APPELLATE CASE SUMMARIES

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Medical staff credentialing recommendations cannot support a physician's action against a hospital, a separate legal entity

Bichai v. Dignity Health (Feb. 25, 2021, ordered published Mar. 12, 2021, F078658) __ Cal. App.5th __ [2021 WL 948647]

Dr. William Bichai surrendered his medical staff privileges at Mercy Hospital in 2012. He had privileges at San Joaquin Community Hospital (SJC Hospital), but had been on a leave of absence since 2013. In 2016, Dr. Bichai reapplied for medical staff membership at Mercy Hospital. He interviewed with the medical executive committee (MEC) of Mercy Hospital's medical staff and was informed by the chief of staff that he would be granted conditional privileges. Dr. Bichai later got into verbal altercations with doctors at SJC Hospital regarding the treatment of his former patient. The MEC of Mercy Hospital's medical staff then recommended that Mercy Hospital deny Dr. Bichai's reapplication for privileges based on his conduct at SJC Hospital, believing it reflected faulty judgment and an inability to follow rules, regulations, policies, and medical ethics. The Mercy Chief of Staff notified Dr. Bichai of the MEC's recommendation and his right to challenge it by requesting a hearing before a judicial review committee of the medical staff. Dr. Bichai requested the administrative hearing, and then sued both Mercy Hospital and SJC Hospital.

Dr. Bichai's lawsuit alleged, among other things, unfair competition in violation of Business and Professions Code section 17200 and a conspiracy to retaliate against him in violation of Health and Safety Code section 1278.5. Mercy Hospital demurred, asserting that Dr. Bichai failed to exhaust administrative remedies and did not state a valid claim because his complaint rested on the conduct of Mercy Hospital's medical staff, a separate legal entity. The trial court sustained the demurrer. It rejected the failure to exhaust administrative remedies argument (because exhaustion is not required before asserting a section 1278.5 claim), but ruled that Mercy Hospital had not taken any adverse action against Dr. Bichai. Dr. Bichai appealed.

The Court of Appeal affirmed, holding that Dr. Bichai's claims against Mercy Hospital were not ripe. A lawsuit is ripe when a cause of action has accrued, and a cause of action accrues when there is wrongdoing, causation, and harm. Here, there was no wrongdoing by *Mercy Hospital*—it had made no decision based on the MEC's *recommendation* that it deny Dr. Bichai's preapplication for privileges, and the MEC is a separate legal entity whose conduct is not imputed to the hospital. Accordingly, any claims Dr. Bichai might have against Mercy Hospital had not accrued and thus were not ripe. The Court rejected Dr. Bichai's contention that *Armin v. Riverside Community Hospital* (2016) 5 Cal.App.5th 810 had decided that wrongdoing by a medical staff is wrongdoing by the hospital. The court also rejected Dr. Bichai's claim that the trial court erred by failing to grant him leave to amend his complaint because the trial court had given leave.

Administrative law judges may not issue evidentiary sanctions to remedy discovery abuses

Podiatric Medical Board v. Superior Court (Mar. 30, 2021, A155260)__ Cal.App.5th __ [2021 WL 1183162]

Dr. Peter Redko designated Dr. Thomas Chang as his standard of care expert witness in a disciplinary proceeding before the Podiatric Medical Board. The Board issued a subpoena seeking production of all documents and records Dr. Chang had relied on in forming his expert opinion and all communications between him and Dr. Redko's defense counsel. Dr. Redko moved unsuccessfully to quash the subpoena, claiming it sought production of privileged information. When Dr. Chang declined to comply with the subpoena, the Board moved to exclude his testimony, but did not move for an order compelling production. The presiding ALJ granted the motion, ruling that Dr. Chang had refused to comply with the subpoena " 'without any reasonable basis' " and prohibiting him from testifying. At the hearing, a different ALJ sustained the Board's charges against Dr. Redko. The trial court granted Dr. Redko's petition for writ of administrative mandate, ruling that "the Administrative Procedure Act (APA) governing contested adjudicatory hearings (Gov. Code, § 11400 et seq.) do[es] not expressly provide for imposition of witness exclusion as a discovery sanction." The Board appealed.

The Court of Appeal affirmed. First, the court rejected the Board's argument that the ALJ was authorized to exclude Dr. Chang's testimony as an implied power relating to the ALJ's statutory authority to the conduct the hearing (see Gov. Code, §11512), because the ruling was made *prior* to the hearing and by a different ALJ than the one who conducted the hearing. The court also reasoned that it would be improper to imply authority to order evidentiary sanctions when the APA expressly authorizes certain remedies (including orders compelling production, monetary sanctions, and contempt sanctions), but does *not* authorize evidentiary sanctions. Finally, the court rejected the Board's analogy to the implied authority possessed by federal ALJs and superior court judges, since their powers derive from different sources.

CalPERS's health plan enrollment forms satisfy Knox-Keene Act arbitration clause notice requirements

Kuntz v. Kaiser Foundation Hospital (Apr. 12, 2021, C087967) __ Cal.App.5th __

Edward Kuntz's estate and immediate family sued Kaiser for elder abuse, negligent infliction of emotional distress, and wrongful death. Kaiser petitioned to stay the action and compel arbitration, asserting that Kuntz had been enrolled in its health plan pursuant to his wife's employment under a California Public Employees' Retirement System (CalPERS) Agreement and that an arbitration provision in that plan required binding arbitration. The trial court granted Kaiser's petition as to the elder abuse cause of action, stayed the other causes of action, and ultimately entered judgment in favor of Kaiser. Plaintiffs appealed.

The Court of Appeal affirmed. Plaintiffs had argued that, under the Secondary Evidence Rule (Evid. Code, § 1523, subd. (a)), Kaiser was required to (but did not) produce Kuntz's actual enrollment form. The court disagreed, holding that the enrollment form would prove only that Kuntz sought to enroll in the health plan while Kaiser's evidence of Kuntz's membership history records and CalPERS's practices of advising members that the Kaiser plan required binding arbitration of claims were adequate to prove Kuntz's enrollment at the relevant times and that a valid arbitration agreement existed. The court also held that Kaiser did not need to comply with the arbitration notice requirements of Health and Safety Code section 1363.1 because CalPERS administers its own enrollment process using its own forms. Kaiser is not allowed to substitute its own enrollment forms or to modify CalPERS's forms. Kuntz's enrollment materials were therefore disseminated by CalPERS pursuant to Government Code section 22863, and thus were deemed to satisfy the notice requirements of Health and Safety Code section 1363.1 pursuant to Government Code section 22869.

District courts lack jurisdiction to award a Medicare provider injunctive relief until administrative remedies are exhausted

Odell v. U.S. Dep't of Health & Human Servs., ___ F.3d ___, 2021 WL 1621311 (9th Cir., Apr. 27, 2021)

Medicare contractors determine provider reimbursement eligibility based on several sources, including

local coverage determinations (LCD). A provider can challenge a contractor's denial of reimbursement through four levels of administrative review. Here, a contractor repeatedly invoked a particular LCD in denying reimbursement claims by Dr. Robert Odell, who treats Medicare patients suffering from a neurological pain disorder with a combination of nerve blocks and electrical stimulation. Dr. Odell successfully challenged some of the denials via administrative review. He then sued the Secretary of Health and Human Services to enjoin the contractor from applying that LCD to deny his reimbursement claims.

The Secretary moved to dismiss for lack of subject-matter jurisdiction, arguing that Dr. Odell was required to (yet did not) exhaust his administrative remedies before seeking judicial review. The district court found that Dr. Odell had failed to exhaust, but excused the failure on the ground it was futile to challenge hundreds of denials individually before seeking injunctive relief. The court then denied the Secretary's motion to dismiss and granted the injunction. The Secretary appealed.

The Ninth Circuit vacated and remanded for dismissal, holding that the district court lacked subject-matter jurisdiction. The Social Security Act, incorporated into the Medicare statute, provides the exclusive mechanism for review of the agency's decision. Under the Act, judicial review is available only after a final agency decision. Here, in bypassing full administrative review and seeking a blanket injunction, Dr. Odell failed to meet the presentation requirement for his claims. The district court lacked jurisdiction to adjudicate past claims because Dr. Odell failed to challenge any particular adverse "final decision" by the agency. The district court also lacked jurisdiction to furnish prospective relief as to his *future* claims because they had not yet been presented to the agency. The court held that jurisdiction to adjudicate unpresented claims was lacking even if those claims appear to be identical to ones the agency had previously considered. The court rejected Dr. Odell's argument that the presentation requirement improperly deprived him of any opportunity for review, holding that the existing administrative channels were adequate to challenge future claims. Finally, the court recognized that the claim-by-claim administrative review process imposes a high cost on individuals like Dr. Odell, who must challenge each denial individually, but concluded that "[w]hether that price is worth paying is a judgment for Congress to make."

Application to reactivate Medicare billing privileges sought a new "enrollment," triggering a new (rather than retroactive) effective billing date

Goffney v. Becerra, __ F.3d __, No. 19-56368, 2021 WL 1682249 (9th Cir. Apr. 29, 2021)

Dr. Willie Goffney is a surgical oncologist who has provided services to Medicare patients since 1991. In 2005, Dr. Goffney stopped receiving reimbursement payments for his Medicare claims, but continued to provide services. In 2012, Dr. Goffney was informed that his billing privileges had been deactivated since 2008 for not submitting a claim for more than a year. In 2015, he filed a Medicare Enrollment Application to reactivate his billing privileges, seeking to maintain his original 1991 effective billing date and to be paid for the services he provided while his Medicare privileges were inactive. Although his application was approved, Dr. Goffney's Medicare contractor assigned a new effective date of August 31, 2015, which precluded him for being reimbursed for the prior services. The contractor categorized Dr. Goffney's reactivation application as an "enrollment application" under 42 C.F.R. § 424.520(d), which defines the effective date for billing as the application's approval date.

Dr. Goffney appealed through the administrative channels, all of which affirmed the contractor's decision. Goffney then sought review in federal district court, which likewise affirmed the contractor's decision. The district court explained that the regulation's silence about whether "effective dates" could be set at a past date created an ambiguity, meaning the agency's interpretation was entitled deference and their interpretation of the regulation was reasonable. Goffney appealed.

The Ninth Circuit affirmed, concluding the Health and Human Services Departmental Appeal Board had reasonably interpreted Goffney's reactivation request as an "enrollment application" under section 424.520(d). First, the court found that section 424.520(d) was "genuinely ambiguous" as to whether *reactivation* applications should be

classified as *enrollment* applications that trigger new effective dates, and other regulations do not resolve that ambiguity. The Board's reasonable interpretation of the regulation qualified for deference under *Auer v. Robbins*, 519 U.S. 452, 461 (1997), and *Kisor v. Wilkie*, 139 S. Ct. 2400 (2019). First, the Board's decision was an authoritative "official" statement of the agency. Second, the Board's decision implicated its substantive expertise in administering the Medicare program. Third, the interpretation reflected a "fair and considered judgment" since it was consistent with certain regulations and a CMS contractor guidebook.

CMA lacks standing to seek injunction against health plan that inhibits in-network physicians from referring patients to out-of-network physicians

California Medical Association v. Aetna Health of California Inc. (2021) __ Cal.App.5th__ [2021 WL 1660614]

The California Medical Association (CMA) is a nonprofit, professional organization that advocates on behalf of its physician members, including Aetna in-network physicians. CMA sued Aetna under the Unfair Competition Law (UCL) (Bus. & Prof. Code, § 17200), seeking to enjoin it from inhibiting in-network physicians from referring their patients to out-of-network providers. The CMA alleged that Aetna's policy unlawfully interfered with its members' ability to exercise independent medical judgment and violated various California statutes.

Aetna moved for summary judgment, contending CMA lacked standing to bring a nonclass representative UCL action because it was not directly harmed by Aetna's policy. CMA argued it had standing because it had diverted substantial resources to investigate Aetna's policy and to assist its member physicians who had been harmed. The trial court granted Aetna's motion, ruling that CMA had failed to show a direct injury, or loss of money or property, as a UCL claim requires.

The Court of Appeal affirmed, holding that an organization must show it directly suffered economic loss to have standing under the UCL. In 2004, Proposition 64 amended the UCL to require that plaintiffs show they "suffered injury in fact and [have] lost money or property as a result of the unfair competition." (Bus. & Prof. Code, § 17204.) The court held that the amended UCL required the CMA to show that it—not just its members—lost money or property in order to seek injunctive relief. The court then rejected CMA's argument that its diversion of resources was a sufficient injury to confer UCL standing. Because CMA's purpose is to advocate on behalf of its members, the time it spent on Aetna's policy was typical of the work CMA already does. Additionally, CMA had brought a representative action on behalf of its members, rather than an action seeking redress for its own harm. Accordingly, CMA lacked standing because it failed to show that it personally suffered any direct economic loss.

Doctrine of primary jurisdiction, not exhaustion of remedies, warrants staying litigation to obtain a decision on issues within an agency's expertise

Bradley v. CVS Pharmacy, Inc. (May 28, 2021, B308040) __ Cal. App.5th __ [2021 WL 2176797]

CVS Pharmacy stopped filling controlled substance prescriptions for Dr. Kenneth Bradley, a pain management specialist, citing concerns about his prescription patterns. Dr. Bradley sued CVS, seeking an injunction compelling it to fill his prescriptions. The trial court denied the injunction and stayed the litigation, ruling that Dr. Bradley had to exhaust his administrative remedies before the California State Board of Pharmacy. The trial court reasoned that "an order requiring CVS to honor particular prescriptions would involve judgments concerning the statutory obligations of pharmacists that the Board is both expected and equipped to resolve." Dr. Bradley appealed the denial of injunctive relief and sought review of the exhaustion rationale.

The Court of Appeal affirmed on the "alternative but closely related ground" of primary jurisdiction. The court explained that the exhaustion doctrine applies when a claim is cognizable in the first instance by an administrative agency *alone*, while the primary jurisdiction doctrine applies when a claim originally cognizable in the courts involves issues within the special competence of an administrative body. The exhaustion doctrine thus applies in any of three situations: (1) a statutory scheme establishes a quasi-judicial administrative tribunal to adjudicate remedies; (2) a private or public

organization offers an internal remedy procedure; or (3) a public agency possesses specialized and specific expertise that particularly equips it to resolve the dispute. If the exhaustion doctrine applies, a lawsuit before a court should be dismissed. In contrast, the doctrine of primary jurisdiction permits, but does not require, courts to take advantage of administrative expertise by staying a lawsuit pending an administrative decision. Here, the exhaustion doctrine did not apply because the Pharmacy Board's governing statutes did not task it with responsibility to adjudicate individual claims for relief against pharmacists—thus it was not the *exclusive* forum for resolving Dr. Bradley's claims. However, his claims did implicate the primary jurisdiction doctrine because they presented issues within the Board's particular expertise, there is a need for regulatory uniformity regarding the adjudication of such claims, and monetary damages would provide Dr. Bradley with an adequate remedy should he eventually prevail. Therefore, the trial court properly exercised its discretion to deny the injunction and stay the litigation until the Board weighed in on the merits of Dr. Bradley's claims.

Medical records pertaining to substance abuse treatment are protected from discovery by the patients' right to privacy

County of Los Angeles v. Superior Court (Johnson & Johnson) (June 15, 2021, D077794) __ Cal. App.5th __ [2021 WL 2426564]

Various counties and cities (the People) sued certain pharmaceutical companies (Pharma) for false and misleading statements made in a deceptive opioid marketing scheme that caused a public health crisis. Pharma sought to compel production of the medical records of more than 5,000 patients diagnosed with or treated for opioid abuse, addition, and overdoses at government facilities. The trial court ordered production, provided the records were first de-identified by a third-party vendor that itself would be subject to a protective order. The People sought writ relief, asserting the patients' right to privacy.

The Court of Appeal granted writ relief. Applying *Hill v. National Collegiate Athletic Assn.* (1994) 7 Cal.4th 1, the Court first determined that the order threatened "serious intrusion" into the patients' well-settled privacy rights, which state and federal law strongly protect. The Court of Appeal observed that the patients had a reasonable expectation of privacy under the circumstances since they had never taken litigation positions putting their private medical information at issue. The privacy invasion was serious due to the sensitive nature of substance abuse treatment, the lack of notice to the patients, the broad scope of disclosure, and the possibility that the vague protective order might not prevent inadvertent or intentional disclosure, possibly through insufficient de-identification protocols to prevent reidentification via data mining. The court then held that Pharma failed to identify countervailing interests in disclosure that outweighed these serious privacy concerns. The Court relied heavily on *Board of Registered Nursing v. Superior Court* (2021) 59 Cal.App.5th 1011, its prior decision in the same litigation holding that the defendants' interest in discovering whether their drugs were associated with opioid abuse and overdoses, and whether patients were engaged in illicit activities such as securing drugs from unauthorized prescribers, was insufficient to overcome the patients' privacy rights.

States and individuals lacked standing to challenge Affordable Care Act's individual mandate in an effort to strike down the Act

California v. Texas, 593 U.S. __, 2021 WL 2459255 (June 17, 2021)

The Patient Protection and Affordable Care Act ("ACA") required most Americans to have minimum essential health insurance coverage (the individual mandate) and to pay money if they failed to do so. In *National Federation of Independent Businesses v. Sebelius*, 567 U.S. 519 (2012), the Court upheld the mandate as a constitutional exercise of Congress's power to tax. The 2017 ACA amendments essentially removed this tax by setting its amount to $0. In a suit against the United States and federal officials, Texas (along with 17 other States and two individuals) claimed that, because no payment is required, the mandate (codified at 26 U.S.C. § 5000A(a)) is unconstitutional. They sought both declaratory and injunctive relief invalidating the ACA on the ground it was inseverable from the unlawful mandate.

The district court held that the

individual plaintiffs had standing and that § 5000A(a) was both unconstitutional and inseverable from the rest of the ACA, therefore toppling the entire ACA. The Fifth Circuit agreed as to standing and unconstitutionality, but remanded for further analysis of severability. California and other States intervened to defend the ACA's constitutionality and to seek Supreme Court review (when the federal government would not).

In a 7-2 decision, the Supreme Court reversed, holding that neither the individual nor the State plaintiffs had standing to challenge the now-toothless $0 tax because it did not aggrieve them. "Neither the individual nor the state plaintiffs have shown that the injury they will suffer or have suffered is 'fairly traceable' to the 'allegedly unlawful conduct' of which they complain." As a result, the Court did not reach the merits of the constitutional challenge to the individual mandate or determine whether the individual mandate was severable from the rest of the ACA.

The individual plaintiffs had claimed they felt compelled by the mandate to purchase health insurance. However, the government could no longer enforce the mandate because Congress had zeroed out the tax. Therefore, the individual plaintiffs could not show that a government action caused them to purchase health insurance, disabling them from showing the kind of concrete injury necessary for Article III standing.

Similarly, the court rejected the State plaintiffs' argument that the mandate had caused increased enrollment in state health programs, adding to their fiscal burden. The Court held that "[n]either logic nor evidence suggests that an unenforceable mandate will cause state residents to enroll in valuable benefits programs that they would otherwise forego."

In a concurrence, Justice Thomas agreed that plaintiffs had not demonstrated standing, but left open the possibility that a future plaintiff could do so. Both Justice Thomas and the majority declined to consider plaintiffs' belated standing argument based on the inseverability of the Act.

Justice Alito, joined by Justice Gorsuch, dissented. Justice Alito wrote that the majority evaded the constitutional issue to save the ACA and that the ACA was "clearly unconstitutional."

Physician assistant's unsupervised liposuctions and "Director of Surgery" title misled patients and was unauthorized practice of medicine

Davis v. Physician Assistant Board (July 2, 2021, C084559) _ Cal. App.5th _ [2021 WL 2767339]

Rodney Davis, a physician assistant, learned to perform liposuction while working under a physician. Davis later opened his own practice and hired Dr. Jerrell Borup to be his supervising physician and "Medical Director." Dr. Borup had not practiced medicine in 12 years or performed liposuction. Davis gave himself the title of "Director of Surgery" and performed all liposuction procedures. The Physician Assistant Board accused Davis of unlicensed practice of medicine, negligence, and false or misleading advertising. An administrative law judge found that Davis created a practice that appeared legitimate, but allowed him to operate autonomously; that Dr. Borup lacked relevant experience and failed to meet supervising physician requirements; and that Davis provided materials, including a consent form, that led patients to believe he was a doctor. The Board adopted the ALJ's findings and revoked Davis's license. The superior court denied Davis's writ petition and he appealed.

The Court of Appeal affirmed. The court first held that the unlawful practice of medicine laws apply to physician assistants who operate without physician supervision. A supervising physician may delegate tasks consistent with his specialty, but Dr. Borup had never performed surgery and had taken only a two-day course in liposuction, thus he was not competent to delegate liposuction tasks to Davis. The court rejected Davis's contention that Dr. Borup's failure to supervise could not form the basis of a claim *against Davis*, noting that a physician assistant is prohibited from practicing without adequate supervision, which was Davis's purpose in hiring Dr. Borup. Davis claimed he never intended to practice medicine without a license, but the court held a finding of intent is unnecessary to impose discipline. Davis's attempted good-faith defense—he had consulted the California Physician Assistant's and Supervising Physician's Handbook

and its author—did not immunize him from discipline because of the Board's central mission to protect the public.

Additionally, the court held the ALJ's finding of false advertising was supported by Davis's misleading statements, especially his adopted title of "Director of Surgery." Statements about who would perform surgeries supported the ALJ's finding that Davis engaged in repeated acts of negligence and failed to obtain informed consent. Finally, the court upheld the revocation of Davis's license. The court determined that substantial evidence supported the ALJ's determination that the public would not be protected if Davis retained his license, and rejected Davis's contention that the ALJ ignored mitigating factors.

Statute criminalizing willful misgendering of transgender residents in long-term care violates First Amendment, but provision requiring gender-based room assignments in accord with resident's gender identity does not violate equal protection

Taking Offense v. State (July 16, 2021, C088485) __ Cal. App.5th __ [2021 WL 3013112]

In 2017, California enacted the Lesbian, Gay, Bisexual, and Transgender Long-Term Care Facility Residents' Bill of Rights. (Health & Saf. Code, § 1439.51.) Taking Offense, an unincorporated association, petitioned for a writ of mandate asserting facial constitutional challenges to two provisions: (1) the pronoun provision (§ 1439.51, subd. (a)(5)), which makes it a crime for long-term care employees to "willfully and repeatedly" fail to use a resident's preferred name and pronoun that they know; and (2) the room-assignment provision (§ 1439.51, subd. (a)(3)), which makes it unlawful for a facility that uses gender-based room assignments to non-consensually assign a transgender resident a room not matching their gender identity. Taking Offense alleged the pronoun provision is a content-based speech restriction that violates employees' free speech rights, and the room assignment provision violated nontransgender residents' equal protection rights because they lack the same opportunity to choose whether to be assigned a roommate based on their gender identity or their sex assigned at birth. The trial court denied the petition and Taking Offense appealed.

The Court of Appeal reversed in part and affirmed in part, holding that the pronoun provision violated the First Amendment but the room assignment provision was not unconstitutional. The court subjected the content-based restriction in the pronoun provision to strict scrutiny because its enforcement required analysis of an employee's speech and the Legislature's reason for prohibiting it. The court declined to rely on the "captive audience" doctrine to apply a lesser standard because neither employees nor residents could readily express their views elsewhere. Applying strict scrutiny, the court held that the State had not narrowly tailored the pronoun provision to achieve its compelling interest in eliminating discrimination in long-term care facilities. The pronoun provision burdened more speech than was necessary by criminalizing speech that did not amount to actionable harassment, including isolated instances of misgendering, regardless whether the resident was negatively affected or even aware of the remarks.

The court also applied strict scrutiny to the room-assignment provision. The court first determined that all residents were similarly situated because they were subject to a facility's gender-based room assignments, while the law classifies residents based on transgender status. The court next concluded that the general rule that rooms be assigned based on gender identity does not provide special rights to transgender residents; it merely clarifies that gender-based room assignments must be made in accordance with a resident's gender identity, rather than their sex assigned at birth. The court also held that the consensual exception permits a facility to accommodate a transgender resident's request without creating a right that any roommate request be honored. Thus, the provision was not a *facially* unconstitutional gender-based classification. A two-justice concurring opinion explained that the room-assignment provision could later be challenged as applied if evidence showed the exception was being applied selectively, rather than uniformly, in a long-term care facility.

Medicare's notice-and-comment provision does not apply to local coverage determinations

Agendia, Inc. v. Becerra, __ F.4th __, 2021 WL 3011982 (9th Cir. July 16, 2021)

The Department of Health and Human Services reimburses medical providers for the cost of items and services that are "reasonable and necessary" for the treatment of Medicare beneficiaries. HHS employs private Medicare administrative contractors (MACs) to process providers' claims and make initial reimbursement determinations. To promote consistency, MACs may issue "local coverage determinations" that specify whether and when certain items or services will be reimbursed.

Agendia submitted claims for reimbursement for molecular diagnostic tests, which a MAC denied based on a local coverage determination that such tests were not reasonable and necessary. Agendia sued the HHS, arguing that the denial was improper because the local coverage determination had been issued without notice and opportunity for comment, in violation of the Medicare Act, 42 U.S.C. § 1395hh. Agendia also argued that the Medicare Act and its implementing regulations unconstitutionally delegate regulatory authority by permitting MACs to issue local coverage determinations. The district court rejected Agendia's constitutional challenge, but agreed with its statutory argument, ruling that local coverage determinations require notice and comment opportunities. The district court granted summary judgment for Agendia because no such opportunities had been provided. The HHS appealed.

The Ninth Circuit reversed in a split decision. The majority held that local coverage determinations are not subject to the § 1395hh notice-and-comment process because they do not "establish[] or change[] a substantive legal standard," the statutory trigger for the notice-and-comment process. The Medicare Act addresses whether an item or service is "reasonable and necessary," and a local coverage determination does not establish or change that standard. Although HHS officials must consider the local coverage determination, it is not binding. A local coverage determination is therefore valid without undergoing the § 1395hh notice-and-comment process. The majority also rejected Agendia's unconstitutional delegation argument because local coverage determinations are not binding and MACs function subordinately to the HHS officials implementing Medicare.

The dissenting judge would have held that local coverage determinations are subject to the Medicare Act's notice and comment provision and urged the U.S. Supreme Court to address this "important and unresolved issue."

Anti-SLAPP statute applies to some (but not all) aspects of peer review proceedings

Bonni v. St. Joseph Health System (July 29, 2021, S244148) __ Cal.5th __ [2021 WL 3201090]

Dr. Aram Bonni sued two hospitals under Health and Safety Code section 1278.5, which prohibits health facilities from retaliating against medical staff members for presenting grievances, complaints, or reports to the facility or its medical staff. Dr. Bonni alleged the hospitals retaliated against him by summarily suspending his medical staff privileges and initiating peer review proceedings against him after he reported safety concerns; he had experienced patient complications in successive surgeries involving robotic equipment. The hospitals moved to strike the retaliation causes of action under the anti-SLAPP statute (Code Civ. Proc., § 425.16), arguing that the claims arose from protected peer review proceedings. The trial court granted the hospitals' motion, ruling that the gravamen of the retaliation claims were based on protected peer review activities. The Court of Appeal reversed. Applying *Park v. Board of Trustees of California State University* (2017) 2 Cal.5th 1057, the court held that the anti-SLAPP statute does not protect actions undertaken with retaliatory motive. The Supreme Court granted review.

The California Supreme Court agreed in part with the Court of Appeal. The Supreme Court explained that, for anti-SLAPP purposes, each act or set of acts alleged in a complaint must be analyzed separately to determine whether protected activity forms the basis of the claim, or is merely incidental or collateral to that claim. The Court agreed that medical peer review is a protected activity under *Kibler v. Northern Inyo County Local Hospital Dist.* (2006) 39 Cal.4th 192, but only up to a point. The Court clarified that, under *Park*, the anti-SLAPP statute protects only speech and petitioning activity taken in

connection with peer review that is the alleged wrongdoing. Thus, while the anti-SLAPP statute applies to alleged *statements* made in a peer review proceeding, and to hospitals' required reporting of any decision to the Medical Board and a national database, the anti-SLAPP statute does not apply to final disciplinary decisions. Without addressing Evidence Code section 1157, the Supreme Court stated that Dr. Bonni could rely on protected statements made during peer review proceedings as evidence of the hospitals' alleged improper motive for imposing discipline. Having determined that the hospitals could not prevail entirely under the first step of anti-SLAPP analysis, the Supreme Court remanded for further analysis under the second step—whether Dr. Bonni had established "minimal merit" regarding his surviving claims.

County properly withheld COVID-19 outbreak locations from news organizations because disclosure would undermine contact tracing

Voice of San Diego v. Superior Court (July 16, 2021, D078415) __ Cal. App.5th __ [2021 WL 3162604]

News organizations sought records from San Diego County under the Public Records Act regarding the exact locations of COVID-19 outbreaks. The County produced some information—the outbreak city, number of cases, deaths, dates, and sector (such as skilled nursing facility, restaurant/bar, church, gym, etc.), but redacted other information, including the exact name and address of an outbreak location. The news organizations filed a petition for writ of mandate, seeking to compel production of the unredacted spreadsheet under the Public Records Act. (Gov. Code, § 6250 et seq.) The County opposed the petition, arguing that the public's interest in nondisclosure outweighs the news agencies' interest in disclosure. (*Id.* § 6255, subd. (a).) The County offered the uncontradicted declaration of its public health officer, who explained that disclosure would chill the public's willingness to cooperate with contact tracing efforts. The health officer's declaration also explained that the County must take reasonable efforts to protect persons' medical privacy, and that publication of specific outbreak locations would not impact the spread of disease. The trial court denied the petition, and the news organizations petitioned for writ relief.

The Court of Appeal affirmed, holding that the County convincingly showed that its ability to conduct effective contact tracing during a deadly pandemic outweighed the news agencies' interest in obtaining information about exact outbreak locations. The court rejected the news agencies' argument that the County's evidence was speculative, noting that the public health officer's uncontradicted opinion that disclosure of outbreak locations would undermine contact tracing efforts was based on her expertise and her concrete experience combatting the pandemic. The court also rejected the news agencies' claim that disclosure of outbreak location information would benefit public health based on the County's uncontradicted evidence that disclosure would not help anyone avoid COVID. Finally, the court held that the news agencies failed to explain how disclosure of specific outbreak locations would improve the public's ability to assess the County's pandemic response.

A federally qualified health center's community outreach expenses to increase utilization are not reimbursable under Medi-Cal

Family Health Centers of San Diego v. State Department of Health Care (July 6, 2021, C089555) __Cal.App.5th.__ [2021 WL 3240274] [ordered published July 30, 2021]

Family Health Centers of San Diego operates a federally qualified health center (FQHC) that provides various medical services to its patients, including Medi-Cal beneficiaries. An FQHC can receive grants under the Public Health Service Act (42 U.S.C. § 201 et seq.) and can seek reimbursement under Medi-Cal for certain expenses, including reasonable costs directly or indirectly related to patient care. Family Health sought reimbursement from Medi-Cal for nearly $80,000 of salary and benefit expenses incurred for required community outreach efforts aimed at increasing patient utilization of available services. The State Department of Health Care Services (DHCS) disallowed reimbursement after determining that the expenses were not tied closely enough to patient care to be reimbursable. Family Health's administrative appeals were rejected by a hearing officer, an ALJ, and the

Chief ALJ. Family Health then filed a petition for writ of mandate, which the trial court denied. It appealed.

The Court of Appeal affirmed, holding that DHCS and the administrative law judges did not abuse their discretion in finding that Family Health's outreach costs were not reimbursable. The court acknowledged that the outreach activities were required as part of Family Health's role as a FQHC grant recipient. But the court explained that the mere fact Family Health was required to perform these services did not make their costs eligible for reimbursement, even if the services provided a benefit. Reimbursement eligibility is governed by the CMS's Provider Reimbursement Manual, which clearly states that advertising costs seeking to increase patient utilization of a provider's services are not reimbursable.

Peer review hearing officer is not automatically disqualified by the prospect of future engagements at the same hospital

Natarajan v. Dignity Health (Aug. 12, 2021, S259364) __ Cal.5th __ [2021 WL 3557299]

Following an investigation, the medical staff's executive committee revoked the privileges of Dr. Sundar Natarajan, a hospitalist at St. Joseph's Medical Center of Stockton (a Dignity facility), due to record keeping problems, untimely responses while on call, and the length of his patients' hospitalizations. Dr. Natarajan appealed to the hospital's peer review committee. The medical staff delegated the authority to appoint a peer review hearing officer to the hospital's president, who appointed Robert Singer—a semiretired attorney who worked exclusively as a medical peer review hearing officer at various hospitals. Singer required that his contract bar St. Joseph's from appointing him in another peer review proceeding for three years. Singer had served as the hearing officer in eight peer review proceedings at other Dignity Health hospitals and was appointed to two more after Dr. Natarajan's proceeding, none involving St. Joseph's. Singer served as the hearing officer for a similar number of hearings at entities affiliated with Sutter Health, and worked as a hearing officer for other health facilities as well. Singer denied Dr. Natarajan's request that he recuse himself. After a year of evidentiary hearings, the review committee adopted the executive committee's decision to revoke Dr. Natarajan's privileges. Dr. Natarajan appealed that decision to St. Joseph's governing board, which affirmed.

Dr. Natarajan filed a petition for a writ of administrative mandate, arguing he was denied due process because (1) Singer's relationship with Dignity created an unacceptable risk of bias based on his pecuniary interest in future employment, and (2) the decision to revoke his privileges was not based on objective standards. The trial court denied the petition and Dr. Natarajan appealed. The Court of Appeal affirmed. Expressly disagreeing with *Yaqub v. Salinas Valley Mem. Healthcare Sys.* (2004) 122 Cal.App.4th 474, the Court of Appeal rejected Dr. Natarajan's contention that Singer's relationship with Dignity hospitals created an unacceptable and disqualifying risk of possible bias. The Court of Appeal affirmed the trial court's judgment because there was no evidence that Singer had a direct financial interest in the peer review proceeding, and the hospital had based its disciplinary decision on sufficiently objective criteria that were uniformly applied. The Supreme Court granted review.

The Supreme Court disapproved *Yaqub* and affirmed the result (but not the reasoning) of the Court of Appeal's decision. The Court explained that the prospect of future employment was *not* categorically non-disqualifying; instead, a peer review hearing officer may be disqualified based on a direct financial benefit that creates an intolerable risk of actual bias under the circumstances—a context-sensitive inquiry. But such a risk does not arise simply because a hearing officer has been hired by a hospital on an ad hoc basis and may be hired again by the same hospital at some point in the future.

In determining whether a hearing officer is disqualified, courts must consider two factors: (1) which entity exercises control over the hearing officer selection process, and (2) the extent and likelihood of future financial opportunities the hearing officer may receive from the same entity. Here, the 3-year ban on serving as a hearing officer for the same hospital eliminated any significant risk of Singer harboring a financial temptation to favor the hospital during the proceedings. Moreover, Dignity Health did not

control the hearing officer selection process at any of its hospitals; rather, hearing officers are selected by the medical staff or their designees. Thus, lower courts had properly ruled that the circumstances of Singer's appointment did not create an intolerable risk of bias in favor of the hospital.

Non-solicitation provision in healthcare staffing agency's vendor contract does not violate antitrust laws

Aya Healthcare Services, Inc. v. AMN Healthcare, Inc., __ F.4th __, No. 20–55679, 2021 WL 3671384 (9th Cir. Aug. 19, 2021)

Aya Healthcare Services and AMN Healthcare are both healthcare staffing agencies that place travel nurses on temporary assignments at hospitals and other healthcare facilities. When AMN could no longer fulfill its hospital customers' demand for travel nurse assignments, it entered into associate vendor (AV) contracts with other providers, including Aya. The contract prohibited Aya from soliciting AMN employees. A few years later, Aya began soliciting AMN's travel nurse recruiters, after which the two parties terminated their AV contract. Aya then sued AMN alleging various state and federal claims, including an antitrust claim under the Sherman Act. Aya claimed exclusionary and retaliatory damages resulting from the non-solicitation provision and from AMN's termination of the AV relationship, respectively. The district court granted summary judgment to AMN, ruling that Aya had not demonstrated a retaliatory cartel action, provided evidence of AMN's market power, or shown that AMN's actions had an anti-competitive effect. Aya appealed, arguing that the non-solicitation provision was a naked no-poaching restraint that should be analyzed under the per se standard, and that it violated the Sherman Act under the quick-look and rule-of-reason standards. Aya also claimed entitlement to retaliatory damages because AMN had "cartelized" the labor market.

The Ninth Circuit affirmed. It explained that naked restraints are limited to agreements that have no purpose other than stifling competition, which was not the case here. The non-solicitation provision was exempt from the per se rule under the ancillary restraints doctrine because it was subordinate and collateral to the legitimate AV contract and the provision was reasonably necessary to achieve the parties' pro-competitive purposes of meeting hospital staffing needs. The Ninth Circuit rejected Aya's claim that the unlimited duration of the non-solicitation provision made it a naked restraint because it was entered into at the same time as the AV agreement. It also rejected Aya's claim that AMN had to prove there were no less restrictive means of ensuring competition, because that is merely one factor considered under the rule of reason test. The Court held that the district court properly applied the rule-of-reason standard and properly upheld the provision under that standard because Aya failed to meet its threshold burden of proving the provision's substantial anticompetitive effect. The Court also affirmed the district court's determination that the evidence Aya provided (a study from an expert economist) was flawed and lacked concrete economic analysis, and thus did not prove the non-solicitation provision's anticompetitive effects or AMN's market power. Finally, the Court also denied Aya's retaliatory damages claim on the grounds that Aya did not provide sufficient evidence of a cartel or concerted action by AMN.