# APPELLATE CASE SUMMARIES

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## CASE NOTES

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### Medical malpractice plaintiff's ostensible agency theory rebutted by hospital's independent contractor notice

*Wicks v. Antelope Valley Healthcare District (June 1, 2020, No. B297171) __ Cal. App.5th __ [2020 WL 2832563]*

Matthew Wicks went to Antelope Valley Hospital's emergency room for stomach, chest, and neck pain. Hospital nurses and two independent contractor ER doctors evaluated him. He was then discharged with instructions to see a cardiologist the next day, but he died eight hours later from an acute aortic dissection. His family sued the hospital, alleging its nurses provided negligent care, it negligently credentialed the ER doctors, and the ER doctors were its ostensible agents.

The hospital moved for summary judgment. In opposition, plaintiffs offered expert testimony that if the nurses had gathered Wicks's complete medical history, they likely would have alerted the ER doctors, who probably would have consulted with a cardiologist, who probably would have ordered a CT scan with IV contrast that probably would have revealed the aortic dissection, leading to a cardiothoracic surgery consult that probably would have resulted in Wicks receiving a timely diagnosis and treatment. Plaintiffs also argued the hospital's expert declarations of adequate treatment and supervision were conclusory and hearsay, and whether a hospital is responsible for negligent ER physicians is always a triable issue of fact. The trial court granted summary judgment for the hospital.

The Court of Appeals affirmed. The hospital properly relied on authenticated business records and an expert's review of those records. In contrast, plaintiffs' theory of causation was too speculative to create a triable issue of causation. In addition, the hospital granted the ER doctors staff privileges using appropriate procedures for the appointment and evaluation of independent contractor physicians. Further, the hospital proved that Wicks was alert in the ER and could have conveyed any important medical information to the ER doctors when they took his history, and understand the admission forms he executed and initialed. Finally, the ER doctors were not ostensible agents of the hospital because the hospital admissions forms provided clear notice that the ER physicians were independent contractors.

### Supreme Court clarifies equitable tolling principles applicable to challenges to DPH rulings

*Saint Francis Memorial Hospital v. State Department of Public Health (June 29, 2020, S249132) __ Cal.5th __ [2020 WL 3526741]*

After a surgical sponge was inadvertently left inside a patient, the State Department of Public Health fined Saint Francis Memorial Hospital for failing to develop and implement a sponge count procedure and a policy for properly training its staff. Saint Francis sought administrative review. The administrative law judge issued a proposed decision reversing the fine on the ground that Saint Francis had adequate surgical safety policies in place and the governing regulations did not impose strict liability for deviations from those policies. On administrative appeal, the Department reversed, ruling that the fine was appropriate because Saint Francis necessarily failed to "implement" its sponge count policy.

Because the Department's appellate decision was "effective immediately," it triggered the 30-day deadline to file a petition for writ of administrative mandate. But Saint Francis sought reconsideration, which the Department denied on the ground reconsideration was unavailable because its decision was final immediately. Saint Francis then filed a petition for a writ of administrative mandamus. The writ petition was filed within 30 days of the denial of reconsideration, but more than 30 days after the Department's initial appellate decision. The Department demurred to Saint Francis's writ petition, arguing it was untimely. The trial court sustained the demurrer, agreeing with the Department and rejecting Saint Francis's mistake of law argument. (See Gov. Code, § 11523.) The Court of Appeal affirmed, holding that, because Saint Francis's request for reconsideration was not a "timely pursuit

of an available remedy," equitable tolling of the writ deadline was unavailable.

The Supreme Court granted review, reversed the Court of Appeal, and remanded for further proceedings on whether the limitations period was equitably tolled. In doing so, the Supreme Court clarified equitable tolling law. Initially, the Court explained that equitable tolling is presumptively available unless the Legislature clearly forbids it. It then held that equitable tolling may apply to petitions filed under section 11523 because nothing in the text or legislative history of that statute expressly forbids tolling.

Next, the Court explained that, regardless whether a litigant had pursued a viable alternative remedy, equitable tolling may apply if three elements are satisfied: (1) timely notice to the defendant of the plaintiff's claim, (2) a lack of prejudice to the defendant's ability to address the merits of the claim, and (3) the reasonable and good faith conduct of the plaintiff. Here, Saint Francis could potentially satisfy all three elements.

First, Saint Francis's request for reconsideration, although defective, gave the Department adequate and timely notice of its claim. Second, the Department's ability to contest the merits of Saint Francis's claim would be unimpaired by tolling. Third, whether Saint Francis's actions were reasonable and in good faith depends on its ability to establish *both* that its late filing was *objectively* reasonable under the circumstances *and* that it acted with *subjective* good faith (i.e., the result of an honest mistake). Because the record was undeveloped, the Court remanded the case for a determination whether Saint Francis satisfied the third element.

### Federal law regulating medical devices does not preempt all state products liability claims

*Mize v. Mentor Worldwide LLC (July 2, 2020, B295829) __Cal.App.5th __ [2020 WL 3602482]*

Under the Medical Device Amendments (MDA) to the federal Food, Drug, and Cosmetic Act, breast implants are Class III medical devices, which require a rigorous and lengthy premarket approval process. During that period, manufacturers can apply to use the device in clinical tests. Mentor Worldwide LLC obtained FDA approval for several clinical studies of its non-approved MemoryGel breast implants. A few years into the trials, the FDA sued Mentor for failing to meet manufacturing quality standards, high implant rupture rates, and other violations. The FDA and Mentor resolved that lawsuit with a consent decree. Two years later, plaintiff Rexina Mize received MemoryGel implants through one of the clinical studies. She allegedly did not meet the study criteria and never consented to participating in the study or to the use of non-approved implants. Mize sued Mentor in state court, alleging that defects in the MemoryGel implants caused her to suffer health injuries and lost business opportunities. The trial court sustained Mentor's demurrer, ruling that Mize's product defects claims were preempted by federal law and that she insufficiently pleaded causation. Mize appealed.

The Court of Appeal reversed. The court explained that the MDA expressly preempts state requirements that are "different from, or in addition to" any federal requirement and relate to the "safety or effectiveness of the device" or other matters included in a federal requirement. Another provision provides that all proceedings to enforce, or to restrain violations, of the MDA "shall be by and in the name of the United States." Together, these preemption and enforcement provisions create a "narrow gap" through which a state-law claim must fit to survive preemption: the claim must be premised on conduct that both violates the MDA and would give rise to a state-law recovery in the absence of the MDA. Here, Mize's claims survived preemption because Mentor had a state-law tort duty to manufacture implants in compliance with FDA requirements that "would exist regardless of whether the FDA or some other federal or state agency imposed the obligations." The Court of Appeal also held plaintiff pleaded the requisite causal connection between her injuries and Mentor's tortious act to survive demurrer.

### Health Insurer violates the Cartwright Act by prohibiting wrapping of insurance plans by brokers and agents

*Ben-E-Lect v. Anthem Blue Cross Life and Health Ins. Co. (July 2, 2020, A152080) __ Cal.App.5th __ [2020 WL 3603928]*

Ben-E-Lect, a third-party insurance claim administrator, developed a "wrapping" strategy for reducing employer health insurance costs by bundling low-premium, high-deductible health insurance with self-funded accounts to pay employee healthcare expenses within the annual deductible and any co-pay requirements. Ben-E-Lect sold its wrapping services through insurance brokers and agents to the small-employer market. Between 2006 and 2014, Anthem restricted and eventually prohibited wrapping of all Anthem insurance policies, threatening to withhold commissions and terminate its relationship with any broker or agent that wrapped an Anthem policy. Ben-E-Lect sued Anthem under several legal theories for prohibiting the wrapping of its insurance policies. Following a bench trial, the trial court found that Anthem's wrapping prohibition violated the Cartwright Act and tortiously interfered with Ben-E-Lect's business relations, awarded treble damages of $7.33 million under the Cartwright Act, and enjoined Anthem from prohibiting wrapping of insurance products offered to the California small-employer market. Anthem appealed.

The Court of Appeal affirmed. The court held that substantial evidence supported the trial court's determination that, analyzed under antitrust law's rule of reason, Anthem's wrapping prohibition amounted to a vertical boycott that had a substantial adverse effect on competition. The court rejected Anthem's argument that it could not be liable for conspiring with its own agents because the agents could act independently on behalf of their clients, could sell non-Anthem insurance products, and had separate economic interests.

The court also rejected Anthem's argument that Ben-E-Lect failed to prove that Anthem had sufficient market power in the relevant geographical market to charge prices higher than the competitive level. The court explained that, in a vertical boycott case, the inquiry is whether the defendant plays enough of a role in the relevant market to significantly impair competition, not whether it could raise prices above the competitive level. Here, there was substantial evidence that Anthem could significantly influence the market for small-employer health plans; it controlled 25% of the California market and was the

dominant provider to the small-employer market in numerous large geographic areas.

Substantial evidence also supported the trial court's determinations that the anticompetitive aspects of Anthem's conduct outweighed its procompetitive aspects, and that Anthem's wrapping prohibition unreasonably relied on projected utilization rates based on generalized statistical guidelines rather than an analysis of Anthem's actual experience that conflicted with the general statistical guidelines. Ben-E-Lect also presented evidence that wrapping only minimally increased utilization, and that it experienced a pattern of reduced sales over the years Anthem's wrapping prohibition was in place. Finally, Anthem's own expert evidence supported the damage award.

### Medical expert's conclusory standard of care declaration does not support summary judgment

*McAlpine v. Norman (June 22, 2020, C088327) __ Cal.App.5th __ [2020 WL 3833019]*

Christi McAlpine filed a medical malpractice action against Dr. Daniel Norman for injuries stemming from colonoscopies that he performed. Dr. Norman moved for summary judgment based on a declaration from a gastroenterology expert who reviewed the medical records and opined that Dr. Norman's actions were "at all times" within the standard of care. The expert noted that McAlpine's colon perforation was a known risk of a colonoscopy and that she gave informed consent for the procedure after being advised of that risk. McAlpine opposed the motion, but failed to submit any expert declarations. McAlpine also sought leave to amend her complaint to add (1) the physician who lacerated her liver and spleen during a follow-up emergency surgery, (2) a new cause of action against Dr. Norman for improperly delegating to his staff the duty to obtain her informed consent, and (3) additional factual allegations supporting her malpractice claim against Dr. Norman based on his failure to properly examine her colon for perforations before terminating the procedure. The trial court denied leave to amend and granted summary judgment. McAlpine appealed.

The Court of Appeal reversed, holding that the trial court improperly granted summary judgment based on the gastroenterologist's opinion that was "unsupported by factual detail or reasoned explanation." The court explained that the expert had failed to address whether Dr. Norman had negligently failed to detect the colon perforation, the standard for determining whether a perforation had occurred, and the type of conduct required to meet that standard. Although the expert opined that Dr. Norman "at all times" met the standard of care, that conclusory statement was insufficient to negate malpractice at the summary judgment stage.

The Court of Appeal affirmed the denial of McAlpine's request to amend her complaint. First, McAlpine long knew about the physician who lacerated her liver and spleen during emergency surgery and had no adequate excuse for not suing him when she sued Dr. Norman. McAlpine similarly had no excuse for waiting until the eve of trial to raise the informed consent issue. Finally, while alleging additional factual support for her malpractice claim "might have been helpful to better frame the issues in the pleadings, it was not strictly necessary." Therefore, the trial court did not abuse its discretion by denying leave to amend.

### The ACA authorizes regulators to create religious and moral exemptions to mandated contraceptive health insurance coverage

*Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, __ U.S. __, Nos. 19-431 and 19-454, 2020 WL 3808424 (July 8, 2020)*

The Patient Protection and Affordable Care Act (ACA) requires employers to provide women with "preventive care and screenings" without cost sharing, and requires the Heath Resources and Services Administration (HRSA) to issue comprehensive guidelines defining such services. These requirements have been the subject of continuous litigation. The HRSA initially issued guidelines defining "preventative care" as including a "contraceptive mandate." In response to complaints by religious employers, federal agencies administering the ACA directed the HRSA to exempt churches and a narrow category of religious nonprofit entities from the contraceptive mandate (the "church exemption"). Then, in response to continued objections, agencies issued a new regulation that created an "accommodation" for certain religious non-profit employers, allowing them to "self-certify" their eligibility and provide that certification to their health insurer, who would exclude contraceptive coverage from the employer's group health plan while providing payments to beneficiaries for contraceptive services separate from the health plan. After *Burwell v. Hobby Lobby Stores, Inc., 573 U.S.* 682, 696-697 (2014), and *Zubik v. Burwell*, 578 U.S. __, __, 136 S. Ct. 1557, 1560 (2016), the HRSA issued interim rules expanding the definition of exempt religious employers and creating a "moral exemption" for employers holding a sincere moral objection to the contraception mandate. After completing the Administrative Procedure Act's (APA) rule-making procedure, HRSA issued final rules that closely tracked its interim rules.

Pennsylvania and New Jersey sued in federal court, contending that the new rules violated both the ACA and the APA. The Little Sisters of the Poor, a Catholic organization, intervened to defend the exemption rules. The district court issued a nationwide injunction blocking enforcement of the rules. The Little Sisters and the Government appealed. The Third Circuit affirmed, holding that (1) the ACA authorized the HRSA to define what preventive care and screening services are required, but did not authorize the HRSA to carve out exemptions from those requirements, (2) the Religious Freedom Restoration Act (RFRA) did not compel or permit the exemption, (3) the self-certification accommodation did not substantially burden religion, and (4) the final rules were procedurally defective under the APA because agencies failed to exhibit open-mindedness during the notice-and-comment process.

The Supreme Court reversed (7-2), holding that federal agencies had statutory authority to enact the religious and moral exemptions, and that the rules promulgating these exemptions were free from procedural defects. First, the Court held the ACA itself grants "sweeping authority to the HRSA" to craft "comprehensive guidelines" and this "virtually unbridled discretion to decide what counts as preventative care and screening" includes the power to create religious and moral exemptions. The Court did not decide whether RFRA independently compelled or authorized the religious exemption, but

it held that it was appropriate for HRSA to consider RFRA when establishing exemption rules. Finally, the Court held that the exemptions were not procedurally defective under the APA because promulgating a document entitled "Interim Final Rules with Request for Comment" provided sufficient notice, even though it was not labelled "General Notice of Proposed Rulemaking." Moreover, there is no "open-mindedness" test under the APA and courts are not permitted to impose judge-made procedural requirements exceeding APA mandates, which the final exemption rules met.

Justice Alito filed a concurring opinion, which Justice Gorsuch joined, stating that RFRA *compels* HRSA to create the religious exemption to the contraceptive mandate because neither the ACA nor any other law makes RFRA inapplicable. He would have held that the contraceptive mandate (1) is a substantial burden on an employer's free exercise of religion, as *Hobby Lobby* held, (2) does not further a compelling government interest, as reflected by the fact that *Congress* did not treat it as a compelling interest when enacting the ACA; and (3) was not the least restrictive means of providing cost-free contraception, since Congress could create a stand-alone program to do that.

### ACA's nondiscrimination mandate prohibits discriminatory design of health insurance benefits

*Schmitt v. Kaiser Foundation Health Plan, __ F.3d __, No. 18-35846, 2020 WL 3969281 (9th Cir. July 14, 2020)*

Section 1557 of the Patient Protection and Affordable Care Act (ACA) prohibits discrimination in the healthcare system by incorporating four nondiscrimination statutes—including the Rehabilitation Act, which prohibits certain types of disability discrimination. Andrea Schmitt, who has a severe hearing loss disability, filed a class action against Kaiser Foundation Health Plan, alleging that it unlawfully discriminated against her and other hearing-disabled plan members by excluding all hearing loss treatments except cochlear implants. The district court dismissed the complaint with prejudice for failure to state a claim, ruling that Kaiser has discretion under the ACA regarding the scope of benefits it provides in a non-discriminatory manner, and Schmitt's allegations failed to raise a plausible discrimination claim because Kaiser afforded the same benefits to disabled and nondisabled plan participants.

The Ninth Circuit affirmed the dismissal of Schmitt's complaint, but reversed to allow her to amend the complaint. The court explained that an insurer does not provide essential health benefits under the ACA if its plan design discriminates based on disability status. Kaiser had defended its plan because it complied with the state's benchmark plan, but the court held that was not the same as compliance with section 1557. Compliance with the ACA presents a federal question that a state cannot control through benchmarks. The court also rejected Kaiser's contention that, if the ACA required nondiscriminatory plan benefit design, then insurers will be forced to cover all treatments; the court explained that, if insurers have reasonable, nondiscriminatory reasons to exclude certain coverage, they may do so.

The court then held that Schmitt's complaint failed to state a plausible discrimination claim because it defined "people with hearing loss" as a proxy for "hearing disability" when many non-disabled people experience some loss of hearing. Moreover, while "'overdiscrimination is prohibited,'" the complaint alleged no factual basis for inferring that the proxy's " 'fit' is 'sufficiently close' to make a discriminatory inference plausible." Further, Kaiser's coverage of cochlear implants and related services could meet the needs of some or most disabled plan members, undermining a discrimination claim. However, the court determined that Schmitt might be able to cure the deficiencies in her complaint and remanded with instructions to allow such an amendment.

### Temporary conservators cannot bind conservatee to arbitration agreement absent consent or lack-of-capacity ruling

*Holley v. Silverado Senior Living Management, Inc. (August 7, 2020, G058576) __Cal. App.5th__[2020 WL 4558940]*

Elizabeth Holley became a patient at the Silverado Senior Living facility when she was 77 years old and suffering from dementia and other medical problems. Diane and James Holley became Elizabeth's temporary conservators. When admitting Elizabeth to Silverado, Diane and James signed a "Resident-Community Arbitration Agreement" on her behalf. Six days later, the probate court granted Diane and James's petition, as Elizabeth's temporary conservators, to place Elizabeth at Silverado and ordered them to assume the role of Elizabeth's conservators with the authority to place her in a locked facility.

A few months later, Elizabeth died after suffering a humeral fracture, an injury to her arm, a fractured hip, and numerous bruises. Diane and James sued Silverado for elder abuse, negligence, breach of contract, and wrongful death. Silverado moved to compel arbitration, which the trial court denied after finding that Diane and James had no authority to bind Elizabeth to an arbitration agreement. Silverado appealed, arguing "the agreement to arbitrate was a 'health care decision' to which a conservator had the authority to bind a conservatee."

The Court of Appeal affirmed. The court explained that, as temporary conservators, Diane and James "lacked the power to bind Elizabeth to an agreement giving up substantial rights [such as 'the right to use the courts for redress of grievances'] without her consent or a prior adjudication of her lack of capacity." Prior cases have held that the decision to execute an arbitration agreement upon admission to a senior living facility is a healthcare decision. However, the power of a *temporary* conservator to make medical decisions on behalf of a conservatee is limited. If a conservatee's lack of capacity has not been adjudicated, then the conservatee must consent to medical treatment (including arbitration). Here, there was no evidence of Elizabeth's consent, and a court first ruled that she lacked capacity six days after Diane and James executed the arbitration agreement on her behalf. Diane and James therefore lacked the power to bind Elizabeth to arbitration at the time they executed the agreement.

### DHS must reimburse Medi-Cal providers for employees' in-house treatments

*Oak Valley Hospital District v. State Dept. of Health Care Services (Aug. 8, 2020, C085869) _ Cal.App.5th _ [2020 WL 4581286]*

The Department of Health Services (DHS) administers the California's Medi-Cal program and reimburses Medi-Cal hospital service providers for allowable costs. The Center for Medicare and Medicaid Services issues the Medicare Provider Reimbursement Manual, which governs what payments are owed. Section 2144.4 of the Manual allows reimbursement for the cost of providing in-house services to hospital employees through self-insurance programs. Under section 2162.7 of the Manual, hospitals with non-qualifying self-insurance programs are entitled to reimbursement only for payments *from* their fund, which must be based on the reasonable cost of the services provided.

Oak Hospital District and Ridgecrest Regional Hospital provided health benefits to their employees through non-qualifying self-insurance programs that allowed the employees to obtain medical services in-house or from third-party providers. Third-party claims administrators reviewed all claims, then paid approved claims from accounts funded by the hospitals. The hospitals included the cost of these in-house and third-party-approved claims in their cost reports to DHS. The DHS reimbursed them for third-party provider costs, but not for in-house services. The DHS's decisions were upheld in formal administrative proceedings, but the hospitals successfully petitioned for writs of administrative mandate reversing the administrative decisions. DHS appealed.

The Court of Appeal affirmed, holding Medi-Cal providers *are* entitled to reimbursement for the costs of providing in-house medical services for their own employees through self-insurance programs. The court rejected DHS's argument that in-house costs were categorically nonallowable. The court found nothing in Manual section 2162.7 distinguishing claims paid for in-house services from those paid to third parties. Additionally, the costs for in-house services were not inherently unreasonable. The hospitals incurred actual costs by providing services that were not otherwise reimbursed. The court also rejected DHS's argument that Manual sections 332, 332.1, and 2144.4 support categorical denial. Sections 332 and 332.1 apply only when the patient is billed directly; they do not apply to the reimbursement of hospital self-insurance plans. Moreover, there were no "unrecovered costs" triggering section 2144.4 because the hospitals were entitled to reimbursement under section 2162.7.

### "Patients Bill of Rights" statutory penalty applies per action, not per violation

*Jarman v. HCR Manorcare, Inc. (Aug 17, 2020, S241431) __ Cal.5th __ [2020 WL 4744241]*

John Jarman stayed three months at an HCR ManorCare skilled nursing facility while recovering from hip surgery. About two years later, Jarman sued HCR, alleging violations of the "Patients Bill of Rights" (Health & Saf. Code, § 1430, subd. (b) (section 1430(b)), elder abuse, neglect, and negligence. The jury found that HCR was liable for 382 regulatory violations, and awarded Jarman $250 per violation, plus $100,000 in damages. The trial court struck Jarman's punitive damages claim even though the jury found that HCR engaged in oppression, malice, or fraud, due to concerns regarding the sufficiency of the evidence. The court entered judgment for $195,500 plus attorney fees. Both sides appealed. The Court of Appeal held that the trial court had erred by striking the punitive damages claim, and rejected HCR's claim that Jarman was limited to $500 in statutory damages under section 1430, subdivision (b). The court instead held that a statutory penalty of up to $500 could be recovered on each of cause of action.

The Supreme Court granted review to address two questions: (1) Does the Patients Bill of Rights authorize a maximum penalty of $500 per "cause of action" against a skilled nursing facility or only $500 per lawsuit? (2) Does the Patients Bill of Rights authorize an award of punitive damages? (The Court ultimately declined to review the second issue.)

The Supreme Court held that the section 1430(b) penalty applied per action (meaning per lawsuit), rejecting a dissenting opinion that it should be applied per violation. The Court observed that section 1430(b) "is far from clear" regarding how the statutory penalty is applied. However, the Court observed that, in related contexts, the Legislature had clearly specified when other penalties were to be assessed per violation. Moreover, because many of the rights protected by section 1430(b) overlap, and there was difficulty distinguishing a series of violations from a single continuing violation, the Court thought it improbable that the Legislature intended the penalty to be applied in a sliding-scale fashion based on the severity of the infraction. Furthermore, the statutory penalty in private enforcement actions applies to all infractions regardless of severity, while citations issued by the Department of Public Health are classified based on severity. Allowing private penalties to be assessed per violation would anomalously allow penalties for minor infractions to be worth twice the monetary redress that the Department could impose for more severe violations. In addition, the Legislative history of section 1430(b) indicated that the Legislature originally and consistently thereafter intended the penalty to apply per lawsuit. Finally, the Court rejected the claim that limiting the section 1430(b) penalty to $500 per lawsuit rendered the statute "toothless" since injunctive relief, damages, and attorney fees were available in addition to the penalty, and doctrines of claim and issue preclusion would prevent plaintiffs from evading the cap by filing multiple lawsuits.

Justice Cuellar filed a dissenting opinion, joined by Justice Liu, arguing that a per violation approach did not present significant practical difficulties and would further the Patients Bill of Rights' fundamental purpose of deterring violations. He urged the Legislature to modify the statutory scheme to achieve a more robust deterrent effect.

### MICRA damages cap does not apply to certain medical battery claims

*Burchell v. Faculty Physicians & Surgeons of Loma Linda School of Medicine (Sept. 10, 2020, E071146) __Cal.App.5th__ [2020 WL 5422950]*

Keith Burchell consented to undergo a surgical procedure to remove a mass in his scrotum for testing. During the surgery, Dr. Gary Barker discovered the mass was much larger than expected. Believing the mass was malignant, Dr. Barker decided to remove it entirely. Dr. Barker did not first consult Burchell (who was under general anesthesia) or Burchell's medical proxy (who was present but unknown to Dr. Barker) before performing the more extensive surgery. Burchell suffered serious side effects from this surgery.

Burchell sued Dr. Barker and the Faculty Physicians & Surgeons of Loma Linda School of Medicine (FPS), alleging professional negligence and medical battery. The jury found for Burchell on both claims and awarded him $4 million in past noneconomic damages and $5.25 million in future noneconomic damages (the parties had stipulated to about $22,000 in economic damages). FPS appealed, arguing the noneconomic damage award should be reduced to the $250,000 MICRA limit under Civil Code section 3333.2, subdivision (a), which applies to "any action for injury against a health care provider based on professional negligence." FPS argued, in the alternative, the award of noneconomic damages was excessive due to improper argument by Burchell's counsel.

The Court of Appeal affirmed the damages awards. The court explained that the MICRA limitation on noneconomic damages applies to actions based on professional negligence, but does not apply to certain types of medical battery. The court distinguished two types of medical battery. First, a battery is an intentional tort *outside* the scope of MICRA "'when a physician obtains the patient's consent to perform one type of treatment, but performs a substantially different treatment for which the plaintiff gave no consent.'" Second, a battery is rooted in negligence *within* the scope of MICRA "'when a physician performs the treatment for which consent was obtained and an infrequent complication occurs that the physician failed to disclose when obtaining the patient's consent.'" Here, the court held that Dr. Barker committed the first type of medical battery. Accordingly, the MICRA limitation did not apply. (The court separately rejected an excessive damages argument, but agreed that the trial court had improperly awarded costs under an invalid Code of Civil Procedure section 998 settlement offer.

### California may recoup overdue tax by reducing supplemental Medi-Cal payments owed to bankrupt hospital that are funded by that tax

*In re Gardens Regional Hosp. & Med. Ctr., Inc.*, __ F.3d __, 2020 WL 5541387 (9th Cir., Sept. 16, 2020)

Gardens Regional Hospital and Medical Center was a private, nonprofit hospital participating in Medi-Cal. Gardens Regional received payments through Medi-Cal's "fee-for-service" system, and supplemental payments through California's Hospital Quality Assurance Fee (HQAF) program. HQAF is a broad-based healthcare tax on most non-public hospitals in the state. It is *not* a prohibited "circular-funding" practice because the collected taxes are deposited into a separate fund to be used for enumerated purposes, one of which is to make supplemental payments to Medi-Cal participants.

Gardens Regional stopped paying its HQAF assessments, filed for bankruptcy, and ceased operations. The State recovered Gardens Regional's pre- and post-petition HQAF debt by withholding both Medi-Cal service payments and HQAF supplemental payments. Gardens Regional responded that the State's withholding of post-petition funds violated the Bankruptcy Code's automatic stay, which prohibits a setoff by a creditor of any debt after the debtor files a bankruptcy petition. The State argued it had properly claimed recoupments, which are exempt from the automatic stay. The bankruptcy court and the Ninth Circuit Bankruptcy Appellate Panel agreed with the State, and Gardens Regional appealed.

The Ninth Circuit affirmed in part and reversed in part, holding that some of the State's deductions were proper recoupments, while others were improper setoffs. To qualify as a recoupment, "the rights being asserted against the debtor" must be closely and logically related to "the debtor's countervailing obligations[,] such that they may be fairly said to constitute part of the same transaction." Thus, the State's recovery of unpaid HQAF assessments by withholding supplemental HQAF-funded supplemental payments was proper—there was an obvious connection between the two. However, no logical connection existed between unpaid HQAF assessments and the Medi-Cal fee-for-service payments that the State separately owed Gardens Regional, so the Sate's deductions of those assessments were setoffs violating the bankruptcy stay.

### Statements questioning doctor's quality of care receive anti-SLAPP protection if connected to the "public conversation" about that care

*Murray v. Tran* (Sept. 24, 2020, D076104) __Cal.App.5th __ [2020 WL 5668741]

Dr. Ian Murray and Dr. My Tran co-owned a dental practice. During a financial dispute, Dr. Tran accused Dr. Murray of "substandard dental work." He repeated that claim to his attorney, their employees, a retired dentist who knew Dr. Murray, and Dr. Murray's new employer. Dr. Murray sued Dr. Tran, alleging multiple defamation claims. The trial court dismissed those claims under the anti-SLAPP statute. Dr. Murray appealed.

The Court of Appeal reversed in part and affirmed in part. The court concluded Dr. Murray had alleged five separate defamation claims, but only one—arising from the statements to Dr. Murray's new employer—involved speech protected by the anti-SLAPP statute.

The anti-SLAPP statute can apply "when the statements concern public interest but were not made in a public forum," as was the case here. Under the two-part test from *FilmOn.com v. DoubleVerify, Inc.* (2019) 7 Cal.5th 133, 149-150, a court first considers " 'what "public issue or [ ] issue of public interest" the speech in question implicates,' " and second, " 'what functional relationship exists between the speech and the public conversation about some matter of public interest.' "

The Court of Appeal held that all statements Dr. Tran made about the quality of Dr. Murray's care were matters of vital public interest (step one). However (at step two), Dr. Tran's private statements to employees and other acquaintances lacked the requisite "functional relationship" with the public conversation, while Dr. Tran's statement to Dr. Murray's new employer possessed that relationship—it was "directly tethered to the issue of public interest (a dentist's competence to perform dental work) and promoted the public conversation on that issue because they were made to a person who had direct connection to and authority over [the accused doctor's] patient population." At that point, the burden shifted to Dr. Murray to prove a probability of prevailing. He could not do so because he had failed to present evidence that Dr. Tran actually made a statement to Dr. Murray's new employer. Accordingly, the trial court had properly dismissed Dr. Murray's defamation claim based on that allegation.

### Physician may pursue whistleblower suit—alleging hospital's exclusive staffing agreement was retaliatory—without first seeking writ relief

*Alborzi v. University of Southern California (Sept. 29, 2020, B299067) __ Cal.App.5th __ [2020 WL 5792911]*

Dr. Arash Alborzi, who had been on the infectious disease call panel at Verdugo Hills Hospital, sued the hospital and related USC entities (collectively VHH) for violating (among others) a healthcare whistleblower statute (Health & Saf. Code, § 1278.5), the false claims act (Gov. Code, § 12653), and the unfair competition law (Bus. & Prof. Code, § 17200 et seq.). Dr. Alborzi's complaint alleged that, after experiencing a significant reduction in patient assignments, he complained to VHH's chief executive and medical officers that patient safety was being compromised by an illegal referral and kickback scheme engineered by other infectious disease physicians and their affiliated medical groups. He further alleged that, after lodging that complaint, VHH retaliated by no longer referring patients to him and dissolving the on-call infectious disease panel. The trial court sustained VHH's demurer with prejudice on the ground Dr. Alborzi had failed to exhaust judicial remedies. Specifically, he had not first sought a writ of mandate challenging VHH's quasi-legislative decision to dissolve the call panel. Dr. Alborzi appealed.

The Court of Appeal reversed, directing the trial court to sustain the demurrer in part and overrule it in part. The court agreed that quasi-legislative hospital decisions must be challenged by writ of mandate, but here the complaint alleged that VHH's dissolution of the call panel was *not* a quasi-legislative decision, but instead an act of retaliation to cover up an illegal kick-back scheme. Accordingly, the trial court erred by sustaining a demurrer on that ground. Moreover, even if VHH's decision was quasi-legislative, the doctrine of exhaustion of judicial remedies did not apply under either party's theory of the case. There was no "administrative decision making process" to complete, nor did exhaustion doctrine apply to the false claims act and whistleblower causes of action in any event.

Addressing the merits of the individual claims, the court first held that Dr. Alborzi had adequately pleaded his section 1278.5 claim. He had complained about patient safety being jeopardized by illegally incentivized patient care decisions and VHH's retaliation, causing his loss of income. The court held that Dr. Alborzi had *not* adequately pleaded his false claims act claim because he failed to allege that any false claims were filed with Medicare, but the trial court should have given him leave to amend. Finally, the court rejected VHH's argument that the UCL was pleaded imprecisely, since particularized fact pleading is not required to assert a UCL claim.

### Manufacturer must find a proxy (Medicare beneficiary) to exhaust administrative channels before seeking judicial review of Medicare product coverage decision

*Sensory NueroStimulation v. Azar, __ F.3d __, 2020 WL 6110132 (9th Cir. Oct. 16, 2020)*

The Centers for Medicare and Medicaid Services (CMS) may make a "national coverage determination" (NCD) regarding whether Medicare will pay for "durable medical equipment." Either the manufacturer or a Medicare beneficiary may seek an NCD determination. But only a beneficiary has the right to appeal CMS's ruling to an Appeals Board of the Department of Health and Human Services (the agency that houses CMS), whose decision is administratively final and subject to judicial review. At the same time, the Medicare statute, 42 U.S.C. § 405(h), eliminates federal question jurisdiction over lawsuits seeking to "recover on any claim arising under" Medicare. This is known as the "channeling requirement," since beneficiaries must first exhaust available administrative channels before seeking judicial review. However, this requirement is not enforced if it would foreclose all review.

Sensory Neurostimulation, Inc., sought an NCD for Relaxis, a prescription leg massage. CMS determined that it was a "personal comfort item" that did not qualify for NCD status. Sensory sued, and the Government moved to dismiss the claim, arguing the district court lacked subject matter jurisdiction because Sensory failed to comply with section 405(h)'s channeling requirement. The district court dismissed the lawsuit, ruling that Sensory's claim "arose under" the Medicare statute (so it had to comply with the channeling requirement); that enforcing the requirement did not result in "no review at all"; and that no exception obviated Sensory's requirement to exhaust administrative remedies. Sensory appealed.

The Ninth Circuit affirmed. Sensory's claim "arose under" the Medicare statute because, if successful, it might lead to Medicare paying for Relaxis devices. In addition, applying the channeling requirement did not foreclose all review. Sensory simply needed to recruit a proxy—a Medicare beneficiary with standing to seek a final administrative NCD decision subject to judicial review, which would give the agency an opportunity to "correct its own errors" and produce an administrative record that would aid judicial review.

### Doctor network agreement may require arbitration review of an administrative dispute resolution panel's decision

*Epstein v. Vision Service Plan (Oct. 22, 2020, A155219) __ Cal.App.5th __ [2020 WL 6165494]*

Dr. Gordon Epstein, an optometrist, entered into a "Network Doctor Agreement" with Vision Service Plan (VSP) to be part of its provider network. After auditing Dr. Epstein's reimbursement claims, VSP determined that he had knowingly purchased lenses from an unapproved supplier, terminated the agreement, and demanded that Dr. Epstein pay $104,333 in restitution. Dr. Epstein invoked VSP's two-step Fair Hearing/Binding Arbitration dispute resolution procedure to appeal that decision. In the first step, counsel for both Dr. Epstein and VSP presented documentary and testimonial evidence to a three-person panel, which upheld VSP's decision. The second step required binding arbitration pursuant to the Federal Arbitration Act and in accordance with procedures set forth in VSP's plan and policy. Rather than invoking arbitration, Dr. Epstein sought a writ of administrative mandamus from the superior court. The court denied the petition on the ground that Dr. Epstein had failed to exhaust his administrative remedies. He appealed.

The Court of Appeal affirmed. It rejected Dr. Epstein's argument that VSP's dispute resolution process violated Health and Safety Code section 1367 and its implementing regulation. The court held that this

regulatory law "requiring certain network provider agreements to include a dispute resolution process *that is not arbitration*, pertains only to the first step of the dispute resolution process and does not foreclose the parties from agreeing to arbitration in lieu of subsequent judicial review through administrative mandamus." The court noted that the relevant regulation did not address, much less limit, the means by which the parties were permitted to *challenge* a final dispute resolution decision. "[N]o statutory provision purports to make administrative mandamus the exclusive means for review of such a decision . . . and no statutory provision purports to bar the parties from agreeing to binding arbitration." The court further held that VSP could enforce the arbitration provision because, while it was procedurally unconscionable in minor respects, it was not substantively unconscionable.