APPELLATE CASE SUMMARIES

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Arbitration provisions in health insurance contracts that do not comply with Health and Safety Code section 1363.1 are void

Baglione v. Health Net of California, Inc. (Nov. 27, 2023, B319659) __ Cal.5th __ [2023 WL 8446102]

Salvatore Baglione obtained his medical insurance through his employer, the County of Santa Clara, which contracted with insurance provider Health Net. Baglione signed an enrollment form for Health Net, as well as a group contract between the County and Health Net. A few months later, Baglione was diagnosed with a chronic condition requiring a monthly injectable medication. While the drug qualified for coverage under Baglione's health plan, Health Net repeatedly refused to authorize the medication. Baglione sued, alleging breach of contract and bad faith causes of action. Health Net moved to compel arbitration. The trial court denied Health Net's motion, ruling that the arbitration provision was unenforceable because the group contract failed to comply with the disclosure requirement in Health and Safety Code section 1363.1, subdivision (d). Health Net appealed.

The Court of Appeal affirmed, holding the arbitration provision unenforceable because neither the enrollment form nor the group contract complied with section 1363.1's mandatory clarity-of-disclosure requirements. The enrollment form was insufficiently clear because it included references to additional documents and inapplicable laws; it also failed to specify which disputes were subject to arbitration. Additionally, the references to additional documents and inapplicable laws were located in between the arbitration disclosure and the signature line, which violated another section 1363.1 requirement, and the group contract violated section 1363.1 for the same reason. Health Net argued that Baglione lacked standing to enforce section 1363.1, subdivision (d), reasoning that the County alone had standing to contest enforceability of the arbitration provision in the group contract. But the court rejected Health Net's argument on standing, as well as its contention that noncompliance with section 1363.1 merely rendered the arbitration provisions voidable rather than void. Finally, the court held that the Federal Arbitration Act did not require reversal of the trial court's order.

The State is not vicariously liable for in-home service providers' torts

Yalung v. State (Dec. 21, 2023, F084367) __ Cal.App.5th __ [2023 WL 8821363]

Sara Spagnolini worked as an In-Home Supportive Services (IHSS) provider running errands for an IHSS recipient. She ran a stop sign and crashed into Hanah Yalung's vehicle, killing one of Yalung's children and seriously injuring Yalung and four other children. Yalung sued the State of California, alleging it was vicariously liable for Spagnolini's negligence, either as her employer or as a joint employer with the IHSS recipient because it paid her salary. The trial court sustained the State's demurrer and entered a judgment of dismissal, ruling that the IHSS statutes did not make the State

an employer or joint employer of IHSS providers. Yalung appealed.

The Court of Appeal affirmed, holding that the IHSS statutes are incompatible with vicarious liability. The court explained that, under the IHSS statutory scheme, the *County* administering a local IHSS program on the State's behalf is considered an employer of providers "for some, but not all, purposes." But the statutes do not set similar employment parameters for the *State*. To the contrary, the State's IHSS role does not satisfy the special employment criteria because the statutory scheme does not entitle the State to supervise the details of IHSS providers' work. The providers perform their work under the *recipient's* supervision and direction; and the State does not supply the instrumentalities, tools, or place of work. The State must " ' "perform or ensure the performance of all rights, duties, and obligations" that otherwise would be the legal responsibility "of the recipient." ' " But that requirement does not create an employment relationship with the provider, the court held; it merely requires the State to act as the IHSS recipient's agent in performing duties owed to the recipient. Accordingly, there was no basis for holding the State vicariously responsible for Spagnolini's negligence while running an errand for an IHSS recipient.

Regional centers have no duty to protect residential facility employees from injury by residents.

Shalghoun v. North Los Angeles County Regional Center, Inc. *(Jan. 25, 2024, B323186) __ Cal. App.5th __ [2024 WL 277313]*

Under the Lanterman Developmental Disabilities Services Act (Welf. & Inst. Code, § 4500 et seq.), California uses a network of private, nonprofit entities called "regional centers" to provide developmentally disabled persons with individually tailored services and support. The North Los Angeles County Regional Center placed J.C., a developmentally disabled adult, in a licensed adult residential facility. Ali Shalghoun, the facility's administrator, asked the Regional Center to relocate J.C. after he repeatedly exhibited aggressive behavior. While the Regional Center was seeking to place J.C. in another facility, he attacked and seriously injured Shalghoun. Shalghoun sued the Regional Center for negligently failing to prevent the attack. The trial court granted the Regional Center's motion for summary judgment on the ground that the Regional Center owed Shalghoun no duty of care. Shalghoun appealed.

The Court of Appeal affirmed, holding that—for three reasons—regional centers have no duty to protect employees of residential facilities from injuries caused by a developmentally disabled resident when the regional center does not immediately relocate the resident at the facilities' request.

First, the court held that regional centers have no special relationship with employees of facilities supporting a duty of care. The regional centers cannot control residents or the environments in which they are placed; they merely coordinate residents' services. Second, even if regional centers had the ability to control residents, their duty would be to protect *residents*, not employees of the facility. The Lanterman Act provisions evince an intent to protect developmentally disabled persons, but no one else. Third, public policy disfavors imposing liability in this situation. Regional centers cannot unilaterally relocate residents and cannot prevent future injuries, and therefore do not bear moral blame—even for foreseeable injuries. Imposing liability on regional centers for injuries caused by facility residents would essentially make them insurers against such injury, and that would likely drive regional centers out of business or impede their ability and willingness to provide needed services to the disabled without preventing future harm.

Tax garnishment qualifies as income when determining Medi-Cal eligibility.

Abney v. State Dept. of Health Care Services *(Jan. 31, 2024) __ Cal. App.5th __ [2024 WL 356944]*

The Social Security Administration began withholding money from Debra Abney's monthly Social Security payment to satisfy an IRS debt. Consistent with advice from the California Department of Health Care, which administers Medi-Cal, San Francisco counted the wage garnishment amount as income "actually available to meet [her] needs" and on that basis found Abney to be ineligible to receive Medi-Cal benefits without sharing the cost. The trial court denied her petitions seeking administrative writ relief from the eligibility decision. Abney appealed.

The Court of Appeal affirmed,

holding that (1) the garnishment amount is "actually available" even if it never passes through Abney's hands, as long as the money actually exists (rather than being assumed or imputed) and (2) the garnishment "meets [Abney's] needs" because paying off her IRS debt financially benefitted her.

Hospitals must count "bed holds" in subacute section as "patient days" when determining Medi-Cal reimbursement.

Gardena Hospital, L.P. v. Baass (Feb. 9, 2024, B316529) __ Cal. App.5th __ [2024 WL 510108]

Gardena Hospital offers acute and long-term care. Its care for Medi-Cal patients is reimbursed by the state. The reimbursement formula divides costs by "patient days," so Gardena gets a larger per diem if it reports fewer patient days. Relying on the state Accounting and Reporting Manual for California Hospitals (Hospital Manual), Gardena *excluded* "bed holds"—days where patients' beds in the subacute care section are left empty because those patients are expected to return after receiving acute care—from reported patient days. The state audited Gardena and said it must *include* bed holds as patient days in its report. Gardena sought a writ of mandate from the superior court, arguing the Hospital Manual specifies that hospitals should report patient days for patients that were " 'provided sub-acute care,' " but it is not "providing" care to patients during a bed hold. The state relied on a different resource, the Accounting and Reporting Manual for California Long-Term Care Facilities (Long-Term Manual), and argued that it controls over the Hospital Manual. Under the Long-Term Manual, bed holds should be included in total patient days. The court ruled in favor of the state. Gardena appealed.

The Court of Appeal affirmed, holding that the more specific Long-Term Manual governs over the more general Hospital Manual under the specific-trumps-general canon of statutory construction. The court emphasized "the particular provision [in the Long-Term Manual] is a nearer and more exact view of the subject than the general, of which it may be regarded as a correction."

A city's grandfathered right to regulate ambulance services is not lost until it transfers administrative control

Symons Emergency Specialties v. City of Riverside (Jan. 9, 2024, E078113) __ Cal.App.5th __ [2024 WL 470492], ordered published Feb. 7, 2024

The Emergency Medical Services System and Prehospital Emergency Medical Care Act (the Act) (Health & Saf. Code, § 1797 et seq.) "precludes cities from regulating the provisions of emergency medical services." But it has a "grandfathering" provision that allows a city to maintain control of services it operated or contracted for as of June 1980. Under this provision, the city can maintain control of prehospital emergency medical services until it reaches an agreement with the county to provide them. Riverside Municipal Code section 5.66.020 requires persons operating ambulance services originating in the city to first obtain a valid franchise or permit from the city. Symons Emergency Specialties sought declaratory and injunctive relief against the City of Riverside, arguing that its municipal code section does not apply because the Act's grandfathering provision does not apply. The trial court denied relief, ruling that Symons failed to prove that the city had lost its grandfathered right to regulate ambulance services. Symons appealed.

The Court of Appeal affirmed. First, the court held that substantial evidence, including the testimony of city employees with personal knowledge of the City's ambulance regulations during that time, supported the court's finding that emergency ambulance vehicles operating under the pre-June 1980 ordinances provided both emergency and nonemergency services. Although one of the ordinances granting a franchise extension was "formally adopted" after June 1, 1980, the City did not thereby lose its right to regulate such services because it had never entered into a formal agreement with a county or local EMS agency delegating administrative control of ambulance services. Finally, the court rejected Symons' argument that the city's ordinance violated antitrust laws because the city complied with the Act when it enacted its ordinances.

In emergency circumstances, a psychiatrist does not violate ethical standards by examining children without full parental consent.

Geffner v. Board of Psychology (Feb. 28, 2024, B322991) __ Cal. App.5th __ [2024 WL 834986]

After two brothers (both minors) expressed suicidal and homicidal ideations, their mother asked Dr. Robert Geffner, a psychologist, to evaluate them. Both said they would act on these thoughts if they saw their father. Dr. Geffner recommended that the brothers be kept away from their father until further treatment and a risk assessment was completed. Dr. Geffner also said that the father needed to be warned of this threat, and he requested confirmation that the father had received this warning within 24 hours. After the father filed a consumer complaint, the California Board of Psychology charged Dr. Geffner with gross negligence and unethical behavior. The Board eventually revoked Dr. Geffner's psychology license, finding that he violated ethical standards by evaluating the brothers without their father's consent, without consulting their existing therapist, making custodial recommendations that went beyond the scope of an emergency risk assessment, and delegating the duty to warn the father that one child had thoughts about killing him. Dr. Geffner unsuccessfully petitioned the superior court for a writ of administrative mandamus to vacate the Board's decision, then appealed.

The Court of Appeal reversed. First, the court held that neither the governing ethical standard nor the evidence supported the finding that Dr. Geffner acted unethically by failing to obtain the father's consent. The parties agreed that the father's consent was unnecessary in the case of an emergency, and no expert denied that an emergency existed (the experts simply said they would have handled the situation differently). Next, the Court of Appeal held there was no evidence that Dr. Geffner acted unethically by failing to consult the children's therapist because the ethical standard gave him discretion regarding whether to seek such consultation; the undisputed evidence showed that the therapist was unavailable and that further efforts to contact the therapist were not required due to the emergency. The Court of Appeal then held there was insufficient evidence that Dr. Geffner made inappropriate custody recommendations because his report did not address custody issues. Finally, the Court held that Dr. Geffner did not unethically delegate his duty to warn the father of the risk of harm. No such duty to warn was triggered because the risk to the father was neither foreseeable nor unavoidable.

The comprehensive statutory peer review scheme preempts common law fair procedure guarantees.

Asiryan v. Medical Staff of Glendale Adventist Medical Center (Feb. 29, 2024, B316313) ___ Cal.Rptr.3d ___ [2024 WL 1171035], certified for publication Mar. 19, 2024

Dr. Vardui Asiryan had medical staff privileges at Glendale Adventist Medical Center (GAMC). The GAMC Medical Staff (a separate legal entity from GAMC) is responsible for reviewing physician performance at GAMC to ensure patients receive quality healthcare. After members of the Medical Staff voiced concerns that Dr. Asiryan's medical incompetency was a threat to patient safety, the Medical Staff summarily suspended her privileges pending an investigation, without providing prior notice or a hearing. Dr. Asiryan attended a meeting with Medical Staff officers and its counsel where she was informed of the summary suspension. At that meeting she elected to resign her privileges. GAMC then reported her resignation to the Medical Board and the National Practitioner Data Bank. Dr. Asiryan sued GAMC and the Medical Staff alleging they denied her due process and that the Medical Staff violated statutory and common law notice obligations by lying to her regarding its reporting obligations. The trial court suggested pretrial that Dr. Asiryan should consider amending her complaint to allege fraud or misrepresentation claims, but then declined her attempt to do so on the eve of trial. The trial court granted summary judgment for GAMC, and later granted nonsuit in favor of the Medical Staff on Dr. Asiryan's common-law "fair procedure" claim. The jury then returned a verdict in the Medical Staff's favor on her statutory claim, finding it did not misinform Dr. Asiryan regarding its reporting plans and duties. Dr. Asiryan appealed, challenging the dismissal of her fair procedure cause of action.

The Court of Appeal affirmed. It explained that California enacted a comprehensive medical staff peer review statutory scheme (Bus. & Prof. Code, §§ 805–809.9), which requires a peer review body or the administration of the body's affiliated hospital to file an "805 report" to the licensing agency within 15 days of certain actions, including when a licentiate resigns from

staff privileges after being notified of a pending investigation. The court held that this comprehensive statutory scheme is the only source of procedural protections in the hospital peer review context, leaving no place to apply common-law fair procedure principles. The statutory scheme "methodically delineates specific and detailed procedural requirements for each step of a peer review proceeding," which reflects the Legislature's intent to replace the common law in this area. The scheme sets "minimum" standards, permitting hospitals to establish additional procedural protections, but that does not imply a continuing role for the common law in this context. Because the common law right to fair procedure does not support a separate cause of action, the court properly granted a nonsuit on that claim.

Dismissal of doctor's first lawsuit based on privileged peer review statements did not preclude second lawsuit based on related conduct.

Williams v. Doctors Medical Center of Modesto (March 27, 2024, F084700/F085710) __ Cal. App.5th __ [2024 WL 1298913]

Dr. R. Michael Williams is a board-certified oncologist who practiced at the Doctors Medical Center of Modesto (DMCM). Disagreement over patient care strained the relationship between Dr. Williams and DMCM. Dr. Williams sued, claiming that DMCM improperly curtailed his hospital privileges, limiting his capacity to care for patients. Dr. Williams's initial lawsuit included allegations about *statements* made in connection with peer review proceedings or concerning his competency. Dr. Williams voluntarily dismissed the lawsuit without prejudice in response to DMCM's anti-SLAPP motion. The trial court then granted DMCM's motion for attorney fees, ruling that the initial lawsuit was based on protected activity. In his second lawsuit, Dr. Williams alleged various *conduct* by DMCM that improperly restricted his privileges to care for patients at DMCM, but expressly disavowed any allegations about wrongful peer review or protected *speech*. The trial court once again granted DMCM's anti-SLAPP motion. Relying on *South Sutter LLC v. LJ Sutter Partners, L.P.* (2011) 193 Cal.App.4th 634, the court ruled that both lawsuits concerned the same primary right, which satisfied the first prong of the anti-SLAPP analysis (that the second lawsuit was based on protected activity). Dr. Williams appealed.

The Court of Appeal reversed. The court explained that the trial court erred by relying on *South Sutter's* primary rights analysis because subsequent Supreme Court decisions (*Bonni v. St. Joseph Health System* (2021) 11 Cal.5th 995 and *Baral v. Schnitt* (2016) 1 Cal.5th 376) established that the primary rights theory does not apply in the anti-SLAPP context. Rather than focusing on *primary rights*, an anti-SLAPP motion tests whether *allegations* of protected activity are asserted as grounds for relief. Because Dr. Williams's second lawsuit disavowed any allegation of protected activity as a basis for relief, the earlier ruling that the initial lawsuit was based on protected activity had no preclusive effect. Aside from its misplaced reliance on issue preclusion, DMCM did not meet its burden of showing that Dr. Williams's second lawsuit was based on allegations of protected activity.

A power of attorney for health care decisions does not authorize the health care agent to execute a binding arbitration agreement.

Harrod v. Country Oaks Partners, LLC (Mar. 28, 2024, S276545) ___ Cal.5th ___ [2024 WL 1319134]

Charles Logan executed a power of attorney for health care decisions using a form patterned on the Health Care Decisions Law (Prob. Code, § 4600 et seq.), which authorized his nephew, Mark Harrod, to make "health care" decisions on Logan's behalf. Logan was later admitted to Country Oaks Care Center to rehabilitate a broken leg. Harrod signed Logan's admission agreement with Country Oaks, and also signed a separate, nonmandatory agreement requiring arbitration of all legal disputes between Logan and Country Oaks. After staying at Country Oaks for less than two months, Logan, through Harrod as his guardian ad litem, sued Country Oaks alleging that its negligence resulted in Logan suffering a second fracture, pressure ulcers, and improper treatment. The trial court denied Country Oaks's motion to compel arbitration, ruling that Harrod had no authority to execute an arbitration agreement on Logan's behalf because that was not a health care decision. After the Court of Appeal affirmed, Country Oaks successfully petitioned for review by the Supreme Court.

The Supreme Court affirmed,

resolving a split of authority among the Courts of Appeal. First, the Supreme Court concluded that the Health Care Decisions Law, which authorizes a principal to appoint an agent to make health care decisions, does *not* authorize the health care agent to execute a separate, optional dispute resolution agreement on behalf of the principal. Rather, such authority is conveyed (if at all) under the Power of Attorney Law. The Supreme Court explained that the statutory definition of a "health care decision" is limited to decisions involving the people and places that provide care and the treatments and procedures provided. Because Harrod's choice to sign Country Oaks's arbitration agreement was not a decision about who would provide medical services or which treatments Logan would receive, Harrod was not authorized to enter that agreement on Logan's behalf. Next, the Court rejected Country Oaks's argument that, under Civil Code section 2319, Harrod had implied power to execute the arbitration agreement on Logan's behalf as a proper and usual step taken in furtherance of obtaining medical care. The Court explained that such power is implied only when necessary to facilitate a power of attorney, and here that purpose was limited to making health care decisions—not dispute resolution decisions. The Court also rejected Country Oaks's argument that its decision improperly disfavored arbitration in violation of the Federal Arbitration Act (9 U.S.C. § 1 et seq.), explaining that arbitration can still be compelled under an appropriate agreement executed by a properly authorized agent. Finally, the Court noted that open questions remained regarding (1) whether an agent with power over claims and litigation, but without power over health care decisions, may agree to arbitration with a health care facility when the agent has no right to contract for healthcare services in the first instance; and (2) whether any particular familial relationship would itself convey authority to agree to arbitration with a skilled nursing facility.

ERISA plans violate the Parity Act by processing mental health claims more stringently than medical/surgical claims.

Ryan S. v. UnitedHealth Group, Inc., __ F.4th __, No. 22-55761, 2024 WL 1561668 (9th Cir. Apr. 11, 2024)

Ryan was a beneficiary of an ERISA group health plan through UnitedHealthcare (UHC). He completed outpatient, out-of-network substance use disorder programs, but UHC did not cover most of those costs. Ryan sued, alleging UHC violated the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Parity Act) (29 U.S.C. § 1185a) by using improper internal processes to determine whether outpatient, out-of-network mental health and substance use disorder (MH/SUD) treatment is covered, and violated its fiduciary duty under ERISA, 29 U.S.C. § 1104. Ryan cited a California Department of Managed Healthcare (CDMH) report that concluded UHC imposed a more stringent review process on MH/SUD treatment claims than it used for medical/surgical claims. The district court dismissed the lawsuit and Ryan appealed.

The Ninth Circuit reversed. The Court explained that the Parity Act prohibits an ERISA plan from imposing more restrictive limitations on MH/SUD treatment than on medical/surgical treatment. To bring a Parity Act claim based on improper internal processes, a plaintiff need not allege a "categorical" practice. "Handling MH/SUD treatment claims more stringently violates the Parity Act regardless of whether such differential treatment leads to the uniform denial of all claims." A plaintiff must allege the challenged process is specific to MH/SUD claims and does not apply to analogous medical/surgical claims but need not identify the analogous category of medical/surgical claims with precision. Here, the complaint alleged an actionable Parity Act claim because UHC subjects MH/SUD claims to an additional review process that is not applied to medical/surgical claims. Because the complaint sufficiently alleged a violation of the Parity Act, it also sufficiently alleged a breach of UHC's fiduciary duty.