S271501

IN THE

Supreme Court

OF THE STATE OF CALIFORNIA

LARRY QUISHENBERRY,
Plaintiffs and Appellants,

v.

UNITED HEALTHCARE, INC., et al.,
Defendants and Respondents.

Court of Appeal, Second Appellate District, Division Seven,
case number B303451,
Los Angeles Superior Court, case number BC631077,
Hon. Ralph Hofer, Judge presiding

AMICI CURIAE BRIEF OF CALIFORNIA MEDICAL ASSOCIATION, CALIFORNIA DENTAL ASSOCIATION, AND CALIFORNIA HOSPITAL ASSOCIATION IN SUPPORT OF DEFENDANTS AND RESPONDENTS

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ISSUES PRESENTED

1. Are Plaintiff's claims for negligence, elder abuse, and wrongful death expressly preempted by the Medicare Part C preemption clause (42 U.S.C. § 139w-26(b)(3))?

2. Are Plaintiff's claims for negligence, elder abuse and wrongful death impliedly preempted based on the doctrine of "obstacle preemption?"

WHAT *ARE* PLAINTIFF'S CLAIMS?

As against Defendants and Respondents UnitedHealthcare ("UHC") and Healthcare Partners Medical Group ("HCP"), the entities that provided managed care to Plaintiff's decedent, Plaintiff's claims are for the alleged failure of those defendants to provide a Medicare benefit and, to the degree the benefit was provided, their alleged failure to comply with applicable Medicare standards. Plaintiff further alleged the "motive" for those failures was "financial" (1 AA 20:26-28); specifically that "HCP and the United Healthcare entities were motivated by their need to increase profit by reducing the cost of providing care to enrollees including Eugene in a skilled nursing facility setting." (1 AA 36:1-3.)

As against the other defendants in the case – the skilled nursing facility, the home health care agency, and the primary care physician who cared for Plaintiff's decedent – Plaintiff's claims are for the alleged failure of those defendants to provide adequate care. None of those defendants, however, are parties in this appeal.

INTERESTS AND CONCERNS OF *AMICI*

The California Medical Association ("CMA") is a nonprofit, incorporated, professional association of more than 50,000 member-physicians practicing in the State of California, in all specialties. The California Dental Association ("CDA") represents over 27,000 California dentists, more than 70 percent of the dentists practicing in the State. CMA's and CDA's memberships include most of the physicians and dentists engaged in the private practices of medicine and dentistry in California. The California Hospital Association ("CHA") represents the interests of more than 400 hospitals and health systems in California, having approximately 94 percent of the patient hospital beds in California, including acute care hospitals, county hospitals, nonprofit hospitals, investor-owned hospitals, and multi-hospital systems. Thus, *Amici* represent much of the health care industry in California.

CMA, CDA, and CHA have been active before the courts in all aspects of litigation affecting California health care providers. Such cases have included *American Bank & Trust Co. v. Community Hospital* (1984) 36 Cal.3d 359, *Barme v. Wood* (1984) 37 Cal.3d 174, *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, *Central Pathology Service Medical Clinic, Inc. v. Superior Court* (1992) 3 Cal.4th 181, *Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, *Rashidi v. Moser* (2014) 60 Cal.4th 718, and *Flores v. Presbyterian Intercommunity Hospital* (2016) 63 Cal.4th 75.

On issues of elder abuse, *Amici* filed briefs in *Delaney v. Baker* (1999) 20 Cal.4th 23, *Covenant Care, Inc. v. Superior Court* (2004) 32 Cal.4th 771, and *Winn v. Pioneer Medical Group, Inc.* (2016) 63 Cal.4th 148. More recently, CMA, CDA, and CHA filed a brief in *Jarman v. HCR ManorCare, Inc.* (2020) 10 Cal.5th 375.

CMA, CDA, and CHA have long been concerned about the potential for unpredictable and unreasonably large awards in professional negligence actions against health care providers. CMA, CDA, and CHA provided substantial input to the legislative process that led to enactment of the MICRA statutes, and they continue to support MICRA's ongoing viability.

Amici fear a cascade of adverse effects on California health care providers from strategies like that Plaintiff pursues in this case. First, other plaintiffs will routinely plead many, separate causes of action to achieve as much damages as possible, which will render litigation against health care provider employers unnecessarily complex. Second, the professional standard by which juries traditionally assess the conduct of health care provider employers will be blurred with – if not supplanted by – allegations of intentional misconduct and "financial incentives." Third, and of greatest concern, California health care providers will find that their professional liability insurance does not cover the penalties, attorney fees, and, perhaps most importantly, the extremely excessive and punitive damages that plaintiffs seek to recover.

In this case, for example, as against physician-defendant Dr. Lee, the only claim that should go forward is professional

negligence, not the claim of elder abuse, and certainly not the claim of improper financial motives. *Amici* are concerned the Court be aware of the flaws in Plaintiff's claims and not say something incorrect in its opinion that leads to unintended consequences in future litigation against California health care providers. That is why, in this brief, *Amici* provide the Court more context. *Amici* explain why the theory of the Complaint and Second Amended Complaint is invalid, even under state law.

Amici agree with Defendant and Respondents' analysis of express preemption and do not address that issue. *Amici* also agree with their analysis of implied preemption but provide further justification for implied preemption, explaining why plaintiffs who sue California health care providers should not be allowed to use the supposed incentives created by capitated payments as a basis for liability.

Amici reassure the Court that this brief was not authored, either in whole or in part, by any party to this litigation or by any counsel for a party to this litigation. No party or counsel made a monetary contribution intended to fund the preparation or submission of this brief.

Some funding for this brief was provided by organizations and entities that share *Amici*'s interests, including physician-owned and other medical and dental professional liability organizations and nonprofit entities engaging physicians, dentists, and other health care providers for the provision of medical services, specifically The Cooperative of American Physicians, Inc., The Dentists Insurance Company, The Doctors

Company, Kaiser Foundation Health Plan, Inc., Medical Insurance Exchange of California, Norcal Mutual Insurance Company, and The Regents of the University of California.

STATEMENT OF THE CASE

In the Superior Court, Plaintiff alleged decedent was neglected due to the "financial incentives" in the managed care program in which he was enrolled. Plaintiff's case was framed in terms of *elder abuse,* pursuant to California's Elder and Dependent Adult Civil Protection Act, Welfare and Institutions Code section 15657. Specifically, Plaintiff alleged decedent "developed severe pressure sores on his feet as a consequence of *neglect* at GEM." (1 AA 32:20-21. Emphasis by italics added.) GEM is the skilled nursing facility which was providing the ***custodial care*** decedent needed when those sores first began to develop. In this lawsuit, Los Angeles Superior Court case number BC631077, the question of who was liable for the alleged "*neglect*" that took place in the skilled nursing facility should have ended there, when that nursing home settled with Plaintiff. [1]

The lawsuit did not end with that settlement, however.

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[1] Plaintiff also filed a lawsuit against the *home* health care company that provided ***custodial care*** to decedent *after* he was discharged from the skilled nursing facility. (1 AA 72 ["*Quishenberry v. Berger, Inc., dba Accredited Home Care, et al.*, case no. BC615178"].) The trial court deemed the two lawsuits related.

Plaintiff was determined to recover more, from all other conceivable defendants, whether directly or indirectly involved in decedent's care, whether before, during, or after the pressure sores first appeared. To begin with, Plaintiff sought to recover from the physician, Dr. Lee, who provided ***professional care*** to decedent.

Plaintiff did not sue Dr. Lee for "*professional negligence*," however, but instead characterized Dr. Lee's decision regarding physical therapy as "*negligence and recklessness*." Plaintiff did so even though this Court repeatedly has said that "professional negligence" and "elder neglect" are "mutually exclusive." (*Delaney v Baker, Covenant Care v. Superior Court, Winn v. Pioneer Medical Group,* all *supra.*)[2] Whether Plaintiff amends his complaint as it relates to Dr. Lee to plead "*professional negligence*" remains to be seen. If not, Plaintiff's characterization of Dr. Lee's treatment decision as "*elder abuse"* is wrong, and Dr. Lee will prevail on the "*elder abuse*" cause of action.

Even then, however, the lawsuit will not end. Plaintiff continues to pursue the remaining defendants, his health insurer and its affiliated health care provider organization, in whose managed care program Dr. Lee provided professional services to decedent. Plaintiff does not sue Dr. Lee or those entities for

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[2] Plaintiff's counsel filed a brief in each of those cases, two on behalf of the California Advocates for Nursing Home Reform. (See discussion *supra,* at footnotes 5-8.) In this case, in the Appellant's Reply Brief, he argued, "whether negligence or elder abuse are mutually exclusive is meaningless." (ARB, p. 12. Emphasis in heading deleted.)

"*professional negligence,*" however. Instead, Plaintiff claims the entire managed care program was "***improperly designed and implemented***." (1 AA 20:13. Emphasis by bold and italics added.) Specifically, Plaintiff alleges improper "financial incentives."

For example, in the Complaint he filed in 2016, Plaintiff alleged that Defendants' "financial risk" (1 AA 18:8-11, 36:19-21), due to "the cost of needed care" (1 AA 19:20-22), was a "financial" "motive" (1 AA 20:20-25), meaning a "motive" "to reduce the cost of providing care." (1 AA 22:18-20.)

For another example, in the Second Amended Complaint he filed in 2019, Plaintiff alleged all of the Defendants, not just United Healthcare, would "share in its profits and losses" (1 AA 29:22-25) which resulted in corresponding incentives and disincentives: "the less care a patient received, the smaller the cost of providing care" (1 AA 30:11-12), "completely liquidated the cost and risks of providing care" (1 AA 30:23-26), and "identify and exploit opportunities to reduce the cost of care." (1 AA 31:7-10.) According to Plaintiff, everyone in the program was "motivated by their need to increase profit by reducing the cost of providing care." (1 AA 36:1-3.)

Plaintiff alleged it was these financial incentives and disincentives that motivated Dr. Lee to make the treatment decision that resulted in decedent being discharged from the skilled nursing facility so he could go home. According to Plaintiff, that was elder abuse, so-called "managed care elder abuse." (Balisok, Elder Abuse Litigation (The Rutter Group

2021) Ch. 14, "Managed Care Liability," § 14:7.1 "Fact Patterns in Managed Care Elder Abuse.")

The trial court acknowledged the expertise of Plaintiff's counsel, author of the aforementioned treatise (RT, Oct. 25, 2019, p. 9:9-26), but the court nevertheless disagreed with counsel's argument and held the claim was preempted. (3 AA 668-673 ["Tentative Ruling"], 686-687 ["Judgment"].) Plaintiff appealed. (3 AA 690.)

Now, in the appellate courts, Plaintiff either distances himself from or ignores his allegations about "financial incentives." On appeal, Plaintiff backtracked, denying he contended the financial incentives within managed care organizations were "improper." (AOB, pp. 21-22.) The Court of Appeal disagreed with Plaintiff and affirmed the trial court holding that "*Quishenberry's Claims Are Expressly Preempted by the Medicare Part C Preemption Clause.*" (Slip Opinion, pp. 12-24. Emphasis by italics in original heading.)

Now that this Court has granted Plaintiff's Petition for Review on the two preemption issues he raises, he says absolutely nothing about financial incentives. [3] For that matter, there is no "Statement of the Case" in his Opening Brief on the Merits. Plaintiff ignores the foregoing allegations in his pleadings about financial incentives and, instead, broadly

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[3] For that matter, Plaintiff says nothing about the allegations in the Complaint (1 AA 15-24) and Second Amended Complaint. (1 AA 25-40.) Notably, the Opening Brief on the Merits has no Statement of the Case or other section explaining his pleadings. There is no citation to the appellate record.

characterizes his claims as torts, based on "common law and statutes of general applicability." (OBM, p. 6.) Plaintiff adds that his

> claims include Respondents' violation of federal standards concerning his right to remain in a skilled nursing facility environment for 100 days to provide physical therapy to assist him to attain or maintain function. In addition, the federal standard requires Respondents to provide skilled nursing facility care when necessary to treat conditions arising out of his care at the nursing facility.

(OBM, pp. 9-10.) The implications are that decedent was denied physical therapy and denied care for pressure sores on his feet. (1 AA 30:9-13.)

To be sure, what Plaintiff alleged in his Superior Court pleadings was that,

> In order to reduce the cost of care provided to enrollees, and in particular, Medicare enrollees like Eugene, *the portion of the health care industry providing care through HMOs* where participants receive a fixed periodic fee, have throughout the United States embarked on an effort *to identify and exploit opportunities to reduce the cost of care* to enrollees.

(1 AA 31:7-13. Emphasis by italics added.)

> Although *these methods did not result in the denial of care* to enrollees, these methods affected Dr Lee's treatment decisions and also affected his judge and treatment decisions of allied practitioners at GEM, including the judgment and decisions of its nurses and physical therapists.

(1 AA 31:19-22. Emphasis by italics added.)

SUMMARY OF ARGUMENT BY *AMICI*

Plaintiff is wrong, in every respect.

Plaintiff is wrong to characterize the decision by Dr. Lee about physical therapy as elder abuse. While the nursing home defendant GEM provided *custodial care*, Dr. Lee and the other defendants did not. They provided *professional care*, in the form of Dr. Lee's services as well as the corporate defendants' "utilization review," "quality assurance," and other insurance related services to which Plaintiff refers in his complaints. After all, a physician's decision to discharge his patient to have physical therapy at home is professional, not custodial care. When there is a poor outcome, the question is whether the diagnostic and treatment decisions conformed to the applicable standards, not whether there were financial incentives and disincentives.

Plaintiff is wrong to characterize the financial incentives and disincentives in managed care as improper. Regardless of who ultimately pays, all health care in the United States entails financial incentives and disincentives, both direct and indirect. That includes the health care that is provided to Medicare patients by health maintenance organizations. Both federal and state law approve such. Ironically, Plaintiff has "financial" motives for arguing *elder abuse*:[4] to assure survival of decedents' damages for pain and suffering, to recover attorney fees, to

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[4] Plaintiff went a step further than just alleging elder abuse and alleged "*unfair and deceptive business practices* against senior citizens" under Civil Code section 3345 to achieve treble punitive damages. (1 AA 34:11-13. Emphasis by italics added.)

recover punitive damages, and perhaps most importantly, to avoid the Medical Injury Compensation Reform Act. (Balisok, Elder Abuse Litigation, *supra*, § 14:15, "Pleading Around MICRA in Malpractice or Elder Abuse Action In Managed Care Cases.") Plaintiff is wrong to suggest the Elder Abuse Act is so broad that it applies to managed care programs. There is nothing in the statutory language or the legislative history to suggest that, and there is much to suggest the contrary. The Elder Abuse Act was a result of the movement for nursing home reform.

Finally, to the point of the two issues presented in this case, Plaintiff is wrong to deny that preemption applies. In the context of Medicare Advantage, his attorney's theory of *"managed care elder abuse"* raises questions of Medicare preemption, which is why preemption – both express and implied – is discussed at length in his attorney's treatise. (Balisok, Elder Abuse Litigation, *supra*, § 14:16, "Federal Preemption in Actions Against Medicare Financed HMO's," § 14:23, "Preemption of specific California laws in actions against Medicare HMOs," § 14:35, "Preemption Analysis 42 USC § 1395W-26(B)(3).")

LEGAL ANALYSIS

I. In Order To Avoid Preemption, Plaintiff Ignores What He Alleged In The Superior Court, That Decedent's Care In The Nursing Home Was "Inadequate" And The "Motive" Was "Financial" Because Defendants Were Managed Care Entities

As against Defendants and Respondents UnitedHealthcare and Healthcare Partners Medical Group, Plaintiff's claims are for the alleged failure of those managed care entities to provide a Medicare benefit and, to the degree the benefit was provided, their alleged failure to comply with applicable Medicare standards. In order to reverse the holdings of the Superior Court and Court of Appeal that his claims fall within Medicare preemption, Plaintiff must overcome the very detailed factual allegations in his Complaint (1 AA 15-24) and Second Amended Complaint (1 AA 25-40), that those defendants failed to provide a Medicare benefit and failed to comply with Medicare standards.

To do that, Plaintiff summarizes his claims in broad terms of "reasonably needed healthcare" (OBM, p. 6 ["Plaintiff's claims each address the failure of the defendants to provide reasonably needed healthcare"]) and then characterizes such as "elder abuse." (OBM, pp. 7-8.) Or, to use the words of the Elder Abuse Act itself, Plaintiff's claims are for "[f]ailure to provide medical care for physical and mental needs." (Welf. & Inst. Code § 15610.57(b)(2).) Because "the statutory definition of 'neglect' speaks not of the *undertaking* of medical services, but of the failure to *provide* medical care" (*Covenant Care, Inc. v. Superior Court, supra,* 32 Cal.4th at 783, citing *Delaney v. Baker, supra,*

20 Cal.4th at 34, emphasis by italics in original), that means the complete denial of medical services or the complete withholding of treatment. (*Carter v. Prime Healthcare Paradise Valley* (2011) 198 Cal.App.4th 396, 407-408; *Worsham v. O'Connor Hospital* (2014) 226 Cal.App.4th 331, 336-338.)

That is inconsistent with Plaintiff's allegations that defendants provided and decedent received care—at most contending it was "inadequate care" (1 AA 20:2-9, 21:19-28, 22:18-20, 32:21-23, 33:13-15), rather than denial of care.

Plaintiff alleged the "motive" was "financial." (1 AA 20:26-28, 31:7-22, 36:1-3.) Specifically, Plaintiff alleged the denial or withholding allegedly is motivated by the "financial incentives" built into the design and implementation of managed care programs such as that of Defendants UnitedHealthcare and Healthcare Partners Medical Group. Elsewhere, Plaintiff's counsel has characterized such as "managed care elder abuse." (See, *e.g.,* Balisok, Elder Abuse Litigation, *supra*, Ch. 14, "Managed Care Liability," § 14:7.1 "Fact Patterns in Managed Care Elder Abuse.")

Plaintiff's basic assumption was that health care benefits provided by a managed care organization included custodial care (1 AA 28:26 to 29:5 ["health care benefits including custodial care"]), such that "[e]ach defendant had responsibility for the care and custody of [Plaintiff's decedent]" (1 AA 23:4, emphasis by italics added), in other words, the Defendants all had "a robust caretaking or custodial relationship" (*Winn v. Pioneer Medical*

Group, Inc., *supra,* 63 Cal.4th at 158) with Plaintiff's decedent. Now, on appeal, Plaintiff says nothing about those allegations.

In summary, on appeal, Plaintiff attempts to distance himself from – if not completely ignore – what he alleged in the trial court.

II. Plaintiff Also Ignores That He Alleged Defendants' Program Was "Improperly Designed And Implemented" Because Of The "Financial Incentives" "To Reduce The Cost Of Care"

Plaintiff alleged Defendants' managed care program was "*improperly designed and implemented*," and Defendants' purpose was "to identify and exploit opportunities to reduce the cost of care to enrollees." As Plaintiff stated it in his original Complaint.

> 19. In their conduct, UHC, HCP and LLC knew that their failure to comply with their own *federally approved utilization review and quality assurance programs (and instead instituting their own* ***improperly designed and implemented programs)*** posed the probability that patients including Eugene would not receive all of the care to which they were entitled and that the quality of care offered by UHC, HCP and LLC, and other health care providers such as GEM with which said defendants might contract, would not meet the standard of care and that enrollees such as Eugene would receive inadequate care, would be injured, sicken or die.
>
> 20. Notwithstanding such knowledge, UHC, HCP and LLC *failed and continued to fail to comply with approved quality assurance and utilization review programs, and instead* ***pursued their plans and policies*** *to deprive enrollees*

including Eugene of reasonably necessary medical care from reasonably well qualified health care providers. In said failures, UHC, HCP and LLC *knowingly and consciously disregarded the probability that without honest implementation of an approved utilization review and quality assurance programs*, that enrollees would be denied necessary medical care and treatment and that the quality of health care services provided to enrollees including Eugene would be inadequate to meet their needs, and that enrollees would become ill, sicken and die.

(1 AA 20, lines 6-25. Emphasis by bold and italics added.) As Plaintiff stated it in his Second Amended Complaint:

16. In order to reduce the cost of care provided to enrollees, and in particular, Medicare enrollees like Eugene, **the portion of the health care industry providing care through HMOs** where participants receive a fixed periodic fee, have throughout the United States embarked on an effort to identify and exploit opportunities to reduce the cost of care to enrollees. One such opportunity was to arrange for and provide care to enrollees following their discharge from hospital to a skilled nursing facility but to limit their opportunity to fully realize and receive physical therapy following admission to hospital in accord with Medicare rules and benefits.

17. Plainly stated**,** *this effort required United Healthcare entities, HCP and Lee to find* **methods to provide less than daily care for its patients** *because daily (or nearly daily) care qualified enrollees including Eugene for care in a skilled nursing facility.* If only intermittent care was needed, either for care of pressure sores or for Physical Therapy, Medicare allowed for transfer of the patient to home where home health care could be brought into the patient's home to provide care for pressure sores, and or

> Physical Therapy. Therefore, although these methods did not result in the denial of care to enrollees, these methods affected Lee's treatment decisions and also affected the judgment and treatment decisions of allied practitioners at GEM, including the judgment and decisions of its nurses and physical therapists

(1 AA 31:7-22. Emphasis by bold and italics added.) To summarize and simplify those allegations, the "improperly designed and implemented programs" were "to reduce the cost of care," one aspect of which was "to provide less than daily care for its patients." As Plaintiff explained it to the Court of Appeal:

> Essentially, Plaintiff alleged Eugene was injured as a result of the too early termination of physical therapy at the skilled nursing facility, and also that the nursing facility failed to provide adequate care. Plaintiff alleged that the early termination of his residence at the skilled nursing facility was the consequence of the early termination of his physical therapy and *was* ***part of a practice*** *by or was authorized or ratified by each defendant and was* ***financially motivated***

(AOB, p. 9. Emphasis by bold and italics added.)

Now that the case is on review, following appeal, Plaintiff says nothing in that regard.

III. The "Financial Incentive" Feature Of Managed Care Programs, Including Medicare Advantage Organizations, Is Consistent With Public Policy

Plaintiff's theory of "managed care elder abuse" is a thinly-veiled attack of the whole idea of "managed" health care. Essentially, Plaintiff claims that such care is designed to

"neglect" patients, by the device of "financial incentives" to the patients' health care providers and insurers who implement the care. That theory of elder abuse is particularly significant in the context of Medicare, where the federal government is determined to achieve the efficient delivery of medical care to the elderly. More to the point of this appeal, that is why federal preemption applies to Plaintiff's claims.

Although there are "incentives" in "managed care," usually provided by "health maintenance organizations" like Kaiser Permanente, those "incentives" are consistent with national policy. "[T]he use of such 'incentive' plans is not only recommended by professional organizations as a means of reducing unnecessarily high medical costs, but [ ] they are specifically required by section 1301 of the Health Maintenance Organization Act of 1973 (42 U.S.C. § 300e)." (*Pulvers v. Kaiser Foundation Health Plan, Inc., et al.* (1979) 99 Cal.App.3d 560, 565.)

In the Knox Keene Act, at Health and Safety Code section 1348.6, the Legislature approved risk-bearing agreements such as managed care agreements containing financial incentives. In Health and Safety Code section 1371.5, the Legislature provided health care service plans are protected from vicarious liability claims by claimants such as Plaintiff. (See, *e.g.,* 1 AA 29:5-7, 17-18, 28:29 to 30:4, 30:14 to 31:6; AOB, pp. 44-46; ARB, pp. 14-15, 17-19.)

IV. The Superior Court And The Court of Appeal Correctly Ruled That Preemption Applied

Because Plaintiff's theory is that managed care is improperly motivated by "financial incentives," so much so that in the context of Medicare it qualifies as elder abuse, the question of federal preemption obviously arises. (See, *e.g.,* Balisok, Elder Abuse Litigation, *supra*, § 14:16, "Federal Preemption in Actions Against Medicare Financed HMO's," §§ 14:20, 14:21, "Preemption Analysis 42 USC § 1395W-26(B)(3)." See also DiMugno & Glad, Cal. Insurance Law Handbook (2021) Ch. 37, "Health Insurance," §§ 14:20, "Federal preemption of extra-contractual claims against Medicare Advantage Plans." See also Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2021) Ch. 6E, "Health Coverages," §§ 6:1275-1290 "Preemption Defenses.") After all, Plaintiff's fundamental assumption is that Defendants' program was "improperly designed and implemented."

The Superior Court applied the Medicare Act preemption provision because Plaintiff alleged "*failure to administer properly the health care plan*." (3 AA 672; Slip Opn., p. 8. Emphasis by italics added.) Stated in other allegations by Plaintiff, Defendants "failed to insist on adequate care" (3 AA 669) "pursuant to business practices of HCP and United Healthcare entities." (3 AA 670.)

The Court of Appeal agreed, as it explained under the heading "D. *Quishenberry's Claims Are Expressly Preempted by the Medicare Part C Preemption Clause*." (Slip Opn., pp. 12-24.)

> Quishenberry's common law negligence and statutory elder abuse and wrongful death claims against the United Healthcare entities and Healthcare Partners are based on the premature discharge of Eugene from GEM without adequately treating his pressure sores or providing sufficient physical therapy. […] *These allegations require a determination of the amount of allowable Medicare benefits for skilled nursing care,* ***an area regulated by standards established by CMS***; thus, Quishenberry's claims are preempted."

(Slip Opn., pp. 14-15. Emphasis by bold and italics added.)

> Quishenberry argues that because the complaint alleged it is "uncertain[ ]" which of the UnitedHealthcare entities contracted with CMS to provide an MA plan to Eugene, none of the entities qualifies as an MA organization. But Quishenberry's claims are premised on the provision of an MA plan to Eugene, and therefore, only the United Healthcare entity that provided the MA plan would be directly liable. *Any liability of the related United Healthcare entities would be derivative of the liability of the MA plan provider, and thus* ***preempted to the same extent*** *that claims against the MA organization are preempted.* (See *Uhm v. Humana, Inc., supra*, 620 F. 3d at pp. 1157-1158 [claims against parent company of MA plan provide were preempted because the liability of the parent was "entirely derivative of its relationship with the [MA plan provider]"].)

(Slip Opn., pp. 14-15, fn. 8. Emphasis by bold and italics added.)

Plaintiff argues that was error, both as to express preemption (OBM, pp. 6-10) and implied preemption. (OBM, pp. 10-11.) Plaintiff argues that his "claims … are based on laws which apply to every person within the state" (OBM, p. 10),

which is to say his claims are based on the "laws" of "negligence, elder abuse, and wrongful death," but he fails to provide any analysis of his allegations of misconduct. For the most obvious example, Plaintiff does not deny, let alone explain, that he alleged "failure to administer properly the health care plan," as the Superior Court noted. (3 AA 672.) For another example, Plaintiff does not deny let alone explain that his "allegations require a determination of the amount of allowable Medicare benefits for skilled nursing care, an area regulated by standards established by CMS," as the Court of Appeal put it. (Slip Opn., p. 15.)

V. Preemption Is Not The Only Problem With Plaintiff's Theory Of "Managed Care Elder Abuse"

Amici submit that this case is simply a variation of prior cases where elder abuse claimants conflated "health care" with "custodial care" and conflated "professional negligence" with "elder neglect." The difference here is that Plaintiff alleges all of the defendants – not just the skilled nursing facility, GEM, and the home health care company, Accredited Home Health – were in a custodial care relationship with Plaintiff's decedent.

Plaintiff is wrong.

A. Plaintiff's theory is based on the false assumption that a managed care health plan and its affiliated entities are in a custodial care relationship with the patient-members

One problem with Plaintiff's theory of "managed care elder abuse" is that managed care health benefits plans do not fall within the definition of "care custodian" at Welfare and Institutions Code section 15610.17.

The basic assumption of Plaintiff's theory of "managed care elder abuse" is that the health care provided by a Medicare Advantage organization *includes* custodial care. (See, *e.g.*, 1 AA 28:26 to 29:5 ["health care benefits including custodial care"].) Based on that assumption, Plaintiff alleged, "Each defendant had responsibility for the care and custody of [Plaintiff's decedent]." (1 AA 23:4.) As to Dr. Lee, Plaintiff alleged, "Such physician's care of skilled nursing facility residents, being part of the nursing facility's responsibility to its residents, is custodial in nature" (1 AA 27:9-11) and "Lee participated in the fulfillment of GEM's responsibility to provide custodial care to Eugene and for that reason, too, Lee had care or custody of [Plaintiff's decedent] under Welfare & Institutions Code §15610.57." (1 AA 35:3-5.) As to Defendants UnitedHealthcare and Healthcare Partners Medical Group, Plaintiff alleged, "Those health care benefits for which each of the said United Healthcare entities were responsible by contract and by law, included *custodial care* within skilled nursing facilities such as GEM." (1 AA 28:26-28. Emphasis by italics added.)

The reason why Plaintiff pleaded the lawsuit that way in 2016 was *Winn v. Pioneer Medical Group, supra*, 63 Cal.4th 148, which the Court decided earlier that year.[5] (63 Cal.4th at 156.) The Court explained, "The Elder Abuse Act's heightened remedies are available only in limited circumstances." "Because plaintiffs allege neglect in the context of medical care and not self-care, we deal only with section 15610.57's first definition of neglect." (63 Cal.4th at 156.) "Ultimately, the focus of the statutory language is on the nature and substance of the relationship with an elder or a dependent adult – not the defendant's professional standing or expertise – that makes the defendant potentially liable for neglect." (63 Cal.4th at 158.) *Winn* is the reason why Plaintiff claims *all of the defendants* – not just the skilled nursing facility, GEM, and the home health care company, Accredited Home Health – are custodial care providers.

Plaintiff is wrong. As the Court said in *Winn,* "the terms 'care' and 'custody' are used together, and are best understood to denote a distinctive caretaking or custodial relationship." (63 Cal.4th at 161.) "What the text of section 15610.57 conveys about

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[5] *Amici* filed an *amicus* brief in *Winn*. Plaintiff's counsel filed the brief for *amicus* California Advocates for Nursing Home Reform. (63 Cal.4th at 151.) In that brief (*Winn v. Pioneer Medical Group,* case no. 211793, Brief on the Merits by Amicus Curiae California Advocates for Nursing Home Reform, Inc., In Support of Plaintiff, Kathleen Winn), counsel argued, "A Requirement of 'Custody,' or of 'Basic Needs' in the Act leads to Anomalous Results" (*id.* at p 28, emphasis in heading deleted), expressing CANHR's disagreement with the Court's prior decisions. The Court rejected his argument.

the Legislature's purpose here – along with related provisions, and similar language in other statutes – supports tethering the concept of neglect to caretaking or custodial situations." (63 Cal.4th at 162.) While the concept of custodial care applies to GEM, and Accredited Home Health, it does not apply to United Healthcare, Healthcare Partners Medical Group, or even Dr. Lee.

B. Plaintiff's claim of "managed care elder abuse" conflates the concepts of "medical care" and "custodial care"

Another problem is that Plaintiff conflates the medical care decisions of Dr. Lee and the nurses with the custodial care decisions of the staff at GEM and Accredited Health Care.

As the Court also explained in *Winn*, custodial care refers to the provision of basic human needs such as nutrition, hydration, and medication. (63 Cal.4th at 161 ["to provide nutrition, hydration, and medication—needs that an able-bodied and fully competent adult would ordinarily be capable of handling on his or her own"; "the type of caretaking or custodial relationship that the Act requires: one where a party has accepted responsibility for attending to the basic needs of an elder or dependent adult"].) "Neglect," as it relates to medical care, refers to the extreme situation where a custodial care provider denies all medical care. (*Id*. at 158 ["to deprive an elder or a dependent adult of medical care"; "whether to initiate medical care at all"]. Emphasis by italics in original.)

"Our reading of [Welfare and Institutions Code] section 15610.57 also fits our conclusions in prior cases." (63 Cal.4th at

160.) "It is this reading of the Act that most readily fits with how we have interpreted analogous statutory provisions arising beyond the Act that nonetheless use the phrase 'having the care or custody.'" (*Id.* at 161.) "[T]he legislative history of the Act likewise suggests that the Legislature was principally concerned with particular caretaking and custodial relationships, and the abuse and neglect that can occur in that context." (*Id.* at 162.)

The Court concluded, "To elide the distinction between neglect under the Act and objectionable conduct triggering conventional tort remedies—even in the absence of a care or custody relationship—risks undermining the Act's central premise." (63 Cal.4th at 165.)

C. Plaintiff's claim of "managed care elder abuse" also conflates the concepts of "professional negligence" and "abuse neglect"

Plaintiff conflates the concepts of "professional negligence" and elder abuse "neglect," such as where he argues "Respondents' violation of federal standards concerning his right to remain in a skilled nursing facility environment for 100 days to provide physical therapy to assist him to attain or maintain function" (OBM, p. 9) is a "parallel" claim (OBM, p. 10) of elder abuse. Physical therapy is *professional*, not *custodial*, care. A physician's decision to discharge his patient to have physical therapy at home is a decision regarding *professional*, not *custodial* care

As noted above, Plaintiff is not the first to attempt such an extension of the Elder Abuse Act to *professional care,* and his will

be the fourth case (after *Delaney, Covenant Care,* and *Winn*) where this Court finds itself having to explain that "professional negligence" and "abuse neglect" are "mutually exclusive" concepts.

Eight years after enactment of the Elder Abuse Act, in *Delaney v. Baker, supra,* 20 Cal.4th 23,[6] the Court explained the distinction between "professional negligence," as that phrase is used in MICRA, and nursing home "neglect," as that term is used in the Elder Abuse Act. Five years later, in *Covenant Care, Inc. v. Superior Court*, *supra*, 32 Cal.4th 771,[7] the Court found it necessary to explain the distinction again. A dozen years after that, in *Winn v. Pioneer Medical Group, Inc.*, *supra,* 63 Cal.4th 148,[8] the Court yet again found it necessary to explain the

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[6] *Amici* filed an *amicus* brief in *Delaney*, warning of the many problems that will arise when "professional negligence" and "neglect" are conflated. Plaintiff's counsel filed the brief for *amicus* California Advocates for Nursing Home Reform (20 Cal.4th at 25), arguing the opposite.

[7] *Amici* filed an *amicus* brief in *Covenant Care,* again arguing the distinction. Plaintiff's counsel filed the briefs for Plaintiffs and Real Parties in Interest, Lourdes Inclan*, et al.* (32 Cal.4th at 775), again arguing the opposite.

[8] As noted at footnote 5, in *Winn,* Plaintiff's counsel filed the brief for *amicus* California Advocates for Nursing Home Reform. He argued, "The Line Between Professional Negligence And Liability Under The Act Is Ill-Conceived", p. 21, emphasis in heading deleted), and "In *Delaney v. Baker, supra,* the Court appears to have created substantial confusion re the meaning and scope of the definition of 'neglect'" (*id.* at p.24), expressing CANHR's disagreement with the Court's prior decisions. To repeat what was said in footnote 5, the Court rejected his argument.

distinction. The Court reiterated that "professional negligence" arises from the rendition of *health care*, whereas "neglect" arises from the rendition of *custodial care* (63 Cal.4th at 157-158) and emphasized they are very distinct concepts.

The Court in *Winn* stated, "What seems beyond doubt is that the Legislature enacted a scheme distinguishing between—and decidedly not lumping together—claims of professional negligence and neglect." (63 Cal.4th at 159.) "Blurring the distinction between neglect under the Act and conduct actionable under ordinary tort remedies—even in the absence of a care or custody relationship—risks undermining the Act's central premise." (*Id.* at 160.)

In summary, like his predecessors in *Delaney, Covenant Care*, and *Winn,* Plaintiff conflates concepts that are "mutually exclusive."

VI. There Will Be Adverse Impacts If Plaintiff's Theory Of "Managed Care Elder Abuse" Is Endorsed By This Court

A. Health care providers will be adversely impacted

If this Court rejects the preemption defense and authorizes Plaintiff's theory of "managed care elder abuse," there will be multiple adverse effects on California health care providers who are affiliated with Medicare Advantage organizations. Most significantly, plaintiffs who sue those health care providers will follow Plaintiff's lead and conflate the two, distinct concepts to sidestep the provisions of MICRA, thereby defeating the

statutory purpose of MICRA to assure the availability and affordability of medical malpractice insurance for the health care industry.

Worse, those plaintiffs then will be in the position to misleadingly characterize "professional negligence" as a far more deplorable concept, "*neglect*," coupled with harsh condemnation for having "*financial incentives,*" thereby demonizing health care provider defendants in the eyes of the jurors who sit in judgment of those defendants.

Worst of all, the jurors in those cases will be ripe for arguments imploring them to collectively "send a message" by awarding extremely excessive damages, that is, damages that are for punishment rather than compensation. Notably, Plaintiff goes one step further here, arguing for treble punitive damages for "*unfair and deceptive business practices* against senior citizens" under Civil Code section 3345. (1 AA 34:11-13 ["said damages should be trebled per Civil Code section 3345"].)

B. Patients will be adversely impacted

One adverse effect will be to force patients in Medicare Advantage organizations to undergo physical therapy they may not want. Providers will fear being sued for elder abuse for failing to *persuade and cajole,* that is to say, *pressure* the patient sufficiently. As reflected in a "Comment" about physical therapy in the chapter on "Managed Care Liability" in the treatise, Elder Abuse Litigation:

> Some elderly patients in pain following surgery need to be *persuaded and cajoled* into participating, and physical

> therapist are trained to encourage participation. Other patients simply need time in order to return to their baseline level of functioning. But with financial incentives at play, a simple "no" from the patient can lead to a determination that the patient cannot progress and relief for the HMO seeking to avoid the cost of skilled nursing care.

(Balisok, Elder Abuse Litigation, *supra*, § 14:6, "'Physical Therapy mandated step down' in care." Emphasis in heading deleted. Emphasis in text by italics added.)

Another adverse effect will be to pressure patients who want to go home to remain in the skilled nursing facility.

C. Managed care plans, if not all payors, will be adversely impacted

The most obvious adverse effect on Medicare Advantage organizations, if not all payors, will be to increase costs.

Another will be to create tensions within the organizations, for example over differences of opinion about the "financial incentives" that arise in the "design" and "implementation" of the program, arguing "the agreements in question require the managed care organization to provide all of the care enrollees need, without regard to its expense." (Balisok, Elder Abuse Litigation, *supra*, § 14:11, "The Legislative Recognition of Risk-Bearing Agreements and Financial Incentives to Deny Care." Emphasis in heading deleted.)

More fundamentally, Plaintiff's theory of "managed care elder abuse" calls into question the whole idea of managed care. After all, the theory is a thinly-veiled attack of all health care that is "managed." Essentially, Plaintiff claims, such care is

designed to "neglect" patients, by the device of "financial incentives" to the patients' health care providers and insurers who implement the care. That is particularly problematic in the context of Medicare, where the federal government is determined to achieve the efficient delivery of medical care to the elderly.

More to the point of the issue on review, that is why federal preemption applies to Plaintiff's claims.

CONCLUSION

Plaintiff's theory of "managed care elder abuse" should be rejected. Preemption is one way to do so. There are other ways of rejecting Plaintiff's theory, as well. (See, *e.g.*, Slip Opn., p. 24, fn. 12.) For now, preemption is sufficient.

Dated: April 27, 2022

COLE PEDROZA LLP

By: _____

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CERTIFICATION

Appellate counsel certifies that this document contains 6754 words. Counsel relies on the word count of the computer program used to prepare the document.

Dated: April 27, 2022 COLE PEDROZA LLP

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Elizabeth Lopez

Elizabeth Lopez

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