# *CASE SUMMARIES*


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## In calculating the Medicare fraction of the disproportionate share hospital adjustment, an individual is "entitled to supplementary security income benefits" when she is eligible to receive an SSI cash payment during the month of her hospitalization.

Advocate Christ Medical Center v. Kennedy, 605 U.S. __ (2025) [2025 WL 1224342]

The government reimburses hospitals that provide inpatient care to Medicare recipients. Hospitals that treat a disproportionate share of low-income patients typically have higher Medicare costs, and are reimbursed at a higher rate as determined by a "disproportionate-share" formula. The formula is the sum of two fractions: the Medicare fraction (the proportion of a hospital's Medicare patients with low incomes) and the Medicaid fraction (the proportion of a hospital's low-income patients who are eligible for Medicaid, but not for Medicare). The larger the fraction, the more funding the hospital receives.

A group of hospitals challenged how the Department of Health and Human Services (HHS) calculates the numerator of the Medicare fraction, which represents the "number of patient days attributable to Medicare patients who were 'entitled to benefits under [Medicare] part A' and were 'entitled to supplementary security income [(SSI)] benefits . . . under subchapter XVI.' " HHS interpreted the phrase entitled to SSI benefits to refer to patients who are entitled to receive SSI benefits during the month they were hospitalized. The hospitals disagreed, insisting that the phrase encompasses all patients enrolled in the SSI system at the time of their hospitalizations, regardless whether they were entitled to an SSI payment that month. The hospitals argued HHS underfunded them by misinterpreting the Medicare fraction. The district court rejected the hospitals' claims and granted summary judgment to HHS. The D.C. Circuit affirmed, and the Supreme Court granted a writ of certiorari to decide what it means to be "entitled" to SSI benefits in this context.

The Supreme Court affirmed the D.C. Circuit decision: a person is "entitled" to SSI benefits when she is eligible to receive a cash payment during the month of her hospitalization. The Court distinguished Becerra v. Empire Health Foundation, 597 U.S. 424 (2022), which held that the phrase "entitled to benefits under [Medicare] Part A" means qualifying for them, whether or not a payment was actually received. The majority noted that Medicare Part A's "entitlement is automatic and ongoing," while "the SSI [monthly cash] benefit is neither: Recipients must apply for and be deemed eligible for benefits, and recipients can (and do) fluctuate in and out of eligibility depending on their income and resources from one month to the next." Finally, the majority explained that Congress's choice of formula, though imperfect, balances multiple competing interests, including administrability and efficiency.

Justice Jackson dissented, joined by Justice Sotomayor. The dissent interpreted "entitled" to SSI benefits to refer to all patients enrolled in SSI at the time of hospitalization, reasoning that "the true 'benefit' of SSI" is the assurance of having an annual income above the federal minimum guaranteed to all enrollees, regardless whether payments come from salary or the Government.

## Patient billed by hospital for EMS fee may assert a breach of contract claim where the admissions form required payment only for "services."

Naranjo v. Doctors Medical Center of Modesto, Inc. (May 23, 2025, F083197) __ Cal.App.5th __ [2025 WL 1482842]

After emergency treatment at Doctors Medical Center of Modesto (the Hospital), Joshua Naranjo filed a class action alleging that the Hospital's failure to disclose its emergency room evaluation and management service (EMS) fee violated the Consumer Legal Remedies Act (CLRA) and the unfair competition law (UCL). The trial court sustained the Hospital's demurrer, and Naranjo appealed. The Court of Appeal reversed and remanded so the trial court could decide whether to allow Naranjo to assert a breach of contract claim. The California Supreme Court granted the Hospital's petition for review and transferred the case back to the Court of Appeal with directions to reconsider its decision in light of Capito v. San Jose Healthcare Systems, LP (2024) 17 Cal.5th 273, which held that hospitals have no duty to disclose to patients EMS fees other than those specified by statute.

# A conditions of admission provision assigning uninsured motorist benefits to the hospital is an unenforceable adhesion contract even for Medi-Cal patients.

Dameron Hospital Association v. Progressive Cas. Ins. Co. (May 27, 2025, C099467) _ Cal.App.5th _, 2025 WL 1502017

M.G. was treated at Dameron Hospital following a car accident. Dameron required her to sign its standard conditions of admissions (COA) form, which included a provision assigning M.G.'s underinsured motorist (UM) auto insurance benefits to Dameron and directing her auto insurer (Progressive) to pay those benefits directly to Dameron. Although M.G. had Medi-Cal coverage, Dameron demanded that Progressive pay UM benefits toward her medical services at Dameron's full billed rate, rather than at the lower rates Medi-Cal would pay. After Progressive declined, Dameron filed suit against Progressive seeking damages, an injunction enjoining Progressive from ignoring the assignment of benefits, and a declaration that the assignment of benefits was enforceable. The trial court sustained Progressive's demurrer, relying on Dameron Hospital Assn. v. AAA Northern California, Nevada & Utah Ins. Exchange (2022) 77 Cal.App.5th 971 (AAA), which held the same COA form was beyond patients' reasonable expectations and an unenforceable contract of adhesion. Dameron appealed.

The Court of Appeal affirmed. Dameron argued that AAA was distinguishable because it addressed patients who had private health insurance or were uninsured, not patients covered by Medi-Cal. The court disagreed, holding that the COA were still an unenforceable adhesion contract because "it is not within the reasonable expectation of a Medi-Cal patient that a COA will contain an assignment of UM benefits to the facility providing him or her with emergency care, particularly an assignment that allows the hospital to collect its full bill without ever presenting a bill to Medi-Cal." The court explained that providers must submit

a claim to Medi-Cal for reimbursement when a patient has Medi-Cal coverage and must not seek payment from anyone other than the Department of Healthcare Services or third-party payors who provide contractual or legal entitlement to healthcare services. Because a UM insurer does not provide entitlement to healthcare services, a provider cannot seek payment from UM insurance. The court rejected Dameron's argument that Medi-Cal priority of payments laws (making Medi-Cal a "payor of last resort") compelled a different result because those laws require state plans to seek recovery from liable third parties and compel an assignment to the state of a beneficiary's right to third-party payments for medical care. In sum, while M.G. might be expected to use some portion of her UM benefits to pay medical expenses, she would not reasonably expect Dameron to use its COA assignment of benefits to collect its full hospital bill from her limited UM coverage—which was intended to cover her lost wages, pain and suffering, and other damages—without submitting a mandatory Medi-Cal claim.

## Individual beneficiaries may not sue state officials under 42 U.S.C. § 1983 for violating Medicaid's "any qualified provider" provision.

Medina v. Planned Parenthood South Atlantic, 606 U.S. __, 2025 WL 1758505 (June 26, 2025, No. 23-1275)

Based on state law prohibiting public funds for abortion, South Carolina barred Planned Parenthood from participating in the state's Medicaid program. Planned Parenthood and a patient sued the director of the state's Department of Health and Human Services, bringing a putative class action under § 1983 to "vindicate rights secured by federal Medicaid statutes." They claimed the exclusion violated Medicaid's any-qualified-provider provision (42 U.S.C. § 1396a(a)(23)(A)), which conditions federal Medicaid funding on the states' agreement that beneficiaries may obtain care from "any qualified provider." The patient alleged she needed Medicaid coverage and preferred Planned Parenthood provide her gynecological care. The district court granted summary judgment for plaintiffs and enjoined the exclusion, and the Fourth Circuit affirmed. The Supreme Court vacated and remanded in light of Health and Hospital Corporation of Marion County v. Talevski, 599 U.S. 166 (2023), which addressed whether a spending-power statute created enforceable rights under § 1983. The Fourth Circuit reaffirmed.

The Supreme Court again granted certiorari, reversed, and remanded. The 6-justice majority explained that spending-power statutes, like Medicaid, rarely confer enforceable rights because Congress's spending power, attributable to Article I, section eight, clause one of the U.S. Constitution, does not expressly give Congress the power to regulate conduct. For that reason, the Court has long distinguished between mere benefits and rights that are enforceable under § 1983. Moreover, the federal government's conditional grants to states are akin to treaties between sovereigns.

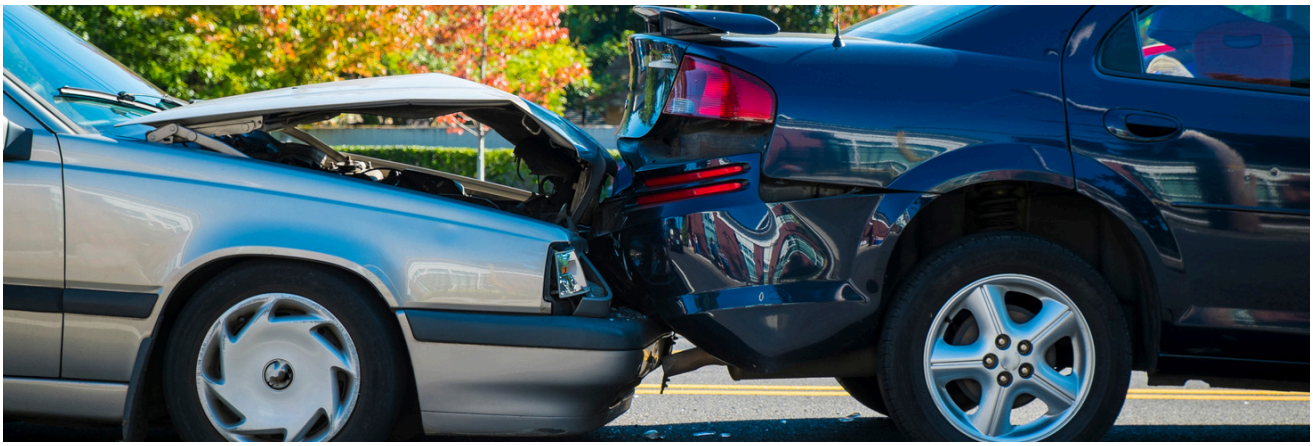
It follows that Congress alone has the power to enforce grant conditions unless it "clearly and unambiguously" alerted the States in advance that responding to private lawsuits was a condition of the offer. As explained in Talevski, statutes creating enforceable individual rights must do so in "clear and unambiguous terms" using "rights creating terms" and displaying an "unmistakable focus" on individuals. The majority held that Medicaid's "any qualified provider" provision failed to meet this stringent standard and therefore created no individually enforceable right under § 1983. While undoubtedly seeking to benefit both providers and patients, the statute contains no clear and unambiguous rights-creating language; instead, it focuses on what states must do to participate in Medicaid and explains that failure to meet certain standards may result in a loss of federal funding.

## MICRA statute of limitations does not apply to negligence action brought by the injured driver of a vehicle rear-ended by an ambulance transporting a patient.

Gutierrez v. Tostado (July 31, 2025, S283128) _ Cal.5th _ [2025 WL 2169453]

Francisco Gutierrez was injured when an ambulance transporting a patient rear ended his vehicle. Nearly two years later, Gutierrez filed a negligence complaint against Uriel Tostado, the EMT who drove the ambulance. Tostado moved for summary judgment on the ground that Gutierrez's claim was time barred under MICRA's one-year statute of limitations in Code of Civil Procedure section 340.5, which applies to actions "against a health care provider based upon such person's alleged professional negligence." The trial court granted Tostado's motion, ruling that the MICRA statute of limitations applied because he was a healthcare provider who was rendering professional medical services within the scope of his license at the time of the accident. Gutierrez appealed, and a divided Court of Appeal affirmed. The Supreme Court granted Gutierrez's petition for review.

The Supreme Court reversed, holding that MICRA's one-year statute of limitations does not apply where a plaintiff sues a healthcare provider for breach of a duty owed to the public generally, as opposed to a violation of professional obligations owed to patients.



The Court explained that the definition of "professional negligence" in section 340.5 "suggests the statute is only concerned with injuries resulting directly from the negligent rendering of medical care, as opposed to all injuries that might occur during or that arise out of the provision of medical care." Because the ambulance driver's alleged failure to follow traffic laws was connected not to a professional medical duty but to the general duty all drivers have to operate their vehicles safely, the two-year general negligence statute of limitations applied.

Although the Court did not decide whether the patient riding in the ambulance would have faced the shorter MICRA statute of limitations had they sued for injuries sustained in the accident, it stated that "the plaintiff's status as a patient or nonpatient is not necessarily determinative." The Court explained that the "possibility of different plaintiffs being subject to different statutes of limitation is neither unworkable nor inherently unfair." The Court also explained that the claims of non-patients may be covered by MICRA, provided those claims stemmed from the negligent provision of medical care. The Court acknowledged that professional duties may overlap with general duties owed to the public, but nonetheless perceived a "fundamental distinction between claims involving 'professional negligence . . . and claims involving only general negligence." In the case of ambulance services, the Court held that, while the "existence of an emergency may affect what will constitute ordinary care, it does not fundamentally alter the fact that the ambulance driver's duty to other drivers is one of ordinary care."

Finally, the Court disapproved two prior decisions—Canister v. Emergency Ambulance Service, Inc. (2008) 160 Cal.App.4th 388 and Lopez v. American Medical Response West (2023) 89 Cal.App.5th 336. The Court explained that Canister and Lopez incorrectly suggested "that a plaintiff's claim sounds in professional negligence whenever the plaintiff's injuries 'occur[ed] during the rendering of services' to a patient." The Court emphasized that MICRA requires more than just an injury occurring during medical services—the professional negligence must be the proximate cause of the injury, meaning there must be a breach of a professional obligation owed to a patient.