APPELLATE CASE SUMMARIES

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CASE NOTES

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 (April 5, 2022, B302321) __ Cal. App.5th __ [2022 WL 1010252]

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 65 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.

The court also 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. Finally, the court reversed the nonsuit of plaintiffs' claim that the hospital was vicariously responsible for Valencia's misconduct, holding there were triable issues of fact regarding both respondeat superior and ratification.

Section 1278.5 whistleblower claims are analyzed under the McDonald Douglas framework, not the Lawson framework

Scheer v. Regents of the Univ. of California (Mar. 28, 2022, B303379) __ Cal.App.5th __ [2022 WL 896766]

Dr. Arnold Scheer filed whistleblower claims under Labor Code section 1102.5, Government Code section 8547 et seq., and Health and Safety Code section 1278.5 against the Regents. He alleged wrongful termination in retaliation for his alleged attempts to report and correct patient safety issues, mismanagement, and other fraudulent, illegal and/or unsafe practices. The Regents moved for summary judgment, asserting that it terminated Dr. Scheer for a legitimate, nonretaliatory reason—his overly aggressive, harsh, disruptive, and ineffective work style. The trial court applied the burden-shifting

analysis in *McDonnell Douglas Corp. v. Green* (1973) 411 U.S. 792 and granted summary judgment, ruling that Dr. Scheer failed to raise a triable issue that the Regents' nonretaliatory termination reasons were pretextual. Dr. Scheer appealed.

The Court of Appeal reversed and remanded. Regarding retaliation claims under the Labor Code and Government Code, the Court held that the standard in *Lawson v. PPG Architectural Finishes, Inc.* (2022) 12 Cal.5th 703 provides the correct analytical framework. Under *Lawson*, a whistleblower need not prove pretext; rather, once he establishes by a preponderance of the evidence that retaliation was a contributing factor in the adverse employment decision, the burden shifts to the employer to prove by clear and convincing evidence that it would have taken the same action for legitimate reasons. The court ruled that, upon remand, The Regents can move for summary judgment under the *Lawson* standard. In contrast, the court held that the Lawson framework does not apply to whistleblower claims under section 1278.5; the *McDonnell Douglas* approach used by the trial court applies instead. The court nonetheless reversed the summary judgment on that claim as well, because Dr. Scheer had presented sufficient evidence to create a triable issue that the Regents' stated reasons for the termination were a pretext for a retaliatory discharge.

Medicare Advantage plan beneficiaries must exhaust administrative remedies before seeking judicial review of a benefits claim

Global Rescue Jets, LLC v. Kaiser Foundation Health Plan, Inc., ___ F.4th ___, 2022 WL 1052671 (9th Cir. Apr. 8, 2022)

Jet Rescue transported two Kaiser Medicare Advantage enrollees by air from Mexico to a Kaiser hospital in the United States. The enrollees assigned their claims for benefits under Kaiser's plans to Jet Rescue. Jet Rescue lacked a services contract with Kaiser so Jet Rescue billed Kaiser $516,200, its "usual and customary" rate. Kaiser paid only $40,461, the Medicare-approved rate. Jet Rescue sued to recover the balance. The district court dismissed for lack of subject matter jurisdiction, ruling that Jet Rescue had failed to exhaust its administrative remedies. Jet Rescue appealed.

The Ninth Circuit affirmed, holding that Medicare Advantage plan beneficiaries, and their assignees (like Jet Rescue here), must exhaust administrative remedies before seeking judicial review. The court explained that, under Parts A and B of the original Medicare Act, the federal government pays healthcare providers on a fee-for-service basis at rates approved by the Centers for Medicare & Medicaid Services. Congress amended the Medicare Act in 1997 to add Part C, under which the CMS pays Medicare Advantage organizations fixed monthly sums per enrollee to provide all services under Parts A and B. Medicare Advantage organizations also may offer enrollees "supplemental benefits" for an additional premium, as approved by the CMS, and they may have contracts with providers that fix the rates for services. If a non-contracting provider provides services to enrollees that would have been covered under Parts A and B, the Medicare Advantage organization must pay the provider at least the Medicare rate and the provider must accept that rate as payment in full. Jet Rescue and Kaiser disputed whether the air ambulance services were covered under Parts A and B, or only as a supplemental benefit.

Under 42 U.S.C. § 405, claimants must exhaust five levels of administrative review before seeking judicial review. Jet Rescue argued that § 405 did not apply because Kaiser is a private entity, but the Ninth Circuit disagreed because a Medicare Advantage organization such as Kaiser qualifies as an "officer or employee" of the United States or the Secretary for purposes of § 405. The court also held that Jet Rescue's claims were "inextricably intertwined" with a claim for Medicare benefits and therefore arose under Part C. The exhaustion requirement may be excused if exhaustion would be futile or the claim is wholly collateral to a Medicare benefits claim. Because Jet Rescue could not make that showing here, the failure to exhaust administrative remedies deprived the district court of subject matter jurisdiction.

Medicare need not reimburse critical access hospitals for the cost of keeping nonemergency specialty doctors on call

St. Helena Clear Lake Hospital v. Becerra, __ F.4th __, 2022 WL 1051987 (D.C. Cir. March 31, 2021)

Critical access hospitals provide 24-

hour emergency services at remote rural locations. They are limited to 25 inpatient beds. They may not provide nonemergency inpatient care for more than 96 hours; persistently sick patients must be transferred to a larger hospital. Medicare reimburses critical access hospitals for 101% of their "reasonable costs," while reimbursing ordinary hospitals on a less favorable fixed fee schedule. Medicare also reimburses critical access hospitals for the cost of on-call emergency room doctors, contrary to the Secretary of Health and Human Services's longstanding practice of denying reimbursement for on-call costs.

St. Helena Clear Lake Hospital, a California critical access hospital, sought Medicare reimbursement for the cost of maintaining *nonemergency* room specialists on call. After its Medicare contractor denied reimbursement, St. Helena appealed to the Provider Reimbursement Review Board, arguing that, because federal law requires it to provide certain specialty services and to stabilize patients before transferring them, the on-call cost for these services is "necessary and proper" and therefore must be "reasonable." The Board rejected St. Helena's argument, ruling that the governing regulations only permit reimbursement of on-call costs for the emergency room. St. Helena sought review in the United States District Court for the District of Columbia, which granted the Secretary's motion for summary judgment. St. Helena then appealed to the D.C. Circuit.

The D.C. Circuit affirmed. The court held that the federal obligation to stabilize emergency patients does not require critical access hospitals to maintain various on-call specialists, since emergency physicians are readily available and capable of stabilizing patients for transfer. The court then held that the Board properly construed the federal regulations as allowing reimbursement for on-call emergency room costs only.

The rule of academic deference is no defense against a medical resident's FEHA discrimination and retaliation claims

Khoiny v. Dignity Health (Mar. 16, 2022, B301486) __ Cal. App.5th __ [2022 WL 794826]

A Dignity Health hospital dismissed Dr. Noushin Khoiny after her second year of a three-year internal medicine residency. She sued Dignity, alleging retaliation and gender discrimination in violation of the Fair Employment and Housing Act (FEHA). The trial court gave the jury an "academic deference" special instruction: because the residency program was "academic in nature," Dignity's "academic judgment" to dismiss Dr. Khoiny should not be overturned "unless it is found to have been arbitrary and capricious, not based on academic criteria, or motivated by retaliation or discriminatory reasons unrelated to her academic performance." The special instruction directed the jury to uphold Dignity's dismissal decision "unless you find its decision was a substantial departure from accepted academic norms as to demonstrate that [Dignity] did not actually exercise professional judgment." The verdict form included similar language. The jury found for Dignity. Dr. Khoiny appealed, asserting instructional error.

The Court of Appeal reversed. Deciding an issue of first impression, the court held that academic deference does not apply to hospital residency programs. Although residency programs have educational and training aspects, the "predominant relationship between a medical resident and a hospital residency program is an employee-employer relationship." Accordingly, Dr. Khoiny, like all FEHA plaintiffs, may prevail by proving that gender or retaliation was a substantial motivating factor for her termination—even if other factors also motivated it. The special instruction was erroneous because Dignity's dismissal was not entitled to a presumption of correctness, and because Dr. Khoiny was not required to disprove Dignity's claim that her academic performance precipitated her dismissal. The error was prejudicial because, viewing the evidence in the light most favorable to Dr. Khoiny, a properly instructed jury could have returned a verdict in her favor. The court remanded for a new trial, directing the trial court to instruct the jury "to evaluate, without deference, whether the program terminated [Dr. Khoiny] for a genuine academic reason or because of an impermissible reason such as retaliation or the resident's gender."

Nondisclosure of hospital's emergency room evaluation and management fee does not violate the Consumer Legal Remedies Act

Torres v. Adventist Health System/ West (Apr. 14, 2022, F081415) __ Cal.

App.5th __ [2022 WL 1115068]

Kasondra Torres filed a class action lawsuit against Hanford Community Hospital, seeking declaratory relief that the hospital's nondisclosure of a $3,200 emergency room evaluation and management service (EMS) fee, in addition to fees for each treatment and service provided, violated the Consumer Legal Remedies Act (CLRA). Torres argued that Hanford's concealment of the EMS fee violated the CLRA for two reasons: (1) it had exclusive knowledge of material facts regarding that fee, which were not known or reasonably accessible to her, and (2) it actively concealed the fee. The trial court granted Hanford's motion for judgment on the pleadings, ruling that Hanford owed no duty to disclose the EMS fee under the CLRA. Torres appealed.

The Court of Appeal affirmed. Although Torres adequately alleged her lack of reasonable access to the facts that triggered Hanford's imposition of an EMS fee and Hanford's fee-setting formula, Torres failed to adequately allege that she *relied* on not being billed an EMS fee. In other words, she did not claim that she would have sought treatment elsewhere had Hanford disclosed the EMS fee. Accordingly, Torres failed to sufficiently allege a CLRA violation under the exclusive knowledge criterion. The court also held that Torres failed to sufficiently allege active concealment by Hanford because she alleged only a disclosure *omission*, rather than any affirmative act to conceal information.

Code of Civil Procedure section 425.13 broadly bars untimely punitive damages claims against health care providers arising from professional negligence

Divino Plastic Surgery v. Superior Court of San Diego County (April 22, 2022, D079661) __ Cal. App.5th __ [2022 WL _____]

Megan Espinoza died of cardiac arrest during surgery with Dr. Carlos Chacon at Divino Plastic Surgery clinic. Her husband and children sued Divino, Chacon, and the assisting nurse for, among other things, medical malpractice, intentional misrepresentation, promissory fraud, and battery. Less than 6 months before the case was first set for trial, plaintiffs sought leave to add a punitive damages claim. Defendants argued the motion was untimely under Code of Civil Procedure section 425.13. The statute requires plaintiffs to amend their complaints in order to seek punitive damages arising out of a healthcare provider's professional negligence, and to do so "within two years after the complaint . . . is filed or not less than nine months before the date the matter is first set for trial, whichever is earlier." The trial court granted plaintiffs' motion, ruling that their intentional tort claims were outside the scope of section 425.13 and that defendants waived their right to assert section 425.13 by not challenging the original complaint's allegations of malice, oppression, and fraud. Defendants petitioned for a writ of mandate.

The Court of Appeal granted writ relief. First, the court held that section 425.13 applied because defendants were licensed "health care providers" regardless whether they acted outside the scope of their licenses, as plaintiffs alleged. The court also held that plaintiffs' intentional tort claims all "arose out of professional negligence" because they pleaded conduct "directly related" to rendering professional services. The court explained that the "arising out of" language in section 425.13 is broader than the MICRA statutes, whose case law was inapplicable. Because section 425.13 applied, plaintiffs' motion was untimely unless their tardiness was excused. Distinguishing situations where a trial is scheduled so early that a plaintiff could not realistically comply with section 425.13, the court held that plaintiffs here had an adequate opportunity to comply. Finally, the court rejected plaintiffs' waiver argument: defendants had no right or reason to attack pleadings "going to punitive damages" in a complaint that could not lawfully seek punitive damages.

The Knox-Keene Act does not permit (and the Government Claims Act otherwise bars) unaffiliated hospitals from suing counties for emergency services reimbursements

County of Santa Clara v. Superior Court (Apr. 26, 2022, H048486) __ Cal.App.5th __ [2022 WL 1223254]

The County of Santa Clara operates a health service plan licensed under the Knox-Keene Act. Two hospitals that did not have contracts with the county provided emergency medical services to plan members. The hospitals submitted reimbursement claims to the county, which provided partial reimbursement. The hospitals sued the county for the balance, alleging breach of a contract implied-

in-fact or implied-in-law (meaning implied in the Knox-Keene Act). The hospitals argued that they had provided emergency medical services to plan members expecting the county to pay their reasonable and customary rates (about five times the county's payment). The county demurred, arguing that there is no express right of action for reimbursement under the Knox-Keene Act, that no right of action may be implied against a public entity, and that the county is immune under the Government Claims Act (Gov. Code, § 810 et seq.). The trial court overruled the demurrer and the county petitioned for writ relief.

The Court of Appeal granted writ relief. The Knox-Keene Act does not provide an express right of action, and none could be implied here because Government Code section 815 bars a quantum meruit or other common law action against the county. The mandatory duty exception in section 815.6 did not salvage the hospitals' claim. While the Knox-Keene Act requires the county to pay the reasonable and customary *value* of the emergency health care services provided to its members, the county has discretion to determine the reasonable and customary value of the services being reimbursed. The court rejected the trial court's constitutional concerns about allowing the county to have unfettered discretion to set the reimbursements amounts, noting that the Knox-Keene Act provides enforcement alternatives to litigation: providers may report allegedly unfair payment patterns to the Department of Managed Health Care, which has the authority to investigate and impose penalties on health care service plans. The hospitals' implied-in-fact contract claim likewise failed. Because the hospitals' suit was based on an alleged breach of a statutory duty rather than the breach of a promise, the nature of the action was tortious and the county is immune from tort suits under section 815. Finally, the court concluded that affording leave to amend would be futile because the hospitals failed to identify any other statutory basis for abrogating government immunity.

Party *not* bearing the burden of proof need not present medical causation evidence to a reasonable degree of medical probability

Kline v. Zimmer, Inc. (May 26, 2022, B302544) __ Cal.App.5th ___ [2022 WL 1679539]

Gary Kline was implanted with an artificial hip joint manufactured by Zimmer, Inc. The surgery was unsuccessful. Kline underwent further procedures and therapy for the next eight years. He then sued Zimmer on a products defect theory. At trial, the court excluded Zimmer's proffered expert testimony regarding possible explanations of Kline's persistent pain that were expressed to less than a reasonable medical probability. In contrast, the court allowed Kline's expert to testify that, to a reasonable degree of medical probability, Zimmer's defective product caused Kline's symptoms. The jury returned a verdict for Kline, and the trial court denied Zimmer's motion for posttrial relief. Zimmer appealed the ensuing judgment.

The Court of Appeal reversed the judgment and remanded for retrial on whether Zimmer's defective product caused Kline's alleged harm. The court held that Zimmer was entitled to introduce expert testimony regarding *possible* (albeit not probable) explanations for Kline's symptoms to show that Kline had failed to satisfy his burden of proving that Zimmer caused Kline's injuries. The court explained that "Zimmer did not need to show that a different cause was more likely than not the cause of Kline's injuries. All that Zimmer needed to show was that Kline's evidence was insufficient to prove Kline's injuries were more likely than not caused by Zimmer. It should have been permitted to do so by offering expert opinions offered to less than a reasonable medical probability that Kline's injuries may have been attributable to other causes" because such testimony "could cast doubt on the accuracy and reliability of a plaintiff's expert." When the jury is called upon to decide complex issues of medical causation it is "imperative that the party without the burden of proof be allowed to suggest alternative causes, or the uncertainty of causation, to less than a reasonable medical probability. To withhold such information from the jury is to deprive it of relevant information in assessing whether the plaintiff has met its ultimate burden of persuasion." The court found the error was necessarily prejudicial because it affected a core issue on which expert testimony was needed.

State may lien a Medi-Cal beneficiary's third-party tort settlement allocated to past medical expenses

Daniel C. v. White Memorial Medical Center (May 26, 2022, B308253) __ Cal.App.5th __ [2022 WL 1682925]

Daniel C. was born with severe disabilities after his congenital abnormalities were not detected during his mother's pregnancy until after viability. The California Department of Health Care Services (DHCS) paid for his medical care through the Medi-Cal program. Daniel filed a wrongful life suit against his mother's prenatal doctors, eventually settling with one. DHCS asserted a lien on this settlement, seeking to recover what it had paid for his medical care. The trial court granted DHCS the full amount of Daniel's past medical expenses, reduced by 25 percent as required by statute to account for its share of attorney fees. Daniel appealed, contending (1) the Medi-Cal Act provision authorizing the DHCS to assert a lien is preempted by the anti-lien and anti-recovery provisions of the federal Medicaid Act, (2) there was no evidence the parties allocated any portion of the settlement to past medical expenses, and (3) the court failed to equitably allocate the settlement.

The Court of Appeal reversed in part. As a threshold matter, the court agreed with DHCS in holding the lien was not preempted by the Medicaid provisions. The Court of Appeal followed *L.Q. v. California Hospital Medical Center* (2021) 69 Cal.App.5th 1026, which held that the federal anti-lien and anti-recovery provisions did not preempt California law because the DHCS lien attaches only to the portion of the settlement that is State property. The court rejected Daniel's argument that the parties to the settlement agreement control its allocation, since Medi-Cal directs the trial court to determine that allocation.

However, relying on *Arkansas Department of Health and Human Services v. Ahlborn* (2006) 547 U.S. 268, the Court of Appeal also held the trial court erred in failing to apportion the settlement between past medical expense damages, which DHCS is entitled to recover, and other damages beyond its reach. The court must make such an allocation to avoid creating a lien contrary to the anti-lien provision of the Medicaid Act. Because neither the state statute nor *Ahlborn* specifies an allocation formula, the court sought to identify " 'a rational approach.' " The Court of Appeal explained that a trial court may allocate most or all of a settlement to *past* medical expense damages (which the DHCS may lien) if it finds, based on competent evidence, that DHCS probably will pay all future medical expenses. Here, the Court of Appeal instructed the trial court to use the following formula on remand to calculate DHCS's recovery amount: (Total Settlement ÷ [Full Value of Claim – Future Expenses To Be Paid By DHCS]) x (Reasonable Value of Past Benefits Provided by DHCS – DHCS's Share of Attorney Fees and Costs).

State-law formula for allocating tort settlement funds between past and future medical expenses not preempted by the Medicaid Act

Gallardo v. Marstiller, 596 U.S. __, No. 20–1263, 2022 WL 1914096 (June 6, 2022).

Petitioner Gianna Gallardo was hit by a truck , suffering catastrophic injuries that placed her in a persistent vegetative state. Medicaid paid for her medical care. Gallardo sued the truck driver and others in Florida for medical expenses and other damages. She settled her claims in an agreement that expressly allocated $35,368 as compensation for past medical expenses, but allocated nothing for future medical expenses. Under a statutory formula for seeking reimbursement for Medicaid expenses from beneficiaries' tort recoveries, Florida's Medicaid agency was entitled to $300,000 of the settlement as the presumptive portion compensating Gallardo for past and *future* medical expenses. Gallardo unsuccessfully challenged this presumptive allocation in an administrative proceeding, arguing the state could seek reimbursement only from the $35,368 allocated to past medical expenses. Gallardo then sued in federal court seeking a declaration that Florida's statutory scheme was preempted by the Medicaid Act's anti-lien provision.

The district court granted summary judgment for Gallardo, but the Eleventh Circuit reversed, holding that Florida's statute did not conflict with the Medicaid Act. The Eleventh Circuit explained that Medicaid's anti-lien provision prohibits states from asserting liens against portions of a settlement not "designated as payment for medical care," but does not prohibit states from recovering from the portion of a settlement allocated to future medical expenses. Meanwhile, the Florida Supreme Court came to the opposite conclusion. *See Giraldo v. Agency for Health Care Admin.*,

248 So.3d 53 (Fla. 2018). The U.S. Supreme Court granted certiorari to resolve this split of authority.

In a 7-2 decision, the Supreme Court sided with the Eleventh Circuit. The majority relied on the plain text of the Act's assignment provision, 42 U.S.C. § 1396k(a)(1)(A), which requires states "to acquire from each Medicaid beneficiary an assignment of 'any rights ... of the individual ... to support ... for the purpose of medical care ... and to payment for medical care from any third party." The majority reasoned that this provision plainly allows states to seek reimbursement from *future* medical expense allocations because it conditions eligibility on assignment of "any rights" of the beneficiary "to payment for medical care from any third party," without limiting the assignment to payments for past medical care. Because Florida's statutory allocation presumption is consistent with the Medicaid Act's assignments provision, it falls within the exception to the Act's anti-lien provision for liens against funds in which the beneficiary has no property right, which the Court recognized in *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268 (2006). The Court rejected Gallardo's argument that this interpretation of the assignment provision conflicted with the Act's more limited third-party liability provision, holding instead that the provisions complement each other. While the former provides a broad contractual right to recover all third-party payments for medical care, the latter provides a narrow statutory right to recover third party medical expense payments when the contractual assignment might fail. The Court also rejected Gallardo's argument that a broad construction of § 1396k(a)(1)(A) improperly authorizes a lifelong assignment of all rights to recover medical expenses regardless whether the individual remains a Medicaid beneficiary; the Court explained that the provision applies only to rights the individual possesses while on Medicaid.

The dissenting justices construed the § 1396k(a)(1)(A) assignment provision as limited to payments for past medical expenses, in harmony with the Act's third-party liability, cooperation, insurer acceptance, and acquisition provisions. The dissent argued that the majority had read the assignment provision in isolation, displacing the general asset-protective rule established by the anti-lien and anti-recovery provisions. The majority's interpretation of the Act was thus inconsistent with the structure of the Medicaid program as a whole, and would cause unfairness and disruption.

HHS may not vary Medicare prescription drug reimbursement rates by hospital group unless it surveys hospital acquisition costs

American Hosp. Assn v. Beccera, 596 U.S. __, No. 20–1114, 2022 WL 2135490 (June 15, 2022)

A 2006 Medicare statute offers the Department of Health and Human Services (HHS) two alternatives for setting reimbursement rates for certain prescription drugs hospitals provide to Medicare patients. 42 U.S.C. § 1395l(t)(14)(A)(iii). The first option applies if HHS has surveyed hospitals' acquisition costs for each covered outpatient drug; HHS then sets the reimbursement rate based on "the average acquisition cost" of each drug, which may vary "by hospital group." The second option applies if no survey was taken, in which case HHS must set the reimbursement rate based on the average price manufacturers charge for the drug as "calculated and adjusted by the Secretary." HHS did not conduct any surveys or attempt to use the first option for more than a decade. Instead, it used the second option and reimbursed all hospitals at the same adjusted manufacturers' price. But in 2018 and 2019, without conducting surveys, HHS established separate reimbursement rates for hospitals serving lower-income and rural populations through the 340B program. The American Hospital Association and other interested parties challenged the disparate 2018 and 2019 reimbursement rates for 340B hospitals in federal court. The district court ruled for the Association. The D.C. Circuit reversed and the U.S. Supreme Court granted certiorari.

The Supreme Court unanimously reversed the D.C. Circuit, holding that HHS may not vary the reimbursement rates for 340B hospitals if it fails to conduct a survey of hospital acquisition costs and instead sets the reimbursement rate based on the average manufacturer charge. The Court concluded that a federal law permitting 340B hospitals to pay less for covered prescription drugs was immaterial. Congress was aware of that law when it later enacted the prescription drug reimbursement provisions, which

allow HHS to vary reimbursement rates by hospital group only when HHS has performed a survey of hospital acquisition costs. The Court acknowledged that Congress may have intentionally allowed 340B hospitals to receive prescription drugs reimbursements in excess of their acquisition costs to help offset other costs they incur when providing healthcare to uninsured and underinsured individuals, and those who live far away from hospitals and clinics. The Court also rejected HHS's argument that the Medicare statute precludes judicial review of reimbursement rates since HHS relied on Medicare previsions other than the provisions governing prescription drug reimbursement rates. The Court neither mentioned the doctrine of *Chevron* deference nor gave HHS's interpretation of the Medicare Act any deference.

Healthcare providers may not enforce the Medicaid Act's anti-reassignment provision under 42 U.S.C. § 1983

Polk v. Yee, __ F.4th __, No. 20–55266, 2022 WL 2062316 (9th Cir. June 8, 2022)

California's In-Home Support Services (IHSS) program uses Medicaid funding to provide assistance with daily activities to elderly and disabled beneficiaries, often by family members. Although the beneficiaries are responsible for employing and overseeing their IHSS providers, the providers are paid by the State Controller because California designates them as public employees. The Controller makes standard payroll deductions and, as allowed under California law, deductions for union dues. Plaintiffs are IHSS service providers from whose pay the Controller deducted public-sector union dues. When the deductions continued after Plaintiffs resigned from the unions outside annual revocation windows, they sued state officials and their former unions in two class actions under 42 U.S.C. § 1983. They alleged that the dues deductions violated the Medicaid Act's anti-reassignment provision, 42 U.S.C. § 1396a(a)(32), which states "no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service." The district court dismissed both cases, ruling Plaintiffs lacked standing because the anti-reassignment provision does not confer a right that is enforceable under § 1983. Plaintiffs appealed.

The Ninth Circuit affirmed, holding that the anti-reassignment provision does not confer a right that Medicaid providers may enforce under § 1983. The court explained that, for a federal statute to confer a right that is enforceable under § 1983, Congress must have "unambiguously" intended to confer a federal right (and not a mere benefit) upon the particular plaintiff. Statutes generally focused on program policies and procedures typically are not intended to aid particular persons and thus do not create an enforceable right. Here, the Ninth Circuit found nothing in the language or legislative history of the anti-reassignment provision reflecting a Congressional concern with the needs of Medicaid providers. Rather, Congress focused on state administrative payment practices and the need to avoid fraud and abuse in the Medicaid program that was closely connected with the factoring of providers' receivables. Because the statute addresses the state as an administrator in an effort to curb Medicaid fraud and abuse, and only indirectly and incidentally benefits providers, the court concluded that Congress had not "unambiguously" conferred an enforceable right. Accordingly, healthcare providers have no right to enforce Medicaid's anti-reassignment provision under § 1983.

Group health plans do not violate Medicare's Secondary Payer statute by offering all participants the same limited dialysis coverage

Marietta Memorial Hospital Employee Health Benefit Plan v. DaVita Inc., 596 U.S. __, No. 20–1641, 2022 WL 2203328 (June 21, 2022)

Medicare's Secondary Payer statute, 42 U.S.C. § 1395y(b), makes Medicare a "secondary" payer for certain medical services when an individual's insurance plan also provides coverage. Those services include dialysis, a treatment reserved almost exclusively for patients with end stage renal disease. To prevent plans from denying or reducing coverage to circumvent their primary-payer obligation for renal disease, the Medicare statute imposes two restrictions on group health plans. First, plans may not "differentiate in the benefits [they] provide between individuals having end stage renal disease" and other covered individuals based on "the existence of end stage renal disease, the need for renal dialysis, or in any other manner." § 1395y(b)(1)(C)(ii). Second, plans cannot "take into

account that an individual is entitled to or eligible for" Medicare due to end stage renal disease. § 1395y(b)(1)(C)(i).

In this case, the Marietta plan offered all participants the same limited coverage for outpatient dialysis. DaVita, a major dialysis provider, sued the plan, arguing that its limited dialysis coverage violated both statutory restrictions. The district court dismissed DaVita's claims, finding no violation of either provision. The Sixth Circuit reversed, holding that the statute authorized disparate-impact liability and that the plan's limited dialysis coverage imposed such a disparate-impact on individuals with end stage renal disease. The U.S. Supreme court granted certiorari.

The Supreme Court reversed the Sixth Circuit, holding the Marietta plan did not violate the Medicare Secondary Payer statute. The Court explained that § 1395y(b)(1)(C)(ii) only prohibited plans from *differentiating* in benefits between individuals with and without end stage renal disease. Thus, it prohibits plans from imposing higher deductibles or covering fewer services based whether a member has end stage renal disease. The statute does not bar plans, such as Marietta's, that provide uniform (albeit limited) coverage to their participants. The court rejected DaVita's argument that the plan's limited coverage for dialysis was a proxy for differentiating benefits based on whether a plan member had end-stage renal disease—even if individuals with end-stage renal disease disproportionately receive outpatient dialysis. The Court also rejected DaVita's argument that the provision authorized disparate-impact liability, holding that "the text of the statute cannot be read to encompass a disparate impact theory" because it did not address the *effects* of otherwise equitable plan terms. Moreover, the disparate-impact theory would be "all but impossible to fairly implement" because courts would have no basis for determining adequate coverage for different services. Finally, the Court found that Marietta's plan did not impermissibly "take into account" the Medicare eligibility of plan participants with end stage renal disease in violation of 42 U.S.C. § 1395y(b)(1)(C)(i) because the plan offered uniform coverage regardless of enrollees' Medicare eligibility.

Justices Kagan and Sotomayor dissented, arguing that the Court should have ruled that, because outpatient dialysis is an almost perfect proxy for end stage renal disease, the plan's reimbursement limit for outpatient dialysis was really a limit imposed solely on individuals with end stage renal disease, a violation of the differentiation prohibition in § 1395y(b)(1)(C)(ii).

The government must prove beyond a reasonable doubt that a physician knowingly or intentionally acted in an unauthorized manner to convict under the Controlled Substance Act

Ruan v. United States, 597 U.S. __, No. 20–1410, 2022 WL 2295024 (June 27, 2022)

The federal government separately charged Doctors Xiula Ruan and Shakeel Kahn with unlawful dispensing and distribution of drugs in violation of the Controlled Substances Act (CSA), 21 U.S.C. § 841, which makes it a federal crime, *"[e]xcept as authorized*[,] . . . for any person knowingly or intentionally . . . to manufacture, distribute, or dispense . . . a controlled substance." They were convicted at separate trials and their convictions (and sentences in excess of 20 years) were affirmed on appeal. The Tenth Circuit affirmed Dr. Kahn's conviction, holding that his subjective belief that he was meeting a patient's needs was not a complete defense because his conviction could be upheld on the ground his conduct was *objectively* outside the usual course of professional practice. The Eleventh Circuit similarly upheld Dr. Ruan's conviction, rejecting his claim that the government failed to prove that he *subjectively* knew the prescriptions were unlawful. The Eleventh Circuit held the government may prove *either* that Dr. Ruan (1) subjectively knew a prescription was issued for an illegitimate purpose, *or* (2) issued a prescription *objectively* inconsistent with usual medical practice. The U.S. Supreme Court granted petitions for writs of certiorari and consolidated the two cases to decide what *mens rea* applies to § 841's authorization exception.

The Supreme Court reversed both convictions, holding that—once the defendant meets an initial burden of producing evidence of authorized conduct—a conviction under the CSA requires the government to prove beyond a reasonable doubt the physician knowingly or intentionally acted in an unauthorized manner. The government had argued the scienter clause only required proof of "knowingly or intelligently" distributing a controlled substance. But the Court held the scienter

clause also applies to the "except as authorized" clause, even though the former does not immediately precede the latter, because a lack of authorization distinguishes wrongful from proper conduct. If "knowingly" does not modify "unauthorized," then the CSA would criminalize and over-deter innocent and socially beneficial conduct. The severe penalties attached to a CSA conviction further support broad application of the strong scienter requirement.

A concurring opinion by three Justices viewed the CSA "authorization" provision as an affirmative defense, to which a mere preponderance of the evidence standard of proof should apply.

Medicare's low-income patient hospital reimbursement adjustment is based on individuals "entitled" to Part A benefits, even if Medicare doesn't pay for their treatment

Becerra v. Empire Health Foundation, 597 U.S. __, No. 20–1312, 2022 WL 2276810 (June 24, 2022)

Medicare pays hospitals a fixed rate for treating each Medicare patient, regardless of actual costs, subject to hospital-specific rate adjustments. Hospitals that serve an unusually high percentage of low-income patients receive increased Medicare payments via a "disproportionate share hospital" (DSH) adjustment. To calculate entitlement to, and the amount of, a DSH adjustment, the Department of Health and Human Services (HHS) uses a "mind-numbingly complex" formula that adds two statutorily described fractions: the Medicare and Medicaid fractions. The former roughly measures the hospital's low-income senior-citizen population. The latter roughly measures the hospital's low-income non-senior population. The Medicare fraction is the number of patient days attributable to patients "entitled to benefits under part A of Medicare," plus supplementary security income benefits (SSI), divided by the number of days attributable to all Medicare patients. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Medicaid fraction is the number of patient days attributable to patients "eligible for Medicaid," but not entitled to benefits under Part A, divided by the total number of patient days. Id. § 1395ww(d)(5)(F)(vi)(II).

When a person turns 65, or has received federal disability benefits for 24 months, he automatically becomes "entitled" to benefits under Medicare Part A, which includes coverage for in-patient hospital treatment. However, there are instances where Part A will not cover qualifying patients' treatment, for example, because they have private health insurance that must be exhausted first. The issue presented here is whether the numerator of the Medicare fraction includes patients "entitled" to Medicare benefits by virtue of their age or disability, even if Medicare did not actually pay for hospitalization expenses because, for example, those expenses were paid by private health insurance.

For seven years after it was enacted, HHS construed the statute as *excluding* from the Medicare fraction Medicare patients whose treatment was not paid by Medicare. Then, in 2004, HHS adopted a regulation requiring the Medicare fraction to *include* all patients who meet the criteria for Medicare Part A coverage regardless whether Medicare paid for their treatment. Empire Health Foundation challenged the regulation as inconsistent with the statute. The Ninth Circuit agreed with Empire Health, holding that "entitled" to Part A benefits "meets the Medicaid statutory criteria" but "eligible" for Medicare assistance means an absolute right to have Medicare pay for treatment. The Supreme Court granted certiorari on the issue of whether a patient who qualifies for Medicare Part A, but who does not pay for treatment under the plan, is "entitled to [Medicare Part A] benefits" for the purpose of computing a hospital's DSH percentage?

The Supreme Court reversed, holding that, in calculating the Medicare faction, patients "entitled" to Medicare Part A benefits are those who qualify for the program, regardless whether Medicare pays for their hospital expenses. The Court held that "entitled" to benefits is a term of art that means qualifying for benefits. A limitation on payments due to a condition, such as exceeding the 90-day hospital stay cap, does not terminate a patient's entitlement to coverage for other medical treatment. Moreover, because other Medicare beneficiary rights are conditioned on entitlement to benefits, Empire's definition would fluctuate constantly depending on whether Medicare paid for patients' hospital care each day. The Court also rejected Empire's argument that the uses of "(for such days)" in the statue gives "entitled" a meaning different from the rest of the Medicare statute, concluding that it only requires

the HHS to exclude days before the beneficiary became eligible for Part A benefits. Finally, under the HHS definition, all low-income people fit neatly into either the Medicare or the Medicaid fraction, with the "sum of the two leaving no one out."

Justice Kavanaugh dissented, joined by Chief Justice Roberts and Justices Alito and Gorsuch. The dissent zeroed in on the statutory phrases "entitlement to have payment made" and "for such days" as requiring the Medicare fraction to include only patients whose treatment was paid by Medicare. They explained that a patient was *not* entitled to have payment made by Medicare for days spent in the hospital if the patient could not (and did not) have payment made by Medicare for those days. The dissent reasoned that "the retrospective reimbursement provision at issue focuses laser-like on whether the patient was actually entitled to have payment made by Medicare for particular days in the hospital. A patient cannot be simultaneously entitled and disentitled to have payment made by Medicare for a particular day in the hospital." Finally, the dissent faulted the HHS for changing its position over time to reduce its reimbursement requirement to hospitals serving low-income patients.

Ostensible agency theory fails where patient's personal physician performs surgery at a hospital

Magallanes de Valle v. Doctors Medical Center of Modesto (June 24, 2022, F082099), __ Cal.App.4th ___, 2022 WL 2286969, ordered published July 5, 2022

Elisa Magallanes de Valle selected Dr. Rebecca Brock as her treating physician. Dr. Brock treated her for about a year before performing her hysterectomy at Doctors Medical Center of Modesto (DMC). Magallanes sued Dr. Brock for medical negligence after sustaining rectal injuries during that surgery. She also sued DMC, alleging that Dr. Brock was its ostensible agent. DMC moved for summary judgment, presenting evidence that Magallanes selected her personal physician and signed DMC's Conditions of Service form stating that physicians were not employees or agents of the hospital. Magallanes filed an opposing declaration stating that she did not understand the admissions form because it was written in English and she only understands Spanish, and argued there was a triable issue whether she received actual notice that Dr. Brock was an independent contractor and not DMC's agent. The trial court granted DMC's motion, ruling that Magallanes's pre-existing relationship with Dr. Brock defeated the ostensible agency claim as a matter of law. Magallanes appealed.

The Court of Appeal affirmed. The court explained that "this was not a situation where Magallanes 'looked to the hospital' for surgical care and relied on the hospital's selection or assignment" of her surgeon. Rather, Magallanes had previously selected and maintained a relationship with Dr. Brock, and therefore "did not rely on the apparent agency relationship between DMC and Dr. Brock" when seeking and receiving surgical care. Under the circumstances, Magallanes reasonably should have known that Dr. Brock was not an agent of the hospital, and was instead utilizing the hospital's surgical facility to care for her own patient. The trial court therefore correctly ruled that Magallanes' ostensible agency theory failed as a matter of law.

Noncontracted providers of nonemergency services to Medi-Cal managed care plan enrollees are not entitled to reimbursement exceeding Medi-Cal fee schedule rates

Allied Anesthesia Medical Group, Inc. v. Inland Empire Health Plan (June 10, 2022, E074729) __ Cal. App.5th __ [2022 WL 2390162]

Plaintiffs Allied Anesthesia Group, Inc., and Upland Anesthesia Medical Group provided anesthesia services for elective, nonemergency surgeries to enrollees of Inland Empire Health Plan (IEHP), a Medi-Cal managed care plan. Plaintiffs had no provider contract with IEHP, but had exclusive agreements with the hospitals where the surgeries were performed. After IEHP reimbursed plaintiffs at the Medi-Cal fee schedule rate for anesthesia services, plaintiffs sued IEHP for breach of contract (as third-party beneficiaries) and breach of implied-in-fact contract, arguing that its payments were less than the "reasonable and customary value" of the services that IEHP was required to pay plaintiffs as contracted providers without a written contract pursuant to the Knox-Keene Act's implementing regulation, California Code of Regulations, title 28, section 1300.71, subdivision (a)(3)(B). The trial court sustained IEHP's demurrer without leave to amend, and entered judgment for IEHP. Plaintiffs appealed.

The Court of Appeal affirmed. First, the court held that plaintiffs' breach of contract claim failed because they were not third party beneficiaries of IEHP's contract with the California Department of Health Care Services. The intended beneficiaries of that contract were the plan's enrollees. While that contract contained some provider compensation provisions, its overriding purpose was to ensure enrollees had access to health care; any benefit to providers was incidental and therefore inadequate to support a third party beneficiary claim. Second, the court held plaintiffs failed to allege essential elements of an implied-in-fact contract claim. Because plaintiffs failed to allege any communications or agreement with IEHP regarding their anesthesia services, the court rejected plaintiffs' argument that IEHP's authorization of its enrollees' elective, nonemergency surgeries that required anesthesia supported an implied agreement to pay plaintiffs a higher rate than the Medi-Cal fee schedule rate. Plaintiffs did not ask IEHP for separate authorization and did not communicate a customary rate to IEHP before providing anesthesia services. IEPH's reimbursement at Medi-Cal rates reflected its belief that those rates applied, defeating a "meeting of the minds" claim about paying more than Medi-Cal rates. Moreover, even if IEHP were required to reimburse plaintiffs for the reasonable and customary value of their services, California Code of Regulations, title 22, section 51503, would cap that amount at the Medi-Cal rate absent an agreement to pay more (which was lacking here). The court distinguished authority allowing providers to recover in quantum meruit for *emergency* services.

Hospitals have no duty to post signs disclosing the ER fees published in the chargemaster

Saini v. Sutter Health (June 17, 2022, A162081) __ Cal.App.5th __ [2022 WL 2643451], ordered published July 8, 2022

After plaintiff Dar Saini was treated at a Sutter Health emergency room, he received a $4,593 bill that included a $2,811 evaluation and management services (EMS) fee. Saini sued Sutter, alleging that its failure to disclose the EMS fee in emergency room signage violated both the unfair competition law (UCL) and the Consumer Legal Remedies Act (CLRA). Under the Payers' Bill of Rights, California hospitals must publish a "charge description master" (chargemaster) identifying uniform charges for their services and post notices informing patients how to access the chargemaster. Although Sutter had disclosed the EMS fee in its chargemaster and provided the required notice of how to access it, Saini argued that Sutter had a separate duty to notify prospective patients of its intent to bill the EMS fee before providing emergency services. The trial court sustained Sutter's demurrer, ruling that it had no duty to separately post notice of the EMS fee in its emergency room. Saini appealed.

The Court of Appeal affirmed, following a recent decision in *Gray v. Dignity Health* (2021) 70 Cal.App.5th 225 that rejected an essentially identical CLRA claim. The court rejected Saini's contention that *Gray* was wrongly decided, agreeing with *Gray* that " 'requiring such disclosure would be inconsistent with the "strong legislative policy" reflected in the applicable "multifaceted statutory and regulatory scheme" designed "to ensure that emergency medical care is provided immediately to those who need it, and that billing disclosures not stand in the way of that paramount objective.' " The court also noted that the UCL requires only reasonable notice–not " 'the best possible notice.' " Because Sutter complied with its statutory and regulatory disclosure requirements, it did not conceal or have "exclusive knowledge" that it would charge the EMS fee and therefore owed no additional disclosure duty under the UCL or CLRA. The court further agreed with *Gray* that state and federal legislative bodies are in a superior position to balance the need to ensure full disclosure of fees against the need to provide prompt emergency medical treatment.

Hospital not liable for staff physician's alleged malpractice under actual or ostensible agency theories

Franklin v. Santa Barbara Cottage Hospital (Aug. 8, 2022, B311482) __ Cal.App.5th __, 2022 WL 3151202, ordered published August 22, 2022.

Plaintiff Michael Franklin's primary care physician referred him to Dr. John Park, a neurosurgeon, for herniated disc treatment. Franklin viewed webpages indicating that Dr. Park was associated with Cottage Hospital before seeing him for treatment. Dr. Park concluded that Franklin needed surgery and advised him to present at

the Hospital's emergency room when Dr. Park was on duty to ensure the cost would be covered by insurance. When Franklin went to the ER, Hospital staff provided him with an admissions form (which he signed) stating that Dr. Park was an independent contractor, not an employee. After the surgery, Franklin developed neurological issues and sued Dr. Park for medical malpractice. Plaintiff also sued the Hospital, alleging it was responsible for Dr. Park's malpractice under actual and ostensible agency theories. Dr. Park settled and the trial court granted the Hospital's motion for summary judgment. Franklin appealed.

The Court of Appeal affirmed. First, the court held that, as a matter of law, Dr. Park was not the Hospital's *actual* agent with respect to the surgery that allegedly injured Franklin because the Hospital had no ability to control how Dr. Park performed that surgery. The Hospital's contracts with Dr. Park concerned other matters, such as requiring him to treat Medicare patients, participate in an on-call physician panel, and limit his vacations. Next, the court held that no evidence supported Franklin's claim that Dr. Park was the Hospital's *ostensible* agent. Franklin, not the Hospital, had selected Dr. Park for the surgery. Additionally, Franklin had signed a written admissions form explaining that Dr. Park was not the Hospital's employee. In addition, online articles stating Dr. Park had joined the Hospital did not create a triable issue because they did not state that Dr. Park was the Hospital's employee and "it is common knowledge that Hospital websites often list staff physicians." Finally, Franklin's admission that he never considered the legal relationship between the Hospital and Dr. Park (before suing) proved that he did not rely on any alleged representation that Dr. Park was the Hospital's agent.

Agent authorized to make health care decisions under an Advanced Directive may not bind patient to nursing facility's arbitration agreement

Logan v. Country Oak Partners, LLC (Aug. 18, 2022, B312967) __ Cal. App.5th __ [2022 WL 3500353]

Plaintiff Charles Logan executed an Advanced Directive (Prob. Code, §§ 4600–4805) appointing his nephew, Mark Harrod, as his health care agent. Harrod had authority to make "health care decisions" for Logan if he could not make them himself. Logan was admitted to defendants' skilled nursing facility, where Harrod executed an admissions agreement and a separate arbitration agreement on Logan's behalf as his "Legal Representative/Agent." Logan later sued the facility and its owners, alleging elder abuse, negligence, and violations of the Residents' Bill of Rights. The defendants moved to compel arbitration, which the court denied. Defendants appealed.

The Court of Appeal affirmed, holding that an agent's authority to make health care decisions does not include the authority to enter into arbitration agreements. Relying on *Garrison v. Superior Court* (2005) 132 Cal.App.4th 253, defendants argued Harrod could sign the arbitration agreement on Logan's behalf because the Directive authorized him to choose an appropriate health care facility. The Court of Appeal disagreed, holding that—contrary to the reasoning in *Garrison*—the relevant statutes limit health care decisions to the treatment of "physical or mental conditions." (Prob. Code, § 4615.) The decision to enter into an arbitration agreement is not a health care decision, "[r]ather it is a decision about how disputes over health care decisions will be resolved." The court also rejected *Garrison*'s holding that an agent could enter into an arbitration agreement as part of the "necessary or proper" excise of an agent's authority. Because the arbitration agreement was optional, its execution could not be necessary to Harrod's agency. Finally, the court drew support from recent federal regulations prohibiting Medicare and Medicaid nursing facilities from requiring arbitration agreements for admission; "arbitration agreements are not executed as part of the health care decision making process, but rather are entered into only *after* the agent chooses a nursing facility based on the limited options available and other factors unrelated to arbitration."