S276545

IN THE SUPREME COURT
OF THE
STATE OF CALIFORNIA

CHARLES LOGAN

Plaintiff and Respondent,

vs.

COUNTRY OAKS PARTNERS, LLC, et al.

Defendants and Appellants.

On Review from the Court of Appeal for the Second Appellate District,
Division Four, Case No. B312967

After an Appeal from the Superior Court for the State of California,
(Los Angeles County Super. Ct. No. 20STCV26536)

APPLICATION BY CALIFORNIA ASSOCIATION OF HEALTH FACILITIES TO FILE [PROPOSED] *AMICUS CURIAE* BRIEF IN SUPPORT OF DEFENDANTS AND APPELLANTS; AMICUS BRIEF

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APPLICATION BY CALIFORNIA ASSOCIATION OF HEALTH FACILITIES TO FILE PROPOSED *AMICUS CURIAE* BRIEF IN SUPPORT OF DEFENDANTS AND APPELLANTS

The California Association of Health Facilities ("CAHF"), through its attorneys and pursuant to Rule 8.520(f) of the California Rules of Court, respectfully applies for permission of the Chief Justice to file the attached proposed *amicus curiae* brief in support of Defendants and Appellants Country Oaks Partners, LLC, *et al*.

I. THE PROPOSED *AMICUS CURIAE*

CAHF is a non-profit association representing more than 1,300 licensed skilled nursing, intermediate care, ICF-DD, ICF-MR, and subacute facilities (Collectively, "long-term care facilities") in the State of California. The long-term care facilities represented by CAHF have been and continue to be subject to a multitude of lawsuits similar to the present action and will be directly impacted by this decision and its impact of the enforceability of pre-dispute binding arbitration agreements. CAHF provides a statewide, policy perspective to this case and issues regarding arbitration on behalf of the long-term care facilities in California.

CAHF has represented the interests of long-term care facilities before California's legislature and its regulatory agencies, including on those issues specifically addressed in the proposed brief. Notably, CAHF was integrally involved with the rulemaking regarding California Code of Regulations, title 22, sections 72516 and 73518 involving the Standard

Admission Agreement ("SAA").

CAHF has participated in litigation as a party or an *amicus curiae* in a number of cases involving binding arbitration. (See, e.g., *Valley View Health Care, Inc. v. Chapman* (E.D. Cal. 2014) 992 F.Supp.2d 1016; *Hogan v. Country Villa Health Services* (2007) 148 Cal.App.4th 259; *Ruiz v. Podolsky* (2010) 50 Cal.4th 838; *Goldman v. Sunbridge Healthcare, LLC* (2013) 220 Cal.App.4th 1160; *Hatley v. Superior Court* (Cal. Ct. App., Jan. 30, 2008, No. F052747) 2008 WL 240841; *Parkside Special Care Center, Inc., et al v. Shewry, et al.* (Super. Ct. San Diego County, 2006, No. GIC860574) ("*Parkside*")[1].)

Additionally, CAHF has participated in many other cases of concern to long-term care facilities, including *California Association of Health Facilities v. Department of Health Services* (1997) 16 Cal.4th 284; *Delaney v. Baker* (1999) 20 Cal.4th 23; *Covenant Care, Inc. v. Superior Court* (2004) 104 Cal.4th 1049; *Alvarado v. Selma Convalescent Hosp.* (2007) 153 Cal.App.4th 1292; *Ruiz v. Podolsky* (2010) 50 Cal.4th 838; *Shuts v. Covenant Holdco LLC* (2012) 208 Cal.App.4th 609; *Nevarrez v. San Marino Skilled Nursing and Wellness Centre* (2013) 221 Cal.App.4th 102; *Lemaire v. Covenant Care Cal., LLC* (2015) 234 Cal.App.4th 860; *California Ass'n of Health Facilities v. Maxwell-Jolly,* No.

[1] In *Parkside*, the San Diego Superior Court upheld the legality of the separation of a voluntary arbitration agreement from the SAA.

CV103259CASMANX, 2011 WL 13269770, at *1 (C.D. Cal. May 24, 2011), vacated and remanded *sub nom Developmental Servs. Network v. Douglas*, 666 F.3d 540 (9th Cir. 2011); *Chamber of Commerce v. Lockyer* (9th Cir. 2003) 364 F.3d 1154, *Plott Nursing Home v. Burwell,* 779 F.3d 975 (9th Cir. 2015); *Anderson v. Ghaly,* 930 F.3d 1066 (9th Cir. 2019); *Saldana v. Glenhaven Healthcare LLC* (9th Cir. 2022) 27 F.4th 679, cert. denied (2022) 214 L.Ed.2d 253; and *Martin* v. *Filart* (9th Cir., Feb. 25, 2022, No. 20-56067) 2022 WL 576012.)

II. INTEREST OF PROPOSED *AMICUS CURIAE*

This case directly impacts the relationships between CAHF member facilities and thousands of residents in California. If the appellate panel's decision stands, it would disrupt the long-term care industry and its residents. Residents would not be able to rely on an Advanced Health Care Directive ("AHCD") or Durable Power of Attorney for Health Care ("DPOA") for their self-appointed legal representatives to agree to utilize arbitration to resolve disputes, vastly reducing the number of residents who could resolve disputes via arbitration.

Fewer arbitration agreements would only operate to strain the already overburdened long-term care industry with excessive litigation costs. Already, long-term care facilities in California suffer from a higher frequency and severity of claims compared to other states. (See *2022 General and Professional Liability Benchmark Report: For Senior Living*

and Long-Term Care Providers (March 2023) Oliver Wyman & Marsh at p. 33 <https://www.marsh.com/us/industries/senior-living-long-term-care/insights/gl-pl-benchmark-report/gl-pl-benchmark-report-download.html>.) California had an average claim of more than $306,000, almost $100,000 more than the nationwide average in 2022. (*Id.* at pp. 8, 32.) This is coming at a time when long-term care facilities are facing challenges in obtaining insurance. (*See* Amy O'Connor, *COVID-19 Hits Already-Troubled Nursing Home Insurance Market; Brokers Try to Help*, Insurance Journal (May 10, 2020) https://www.insurancejournal.com/news/national/2020/05/10/567421.htm.)

Effectively removing arbitration as an option would inevitably drive up already high costs for long-term care facilities and prevent them from investing additional resources into resident care. (See *Referee Deck v. Developers Investment Company, Inc.* (2023) 89 Cal.App.5th 808, 831 [holding that the production of over 25,000 pages of documents and 40 depositions is not excessive discovery].) At the same time, it would remove an important choice for residents—a less costly and more expeditious approach to dispute resolution.

The growing elderly population makes arbitration acutely more important. By 2030, adults 60 and over will "make up more than 30% of California's population." (See *Governor's Master Plan for Aging* (Jan.

2021), available at https://mpa.aging.ca.gov/.) As the elderly population rapidly increases, so too will disputes between long-term care facilities and residents. Arbitration offers a less expensive and more efficient method to resolve those disputes. Through arbitration, residents can expect fair compensation when truly wronged, and long-term care facilities can effectively mitigate the threat of constant litigation.

Although these long-term care facilities must present the SAA to a resident before addressing the opportunity for voluntary arbitration, this requirement of sequential presentation of the SAA and then other documents and materials reflecting important health care decisions (including voluntary arbitration) does not argue against enforceability of an arbitration agreement. This is the fundamental flaw in the reasoning of the appellate panel in the present case. Simply put, if agents for residents cannot agree to an arbitration agreement under an AHCD or a DPOA, then agents for thousands of residents at long-term care facilities would not be able to agree to arbitration agreements and take advantage of a lower cost and more expeditious alternative dispute resolution process. (See Yadav et al. (July 2017) *Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care*, Health Affairs <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0175> [In a review of nearly 800,000 adults in the United States, a study found that around 35 percent of that population had a health care power of attorney].)

In light of these elements and because of CAHF's direct involvement in the SAA rulemaking, CAHF and its members have a substantial interest on the issue of whether AHCDs and DPOAs encompass enforceable agreements to arbitrate disputes.

III. NEED FOR FURTHER BRIEFING

CAHF is familiar with the issues before the California Supreme Court and the scope of their presentation and believes it can be of assistance to this Court by providing additional briefing that complements the parties' briefs regarding several matters, including: (1) the rulemaking history of California Code of Regulations, title 22, sections 72516 and 73518; (2) agreements and other materials which must be completed outside of the SAA clearly reflect health care decisions; and (3) the laws protecting Californians from unfair arbitration agreements.

IV. STATEMENT OF AUTHORSHIP

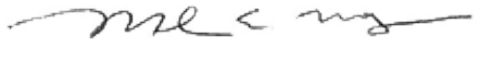
No party or counsel for a party authored the proposed *amicus* brief in whole or part. Further, the cost for preparing and submitting the proposed brief was born entirely by CAHF and no party or other person or entity made a monetary contribution intended to fund the preparation or submission of the brief.

V. CONCLUSION

For the foregoing reasons, CAHF respectfully requests permission to file its proposed *amicus* brief in support of Defendants and Appellants.

DATED: May 31, 2023

HOOPER, LUNDY & BOOKMAN, P.C.

By: 

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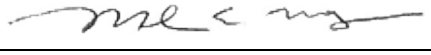
CERTIFICATE OF COMPLIANCE PURSUANT TO CALIFORNIA RULES OF COURT RULE 8.504(d)(1)

Pursuant to California Rules of Court Rule 8.504(d)(1), I certify that according to Microsoft Word the attached brief is proportionally spaced, has a typeface of 13 points and contains 1,271 words.

DATED: May 31, 2023

HOOPER, LUNDY & BOOKMAN, P.C.

By: 

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AMICUS BRIEF

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I. INTRODUCTION

Amicus Curiae California Association of Health Facilities ("CAHF") files this brief in order to supplement and support Appellants' arguments in this matter. This case involves a significant issue impacting long-term care facilities and their residents—whether agents lawfully appointed by those residents possess the right to voluntarily agree to resolve future legal disputes involving the care and treatment provided through the use of arbitration.

As an initial point, CAHF endorses the entirety of Appellants' arguments regarding applicable California law and the Federal Arbitration Act, as they both relate to the enforceability of the arbitration agreement in this case and generally. CAHF files this brief primarily to address the misunderstanding and resulting mischaracterization of the relationship between the voluntary arbitration agreements permitted under state and federal law and the rights and responsibilities of residents in gaining admission to facilities through the execution of the prescribed Standard Admission Agreement ("SAA").

More specifically, channeling the judgment of the Court of Appeal, Respondent argues that the "decoupling" of a voluntary arbitration agreement from the SAA means that the choice to utilize arbitration to resolve disputes over care and treatment is not a health care decision. However, the regulatory history of Title 22 of the California

Code of Regulations, sections 72516 and 73518 unequivocally demonstrates that the California Department of Health Services[1] (the "Department") excluded arbitration agreements from the SAA for a far simpler and unrelated reason.

The presentation of arbitration agreements to residents was separated from the SAA because Health and Safety Code section 1599.81 requires the selection of arbitration to be voluntary and prohibited from serving as a condition of admission or treatment.[2] In turn, Health and Safety Code section 1599.61 requires that only those elements that are conditions of such admission or treatment may be described in the SAA.

However, as described throughout the regulatory history, there are several other matters (along with the option of choosing arbitration) that are not covered by the SAA that also reflect health care decisions to be considered and made after the SAA is executed, including selecting a physician to follow their care (in conjunction with facility services), selecting a pharmacy (to fill necessary prescriptions), reviewing Medi-Cal

[1] The California Department of Public Health ("CDPH") was formerly known as the California Department of Health Services, which was reorganized into the CDPH and the Department of Health Care Services. CDPH is now responsible for the content and process associated with the SAA.

[2] The Centers for Medicare and Medicaid Services ("CMS"), the federal agency overseeing the Medicare and Medicaid programs, has similarly prohibited arbitration agreements to be presented on anything other than a voluntary basis. (42 C.F.R. § 483.70(n)(1).)

eligibility (relating potential insurance coverage for their stay), reviewing privacy notices (to determine who can receive access to personal health information), receiving information about advance directives (to appoint an agent, if and when necessary) and several other important health topics. Therefore, many health care decisions are not covered by the SAA and do not lose their status as health care decisions merely based upon the contents of the SAA.

In the context of long-term care specifically (and health care generally), the choice to utilize arbitration to resolve disputes that arise out of care and treatment is a health care decision. Critically, it is just one of many decisions within the "proper and usual" course of an agency "healthcare decision making" authority. The decision certainly may have legal components (as do many elements that are covered by or outside the SAA) but those components do not disqualify it from being a health care decision. Rather, prohibiting an agent from making a decision about voluntary arbitration is tantamount to stripping them of the full power to make the full complement of health care decisions that California agency law supports.

Finally, residents and their agents are not at the mercy of "unequal bargaining" or other potential abuses associated with arbitration. As demonstrated by Health and Safety Code sections 1599.61 and 1599.81 and the SAA regulatory history, the voluntary use of arbitration (and any other

matter outside of the SAA to be decided) can only be addressed after the SAA has been executed and admission has been secured. Additional consumer protections likewise ensure fairness in the arbitration process. There is no evidence of which CAHF is aware that indicates anything other than a purely voluntary arbitration agreement was executed in the present case.

For these reasons and as set forth below, CAHF requests that the judgment of the Court of Appeal be reversed.

II. BACKGROUND

A. Importance of Arbitration and CAHF's Interest

CAHF seeks involvement in this case because the issues to be decided directly impact the relationships between CAHF member facilities and thousands of residents in California. If the Court of Appeal's decision stands, residents would not be able to rely on an Advanced Health Care Directive ("AHCD") or Durable Power of Attorney for Health Care ("DPOA") for their *self-appointed legal agents* to agree to utilize arbitration *to resolve disputes*, vastly reducing the number of residents who could resolve disputes via arbitration. Fewer arbitration agreements would only operate to strain the already overburdened long-term care industry with excessive litigation costs. Already, long-term care facilities in California suffer from a higher frequency and severity of claims compared to other states. (See *2022 General and Professional Liability Benchmark*

Report: For Senior Living and Long-Term Care Providers (March 2023) Oliver Wyman & Marsh at p. 33 <https://www.marsh.com/us/industries/senior-living-long-term-care/insights/gl-pl-benchmark-report/gl-pl-benchmark-report-download.html>.) Relevant here, California had an average claim of more than $306,000, almost $100,000 more than the nationwide average in 2022. (*Id.* at pp. 8, 32.) This is coming at a time when long-term care facilities are facing challenges in obtaining insurance. (See Amy O'Connor, *COVID-19 Hits Already-Troubled Nursing Home Insurance Market; Brokers Try to Help*, Insurance Journal (May 10, 2020) <https://www.insurancejournal.com/news/national/2020/05/10/567421.htm>.)

Effectively eliminating arbitration as an option would inevitably drive up already high costs for long-term care facilities and prevent them from investing additional resources into resident care. (See *Referee Deck v. Developers Investment Company, Inc.* (2023) 89 Cal.App.5th 808, 831 [holding that the production of over 25,000 pages of documents and 40 depositions is not excessive discovery].) At the same time, it would reduce the availability of arbitration for residents—a less costly and more expeditious approach to dispute resolution.

As the elderly population grows, an efficient method to resolve disputes—arbitration—will become even more necessary for residents and

the long-term care facilities. By 2030, adults 60 and over will "make up more than 30% of California's population." (See *Governor's Master Plan for Aging* (Jan. 2021), available at https://mpa.aging.ca.gov/.) Simply put, if agents for residents cannot agree to an arbitration agreement for residents under an AHCD or DPOA, then agents for hundreds of thousands of residents at long-term care facilities would not be able to agree to arbitration agreements and take advantage of a lower cost and more expeditious dispute resolution process. (See Yadav *et al.* (July 2017) *Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care*, Health Affairs <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0175> [In a review of nearly 800,000 adults in the United States, a study found that around 35 percent of that population had a health care power of attorney].)

B. The California Department of Health Recognized Health Care Decisions Exist Outside the Standard Admission Agreement.

In the summer of 2004, the Department initiated a rulemaking under the California Administrative Procedure Act to implement Health and Safety Code section 1599.61, which requires the Department to develop the SAA for skilled nursing facilities and intermediate care facilities (collectively, "SNFs"). (See Exhibit 2 of Proposed Amicus Curiae's Request for Judicial Notice ("RJN"), at p. 3 [Notice of Proposed

Rulemaking].) The Department proposed to add Section 72516 and Section 73518 (Collectively, "Section 72516") to Title 22 of the California Code of Regulations implement the requirement for SNFs to use the SAA. In its Initial Statement of Reasons, the Department stated that Section 72516 required SNFs to use the SAA, which contains a variety of sections:

- Preamble;
- Identification of Parties to this Agreement;
- Consent to Treatment;
- Your Rights as a Resident;
- Financial Arrangements;
- Transfers and Discharges;
- Bed Holds and Readmission;
- Personal Property Protection;
- Photographs;
- Confidentiality of Your Medical Information;
- Facility Rules and Grievance Procedure; and
- Other Provisions of this Agreement. (See Exhibit 2 of RJN, at p. 4 [Notice of Proposed Rulemaking].)

The Department explicitly noted in the responses to stakeholder comments that Section 72516(c) does not preclude SNFs from discussing documents regarding health care decisions before admission. (*Id.*, at p. 11.) This includes the following:

- Physician designation;

- Selection of a pharmacy;
- Medi-Cal eligibility;
- Privacy notices;
- Information on advance directives; and
- Facility-specific rules and procedures.[3] (*Id.*, at p. 14 .)

Along with other stakeholders, CAHF submitted comments regarding the rulemaking. In responses to those comments, the Department stated that the purpose of the regulations was to impose restrictions on the use of arbitration agreements, not prohibit their use. (*Id.*, at p. 3 .) The sole purpose of Section 72516(c) is to make clear to residents that agreeing to arbitration is not a "precondition for admission or continued stay in a facility." (See Health & Saf. Code 1599.81.) Separating an arbitration agreement from the SAA does "not compromise any consumer protections provided by use of the arbitration agreement ." (Exhibit 3 of RJN, at p. 9 [Rulemaking - Addendum II].)

In its Final Statement of Reasons, the Department repeated that it did not believe Section 72516(c) precluded SNFs from discussing and presenting documents regarding health care decisions, such as pharmacy selection, to prospective residents as long as those documents were separate from the admission agreement and not a pre-condition for admission.

[3] Facility-specific rules and procedures regarding a resident's care must also be outside of the SAA, pursuant to California law. (Health & Saf. Code, § 1599.61, subd. (b)(1).)

(Exhibit 4 of RJN at p. 4 [Final Statement of Reasons].)

III. ARGUMENT

A. Respondent's Decoupling Theory is Contrary to the Rulemaking History.

The notion that the separation of the arbitration agreement from the SAA means that agreeing to arbitration is not part of a health care decision is contrary to the rulemaking history. Respondent reiterates the argument that because the arbitration agreement was "decoupled" from the SAA, it is not a "'necessary or proper and usual'" for placing Mr. Logan into a skilled nursing facility. (Respondents' Answering Brief at p. 23, citing *Logan v. Country Oaks Partners, LLC* (2022) 82 Cal.App.5th 365, 373 [quoting Civ. Code, § 2319, subd. (1)].) But Respondent and the Court of Appeal fail to recognize there are several other health care decisions that are clearly "necessary or proper and usual" for the admission of residents into a SNF. This is a truth that the Department identified in the rulemaking behind Section 72516.

Courts may turn to the rulemaking history of a regulation when the plain language of the regulation is ambiguous. (*Department of Industrial Relations v. Occupational Safety & Health Appeals Bd.* ("*Department of Industrial Relations*") (2018) 26 Cal.App.5th 93, 101.) In *Department of Industrial Relations*, the court held that the initial statement of reasons, responses to comments, and final statement of reasons was relevant in

interpreting the definition of "outdoor places of employment" in a regulation. Similarly here, this Court can analyze the rulemaking history of Section 72516 to understand that the Department acknowledged that documents related to health care decisions will exist outside of the SAA. Notably, one commentator stated that a variety of other documents related to health care decisions including "*Medi-Cal eligibility, privacy notices, **physician designation** and information on advance directives (among others)*" are outside of the SAA. (Exhibit 3 of RJN, at p. 14 [Rulemaking - Addendum II] [emphasis added].) The Department responded that "[t]hese and other documents are legitimate items for discussion, so long as they are brought up separately following admission, and it is clear to the prospective resident that no document other than the Standard Admission Agreement shall be signed as a condition of admission or continued stay in the facility." (*Ibid.*) This response demonstrates that these materials are critical to the admission process even though they are absent from the SAA.

Under this "decoupling" theory, Respondent suggests that choosing a physician is not a health care decision. But clearly, a resident's choice of a physician is not only a health care decision but also arguably the most important decision a resident could make about their care. Physician supervision is also a requirement under federal and California law. Under federal regulations, a physician must "personally approve" admission into a skilled nursing facility. (42 C.F.R. § 483.30.) After admission, residents

must remain under the care of a physician who must provide "orders for the resident's immediate care and needs." (*Ibid.*) Similarly in California, a physician must evaluate a resident at a skilled nursing facility every "30 days unless there is an alternate schedule." (Cal. Code Regs., tit. 22, § 72307, subd. (a).)

In a world where this "decoupling" theory stands, absurd conclusions abound. Choosing a physician is not a health care decision? A SNF cannot ask a resident to choose one even though a physician must be designated to supervise resident care? When viewed through the lens of reality, the theory completely falls apart.

Additionally, the Department repeatedly stated in responses to comments that there would also be voluntary documents and materials presented outside of the SAA that require consideration and potential execution. The Department stated in its Initial Statement of Reasons that that "other documents *(such as selection of a pharmacy)*" may be discussed following a resident's admission to a facility. (Exhibit 2 of RJN, at p. 10 [Initial Statement of Reasons] [emphasis added].)

The Department also acknowledged that other documents, such as facility-specific rules and procedures, will be provided outside of the SAA. (Exhibit 3 of RJN, at p. 4 [Rulemaking - Addendum II].) "Facility-specific rules, procedures and other matters of a *resident's care* may be presented and resolved, provided they are not included in the Standard Admission

Agreement or presented as a condition of admission or continued stay in the facility." (*Id.*, at p. 13 [Rulemaking - Addendum II] [emphasis added].) Like arbitration agreements, facility -specific rules and procedures regarding a resident's care must be outside of the SAA, pursuant to California law. (Health & Saf. Code, § 1599.61, subd. (b)(1).) However, these rules and procedures govern how a SNF will care for its residents. Even though California law separates these from the SAA, they remain relevant to resident care and treatment.

Relatedly, the Department also *intentionally* excluded documents related to health care decision making from the SAA. One commenter recommended that the SAA include a reference to the state-designated document required under the Federal Patient Self-Determination Act. (Exhibit 3 of RJN, at p. 20 [Rulemaking - Addendum II].) The Federal Patient Self-Determination Act mandates that all health care providers receiving Medicare or Medicaid payment must inform all competent adult patients about state laws on advanced directives and record any advance directives a patient may have. (Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101–508, § 4206, November 5, 1990, 104 Stat. 1388–115 [codified at 42 U.S.C. § 1395cc(f)].) The Department believed it was unnecessary to do so because residents in licensed-only facilities are sufficiently informed of their rights with regard to Consent to Treatment. (Exhibit 3 of RJN, at p. 20 [Rulemaking - Addendum II].) The purposeful

exclusion of a document regarding a health care decision by the Department demonstrates that a document's absence from the SAA does not categorically exclude it from being a health care decision.

B. The Decision to Choose Arbitration is a Health Care Decision.

As demonstrated in section II.A, simply because the arbitration agreement is separate from the SAA does not make it less intertwined with admission to a SNF. In reality, arbitration is just one of many decisions within the "proper and usual" course a resident representative makes in "healthcare decision making". Both courts in *Garrison v. Superior Court* ("*Garrison*") and *Hogan v. Country Villa Health Services* ("*Hogan*") recognized this. In *Garrison*, the Court of Appeal concluded that entering into "revocable arbitration agreements" was part of the "health care decision making process." (*Garrison v. Superior Court* (2005) 132 Cal.App.4th 253, 266.) Similarly, the Court of Appeal in *Hogan* recognized a representative for a resident must make a number of choices to make the health care decision of admission of a resident into a SNF:

> "It necessarily follows that when a representative of a prospective long-term health care facility resident reviews and evaluates contracts of admission with an eye towards deciding whether to place the individual at the facility, that decisionmaking process may include the review and evaluation of arbitration agreements meeting the requirements of Health and Safety Code section 1599.81, if such

> agreements are presented by the facility. In other words, when an agent under a health care power of attorney is faced with selecting a long-term health care facility, as part of the health care decisionmaking process (Prob.Code, § 4617), he or she may well be asked to decide whether to sign an arbitration agreement as part of the admissions contracts package."

(*Hogan v. Country Villa Health Services* (2007) 148 Cal.App.4th 259, 267.)

Admitting a resident into a SNF involves a number of separate choices, but they are all a part of the overall process of admission. Barring a resident's agent from making such decisions arguably prevents them from even executing the SAA, defeating the very purposes of an AHCD and a DPOA. Indeed, prohibiting a SNF resident's agent from making a decision about voluntary arbitration is tantamount to stripping them of the full power to make the full complement of health care decisions that California law supports.

As the Tennessee Supreme Court similarly realized, the distinction between "legal decisions" and "health care decisions" fails to appreciate "that signing a contract for health care services, even one without an arbitration provision, is itself a 'legal decision.'" (*Owens v. National Health Corp.* (Tenn. 2007) 263 S.W.3d 876, 884.) The implication of the appellate panel's argument creates a contradiction—a SNF resident's agent can sign one agreement, the SAA, but not an arbitration agreement.

In fact, when a SNF resident or their agent agrees to the SAA, they

are already making decisions indirectly related to the provision of care. There are a number of clauses in the SAA that are not directly related to health care:

- A choice of law provision;
- A provision that the SAA constitutes the entire agreement between the facility and the resident;
- A photography provision;
- A theft and loss prevention policy; and
- A grievance procedure. (See California Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities, form number CDPH 327 (05/11), Sections VIII, IX, XI, and XII.)

These are all decisions necessary for admission into a SNF. The reality is that those provisions in the SAA, like arbitration, are "bound up in the context of a health care decision"—a resident's admission into a SNF. (*Williams v. Smyrna Residential, LLC* (Tenn. Ct. App., Apr. 8, 2022, No. M202100927COAR3CV) 2022 WL 1052429, at *6, appeal granted (Sept. 29, 2022).) The bottom line is that an agent must make a number of choices that impact health care decisions, including whether voluntary arbitration is offered by a facility (See *Owens v. National Health Corp.*, *supra*, 263 S.W.3d at pp. 885-86, citing *Hogan v. Country Villa Health Services*, *supra*, 148 Cal.App.4th at p. 264 and *Garrison v. Superior Court*, *supra*, 132 Cal.App.4th at p. 258.) As a result, arbitration and other provisions in the SAA with legal components are *de facto* health care

decisions.

C. Arbitration Does Not Create Unequal Bargaining Position Between Residents and SNFs.

The Court of Appeal incorrectly implies that the arbitration agreement is negotiated between parties of unequal bargaining power. (See *Logan v. Country Oaks Partners, LLC, supra*, Cal.App.5th at p. 373 ["The holding in *Madden* is inapplicable here, however, where the skilled nursing facility's admission agreement does not contain an arbitration provision negotiated between parties of equal bargaining power."] The standardized admission process utilizing the SAA demonstrates the that there is no unequal bargaining position. First, it is clear that the SAA cannot have an arbitration agreement embedded within it. Second, only after the SAA is executed can a resident or their agent sign a binding arbitration agreement. (See Cal. Code Regs., tit. 22, §§ 72516(d), 73518(d).) In fact, the Department declared that no other documents can be signed with the SAA as a condition of admission. (See Exhibit 3 of RJN, at pp. 5-6 [Rulemaking - Addendum II].) By the time the resident or their agent lays eyes on the arbitration agreement, the resident has already secured admission to the facility.

In addition, statutes such as Code of Civil Procedure section 1295, and the mentioned Health and Safety Code section 1599.81, preserve the contracting rights of residents in SNFs. Code of Civil Procedure section

1295 was enacted as part of the Medical Injury Compensation Reform Act, which was passed in response to the "medical malpractice crisis." (*Gross v. Recabaren* (1988) 206 Cal.App.3d 771, 775.) In response to this "crisis," the California Governor in 1975 requested that the Legislature consider a "[v]oluntary binding arbitration [process] in order to quickly and fairly resolve malpractice claims while maintaining fair access to the courts." (*Ibid.*, citing Governor's Proclamation to Leg. (May 16, 1975), 10 Senate J. (1975-1976 Second Ex. Sess.) p. 2; (emphasis added).) Code of Civil Procedure section 1295 was the Legislature's solution—it encourages and facilitates the arbitration of medical malpractice disputes by specifying uniform language for binding arbitration contracts to assure that the patient or their agent understands what they are signing and what the ramifications are. (See *Gross v. Recabaren*, *supra*, 206 Cal.App.3d at p. 776.) Specifically, it imposes certain form and content requirements on contracts for medical services which contain provisions for arbitration and provides that a contract conforming with its form and content requirements is not "a contract of adhesion, nor unconscionable nor otherwise improper."

To further protect the interests of the residents of SNFs, the Legislature added Chapter 3.95, now Chapter 3.93, of Division 2 of the Health and Safety Code, commencing with Health and Safety Code section 1599.60 in 1987. (Stats. 1987, ch. 625, § 1.) Chapter 3.93 governs admission contracts to SNFs and clearly reflects the Legislature's concern

that admission contracts be equitable and understandable to those residents. This package included Health and Safety Code section 1599.81, which governs arbitration agreements. As discussed above, Health and Safety Code section 1599.81, imposes form and content requirements in addition to those in Code of Civil Procedure section 1295. These requirements include: (1) a statement that agreement to arbitration is not a precondition for admission to a facility; (2) clear separation of clauses referring to arbitration of medical malpractice claims from other arbitration clauses; and (3) separate execution of each of these clauses. These form and content requirements further protect the residents of SNFs by ensuring that those residents or their agents understand the arbitration agreements and are not coerced into entering into arbitration agreements as a condition of admission.[4]

Moreover, in 2002, the California Legislature passed and the California Governor signed *five statutes*, specifically Assembly Bills 2504, 2574, 2656, 2915 and 3030, amending the Code of Civil Procedure to

[4] As previously stated in footnote 2, there are also federal regulations governing Medicare and Medicaid participation that provide similar protections. These regulations require, among other things, that the execution of an arbitration agreement is voluntary in nature and cannot be presented as a condition of admission or continued care, that the agreement be presented in a form and manner that the resident or their agent understands and be accompanied by an acknowledgement of such understanding. (See 42 C.F.R. § 483.70(n)(1) and (2).)

regulate private arbitration companies and the administration of consumer arbitrations. These bills provided for the following legislative reforms, *inter alia*:

- disclosure by an arbitrator of all matters to notify a person of facts needed to reasonably entertain doubts that the proposed neutral arbitrator would be able to be impartial (Assem. Bill No. 2504, Stats. 2002 (2001-2002 Reg. Sess.) ch. 1094, § 2.);
- prohibiting a private arbitration company from administering a consumer arbitration if that company has a financial interest in any party or attorney for a party, or vice versa (Assem. Bill No. 2574, Stats. 2002 (2001-2002 Reg. Sess.) ch. 952, § 1);
- requiring that a private arbitration company publicly disclose the identity of any non-consumer parties, types of arbitration, and the prevailing party (Assem. Bill No. 2656, Stats. 2002 (2001-2002 Reg. Sess.) ch. 1158, § 1);
- barring the arbitration of contracts that provide for mandatory fee shifting to a non-prevailing consumer party and fee waivers for certain consumers (Assem. Bill No. 2915, Stats. 2002 (2001-2002 Reg. Sess.) ch. 1101, § 1); and
- permitting a court to disgorge administrative fees from any private arbitration company that violated any of the provisions of this set of bills (Assem. Bill No. 3030, Stats. 2002 (2001-2002 Reg. Sess.) ch. 1159, § 1).

Even though these bills were not specifically targeted toward the residents of SNFs, they also protect such residents from potential abuses of arbitration.

Considered as a whole, this statutory scheme protects the interests of SNF residents by ensuring that residents or their agents are fully aware of what type of document they are signing and are not coerced into agreeing to arbitration as a precondition of a SNF admission. These statutes further

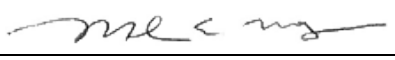
ensure that arbitration is conducted in a manner that is fair and protective of the interests of consumers, including SNF residents. Most significantly, nothing in the record of this case suggests that Appellants interfered with Respondent's protections.

IV. CONCLUSION

For the reasons set above, CAHF respectfully urges this Court to reverse the Court of Appeal's decision in this case.

DATED: May 31, 2023

HOOPER, LUNDY & BOOKMAN, P.C.

By: 

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CERTIFICATE OF COMPLIANCE PURSUANT TO CALIFORNIA RULES OF COURT RULE 8.504(d)(1)

Pursuant to California Rules of Court Rule 8.504(d)(1), I certify that according to Microsoft Word the attached brief is proportionally spaced, has a typeface of 13 points and contains 4299 words.

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HOOPER, LUNDY & BOOKMAN, P.C.

By: _____

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PROOF OF SERVICE

Logan v. Country Oaks Partners, LLC
Case No. S276545

STATE OF CALIFORNIA, COUNTY OF SAN FRANCISCO

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/s/ Diana Morgan
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5/31/2023

Date

/s/Mark Reagan

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