



February 2019

## Challenging Medical Necessity Denials to Increase Your Reimbursement – Key Considerations for Providers

By Bridget Gordon

Recently, many of our clients have found that more and more of their in-network, contracted claims which they have billed to the various payors are being denied, in whole or in part, for an alleged lack of medical necessity. This article provides some considerations to be made when dealing with pay-

ors who have denied claims based on medical necessity grounds.

### **Examine Your Contract**

#### **Definition of Medical Necessity**

Providers should examine their contracts with the payor at issue. First, determine how the terms “Medical Necessity” or “Medically Necessary Services” (or the equivalent) have been defined in your contract. Ensuring that the services in question comply with that definition will be critical to succeeding in any challenge to the payor’s denial of the claim. Should any challenge of the payor’s denial result in litigation or arbitration, your expert witness will also need to become very familiar with the definition included in your contract and be able to support that the services provided do meet the definition provided.

This means that during the contract negotiation and/or drafting stage, providers should seek to include expansive definitions of medical necessity and avoid allowing payors to insert specific guidelines that are more limited or not readily used by physicians and or other providers who actually make treatment decisions. For instance, many payors will attempt to insert language defining “Medical Necessity” by the Milliman Care Guidelines (MCG), a set of guidelines that physicians and other providers do not consider (nor are they supposed to consider) when making medical decisions

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based on their professional judgment. The MCG attempt to usurp physicians' opinions and expertise in favor of a strict, funnel-like system that narrows the acceptable care based on the patient in question's symptoms and diagnoses. Challenging the acceptability and applicability of the MCG when they do not appear in the contract is quite feasible as providers do not use or rely on these guidelines and they often do not meet the clinical standard of care, but challenging the MCG when a payor has inserted them as the measure of medical necessity in a contract becomes more difficult.

Payors will often also try to insert language into the definition of Medical Necessity section of the contract which states that the payor's own plan document will define what is medically necessary. Again, providers should strike this language, as it allows the payors to control what will be deemed medically necessary, another attempt to move away from the treating provider's own clinical judgment.

### **Timeframes and Processes for Challenging Denial**

Providers should also examine their contracts to determine how long they have to challenge the payor's denial and what processes they must follow to challenge the denial, including those that must be completed before litigation or arbitration can proceed.

Timeframes for challenging denials will vary, but providers should become familiar with the

payor's guidelines for appeals (often 30, 60, 90, or 180-day timeframes). While it's better to comply with these deadlines, deviation and variation from appeal deadlines is not fatal to pursuing these claims. Assuming the provider in question provided medically necessary services to the payor's member pursuant to the contract, the provider has substantially complied with their contractual obligations, even if it sent an untimely appeal. Additionally, in certain circumstances, appealing may be futile, and the futility of appeal can be used to explain why a provider did not appeal and should not be penalized for failing to do so.

Determining the deadline by which an arbitration or litigation must be filed will be even more critical. Such a deadline can often be located in a section of the contract which deals with arbitration or litigation or in a provision titled, "Statute of Limitations." Common limits on the ability to bring arbitration or file suit include 12-months, 18-months, or 24-months from when a claim arose and may be much shorter than provided by state law. Determining when a claim arose can become a hotly contested issue between the parties, and taking a conservative approach, such as the date of the patient in question's discharge from the provider, will protect the provider from arguments that its claims are contractually stale. Deadline for pursuing arbitration or filing suit should be strictly adhered to, in order to avoid challenges from the payor that such claims have

## **HLB Briefs**

### **Jeremy Sherer recognized by ABA as an "Emerging Young Lawyer in Healthcare"**

Hooper Lundy is pleased to announce that Jeremy D. Sherer will be recognized by the American Bar Association's Health Law Section with an Emerging Young Lawyers in Healthcare Award at the *20th Annual Emerging Issues in Healthcare Conference* being held March 13-16, 2019 at the JW Marriott in Orlando, Florida. The ABA recognizes Jeremy for a broad range of achievement, vision, leadership, and legal and community service in health law. The award will be presented by the Section Chair, Alexandria Hien McCombs, during her State of the Section presentation on Friday, March 15.

expired and can no longer be pursued by the provider. Entering a tolling agreement with the payor can prevent claims from going stale, and can be employed as a tactic to allow for more meet and confer and settlement discussions between the provider and payor to proceed before filing suit/arbitration. Also of note, in certain states, contractual limitations periods are unenforceable. The applicable state law should be researched to determine if this is so for the claim(s) at issue.

Often, payors require the provider to exhaust the appeals process, generally through at least a second-level appeal, before proceeding to arbitration or litigation. Some payors also require a formal meet and confer process before arbitration or litigation can proceed. The meet and confer may take the form of a formal demand letter, which can be generated by outside counsel or someone within the organization, but may also require a telephonic or in-person meeting with payor representatives. Depending on the ongoing business relationship between the entities, the meet and confer can function as an informal mediation and a way to resolve ongoing claim processing issues, or may instead function as a formality that must be adhered to before more formal arbitration and/or litigation efforts may proceed.

Before generating a demand letter or engaging in a telephonic or in-person meet and confer, a provider should organize all of its claims which have been denied for alleged medical necessity with the payor in question, and determine the total value of those claims. To the extent those claims can be classified to fit into particular categories based on the particular medical necessity issue and/or issues in dispute, the categorization can help identify trends in the payor's denials, and ensure that the letter and/or meeting agenda is organized to alert the payor of their improper denial trends.

## **Filing Suit or Pursuing Arbitration**

### **Gathering Evidence**

Providers should ensure that they have as robust a medical record as possible and that they have collected the appropriate documentation from all of the patients in question's treating providers for the denied or downcoded services in question. Collecting records for other related

stays for the same patient (either before or after the denied dates of service) may also be helpful to emphasize the overall status and condition of the patient during the denied dates in question. Providers should also consider exactly what type of medical necessity denial the payor has asserted. For example, a payor may have chosen to challenge the medical necessity of services based on the level of care provided. Providers should ensure they have documents reflecting that the level of care provided was a clinically appropriate level at which to treat the patient.

The provider may also want to gather peer-reviewed scholarly and scientific articles, FDA findings, Medicare guidelines, and other supporting materials for the services provided. In the alternative, this task can be left to the medical necessity expert selected by the provider.

### **Selecting an Expert**

Medical necessity disputes frequently become what is known as a "battle of the experts," in which each party will put forth an expert to explain why the healthcare services provided were or were not medically necessary. Typically, payors will utilize an in-house medical director or nurse as their expert. Providers should consider what type of medical necessity claim denials they are challenging, in order to select an appropriately knowledgeable expert. Often, the denied claims will range through a varied assortment of medical ailments and medical specialties. A physician with broad-experience, such as an internal medicine physician or general practitioner, will likely be able to serve as the expert on many of the claims at issue due to their broad based knowledge. However, for highly specialized claims, providers should consider engaging a more specialized expert to opine on the services. This may provide a higher level of clarity, skill, and credibility to the arbitrator, judge, and/or jury. Providers may also want to consider utilizing the treating physicians for the patient in question, especially when their unique knowledge of the patient's situation may be more compelling to the trier of fact.

*For additional information and guidance on the issues outlined above, please contact [Bridget Gordon](#) in Los Angeles at 310-551-8175.*

## A New Rush of Class Action Suits Attacking Hospital Emergency Room Level Charges

By Jennifer Hansen and Sansan Lin

A new round of putative class action lawsuits brought by counsel for patients who received treatment in a hospital emergency room alleging that hospitals charge emergency room patients a hidden and undisclosed “surcharge” or “cover charge” on top of charges for services provided is hitting hospitals throughout California. These suits are the progeny of prior unsuccessful putative class action lawsuits brought by the same plaintiff’s counsel alleging that hospitals’ charges for emergency services are unreasonably high and that the financial arrangements provision within the Conditions of Admission agreement signed by the patients requiring payment of charges are improper and not enforceable.

In the past decade, Plaintiff’s counsel have brought a number of lawsuits in California (as well as in other states) challenging hospital emergency room charges. After failed attempts to sustain a cause of action for breach of contract and decertification of the class (see e.g., *Hale v. Sharp Healthcare* (2010) 183 Cal.App.4th 1373 and *Hale v. Sharp Healthcare* (2014) 232 Cal.App.4th 50), plaintiff’s counsel filed a round of lawsuits between 2013 and 2015 with modifications to the putative class definition and causes of action alleged. The 2013 through 2015 lawsuits sought to certify a class of self-pay patients who were charged for emergency room services at the hospitals’ Chargemaster rates.

Hooper, Lundy & Bookman, P.C. represented hospital defendants in a number of those lawsuits, and after years of motion practice and briefing, successfully prevented class certification in a number of those cases and secured published Court of Appeal opinions upholding trial court denials of class certification. (*Kendall v. Scripps Health* (2017) 16 Cal. App.5th 553 and *Hefczyk v. Rady Children’s Hospital-San Diego* (2017) 17 Cal.App.5th 518.)

After failing to certify a class in *Kendall v. Scripps* (San Diego Superior Court, Case No. 37-2013-00073680), plaintiff’s counsel tested its new emergency surcharge theory in the first (and cur-

rently only) of any of these emergency services cases to go to trial. At a jury trial, the jury found plaintiff’s surcharge theory unconvincing and found in favor of the hospital on all counts.

These new alleged class action lawsuits appear to be plaintiff’s counsel’s latest efforts to further test and refine their new theory premised on hospitals’ emergency room level charges. Although California law does not give every patient the right to have every individual charge specifically disclosed to him or her in advance of receiving a hospital bill (*Nolte v. Cedars-Sinai Medical Center* (2015) 236 Cal. App.4th 140), these new lawsuits allege that plaintiffs are entitled to a declaration that the hospitals’ practice of charging a “substantial, undisclosed surcharge” is not authorized by the hospitals’ Conditions of Admission. In addition to declaratory relief, these suits also allege causes of action for violations of the unfair business competition law and the Consumer Legal Remedies Act. Rather than trying to limit the class to self-pay, uninsured patients, where plaintiff’s counsel faced insurmountable ascertainability challenges for class certification, these new lawsuits have broadened the class definition to include any patient who was charged an emergency room charge.

*We have experience in representing clients in all stages of litigation for these types of cases. For more information please call Patric Hooper or Sansan Lin in Los Angeles at 310-551-8111, or Jennifer Hansen or Joseph LaMagna at 619-744-7300.*

## CMS Proposes Coverage with Evidence Development for CAR T-Cell Therapies

By Amy Joseph and Katrina Pagonis

On Friday, February 15, 2019, CMS released a proposed decision memo to cover FDA-approved Chimeric Antigen Receptor (CAR) T-cell therapy, which uses a patient’s immune system T-cells to fight certain types of blood cancers, pursuant to a Coverage with Evidence Development (CED). Two CAR T-cell products are currently approved by the FDA for treatment of certain patients with relapsed or refractory acute myeloid leukemia and large B-cell lymphoma. In addition, multiple clinical trials involving CAR T-cell therapies are currently underway

across the country, including FDA-required post-approval studies. There is no national Medicare policy currently regarding coverage for this therapy, and local Medicare Administrative Contractors currently determine whether to pay for it.

This announcement by CMS appears to be a generally positive development for stakeholders seeking more clarity regarding parameters for coverage of the therapy. If adopted, the CED does ensure coverage on a national basis for the near future for certain types of CAR T-cell therapy under certain conditions, and during that time stakeholders can continue to gather additional data to support an argument for broader coverage as appropriate, as well as to support an argument for an appropriate reimbursement methodology.

The goal of the CED is to provide nationwide consistency in Medicare coverage determinations, improve patient access, and generate further evidence regarding the therapy. Under the proposed decision memo, a number of requirements would apply for coverage, including, without limitation, the following: (1) the patient must either be enrolled in a prospective, national, audited registry or enrolled in a CMS-approved clinical study; (2) the hospital must have a cellular therapy program that meets certain conditions, along with a designated care area and written guidelines; (3) the treatment must be an FDA-approved biological; (4) specific data regarding the clinical characteristics of patients and outcomes must be provided in response to the CED questions; (5) the patient must be monitored for at least two years after treatment; and (6) the studies must adhere to certain standards of scientific integrity and relevance to the Medicare population. CMS would then use the evidence generated to further evaluate coverage for the therapy.

This proposed decision memo has been in process for some time, with CMS initially commencing a National Coverage Analysis (NCA) in May of 2018, including an initial comment period, which ran through June 15, 2018. In the proposal, CMS describes the review that it has engaged in to date to determine whether there is sufficient evidence to conclude that the therapy will improve health outcomes, including the review of results of multiple clinical trials published in peer-reviewed journals, FDA materials, professional society recommendations, and other expert opinions. CMS concluded that “this is a rapidly evolving field and that initial

evidence appears promising but inconclusive at this time to definitively determine whether CAR T-cell therapy improves health outcomes in the Medicare population.”

For the avoidance of doubt, CMS states, in proposed language to be added to the National Coverage Determination (NCD) Manual, that the proposed CED would not alter Medicare coverage for items or services that are covered or non-covered pursuant to the existing national coverage policy for Routine Costs in a Clinical Trial, NCD section 310.1 (the Medicare Clinical Trial Policy or CTP). Under the CTP, the clinical trial item or service is an excluded cost, but routine costs -- including items and services typically provided absent a clinical trial (referred to as “standard of care”), clinically appropriate monitoring and prevention of complications, and reasonable and necessary items and services in the event of complications from participation in the clinical trial – are covered. In this case, routine costs would continue to be covered, as well as other items and services provided as a result of coverage under the CED.

Of note, an NCD addresses coverage parameters, but the reimbursement methodology for the therapy is a separate process altogether. Receiving appropriate reimbursement for CAR T-cell therapy, which is extremely expensive (i.e., \$373,000 or more for the drug product alone) continues to be a significant issue because Medicare does not generally provide for pass-through payment of high-cost inpatient drugs. Academic medical centers and other health systems that offer the therapy rely on new technology add-on payments and outlier payments to offset (often only partially) the substantial costs associated with CAR T-cell therapy. The reimbursement problems associated with inpatient CAR T-cell therapy are expected to intensify in the coming years because the new technology add-on payments will expire after FY 2020 and the high cost of CAR T-cell drug products is expected to distort the weighting of inpatient diagnosis related groups (DRGs), which are set in a budget-neutral manner, as well as the outlier payment threshold, which must be set to produce outlier payments of only 5 to 6 percent of DRG payments. These Medicare reimbursement concerns may also fuel efforts to transition CAR T-cell therapy from the inpatient to outpatient setting, where Medicare reimbursement for drugs is largely based on the average sales

price plus six percent, to the extent evidence from the CED process indicates such a transition is feasible from a clinical care perspective.

CMS is seeking comments on the proposal through March 17, 2019, and anticipates completing the NCA process in May 2019.

*Hooper, Lundy & Bookman's Academic Medical Center/Teaching Hospital Working Group provides assistance to academic medical centers and teaching hospitals in all aspects of medical education compliance. For assistance relating to this issue, please contact Katrina Pagonis in San Francisco at 415.875.8500, Bob Roth or David Vernon in Washington, D.C. at 202.580.7713, Amy Joseph in Boston at 617.532.2702, or your regular Hooper, Lundy & Bookman contact.*

## CMS Issues Proposed Rule on Interoperability, Patient Information

*By Jeremy Sherer and Amy Joseph*

On February 22, 2019, the Centers for Medicare & Medicaid Services ("CMS") and the Office of the National Coordinator for Health Information Technology ("ONC") of the Department of Health and Human Services ("DHHS") formally issued two proposed rules and related Requests for Information (RFIs) intended to advance interoperability and increase patient access to health information (the "CMS Proposed Rule" or "Proposed Rule" and the "ONC Proposed Rule," respectively). This alert focuses on the CMS Proposed Rule, while a subsequent client alert will address the ONC Proposed Rule.

While primarily directed at plans, if finalized, the Proposed Rule would impose significant new requirements on payers and providers alike, including requiring CMS-regulated payers to develop application program interfaces ("APIs") that facilitate sharing of information between patients, payers and providers, and new hospital conditions of participation requiring hospitals to report admission, discharge and transfer events to other providers to participate in the Medicare program. The Proposed Rule would also leverage attestations under the Medicare and Chip Reauthorization Act ("MA-CRA") where providers would confirm that they are

not engaging in information blocking, and a website where the names of providers who refused to complete such attestations, or responded "no" to any of the attestations, would be publicly listed.

Comments on the proposed rules, which were published in the Federal Register on March 4th, 2019, must be received by May 3rd, 2019.

### APIs and Care Coordination

#### Application Programming Interfaces

In its discussion of APIs, the Proposed Rule explains the agency's belief that "every American should be able, without special effort or advanced technical skills, to see, obtain, and use all electronically available information that is relevant to their health, care, and choices – of plans, providers, and specific treatment options." The Proposed Rule would require Medicare Advantage ("MA") organizations, state Medicaid agencies, Medicaid managed care plans, Children's Health Insurance Program ("CHIP") agencies, CHIP managed care plans, and issuers of qualified health plans ("QHPs") in federally-facilitated exchanges ("FEEs"), but not stand-alone dental plans offered in FEEs, to adopt and implement an "openly published" API, which will allow third-party software applications to retrieve, with the approval and at the direction of the patient, clinical and payment information. The information that CMS proposes to make accessible through APIs includes adjudicated claims (including cost), encounters with capitated providers, provider remittances, enrollee cost sharing, clinical data, including lab results when available, provider directory information, and formularies (when applicable).

CMS believes that because consumers perform daily tasks on smart phones using secure applications, consumers should be able to obtain and use health information in the same manner. CMS notes that it has received comments over the course of other undertakings expressing concern about risks to privacy—notably under HIPAA—as well as security. With regard to HIPAA, CMS points readers to existing guidance from the DHHS Office of Civil Rights ("OCR"), as well as Federal Trade Commission ("FTC") recourse, but simultaneously encourages comment on these matters.

CMS also proposes that plans will be required to do routine testing and monitoring of APIs to assure that compliance with HIPAA and security require-

ments are maintained, particularly around protected health information (“PHI”).

### *Health Information Exchange and Care Coordination Across Payers*

The Proposed Rule would require the CMS-regulated payers listed above to maintain a process enabling the electronic exchange of the types of data that would be accessible through APIs (also listed above). When received from another payer, the information would need to be integrated into the receiving payer’s medical records about the patient. Payers would be required to accept data from any other health plan that has treated a patient during the preceding five years, and to send a patient’s data to any plan that covers the patient for up to five years after the patient’s disenrollment from the plan. Such transfers of information would be facilitated through a “Trusted Exchange Framework” to improve interoperability, which is further discussed below.

### *API Access to Published Provider Directory Data*

The Proposed Rule would require CMS-regulated payers to make their provider directory information available through APIs. Specifically, payers would need to make standardized information about their provider networks available through an API, which third-party software applications could access and publish. CMS believes that this would enable a referring provider to securely send patient information to a receiving provider.

### *Care Coordination Through Trusted Exchange Networks*

The Proposed Rule would require payers regulated by CMS to participate in trusted exchange networks as a way to improve interoperability. The goal of trusted exchange networks is to facilitate interoperability extending beyond a single health system or point-to-point connections between payers, patients and providers. CMS is proposing that as of January 1, 2020, MA Plans, Medicaid and CHIP managed care plans, and QHPs in FFEs must participate in a trusted exchange network that is capable of exchanging PHI in compliance with applicable federal and state law, is capable of connecting to inpatient electronic health records (“EHRs”) and

ambulatory EHRs, and supports securing messaging or electronic querying by and between providers, payers and patients. This portion of the Proposed Rule builds on the Trusted Exchange Framework that ONC released for comment in January 2018.

### *Information Blocking Attestations*

The Proposed Rule seeks to further implement information blocking provisions introduced under MACRA. MACRA’s “meaningful use” provisions require eligible professionals, hospitals and critical access hospitals (“CAHs”) to demonstrate they have not “knowingly and willfully” restricted the compatibility or interoperability of certified EHR technology (“CEHRT”). CMS explains that information blocking “could be considered to include the practice of withholding data, or intentionally taking action to limit or restrict the compatibility or interoperability of health IT,” and that it understands “that health care providers may limit or prevent data exchange in an effort to retain patients.”

To implement these interoperability requirements, CMS adopted three attestations that providers must make regarding their use of CEHRT, confirming that they are not engaging in information blocking. The attestations require the clinician to confirm that they did not knowingly and willfully restrict compatibility or interoperability of CEHRT, implemented technologies, standards and procedures needed to ensure that CEHRT was connected and operating optimally at all times, and responded in good faith and timely to requests to retrieve or exchange electronic health information. There are parallel regulatory requirements for hospitals and CAHs.

The Proposed Rule would make the responses of clinicians, hospitals and CAHs to these attestations public. Specifically, a new indicator would be added on Physician Compare for clinicians and medical groups that respond “no” to any of the attestations, and a new CMS website would post the names of hospitals and CAHs that do the same. This information would be posted beginning in late 2020 during the 2019 reporting period.

CMS is seeking comments on how to implement this public reporting initiative, including where to post the names and how frequently they should be posted.

## **Revised Conditions of Participation for**

## Hospitals, Psychiatric Hospitals and Critical Access Hospitals

The CMS Proposed Rule announces that the agency expects to finalize two previously proposed rules involving conditions of participation relating to interoperability this year. The first new conditions of participation would require hospitals, psychiatric hospitals and CAHs to send electronic patient event notifications when a patient is admitted, discharged and transferred to another community provider or facility. These automated, electronic communications would be sent by the discharging provider to a facility or community provider that the patient identifies, and would include basic patient demographic and diagnostic information. CMS explains that the EHR systems that hospitals, CAHs and psychiatric hospitals presently use generate these messages using admission, discharge and transfer (“ADT”) messages.

The only hospitals to which these requirements would apply are those with EMR systems capable of generating information for patient event notifications. To satisfy this condition of participation, such hospitals would need to demonstrate the following:

1. the notification capacity of the EHR system is operational and compliant with federal and state laws governing the exchange of PHI;
2. the system uses the content exchange standard in the ONC Proposed Rule;
3. the system sends notifications with the minimum PHI required – the patient’s name, the treating practitioner’s name, the name of the sending institution, and the patient diagnosis (unless this is prohibited by law);
4. when the patient is admitted, the system sends notifications that allow for the exchange of health information to practitioners, patient care team members, and post-acute services providers and suppliers who receive the notification for purposes of care coordination, treatment or quality improvement, have an established care relationship with the patient that is relevant to such patient’s care, and the hospital is “reasonably certain” that they receive the notifications; and

5. either immediately before or at the time of the patient’s hospital discharge, the system dispatches notifications to the individuals listed in item 4, above.
6. While the new hospital conditions of participation are only required for inpatients, CMS hopes that hospitals will expand these practices to the care of additional patients. The requirements for CAHs and psychiatric hospitals generally mirror the requirements for hospitals.

### Provider Digital Contact Information

The 21st Century Cures Act required the Secretary of the Department of Health and Human Services to establish a digital contact information index, which CMS accomplished by updating the National Plan and Provider Enumeration System (“NPPES”) to capture the digital contact information of providers and facilities. However, because CMS has found that many providers are not adding their digital contact information or ensuring that it is up-to-date, CMS is proposing to publicly report the names and national provider identifiers (“NPIs”) of providers who fail to add their digital contact information to the NPPES beginning in the second half of 2020.

### RFIs on Advancing Interoperability Across the Care Continuum, Improving Patient Matching

The Proposed Rule contains two RFIs involving health information technology, suggesting future regulatory action in this area.

First, CMS is seeking comment on strategies for advancing interoperability across care settings. CMS highlights its concern about a lack of implementation of CEHRT in post-acute care, behavioral health, and home and community-based service settings. Such facilities should take note of this RFI, as CMS issued it in anticipation of future rulemaking. Thus, while the full Proposed Rule’s application is limited to hospitals, CAHs and psychiatric hospitals, it appears likely that similar requirements will be imposed upon post-acute care, behavioral health, and home and community-based providers in the near future.

Second, CMS requested comments about how to improve patient matching efforts. Patient match-

ing refers to efforts to match information about a patient that is held by multiple providers. “Matching” such records allow providers to construct a more complete picture of a patient’s medical history. CMS notes that the lack of a unique patient identifier (“UPI”) across the Medicare program has long stood in the way of safe and secure exchanges of PHI, but that Congress has encouraged DHHS to examine ways to use patient matching.

*Hooper, Lundy & Bookman will continue monitoring these developments. If you have questions or are interested in submitting comments, contact Jeremy Sherer or Amy Joseph in Boston at 617-532-2700, or Marty Corry or Monica Massaro in Washington, D.C. at 202-580-7700, or your regular Hooper, Lundy & Bookman contact.*

## Hooper Lundy & Bookman Congratulates our Clients and all Named to Modern Healthcare’s Top 25 Women Leaders

**Nancy Howell Agee**, President and CEO, Carillion Clinic

**Madeline Bell**, President and CEO, Children’s Hospital of Philadelphia

**Mary Boosalis**, President and CEO, Premier Health

**Marna Borgstrom**, CEO, Yale New Haven Health System

**Debra Canales**, EVP and Chief Administrative Officer, Providence St. Joseph Health

**Dr. Mandy Cohen**, Secretary, North Carolina Department of Health and Human Services

**Tina Freese Decker**, President and CEO, Spectrum Health

**Cynthia Hundorfean**, President and CEO, Allegheny Health Network

**Laura Kaiser**, President and CEO, SSM Health

**Dr. Anne Klibanski**, Chief Academic Officer, Partners Healthcare

**Kathy Lancaster**, EVP and Chief Financial Officer, Kaiser Foundation Health Plan and Hospitals

**Karen Lynch**, Executive Vice President, CVS Health

**Patricia Maryland**, President and CEO, Ascension Healthcare

**Dr. Barbara McAneny**, President, American Medical Association

**Dr. Redonda Miller**, President, Johns Hopkins Hospital

**Dr. Janice Nevin**, President and CEO, Christiana Care Health System

**Amy Perry**, CEO, Hospital Division, Atlantic Health System

**Candice Saunders**, President and CEO, WellStar Health System

**Ninfa Saunders**, President and CEO, Navicent Health

**Dr. Joanne Smith**, President and CEO, Shirley Ryan AbilityLab

**Dr. Johnese Spisso**, President, UCLA Health

**Paula Steiner**, President and CEO, Health Care Service Corp.

**Pamela Sutton-Wallace**, CEO, University of Virginia Medical Center

**Susan Sweeney**, President and Head, U.S. Commercial, Bristol-Myers Squibb

**Seema Verma**, Administrator, CMS

**Andrea Walsh**, President and CEO, HealthPartners



## Go Red for Women Wellness Retreat & Executive Luncheon

Hooper, Lundy & Bookman is a proud sponsor of the American Heart Association's STEM Goes Red program – a year-long enrichment program for more than 100 high school juniors from throughout Los Angeles County designed to empower the next generation of women STEM leaders. To celebrate International Women's Day, the firm sponsored the AHA and Go Red for Women Wellness Retreat & Executive Luncheon on March 8, 2019 in Manhattan Beach.

# CALENDAR

- March 12**      **Hooper, Lundy & Bookman Presents The 2019 Medical Staff Seminar Update, Los Angeles, CA**
- March 13-16**    **ABA 20th Annual Emerging Issues in Healthcare Law Conference, Orlando, FL**  
Jeremy Sherer co-presents *Telemedicine's Evolution: Hot Topics and Privacy Considerations*  
Mark Johnson co-presents *Goodbye RUGS! Hello PDPM! Fundamental Changes to SNF Medicare Payments*
- March 19**      **Strafford Webinar**  
Charles Oppenheim presents *Anti-Kickback Safe Harbor Provisions: HHS and OIG Changes to Regulate and Restrict Remuneration*
- April 5-7**      **2019 CSHA Annual Meeting & Spring Seminar, La Jolla, CA**  
Mark Reagan and Ben Durie present *Emerging Trends in Post-Acute Care*
- April 7-10**     **HCCA 23rd Annual Compliance Institute, Boston, MA**  
David Schumacher presents *A Compliance Case Study from the Trenches with Current and Former DOJ Prosecutors*. Amy Joseph presents *Relationships in the Academic Medical Center Context: Anti-Kickback and Stark Law Issues*. Jeremy Sherer presents *Telehealth Contracting for Compliance Officers*. Mark Reagan presents *Will CMS Turn Down the Volume? Patient-Driven Payment Model (PDPM) and the Effort to Replace RUGs*. Charles Oppenheim presents *Hidden Treasure, or Hidden Kickback? If it looks too Good to Be True, It Might Be an Anti-Kickback / Stark Violation*.
- April 10**      **Mass Senior Care Association Spring Conference, Boxboro, MA**  
Mark Reagan presents *Compliance Under PDPM: The New Frontier*
- April 11**      **Suffolk University Journal on Health and Biomedical Law Symposium 2019**  
Jeremy Sherer presents *Talking Telehealth: Exploring the Role of Technology in Healthcare*
- May 22**        **LeadingAge California Annual Conference, Monterey, CA**  
Mark Johnson presents *Are you prepared for Medicare Patient Driven Payment Model?*
- May 23-24**    **CAMSS Conference, Universal City, CA**  
Ruby Wood and Alicia Macklin present *Sharing Peer Review Information – Practical Approaches to Protect Confidentiality and Immunity Protections*  
Jennifer Hansen presents *Medical Staff Legal Update*
- June 9**        **HCCA 2019 Research Compliance Conference, Orlando, FL**  
Amy Joseph presents *Identifying and Managing Physician Conflicts of Interest in the Research Context*
- June 14**      **HCCA 2019 Orange County Regional Conference**  
Charles Oppenheim and Alicia Macklin present *Regulatory Update*
- June 17-18**    **Northeast Regional Telehealth Conference**  
Jeremy Sherer will be a panelist
- July 14-17**    **CAHF Summer Conference, San Diego, CA**  
Mark Reagan and Jeremy Sherer are co-presenting
- Nov 10-13**    **CAHF Annual Conference, Palm Springs, CA**  
Mark Johnson presents

# HILB

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