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AseraCare Court Confirms that Difference of Reasonable Clinical Opinion Cannot Alone Establish Objective Falsity in False Claims Cases

by Katrina Pagonis and Andrew Struve

SUMMARY

In United States v. AseraCare Inc., decided September 9, 2019, the Eleventh Circuit Court of Appeals ruled that a Medicare hospice claim cannot be deemed false under the federal False Claims Act (“FCA”) based only on a difference in clinical judgment. Instead, there must be proof of an objective falsehood.

The federal False Claims Act imposes treble damages and per-claim statutory damages on any individual or facility that knowingly presents a false or fraudulent claim to the government or who knowingly makes or uses a false record or statement material to a false or fraudulent claim.¹


AseraCare, the government contended that the hospice claims at issue were false because the defendant hospice providers had certified the patients as eligible for Medicare’s hospice benefits on the basis of clinical judgments that, in the view of the government and its experts, were erroneous, and the government sought $202 million in fines and penalties. Yet, the AseraCare court held that reasonable differences of opinion among physicians who have reviewed the same medical charts is not enough: “A properly formed and sincerely held clinical judgment is not untrue even if a different physician later contends that the judgment is wrong.”

HOSPICE CERTIFICATIONS AND OBJECTIVE FALSITY

The Medicare hospice benefit is unique in that a prerequisite for coverage and payment is a question of physician’s clinical judgment of the likeliness of future events. Specifically, in order for a hospice claim to be eligible for Medicare reimbursement, a physician must “certify in writing at the beginning of [each] period, that the individual is terminally ill . . . based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness.”² “Terminally ill” means that the individual has a medical prognosis that the individual’s life expectancy is 6 months or less if the illness runs its normal course.³

Physicians, of course, are neither soothsayers nor seers, and CMS itself has recognized this, cautioning that “[p]redicting life expectancy is not an

Appeals adopted in the new AseraCare court’s reasoning and decision. AseraCare presented the unhappy circumstance in which the government’s experts opined that the Medicare hospice claims at issue were not supported by sound medical judgment, whereas the defense strongly disagreed. The jury found for the government, but the trial court overturned the verdict as a matter of law, and ruled in favor of the physicians.

In reasoning which the Court of Appeals adopted in the new AseraCare decision, the court explained that “If... all the Government needed to prove falsity in a hospice provider case was one medical expert who reviewed the medical records and disagreed with the certifying physician, hospice providers would be subject to potential FCA liability any time the Government could find a medical expert who disagreed with the certifying physician’s clinical judgment.” Hence, the court ruled, reasonable differences of opinion among physicians who have reviewed the same medical charts is not enough: “A properly formed and sincerely held clinical judgment is not untrue even if a different physician later contends that the judgment is wrong.” Instead, the law simply requires that “physicians exercise their best judgment in light of the facts at hand and that they document their rationale.”

Accordingly, in order to properly state a claim under the FCA in the context of hospice reimbursement, a plaintiff alleging that a patient was falsely certified for hospice care must identify an objective and knowing falsehood. Because a difference in clinical opinions does not constitute an objective falsehood, jurors should therefore be instructed that “the mere difference of reasonable opinion between physicians, without more, as to the prognosis for a patient seeking hospice benefits does not constitute an objective falsehood.” The court provided the following examples of situations in which the objective falsity of a clinical judgment could be established: (1) the certifying physician fails to examine the underlying medical records, (2) the certifying physician did not subjectively believe that the patient was terminally ill, or (3) if expert evidence proves that no reasonable physician could have concluded that a patient was terminally ill.

**FURTHER PROCEEDINGS IN ASERACARE**

Although the Eleventh Circuit affirmed the district court’s determination that a difference of clinical judgment alone cannot establish the required objective falsity for False Claims Act liability, the court overturned the district court’s grant of summary judgment for AseraCare because the district court had erred in only considering evidence presented on falsity at the bifurcated trial. The trial in this case was relatively rare in that it was bifurcated, with evidence of the defendant’s knowledge of falsity reserved for the second phase of the trial. At the time of the trial, the district court had declined to apply the “reasonable physician” standard to the falsity analysis. Thus, the government had reserved evidence concerning alleged flaws in AseraCare’s certification procedures for the second phase of the trial. Against this backdrop, the Eleventh Circuit concluded that the government should have been entitled to use this additional evidence to attempt to demonstrate a genuine issue of material fact on objective falsity.

Although the court vacated the grant of summary judgment, it explicitly noted that the government might not succeed in persuading the district court that triable issues remain on the issues of objective falsity and knowledge. The court noted that the record "raises questions regarding AseraCare's certification process writ large. But crucially, on remand the Government must be able to link this evidence of improper certification practices to the specific 123 claims at issue in its case." Thus, if the parties do not settle the case, the district court will need to evaluate whether summary judgment is appropriate on the broader evidentiary record and then, if triable issues remain, hold a new trial.

**COMMENTARY**

The Eleventh Circuit’s articulation of the objective falsity standard is sensible and avoids potential barriers to critical palliative, end-of-life care. If the law were to allow potential False Claims Act liability in situations where reasonable professional minds could differ as to whether a given patient was “terminal” within the meaning of the Medicare standard, such a rule could easily have a chilling effect on access to hospice care, resulting delays of entry into hospice, or worse. Put another way, to allow FCA liability in such cases would be a cure far worse than the disease.

The biggest question that remains is how widely the AseraCare decision will be applied. The court went to great lengths to confine this standard to the particular eligibility requirements for hospice benefits, including by

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6 False Claims Act liability can be very harsh, as the monetary penalties can total three times of amount of the claim, plus fines of $11,181 to $22,363 per claim, in addition to legal fees that accrue over lengthy investigations and litigation. The underlying case in AseraCare began more than a decade ago with a 2008 complaint filed by three former AseraCare employees."
noting that CMS and Congress placed the “physician’s clinical judgment at the center of the inquiry” concerning hospice eligibility. With respect to proof of the exercise of clinical judgment, the court noted that the relevant regulation requires only that the supporting documentation “accompany the certification” and “be filed in the medical record.” Yet there are myriad other contexts, outside of hospice, that carry similar needs for the exercise of professional judgment, and similar certification and documentation requirements, for example with respect to claims for skilled nursing services. There appears no logical reason why fundamental fairness, the rule of lenity, and the interest of preventing barriers to care would not require that the AseraCare rule apply with equal force in those contexts as well.

For more information, please contact Andrew Struve or Mark Johnson in San Diego, Mark Reagan, Scott Kiepen, Katrina Pagonis or Jordan Kearney in San Francisco, Patric Hooper in Los Angeles, or your regular Hooper, Lundy & Bookman contact.

Medicare Bad Debts — New Requirements Concerning “Sub-ledgers” Violate Longstanding Practices

by Arthur Peabody and Robert Roth

According to some MACs, the maintenance of a bad debt sub-ledger to record a patient’s bad debt after the reasonable collection effort required by PRM 15-1 § 310 has been completed, and the account has been reduced to zero on the General Ledger, means that the hospital has not “written off” the bad debt and ceased all efforts to collect the debt. Some MACs are adjusting hospital bad debts because the provider has not reduced all sub-ledger accounts to zero – notwithstanding entries of “zero” on the General Ledger.

These bad debt adjustments are inconsistent with the purpose of a sub-ledger, which is to document the bad debt so that any future recovery of the patient’s debt can be properly recorded.

This practice violates the Medicare statute’s requirement for notice and comment rulemaking; cannot be applied retroactively; and is inconsistent with longstanding precedent defining the requirements of a reasonable collection effort mandated by 42 C.F.R. § 413.89(e)(2) and PRM 15-1, § 310.

HLB is prepared to assist hospitals in the appeal of adjustments made applying these policies and to recommend improvements to a hospital’s debt collection policies to ensure compliance with applicable requirements.

For more information, please contact Robert Roth or Arthur Peabody in Washington D.C., or your regular Hooper, Lundy & Bookman contact.
The Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (HHS), issued two notices of proposed rulemaking (“NPRMs”) last week. The NPRMs relate to the federal regulations governing the confidentiality of health information in federally-assisted substance use disorder (SUD) programs, found in 42 CFR Part 2 and known as “Part 2.” These two rules are the most significant revision to Part 2 since SAMHSA issued a final rule in January 2018 (our summary can be found here), and provide guidance and clarification for Part 2 programs and lawful holders regarding permitted disclosures, with and without patient authorization.

Under current regulations, Part 2 generally requires a federally-assisted SUD program to obtain a patient’s consent before disclosing his or her identifying information outside of the program, including disclosures to other health care providers. However, in an effort to address one of the largest drug crises in the nation’s history, SAMHSA, along with HHS and the U.S. Department of Justice (DOJ), has determined that the prompt revision of Part 2 is necessary. The NPRMs are part of the Administration’s “Regulatory Sprint to Coordinated Care,” which also includes proposed rulemaking to update other laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA), the federal physician self-referral law (the Stark Law), and the anti-kickback statute.

In connection with the release of the Part 2 rulemaking, HHS Secretary Alex Azar said that the agency believes it is not authorized to fully align Part 2 with HIPAA and supports action by Congress to improve data sharing for better opioid response. After legislation for this alignment failed to be included in the final opioids package passed last year under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, bipartisan legislation has been introduced in both chambers to align 42 CFR Part 2 with HIPAA’s patient privacy protections. The Overdose Prevention and Patient Safety Act (H.R. 2062), which passed the House of Representatives last year, was introduced by Reps. Earl Blumenauer (D-OR) and Markwayne Mullin (R-OK) and the Senate companion, the Protecting Jessica Grubb’s Legacy Act (S. 1012) was introduced by Sens. Joe Manchin (D-WV) and Shelley Moore Capito (R-WV). Many provider groups support this legislation, while substance abuse advocates have raised concerns due to privacy protections. Discussion on possible Congressional action following the release of these rules will likely continue when Congress returns in September.
Below follows a brief summary of the major provisions in the two NPRMs.

**PROPOSED DEFINITIONAL CHANGES**

(42 C.F.R. §§ 2.11, 2.12, 2.32)

To start, the proposed rule modifies the definition of what constitutes a “record” and the “applicability” of Part 2 in an effort to give health care providers clarity about what information is subject to Part 2’s protections and to ensure non-Part 2 providers are not discouraged from coordinating or communicating with Part 2 programs or recording SUD information out of concern of inadvertently violating Part 2’s heightened confidentiality requirements. Specifically, the proposed rule would amend the definition of records to note that “information conveyed orally by a part 2 program to a non-part 2 provider for treatment purposes with the consent of the patient does not become a [part 2 record] … in the possession of the non-part 2 provider merely because that information is reduced to writing by that non-part 2 provider.” Additionally, the proposed rule goes on to clarify that a non-Part 2 treating provider’s act of recording SUD information in a patient’s medical record when disclosed willingly by the patient would not be subject to Part 2. However, any SUD patient records originating from a Part 2 program remain subject to the existing rule’s prohibition on redisclosure and must be segregated from the patient’s general medical records when received by a non-Part 2 provider (unless orally received, as discussed above). SAMHSA notes that by segregating records received from a Part 2 program, non-Part 2 providers can ensure that new records (e.g., a treatment note based on a direct clinical encounter with the patient) created by during their own patient encounters would not become subject to Part 2.

**PROPOSED CONSENT FORM CHANGES**

(42 C.F.R. § 2.31)

The proposed rule also simplifies how patients can send their SUD records to entities or agencies without a treating provider relationship. The existing regulations under Section 2.31 require patients to identify a specific person as a recipient within an entity to receive their SUD records when consenting to such disclosure. As a result, patients often struggle applying for and receiving non-medical services and benefits from governmental agencies such as the Social Security Administration or non-governmental agencies including local sober living or halfway house programs, because they are unable to designate a specific employee to receive their SUD information on behalf of the named entity. Under the proposed rule, patients would no longer need to specify an individual person, but rather may provide consent for the entity as a whole on the “to whom” section of a consent form for disclosure of their SUD records. In doing so, SAMHSA notes that it hopes to “empower patients to consent to the release and use their health information in whatever way they choose.”

**PROPOSED AUTHORIZED DISCLOSURE CHANGES**

Payment and Health Care Operations (42 C.F.R. § 2.33). Under the current Part 2 regulations, lawful holders of Part 2 records are permitted to further disclose such records to contractors, subcontractors, and legal representatives, for the purpose of payment and certain health care operations. In an effort to provide further clarity regarding the scope of permitted disclosures in this context, SAMHSA proposed to add an illustrative (not exhaustive) list of permissible activities that are considered to be payment and health care operations activities. For example, this list includes activities such as billing and claims management, quality assessment, and business management and general administrative activities. However, SAMHSA also emphasizes that this provision is not intended to cover care coordination or case management – a significant difference from the broader definition of health care operations under HIPAA – emphasizing the importance of patient choice in disclosing information to health care providers with which they have direct contact.

Central Registries and Prescription Drug Monitoring Programs (42 C.F.R. §§ 2.34, 2.36). SAMHSA recognizes that, given the opioid epidemic, it is important for all providers that work with SUD patients, including non-opioid treatment program (non-OTP) providers, to access information in central registries to prevent duplicative enrollment, as well as to inform prescription decisions as part of a plan of care. Currently, the regulations permit a central registry to disclose certain patient information when asked by a “member program” whether the patient is enrolled in another member program, but central registries are not permitted to disclose to non-OTP providers. The proposed rule would expand the scope of Section 2.34 to permit disclosure of certain patient information to all treating providers on request, for purposes of informed decision-making and coordination of care.

Similarly, given the opioid epidemic, SAMHSA recognizes the value of opioid treatment program (OTP) providers disclosing patient identifying information to a prescription drug monitoring program (PDPM) for greater patient safety, treatment, and care coordination among a patient’s providers. SAMHSA proposed to add a new section, Section 2.36, to permit OTPs and other lawful holders...
to disclose data to PDPMs when dispensing medications upon prior written consent of the patient.

**Medical Emergencies (42 C.F.R. § 2.51).** SAMHSA proposed permitting a Part 2 program to disclose patient identifying information to medical personnel without patient consent in the event that a state or federal authority declares a state of emergency and the Part 2 program is closed and unable to provide services or obtain the patient’s informed consent (in addition to the current ability to disclose such information in the event of a bona fide medical emergency). SAMHSA emphasizes that patient consent should be obtained if possible, but recognizes that in the event of a state of emergency, such as a hurricane or earthquake, obtaining patient consent may not be feasible and the inability of patients to access needed care through their usual providers can itself lead to a medical emergency.

**Research (42 C.F.R. § 2.52).** Currently, Part 2 programs are permitted to disclose patient identifying information for research without patient consent under limited circumstances. In particular, Part 2 programs may disclose patient identifying information where the recipient is a HIPAA covered entity or business associate with a valid authorization from the patient or waiver or alteration of authorization in compliance with HIPAA, or the recipient is subject to HHS regulations regarding the protection of human subjects in research (otherwise known as the Common Rule), including informed consent requirements, or the research meets an exemption to such regulations. However, SAMHSA acknowledges the current rules limit other legitimate stakeholders from obtaining data for research purposes, and it was not SAMHSA’s intent to do so.

In order to more closely align the research disclosure provisions under Part 2 with HIPAA and the Common Rule, SAMHSA proposed to expand the applicable provision to allow research disclosures to individuals and organizations that are neither HIPAA covered entities nor subject to the Common Rule, so long as the data is disclosed in accordance with the HIPAA Privacy Rule provisions governing disclosures for research purposes. SAMHSA proposed to clarify that this data may be disclosed to workforce members of HIPAA covered entities for purposes of employer-sponsored research, and proposed to permit research disclosures to recipients of FDA regulations for the protection of human subjects in clinical investigations (some research studies may fall under the FDA regulations but not the Common Rule).

**Audit and Evaluation (42 C.F.R. § 2.53).** Under the current regulations, disclosures by Part 2 programs or other lawful holders are permitted to individuals and entities who are performing the audit or evaluation on behalf of certain governmental agencies, third-party payers, quality improvement organizations, and under certain circumstances, others determined qualified to conduct an audit or evaluation of the Part 2 program or lawful holder, assuming certain conditions are met. Different rules apply depending on the context, including whether the records will be reviewed only on the premises of the Part 2 program or other lawful holder or removed from the premises (or transferred to another electronic system or device).

SAMHSA clarifies that this data may be disclosed to an “entity that has direct administrative control over the program.” SAMHSA also clarifies that the terms “audit” and “evaluation” include reviews to determine whether patients are receiving appropriate services in an appropriate setting, such as in the context of a licensing or certification survey to ensure compliance with applicable laws. Another helpful clarification is with respect to disclosures to an “entity that has direct administrative control over the program” from the following permitted disclosure under Section 2.63(a)(2):

> investigation or prosecution of an extremely serious crime allegedly committed by the patient, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect...

This phrase was previously added in the 2017 final rule, however, SAMHSA believes that this language may have been misinterpreted and the cause of interference with investigation and prosecution of opioid-related crimes...
allegedly committed by individuals other than patients. Thus, SAMHSA proposed to remove this additional language.

Undercover Agents/Informants (42 C.F.R. § 2.67)
Section 2.67 has generally prohibited the placement of undercover agents or informants in a Part 2 program except as specifically authorized by a court order for the purpose of investigating a Part 2 program, or its agents or employees, for allegations of serious criminal misconduct. In the current rule, the time limitation for the period of placement for undercover agents and informants pursuant to a court order is set at 6 months. SAMHSA has determined, in consultation with DOJ, that this may be burdensome on some ongoing investigations.

Thus, the agency proposed to extend the period for court-ordered placement of an uncover agent or informant to 12 months (starting when the agent is placed or an informant is identified), while authorizing courts to further extend a period of placement through a new court order.

Disposition of Records (42 C.F.R. § 2.19)
Finally, SAMHSA has also provided further guidance on how employees, volunteers, and trainees of Part 2 programs should handle communications with patients on personal devices and accounts. In Section 2.11, records are currently defined to include information related to a patient in email and texts. Further, Section 2.19 requires that all records which are electronic must be “sanitized” within one year of the discontinuation of any Part 2 program. Read together, these two sections could be interpreted to require that personal phones or accounts need to be sanitized and thus may no longer be usable. SAMHSA has clarified that this is not its intent.

Instead, SAMHSA recognizes that patient communication may take place through personal accounts or devices of employees or volunteers or trainees. SAMHSA has clarified in the NPRM that employees, volunteers and trainees should immediately delete any patient identifying information from their personal accounts or devices and respond via authorized Part 2 program channels, unless responding from the personal account is in the patient’s best interest. SAMHSA further clarified that if any communications contain patient identifying information, the communications should be forwarded to Part 2 authorized channels and then deleted from personal accounts and devices.

For more information, the NPRMs are available at 84 Federal Register 44568 (Aug. 26, 2019) and 84 Fed Register 44566 (Aug. 26, 2019); HHS has also issued a fact sheet on the NPRMs as well. SAMHSA will be soliciting comments regarding the proposed rules until October 25, 2019.

For more information, please contact Alicia Macklin in Los Angeles, Amy Joseph in Boston, Andrea Frey or Paul Smith in San Francisco, Monica Massaro in Washington, D.C., or your regular Hooper, Lundy & Bookman contact.
Congressional

HOUSE DEMOCRATS INTRODUCE DRUG PRICING LEGISLATION

On September 19, the Lower Drug Costs Now Act of 2019 (H.R. 3) was formally introduced, led by Speaker Nancy Pelosi (D-CA) and Chairmen of the relevant Committees of jurisdiction as the latest legislation to manage drug prices. The legislation would allow for negotiation of prices on at least 25 of the highest cost medicines. Drugs would be chosen based on their costs and utilization and must not have generic or biosimilar competition. In the bill, the maximum price would be tied to comparisons with six other countries. The bill will be discussed this week during two Committee hearings. This legislation joins the large number of alternative bills that have been introduced in recent months including the Prescription Drug Pricing Reduction Act (PDPRA) of 2019 passed by the Senate Finance Committee in July which is intended to be combined with the Senate Health, Education, Labor & Pensions (HELP) Committee’s Lower Health Care Costs Act of 2019 which includes price transparency, surprise billing and health information exchange. Now that Congress has returned from recess, Committees will be reengaged on this issue to move something forward in the coming months, but it is unclear what ideas may make it into the final package.

HOUSE PASSES CR WITH HEALTH CARE EXTENDERS

On September 19, the House of Representatives passed a continuing resolution (CR) to fund the government through November 21 in order to continue negotiations on appropriations. In addition to funding the government past September 30, several expiring health care extenders were added that were due to expire this month, but now are delayed until Nov 21, including Community Health Centers, Medicaid in Puerto Rico and the U.S. territories, Demonstration Program for Certified Community Behavioral Health Clinics, the Special Diabetes Program, and a short-term delay of Medicaid DSH cuts, amongst others. The CR is expected to pass the Senate this week to be signed by the President before current funding runs out on September 30. Meanwhile, Senate appropriators continue to work on their bills, delaying a markup on the Labor-Health and Human Services appropriation bill following disagreements over abortion language.

Administration

CAR T THERAPY COVERAGE ANNOUNCED

On August 7, the Centers for Medicare and Medicaid Services (CMS) announced its national coverage determination (NCD) to cover FDA-approved cancer treatment, Chimeric Antigen Receptor T-cell (CAR T-cell) therapy.

ET3 MODEL APPLICATION PERIOD EXTENDED

The Center for Medicare and Medicaid Innovation (CMMI) has announced it will extend the application deadline for the Emergency Triage, Treat, and Transport (ET3) Model to October 5, 2019 through their online application portal. Additional information and FAQ for the model can be found here.

DEADLINES TO KNOW

September 27: Physician Fee Schedule, OPPS, and ESRD PPS Proposed Rule Comments

October 5: ET3 Applications due (Deadline Extended)
Amy advises health systems, academic medical centers, teaching hospitals, and a wide variety of other health care providers on business and regulatory matters. A significant portion of her practice is focused on fraud and abuse compliance, including counseling on compliance with federal and state anti-kickback and self-referral laws, and serving as lead deal counsel or regulatory counsel on mergers, acquisitions, and other strategic affiliations. She also counsels providers and health information technology companies in the digital health space, including compliance and reimbursement issues related to digital health.

Amy co-chairs the firm’s Academic Medical Center/Teaching Hospital Working Group and is a member of the firm’s Fraud & Abuse Practice Group. She is co-author of AHLA’s The Stark Law: Comprehensive Analysis and Practical Guide, Sixth Edition, co-author of a chapter of AHLA’s Best Practices Handbook for Advising Clients on Fraud and Abuse Issues, co-author of the telemedicine chapter of ABA’s Physician Law: Evolving Trends & Hot Topics, and regularly presents and writes on these topics.

Prior to practicing law, Amy served in the United States Air Force.

Why did you choose the field of health law?
Unlike some of my HLB colleagues, I did not have a background in the healthcare field prior to attending law school. During law school, I was particularly drawn to health law as an area of interest. From a policy perspective, I viewed it as an incredibly important and interesting area, and one that has a direct impact on lives in a way that many other specializations do not. I also viewed it as an opportunity to specialize in a field that would be continually evolving and changing, and therefore intellectually challenging. That has all proven true, and I am thankful to have such an interesting career with such fantastic colleagues.

How has your practice evolved in the last five years?
Five years ago, my practice was focused on transactional work and privacy and security compliance. While I still engage in transactional work, over time my practice has shifted, and I find I spend much of my days advising clients on regulatory compliance, with a particular focus on fraud and abuse, privacy and security, and research compliance. I engage in this work both in assisting clients to proactively structure new business initiatives, affiliations, and transactions, as well as in assisting clients with internal investigations and compliance assessments. Given my transactional background, I like to think I bring a helpful perspective in understanding the interplay between business strategy and regulatory compliance and in seeking practical solutions that meet both objectives.

What’s the most interesting thing you’re working on right now?
I have a number of interesting projects I’m working on at the moment. I am currently engaging in a few compliance assessments for various health systems and other large provider organizations related
to financial relationships with various physicians (both ownership and compensation arrangements), which involve nuanced questions regarding applicability of the Stark law. I have also been advising multiple clients recently on applicability of 42 CFR Part 2, the federal Substance Abuse Confidentiality Regulations, and we are closely tracking developments in that area, including the recently released proposed rule and potential for Congressional action.

What’s your secret talent that no one knows about?
I wouldn’t call it a talent, but I have been studying classical guitar. The rest of my family plays at a higher level. My husband has worked as a professional guitarist and my kids have been studying guitar since age three. My eight year old loves to remind me that I am nowhere close to keeping up with her, despite my best efforts, which is true. However, there is something therapeutic about practicing scales at the end of a long day, and it brings me joy to make music with the family. Maybe one day this talent will not be so “secret” if I can get up the nerve to play in public.

FIRM NEWS

Things happening at Hooper, Lundy & Bookman

HLB SPONSORS THE AMERICAN HEART ASSOCIATION’S STEM GOES RED PROGRAM

HLB sponsored the STEM Goes Red program, which is aimed at inspiring the next generation of women STEM leaders. Over 100 Los Angeles County high school juniors are immersing themselves in the STEM field through the American Heart Association’s enrichment program. On September 20, students joined current STEM leaders and others in the health care field for a mentor luncheon and friendly STEM-themed competition – The Red Beaker Challenge.

LET’S PLAY BALL!

Partner Mark Johnson throws out the first pitch at the San Diego Padres Game on September 26, 2019.

Left to right: Bob Lundy, Krisianna Bock (HKS Architects), Charles Oppenheim, Brett Moodie, Front Center: Sandi Krul

Mark Johnson, Partner
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<tr>
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<tr>
<td>September 12-13</td>
<td>The Healthcare Roundtable for Chief Compliance Officers, San Diego, CA&lt;br&gt;Jeremy Sherer presents <strong>Telehealth Contracting for Compliance Officers</strong></td>
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<tr>
<td>September 26</td>
<td>Wolters-Kluwer&lt;br&gt;Katrina Pagonis, Nina Marsden, and David Vernon present <strong>FY 2020 IPPS Final Rule</strong></td>
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<td>October 8</td>
<td>HLB-Wolters-Kluwer Webinar Series (Part 4)&lt;br&gt;Bob Roth, Kelly Carroll, Monica Massaro and Alicia Macklin present <strong>Looking Back and Looking Ahead — What's In Store for the Rest of 2019</strong></td>
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<td>October 15</td>
<td>Northeast Regional Telehealth Conference&lt;br&gt;Jeremy Sherer co-presents <strong>Consumer Protection in Telehealth and Artificial Intelligence</strong></td>
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<td>October 17</td>
<td>Los Angeles County Bar Association 16th Annual Healthcare Compliance Symposium, Los Angeles, CA&lt;br&gt;Stephanie Gross presents <strong>Understanding the New Knox-Keene Regulations</strong>&lt;br&gt;Charles Oppenheim presents <strong>Anti-Kickback and Stark Law Primer</strong>&lt;br&gt;Jeremy Sherer presents <strong>Navigating the Telehealth Compliance Minefield</strong></td>
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<td>October 22-23</td>
<td>HLB Managed Care Seminar, Los Angeles and Berkley, CA&lt;br&gt;Hooper, Lundy &amp; Bookman hosts <strong>Managed Care 2019 Update</strong></td>
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<td>November 5</td>
<td>HCCA's 5th Annual Healthcare Enforcement Compliance Conference, Washington, DC&lt;br&gt;Charles Oppenheim presents, <strong>Ask the Stark Law Professionals</strong></td>
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<td>November 8</td>
<td>MHA Conference Center, Burlington, MA&lt;br&gt;David Schumacher moderates the State and Federal Enforcement Priorities and Trends Panel&lt;br&gt;Amy Joseph and Charles Oppenheim present Stark &amp; Kickback: &quot;Recent Developments and Practical Compliance Tips”</td>
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<td>November 10-13</td>
<td>CAHF Annual Conference, Palm Springs, CA&lt;br&gt;Mark Johnson and Scott Kiepen present <strong>Transfer/Discharge Law for Skilled Nursing Facilities</strong></td>
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<td>December 3</td>
<td>HLB Fraud and Abuse Seminar, Los Angeles, CA</td>
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<td>Hooper, Lundy &amp; Bookman hosts Health Care Fraud and Abuse Update 2019</td>
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<td>December 5</td>
<td>Center for Telehealth and eHealth Law (“CTeL”) Fall Summit, Washington, DC</td>
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<td></td>
<td>Jeremy Sherer presents <a href="#">Telehealth and Long-Term Care</a></td>
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Which monument was reserved a prominent space in Washington D.C. as the city was originally being laid out.

[Click here](#) for the answer.