APPELLATE CASE SUMMARIES

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Acute care hospital needed no additional license or approval to operate drug detoxification center

State ex rel. Rapier v. Encino Hospital Medical Center (Dec. 21, 2022, B302426, B303196) __ Cal.App.5th __ [2022 WL 18396584], modified and ordered published Jan. 20, 2023

For about three years, Encino Hospital Medical Center, a licensed acute care hospital, operated at its facility the Serenity Recovery Center to provide acute drug and alcohol detoxification services. Serenity provided no long-term or outpatient services; rather, its patients received round-the-clock care for three to seven days at the hospital. Most patients arrived with a planned transfer to long-term treatment facilities in place. Serenity obtained patients through in-house marketing programs or referrals from entities such as Aid in Recovery, LLC (AIR), which was Serenity's largest referral source. Serenity did not pay for referrals. Mary Lynn Rapier, a former Serenity employee, filed a *qui tam* action against Encino Hospital, alleging employment claims and violations of the Insurance Frauds Prevention Act based on submission of false insurance claims and illegal patient steering. The California Department of Insurance (CDI) intervened and assumed primary responsibility for prosecuting Rapier's claims. Following a bench trial, the court entered judgment for Encino Hospital. CDI appealed.

The Court of Appeal affirmed. First, the court rejected CDI's argument that Encino Hospital made false insurance claims that misrepresented it was licensed to provide detox services when (according to CDI) the hospital had to obtain additional licensing and authorization to provide those services through Serenity. The court explained that general acute care hospitals such as Encino may provide chemical dependency recovery services as a supplemental service without obtaining a separate chemical dependency recovery hospital license. (Health & Saf. Code, § 1250.3, subd. (d)(1).) The governing statute requires the unit of the hospital operating as a detox center to satisfy the criteria for approval as a chemical dependency recovery unit, but it does not require the hospital to obtain separate approval from the California Department of Public Health. Because Encino Hospital did not need any separate license or approval to operate the Serenity detox service, there was no basis for the CDI's false insurance claims cause of action.

Next, the Court of Appeal rejected the CDI's steering claim argument. It is unlawful to employ individuals for the purpose of procuring patients to receive services that will be the basis of insurance claims. (Ins. Code, § 1817.7.) Here, however, there was no evidence that Serenity or Encino Hospital either received compensation for referring patients to residential treating facilities or paid for referrals to the Serenity program. CDI nonetheless argued that Serenity employed AIR by agreeing to honor the referred patients' predetermined treatment plans, which often included transfers to AIR-affiliated long-term care facilities, in exchange for AIR referral of patients to Serenity. Although

no direct evidence of any such agreement existed, CDI argued that the agreement could be inferred because Serenity failed to follow an alleged universal standard that acute detox facilities should refuse to honor preplanned treatment regimens. However, no evidence supported the existence of any such universal standard; rather, the evidence showed it was common for patients to arrive at detox facilities with a predetermined discharge location for long-term care following detox. Because there was no evidence of remuneration, exchanges, or any agreement that Serenity employed AIR to obtain referrals, the CDI's claim steering failed.

A mandatory elder abuse reporter's absolute statutory immunity applies to making a knowingly false report

Valero v. Spread Your Wings, LLC (Jan. 11, 2023, H049119) __ Cal. App.5th __ [2023 WL 1858882]

Lynda Valero shared custodial care duties of dependent elder Michael Barton with Spread Your Wings employee Sabrina Dellard, who was a mandatory reporter of elder or dependent adult abuse. Valero sued Dellard for malicious prosecution, alleging that Dellard knowingly made a false report to law enforcement that she saw Valero attempt to kill Barton and then coerced Barton to corroborate that false accusation. Valero alleged that she was incarcerated for nearly a month before evidence disproved the charges and they were dismissed. Dellard demurred, asserting absolute statutory immunity under the Elder Abuse and Dependent Adult Civil Protection Act. (Welf. & Inst. Code, § 15634, subd. (a).) After the trial court sustained Dellard's demurrer, Valero appealed from the judgment of dismissal.

The Court of Appeal affirmed, rejecting Valero's argument that a mandatory reporter's absolute immunity under section 15634 applies only to reports of *known or suspected* elder abuse, and not to fabricated and knowingly false reports. The court explained that *non-mandatory* reporters have *qualified immunity* that does not extend to *knowingly false* reports, but *mandatory reporters* have *absolute immunity* for all reports. Additionally, the legislative goal of absolute immunity for mandated reporters was intended to increase the reporting of elder abuse and minimize disincentives to reporting, including the fear of getting sued. Accordingly, Dellard enjoyed absolute immunity even as to an allegedly fabricated report. That immunity extended to her alleged post-reporting conduct (coercing Barton to corroborate the false report) because it occurred close in time to the report and concerned the same alleged incident of elder abuse.

Nursing facility's arbitration agreement is unenforceable against cognitively impaired patient

Algo-Heyres v. Oxnard Manor LP (Feb. 28, 2023, B319601) ___ Cal. App.5th ___ [2023 WL 2257761]

Cornelio Algo-Heyres entered Oxnard Manor, a skilled nursing facility, after suffering a stroke. Although Algo-Heyres struggled to communicate and comprehend things, Oxnard Manor had him sign an arbitration agreement waiving his rights to sue for medical malpractice, elder abuse, and other torts. Algo-Heyres lived at Oxnard Manor for nine years. After he died, his successors sued Oxnard Manor for wrongful death, elder abuse, and other causes of action. Oxnard Manor moved to arbitrate the claims. The trial court denied the motion, ruling that Algo-Heyres likely lacked capacity to understand the arbitration agreement that he executed. Oxnard Manor appealed.

The Court of Appeal affirmed, rejecting 's Oxnard Manor's argument that the trial court improperly required it to prove that Algo-Heyres had the capacity to contract. The court first explained that Oxnard Manor had the burden of proving the existence of an enforceable arbitration agreement. Oxnard Manor pointed out that the Probate Code created a rebuttable presumption of capacity and required an incapacity finding to be supported by evidence of deficits in specific areas. (Prob. Code, §§ 810, 811.) But the Court of Appeal found that the more specific guidelines in Civil Code section 39, subdivision (b), governed the controversy. Section 39 establishes a rebuttable presumption that an individual is of unsound mind if he *cannot* manage his own financial resources or resist fraud and undue influence. Here, the trial court reasonably could have found the section 39 presumption applied because Algo-Heyres was unable to solve complex problems like managing a checking account. And even if section 39 didn't apply, substantial evidence supported the trial court's finding that Algo-Heyres lacked the capacity to understand

the arbitration agreement because he struggled with communication, memory, problem solving, following abstract directions, and executive functioning. Accordingly, Oxnard Manor failed to meet its burden of proving the existence of an enforceable agreement.

MICRA applies when ambulance passengers are injured during a collision

Lopez v. American Medical Response West (Mar. 15, 2023, A161951) __ Cal. App.5th __ [2023 WL 2518511]

Ubaldo and Leobardo Lopez were allegedly injured when the American Medical Response West (AMR) ambulance in which Leobardo was being transported collided with another vehicle. Eleven months later, the Lopezes' counsel sent a settlement demand letter to the AMR's claims administrator. Then, a few days before the accident anniversary, the Lopezes' counsel sent a letter directly to AMR stating it constituted notice of the Lopezes' intent to file a lawsuit under Code of Civil Procedure section 364. Eleven weeks later (about 14 months after the accident), the Lopezes' filed a complaint alleging motor vehicle and medical negligence causes of action. AMR moved for summary judgment based on the one-year MICRA statute of limitations (Code Civ. Proc., § 340.5). The trial court found that MICRA applied based on declarations from the emergency medical technicians establishing their EMT certification at the time of the accident. The court treated the initial settlement demand letter as a notice of intent to sue under section 364, so the second letter did not toll the limitations period. The court concluded the lawsuit was untimely and granted summary judgment. The Lopezes appealed.

The Court of Appeal affirmed. First, the court held that the EMTs' declarations established their certification at the time of the accident, so there was no reason for them to submit actual certificates. The court then held that, under *Flores v. Presbyterian Intercommunity Hospital* (2016) 63 Cal.4th 75 and *Canister v. Emergency Ambulance Service, Inc.* (2008) 160 Cal.App.4th 388, transporting a patient by ambulance counts as providing "professional services" under section 340.5. Here, Lopezes' injuries resulted from AMR's alleged negligence in the " 'use or maintenance of equipment . . . integrally related to [plaintiff Leobardo's] medical diagnosis and treatment.' " The court explained that MICRA applies to all injuries resulting from professional medical negligence regardless whether an injured party was receiving medical treatment, so it was immaterial that Ubaldo was not a patient. Finally, the court rejected the Lopezes' argument that their second letter tolled the statute of limitations. The Lopezes' initial settlement demand letter adequately explained the legal basis of their claim against AMR, including details of their alleged injuries. That first letter therefore constituted a section 364 notice of intent to sue, meaning the Lopezes were not permitted to toll the limitations period by sending a second letter.

Plaintiffs suing public entities for medical negligence must meet both Government Claims Act and MICRA deadlines

Carrillo v. County of Santa Clara (Mar. 13, 2023, B322810) ___ Cal. App.5th ___ [2023 WL 2469717]

A nurse for Santa Clara County's Department of Corrections popped a blister on Emilio Carrillo's foot over his objection while he was forcibly detained. Within three days, the wound became infected. Carrillo developed gangrene, became febrile, and went into septic shock. Doctors amputated his foot later that month. Four months later, Carrillo was advised to pursue legal action while visiting the Mexican Consulate for immigration advice. Carrillo waited two months, then filed a claim with the County for negligence, which was rejected the next month. One day shy of six months from the rejection—and 13 months after his foot was amputated—Carrillo sued the County. The County demurred, citing MICRA's one-year statute of limitations. The trial court sustained the County's demurrer and entered a judgment of dismissal. Carrillo appealed.

The Court of Appeal affirmed. Under the Government Claims Act, suits against public entities must be filed within six months after the government rejects the claim. (Gov. Code, § 945.6, subd. (a)(1).) In addition, under MICRA, a plaintiff alleging medical negligence must sue within three years after the injury or one year after the plaintiff knew or should have known of the injury, whichever is earlier. (Code Civ. Proc., § 340.5.) Relying on *Roberts v. County of Los Angeles* (2009) 175 Cal.App.4th 474, 481, Carrillo argued there is always a three-year limitations

period when both the Claims Act and MICRA apply. The court disagreed, construing a statement in *Roberts* about the MICRA three-year period being an "outer limit" for lawsuits against public healthcare providers as meaning that plaintiffs must comply with both the Claims Act and MICRA. Here, MICRA's one-year statute of limitations barred Carrillo's claim because he knew of the nurse's unauthorized blister treatment and his consequent foot amputation, yet he failed to plead specific facts showing that he could not have discovered a connection between those events with reasonable diligence.

Doctor's irregular prescription of controlled substances to family member is good cause for disclosure of family member's private medical information

Kirchmeyer v. Helios Psychiatry Inc. (Feb. 14, 2023, A165128) ___ Cal. App.5th ___ [2023 WL 2518258]

When a patient complained to the Medical Board of California (Board) that Dr. Jennifer Dore—a certified psychiatrist and surgeon—inappropriately prescribed controlled substances, the Board opened an investigation into Dore and her practice. After finding an irregular prescription of Adderall and Klonopin (both controlled substances) to a family member employed by her medical practice, the Board served Dore with an investigative subpoena for the family member's medical records. Dore refused to produce the records. The Board filed in the trial court a petition to compel Dore and her practice to comply with the subpoena and other interrogatories. Dore opposed the petition. The trial court granted the petition. Dore and her practice appealed.

The Court of Appeal affirmed. First, it held that the Board provided sufficient evidence showing that it had compelling interest in reviewing the medical records. The Board's expert declaration explained that treating family members is traditionally outside the scope of standard medical care. Here it was highly unlikely that extenuating circumstances (like an emergency) justified such care. Second, the court held that the Board produced sufficient evidence to support a finding that the family member's records were relevant and material to the Board's investigation, which was narrowly crafted to exclude immaterial records. Moreover, the trial court's failure to make factual determinations was not error because the Board was not obligated to prove wrongdoing. Additionally, the court rejected Dore's claim that the Board's expert declaration should have addressed how often other physicians would have issued similar prescriptions. Last, the court distinguished *Grafilo v. Wolfsohn* (2019) 33 Cal.App.5th 1024, by noting that this case began with a patient complaint (as opposed to one by a third party), the expert declaration described a deviation from the standard of care, and the subpoena was not a fishing expedition.

DHCS has no mandatory duty to "deem audited" any unaudited cost reports and data after three years

Crestwood Behavioral Health, Inc. v. Baass (May 1, 2023, C094882) __ Cal.App.5th __ [2023 WL 3166593]

Some skilled nursing facilities serving Medi-Cal beneficiaries may provide special treatment program (STP) services to patients with chronic psychiatric impairments, for which they receive reimbursement from the Department of Health Care Services based on days of care and type of services provided. Under the Quality and Accountability Supplemental Payment System (QASP), the Department may authorize supplemental payments to facilities meeting certain performance standards, using audited bed days to calculate payment amounts. However, because the Department does not audit STP days, they are not included in QASP calculations. Crestwood Behavioral Health and other facilities providing STP services petitioned for administrative writ relief mandating the Department to include STP days in QASP calculations, which they alleged would result in recovering millions of dollars in QASP payments. The trial court denied writ relief, and the facilities appealed.

The Court of Appeal affirmed, holding that appellants failed to identify an appropriate basis for writ relief. The court explained that Welfare and Institutions Code, section 14170, subdivision (a)(1), which requires the Department to implement an auditing system, does not impose a mandatory or ministerial duty on the Department to "deem audited" the unaudited cost reports and data after three years. Rather, the section vests the Department with discretion to decide which cost reports and data to audit and limits its discretion

by providing that reports and data shall be considered true and correct *unless* audited or reviewed within three years. The Department was not required to take any particular action with respect to the cost reports and data, so writ relief could not be granted to compel the performance of a mandatory, ministerial act. The facilities also failed to demonstrate any abuse of discretion by the Department, because it could reasonably exercise discretion to decline to audit STP days due to its limited resources, and could not exercise discretion to include unaudited STP days in the QASP calculations without violating the State Plan.

Hospital's failure to disclose an ER fee supports a claim under the Consumer Legal Remedies Act

Naranjo v. Doctors Medical Center of Modesto, Inc. (2023) 90 Cal.App.5th 1193

After receiving a bill for emergency medical treatment at Doctors Medical Center of Modesto (Hospital), Joshua Naranjo filed a class action lawsuit seeking declaratory and injunctive relief. Naranjo alleged the Hospital's failure to disclose the emergency room evaluation and management service (EMS) fee included in his bill violated the Consumer Legal Remedies Act (CLRA) and the unfair competition law (UCL). The trial court sustained the Hospital's demurrer and entered a judgment of dismissal. Naranjo appealed.

The Court of Appeal reversed. First, the court held the Hospital had a duty to disclose its EMS fee because it had exclusive knowledge of the fee, which was not reasonably ascertainable by patients, and the Hospital's failure to disclose its EMS fee could support CLRA liability. Departing from three recent appellate decisions holding that hospitals had no duty to disclose EMS fees, the court explained that none of those decisions had addressed the "exclusive knowledge" issue. Next, the court held that, contrary to the rationale of prior decisions, requiring disclosure of the potential EMS fee was consistent with state and federal laws requiring the provision of emergency medical services before questioning the patient or others about payments, and requiring the disclosure of certain fee information. Moreover, those laws do not create a safe harbor from CLRA and UCL claims—a safe harbor exists only if a statutory provision bars the litigation or expressly permits the conduct. Finally, the court held that Naranjo adequately alleged that the Hospital had exclusive knowledge of its EMS fee billing practices (which information he lacked); that the EMS fee was material to his decision to receive emergency treatment; that he would not have consented to the emergency treatment if the EMS fee had been disclosed; and that he sustained damages by paying part of the EMS fee. Accordingly, the trial court erred by sustaining the Hospital's demurrer to Naranjo's CLRA claim and to the UCL claim premised on his CLRA claim.

Kaiser cannot avoid class claims that it failed to provide medically necessary treatments required by the Mental Health Parity Act

Futterman v. Kaiser Foundation Health Plan, Inc. (Apr. 25, 2023, A162323) __ Cal.App.5th __ [2023 WL 3070944], ordered published May 17, 2023

Three plaintiffs sued Kaiser Foundation Health Plan under the Unfair Competition Law alleging the Plan violated the California Mental Health Parity Act by failing to provide coverage for medically necessary mental health treatments for themselves or their dependents. They presented evidence that the Plan denied, or deterred members from obtaining, one-on-one therapy sessions without determining medical necessity. The Plan instead required or recommended group therapy, practices that did not mirror the Plan's treatment of physical health conditions and that, in some instances, were inappropriate clinically. Plaintiffs sought class-wide injunctive relief and statutory penalties. Plaintiffs also invoked the Unruh Civil Rights Act, arguing the Plan intentionally discriminated against persons with mental disabilities or conditions. The trial court granted the Plan's motion for summary judgment on the basis that plaintiffs were seeking relief for actions taken by healthcare providers that contracted with the Plan (but not the Plan itself), and that no contractual benefits were denied for a discriminatory reason. Plaintiffs appealed.

The Court of Appeal reversed (except as to one plaintiff's individual claims). Plaintiffs had presented evidence that the Plan—not medical groups and physicians—arranges and pays for mental health treatment more stingily than for treatment of physical illnesses. Return or repeat appointments were virtually impossible to arrange; doctors were

scheduled in a manner frustrating one-on-one therapy sessions; and the Plan's model emphasized group therapy, even for actively suicidal or psychotic patients for whom group sessions were clinically improper. Together, this and other evidence supported an inference that the Plan was making decisions regarding individual mental health treatment based on criteria other than medical necessity. So too, this evidence supported an inference the Plan was providing less robust coverage for mental health issues than it provides for physical illnesses. Distinguishing several other cases, the court rejected the Plan's argument that plaintiffs were actually seeking to hold the Plan vicariously liable for the actions of doctors, medical groups, and other providers, which the Knox-Keene Act forecloses. The court also determined that plaintiffs could pursue their claims without interfering with the DMHC's regulatory authority. On the Unruh Act claims, the Court of Appeal held that evidence of the Plan's decision not to fund its coverage at a level necessary to provide all medically necessary treatment supported an inference of discrimination against patients with certain mental illnesses. Summary judgment for the Plan was therefore inappropriate.

"Deemed" Public Health Service employees are immune from liability to third parties for conduct related to health services under 42 U.S.C. § 233

Friedenberg v. Lane County, __ F.4th __, No. 21–35078, 2023 WL 3558224 (9th Cir. May 19, 2023)

A municipal court referred Michael Bryant to a jail diversion program (as a condition of probation) and ordered him to report to Lane County Mental Health (LCMH) for treatment. But Bryant stopped taking his medications, leading to a psychotic break during which he killed two people and maimed another. The crime victims (or their estates) sued Lane County, LCMH, and its employees, alleging negligence and wrongful death claims stemming from the defendants' failure to report Bryant's probation violations to the court, which would have incarcerated him. The defendants removed the case to federal court under the Federally Supported Health Centers Assistance Act (FSHCAA), 42 U.S.C. § 233. The defendants argued that, because the FSHCAA deems them Public Health Service (PHS) employees, the Federal Tort Claims Act requires the United States to be substituted in their place as the sole defendant. Plaintiffs moved to remand on grounds the district court lacked jurisdiction under the FSHCAA. The district court granted the remand motion, ruling that, as "deemed" PHS employees (rather than actual PHS employees), the defendants were not entitled to § 233 immunity because plaintiffs were not LCMH patients when they suffered injury. Defendants appealed.

The Ninth Circuit reversed and directed the district court to substitute the United States as the sole defendant. The court explained that Congress enacted the FSHCAA to prevent community health centers serving underprivileged populations from having to use their federal funds to purchase costly medical malpractice insurance. To further this objective, Congress extended the absolute immunity "provided to actual PHS employees in § 233(a) to 'deemed' PHS employees under § 233(g)." Moreover, § 233 immunity does not turn on who brings a claim, but rather whether the claim arose out of the defendants' performance of medical, dental, surgical, or related services—regardless whether the injured plaintiff was a patient. And while Congress's concerns regarding medical malpractice insurance premiums were the driving force behind enactment of FSHCAA, Congress elected not to limit § 233 immunity to malpractice claims when it could have done so. Finally, the court held that the defendants' alleged failure to notify the municipal court of the probation violations was a "'related function'" under § 233, bringing it within the scope of the statutory immunity, because their duty to report Bryant's violations and his potential threat to public safety was tied to their status as medical health professionals.

Corrections officials may not engage in unconsented "patient dumping" of medically compromised parolees

Kern County Hospital Authority v. Department of Corrections and Rehabilitation (May 26, 2023, F083743) __ Cal.App.5th __ [2023 WL 3675914]

The California Department of Corrections and Rehabilitation (CDCR) unsuccessfully attempted to locate skilled nursing facilities to accept four medically compromised inmates approaching their parole dates. CDCR then "paroled" and transported them to the emergency department at Kern Medical Center, a general acute care hospital. Kern County Hospital Authority, which

operates the center, sought and obtained a writ of mandate and a permanent injunction barring CDCR from transferring parolees to the authority's facilities absent advance permission or a medical emergency. CDCR appealed.

The Court of Appeal affirmed, but modified the scope of the injunction. The court recognized the tension between CDCR's duty to the parolees as patients and the parolees' liberty interests. Parolees are entitled to be released, yet CDCR retains statutory discretion to determine a parolee's placement. Some parolees require skilled nursing care. Under California Code of Regulations, title 22, section 79789, however, CDCR may not transfer parolees to another facility unless transfer arrangements are made beforehand. The Court of Appeal rejected CDCR's argument that this regulation covers only inmates, not parolees, as well as CDCR's argument that the facility's advance agreement to accept the parolee was unnecessary. The court also found EMTALA inapplicable because the parolees did not require *emergency* medical care; they needed only skilled nursing care. To vindicate parolees' liberty interests, the Court of Appeal modified the injunction to allow a parolee to decline further care and treatment at the correctional facility, enabling the parolee to choose either to be discharged to a hospital emergency room (regardless of the hospital's prior consent) or continue to receive skilled nursing care at the correctional treatment center while awaiting an agreed placement at a skilled nursing or other medical facility. "What the Department cannot do is drop the parolees off at the emergency department while the parolees remain correctional treatment center patients without making advance arrangements for their admission to the hospital."

"Aggravated identity theft" sentence enhancement is inappropriate in healthcare fraud case based on overbilling Medicare

Dubin v. United States, 599 U.S. __, 2023 WL 3872518 (June 8, 2023)

David Dubin overbilled Medicaid $338 by overstating the qualifications of employees who performed psychological testing. A jury convicted him of healthcare fraud under 18 U.S.C. § 1347 and aggravated identity theft under § 1028A. The Government sought a 2-year prison sentence enhancement for aggravated identity theft under § 1028A(a)(1). That statute applies when "'during and in relation to any [predicate offense, including healthcare fraud]'" a defendant "'knowingly transfers, possesses, or uses, without lawful authority, a means of identification of another person.'" The Government argued that § 1028A(a)(1) applied because Dubin committed healthcare fraud using patients' Medicaid reimbursement number, a "'means of identification.'" The district court was dubious because the crux of the case was fraudulent billing, not identity theft, but nonetheless imposed the sentence enhancement due to controlling Fifth Circuit precedent.

The U.S. Supreme Court granted review to determine "whether in defrauding Medicaid, [Dubin] also committed '[a]ggravated identity theft.'" The Supreme Court reversed the Fifth Circuit, holding that "under § 1028A(a)(1), a defendant 'uses' another person's means of identification 'in relation to' a predicate offense when the use is at the crux of what makes the conduct criminal" and does not merely facilitate the crime. The Court reasoned that the title and language of § 1028A(a)(1) together reflected a targeted meaning that "accurately captured the ordinary understanding of identity theft, where misuse of a means of identification is at the crux of the criminality." Thus, Congress' decision to title § 1028A "Aggravated identity theft" and to separate *identity fraud* crimes from *identity theft* crimes shows the statute "is focused on identity theft specifically, rather than all fraud involving means of identification." Likewise, the verbs used in § 1028A(a)(1) (transfers, possesses, and uses) speak to classic identity theft where the means of identification is the locus of the criminal undertaking. In contrast, the "Government's broad reading, covering any time another person's means of identification is employed in a way that facilitates a crime, bears little resemblance to any ordinary meaning of 'identity theft.'" The statute's list of predicate offenses and its separate 2-year sentence enhancement also reflects an intent to target "situations where the means of identification itself is at the crux of the underlying criminality, not just an ancillary billing feature." Finally, under the rule of lenity, the Court typically eschews broad readings of federal criminal statutes to ensure people have "fair warning" of what conduct is forbidden.

A concurring opinion by Justice Gorsuch opined that § 1028A(a)(1) was unconstitutionally vague, and not merely ambiguous, because it failed to provide even rudimentary notice of what it does and does not criminalize.

State employees do not face § 1983 stigma-plus liability for losses that would have occurred absent state action

Chaudhry v. Aragon, 68 F.4th 1161 (9th Cir. May 23, 2023)

A patient suffered hypoxic brain injury during open heart surgery at a private hospital. The hospital, California Department of Public Health (CDPH), and Centers for Medicare and Medicaid Services conducted separate investigations and found that the lead surgeon, Dr. Pervaiz Chaudhry, left the operating room before the patient was stable and his chest was closed. The hospital suspended Dr. Chaudhry's medical staff membership and clinical privileges, revoked his appointment as Medical Director of Cardiac Surgery and Thoracic Services, and declined to renew consulting services agreements with him and his medical group. Several months later, CDPH published a statement of deficiency on its website, which summarized its findings but did not identify Dr. Chaudhry by name. Thereafter, a hospital employee with independent knowledge about the surgery notified the patient's family of Dr. Chaudhry's potential malfeasance. The patient's family sued the hospital and Dr. Chaudhry for malpractice, securing a $60 million jury verdict. Dr. Chaudhry and his medical group separately sued current and former CDPH employees, alleging a "stigma-plus" due process claim under 42 U.S.C. § 1983. They asserted that CDPH employees violated their Fourteenth Amendment rights by publishing the statement of deficiency without first providing Dr. Chaudhry an opportunity to be heard. They asserted that the publication of the statement of deficiency damaged Dr. Chaudhry's reputation and deprived him of protected employment-related interests. Following a bench trial, the district court entered judgment for the CDPH employees. Plaintiffs appealed.

The Ninth Circuit affirmed, holding that the record supported the district court's finding that publishing the statement of deficiency was not the but-for cause of plaintiffs' loss of positions and contracts with the hospital. The hospital conducted an internal investigation before CDPH began investigating, and the hospital's internal investigation yielded the same conclusions as CDPH's statement of deficiency. Therefore, it was plausible that the hospital would have terminated Dr. Chaudhry's privileges and declined to renew his consulting contract based on those same findings and conclusions. The court rejected plaintiffs' argument that the publication of the statement of deficiency increased his medical malpractice insurance premiums. The court reasoned that Dr. Chaudhry's insurance premiums would have increased regardless of CDPH's publication of the statement of deficiency because there were five unrelated malpractice lawsuits pending against him. The court also rejected plaintiffs' argument that the patient's family sued him because CDPH published the statement of deficiency, agreeing with the district court that the family likely would have sued Dr. Chaudhry (and prevailed in that lawsuit) with or without the statement of deficiency because the family received an anonymous tip about the incident and had access to the hospital's internal findings.

Nursing home residents may sue under 42 U.S.C. § 1983 for FNHRA violations

Health & Hospital Corp. v. Talevski, 599 U.S. __, 2023 WL 3872515 (June 8, 2023)

Family members placed Gorgi Talevski in a county-owned nursing home in Indiana when his dementia progressed to the point they could no longer care for him. His condition quickly deteriorated. The family attributed his decline to the nursing home's use of powerful psychotropic medications. When the nursing home began transferring Talevski to a distant psychiatric hospital for days at a time, the family complained to the state health department. An administrative law judge nullified the transfer, but the nursing home ignored the decision and refused to readmit Talevski. Talevski (via a relative) sued the nursing home's operator (HHC) in federal court under 42 U.S.C. § 1983, alleging that HHC violated his rights under the Federal Nursing Home Reform Act (FNHRA), a statute enacted by Congress under its Spending Clause authority. The district court dismissed the complaint, ruling

that Section 1983 may not be used to enforce the FNHRA. The Seventh Circuit reversed, holding that the FNHRA confers on nursing home residents certain individual rights that may be enforced by litigating under Section 1983.

The Supreme Court granted review and affirmed the Seventh Circuit. The Court explained that Section 1983 supplies a plaintiff with a cause of action against a person (acting under color of state law) who has deprived the plaintiff of rights "secured by the Constitution *and laws*" of the United States. The "laws" enforceable via Section 1983 are not limited to federal statutes focused on civil rights or equal protection, but neither is every federal statute such a "law[ ]." The Supreme Court considers a variety of factors to determine which federal statutes may be enforced under Section 1983. Here, the Court held that FNHRA provisions create Section 1983-enforceable rights because they contain rights-creating, individual-centric language focused on the benefited class (specifically, FNHRA provisions bar unnecessary restraints and mandate predischarge notice). FNHRA provisions also specify that Medicaid-participant nursing homes must respect and honor these rights. In addition, Congress did not provide a private right of action within the FNHRA, and the Act lacks an internal administrative enforcement scheme that could be thought incompatible with enforcement efforts under Section 1983.

Justice Barrett (joined by the Chief Justice) concurred separately to caution that Section 1983 actions should be the exception (not the rule) for violations of federal statutes enacted under the Spending Clause. The typical remedy for non-compliance with Spending Clause statutes is an action by the federal government to terminate funds to the state, not a private lawsuit. Justice Barrett nonetheless found a private lawsuit suitable in the FNHRA context. Justice Thomas dissented on the ground that Spending Clause statutes like FNHRA should not be enforceable under Section 1983. Spending Clause statutes resemble contracts between states and the federal government, not regulations conferring individual rights. A contrary view (he suggested) could enable Congress to commandeer states to administer federal programs that Congress might otherwise lack authority to enact. Finally, Justice Alito dissented to criticize the majority's holding that the FNHRA creates Section 1983-enforceable rights given its unique remedial scheme and grievance process.

Terminating a hospital administrator for refusing to get a flu shot in violation of employer policy is not prohibited by FEHA

Hodges v. Cedars-Sinai Medical Center (2023) 91 Cal.App.5th 894

Deanna Hodges worked for Cedars-Sinai Medical Center in an administrative role with no patient care responsibilities. Cedars terminated her employment because she refused to get a flu vaccine. Cedars's flu vaccine policy made exceptions for employees who established "a valid medical or religious exemption." Employees who declined the vaccine "based on medical contraindication, per CDC guidelines" were required to submit an exemption request completed by their physician. Hodges's doctor wrote a note recommending an exemption based on her history of cancer and general allergies. None of those reasons were medically recognized contraindications, however. Hodges continued to refuse a flu vaccination after Cedars' review panel declined her exemption request, so Cedars terminated her employment. Hodges sued Cedars for disability discrimination and related claims under the Fair Employment and Housing Act (FEHA). The trial court granted Cedars summary judgment, and Hodges appealed.

The Court of Appeal affirmed. Because there was no direct evidence that Cedars acted with a "prohibited motive," the court applied the *McDonnell Douglas* three-step burden-shifting framework commonly used in employment discrimination cases and concluded that Hodges failed to show a prima facie case, the initial step. The court explained that terminating a person because she refused to get a flu shot in violation of employer policy is not prohibited by FEHA. The court noted that there was no evidence that Cedars terminated Hodges because she was "unable" to get the vaccine, or due to any claimed disability. To the contrary, the direct evidence, including the written policy and exemption request form, showed that Cedars had a policy of terminating employees who failed to receive the flu vaccine without a religious exemption or medically recognized contraindication to receive the flu vaccine, and that it followed the

policy here. The court noted that Cedars would have prevailed at other steps of the burden-shifting framework as well: Cedars presented a legitimate, nondiscriminatory reason for terminating Hodges, and Hodges failed to argue the reason was pretextual.

Public health care service plans are not immune from provider reimbursement actions under the Knox-Keene Act

County of Santa Clara v. Superior Court (July 10, 2023) __ Cal.5th __ [2023 WL 4414084]

As required by state and federal law, Doctors Medical Center of Modesto, Inc., and Doctors Hospital of Manteca, Inc., provided emergency medical care to three individuals enrolled in a health care service plan operated by the County of Santa Clara. The hospitals had no contract with the County governing rates payable for emergency services rendered to plan members. The hospitals billed the County for the emergency services rendered, but the County paid only a portion of the billed amounts. The hospitals then sued the County for the balance under a provision of the Knox-Keene Act (and implementing regulations) requiring a health care service plan to reimburse medical providers for the "reasonable and customary value" of the emergency care. (Health & Saf. Code, § 1371.4, subd. (b); Cal. Code Regs., tit. 28, § 1300.71, subd. (a)(3)(B).) After the trial court overruled the County's demurrer, the County petitioned for a writ of mandate, The Court of Appeal granted writ relief, holding that the County was immune from suit under the Government Claims Act's general immunity provision (Gov. Code, § 815). The Hospitals sought and obtained review in the California Supreme Court.

The Supreme Court reversed, holding that the Claims Act does not immunize a public health care service plan from an emergency medical provider's implied-in-law quantum meruit claim seeking reimbursement under the Knox-Keene Act. Noting that the Claims Act does not preclude contract liability, or the right to obtain relief "other than money or damages" (Gov. Code, § 814), the Supreme Court explained that the Claims Act immunizes public entities only from tort claims seeking money damages. The Court rejected the County's characterization of the hospitals' quantum meruit claim as a tort claim seeking money damages, and instead viewed the hospitals' claim as seeking County compliance with the statutory duty of reimbursement. The Court further reasoned that the Knox-Keene Act should apply equally to private and public health care service plans, and that treating public plans differently would risk systemic underpayment of emergency services, which the Legislature had sought to avoid by enacting the Knox-Keene Act's reimbursement provision. The Court also distinguished its decisions predating the Claims Act that barred quasi-contractual recovery against public entities; those cases involved express contracts with public entities that proved to be void for violating applicable statutes or charters. Here, by contrast, the hospitals had no express contract with the County and the hospitals' quasi-contractual claims sought payment required by statute.