includes a patient representative who is unaffiliated with the nursing home.

PATIENT'S HUSBAND WASN'T AUTHORIZED AGENT IN SIGNING ADMISSION DOCUMENTS, DOOMING HEALTH FACILITY'S RELIANCE ON ARBITRATION AGREEMENT IN DOCUMENTS

Valentine v. Plum Healthcare Group, LLC *(July 2, 2019, No. C080940) __ Cal. App.5th __ [2019 WL 3338166], certified for publication July 25, 2019*

Lila Valentine was admitted to the Midtown Oaks Post-Acute skilled nursing facility to rehabilitate a fractured shoulder. Lila's husband signed the admission papers, which included two arbitration agreements. Under these agreements, Lila's husband represented

that he had authority to execute them on her behalf and to bind all "heirs, representatives, executors, administrators, successors, and assigns." Lila developed a urinary tract infection, which led to sepsis and death from cardiac arrest. Lila's husband and children sued Midtown for wrongful death, elder abuse, violations of the patient's bill of rights, and negligent infliction of emotional distress. Midtown petitioned to compel arbitration. The trial court ruled that the arbitration agreements applied to the husband's claims (both as Lila's successor in interest and for himself), but not to the children's wrongful death claims because they had not signed. The court then refused to compel arbitration—even as to the husband—because arbitrating some claims and litigating others might result in conflicting rulings on common issues.

The Court of Appeal affirmed. The court explained that a patient may execute an arbitration agreement that binds her heirs, requiring them to arbitrate any wrongful death claim. But Midtown failed to establish that Lila's husband was acting as her authorized agent when he executed the arbitration agreements on her behalf. The court held such agency cannot be implied from the marriage relationship alone. Midtown's ostensible agency theory failed because Lila had done nothing to cause Midtown to believe her husband was authorized to sign the admissions papers for her. Although Lila's fractured shoulder prevented her from signing herself, Midtown had not shown that she lacked capacity to make healthcare decisions or to communicate her consent. Finally, the court held that the trial court had the discretion to deny otherwise proper arbitration of the husband's individual claims to order to avoid inconsistent results.

DMHC LETTERS TO KNOX-KEENE PLANS ABOUT ABORTION RESTRICTIONS WERE NOT IMPERMISSIBLE UNDERGROUND REGULATIONS

Missionary Guadalupanas of the Holy Spirit, Inc. v. Rouillard *(Aug. 6, 2019, C083232) __ Cal.App.5th __ [2019 WL 3561824]*

The Knox-Keene Act requires all health care service plans to offer "basic health care services 'where medically necessary,' " including "preventative health services." (Health & Saf. Code, § 1367, subd. (i)). The legislature delegated to the Department of Managed Health Care the authority to enact regulations governing the basic services that must be covered. The minimum coverages are set forth in California Code of Regulations, title 28, section 1300.67, which requires plans to include, inter alia, " 'a variety of voluntary family planning services.' " After approving health insurance policies that limited or excluded coverage for voluntary abortions, the DMHC sent letters to seven plans stating that it had erred in approving them because the Knox-Keene Act prohibits coverage limits or exclusions for legal abortions. DMHC required the plans to file amended documents removing the abortion restrictions.

A Catholic religious order filed a petition for writ of mandate alleging the DMHC's letters were "underground regulations" that violated the Administrative Procedure Act. The petitioners also objected to the requirement that plans cover "voluntary" abortions since, by definition, those services are not "medically necessary." The trial court sustained the DMHC's demurrer, ruling that the letters did not violate the APA because "the only legally tenable interpretation of the law is that all abortion procedures are deemed medically necessary as basic health care services under Knox-Keene."

The Court of Appeal affirmed. The APA establishes procedures that state agencies must follow when adopting regulations, which include furnishing notice and an opportunity to be heard to persons affected by a regulation. A non-complying regulation is nullified as an "underground regulation," but the APA does not apply to regulations embodying "the only legally tenable interpretation of a provision of law." (Gov. Code, § 11340.9, subd. (f).) The court explained that an abortion is one of two possible medically necessary procedures when a patient is pregnant: medical services to facilitate labor and delivery, or medical services to terminate the pregnancy. Both types of services are medically necessary "voluntary family planning services" to treat the condition of pregnancy that fall within the statutory requirement of coverage for "basic health care services." Accordingly, although the DMHC's letters were a regulation, they were not subject to the APA because they resolved no ambiguities in the Knox-Keene Act; they instead reflected "the only legally tenable interpretation of the statute."

FACILITY CAN'T FORCE ARBITRATION WHEN PATIENT'S DAUGHTER CREDIBLY DENIES THE AGREEMENT WAS AUTHORIZED

Lopez v. Bartlett Care Center, LLC *(July 30, 2019, No. G056249) __ Cal.App.5th __ [2019 WL 3422610], certified for publication Aug. 28, 2019*

After a brief hospitalization, Irene Lopez was readmitted to Bartlett Care Center, a skilled nursing facility, with numerous medical issues, including dementia. Several days later, Irene's daughter, Jasmine Lopez, signed a two-page arbitration agreement above the designation for "Resident Representative/ Agent Signature." The agreement required Irene and Jasmine, in both her individual and representative capacities, to arbitrate any disputes other than claims involving collections or evictions. Irene was later hospitalized for treatment of ulcers, wet gangrene, and sepsis; she died 23 days after leaving Bartlett.

As Irene's successor, Jasmine sued Bartlett and related entities for negligence, willful misconduct, elder abuse, and violation of the patient's bill of rights; in her own name, Jasmine also sued for wrongful death. Bartlett petitioned to compel arbitration, presenting evidence that its employee explained the agreement to both Irene and Jasmine and that Irene gave a verbal authorization for Jasmine to execute it. Jasmine's opposition declaration stated that Irene never authorized her to execute the arbitration agreement and disputed the circumstances of execution. The trial court denied the petition, ruling that Bartlett failed to prove that Irene had authorized Jasmine to sign the agreement on her behalf. The court further ruled that the arbitration agreement was unenforceable against Jasmine in her individual capacity, due to procedural and substantive unconscionability. Bartlett appealed.

The Court of Appeal affirmed the ruling on Jasmine's lack of agency based on her declaration. The court also held the agreement unenforceable as to Jasmine personally because (1) it was procedurally unconscionable because it was titled as an agreement between the resident and the Center and lacked adequate warnings that those signing for residents were binding themselves; and (2) it was substantively unconscionable because the evictions and collections exceptions benefited the Center exclusively, and therefore lacked mutuality.

NO FALSE CLAIMS ACT LIABILITY BASED ON 2009 STATE LAW CAPPING MEDI-CAL BILLINGS ABSENT FEDERAL APPROVAL OF THE STATE LAW

Omlansky v. Save Mart Supermarkets *(July 31, 2019, No. C085294) __ Cal. App.5th __ [2019 WL 4072142], certified for publication Aug. 29, 2019*

Matthew Omlansky, a relator, brought a qui tam action against Save Mart Supermarkets alleging False Claims Act violations for seeking reimbursement for prescription and nonprescription medications sold to Medi-Cal patients at rates higher than the rates charged to customers paying cash. Specifically, Omlansky alleged this practice violated a 2009 state statute capping Medi-Cal billings at Save Mart's "usual and customary price." (See Welf. & Inst. Code, §§ 14105.45, subd. (b), 14105.255, subd. (b).) The trial court sustained Save Mart's demurrer and Omlansky appealed.

The Court of Appeal affirmed. Omlansky failed to plead or prove that the 2009 statutory cap took effect since he did not establish that the cap had received federal approval from the Centers for Medicare & Medicaid Services. Absent federal approval, Omlansky was unable to show that, during the alleged wrongful billing period, Save Mart had been required to conform its billings to the 2009 statute. Nor could Omlansky prevail under the pre-2009 statutory regime, which did not cap prescription reimbursements in the fashion Omlansky alleged was required.

THE MEDICAL BATTERY STATUTE OF LIMITATIONS IS TOLLED BY THE DISCOVERY RULE

Daley v. Regents of the University of California, et al. *(Aug. 30, 2019, A153501) __Cal.App.5th__ [2019 WL 4127269]*

Plaintiff Alycesun Daley was pregnant with twins who suffered from twin-twin transfusion syndrome (TTTS), a congenital condition involving inter-twin vascular connections. As part of a National Institute of Health clinical study, she underwent two fetoscopic laser surgeries to treat the TTTS at UCSF's Fetal Treatment Center. After the second

surgery, she developed a bacterial infection which led to an induced delivery. Neither twin survived.

Eleven years later, Daley sued her doctors and the Regents for medical battery, claiming she consented to percutaneous surgery (where the uterus is accessed via a needle puncture), but the surgeons exceeded the scope of her consent by performing open fetal surgery (where a subcutaneous incision is made in the abdominal wall to access the uterus), which caused her bacterial infection. The trial court sustained a demurrer based on the two-year statute of limitations, ruling that the discovery rule—which delays accrual of a cause of action until a plaintiff has a reason to know or at least suspect wrongdoing caused her injury—does not apply to a medical battery claim.

The Court of Appeal reversed, holding that the discovery rule applies to medical battery claims, and may be particularly applicable to claims of a sedated plaintiff who does not learn of potential wrongdoing before the limitations period expires. The court remanded for a determination of whether Daley could not have reasonably discovered facts supporting her claim within the limitations period.

RESIDENTIAL DRUG TREATMENT FACILITIES VIOLATING ZONING ORDINANCES MAY BE ENJOINED AS PER SE NUISANCES

New Method Wellness, Inc. v. City of Dana Point *(Aug. 23, 2019, No. G056741) __ Cal.App.5th __ [2019 WL 3980797], certified for publication Sept. 13, 2019*

New Method Wellness, Inc., operates a substance abuse treatment center headquartered in San Juan Capistrano, where it is licensed to offer mental health and substance abuse services. An affiliated company, NMW Beds, owns three properties in residential zones in the City of Dana Point, where New Method houses some of its patients. Dana Point filed a nuisance action, seeking an injunction barring New Method and NMW Beds from using the residences to house patients in violation of zoning ordinances. The trial court granted injunctive relief, ruling that the unlicensed residences were nuisances per se because they violated zoning ordinances in operating as drug treatment centers. Defendants appealed.

The Court of Appeal affirmed. First, the court explained that ownership of the property is irrelevant to the nuisance action; instead, how the property is being used is probative. Here, substantial evidence supported the trial court's finding that defendants' property was being used for drug rehabilitation and therefore had to be licensed by Dana Point for that use. Because the residences were unlicensed, they were nuisances per se that could be enjoined without proof of irreparable injury. Second, the court rejected defendants' argument that Dana Point's zoning ordinance was preempted by Health and Safety Code section 11834.23, holding that unlicensed facilities may not invoke that statute. The court also rejected defendants' contention that the residences did not need to be licensed under Health and Safety Code section 1505, subdivision (i), because that statutes applies only "where the facilities provides no care or supervision."

UNRUH ACT FORBIDS RELIGIOUS HOSPITAL FROM DENYING TREATMENT BASED ON GENDER IDENTITY WITHOUT PROVIDING TREATMENT AT COMPARABLE FACILITY

Minton v. Dignity Health *(Sept. 17, 2019, No. A153662) __ Cal.App.5th __ [2019 WL 4440132]*

Evan Minton sued Dignity Health, alleging it violated the Unruh Civil Right Act (Civ. Code, § 51) by refusing to permit his doctor to perform a hysterectomy on him because of his sexual identity. Minton is a transgender man whose physician scheduled a hysterectomy surgery at a Catholic Dignity hospital as treatment for gender dysphoria. The day before the scheduled surgery, the hospital's president cancelled the surgery after learning the circumstances. After Minton and his representatives exerted pressure through the media and political connections, the procedure took place three days later at a non-Catholic Dignity hospital. Minton claimed that Dignity violated its duty to provide "full and equal" access to medical treatment by canceling his initial surgery. (Civ. Code, § 51, subd. (b).) The trial court sustained Dignity's demurrer, ruling that it satisfied its statutory obligation by completing the procedure at another location three days after it was initially scheduled.

The Court of Appeal reversed. First, the court rejected Dignity's claim that it had denied service based on the sterilization prohibition in the "neutral" "Ethical and Religious Directives for Catholic Health Care Services" issued by the United States Conference of Catholic Bishops. The court held that issue could not be resolved on demurrer to a complaint that alleged a discriminatory motive for denying services. The court observed that "[d]enying a procedure as treatment for a condition that affects only transgender persons [while allowing the same service for other ailments] supports an inference that Dignity Health discriminated against Minton based on his gender identity." Second, the court rejected Dignity's claim that it provided Minton with "full and equal" access to medical treatment by allowing the procedure to take place three days later at another location. The court explained that, while the later procedure may have mitigated Minton's damages, Dignity would remain liable for any unlawful cancelation of his initial surgery. " 'Full and equal' access requires avoiding discrimination, not merely remedying it after it occurred." Finally, the court rejected Dignity's free exercise defense. The court held that Minton's claim does not compel Dignity to violate its religious principles if it can provide all persons with full and equal access to medical care at comparable facilities not subject to religious restrictions. And relying on North Coast Women's Care Medical Group, Inc. v. Superior Court (2008) 44 Cal.4th 1145, the court held that any burden on religion imposed by the Unruh Act in this circumstance did not violate the First Amendment.

MEDICARE ACT DOES NOT PREEMPT CALIFORNIA LAW GOVERNING INSOLVENT INSURERS

Cal. Ins. Guarantee Ass'n v. Azar, ___ F.3d ___, 2019 WL 5076945 (9th Cir. Oct. 10, 2019)

The California Insurance Guarantee Association (CIGA) is a state-run insurance scheme that pays benefits on behalf of insolvent insurers. California law prohibits CIGA from reimbursing state and federal agencies, like Medicare. In contrast, the Medicare Act contains a Secondary Payer Provision that requires a primary insurer to reimburse Medicare for any medical care included under the beneficiary's policy with a primary insurer. In this case, CIGA administered workers' compensation claims for several individuals whose insurers were insolvent. CIGA notified the Center for Medicare Services that some of the beneficiaries were entitled to medical care under Medicare, and Medicare paid for those expenses. CMS contended CIGA was the primary insurer required to reimburse Medicare for those expenses. CIGA sought a declaratory judgment to the contrary, but the district court ruled that federal law preempted California law, obligating CIGA to reimburse CMS.

The Ninth Circuit reversed, holding that insurance regulation is a field traditionally occupied by the states, and that nothing in the Medicare Act suggested that Congress intended to interfere with state regulation of insolvent insurers. Specifically, the Court determined that the Secondary Payer Provision did not apply to CIGA, so it was not obligated to reimburse Medicare for the medical expenses at issue. CIGA is not a workers compensation plan within the meaning of the Medicare regulations—an insured employee's work-related injury is insufficient to trigger CIGA's obligations, even though CIGA happened to pay the obligations of an insolvent workers compensation plan here. CIGA is simply an insurer of last resort that pays claims when there is no other insurer available.

PHARMACY BOARD NOT REQUIRED TO LIST AND REJECT EVERY LESSER SANCTION BEFORE REVOKING LICENSE

Oduyale v. California State Board of Pharmacy (Sept. 23, 2019, D073755) ___ Cal.App.5th ___ [2019 WL 5196663], certified for publication Oct. 15, 2019

The Board of Pharmacy filed an accusation against Solomon Oduyale, a licensed pharmacist, to revoke or suspend his license. The accusation was based on 16 causes for discipline ranging from possession of controlled substances without proper labeling to failure to maintain accurate and complete pharmacy records. After a hearing, the Board adopted an ALJ's decision proposing revocation of Oduyale's license and a stay of the revocation with probation for three years. Almost a decade later, the Board filed another accusation against Oduyale focused on additional record-keeping violations. After the Board revoked Oduyale's license, he sought to set aside the revocation via writ of mandate. The trial court found that the Board had abused its discretion by failing to analyze alternative sanctions and remanded to allow the Board to reconsider

why lesser punishments would not protect the public. Both parties appealed.

The Court of Appeal reversed and reinstated the Board's revocation decision. The trial court erred by directing the Board to provide written reasons for not imposing each penalty short of revocation. Once the trial court determined that the Board's findings were supported by the weight of the evidence (at least for certain charges), the trial court needed to assess whether the Board's findings "bridged the gap" between the evidence and its decision. The Board was not obliged to outline every reason it declined to impose a lesser form of discipline; the Board was only required to justify its penalty with statements having a factual and legal basis. The appellate court found the Board's decision satisfied this standard, since the Board had reviewed the entire record, listed and evaluated each cause for discipline, and explained why Oduyale's violations were sufficient to warrant revocation of his license. Finally, even though Oduyale was being punished only for record-keeping violations, their frequency warranted increased punishment. The court therefore rejected Oduyale's cross-appeal asserting the Board should be required to impose a lesser penalty.

UNDER MEDICAID, CALIFORNIA MUST PAY FEDERALLY QUALIFIED HEATH CENTERS THE FULL AMOUNT OF CONTRACTING PROVIDERS' CHARGES

Tulare Pediatric Health Care Center v. State Department of Health Care Services (Oct. 16, 2019, B287876) __ Cal. App.5th __ [2019 WL 5205998]

States participating in the federal Medicaid program must pay federally qualified heath centers for the services they provide to Medicaid beneficiaries. California participates through Medi-Cal. Under Medicaid, California must pay such health centers 100 percent of their costs of furnishing required services. Tulare Pediatric Health Care Center (the Clinic) is a federally qualified health center. The Clinic hired Dr. Prem Kamboj, who charged $106 per patient visit. Adding this figure to Clinic operating costs, the Clinic charged the California Department of Health Care Service $167.85 per patient visit. DHCS audited the Clinic and found that, on some occasions, Kamboj's costs of providing services were less than $106 per visit. DHCS reduced its payments to the Clinic accordingly, contending the amount it owed the Clinic should be based on Kamboj's actual costs. The Clinic petitioned to require DHCS to pay the full $106. The trial court ruled for the Clinic.

The Court of Appeal affirmed. In its view, both 42 U.S.C. § 1396a(bb) and its state-law counterpart required DHCS to pay 100 percent of the Clinic's reasonable costs. Those costs included the full amount of charges by contracting providers like Dr. Kamboj. In other words, the amount of the Clinic's costs control, reflecting Congress's "mandate that states must fully reimburse health centers for the cost of Medicaid beneficiaries." The court rejected DHCS's reliance on and interpretation of Medicare regulations allowing for consideration of providers' "actual costs," though the court left open the possibility that DHCS's position might properly be applied in disputes with hospitals. *See Oroville Hospital v. Dept. of Health Services* (2006) 146 Cal.App.4th 468.

MEDICAL BOARD MAY COMPEL PRODUCTION OF PATIENT RECORDS BASED ON EXPERT DECLARATION DOCUMENTING PRESCRIPTION IRREGULARITIES

Grafilo v. Soorani *(Oct. 2, 2019, B286912) __Cal.App.5th__, 2019 WL 5561411, publication ordered Oct. 29, 2019*

Dr. Emil Soorani, a psychiatrist, was investigated by the Medical Board after it received information he was overprescribing controlled substances. The Board obtained a Controlled Substance Utilization Review and Evaluation System (CURES) report detailing his prescribing history. The Board's medical consultant identified six patients who were prescribed controlled substances in large quantities or with "erratic patterns." The consultant opined it was necessary to review the medical records of those patients to determine whether Dr. Soorani was excessively prescribing controlled substances. None of the patients granted the Board's request to access their records, so the Board issued subpoenas to Dr. Soorani, who invoked patient privileges and privacy rights and refused to provide records.

The Board (via the director of the Department of Consumer Affairs) petitioned for an order compelling Dr. Soorani to produce the medical records. The petition was supported by the consultant's declaration stating that Dr. Soorani appeared to be prescribing medicine outside the standard of care and that obtaining patient records

was the only way to confirm it. Dr. Soorani opposed the petition and denied overprescribing medication. The superior court granted the petition. The court acknowledged patients' privacy interest in their medical records, but found disclosure justified by the state's interest in ensuring that medical care conforms to the standard of care. The superior court found that the consultant's declaration furnished a reason to suspect that Dr. Soorani had violated the Medical Practice Act. Dr. Soorani appealed.

The Court of Appeal affirmed, holding that the Board made a sufficient factual showing to justify the invasion of Dr. Soorani's patients' privacy. The court rejected Dr. Soorani's arguments that the Board ignored less intrusive means of obtaining information (since it had asked for voluntary production); that the consultant was unqualified (since every physician can opine on standard recommended dosages and possible side effects of prescription drugs); and that the Board's consultant's declaration was speculative and lacked evidentiary support (since the consultant recounted specific prescribing irregularities involving high dosages and large quantities of drugs that had dangerous side effects).

FILING A CIVIL ACTION DOES NOT AUTOMATICALLY ABANDON PENDING PEER REVIEW PROCEEDINGS

Stafford v. Attending Staff Association of LAC + USC Medical Center *(October 30, 2019, B288008)__Cal.App.5th__ [2019 WL 5587044]*

Dr. Novarro Stafford is a retired anesthesiologist whose clinical privileges were terminated by the medical staff at USC Medical Center prior to his retirement. While Dr. Stafford worked at the Medical Center, a female patient had complained that Dr. Stafford had acted inappropriately during an examination. The medical staff summarily suspended Dr. Stafford's privileges and referred him for a neurocognitive evaluation. The medical staff then terminated Dr. Stafford's privileges after he failed to timely submit to the evaluation. Dr. Stafford appealed and requested an administrative hearing. A hearing officer (James Lahana) was appointed.

A series of misunderstandings followed. Dr. Stafford advised the medical staff that he intended to file a civil action because a hearing had not been scheduled promptly. Then Dr. Stafford's attorney emailed the medical staff's counsel about dismissing the proceedings because of Dr. Stafford's retirement. Lahana saw the correspondence and sent a letter to Dr. Stafford's attorney asking if his client was dismissing the administrative appeal. But Dr. Stafford's attorney never saw the letter. Dr. Stafford filed a civil action, but he dismissed it before the superior court ruled on a pending demurrer and anti-SLAPP motion. Dr. Stafford later sought to proceed with his administrative appeal, but Lahana believed it had been abandoned. The parties disputed whether the administrative appeal was closed, but it did not proceed further.

Eventually, Dr. Stafford petitioned for a writ of administrative mandate seeking an order requiring the medical staff to complete the administrative process. The medical staff responded that Dr. Stafford had withdrawn or abandoned his right to a hearing. The superior court granted the petition, finding that Dr. Stafford had not failed to appear, had not abandoned his right to relief, and that his counsel had not requested dismissal. The medical staff appealed.

The Court of Appeal affirmed, holding that Dr. Stafford neither abandoned his administrative remedy nor failed to exhaust remedies by filing a civil action. While the exhaustion of administrative remedies doctrine precludes a party from seeking a judicial remedy before the conclusion of an administrative proceeding, the doctrine does not speak to a party's intention to abandon the administrative process merely by filing a premature civil action. In addition, substantial evidence supported the trial court's finding that Dr. Stafford did not abandon his administrative appeal via his counsel's correspondence. Finally, the court held that the superior court had properly allocated the burden of proof to the medical staff because abandonment is an affirmative defense.