No. S271501

SUPREME COURT
STATE OF CALIFORNIA

LARRY QUISHENBERRY
APPELLANT

VS.

UNITED HEALTHCARE, INC., et al.
RESPONDENTS

Second Appellate District, Division Seven, Case No.: B303451
Los Angeles Superior Court Case No.: BC631077

ANSWER TO PETITION FOR REVIEW

MICHAEL J. TROTTER, NO. 139034
BRENDA J. LIGORSKY, NO. 169707
DAVID P. PRUETT, NO. 155849*
CARROLL, KELLY, TROTTER, FRANZEN & MCBRIDE
111 West Ocean Boulevard, 14th Floor
Post Office Box 22636
Long Beach, California 90801-5636
Tel. (562) 432-5855; Fax. (562) 432-8785

Attorneys for Defendants/Respondents HealthCare Partners Medical Group, HealthCare Partners LLC

*Certified Specialist, Appellate Law, State Bar of California, Board of Legal Specialization

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CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

There are no interested entities or persons to list in this certificate. Cal. Rules of Court, Rule 8.208(d)(3).

Dated: November 17, 2021 CARROLL KELLY TROTTER & FRANZEN

By: */s/ David P. Pruett*
DAVID P. PRUETT
Attorney for Respondents HealthCare Partners Medical Group, HealthCare Partners LLC

ANSWER TO PETITION FOR REVIEW

I. INTRODUCTION

Has the petitioner demonstrated grounds for review by showing that review of the Court of Appeal's decision is "necessary to secure uniformity of decision or to settle an important question of law"? (Cal. Rules of Court, 8.500(b)(1).) That question should be answered, "No."

The petition reasserts plaintiffs' arguments against Medicare preemption, which were asserted in the Superior Court and the Court of Appeal. But, the petition omits plaintiffs' own allegations that demonstrated Medicare preemption, which the decision of the Court of Appeal recited in its decision, asserting that plaintiffs' decedent Eugene Quishenberry was only provided with 24 days of skilled nursing facility care and that defendants should have deemed him eligible and entitled to receive under Medicare an additional 76 days of such skilled nursing facility care, up to the Medicare maximum benefit of 100 days. (Slip op., pp. 4-5.)

While the petition asserts there is a split of authority from the Courts of Appeal, referring to the decisions in *Cotton v. StarCare Medical Group, Inc.* (2010) 183 Cal.App.4th 437 and *Roberts v. United Healthcare Services, Inc.* (2016) 2 Cal.App.5th 132, the difference in approach by those Courts of Appeal would not have changed the outcome in this case. Further, although *Cotton* decided Medicare preemption did not apply and *Roberts* decided it did, that was because of specific facts and circumstances at issue at the time of each of those decisions. Those differences included that between the two decisions, the Ninth Circuit published its decision in *Do Sung Uhm v. Humana, Inc.* (9th Cir. 2010) 620 F.3d 1134, a case that *Cotton* acknowledged would have had bearing on its analysis.

Fundamentally and ultimately, there is no need for review of the unpublished, unanimous decision of the Court of Appeal here because apart from any differences in approach between *Cotton* and *Roberts* on the issue of express preemption, implied preemption or obstacle preemption

applies here, based upon the standards stated in the seminal decision of *Heckler v. Ringer* (1984) 466 U.S. 602, which both *Cotton* and *Roberts* acknowledge and honor.

This case does not call for review by this Court.

II. SUMMARY OF FACTS AT ISSUE

The petition fails to acknowledge that plaintiff's second amended complaint, the pleading at issue, complains about a Medicare benefits determination. Plaintiff alleged: "Eugene was initially admitted to GEM on or about November 4, 2014, and discharged home on physician orders about 24 days later on November 28. ***Eugene was entitled under Medicare to another period of 76 days of care at GEM with daily care of his pressure sores and daily physical therapy.*** Nevertheless, following Lee's direction, and pursuant to the business practice of HCP and United Healthcare entities, ***GEM furnished Eugene with a false statement that he was no longer qualified under Medicare for further inpatient care at GEM.*** [¶] Eugene was transferred to his home, where, without adequate nursing care and physical

therapy and as a proximate cause of Dr. Lee's treatment decisions, Eugene's health declined, he experienced pain and suffering, and died. Said transfer was below the standard of care, and done recklessly and willfully as set forth below." (AA 33; emphasis added.)

Regarding the events allegedly leading to that, plaintiff alleged: "When he broke his hip, Eugene was admitted as a patient at Huntington Hospital for treatment." (AA 32.) The date of that hospital admission was not stated. Plaintiff then alleged: "After a period of hospitalization at Huntington Hospital, Eugene was transferred to GEM, to be under the care and treatment of defendant Lee." (AA 32.) Relative to the time at GEM, plaintiff alleged: "Eugene was initially admitted to GEM on or about November 4, 2014, and discharged home on physician orders about 24 days later on November 28." (AA 33.)

The allegations of the original complaint also included: "During the period from November 4, 201[4] to approximately November 28, 2014 Eugene was a resident and patient of

GEM, Grace Mercado and Dr. Jae H. Lee, and from November 28, 2014 to April 15, 2015, he was a patient of Berger. During the period following November 28, 2014 Eugene lived at home and received care from Berger as a 'home health' patient." (AA 21.)

Plaintiff alleged "Berger, Inc." to be "a 'Home Health Agency' under the name of Accredited Home Care." (AA 16.) "Berger is in the business of employing persons who qualify as licensed health care providers such as registered nurses, licensed vocational nurses, physical therapists, occupational therapists and other persons such as nurse aides or 'caregivers,' to provide supporting unskilled care and skilled care in patients' homes. Berger is subject to the requirements which apply to the operation of a licensed Home Health Agency as generally set forth at and referred to in Health & Safety Code §1728.7." (AA 16.)

Plaintiff's allegations reflect that after discharge home from GEM (the skilled nursing facility), Eugene received additional post-hospital medical services from Berger for 149

days (November 17, 2014 to April 15, 2015). (*Ibid.*) So, following discharge from the hospital, including the 24 days at GEM, Eugene received a total of 173 days of post-hospital medical services.

Eventually, 269 days after the discharge home from the skilled nursing facility, Eugene died, less than two months from his 86th birthday, on August 24, 2015. (AA 26; Respondent's Appendix, HCP RA 3-5.)

Plaintiff failed to allege any facts describing any difference in the care that Eugene received while he was a patient at GEM and the time he received home health care services from Berger. Plaintiff failed to allege any facts regarding Eugene's condition when the services from Berger stopped on April 15, 2015 to date of death on August 24, 2015.

The only facts alleged were that defendants considered Eugene ineligible, under Medicare standards for determinations of eligibility for that benefit, to receive the full 100 days maximum skilled nursing facility benefit available to

qualifying Medicare beneficiaries. Plaintiff's contention was that that Medicare benefits determination was falsely decided, alleging "a false statement that he was no longer qualified under Medicare for further inpatient care at GEM." (AA 33.)

Plaintiff vaguely implies and insinuates that something should have been different relative to Eugene's discomfort and date of death. But, mere allegations that a person experienced discomfort and died after an event in which defendants were involved do not constitute factual allegations of fault and causation against defendants. Prior events are not necessarily legal cause of successive or later events.

III. DECISION OF THE COURT OF APPEAL

While the petition avoids stating the above-stated facts, those pivotal allegations of the subject complaint were included in the Court of Appeal's decision, which observed: "Eugene was at GEM's skilled nursing facility for 24 days, from November 4 through 28, 2014. According to the complaint, Eugene was entitled under Medicare to an additional 76 days of care at GEM's skilled nursing facility

with daily physical therapy and care for his pressure sores. 'Nevertheless, following [Dr.] Lee's direction, and pursuant to the business practice of [Healthcare Partners] and the UnitedHealthcare entities, GEM furnished Eugene with a false statement that he was no longer qualified under Medicare for further inpatient care at GEM. [¶] Eugene was transferred to his home, where, without adequate nursing care and physical therapy and as a proximate cause of Dr. Lee's treatment decisions, Eugene's health declined, he experienced pain and suffering, and died.'" (Slip op., pp. 4-5.)

The Court of Appeal decision was based upon plaintiff's own allegations of deprivation of a Medicare benefit.

IV. ELIGIBILITY FOR SKILLED NURSING FACILITY CARE IS GOVERNED BY MEDICARE

Plaintiff introduced the issue of Medicare benefits determinations with the assertion that "Eugene only received 24 days of physical therapy at GEM. Under Medicare rules he was entitled to another 76 days of physical therapy at GEM

with daily care for his pressure sores and daily physical therapy." (AOB, 16, referring to AA 33:7-12.)

Allegations of an entitlement of another 76 days of physical therapy present a Medicare benefits determination that is outside the jurisdiction of the California courts.

In accordance with *Heckler v. Ringer, supra*, 466 U.S. 602, such determinations of Medicare benefits are subject to resolution exclusively by Medicare administrative remedies, with any judicial review limited only to federal district court. (*Id.* at 614.) Claims that are "at bottom" a challenge to a benefits determination are claims that fall within the scope of the Medicare Act, as are claims "inextricably intertwined" with claims for benefits, all subject to the exclusive remedy of the Medicare Act, and require exhaustion of administrative remedies prior to judicial review, with any such review limited to federal court. (*Ibid.*) Regarding such exclusive federal court jurisdiction, *Ringer* referred to 42 U.S.C. §405(h) section 405(g), limiting review to federal district court, as "the sole

avenue for judicial review of all '[claims] arising under' the Medicare Act." (Ringer at 614-615.)

The issue of eligibility of the Medicare benefit of up to 100 days at a skilled nursing facility was addressed in *United HealthCare Ins. Co. v. Sebelius* (D.Minn. 2011) 774 F.Supp.2d 1014, wherein that District Court observed: "The statute governing Medicare, 42 U.S.C. § 1395 et seq., is essentially broken up into four parts: Part A, which describes certain inpatient services, as well as other services, covered by Medicare; Part B, an optional insurance program that helps to pay for certain outpatient services; Part C, formerly known as Medicare+Choice, allows beneficiaries to receive their Part A and Part B benefits through a MA organization, such as United; and Part D, which provides beneficiaries coverage for prescription drugs." (*United HealthCare* at 1019.) In that action, the plaintiff "had a MA policy with United governed by Part C of the Medicare Act, which allows for beneficiaries to receive their benefits from a Medicare Advantage organization, such as United, who contracts with the Government to

provide Medicare benefits to beneficiaries." (*Ibid.*; citing 42 U.S.C. §§ 1395w-21 through 1395w-28.) "Under such a plan, at a minimum, the beneficiary must receive the benefits covered by Medicare Part A and Part B." (*United HealthCare* at 1019; citing § 1395w-22(a); 42 C.F.R. § 422.100.)

United HealthCare explained: "One of the benefits covered under Part A of the Medicare Act is post-hospital extended care services for up to 100 days." (*Id.* at 1019; citing 42 U.S.C. § 1395d(a)(2)(A).) After discussing certain rules regarding eligibility for "post-hospital extended care services," *United HealthCare* explained that "in order to be able to receive this coverage, a beneficiary must meet certain requirements"; "the beneficiary must (1) require skilled nursing or rehabilitative services, (2) on a daily basis, (3) the services must be furnished for a condition for which the beneficiary received inpatient services, for a condition which arose while the beneficiary was receiving care in an SNF for a condition for which the beneficiary was hospitalized, or, for MA beneficiaries whose plans waive the 3 day hospital stay

requirement, for a condition for which a physician has determined that direct admission to an SNF was medically appropriate without a prior hospital stay, and (4) the services must be such that as a practical matter they can only be provided at an SNF on an inpatient basis." (*United HealthCare* at 1019; citing 42 C.F.R. §§ 409.30-409.35, and particularly § 409.31.)

United HealthCare further explained that "Medicare coverage, in general, does not extend to custodial care." (*Id.* at 1020.) The Court cited 42 U.S.C. § 1395y(a)(9), as stating: "'Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services … where such expenses are for custodial care.'" (*United HealthCare* at 1020.) The Court further explained: "Custodial care is defined in the regulations as 'any care that does not meet the requirements for coverage as SNF care as set forth in §§ 409.31 through 409.35 of this chapter.'" (*Ibid.*; quoting 42 C.F.R. § 411.15(g).)

One of the regulations delineating the scope of Medicare coverage for skilled nursing facility level of care is 42 C.F.R. § 409.33(d), which describes "[p]ersonal care services which do not require the skills of qualified technical or professional personnel," which are generally not considered "skilled services," listing such examples as: "(1) Administration of routine oral medications, eye drops, and ointments; [¶] (2) General maintenance care of colostomy and ileostomy; [¶] (3) Routine services to maintain satisfactory functioning of indwelling bladder catheters; [¶] (4) Changes of dressings for noninfected postoperative or chronic conditions; [¶] (5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems; [¶] (6) Routine care of the incontinent patient, including use of diapers and protective sheets. … [¶] (11) Assistance in dressing, eating, and going to the toilet; [¶] (12) Periodic turning and positioning in bed; and (13) General supervision of exercises which have been taught to the patient…."

Plaintiff contends he was entitled to a longer skilled nursing facility stay. That was a Medicare benefits determination, which is outside of the scope of the jurisdiction of the California courts.

V. MEDICARE PROVIDED EXCLUSIVE REMEDIES FOR A DISPUTE REGARDING THE MEDICARE BENEFIT OF SKILLED NURSING FACILITY CARE OF 100 DAYS

As explained in *Heckler v. Ringer, supra*, 466 U.S. 602, disputes regarding determinations of Medicare benefits are resolved by Medicare administrative remedies and to judicial review only in the federal district court.

Accordingly, *Roberts v. United Healthcare Services, Inc.* (2016) 2 Cal.App.5th 132: "When a Medicare beneficiary participating in a Part C-authorized private health care plan challenges his 'entitle[ment] to receive a health service' or 'the amount (if any) that [he] is required to pay with respect to such service,' Congress has erected a four-tier administrative review scheme." (*Id.* at 149-150.)

Roberts explained: "First, the beneficiary must raise his challenge with the Medicare Advantage plan itself, and Congress requires every such plan to 'have a procedure for making [those] determinations' and requires the plan's administrator to issue a written statement 'of the reasons for the denial.'" (*Id.* at 150; quoting 42 U.S.C. § 1395w-22(g)(1).) "Second, the beneficiary must seek reconsideration of an adverse determination with the Medicare Advantage plan, which Congress also specifies that each plan must offer." (*Ibid.*; citing § 1395w-22(g)(2).)

In addition to those readily available reviews from the health plan, *Roberts* described the additional layers of review provided through Medicare: "Third, the beneficiary must appeal the denial of reconsideration to the 'independent, outside entity' designated by the Secretary.... [§ 1395w-22(g)(4).] Fourth, if the independent outside entity denies relief and 'the amount in controversy is $100 or more,' the beneficiary must seek a hearing before the Secretary. (42 U.S.C. § 1395w-22(g)(5); accord, 42 U.S.C. § 1395mm(c)(5)(B)

….) If the Secretary denies relief and 'the amount in controversy is $1,000 or more,' then and only then may the beneficiary obtain judicial review of that decision. (42 U.S.C. §§ 1395w-22(g)(5), 1395ii [incorporating general administrative exhaustion provision for title 42 into Medicare Act]; see also 42 U.S.C. § 405(g), (h)….)" (*Roberts* at 150.)

The same limitations for review of Medicare benefits determinations were acknowledged in *Cotton v. StarCare Medical Group, Inc., supra,* 183 Cal.App.4th 437, recognizing that even prior to any express preemption provision in the Medicare Act (prior to 1997), the Medicare Act "provide[d] an administrative procedure allowing the Department of Health and Human Services (HHS) to review benefit claim denials that limited judicial review to an action in federal court only if an unsuccessful claim exceeded a specified amount." (*Id.* at 447-448; citing 42 U.S.C. § 405(g) & (h); *Ringer, supra,* 466 U.S. art 606-607.) *Cotton* observed: "*Ringer* held the failure to comply with this administrative procedure barred a legal action if a beneficiary sued for a remedy "'inextricably

intertwined" with [a] claim [] for benefits,' or if "'both the standing and the substantive basis for the presentation" of the claim[] is the [Medicare] Act.'" (*Cotton* at 448; quoting *Ringer* at pp. 614, 615.)

VI. ONLY THE DETERMINATION REGARDING THE MEDICARE BENEFIT OF SKILLED NURSING FACILITY CARE WAS AT ISSUE

Other than a failure to deem Eugene Quishenberry eligible for 76 more days of skilled nursing facility care, to receive the maximum allowable Medicare benefit of 100 days of skilled nursing facility care, plaintiff failed to allege facts that would otherwise support a cause of action.

Plaintiff simply alleged that there was a failure to provide the Medicare benefit of skilled nursing facility care and that eventually, 269 days later, Eugene Quishenberry died. Without facts, plaintiff insinuates, or seeks a deduction without facts supporting it, that the failure to provide skilled nursing facility care led to deterioration and death. But,

there were no facts alleging that the home care was actually deficient.

Simply because the denial of a Medicare benefit of skilled nursing facility care occurred prior to deterioration and death does not amount to allegations of conduct apart from the Medicare benefit determination that was in violation of any right or the legal cause of deterioration or death of an 86-year-old man, especially when the chain of events that led to the skilled nursing facility determination was that he broke his hip at home and required hospitalization for that.

As this Court explained in *PPG Industries v. Transamerica* (1999) 20 Cal.4th 310 instructed: "To simply say, however, that the defendant's conduct was a necessary antecedent of the injury does not resolve the question of whether the defendant should be liable.... '[T]he consequences of an act go forward to eternity, and the causes of an event go back to the dawn of human events, and beyond. But any attempt to impose responsibility upon such a basis would result in infinite liability for all wrongful acts, and would "set

society on edge and fill the courts with endless litigation.”” (*Id.* at 315.)

In accord, the Ninth Circuit recently stated that a “‘Rube Goldbergesque system of fortuitous linkages’” does not support liability. (*Steinle v. United States* (9th Cir. 2021) 11 F.4th 744, 747.)

VII. CONCLUSION

The petition for review should be denied.

Dated: November 17, 2021 CARROLL KELLY TROTTER & FRANZEN

By: */s/ David P. Pruett*
DAVID P. PRUETT
Attorney for Respondents HealthCare Partners Medical Group, HealthCare Partners LLC

CERTIFICATE OF COMPLIANCE

Pursuant to California Rules of Court, I hereby certify that the attached Answer was produced using 13-point Bookman Old Style type style and contains 2,990 words, including footnotes. In making this certification, I have relied on the word count function of Microsoft Word 2010 which was used to prepare the Answer.

DATED: November 17, 2021 By: */s/ David P. Pruett*
DAVID P. PRUETT

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES:

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action. My business address is 111 West Ocean Boulevard, 14th Floor, Long Beach, CA 90802-4646.

On November 17, 2021, I served the **ANSWER TO PETITION FOR REVIEW** via the Court's electronic filing system, operated by TrueFiling to following parties:

Russell S. Balisok Balisok & Associates, Inc. 330 N. Brand Blvd., Ste. 702 Glendale, CA 91203 balisok@stopelderabuse.org rebecca@stopelderabuse.org	Counsel for Plaintiff/Appellant LARRY QUISHENBERRY
Bryan S. Westerfeld, Esq. Walraven & Westerfeld LLP 20 Enterprise, Suite 310 Aliso Viejo, CA 92656 bwesterfeld@walravenlaw.com	Counsel for Defendant/ Respondent UNITED HEALTHCARE, INC.

I declare under penalty of perjury under the laws of the State of California and of the United States that the above is true and correct. I declare that I am employed in the office of a member of the Bar of the within court at whose direction this service was made.

Executed on November 17, 2021, at Long Beach, California.

s/ A. Lorraine Orduno

A. LORRAINE ORDUNO

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **QUISHENBERRY v. UNITEDHEALTHCARE**
Case Number: **S271501**
Lower Court Case Number: **B303451**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

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Lorraine Orduno Carroll, Kelly, Trotter & Franzen	alorduno@cktfmlaw.com	e-Serve	11/17/2021 3:39:32 PM
David Pruett Carroll, Kelly, Trotter & Franzen 155849	dpruett@cktfmlaw.com	e-Serve	11/17/2021 3:39:32 PM
Russell Balisok Balisok & Associates, Inc. 65116	balisok@stopelderabuse.org	e-Serve	11/17/2021 3:39:32 PM
Brenda Ligorsky Carroll, Kelly, Trotter, Franzen & McKenna	bligorsky@cktfmlaw.com	e-Serve	11/17/2021 3:39:32 PM

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

11/17/2021
Date

/s/David Pruett
Signature

Pruett, David (155849)
Last Name, First Name (PNum)

Carroll, Kelly, Trotter & Franzen

Law Firm