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Changes Ahead for California's Managed Care Regulatory Scheme

By Stephanie Gross and Charles Oppenheim

California's Department of Managed Health Care ("DMHC") recently finalized regulations that significantly expand what it means to take on "global risk," which triggers the requirement to obtain a Knox-Keene license or an exemption. Historically, the requirement to obtain a Knox-Keene license has been reserved for health maintenance organizations ("HMOs") or other organizations that are paid on a capitated basis in exchange for providing or arranging health care services.

The new regulation will disrupt this status quo by sweeping in a range of value-based payment arrangements – potentially including independent practice association ("IPA") participation in hospital risk pools and some accountable care organizations ("ACOs") – that providers have historically entered into without needing to be licensed as a Knox-Keene plan. California-based providers that engage in these types of payment arrangements should therefore pay special attention to these new rules as they are implemented.

Though the rules technically take effect **July 1, 2019,** the Department recently released draft guidance indicating that the licensure requirement will be phased in such that prior approval will not be required during the second half of 2019, and for the time being, certain arrangements will not be subject to the licensure requirement at all – including bundled payments, arrangements under the purview of the California Department of Insurance, and ACOs regulated by the Centers for Medicare & Medicaid Services ("CMS"). However, while the guidance remains in draft form, providers should pay close attention to this shifting regulatory landscape.

In This Issue

The Current Regulatory Framework

The Knox-Keene Health Care Service Plan Act of 1975 (the "Knox-Keene Act") was enacted to "promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan …" Accordingly, the focus of the law is "health care service plans." These are defined in the statute to include "any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees." Health & Safety Code § 1345. Under the law, a license issued under the Knox-Keene Act is generally required in order to operate a health care service plan.

Historically, the term "prepaid or periodic charge" has been widely understood to describe capitation, or a per-member, per-month payment made in advance to an organization for providing or arranging for health care services for those members. *A fully-licensed* plan enrolls its members directly (as individuals or groups) and provides or arranges for those members to receive services in exchange for a premium, while a *restricted* plan contracts with a fully-licensed plan to arrange for or provide services to that plan's members.[1]

The statute does not require any other type of organization to be licensed as a health plan. After several large medical groups that accepted capitation from health plans faced financial collapse in the 1990s, however, the Department began regulating these groups indirectly, requiring the licensed Knox-Keene plans that contracted with them to ensure that they had sufficient capitalization to take on financial risk. These medical groups are referred to in the regulations as "risk-bearing organizations" ("RBOs"). Because these groups only take risk for services that are within the scope of their professional licenses, they have traditionally been considered exempt from the requirement to obtain a full or restricted Knox-Keene license.[2]

Setting the Stage for New Rulemaking

Until now, the Department has not sought to regulate other provider types – including hospitals – that take on significant financial risk in their arrangements with health plans or employers. The new regulation represents a step in that direction, though it is not entirely clear why the Department decided to engage in new rulemaking.

Several recent developments may provide insight into the Department's decision-making. First, in a 2015 decision, *Hambrick v. Healthcare Partners Medical Group, Inc.*, the California Court of Appeal invited the Department to determine "the level of financial risk… that causes [an organization]… to become a 'health care service plan,' " because that "is precisely the type of regulatory determination involving complex economic policy that should be made by the DMHC in the first instance."[3] This may have encouraged the Department to engage in rulemaking to provide guidance on the types of activities for which it considers a license to be necessary.

Second, the Department has indicated that it is uncomfortable with the amount of risk-taking by certain provider groups, including those that contract directly with employers that self-insure and are not regulated by the Department. This suggests that the new regulation was specifically intended to allow the Department to oversee these activities. Finally, the Department has expressed a desire to provide clarity around certain concepts, like "restricted" or "limited" licenses, that are not currently described in the Knox-Keene Act or its implementing regulations.

Expanded Licensure Requirement Under the New Regulation

The regulation echoes the statutory requirement that a license is required in order to take on "global risk" (subd. (b)(1)) which is defined as "The acceptance of a prepaid or periodic charge from or on behalf of enrollees in return for the assumption of

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[1] Until now, restricted (or limited) plans have never been described in statute or regulation, and the Department issued licenses to these plans with waivers from the various requirements under the Knox-Keene Act that are only appropriate for plans that market directly to individuals and groups.

[2] Professional corporations, independent practice associations (IPAs) and medical foundations can also be RBOs..

[3] 38 Cal.App.4th 124, 149. While this case dealt squarely with the amount of risk-taking that requires an RBO to obtain a license, it raised questions regarding the level of risk-taking that requires an organization to obtain a Knox-Keene license generally.

both professional and institutional risk" (subd. (a)(1)).[4]

This aligns closely with the language of the statute, which requires a health plan to obtain a Knox-Keene license to accept a "prepaid or periodic charge" in exchange for providing or arranging health care services. While this has historically been understood to refer to capitation, the new regulation departs from this traditional interpretation in how it defines a "prepaid or periodic charge," which is defined under subdivision (a)(4) as "any amount of compensation, either at the start *or end* of a predetermined period, for assuming the risk, or arranging for others to assume the risk, of delivering or arranging for the delivery of the contracted-for health care services for subscribers or enrollees that may be *fixed either in amount or percentage of savings or losses in which the entity shares."* (Emphasis added.)

This new definition changes the historical understanding of a "prepaid or periodic charge" in two key ways. First, the reference to payments made at the "start *or end* of a predetermined period" departs from the traditional understanding that only organizations that charge *advance* payments for providing or arranging for health care services – that is, capitation – would be subject to licensure.

Second, the regulation's reference to charges of amounts "fixed either in amount or percentage of savings or losses in which the entity shares" establishes that payment arrangements involving fee-for-service payments, with an opportunity to share savings if the total amount of payments made under the arrangement is under budget, are *also* considered a "prepaid or periodic charge." This upends the capitation concept entirely: take, for example, a contract by which a provider is paid for health care services using a fee schedule, but is entitled to 50% of any savings the provider can achieve against a target budget. The provider would be accepting compensation at the "end of a predetermined period" that is "fixed" in the "percentage of savings… in which the [provider] shares." This common arrangement, which is currently used by many IPAs in their risk pools, and by accountable care organizations ("ACOs"), would require a Knox-Keene license under the new regulation.

The New Scheme Will Be Phased In Over the Second Half of 2019

The new regulation expressly applies to contracts "issued, amended, or renewed" on or after July 1, 2019. (Subd. (e).) As a result, payment arrangements between providers and payors that satisfy the new definition of a "prepaid or periodic charge" do *not* require a license on July 1, 2019, – if the arrangement is already in place as of that date.

Instead, the regulation requires a license (or exemption) for any payment arrangements that are entered into, amended or renewed on or after July 1. The Department's recently-issued draft guidance indicates that the Department is thinking of phasing in the licensure requirement, giving providers more time to comply with the new rules.

First, the draft guidance indicates that arrangements entered into, amended or renewed in the first six months after the rule is in effect will be deemed exempt from the licensure requirement. An organization would not need to seek prior approval from the Department for arrangements entered into, amended or renewed in the first six months the regulation is in effect. Rather, an organization can simply submit a request for an expedited exemption within thirty days of entering into, amending or renewing the arrangement or beginning to perform under it (whichever is earlier), and the Department will deem the arrangement to be exempt. This six-month phase-in will significantly ease the burden for providers that are establishing new payment relationships, or amending or extending existing relationships, in the latter half of 2019.

Second, the draft guidance document indicates that the Department will consider certain payment arrangements to be entirely outside of the scope of the licensure requirement for now. These include bundled payments, case rate, diagnosis-related group payments, and per diem arrangements; ACOs regulated by CMS; and arrangements where the payor is an insurer licensed by the California Department of Insurance.

If the draft guidance is finalized as currently written, this means that providers will have more time to comply with the new rules, and that certain providers might not need to seek an exemption from the Department at all.

[4] All references are to a new regulatory section, section 1300.49 of title 28 of the California Code of Regulations.

Compliance in 2020 and Beyond

Although the grandfathering and phase-in provisions contemplated by the regulation and draft guidance, respectively, provide some much-needed relief from the immediate need to obtain a license or exemption, many organizations will eventually need to pursue one of these paths. While providers can seek a Knox-Keene license in order to comply with the new rules, this is probably an unrealistic and undesirable option for many providers. Obtaining and maintaining a Knox-Keene license involves complying with a host of complex requirements that are aimed at traditional HMOs and are simply inappropriate for providers whose only risk-bearing activities involve entering into value-based payment arrangements with health plans and other payors. For these providers, obtaining an exemption from the Department will likely be the most efficient way to comply with the new rule in the long term.

The regulation provides some insight into how the Department will respond to exemption requests. First, the regulation identifies materials that should be submitted to the Department by an organization seeking an exemption, including contracts for the assumption of risk, financial information, and information about the patient population affected by the arrangement for which an exemption is being sought. (Subd. (b)(2).) The regulation also specifies the criteria the Department considers in determining whether to grant an exemption, including information related to the applicant's financial wherewithal and market conditions. (Subd. (b)(3).) During informal conversations with stakeholders, the Department has signaled that it is more likely to grant exemptions for relatively low-risk arrangements entered into by well-established organizations that have greater financial resources. Under the new regulation, the Department must respond to requests for exemption within thirty days of receipt of the request. (Subd. (b)(4).)

Another path forward is to enter into only payment arrangements that are not subject to the new rule. Providers could redesign existing payment arrangements to avoid falling within the scope of the new rule; for example, providers that currently share in a payor's savings or losses may redesign those agreements to incorporate different incentives for providing efficient, effective care. Moreover, according to the draft guidance, the Department will not apply the licensure requirement to certain common payment arrangements (such as bundled payments, Medicare ACOs, etc.), though it is unclear how long the Department will take that position.

As **July 1** approaches, California providers should develop a strategy for complying with the new rule. Unless and until the Department's draft guidance is finalized, providers should not rely on draft guidance and should be prepared to comply beginning **July 1**.

To discuss whether the new rule impacts your organization and explore paths forward, please contact *Stephanie Gross* in San Francisco, *Charles Oppenheim* in Los Angeles, or your regular HLB contact.

Medicare Advantage Final Rule - Telehealth Expansion

By Jeremy Sherer, Marty Corry and Stephanie Gross

On Friday, April 5, 2019, the Centers for Medicare & Medicaid Services ("CMS") finalized its fall 2018 proposal to expand coverage of telehealth benefits for Medicare Advantage beneficiaries, creating a new category of benefits entitled "additional telehealth benefits." This brief alert highlights what this development means for healthcare providers, before reviewing the various ways in which Congress and CMS have expanded the telehealth benefits available to Medicare beneficiaries throughout 2018 and 2019.

Background: Telehealth Coverage by Medicare and Medicare Advantage

Medicare Coverage of Telehealth. Historically, Medicare has only covered telehealth services delivered to Medicare fee-for-service ("FFS") beneficiaries when the services at issue satisfy the requirements for "Medicare telehealth services" set forth in § 1834(m) of the Social Security Act, and codified at 42 U.S.C. § 1395m(m). In order to be eligible for payment, such services must satisfy five requirements: the services must be rendered to a patient in a rural health professional shortage area ("HPSA") or in a county which is not included in a metropolitan statistical area ("MSA") (unless an

exception applies); the patient must be located at an approved "originating site;" the services must be delivered through an approved telecommunications system; the service must be rendered by an approved type of provider; and the service provided must be included on CMS' list of approved "Medicare telehealth services," which it updates annually. In the past few years, Congress and CMS have broadened the authority to offer telehealth based services both in Medicare FFS and in Medicare Advantage.

Medicare Advantage Coverage of Telehealth. Medicare Advantage plans have long been able to cover telehealth services beyond the list of "Medicare telehealth services" referenced above. However, such benefits have been covered as "supplemental," not "basic," benefits. "Basic" benefits are covered under Medicare Part A or Part B, as well as Medicare Advantage plans, who are required to cover such benefits. In contrast, "supplemental" benefits are optional benefits that MA plans may cover, with CMS's approval, in addition to "basic" benefits.

"Basic" and "supplemental" benefits are also financed differently. "Basic" benefits are included in the list of services that are covered by traditional Medicare; because all Medicare Advantage plans must cover these services, their cost is factored into the development of annual capitated payments that CMS pays to Medicare Advantage plans. "Supplemental" benefits, meanwhile, are other benefits that an MA plan can offer, but which must be paid for either with rebate dollars and/or quality bonus payment dollars, or with supplemental premiums paid by patients. Because charging or increasing premiums typically results in lower enrollment, plans are often selective offering supplemental benefits that require an additional premium.

What changed? Medicare Advantage plans can now cover telehealth services as "basic" benefits, though they are not required to do so. Pursuant to Section 50323 of the Balanced Budget Act of 2018, CMS has created a new category of telehealth services called "additional telehealth benefits." 42 C.F.R. § 422.135. In the rule, which was published in the Federal Register on April 16, 2019 (the "Final Rule"), "additional telehealth benefits" are defined as services "(1) [f]or which benefits are available under Medicare Part B but not payable [as Medicare telehealth services under 42 U.S.C. 1395m(m)] and (2) [t]hat have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange when the physician … or practitioner … providing the service is not at the same location as the enrollee." In other words, "additional telehealth benefits" are services that Medicare covers as "basic benefits," but in the FFS context would not be covered when delivered via telehealth because they do not satisfy the restrictions for coverage of "Medicare telehealth services" listed above. CMS is also requiring MA plans to confirm that a service can be provided via "electronic exchange" for it to be approved as an "additional telehealth benefit." "Electronic exchange" is broadly defined to mean "electronic information and telecommunications technology."

The Final Rule also states that Medicare Advantage plans will continue to be eligible to provide supplemental telehealth benefits, which it names "MA supplemental telehealth benefits," via remote access technologies and/or telemonitoring for services that are not normally covered by Medicare, and are therefore not "additional telehealth benefits." Medicare Advantage plans that choose to offer services via telehealth as "additional telehealth benefits" must ensure that the same services are also available to Medicare Advantage beneficiaries as "in-person" services, and that "additional telehealth benefits" can only be rendered by appropriately credentialed clinicians. Finally, clinicians who provide "additional telehealth benefits" must be contracted (i.e., "in-network") Medicare Advantage providers.

Analysis: Why this Matters for Providers

Typical Medicare reimbursement standards for "Medicare telehealth services" at 42 U.S.C. § 1395m(m) do not apply to "additional telehealth benefits" provided to Medicare Advantage beneficiaries. Thus, "additional telehealth benefits" can be provided to Medicare Advantage enrollees located anywhere geographically (not just rural areas), and in any originating site, including the home. This is a significant departure from traditional Medicare coverage of telehealth benefits, and one that could result in substantially higher utilization of telehealth services by Medicare beneficiaries.

However, because they would now be provided as "basic benefits" to Medicare Advantage beneficiaries, all Medicare Advantage requirements, such as provider credentialing and coverage appeals, will apply. As a result, even providers with deep experience in obtaining reimbursement from Medicare for telehealth services may face new requirements in obtaining coverage for "additional telehealth services" provided to Medicare Advantage beneficiaries.

Coverage as "basic" instead of "supplemental" benefits will encourage Medicare Advantage plans to expand telehealth coverage. Allowing Medicare Advantage plans to cover "additional telehealth benefits" as "basic benefits," rather than "supplemental benefits," means that MA plans will be paid for providing these services as part of their capitated payments from CMS. This change gives MA plans greater flexibility in their overall benefit design, particularly if an MA plan determines that its telehealth offerings will reduce its overall costs. Utilization of telehealth services among Medicare beneficiaries is historically quite low – CMS reported that just 90,000 Medicare FFS beneficiaries, or one quarter of one percent of eligible individuals, received services via telehealth in 2016[1] – a problem that could be remedied in part by this change, particularly as the share of Medicare beneficiaries in MA—now a third—continues to grow.

Medicare Advantage plans can provide more than "Medicare telehealth services" as "additional telehealth benefits." Historically, the only basic services eligible for Medicare payment when provided via telehealth were those set forth on the list of "Medicare telehealth services" maintained on the CMS website and updated on an annual basis. Under the Final Rule, however, Medicare Advantage plans are authorized to use telehealth to provide *any* service that Medicare typically covers, as long as the plan determines that it is clinically appropriate for the service to be provided via electronic exchange.

The Bigger Picture: Medicare Coverage of Telehealth

It is important to note that the changes introduced in the Final Rule in Medicare Advantage do not alter the status quo regarding Medicare FFS reimbursement of telehealth; conversely, the restrictions on Medicare reimbursement of "Medicare telehealth services" set forth at 42 U.S.C. § 1395m(m) (and summarized above) remain in effect for all services except those provided to Medicare Advantage enrollees. However, in the last few years, CMS has taken steps to embrace telehealth outside of the Medicare Advantage context, sometimes using creative solutions to expand coverage in spite of the limitations on Medicare telehealth services set forth in 42 U.S.C. § 1395m(m).

In the 2019 Physician Fee Schedule, CMS created a new set of services called "communication technology based services." By defining them as something other than "Medicare telehealth services," CMS ensured that these benefits are not subject to the requirements set forth at 42 U.S.C. § 1395m(m). As a result, all Medicare beneficiaries – both FFS and Medicare Advantage patients – can receive "virtual check-ins," "store-and-forward services," and "inter-professional consults" that do not satisfy the requirements for "Medicare telehealth services" at 42 U.S.C. § 1395m(m). In other words, these services can be provided to patients whether or not they are located in a rural area, and from any originating site, including the home.

Congress has also expanded Medicare beneficiaries' access to telehealth in 2018 and 2019. The Bipartisan Budget Act of 2018 added the home as an approved originating site for certain monthly services that patients with end stage renal disease require, added mobile stroke units as an approved originating site for telestroke services, and established a telehealth waiver eliminating the restrictions on "Medicare telehealth services" for patients enrolled in two-sided accountable care organizations ("ACOs") for agreement periods commencing on or after July 1, 2019. Congress also took action through the SUPPORT for Patients and Communities Act, adding the home as an approved originating site for Medicare patients receiving substance use disorder ("SUD") treatment, and requiring the DEA to establish a telemedicine registration process by October 2019 which will enable providers to prescribe controlled substances via telehealth without first examining a patient in-person (This change will also expand telehealth access for non-Medicare patients).

Together with the forthcoming changes to

[1] Centers for Medicare & Medicaid Services, "Information on Medicare Telehealth," Nov. 15, 2018.

Medicare Advantage coverage of telehealth set forth above, these changes suggest that CMS and Congress are both getting more comfortable with Medicare beneficiaries receiving telehealth services, and are chipping away at the restrictions set forth in 42 U.S.C. § 1395m(m) where appropriate. At the same time, as payment for telehealth to providers and plans grows, so will attention to program integrity and payment safeguards. In 2018 and 2019, Medicare, state Medicaid programs, and the Department of Justice have all demonstrated that they are applying greater scrutiny to telehealth programs. Therefore, legal and regulatory compliance is critically important in this rapidly developing space.

Hooper, Lundy & Bookman will continue monitoring the developing changes to Medicare's telehealth landscape. For further information, please contact Jeremy Sherer in Boston, Marty Corry in Washington, D.C., or Stephanie Gross in San Francisco.

Update for Healthcare Providers on Riverstone Capital LLC Liquidation Proceeding

By Eric Chan

A number of our clients have provided medical care to patients covered by the now-defunct Riverstone Capital LLC multiple employer welfare arrangement (the "Riverstone MEWA") and have still not been paid. This article offers an update on the liquidation proceedings in California federal court, and identifies steps that providers should take in order to protect their rights to payment in the coming months.

As background, Bakersfield, CA-based Riverstone Capital LLC was held after an investigation by the U.S. Department of Labor (DOL) to have mismanaged the Riverstone MEWA. Among other things, Riverstone failed to set adequate premiums, commingled funds, and charged excessive fees to over a hundred employers who hired Riverstone to provide healthcare benefits to their employees and dependents. Because there were insufficient assets to pay claims, Riverstone began to delay the payment of approved claims and "cherry-picked" which claims to pay. DOL found these actions to be serious violations of the Employer Retirement Income Security Act (ERISA), which governs the vast majority of the affected employers' participating plans.

On February 1, 2019, DOL filed a lawsuit against Riverstone and its principals. On February 9, 2019, Judge Michael W. Fitzgerald of the United States District Court for the Central District of California issued an order freezing the assets of the Riverstone MEWA and appointing an Independent Fiduciary (IF). After conducting an investigation, the IF determined that there were $36 million in processed, unpaid claims, but only $3.5 million in potentially available assets. Thus, the IF determined that the only path forward was to terminate the Riverstone MEWA and Participating Plans and proceed to liquidation.

Following notice to all affected parties, the IF caused the Riverstone MEWA and all participating employer plans to be terminated at 11:59 p.m. on March 8, 2019 as part of a consent judgment against Riverstone and its principals (the "Consent Judgment"). The Consent Judgment specifically enjoined "all hospitals, physicians, pharmacists, and other health care providers" pursuant to the All Writs Act, 28 U.S.C. § 1651, from seeking to collect or enforce legal rights against any patient covered by the Riverstone MEWA or any participating plan "related to any debt or to any claim for payment for medical or health care services."

The IF has now proposed an orderly plan of liquidation, to be approved by the Court, by which healthcare providers may present all outstanding medical reimbursement claims for payment. On Monday, April 29, 2019, Judge Fitzgerald held a hearing on the IF's proposal, as well as input from the affected employers. The Court then issued a lengthy minute order on Wednesday, May 1, 2019 that required the IF to make a number of changes to the liquidation plan before the Court will approve it.

Crucially, the Court recognized that, while the MEWA itself had insufficient funds in trust to pay the outstanding claims, each of the participating employer plans had established a "self-funded" plan with respect to its participation in the MEWA. Under ERISA, employers who establish self-funded plans are directly liable for medical costs incurred

under those plans. Thus, it is the employers who will ultimately pay the outstanding claims. (A number of employers claimed that they had "side deals" whereby Riverstone, not the employer, agreed to be financially responsible for all claims; both the Court and DOL have found those objections unavailing.) In the meantime, the All Writs prohibition ensures that providers do not also seek payment outside the process that is ultimately approved by the Court.

While no Final Liquidation Plan has yet issued, providers should consider taking the following steps:

- Ensure that all reimbursement claims for patients covered by plans affiliated with Riverstone are timely submitted to the appropriate Third Party Administrator (TPA). We understand that Hawaii Mainland Administrators and S&S Healthcare Strategies, Ltd. were the primary TPAs for Riverstone-affiliated claims. We have heard that Cigna may also have been involved in some capacity. (Of note, the IF originally proposed that providers be required to submit all claims no later than May 7, 2019, an imminent deadline. While the Court recited this part of the IF's proposal, it did not explicitly endorse it.)

- Prepare and maintain a list of all unpaid or underpaid patient claims that they believe relate to the Riverstone MEWA or participating employer plans thereunder.
- Ensure that all enforcement and collection activities against affected patients and employer plans are put on hold. Again, Judge Fitzgerald's most recent order makes clear that he intends to enjoin providers via the All Writs Act from seeking payment outside of the orderly liquidation process.
- After the Court approves the liquidation plan, the IF will send notices out to affected medical providers via both mail and e-mail. The IF will then make available a form on its website that will enable providers to submit a claim for payment against the Riverstone MEWA assets. Providers should be on the lookout for notice from the IF, and should consider whether to submit a form once it becomes available. (It is unclear at this time whether a provider must both submit their claims to the TPAs and submit a Proof of Claim form.)
- Be prepared to negotiate with individual employers regarding outstanding claims. The Court has indicated that employers may reach out to providers directly to negotiate payment amounts that are less than the full billed charges. For any claim paid at less than charges (setting aside patient responsibility), employers will also likely be required to obtain releases from the rendering providers.

We will keep you updated on further developments. If you have further questions, please contact Eric D. Chan in Los Angeles or your regular HLB contact.

Hooper, Lundy & Bookman's Linda Kollar Secures Pro Bono Immigration Victory

Abandoned at 4 years old, OS, now 17, has received his Permanent Resident card thanks to the unwavering support of partner Linda Kollar over the course of two years. The Alliance for Children's Rights asked Ms. Kollar to take on OS' case through the Special Immigrant Juvenile Status (SIJS) program. The case involved navigating the labyrinth of immigration laws, starting with a Petition for Evidentiary Findings in the Probate Court to the application process at Homeland Security.

Kollar said, "OS is a great kid and will graduate next month from Pasadena High with excellent grades. He is a fire fighter explorer, volunteers at a homeless shelter, is active in his church and plays soccer. Now he can apply for scholarships and financial aid for college and get a social security card. He plans to go to Pasadena City College and enroll in the firefighting program."

HLB is proud of the successful road OS now travels and for the wonderful advocacy of Linda Kollar.

Hooper, Lundy & Bookman Recognized Among the Top Health Law Firms in the United States by Chambers USA

Hooper, Lundy & Bookman is proud to announce that the firm has again been recognized in the 2019 edition of leading legal industry ranking publication Chambers USA among the best health care firms in the United States with top-rated lawyers nationally and in California and Washington, D.C. Chambers USA rankings are based on extensive research, including interviews with clients and members of the legal community.

The rankings distinguish the firm as one of the top two firms in California and among the top firms nationally and in Washington, D.C. Seven lawyers are ranked throughout the United States, including a new ranking for Managing Shareholder, Mark Reagan, and a jump in the ranking for D.C. partner Bob Roth.

Chambers describes the firm as an "outstanding healthcare boutique, with significant capability acting for both providers and suppliers across a range of complex and cutting-edge matters."

Clients describe the firm as "Just excellent….The expertise they have is so valuable and so specific," and "an excellent team of attorneys with extensive knowledge" with "vast experience across the country" who "always respond quickly, give us new insights and their arguments are very tight and convincing;"

Chambers USA has ranked the firm in the following categories:

Firm Rankings:
California Healthcare – Band 1
District of Columbia Healthcare – Recognized Practitioner
USA – Nationwide Healthcare – Band 3

Chambers USA also recognized the following HLB attorneys as top in the field of health law:

Nationwide HC Regulatory & Litigation:
Lloyd A. Bookman
Patric Hooper

Nationwide Transactional:
Robert W. Lundy

District of Columbia Healthcare:
Robert L. Roth

California Healthcare:
Lloyd A. Bookman
Patric Hooper
Robert W. Lundy
Steven Lipton
Charles B. Oppenheim
Mark Reagan

Hooper, Lundy & Bookman Congratulates Our 2019 District of Columbia Super Lawyers

Robert Roth, Partner
David Vernon, Rising Star, Associate

Super Lawyers is a rating service of outstanding lawyers from more than 70 practice areas who have attained a high-degree of peer recognition and professional achievement.

Partner Eric Chan Profiled by Los Angeles County Bar Association

Hooper Lundy & Bookman attorney Eric Chan profiled in the Los Angeles County Bar Association's Daily eBriefs in honor of Asian American and Pacific Islander Heritage Month.

Hooper Lundy & Bookman Proudly Supported the SCCLA 44th Anniversary Installation and Awards Banquet and its 2019 Honorees

CALENDAR

April 5-7	**2019 CSHA Annual Meeting & Spring Seminar, La Jolla, CA** Mark Reagan and Ben Durie presented *Emerging Trends in Post-Acute Care* Charles Oppenheim and Stephanie Gross presented *New Knox-Knee Licensure Regulations: A Sea Change?*
April 7-10	**HCCA 23rd Annual Compliance Institute, Boston, MA** David Schumacher presented *A Compliance Case Study from the Trenches with Current and Former DOJ Prosecutors*. Amy Joseph presented *Relationships in the Academic Medical Center Context: Anti-Kickback and Stark Law Issues.* Jeremy Sherer presented *Telehealth Contracting for Compliance Officers.* Mark Reagan presented *Will CMS Turn Down the Volume? Patient-Driven Payment Model (PDPM) and the Effort to Replace RUGs.* Charles Oppenheim presented *Hidden Treasure, or Hidden Kickback? If it Looks too Good to Be True, It Might Be an Anti-Kickback / Stark Violation.*
April 9	**HLB-Wolters-Kluwer Webinar Series (Part 2)** Bob Roth, Katrina Pagonis, Joe LaMagna, and Jeremy Sherer presented *The First Quarter is In the Books — What's In Store for the Rest of 2019*
April 9	**Los Angeles County Bar Association, Los Angeles, CA** Bridget Gordon and Robert Miller presented *Hello from the Other Side: What Litigators and Transactional Attorneys Wish the Other Knew*
April 10	**Massachusetts Senior Care Association Spring Conference, Boxboro, MA** Mark Reagan presented *Compliance Under PDPM: The New Frontier*
April 11	**Suffolk University Journal on Health and Biomedical Law Symposium 2019** Jeremy Sherer presented *Talking Telehealth: Exploring the Role of Technology in Healthcare*
April 12	**CAMSS Desert Chapter Annual Legal Conference 2019, Upland, CA** Jennifer Hansen presented *Handling the Disruptive or Dishonest Physician - From Credentialing to Peer Review*
April 18	**Hooper, Lundy & Bookman Webinar** Stephanie Gross and Charles Oppenheim present *A Regulatory Shift In Knox-Keene Licensing Requirement Takes Effect This Summer*
May 4	**Colorado Association of Medical Staff Services Spring Conference, Colorado Springs, CO** Katherine Dru presents *National Practitioner Data Bank Reporting Guidelines*
May 9	**California Association of Health Facilities, Garden Grove, CA** Mark Johnson presents *Discharge or Dumping: Nursing Home Law, Policy and Practice*
May 15	**HLB Post-Acute Partnership Webinar Series** Ben Durie and Stephanie Gross partner with ECG Management Consultants' Ken Steele and Dave Wofford to present *Strategies for Post-Acute Collaboration - Practical Advice for Approaching CMS Alternative Payment Models.*
May 22	**LeadingAge California Annual Conference, Monterey, CA** Mark Johnson presents *Are you prepared for Medicare Patient Driven Payment Model?*
May 22	**Stafford Webinars** Jennifer Hansen presents *Medicare Staff Challenges: Overcoming Conflicts Between Hospitals and Medical Staffs*
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 and Katherine Dru present *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 13-14	**CTeL Telehealth Spring Summmit 2019** Jeremy Sherer co-presents *Telebehavioral Health: Standards, Reimbursement and Interstate Practice.*

CALENDAR (CONTINUED)

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 and Amy Joseph co-present *Legal and Regulatory Issues in Telehealth.* Jeremy Sherer serves as a panelist on *Plenary Panel - National and Regional Telehealth Policy Perspectives: Key Trends and Considerations.*
July 9	**HLB-Wolters-Kluwer Webinar Series (Part 3)** Bob Roth, Joe LaMagna, Amy Joseph, Andrea Frey and Jeremy Sherer present *The First Half is In the Books — What's In Store for the Rest of 2019*
July 14-17	**CAHF Summer Conference, San Diego, CA** Mark Reagan and Jeremy Sherer co-present *Telehealth for SNFs* Mark Johnson and Scott Kiepen co-present *Fraud and Abuse Legal Update*
Nov 10-13	**CAHF Annual Conference, Palm Springs, CA** Mark Johnson presents

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