APPELLATE CASE SUMMARIES

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CASE NOTES

Rehabilitation center that could reasonably foresee its patient's suicide may not assert superseding cause defense to wrongful death claim

Green v. Healthcare Services, Inc. (Aug. 31, 2021, G057950) __ Cal. App.5th __ [2021 WL 3871958]

Jeffrey Green was admitted to the voluntary nonmedical drug rehabilitation treatment center Anaheim Lighthouse for methadone addiction treatment. During his intake interview, Green stated that he was not suicidal and he was classified as "no safety risk." When Green was transferred to the rehabilitation treatment program following detoxification, he wrote a note stating he would be suicidal if he left the clinic. The supervising psychologist conducted a suicide risk assessment and concluded Green was not suicidal. Accordingly, she did not contact the psychiatric emergency team, but instead placed Green under observation. Green committed suicide by jumping from the facility's roof shortly thereafter. His mother filed a wrongful death and negligence complaint against Lighthouse. The jury found Lighthouse 65 percent negligent and Green 35 percent negligent, awarding $1.7 million for past and $2.2 million for future damages. Lighthouse appealed, requesting a new trial due to the trial court's refusal of jury instructions on its defense that Green's suicide was a superseding cause, foreclosing its liability.

The Court of Appeal affirmed. It explained that an independent intervening act may qualify as a superseding cause that relieves an actor of liability. The court also explained that an intentional suicide can be a superseding cause if it was not reasonably foreseeable. Here, however, in finding Lighthouse negligent, the jury necessarily found Green's suicide was foreseeable to Lighthouse, thus his suicide could not have been a superseding cause. It followed that the trial court did not err by refusing to instruct the jury on Lighthouse's superseding cause defense.

A non-English speaker is bound by an English-language arbitration agreement unless he is prevented from obtaining assistance in understanding it

Caballero v. Premier Care Simi Valley, LLC (Sept. 28, 2021, B308126) __ Cal. App.5th ___ [2021 WL 4434524]

Miguel Caballero, who reads and writes only in Spanish, signed a two-page arbitration agreement written in English when his mother was admitted to Premier Care's facility. Three years later, Caballero's mother was fatally injured in a fall while being transferred by Premier Care employees. Caballero and his siblings sued Premier Care and others for medical negligence and other claims. Premier Care moved to compel arbitration, which Caballero opposed on the ground he did not sign a Spanish language arbitration agreement and no one explained the English language agreement to him. Premier Care's representative declared that her practice is to allow residents or their representatives to review the agreement prior to signing it, and that a Spanish-

speaking staff member assists by explaining and translating the agreement and answering questions. The representative did not recall Caballero having any questions. The trial court denied Premier Care's petition to compel arbitration, finding that Premier Care failed to sufficiently inform Caballero of the arbitration agreement's contents, particularly since it failed to present a declaration from any Spanish-speaking staff member who read and explained the agreement to Caballero.

The Court of Appeal reversed. Under general principles of contract law, Caballero's execution of the arbitration agreement manifested his assent to its terms. Additionally, the agreement complied with the requirements of Civil Code section 1295 and thus was not an unenforceable contract of adhesion, unconscionable, or otherwise improper. Premier Care had no burden to determine whether Caballero could understand the agreement because a person who does not understand English sufficiently to comprehend an English-language contract must request that it be read or explained to him. Here, Caballero presented no evidence that he requested (or was unable to obtain) such assistance, or that Premier Care engaged in fraud or overreaching. Moreover, two uppercase notices in red directly above the signature blocks should have alerted Caballero to the significance of those provisions even if he could not read them. Accordingly, the trial court erred in denying arbitration.

Courts reviewing administrative decisions must take into account the standard of proof in the underlying proceeding

Li v. Superior Court (Medical Board of California) (Sept. 30, 2021, C092584) __ Cal.App.5th __ [2021 WL 4472069]

After the Medical Board of California revoked Dr. Quinn Li's medical license, he petitioned for a writ of administrative mandate challenging the Board's decision. Under Code of Civil Procedure section 1094.5, courts reviewing administrative decisions affecting a fundamental vested right, such as the revocation of a professional license, exercise independent judgment to determine if the decision is supported "by the weight of the evidence." Li acknowledged the long-standing rule from Chamberlain v. Ventura County Civil Service Com. (1977) 69 Cal.App.3d 362 that courts exercising independent judgment must determine if the findings are supported by a preponderance of the evidence, even though the clear and convincing standard applies in the underlying proceeding. But he argued that Chamberlain was no longer good law in light of Conservatorship of O.B. (2020) 9 Cal.5th 989, which held that a court applying substantial evidence review must account for the standard of proof used in the underlying proceeding. The trial court denied relief. Li then sought a writ of mandate from the Court of Appeal, once more challenging the validity of Chamberlain in light of O.B.

The Court of Appeal agreed with Li and disagreed with Chamberlain. The court held that the independent judgment standard, like the substantial evidence standard, requires a reviewing court to view the record through the lens of the standard of proof that applied in the underlying proceeding. The court rejected Li's implied abrogation argument, explaining that O.B. addressed substantial evidence review under section 1094.5, but not independent review. However, the Court agreed that it made no sense to apply different standards of review depending on whether a fundamental right was involved. The court observed that the phrase "weight of the evidence" can apply to the preponderance of the evidence, clear and convincing evidence, and guilt beyond a reasonable doubt standards of proof, and there was no evidence the Legislature intended trial courts to disregard the standard of proof in the underlying administrative proceeding for one of these standards and not the others. Accordingly, a trial court "must account for the standard of proof in the underlying administrative proceeding when exercising its independent judgment in reviewing the sufficiency of the evidence supporting the administrative agency's findings." While a reviewing court does not weigh the evidence to determine if the it meets standard of proof, it does assess whether a reasonable fact finder could have found that the standard was met. Despite the trial court's error in applying Chamberlain, the court nonetheless denied writ relief because Dr. Li had failed to demonstrate that the trial court would have ruled differently had it considered the underlying clear and convincing standard of proof.

Medicaid does not bar States from asserting liens against beneficiaries' recover of medical expense damages from third-party tortfeasors

L.Q. v. California Hospital Medical Center (Sept. 30, 2021, B305723) __ Cal.App.5th __ [2021 WL 4487768]

L.Q. suffered catastrophic birth injuries causing severe disabilities. She sued her medical providers for professional negligence and settled the claims for $3 million. The California Department of Healthcare Services (DHCS) asserted a lien on the settlement to recover amounts DHCS had paid for L.Q.'s medical care through Medi-Cal. The trial court denied the lien, ruling that California law permitting DHCS to place a lien on the settlement was preempted by the anti-lien provision of the federal Medicaid Act. DHCS appealed.

The Court of Appeal reversed. The court explained that the Medicaid Act includes certain provisions that are in tension. On the one hand, the Act's acquisition of rights provision deems states to have acquired the right to third-party payments for medical care, and the reimbursement provision requires states to seek reimbursement for those third-party payments. On the other hand, the anti-lien provision forbids states from asserting liens against the property of Medicaid beneficiaries, and the anti-recovery provision prohibits states from seeking to recover benefits that were correctly paid on behalf of Medicaid beneficiaries. Relying on dicta in Arkansas Dept. of Health and Human Services v. Ahlborn (2006) 547 U.S. 268 and Wos v. E.M.A. ex rel. Johnson (2013) 568 U.S. 627, the Court of Appeal resolved this tension by holding that state liens on Medicaid beneficiary recoveries are not prohibited by the anti-lien or anti-recovery provisions, provided they are limited to past medical costs. The court reasoned that, under the assignment clause, a Medicaid beneficiary's recovery of damages for past medical expenses belong to the state, not the beneficiary. Thus, the portion of L.Q.'s settlement on which DHCS asserted a lien was not L.Q.'s "property" within the meaning of the anti-lien provision. The court also rejected L.Q.'s argument that the reimbursement clause requires states to seek reimbursement directly from third parties, rather than by asserting a lien against recoveries by beneficiaries. The court directed the trial court to determine the portion of L.Q.'s settlement attributable to medical care expenses paid by the State and the amount of DHCS's reimbursement.

Hospitals are not required by consumer-protection laws to make price disclosures beyond what state and federal healthcare laws mandate

Gray v. Dignity Health (Oct. 13, 2021, A158648) __ Cal. App.5th __ [2021 WL 4771982]

After Gordon Gray received emergency medical care at a Dignity hospital, he received a bill that included an $880 ER charge, which was intended to cover the costs of initial patient evaluation and operating a 24-hour emergency department. Gray filed a putative class action against Dignity seeking declaratory and injunctive relief. He claimed Dignity violated the Unfair Competition Law (UCL) and the Consumers Legal Remedies Act (CLRA) by failing to inform him of the ER charge before providing emergency medical services. The trial court sustained Dignity's demurrer and entered judgment. Gray appealed.

The Court of Appeal affirmed. The court emphasized that Gray alleged no violations of the extensive scheme of statutes and regulations governing disclosure of hospital billing information and emergency medical treatment. For example, California's "Payers' Bill of Rights" (Health & Saf. Code, § 1339.50 et seq.) requires all hospitals to publicize their chargemaster prices and rates (including separate information on the 25 most common outpatient procedures and charges). Section 1317 requires hospitals to provide needed emergency medical services without regard to (and before inquiring about) the patient's ability to pay. Federal law imposes similar requirements on hospitals participating in Medicare, and prohibits tax-exempt hospitals from doing anything to discourage emergency room patients from receiving needed treatment. The Affordable Care Act also requires Medicare hospitals to disclose chargemaster rates, payer-specific negotiated charges, and a "consumer-friendly" list of charges for three hundred non-urgent "shoppable" services. During federal rulemaking, the Center for Medicare and Medicaid Services (CMA) explained that the new Hospital Pricing Transparency regulation did not conflict with the Emergency Medical Treatment and Active Labor Act (EMTALA) because

hospitals are not required to post signage or make statements about prices related to emergency care.

As to the UCL claim, the Court of Appeal held that Dignity's alleged failure to disclose its ER charge did not constitute an unfair business practice as a matter of law because Dignity complied with all statutory disclosure requirements. Requiring Dignity to make an extra disclosure about this specific charge before providing emergency care would conflict with state and federal laws requiring immediate emergency medical treatment. The court similarly held that Gray's CLRA claim failed as a matter of law because Dignity did not breach any duty to disclose material facts regarding its charges.

Proper patient referral disclosures do not excuse noncompliance with worker's compensation statute prohibiting a physician's financially interested referrals

Banerjee v. Superior Court (Oct. 5, 2021, E076291) __ Cal. App.5th __ [2021 WL 4551699]

Dr. Sanjoy Banerjee billed Berkshire Hathaway Homestate Companies (BHHC), a workers' compensation insurer, for medical services provided through three entities he owns: Pacific Pain Care Consultants (PPCC), Kensington Diagnostics, and Rochester Imperial Surgical Center. Dr. Banerjee operated all three entities out of a single location consisting of a lobby, a toxicology testing room, and a surgical room. A BHHC investigator identified excessive billing by Dr. Banerjee, as well as his failure to disclose to patients his ownership interest in the three entities. Prosecutors charged Dr. Banerjee with two counts of insurance fraud (Pen. Code., § 550) for violating Labor Code section 139.3, subdivision (a), which prohibits physicians from referring worker's compensation patients for certain specified services if the physician has a financial interest in the entity receiving the referral, and three counts of perjury (Pen. Code,§ 118) based on sworn reports Dr. Banerjee submitted to BHHC stating he had not violated section 139.3(a). At a preliminary hearing, the court denied Dr. Banerjee's motion to dismiss the information and ruled that he must answer the charges. Dr. Banerjee petitioned for writ relief.

The Court of Appeal denied writ relief as to the insurance fraud charges, but granted writ relief as to the perjury charges. Section 139.3(e) requires physicians referring patients to any entity in which the physician has a financial interest to disclose that interest to the patient. Dr. Banerjee argued that his compliance with that disclosure statute excused his noncompliance with section 139.3(a). The court rejected this argument for three reasons. First, Dr. Banerjee presented no evidence that any patient had signed the disclosure form he showed the court. Second, the disclosure form was ineffective since it disclosed only that Dr. Banerjee may have a financial interest in the Kensington and Rochester entities, not that he had such an interest. Third, compliance with section 139.3(e) simply does not excuse noncompliance with section 139.3(a). The sections operate independently, and comprehensive disclosure helps patients understand when a physician has a conflict of interest and may be making a referral for financial reasons, rather than to improve the patient's health. Moreover, section 139.31 lists exceptions to section 139.3, which do not include compliance with the section 139.3(e) disclosure provision. Next, the court held that these statutes are not unconstitutionally vague because they give physicians fair notice of what is required.

Finally, the court ordered the perjury charges dismissed. Those charges were based on violations of section 139.3(a). But Dr. Banerjee did not violate that statute by referring patients to his other legal entities because the physician's office exception (§ 139.31, subd. (e)) allows physicians to refer patients to different entities located in the same office despite the physician's financial interest in those entities. In contrast, the insurance fraud charges were supported by a strong suspicion that Dr. Banerjee created Kensington and Rochester as sham entities for the purpose of defrauding BHHC based on evidence that (1) Dr. Banerjee used these entities to bill substantially higher amounts than he previously charged for the same services, (2) he failed to inform BHHC of his financial interest in the entities, (3) the bills were designed to create the illusion that the entities were unrelated, (4) there was no business reason for forming the separate entities, and (5) Dr. Banerjee double-billed BHHC for some services.

A durable power of attorney authorizes an attorney-in-fact to execute a residential care facility's stand-alone arbitration agreement

Gordon v. Atria Management Company, LLC (Oct. 1, 2021, A161379) __ Cal. App.5th __ [2021 WL 4988882]

Janet Gordon executed a Durable Power of Attorney and Nomination of Conservator (DPOA), appointing her son Randall Gordon as her attorney-in-fact. The DPOA authorized Randall to arbitrate and pursue litigation on her behalf and to make arrangements for her transfer to a residential facility, but the DPOA disallowed him from making medical or healthcare decisions on Janet's behalf. When Janet moved into the Atria Walnut Creek residential care facility, Randall executed an Atria-prepared arbitration agreement on her behalf. After Janet fell and broke her hip, she—through Randall as her guardian ad litem—sued Atria asserting causes of action for elder abuse and negligence. The trial court denied Atria's petition to compel arbitration. Relying on Hutcheson v. Eskaton FountainWood Lodge (2017) 17 Cal. App.5th 937, the court ruled that Randall lacked authority to bind Janet to arbitration because admitting someone to a residential care facility for the elderly is a healthcare decision that the DPOA did not authorize Randall to make. Atria appealed.

The Court of Appeal reversed. The court held that, because the DPOA did not prohibit Randall from agreeing to arbitrate, he was authorized to execute the arbitration agreement on Janet's behalf. The court reasoned that the DPOA's grant of authority allowing Randall to arbitrate on Janet's behalf reasonably included the power to execute an arbitration agreement on her behalf as well. The court distinguished Hutcheson, explaining that it dealt with an individual who was admitted to a residential care facility for dementia care, and admission to such a facility was a healthcare decision that could not be made by someone who lacked authority to make healthcare decisions. The court rejected Janet's reliance on Atria's alleged pre-admission representations about providing for her medical needs, explaining "the upshot of these allegations was not that Janet was admitted to obtain medical care, but that Atria perpetrated a 'bait-and-switch scheme' " and later failed to provide the promised care. Unlike the resident in Hutcheson, Janet was admitted to Atria to obtain supervision and assistance with daily living, not healthcare. The court also explained that, while a healthcare power of attorney is sufficient to confer authority to execute an arbitration provision within an admission agreement, a healthcare power of attorney is not required for an attorney-in-fact to have authority to execute a stand-alone arbitration agreement. Thus, Randall was authorized under the DPOA to execute the stand-alone arbitration agreement after Janet was admitted regardless whether she was admitted for her medical needs.

Federally qualified health center must report nonreimbursable costs that "materially" relate to clinic operations to allocate overhead costs

Family Health Centers of San Diego v. State Department of Health Care Services (Oct. 7, 2021, C090618) __ Cal. App.5th __ [2021 WL 5037621], ordered partially published Oct. 29, 2021

Family Health Centers of San Diego (Family Health) is a federally qualified health center (FQHC) that provides services to qualified Medi-Cal beneficiaries and nonbeneficiaries. The Department of Health Care Service (DHCS) reimbursed Family Health for all costs reasonably incurred in treating beneficiaries using a prospective "per-visit" rate, which is determined by dividing the total allowable costs by the number of patients seen in the previous period. Allowable costs include both the direct cost of services and the indirect cost of providing those services, such as administrative overhead. Once allowable costs are determined, the total must be apportioned between program beneficiaries and other patients, so that only costs reasonably incurred in treating beneficiaries are reimbursed.

Family Health requested a reimbursement rate increase, but an audit was triggered when it eliminated from its cost report nonallowable costs associated with subcontracted medical and homeless services. The DHCS auditor determined that, under 42 C.F.R. 413.24(d)(7), these costs had to be reported as nonreimbursable, which had the effect of disallowing a proportionate share of administrative overhead costs. Family Health filed an administrative appeal, but both the administrative law judge (ALJ) and the Chief ALJ upheld the DHCS auditor's

decision. Family Health then filed a petition for writ of administrative mandate, which the trial court denied. Family Health appealed.

The Court of Appeal affirmed. The court rejected Family Health's contention that the ALJ erred by using a "materiality" standard. The court reasoned that a materiality standard comported with the regulatory objective of apportioning total costs between beneficiaries and nonbeneficiaries so that costs associated with serving nonbeneficiaries are not reimbursed. The court also rejected Family Health's argument that there was no substantial evidence supporting the ALJ's finding of a material connection between Family Health and the excluded costs. Family Health's contracts with outside facilities ensured significant interaction with those facilities, including orientation; ongoing staff meetings and consultations; and regular data collection, evaluation, and reporting requirements. Additionally, Family Health had failed to present detailed work papers justifying an alternative cost allocation.

MICRA limitations period bars personal injury action claiming patient fell because ER nurses negligently failed to accompany her to the restroom

Mitchell v. Los Robles Regional Medical Center (Nov. 2, 2021, B309123) __ Cal. App.5th __ [2021 WL 5071559]

Stacey Mitchell was taken to the Los Robles Regional Medical Center ER after taking 60 Naproxen tablets, vomiting twice, and experiencing ongoing nausea and abdominal pain. Her treating physician noted that Mitchell had a resting tremor, but displayed no motor nor sensory deficits. He diagnosed her with an acute kidney injury. A nurse placed an IV catheter in Mitchell's arm. About two hours later, Mitchell walked to the toilet with help from her husband. While walking back from the restroom unassisted, Mitchell fell, injuring her nose, forehead, and knee. She was admitted to Los Robles, treated, and released a few days later.

More than one year later, Mitchell sued Los Robles for negligence and premises liability, alleging that she fell because the nursing staff did not accompany her to and from the restroom. Los Robles moved for summary judgment based on the MICRA statute of limitations, Civil Code section 340.5, among other grounds. The trial court granted summary judgment and Mitchell appealed.

The Court of Appeal affirmed, holding that Mitchell's filed an untimely medical malpractice lawsuit. The court explained that MICRA applied because the nurses' judgment that Mitchell could walk herself to and from the bathroom without assistance was made in the course of providing medical care. In other words, the nurses' duty to protect Mitchell from falling while walking in the ER was owed to a patient, not to a member of the general public. Because Mitchell filed her lawsuit more than one year after her injury, it was time-barred under section 340.5.

Health plans have no tort duty to avoid underpaying hospitals for emergency services

Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc. (Nov. 4, 2021, B304183) __ Cal.App.5th __ [2021 WL 5118888]

Under the Knox-Keene Act, healthcare service plans must reimburse hospitals for emergency medical services to their enrollees based on either an agreed-upon contractual rate or the "reasonable and customary value" of the services. Several hospitals that no longer had contracts with Kaiser provided emergency services to over 3500 Kaiser enrollees and billed Kaiser at their full rate for those services. Kaiser used an internal methodology to calculate the reasonable value of the services, and reimbursed the hospitals for 53.2 percent of the billed charges. The hospitals sued Kaiser for breach of contract, recovery in quantum meruit, the tort of intentionally violating the Knox-Keene duty to pay the reasonable value of emergency services, and violating the unfair competition law (UCL) by underpaying the required reimbursement. The trial court dismissed the hospitals' intentional tort and unfair competition claims, and a jury found that Kaiser had paid the hospitals the reasonable value of the emergency services. The hospitals appealed.

The Court of Appeal affirmed. The court declined to recognize a new tort duty on the part of health plans to avoid reimbursing less than the "reasonable and customary" value of emergency services. The court reasoned that the social benefit of

recognizing such a tort duty would be slight, since the quantum meruit remedy adequately addressed any inadequate reimbursement problem, while the social costs of recognizing the tort duty would be "staggering." The court explained that tort liability for pure economic harms are the exception, not the rule, since economic relationships are generally governed by contracts and comprehensive statutory and regulatory schemes, as here. Recognizing a tort duty would create a strong incentive for health plans to overcompensate healthcare providers, which conflicts with the Knox-Keene Act's avowed purpose of ensuring health care at the lowest possible cost. Moreover, because health plan payments are always intentional, healthcare providers would have a strong incentive to file intentional tort claims seeking punitive damages in every case, which would likely add an unnecessary and potentially burdensome volume of litigation. The court held that the hospitals' requested injunctive relief under the UCL (to enjoin Kaiser from violating Knox-Keene by underpaying for emergency medical services in the future) is legally unavailable, and that restitution under the UCL would duplicate any quantum meruit award.

Finally, the court held that the trial court did not err in instructing the jury that the reasonable value of emergency medical services is the price that a "hypothetical willing buyer" would pay a "hypothetical willing seller." The court explained that, "[n]ot only is it legally appropriate to key 'reasonable value' to the price fixed by a willing 'hypothetical buyer' and willing 'hypothetical seller' in a 'hypothetical transaction,' but it is affirmatively helpful because it emphasizes another pertinent legal principle—namely, that the parties' prior actual transactions are not dipositive." Because "some market transactions will more closely resemble the transactions at issue in the case before the jury, and some will bear less resemblance," the jury must have "the ability to give greater weight to the former and less weight to the latter in fixing what a hypothetical buyer and seller would pay for the specific services at issue in that case."

A city may not administer ambulance services after delegating those services to the surrounding county

City of Oxnard v. County of Ventura (Nov. 23, 2021, B312348) ___ Cal. App.5th __ [2021 WL 5460725]

Fifty years ago, Ventura County entered into a joint powers agreement with several municipalities, including the City of Oxnard, requiring the County to administer a countywide ambulance system. The County established exclusive operating areas and contracted with private companies to provide ambulance services in each area. It contracted with Gold Coast Ambulance as the exclusive emergency service provider in the area where Oxnard is located.

A decade later, the legislature enacted the Emergency Medical Services Act (EMS Act; Health & Saf. Code, § 1797.200), which authorized counties to designate a local EMS agency to administer countywide services. The EMS Act included a "transitional provision" that allowed cities that were then providing EMS services to continue providing them until they ceded the provision of services to the local agency. Pursuant to the EMS Act, VCEMSA was established as the exclusive EMS agency in Ventura County, and Gold Coast continued providing EMS services under the auspices of VCEMSA.

More than thirty years later, Oxnard became dissatisfied with Gold Coast's service based on evidence that it provided inferior services to the city's less affluent neighborhoods. Relying on the transitional provision, Oxnard believed it could administer its own ambulance services by withdrawing from the pre-EMS joint powers agreement. Oxnard acted on that belief in 2020 by notifying the County of its intent to withdraw from the joint powers agreement and asking the County not to extend its contract with Gold Coast. When the County nonetheless extended the Gold Coast contract, Oxnard sought a preliminary injunction barring the County from providing EMS services within Oxnard city limits. The trial court denied the injunction and Oxnard appealed.

The Court of Appeal affirmed. It explained that Oxnard's underlying belief was mistaken. While the EMS Act allowed cities to continue providing emergency services they had provided when the EMS Act was enacted, that provision was inapplicable because Oxnard did not provide any ambulance services at that time. Oxnard

could not acquire the right to provide or administratively control EMS services by withdrawing from the earlier joint powers agreement because the County's current authority to provide those services through VCEMSA stemmed from the EMS Act, not that agreement. Accordingly, the trial court properly denied injunctive relief because Oxnard was not permitted to control EMS services that were being provided by VCEMSA under the EMS Act.

Regulations authorizing family members to admit elderly relatives to residential care facilities do not authorize them to enter arbitration agreements

Theresa D. v. MBK Senior Living, LLC (Nov. 30, 2021, A163312) __ Cal. App.5th __ [2021 WL 5578055]

Kellie Tennier, Theresa D.'s daughter and authorized representative, executed an arbitration agreement when admitting Theresa D. to Muirwoods Memory Care, a residential care facility for the elderly (RCFE). When Theresa D. sued Muirwoods for negligently allowing her to fall and fracture her hip, Muirwoods moved to compel arbitration. The trial court denied the motion, finding Tennier was not Teresa D.'s agent for purposes of the arbitration agreement. Muirwoods appealed.

The Court of Appeal affirmed. First, it rejected Muirwood's argument that the arbitration agreement delegated to the arbitrator the question whether Tennier was authorized to execute the agreement on behalf of Theresa D. That threshold question was for the court to decide. Second, although RCFE regulations expressly authorized Tennier, as a "family member," to admit Theresa D. to Muirwood, the regulations do not authorize family members to bind residents to arbitration.

Hospital liable for adopting policies that failed to protect female mental patients against the risk of sexual assault

Samantha B. v. Aurora Vista Del Mar, LLC (Dec. 20, 2021, B302321) __ Cal. App.5th __ [2021 WL 5996835]

Aurora Vista Del Mar, LLC, a psychiatric hospital, employed unlicensed mental health workers to monitor and assist patients. One worker, Juan Valencia, sexually abused two Aurora patients. They sued Aurora and Valencia for violations of the Elder Abuse and Dependent Adult Protection Act (Welf. & Inst. Code, § 15600 et seq.). The jury awarded the patients $6.75 million in noneconomic damages and allocated 35 percent fault to Valencia and 75 percent fault to Aurora. Aurora appealed.

The Court of Appeal affirmed. The court explained that "neglect" is not limited to the denial or withdrawal of services and can include a failure to protect against health and safety hazards. Here, Valencia was a hazard to the health and safety of female patients, and Aurora failed to protect them.

The court then found there was clear and convincing evidence that Aurora acted recklessly. Aurora is a sophisticated health care provider and was aware that its female patients were vulnerable, but it adopted policies that exposed those patients to a high risk of sexual predation. Those risky policies included hiring poorly trained, unlicensed mental health workers after a limited background check, understaffing, and allowing male workers to spend 20 minutes unsupervised with female patients.

Finally, the court rejected Aurora's excessive damages argument, holding that the Elder Abuse Act's $250,000 limit on noneconomic damages (Welf. & Inst. Code, § 15657, subd. (b)) applies only to survival actions. The court also held that allocating most of the fault to Aurora was reasonable because its reckless operations made plaintiffs' injuries almost inevitable.

Nursing Board may revoke license for unprofessional conduct and dishonesty in assessing the transfer of a residential care facility resident

Clawson v. Board of Registered Nursing (Dec. 17, 2021, No. A159990) __ Cal.App.5th __ [2021 WL 5976759]

A residential care facility for the elderly (RCFE) that was closing hired William Clawson, R.N., to assess each resident and recommend a new facility. Clawson assessed J.N., an 83-year-old resident, conducting a skin examination that identified coccyx and red and nonblanching heels, but Clawson failed to remove the bandages on J.N.'s feet or notice that one of her knees was significantly contracted. Clawson's appraisal recounted J.N.'s medical history, described her as "frail . . . with severe cognitive impairment, cachexia, and fragile skin," and

certified that "to the best of [his] knowledge [J.N.] does not need skilled nursing care." J.N. was then transferred to another RCFE, where caregivers described her condition as "very horrifying." J.N. was in significant pain, her bandages were old, her wounds "all smelled really bad," her knee had a large open sore with visible tendons, and her toes were black with "a very strong infection odor." The new RCFE caregivers called 911 to have J.N. transferred to a hospital, where she died several weeks later.

A Department of Social Services investigator interviewed Clawson, who stated he had supervised an unlicensed care worker to perform a "head-to-toe" assessment of J.N., and claimed he would have detected any odors of feces, urine, or bacterial infection because his "assessment skills are fine." About fourteen months later, an investigator for the Board of Registered Nursing interviewed Clawson, who then denied participating in J.N.'s assessment, which he claimed was performed solely by the unlicensed care worker. At a later administrative hearing, Clawson said he was not acting as a registered nurse at the time of the assessment, but only as a scribe. The ALJ found clear and convincing evidence that Clawson's appraisal of J.N. was grossly negligent and that he engaged in unprofessional conduct, both as to the assessment and by being untruthful with the Board's investigator. The Board adopted the ALJ's decision and revoked Clawson's nursing license. Clawson filed an unsuccessful petition for writ of administrative mandate, and then appealed.

The Court of Appeal affirmed. Rejecting the same four arguments that Clawson had raised in the trial court, the court held: (1) a RCFE appraisal is a "nursing function" under Business and Professions Code section 2725; (2) the performance of an RCFE assessment by a nurse creates a nurse-patient relationship; (3) the Board was not required to plead a violation of a specific RCFE statute before disciplining Clawson; and (4) the Board was authorized (under section 2761) to discipline Clawson for unprofessional conduct based on dishonesty.

Medical staff bylaws increasing the statutory burden of proof are unenforceable, entitling physician to a new peer review hearing

Bichai v. DaVita, Inc. (Dec. 20, 2021, F079815) __ Cal.App.5th __ [2021 WL 6000005]

Dr. William Biachai voluntarily resigned from the medical staff at DaVita Inc.'s dialysis facilities pursuant to a settlement agreement after DaVita's peer review committees and governing boards revoked his privileges. Dr. Bichai sought to regain privileges at DaVita after completing a Physician Assessment Clinical Education (PACE) program, and then requested a peer review hearing after DaVita denied that application. The hearing officer, following hospital bylaws, concluded that DaVita's decision to deny Dr. Bichai's application was supported by the record and that Dr. Bichai had not proven that the decision lacked a substantial factual basis. Dr. Bichai filed a petition for writ of administrative mandamus challenging the hearing officer's decision. The superior court denied Dr. Bichai's writ petition and he appealed.

The Court of Appeal reversed, holding that the bylaws imposed an impermissibly high burden of proof on a physician contesting a peer review decision. While Business and Professions Code section 809.3, subdivision (b)(2), requires that applicants for medical staff privileges persuade the trier of fact of their qualifications by a preponderance of the evidence, DaVita's bylaws required Dr. Bichai to prove that the peer review body's action "lacks any substantial factual basis" or is otherwise arbitrary or capricious. That burden of proof imposed a more demanding standard on Dr. Bichai than the statutory requirement, unfairly preventing the trier of fact from giving greater weight to the PACE program findings. Accordingly, Dr. Bichai was entitled to a new peer review hearing.

DHCS may recoup the cost of Medi-Cal services from pay-on-death trust beneficiary

Riverside County Public Guardian v. Snukst (Jan. 10, 2022, E074949) __ Cal.App.5th __ [2022 WL 92772]

Joseph Snukst purchased an annuity and created a revocable inter vivos trust. He designated the trust as the pay-on-death beneficiary of his annuity and named his niece Shawna as its beneficiary. He later spent seven years at a senior care facility where he received Medi-Cal benefits.

Upon his death, the trust received $804,456.13 from his annuity. The Department of Health Care Services (DHCS) presented a creditor's claim to Joseph's public guardian seeking nearly $500,000 for the cost of Medi-Cal benefits it provided to Joseph. The probate court disallowed the public guardian's request to satisfy the DHCS's claim, ruling that (upon Joseph's death) the annuity became a trust asset, rather than a conservatorship asset, requiring the entire trust to be distributed to Shawna. The DHCS appealed.

The Court of Appeal reversed, holding that both state and federal law governing revocable inter vivos trusts require reimbursement of Medi-Cal benefits paid by DHCS. The court explained that the public guardian, which acted as both the trustee of Joseph's trust and conservator of his estate, properly notified DHCS of his death, as required by Probate Code section 19202. Both state and federal law entitled the DHCS to seek reimbursement of Medi-Cal benefits from Joseph's estate, which included money transferred to Shawna through the trust because of the broad definition of an "estate" under both 42 U.S.C. section 1396p(b)(4)(A)-(B) and Welfare and Institutions Code section 14009.5, subdivision (a). Public policy also weighed in favor of allowing DHCS to recover "as much as possible" of the costs of providing medical services to low-income people, so that DHCS may continue providing such services.

CMS may enforce interim final rule imposing COVID-19 vaccine mandate on Medicare and Medicaid facilities

Biden v. Missouri, 595 U.S. ___, 2022 WL 120950 (U.S. Jan. 13, 2022) (Nos. 21A240 and 21A241)

The Department of Health and Human Services (HHS), acting through the Center for Medicare and Medicaid Services (CMS), issued an interim final rule requiring healthcare facilities participating in Medicare or Medicaid to ensure their staff is vaccinated against COVID-19 to continue receiving federal funds. Two groups of States filed separate actions challenging the rule. Federal district courts in Louisiana and Missouri enjoined enforcement of the rule. The Government asked the U.S. Supreme Court to stay the injunctions after the Fifth and Eighth Circuits declined to do so.

The Supreme Court stayed the lower court orders enjoining the interim final rule, allowing CMS to enforce it. The Court held that the rule fell within the authority Congress conferred on the HHS to impose conditions on Medicare and Medicaid facilities "necessary in the interest of the health and safety of individuals who are furnished services." 42 U.S.C. § 1395x(e)(9). HHS had concluded that a vaccine mandate was necessary to reduce the likelihood that healthcare workers transmitted COVID-19 to their patients. The Court determined this conclusion "fit neatly within the language of the statute." The Court cited HHS' longstanding historical practice of imposing safety conditions on participating Medicare and Medicaid facilities, including those that address the control of infectious diseases and relate to the specific duties of healthcare workers, as supporting a broad scope of authority conferred on HHS by Congress. The Court next rejected the States' argument that the interim rule was arbitrary and capricious, finding the Secretary did not fail to examine the relevant data or consider the potential staffing shortages the rule could cause. Finally, the Court held that the HHS established good cause to dispense with normal notice and comment protocol because accelerating the rule's issuance could reduce COVID-19's impact before the impending winter flu season. See 5 U.S.C. § 553(b)(3)(B). The HHS was not required to "consult with appropriate State agencies" under 42 U.S.C. § 1395z, or prepare a regulatory impact analysis, and 42 U.S.C. § 1395 could not be read so broadly as to prevent every condition that the HHS and CMS imposed on Medicare and Medicaid facilities.

Four Justices dissented in two separate opinions. Justice Thomas wrote that the Government had failed to make a strong showing (necessary to stay an injunction) that the HHS had statutory authority to issue the interim rule. The dissent reasoned that, under 42 U.S.C. § 1302(a) and 42 U. S. C. § 1395hh(a)(1), HHS was empowered only to publish rules to carry out the "administration" of Medicare and Medicaid, meaning its authority is limited to the "practical management and direction" of the programs. Compelling millions of healthcare workers to undergo an irreversible and unwanted medical procedure had only a

"tangential" connection to Medicare and Medicaid management. The Government failed to cite any other statutes evincing clear Congressional authority for a nationwide vaccine mandate. Instead, vaccine mandates fall squarely within a State's police power, absent Congress's clear statement otherwise.

Justice Alito wrote that HHS failed to establish good cause for avoiding the notice-and-comment procedures. The agency's own delays in issuing and implementing the rule cut against its asserted need to circumvent notice-and-comment. And CMS's acknowledged uncertainty, coupled with the "'rapidly changing nature of the current pandemic'" should have made it "more receptive to feedback, not less." Avoiding notice-and-comment was not harmless, as it prevented States and regulated facilities from presenting evidence refuting or contradicting HHS's justification for the rule.

Before authorizing electroconvulsive therapy for an inmate who lacks capacity to consent, courts must consider treatment preferences the inmate expressed while still competent

In re Rudy Terrazas (Jan. 11, 2022, E077170) __ Cal.App.5th __ [2022 WL 109008]

A prison warden sought court approval under the "Organic Therapy" statutes (Pen. Code, §§ 2670-2680) to perform electroconvulsive therapy (ECT) on inmate Rudy Terrazas to treat his worsening mental illness. The trial court authorized the ECT after making statutorily required findings that Terrazas lacked the capacity to consent to treatment; that the state proved by clear and convincing evidence that there was a compelling need to use ECT on Terrazas; that there were no less-onerous alternatives; and that ECT was a sound medical and psychiatric treatment. (Id., § 2679.) Terrazas petitioned for writ relief.

The Court of Appeal granted a writ of habeas corpus. The court began by rejecting Terrazas's argument that the constitutional right to refuse medical treatment requires the appointment of a surrogate to consent to ECT for an inmate who is unable to consent. The court reasoned that the right to refuse medical treatment is limited by the state's interest in providing care to citizens who cannot care for themselves under the doctrine of parens patriae. The state's high burden under the Organic Therapy statutes restricts its parens patriae power by providing sufficient protection to an inmate who lacks capacity to consent to ECT. The court acknowledged that section 2677 allows inmates to request the appointment of an independent medical expert to review the medical evidence, but Terrazas waived that appointment by not disputing his mental illness.

Nevertheless, the court held that, to comply with the constitutional right to refuse medical treatment, courts must (before authorizing ECT) consider any expressed preferences and beliefs the inmate made when competent. The court explained that a person's refusal to receive medical treatment while competent can preclude such treatment when the person becomes incapacitated. The court explained that the findings required under the Organic Therapy laws to overcome that lack of consent were insufficient to address this separate constitutional issue. The Court of Appeal directed the superior court to develop a record of the inmate's beliefs and to decide in the first instance what "legitimate penological interests" might overcome a finding that the inmate did not consent to the therapy when competent.

Sole successor-in-interest assignee of healthcare provider has derivative standing to sue insurer under ERISA

Bristol SL Holdings, Inc. v. Cigna Health and Life Insurance Company, __ F.4th __, 2022 WL 129139 (9th Cir. Jan. 14, 2022)

Sure Haven, a mental health and substance abuse treatment center that provided out-of-network services for Cigna enrollees, went out of business after Cigna stopped reimbursing for services to Cigna-insured patients. Bristol SL Holdings, Inc., became Sure Haven's successor-in-interest through bankruptcy proceedings. Bristol sued Cigna as Sure Haven's assignee, alleging state law and ERISA claims. The district court summarily adjudicated Bristol's state law claims, and dismissed its ERISA claim for lack of standing. Bristol appealed.

The Ninth Circuit reversed. The court explained that the issue was whether the assignee was authorized by ERISA to bring a claim, not "standing," yet many cases refer to the doctrine as one of "derivative standing." The court held that

Bristol may sue under ERISA as a healthcare provider's first assignee and successor-in-interest through bankruptcy proceedings who owns all of the provider's health benefit claims. The court distinguished Simon v. Value Behavioral Health, Inc., 208 F.3d 1073 (9th Cir. 2000), which held that an attorney who had acquired assignments of hundreds of unrelated health benefit claims lacked derivative standing under ERISA. The Simon panel worried that permitting derivative standing in that situation would transform health benefit claims into tradable commodities, which would not further the purpose of ERISA. But that concern was inapplicable to Bristol, whose claims were limited and specific. Moreover, refusing derivative standing to Bristol would create perverse incentives undermining the goal of ERISA by influencing insurers to force healthcare providers into bankruptcy to ensure they never had to pay for authorized services.

Caps on the costs of copying medical records in Evidence Code section 1158 do not limit the amount an attorney's photocopying agent may charge

Busby v. Bactes Imaging Solutions, LLC (Jan. 19, 2022, D078204) __ Cal. App.5th __ [2022 WL 167582]

Attorney Spencer Busby filed a class action against Bactes Imaging Solutions, a vendor that contracts with healthcare providers to furnish patient information, including requests from attorneys seeking clients' medical records in anticipation of litigation. The attorney alleged that Bactes violated Evidence Code section 1158 (which specifies the reasonable costs of copying and delivering medical records that healthcare providers may charge) by charging rates above the statutory limit. The trial court ruled that Bactes did not violate section 1158 because it was acting as an agent for attorneys, not healthcare providers, when providing attorneys with photocopies of medical records. Busby appealed.

The Court of Appeal affirmed. The court explained that, under Thornburg v. Superior Court (2006) 138 Cal.App.4th 43, agents of healthcare providers may be liable for violating section 1158 when "(1) they have assumed the duty of responding to section 1158 requests by generating photocopies of the requested patient records and providing those photocopied records to the requesting attorney, and (2) they are acting for their own advantage and benefit as well as the interests of entities expressly covered by the statute." However, the agreements between Bactes and the healthcare providers merely required Bactes to gather the requested medical records and make them available for inspection and/or copying, not to provide photocopies to attorneys. Bactes informed attorneys they had the option of inspecting the records, having another service copy them, or entering into a separate principal-agent agreement with Bactes to photocopy the records. Bactes did not violate section 1158 by charging attorneys more than the statutory rate for providing photocopying services because that limitation applies only to healthcare providers and their agents, and not to agents of the requesting attorneys.

Providing wound care (but not basic needs) to an elder does not establish the custodial relationship required for Elder Abuse Act liability

Oroville Hospital v. Superior Court of Butte County (Ambrose) (Jan. 26, 2022) __ Cal.App.5th __, 2022 WL 224494

Oroville Hospital nurses provided Eyvon Ambrose with in-home care for her pressure injury. Ambrose's granddaughter provided for her basic needs, such as dressing, eating, taking medications, and using the restroom. When her pressure wound worsened and she sustained additional wounds, Ambrose was admitted to the hospital where she ultimately died. Ambrose's heirs sued Oroville Hospital for neglect, recklessness, and other theories under the Elder Abuse Act (Welf. & Inst. Code, §15600 et seq.), among other claims. The trial court denied the Oroville Hospital's motion for summary adjudication of the elder abuse claim, ruling there was a triable issue whether it "had a substantial caretaking or custodial relationship" with Ambrose. Oroville Hospital petitioned for writ relief.

The Court of Appeal granted writ relief. Relying on Winn v. Pioneer Medical Group, Inc. (2016) 63 Cal.4th 148, the court explained that Oroville Hospital need not assume all responsibility for an elder's needs to be deemed a caretaker or custodian. Rather, what matters is whether it assumed a significant measure of responsibility for attending to basic needs that a competent, able-bodied adult would ordinarily manage

without assistance. Here there was no evidence that Oroville Hospital established such a relationship. Ambrose's general vulnerability did not mean that anyone who provided her with a service entered into a caretaking or custodial relationship with her. And merely providing wound care did not satisfy a "basic need" envisioned by the Elder Abuse Act. Accordingly, the trial court erred by denying summary adjudication of the elder abuse cause of action.

Providers may potentially compel patients without health insurance to assign their auto insurance medical payment benefits (but not underinsured motorist benefits)

Dameron Hospital Assn. v. AAA Northern Cal. (Jan. 5, 2022, C086518) __ Cal.App.5th __, 2022 WL 304640

Five patients who were treated at Dameron Hospital Association (Dameron) for vehicle accident injuries had automobile insurance policies issued by California State Automobile Association Inter-Insurance Bureau (CSAA) that included both medical payment (MP) and uninsured and underinsured motorist (UM) benefits. Dameron required each patient to sign a Conditions of Admissions (COA) form that assigned to Dameron "all insurance benefits of any kind . . . due for hospital and/or health care services." CSAA paid UM and MP benefits to the five patients and did not respond to Dameron's demands for direct payment based on the assignments. Dameron then sued CSAA alleging breach of contract for failing to pay the assigned UM and MP benefits. The trial court granted summary judgment for CSAA, and Dameron appealed.

The Court of Appeal affirmed as to all but one patient. First, the court held that the assignments by two patients with health insurance were void for lack of lawful consideration. (Civ. Code, §§ 1607, 1667.) The court reasoned that, because patients with health insurance are protected from healthcare care provider collection attempts (see Health & Saf. Code § 1379; Prospect Medical Group, Inc. v. Northridge Emergency Group (2009) 45 Cal.4th 497), Dameron's attempt to extract payments in excess of the amounts negotiated with the patients' health insurers violated public policy.

The court next held that Dameron could not enforce an assignment of policy benefits under a COA executed by the mother of a child patient because the patient's grandmother held the CSAA policy and had not authorized the assignment.

Finally, the court held that Dameron could potentially rely on COAs executed by patients without health insurance to collect MP benefits, but not UM benefits, under their automobile insurance policies. The court concluded the COAs were adhesion contracts enforceable only to the extent they reflected an ordinary person's reasonable expectations. Insureds reasonably expect to recover UM benefits directly to compensate for their bodily injuries. In contrast, a factfinder could determine that insured patients reasonably expected their MP benefits to be assigned to a health care provider.

"Abandonment of patient" jury instruction inapplicable where physician ensured continuity of care

Zannini v. Liker (Jan. 31, 2022, B302404) __ Cal.App.5th __ [2022 WL 278531]

Dr. Mark Liker performed cervical spine surgery on Ronald Zannini. An MRI taken three days after surgery showed no abnormalities, but a week later Zannini was admitted to the ER with acute paralysis. The ER physician managing Zannini's care consulted with Dr. Liker, an on-call neurosurgeon, and an on-call neurologist. Dr. Liker, who was flying out of town on a red-eye that night, contacted the on-call neurosurgeon to discuss the differential diagnoses and to ensure he was ready to respond as needed once the results of a second MRI were known. Dr. Liker also discussed the care plan with Zannini's wife before leaving. The second MRI revealed a rare late-developing spinal blood clot. Zannini underwent another surgery, but remained paralyzed. The Zanninis later sued Dr. Liker for medical malpractice, alleging he negligently left the hospital before reviewing the MRI results and performing surgery. The jury returned a defense verdict. The Zanninis appealed, alleging instructional error.

The Court of Appeal affirmed, holding the trial court correctly refused to instruct the jury on CACI No. 509 (abandonment of patient) because that instruction was not supported by the evidence. The court explained that Dr. Liker had not taken over Zannini's care (which the ER physician was managing); he had informed Mrs. Zannini about his scheduled trip and that the on-

call neurosurgeon was available to perform any needed surgery; he remained available to discuss diagnoses and treatment with the care team; and he left the premises only after a plan for Zannini's treatment was in place. The court also concluded that plaintiffs' theory of the case was adequately addressed by giving CACI No. 502 (standard of care for medical specialists). That instruction allowed the jury to find negligence based on Dr. Liker's departure from the hospital prior to another neurosurgeon's physical arrival in the event they had accepted the testimony of the plaintiffs' expert rather than the defense expert.

MICRA applies to inadequately supervised physician assistants

Lopez v. Ledesma (Feb. 24, 2022, S262487) __ Cal.5th __ [2022 WL 553421]

Two physician assistants (PAs) failed to timely diagnose a malignant melanoma on an infant who later died. Marisol Lopez, the infant's mother, sued the PAs and their supervising physicians for medical malpractice and wrongful death. The trial court found for Lopez, but reduced her $4.25 million noneconomic damages award to $250,000 pursuant to the cap in the Medical Injury Compensation Reform Act (MICRA). (Civ. Code, § 3333.2.) Lopez appealed, arguing that the PAs' conduct fell within MICRA's exclusion for conduct that is outside "the scope of services for which the provider is licensed," or "within any restriction imposed by the licensing agency or licensed hospital," because they were practicing with inadequate supervision. The Court of Appeal affirmed, holding that PAs act within the scope of their licenses if they have a legally enforceable agency agreement with a supervising physician, regardless of the quality of that supervision. Lopez petitioned for Supreme Court review.

The Supreme Court granted review and affirmed, holding that "section 3333.2 applies to a physician assistant who has a legally enforceable agency relationship with a supervising physician and provides services within the scope of that agency relationship . . ., even if the physician violates his or her obligation to provide adequate supervision." The Court rejected Lopez's argument that adequate supervision was required. The Court explained that the relevant statutory definition of "supervision" is met when a physician undertakes legal responsibility for a PA. Lopez's proposed standard would undermine MICRA's goal of reducing malpractice premiums and would lead to inconsistent damages awards whenever a plaintiff sued both a supervising physician (who is covered by MICRA) and a PA (who would not be covered by MICRA under Lopez's proposed test). Furthermore, PAs have limited ability to control how they are being supervised; deciding whether to apply MICRA based on whether a PA knew that supervision was inadequate would complicate litigation and reduce the predictability of results, contrary to MICRA's goals. The Court also reasoned that MICRA was intended to apply when healthcare providers provided inadequate services, provided those services were within the scope of their license, and a PA "does not render services 'within [a] restriction imposed by the licensing agency' (citation) simply by engaging in unprofessional conduct, such as the noncompliance with supervisory regulations . . . ." Put simply, the fact that a PA's "conduct could give rise to professional discipline or criminal liability does not render MICRA inapplicable."

The PREP Act neither requires providers to work under federal officials nor completely preempts state law

Saldana v. Glenhaven Healthcare LLC, __ F.4th __, 2022 WL 518989 (9th Cir. Feb. 22, 2022)

Ricardo Saldana died from COVID-19 while living at a Glenhaven nursing home. His relatives sued Glenhaven in superior court for elder abuse, willful misconduct, negligence, and wrongful death. Glenhaven removed the case to federal district court, which remanded for lack of subject matter jurisdiction. Glenhaven appealed, arguing that federal jurisdiction existed due to (1) the federal officer removal statute, 28 U.S.C § 1442, (2) complete preemption of Plaintiffs' claims under the Public Readiness and Emergency Preparedness (PREP) Act, 42 U.S.C. §§ 247d-6d, 247d-6e, and (3) the complaint's embedded federal question of PREP Act immunity.

The Ninth Circuit affirmed. First, federal officer removal jurisdiction was lacking. Although the PREP Act and related federal regulations impose extensive COVID-related nursing home safety obligations—and nursing homes are designated as "critical infrastructure" entities by the Cybersecurity and Infrastructure

Security Agency—Glenhaven was not acting under a federal official and performing a duty of the federal government. Next, the court explained that the PREP Act does not completely preempt state law. There is no indication Congress intended to displace state-law causes of action, nor that Congress provided a substitute cause of action. The PREP Act "is invoked when 'the [HHS] Secretary makes a determination that a disease or other health condition or other threat to health constitutes a public health emergency, or that there is a credible risk that the disease, condition, or threat may in the future constitute such an emergency ....'" 42 U.S.C. § 247d-6d(b)(1). And a provision of the PREP Act confers an exclusive federal claim to remedy certain "willful misconduct." 42 U.S.C. § 247d-6d(a)(1). Congress's provision of that narrow claim (and not others, such as negligence) showed it did not "intend[ ] the Act to completely preempt all state-law claims related to the pandemic." Finally, Glenhaven failed to show an embedded federal question because PREP Act immunity was not an essential element of Plaintiffs' claims. Even the willful misconduct claim addressed just a subset of Glenhaven's actions implicating the PREP Act.

Residential care facility cannot enforce arbitration agreement signed by resident's son absent evidence he was his father's agent

Rogers v. Roseville SH, LLC (Feb. 8, 2022, C089561) __ Cal.App.5th __ [2022 WL 655631], ordered published March 4, 2022

Claude Rogers was a resident of Meadow Oaks of Roseville, a residential care facility for the elderly, when he died of heatstroke after being left outside. His wife and sons sued Meadow Oaks, alleging elder abuse, fraud, and wrongful death. Meadow Oaks moved to compel arbitration based on an agreement signed by Claude's son, Richard. The agreement identified Claude as the resident and Richard as the resident's "representative." Richard's opposition declaration stated that Claude could read, write, and sign documents on his own behalf; Claude did not direct or authorize him to sign any documents; and he received the agreement via email and did not speak with anyone at Meadow Oaks about it. The trial court denied arbitration, finding that Meadow Oaks did not prove Richard was authorized to sign the agreement on Claude's behalf. Meadow Oaks appealed.

The Court of Appeal affirmed, agreeing that there was no evidence Richard acted as Claude's actual or ostensible agent when he signed the arbitration agreement. There was no evidence Claude's conduct justified Meadow Oaks in believing he authorized Richard to sign the agreement, and Richard's conduct alone cannot create an agency relationship. Nor did Claude's inaction—failing to object to Richard signing admissions documents—support an alleged ostensible agency relationship. There was no evidence Claude had previously approved similar acts by Richard, or that Claude was even aware Richard signed the agreement. Finally, relying on Valentine v. Plum Healthcare Group, LLC (2019) 37 Cal.App.5th 1076, the court held that Claude's failure to rescind the agreement, despite having 30 days to do so, did not constitute ratification because there was no evidence Claude knew of the agreement or knew that he had 30 days to rescind it.

Medical malpractice settlement agreement may not prohibit reporting the incident to the Medical Board

Pappas v. Chang (Mar. 3, 2022, A159792, A160293) __ Cal. App.5th __ [2022 WL 620997]

Dr. Chang performed cosmetic surgery on Helena Pappas's eyes. Pappas was dissatisfied with the result and demanded arbitration of her medical malpractice claim against Dr. Chang. At a later mediation, the parties agreed to settle conditioned on a handful of key terms: (1) Dr. Chang would pay Pappas $100,000; (2) Pappas would release all claims; (3) there would be mutual confidentiality; (4) the settlement would be enforceable under Code of Civil Procedure section 664.6; and (5) the parties would execute a formal and more comprehensive settlement agreement. The parties were unable to agree on comprehensive settlement terms. Pappas objected that Dr. Chang's proposed confidentiality provision would prevent her from filing a complaint with the Medical Board in violation of Business and Professions Code section 2220.7, and the proposed payments of $29,999.99 by Dr. Chang's malpractice insurer and $70,000.01 by Dr. Chang personally (despite insurance coverage for the entire $100,000 settlement) was designed to avoid disclosing the settlement to the

Medical Board under Business and Professions Code section 801.01.

Pappas sued Dr. Chang for breach of contract, seeking to enforce the initial settlement agreement under section 664.6. The court denied Pappas's motion, ruling it had no jurisdiction to enforce the settlement agreement because there was no litigation pending at the time of the settlement. The court entered judgment for Dr. Chang following a bench trial, ruling that Pappas's breach of contract claim failed because she had not complied with her own contractual obligation to sign a more comprehensive settlement agreement and release including a provision for mutual confidentiality. Pappas appealed.

The Court of Appeal affirmed. First, the court rejected Pappas's argument that the final confidentiality provision proposed by Dr. Chang violated section 2220.7, because it did not expressly prohibit Pappas from communicating with the Medical Board. The court also rejected Pappas's argument that the confidentiality provision was void because it sought to circumvent section 801.01: the release stated the $100,000 settlement amount, regardless of the fact Dr. Chang's insurer paid $29,999.99 and Dr. Chang paid $70,000.01.

Justice Kline issued a stinging concurring opinion. He concluded that Dr. Chang's proposed settlement payment scheme, and the initial proposed confidentiality clause, were designed to prevent Pappas from reporting Dr. Chang's malpractice to the Medical Board in violation of sections 801.01 and 2220.7. In Justice Kline's view, "[t]he unlawful purpose of the division of the two payments [Dr.] Chang insisted upon speaks for itself, res ipsa loquitor; it is sufficient in and of itself to support a finding of unlawful obstruction of the Medical Practice Act, because no innocent purpose for the subtraction of a cent from the statutory amount that would require reporting of the settlement to the Board can be found in the record or even imagined."