HEALTH LAW CONNECTIONS

OFFICIAL MAGAZINE OF AMERICAN HEALTH LAW ASSOCIATION

MAY 2020 Volume 1 | Issue 2

ARE **PRACTICE LOSSES** ALWAYS BAD?

ABSOLUTELY NOT! (AND CMS AGREES) *Page 4*

30 YEARS AFTER THE ADA: DISABILITY DISCRIMINATION IN HEALTH CARE UNDER SECTION 1557 OF ACA *Page 12*

ANNUAL MEETING PREVIEW *Page 18*

AMERICAN HEALTH LAW ASSOCIATION

Educating and Connecting the Health Law Community

Let Us Be Your Data's Primary Care Provider.

JND | eDISCOVERY

JND eDiscovery provides healthcare litigation support and cost-effective managed eDiscovery services to health system and healthcare organization clients nationwide. Modernize your approach to litigation planning, simplify operations and reduce your litigation technology spend by partnering with us today.

- ✓ Healthcare Litigation Planning
- ✓ Forensic eDiscovery Consulting
- ✓ ESI Collection and Preservation
- ✓ Data Processing and Analytics
- ✓ Hosted Review
- ✓ Production
- ✓ Managed Services

Chris Raps
Director of Sales - Healthcare
Chris.Raps@JNDLA.com
(651) 260-7348

www.JNDLA.com/eDiscovery

Collegiality and Community

Robert R. Niccolini
President, FY20
robert.niccolini@ogletree.com

As I write this, it is the beginning of April, and my family and I are in the third week of a shelter-at-home order in Maryland. As you read this, I sadly anticipate that the number of COVID-19 deaths will have increased exponentially, with an impact on our country that most of us would have considered utterly unimaginable at the start of the year. We had all anticipated that this new decade would bring rapid change, but 2020 has already brought us challenges and tragedy that almost no one saw coming.

I have written quite a lot in this column over the last year about the accelerating pace of change faced by health law professionals, as well as the future of health law itself. These are urgent issues that directly led us to change our name to the American Health Law Association, in order to best position the Association for the continuing evolution of both the health law and health care industries. But as we face and adapt to these changes, and most especially considering the current crisis, it is critical that we remain grateful for and committed to what has always made AHLA great: collegiality and community.

I have always been proud that collegiality is built directly into the mission statement of AHLA, with a focus on providing "a collegial forum for interaction and information exchange." Various segments of our membership may sometimes find themselves in competition with one another, whether for clients or opportunities. But despite that reality, our leaders and members have always remained committed to helping each other provide not only the answers to challenging questions, but the best service possible for our clients, through in-person sessions, webinars, and publications. At all times, we remain friends and colleagues above all.

From that commitment flows what I believe is the second foundation of our Association: community. Whether in practice groups or at in-person programs, while attending social functions or convener sessions, AHLA offers health law professionals the ability to form connections with their colleagues, as well as a professional and personal system of support. These interactions are crucial to our development and well-being, and their vital importance becomes especially clear during a crisis like this.

As COVID-19 spreads, it has been amazing to watch our members step forward to support one another and exchange crucial information. It started with the Coronavirus Pandemic Hub, where members lent their expertise to review the shifting landscape of legislation and liability and ensured that the entire health law community remained updated on new developments. Next, members began to provide updates through webinars and podcasts, finding time to share their talents and expertise to ensure that our community remained abreast of the latest changes. Then, the COVID-19 Discussion and Resources Community was created to help facilitate discussion among our members, expanding on the information exchange and support already occurring throughout AHLA's online communities, not to mention the personal connections forged by members over the years. Again, even in the face of crisis, we remain friends and colleagues above all.

As I observed all these amazing interactions and cooperation between our members, I was reminded of the words of Coretta Scott King: "The greatness of a community is most accurately measured by the compassionate efforts of its members." By any measure, the AHLA community is strong, as we help each other to weather and overcome this crisis. And I have no doubt that we will emerge even stronger on the other side.

Stay well and stay safe.

Contents

Are Practice Losses Always Bad? Absolutely Not! (and CMS Agrees)
Albert "Chip" Hutzler, HORNE Healthcare

30 Years After the ADA: Disability Discrimination in Health Care Under Section 1557 of ACA
Andrew C. Stevens, Arnall Golden Gregory LLP

Executive Vice President/CEO: David S. Cade
Publisher: Rob Anderson
Director of Member Publications: Lisa Salerno
Editor in Chief: Ana Greene
Creative Director: Mary Boutsikaris
Graphic Designer: Jen Smith
Senior Managing Editor: Bianca L. Bishop
Associate Editor: Matt Ausloos

HEALTH LAW CONNECTIONS
1620 Eye Street NW, 6th Floor,
Washington, DC 20006-4010
202.833.1100
connections@americanhealthlaw.org
www.americanhealthlaw.org/connections

ADVERTISING INQUIRIES
Samantha Roesler, MCI Group
410.584.1996
samantha.roesler@mci-group.com
www.ahla-mediaplanner.com/

Coker GROUP

Business Advisors for the Healthcare Industry

STRATEGY
OPERATIONS
FINANCE
TECHNOLOGY
COMPLIANCE

A trusted advisor for over 30 years, **Coker Group** has the right solutions for your healthcare organization

---

COKERGROUP.COM | 2400 LAKEVIEW PARKWAY, SUITE 400, ALPHARETTA, GA 30009 | 800.345.5829

Feature

Are Practice Losses Always Bad? Absolutely Not! (and CMS Agrees)

Albert "Chip" Hutzler,
HORNE Healthcare

Health care costs money: lots of money. Costs are so high that many countries effectively recognize that health care is not sustainable as an independent industry, and so these countries instead subsidize health care costs through various forms of socialized medicine. Meanwhile, in the United States, while governments also pick up much of the tab for health care costs (particularly for older and lower-income citizens), certain stakeholders continue to operate under the ongoing illusion that physician practices must be profitable to justify the magnitude of payments to the physicians employed by those practices. The government[1] and others continually cite practice losses to argue that physicians have been overcompensated in violation of health care law. This article proposes that physician practices need not always be profitable for physician payments to be defensible as fair market value (FMV) and commercially reasonable.

To be clear, many medical practices are profitable or at least break even; however, survey data show that many others are not profitable (primarily those owned by health systems and other similar entities).[2] It is not uncommon for physicians to take the position that they should be paid compensation consistent with the market for services rendered, regardless of the profitability of those services for their employer. It is certainly true that a physician working at a highly profitable practice who is paid in part based on the profitability of that practice may be in a position to earn higher compensation than comparable physicians working at less profitable practices. Yet, this article asserts that the converse is not true: a lack of profitability should not necessarily mean that a physician must earn below market rates for comparable physicians in the same specialty.

Critics of this position suggest that all physician practice losses are problematic, basing this contention primarily on the following three claims:

1. Physicians in private practice never seem to lose money—they always break even or make money;
2. Survey data are misused by health systems in setting compensation at levels where practices will lose money; and
3. Employers lack fiscal responsibility regarding profits, and only are willing to run losses on employed physicians primarily to secure the lucrative referrals of technical services from the physicians (potentially in violation of health care laws).

Each of these claims are discussed in detail below.

Claim 1: Private Practitioners Never Lose Money

Arguments that hospital-owned practices should behave similarly to private practices ignore many aspects of physician practices. First, private practices that are not profitable have no way to stay in business for the long term, so it is no surprise they are not represented in the survey data, whereas a hospital has the ability to subsidize unprofitable practices from other sources of funding. This suggests the existence of fundamental differences between these two settings that make the comparison complicated at best, including the following:

1. The nature and scope of the risks doctors take in these two settings can be quite different. In private practice, the physician takes on certain business risks, such as ownership of various assets, personal guarantees on office leases, personnel costs, collection risks, contracting with insurance carriers, overhead risks, and other expenses. In the hospital-owned setting, the physician takes other types of risks, including loss of control of their practice and work hours, dilution and/or lower patient panel (leading to lower bonus pay), poorer payor mix, greater case acuity, significant administrative duties, and required call-coverage duties.
2. Private practices can take advantage of the in-office ancillary exception, which is a major accommodation in the Stark Law that creates a fairly wide gap between amounts that private physician practices can pay their doctors, and amounts that hospitals can pay most of their employed doctors.[3] This exception is often a point of discussion; while some believe the exception should be eliminated,

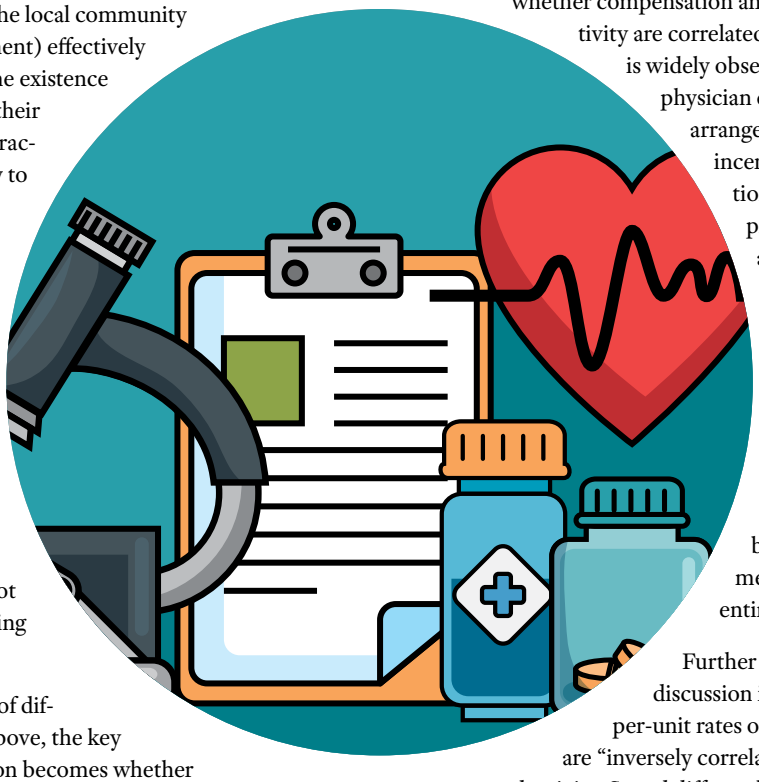
others call for its expansion.[4] The result, though, is that the economics of a hospital-based practice are difficult to compare directly with the economics of a privately owned practice. Ideally, evaluating the financial performance of a hospital-owned practice would include everything that would be included in determining the profitability of a private practice; however, the differences in the applicable regulations preclude the ability to make an "apples-to-apples" comparison by setting up a practice performance disparity that otherwise might not exist.

To be clear, many medical practices are profitable or at least break even; however, survey data show that many others are not profitable (primarily those owned by health systems and other similar entities).

3. Some hospital-owned practices exist primarily to provide care to patient populations that are unlikely to receive care in private practice settings because there is very little profit incentive in doing so. Hospitals will often care for those patient populations even when providing this care is unprofitable. If a hospital does not offer preventative care to low-income patients, those patients are more likely to seek care in the emergency room, where the hospital may be required by law to care for them anyway,[5] likely at substantially higher costs compared to the costs of operating a physician practice to provide preventive care.[6]

4. Some hospital-owned practices are purposely located in remote or rural areas where volumes are too low to sustain a private practice providing comparable services. Often, hospitals operate these clinics as part of their charitable missions

(or local government-owned mandates) to offer rural patients better and more convenient access to health care services in their communities. As a result, many hospitals (sometimes with help from the local community or government) effectively subsidize the existence of some of their physician practices simply to enable the services to be offered in their relatively remote location.[7] This is something that a private practice is generally not able or willing to do.



Given the types of differences listed above, the key corollary question becomes whether physician compensation should also vary to reflect the differences in clinical settings. That question turns on how easily doctors can move from one setting to the other, and what expectations they have about the relative trade-offs of doing so (i.e., differences in compensation, lifestyle, workload, and other risks). In many cases, a physician is doing virtually identical work (same location, similar hours, etc.) in both settings, so it is understandable that these physicians expect comparable compensation, regardless of the relative profitability of each setting (which has little to do with the physician's work effort, assuming comparable effort in both settings).

Claim 2: Misuse of Survey Data Leads to Practice Losses

There is no doubt that the physician compensation surveys are complex and sometimes difficult to understand. Gross misuse of survey data is a real risk, and when it happens, it can lead to overcompensation and questionable practice losses. On the other hand, these surveys are acknowledged by many, including the federal government,[8] to provide the best data available. When used correctly, compensation survey data allow researchers to draw reasonable conclusions. Thus, many claims of data misuses may not be cause for concern, or at least nowhere near the level of concern suggested by critics. Rather, those survey data regarding physician productivity are merely reasonable areas of debate or uncertainty about the relationship among the data, where informed judgment becomes very important.

In particular, there has been reasonable debate about whether compensation and clinical productivity are correlated.[9] In practice, it is widely observed that many physician compensation arrangements provide for incentive compensation based on clinical productivity. In such arrangements, these two metrics are correlated by contract design. Significant noise present in the survey data, however, suggests the correlation between these metrics is not entirely clear.[10]

Further complicating this discussion is the fact that per-unit rates of compensation are "inversely correlated" with clinical productivity. Stated differently, as clinical production increases, the data suggest that total cash compensation tends to increase, while rates of compensation per unit of production decrease.[11] While there is noise in this per-unit data as well, researchers have observed this inverse correlation in the data for well over a decade, and in multiple surveys.[12] So, despite the counter-intuitive nature of this inverse correlation (and any dispersion in the data set), the phenomenon has become a widely accepted reality.

Arguments that hospital-owned practices should behave similarly to private practices ignore many aspects of physician practices.

When considered collectively, one can conclude that physician compensation and clinical production are correlated to some extent, but that correlation is not linear. Instead, given the decreasing per-unit rates, the correlation is likely best described as a curve-shaped relationship, rather than a straight line. At least one survey provides users the ability to see the best fit straight line, using linear regression techniques, and critics argue that it shows that the correlation is very

There are many legitimate reasons employers might compensate physicians at the levels frequently observed in the market, despite the possibility of practice losses.

weak and noisy.[13] However, as suggested, a line determined from linear regression is likely to exhibit weak correlation, precisely because the relationship actually does not behave like a straight line at all. If users had the ability to analyze the data further, the true shape of the relationship might be able to be plotted, and it could be useful to demonstrate how the data behaves and make judgments about reasonable compensation rates. To date, the surveys have only provided access to limited portions of the data, and so outside observers have never been able to complete that analysis.

The important point here is that the lack of a strong linear correlation between two datasets does not imply the data are not correlated at all. While it cannot be proven from the data currently available, it appears to be some type of curve would better describe the correlation, and in practice, this does appear to make some sense.

Therefore, utilizing the non-linear correlation to make judgments about compensation may be a reasonable method to evaluate whether compensation is consistent with FMV and commercially reasonable. Reference to survey data uses the best data available and the regulatory definition of FMV has no requirement that comparable transactions in the marketplace be profitable. Instead, regulations require only that the parties act as well-informed parties would act in an arm's-length transaction, without consideration of the referrals between them.[14]

Claim 3: Employers Ignore Fiscal Responsibility

Employers are not ignoring fiscal responsibility at all; in fact, they are doing just the opposite. Employers are paying acute attention to the financial health of their organizations, and indeed have a fiduciary duty to their stakeholders to do so. For the vast majority of physician employers who wish to stay on the right side of the law, they must walk a fine line between ensuring their businesses are viable going concerns on one hand and ensuring that physician compensation is not determined inappropriately on the other.

For those who believe employers are ignoring fiscal responsibility, their central argument is that, but for the referrals they get from the physicians, hospitals would never be willing to pay physicians at the levels they do (even if consistent with FMV) and/or run losses on physician practices.[15] This premise is flawed however, because it assumes unlawful intent is ubiquitous. There are many legitimate reasons employers might compensate physicians at the levels frequently observed in the market, despite the possibility of practice losses. From a pure economic perspective, the present value of one losing investment may be higher than the present value of the only other viable alternatives. In other words, the avoidance of a larger loss is equivalent to a net gain.[16]

The Stark Law, in particular, does not require that a hospital must earn a profit on every physician practice it operates if the hospital has a good business reason to run a loss in a given situation.[17] The Stark Law merely requires that most payments to physicians be consistent with FMV, commercially reasonable, and not take into account the volume or value of referrals from the physicians.[18]

As stated above, there are many legitimate reasons for an employer to operate a physician practice at a loss, include the following:

1. Some physician arrangements truly are cost centers for a facility in that the hospital will never make money from the arrangement, but cannot operate without them. A perfect example is physician call coverage: hospitals do not profit from paying physicians to provide call coverage, but they pay for it anyway, because the EMTALA law requires hospitals to provide coverage whenever possible to stabilize patients that present to the hospital with emergent conditions, rather than turning them away.[19] A similar argument could be made for hospital-based physicians, who are frequently subsidized by hospitals, because a hospital cannot operate without them.

2. As stated above, situations such as poor payor mix, or low volume (e.g., in rural areas) can contribute to losses. In rural areas, hospitals may not otherwise be viable, but the community may ultimately want to have a hospital, rather than force its residents to travel long distances for hospital-based care. Thus, the community subsidizes the hospital's operations, despite the low volume. Referrals have little or no influence on that situation.

3. In some situations, multiple physicians may be needed to have a viable program. In neurosurgery, for example, the demands on the physicians and the need to cross cover for time that a surgeon may be unavailable necessitate multiple providers; however, if patient volumes would otherwise

not support the minimum number of physicians needed to operate a viable service line, then that service line may need to run at a loss. That may give rise to questions as to whether the services should be offered at all in a given location, but in many cases, non-economic considerations justify offering these services at a loss (distance to the nearest alternative, etc.).

4. Similarly, third-party payor contracts, which are often a function of the relative leverage—or lack thereof—that hospitals have over payors in a given market, may impact profitability. Poor collections efforts by the employer can affect profitability, too. Neither of these factors have anything to do with the employed physician's referrals. Additionally, whether or not hospitals have meaningful leverage, they may approach negotiations of third-party payor contracts with somewhat different priorities than private practices have, given hospitals' other operational considerations. Ultimately, these other considerations can lead to disparities that have nothing to do with referrals from their employed physicians.

5. Finally, competition with other local hospitals can potentially impact the options available to a hospital in its efforts to remain competitive in its market, regardless of the possibility of referrals. That is not to suggest that local competitors' actions can definitively establish FMV of physician compensation in the market. In fact, it is common to mostly avoid consideration of local market data, because of the small sample size and the risk that it may not be comparable (or compliant) at all. But, even if other hospitals' actions may not, by themselves, determine FMV, their actions may impact the market conditions anyway, even if the subject hospital determines that it is unable to match its competitor. It certainly could warrant situations where an employer is under market pressure to pay something additional (not necessarily what the competitor pays, but more than they would otherwise pay) to attract any physicians at all to work for them.

Perhaps prior guidance was misunderstood in part because the term "commercial reasonableness" had never been formally defined in the regulations, leading to frequent speculation about its meaning.

New CMS Guidance on Losses in 2019 Proposed Regulatory Changes

Recently, CMS clarified its position that a transaction need not be profitable to be considered commercially reasonable, citing some of the same rationale discussed in this article. However, although CMS claimed that its position on this actually had never changed, the agency admitted that a "widespread misconception" existed among many stakeholders regarding prior guidance. [20]

Perhaps prior guidance was misunderstood in part because the term "commercial reasonableness" had never been formally defined in the regulations, leading to frequent speculation about its meaning. In particular, the Department of Justice and many qui tam relators on behalf of the United States have regularly argued that practice losses are evidence that physician compensation exceeds FMV, and the associated courts hearing their cases have often agreed with those assertions.[21] Although the newly proposed CMS regulatory definition closely mirrors language from prior commentary,[22] it also includes the specific new statement that "An arrangement may be commercially reasonable even if it does not result in profit . . . ."[23]

Conclusion

When a practice might incur losses, physician compensation will certainly require extra scrutiny and solid documentation of the employer's rationale and the factors influencing the compensation decision. In some cases, compensation may need to be set with consideration of the possibility of practice losses. Despite that, for the reasons outlined herein, physician practice losses are not always inherently suspect, nefarious, or even irresponsible. Rather, such losses are often more of a "necessary evil," and are often rightly defensible and justifiable under the circumstances.

The author wishes to gratefully acknowledge Jim D. Carr, ASA, MBA at HealthCare Appraisers for his assistance in reviewing this article.

Endnotes

1. Here, the term "government" mostly refers to the Department of Justice and courts in *qui tam* cases, as will be discussed in further detail below. In contrast, the Centers for Medicare & Medicaid Services (CMS) has recently taken the opposite position, which will also be discussed further below.
2. The 2019 Medical Group Management Association (MGMA) Cost Survey shows various statistics regarding expenses as a percentage of total medical revenue, and for many specialty categories, a significant percentage (sometimes more than 50%) of respondents report expenses that exceed total medical revenue. In many cases, the physician costs alone exceed corresponding total medical revenue (before factoring in other practice expenses). Similarly, the 2019 MGMA Physician Compensation and Production Survey calculates

the ratio of physician compensation to professional collections for each reported physician, and the reported data often exceeds 1.000 (*i.e.*, the physician's compensation is greater than 100% of his or her own professional collections).

3. 42 C.F.R. § 411.355(b).
4. In its recent proposal to modify the Stark regulations, CMS proposed to retain the exception largely intact, but with changes to the pre-qualifying definitional terms (i.e., the definition of a "Group Practice" found at 42 C.F.R. § 411.352). The associated CMS commentary indicated that the intent of the proposed changes is to reduce perceived barriers to qualifying as a group practice; *see* CMS discussion at 84 Fed. Reg. 55799- 55802 (Oct. 17, 2019).
5. *See* Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd et seq.
6. *See* Kimberly Amadeo, *Why Preventive Care Lowers Health Care Costs* (updated May 28, 2019), https://www.thebalance.com/preventive-care-how-it-lowers-aca-costs-3306074, citing CDC data from *Emergency Room Use Among Adults: Early Release of Estimates From the National Health Interview Survey1Emergency Room Use Among Adults Aged 18–64: Early Release of Estimates From the National Health Interview Survey, January–June 2011* (May 2012), https://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf.
7. A rural hospital may also be among the largest employers in its community, giving the local stakeholders yet another reason (unrelated to designated health services referrals) to take steps to encourage its continued existence.
8. In the commentary to the Stark Phase III regulations, CMS stated that "Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value"; 72 Fed. Reg. 51015 (Sept. 5, 2007).
9. *See* Timothy Smith, CPA, ABV, *Physician practice losses: Red ink from the misuse and abuse of physician compensation survey data*, https://mgma.com/resources/financial-management/physician-practice-losses-red-ink-from-the-misuse (accessed on Feb. 12, 2020). *See also Survey says? Alternative approach to the fair market value of physician compensation*, BVR Healthcare Wire News, Mar. 2018; https://www.bvresources.com/blogs/healthcare-wire-news/2018/03/15/survey-says-alternative-approach-to-the-fair-market-value-of-physician-compensation (accessed Feb. 12, 2020).
10. Statisticians use various types of mathematical analyses to determine if any relationship exists between two variables in a data set (e.g., whether compensation and production are correlated), and how strong or weak that relationship is. An analogy that is frequently used to explain the mathematical concepts in more simple terms is one of a radio receiver that is trying to pick up the "signal" representing the relationship present in the data, and filter out the associated "noise" in the data set that could be distorting or obscuring the signal. Sometimes little or no apparent signal exists, but often a discernable signal may exist, but may be weaker or difficult to notice, if there is lots of noise in the data obscuring the signal. This analogy (signal and noise) will be used throughout this section to simplify the mathematical explanation of how physician compensation data sets behave.
11. The reasons for this behavior are not entirely clear, but observers have suggested several possible explanations. First, low producers often receive a guaranteed minimum salary (regardless of production) and may also perform numerous non-clinical duties reducing their clinical production (but not their aggregate work effort). Similarly, the high producers may be subject to compensation caps in some cases and may also need to incur higher costs to be capable of producing at the very highest reported levels of clinical production.
12. *See 2013 MGMA Physician Compensation and Production Survey* at 10–11. *See also* Smith & Dietrich, *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation* (2012), Chapters 39–40, for extensive discussion of this phenomenon.
13. *See* Smith & Dietrich, *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation* (2012), Chapters 39–40, for discussion of the MGMA survey best fit line data. *See also* Timothy Smith, CPA, ABV, *Physician practice losses: Red ink from the misuse and abuse of physician compensation survey data*, for discussion of why the data is considered by some to be a weak indicator of correlation; https://mgma.com/resources/financial-management/physician-practice-losses-red-ink-from-the-misuse (accessed on Feb. 12, 2020).
14. 42 C.F.R. § 411.351.
15. *See* Timothy Smith, CPA, ABV, *Physician practice losses: Red ink as a red flag for regulatory/enforcement risk*, for discussion of the various arguments that have been made in whistleblower cases and elsewhere that practice losses imply nefarious intent of the parties; https://mgma.com/resources/financial-management/physician-practice-losses-red-ink-as-a-red-flag-f (accessed on Feb. 12, 2020). *See also* Timothy Smith, CPA, ABV, *Physician practice losses: How much red ink can a health system afford?*, https://mgma.com/resources/financial-management/physician-practice-losses-how-much-red-ink-can-a (accessed on Feb. 12, 2020).
16. *See* Ruchaber and Hutzler, *A Balanced Approach to Valuation of Physician Practices*, AHLA Hospital and Health Systems Rx, vol. 13, no. 2 (Dec. 2011); Shannon P. Pratt, Valuing a Business: The Analysis and Appraisal of Closely Held Companies 366, (5th ed. McGraw-Hill 2008).
17. CMS recently clarified that an arrangement need not be profitable to be compliant with the Stark Law; 84 Fed. Reg. 55790 (Oct. 17, 2019).
18. 42 C.F.R. § 411.357.
19. See supra note 5.
20. 84 Fed. Reg. 55790 (Oct. 17, 2019).
21. *See* Timothy Smith, CPA, ABV, *Physician practice losses: Red ink as a red flag for regulatory/enforcement risk*, for discussion of the various arguments that have been made in whistleblower cases and elsewhere that practice losses imply nefarious intent of the parties, https://mgma.com/resources/financial-management/physician-practice-losses-red-ink-as-a-red-flag-f (accessed on Feb. 12, 2020).
22. 63 Fed. Reg. 1700 (Jan. 9, 1998), as clarified in 69 Fed. Reg. 16093 (Mar. 26, 2004).
23. 84 Fed. Reg. 55840 (Oct. 17, 2019).

Albert "Chip" Hutzler, JD, MBA, CVA is a Director for HORNE Healthcare focused on helping clients comply with various health laws that impact them, including Stark, Anti-Kickback, False Claims Act, HIPAA, EMTALA, IRS Regulations and state and local health care laws. He is a published author and regular speaker on health care and legal compliance issues, as well as an active member and former Practice Group leader of AHLA.

AHLA thanks the leaders of the Fraud and Abuse Practice Group for contributing this feature article: *Gary Herschman, Epstein Becker & Green PC (Chair); Kevin Raphael, Pietragallo Gordon Alfano Bosick & Raspanti LLP (Vice Chair—Educational Programming); Matthew Wetzel, GRAIL (Vice Chair—Educational Programming); Tony Maida, McDermott Will & Emery LLP (Vice Chair—Member Engagement); Jacqueline Baratian, Ascension (Vice Chair—Publishing); and Joseph Kahn, Hall Render Killian Heath & Lyman PC (Vice Chair—Publishing).*

Healthcare Administration Expert. Experienced. Thorough.

Jon Burroughs
MD, MBA, FACHE, FAAPL

Winner of the 2016 James A. Hamilton Award for his book "Redesign the Medical Staff Model-A Guide to Collaborative Change"

OFFERING EXPERTISE IN

- Physician Engagement and Alignment Strategies
- Medical Staff Redesign
- Physician Performance Management Strategies
- Negligent Credentialing, Privileging and Peer Review
- Fair/Judicial Hearings
- Medical Staff Bylaws, Policies, Procedures Rules and Regulations
- Population Health and Clinical Integration

President and CEO, The Burroughs Healthcare Consulting Network, Inc.

"In addition to providing a thorough review and extraordinarily detailed report, Dr. Burroughs takes the time to break down difficult concepts in all aspects of hospital administration. Dr. Burroughs gives attorneys the tools necessary, to present very strong system failure cases. He exceeds all expectations to include giving a rock solid deposition. I highly recommend Dr. Burroughs."

- Carol Hay, Esq.

BURROUGHS
HEALTHCARE CONSULTING NETWORK

www.burroughshealthcare.com

JBURROUGHS@BURROUGHSHEALTHCARE.COM

603-733-8156

Feature

30 Years After the ADA: Disability Discrimination in Health Care Under Section 1557 of ACA

Andrew C. Stevens,
Arnall Golden Gregory LLP

2020 marks 30 years since the passage of the landmark Americans with Disabilities Act (ADA). Yet litigation and compliance issues related to disability discrimination in the health care industry continue to expand—in large part due to the enactment of Section 1557 of the Affordable Care Act (ACA) and its accompanying regulation. Given the growing complexity of these issues, this article provides an overview of Section 1557's prohibitions against disability discrimination and summarizes the emerging trends in disability-discrimination litigation and enforcement in the health care industry.

As explained below, a rising tide of disability-discrimination litigation has put tremendous compliance pressure on health care providers, and novel legal questions under Section 1557 continue to work their way through the courts. These developments make clear that health systems and their counsel should devote substantial resources to promote compliance with Section 1557's prohibition on disability discrimination.

Section 1557

Section 1557 of the ACA is entitled "Nondiscrimination" and prohibits discrimination on the basis of race, color, national origin, disability, sex, and age in federally funded health programs and activities.[1] Enacted against a backdrop of federal nondiscrimination law, Section 1557 both expands on a health care provider's existing obligations while also breaking new ground. It is the first federal civil rights law to focus exclusively on nondiscrimination in health care and the first to prohibit discrimination on the basis of sex in health care. It creates new causes of actions, new protected classes, and imposes new regulatory compliance obligations on health care providers. It will, in short, have a significant and long-lasting impact on the health care industry for decades to come and therefore requires renewed attention from compliance professionals and legal counsel.

Section 1557 prohibits disability discrimination in federally funded health care programs by referencing Section 504 of the Rehabilitation Act, and it incorporates the definition of disability discrimination from Section 504.[2] Accordingly, the definition of "disability" under Section 1557 is broad: (1) a physical or mental impairment that substantially limits one or more major life activities; (2) a record or past history of impairment; (3) being regarded as having such an impairment.[3]

Consistent with prior federal law, Section 1557 imposes a multitude of affirmative obligations on health care providers to ensure equal access to patients with disabilities. As summarized by the Department of Health and Human Services (HHS):

> [Section 1557] requires effective communication, including through the provision of auxiliary aids and services; establishes standards for accessibility of buildings and facilities; requires that health programs provided through electronic and information technology be accessible; and requires covered providers to make reasonable modifications to their policies, procedures, and practices to provide individuals with disabilities access to a covered provider's health programs and activities.[4]

In particular, per the regulation, "a covered provider shall take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others in health programs and activities."[5] The regulation in turn defines "auxiliary aids and services" to include an array of communication aids such as qualified interpreters onsite or through Video-Remote Interpretation (VRI) services; qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; and many others.[6] These auxiliary aids and services must be made available to patients free of charge and in a timely manner.[7]

Importantly, under current regulation, health care providers should give "primary consideration" to an individual's preferred auxiliary aid or service for communication.[8] As previously explained by the Department of Justice (DOJ) and as codified in the regulation implementing Section 1557, "primary consideration" means that a provider *"must honor"* the expressed

Americans with Disabilities Act

Enacted against a backdrop of federal nondiscrimination law, Section 1557 both expands on a health care provider's existing obligations while also breaking new ground.

"choice" of an individual, "unless it can demonstrate that another equally effective means of communication is available, or that the use of the chosen means would result in a fundamental alteration in the service, . . . or in undue financial and administrative burdens."[9] Current regulation also requires the use of "qualified" interpreters for individuals with disabilities, which is further defined in the regulation.[10] If remote video interpreting services are used, these services must meet specific regulatory requirements.[11]

Consistent with existing law, health care providers also must ensure that patients' electronic health records are accessible to individuals with disabilities.[12] Providers should address the accessibility of their websites, their medical kiosks, and their electronic health records systems. For more information on how best to ensure accessibility in these areas, legal counsel and compliance professionals should consult the December 21, 2016 guidance from HHS on *Ensuring Equal Access to All Health Services and Benefits Provided through Electronic Means*.[13] In short, providers are encouraged to follow the widely accepted industry standard for web accessibility in the Web Content Accessibility Guidelines (WCAG 2.1).[14] "Websites" should be thought of holistically and include patient web-portals, e-prescriptions, and personal health tools. So too with medical kiosks, which include self-check-in stations, videoconferencing systems, education and consent forms, and medication dispensaries. Providers should consider installing screen readers or tactile interfaces and repositioning kiosks to be within reach of wheelchair users. Lastly, electronic health records also must be accessible: records should be screen-readable and provide audio or narrative descriptions of items (such as x-rays) that would not otherwise be accessible to people with visual disabilities.

Providers should likewise ensure that their medical equipment generally is accessible to patients with mobility disabilities and should review the DOJ and HHS guidance on the topic.[15] Title III of the ADA also imposes additional obligations on a health care provider that are beyond the scope of this article, such as the obligation to remove architectural barriers to equal access for persons with disabilities when it is readily achievable to do so.

Litigation and Enforcement: Auxiliary Aids and Services for Deaf or Hard-of-Hearing Patients

The first trend in this area that will be familiar to most health systems is the increase in litigation and compliance issues related to the provision of auxiliary aids and services to deaf or hard-of-hearing patients. Indeed, private litigation in this area has increased dramatically and most often centers on the effective or ineffective use of VRI services or the denial of a request for an in-person American Sign Language (ASL) interpreter.[16]

At the same time, government enforcement actions addressing these issues have likewise increased since

the ACA. Most notably, on November 13, 2019, the U.S. Attorney's Office for the Eastern District of Michigan announced a far-reaching settlement agreement with Beaumont Health—the largest health care system in Michigan—to resolve allegations that Beaumont Health had violated the ADA for failing to provide effective communication services to deaf or hard-of-hearing individuals.[17] As a part of the announcement, the Civil Rights Unit of the U.S. Attorney's Office specifically noted its investigation revealed that Beaumont Health's systems were not adequate to ensure that deaf and hard of hearing patients were provided auxiliary aids to guarantee effective communication during their treatment.

The settlement agreement that Beaumont Health entered is extensive. It covers three Beaumont hospitals and approximately 30 off-campus outpatient locations and medical centers for a term of 15 months. As a part of the settlement agreement, Beaumont Health agreed to:

- Review and revise its policies on providing effective communication to patients and companions;
- Develop and implement a program to provide appropriate auxiliary aids and services;
- Designate and train personnel to be available to answer questions and provide appropriate assistance regarding immediate access to, and the proper use of, auxiliary aids and services;
- Submit all revisions of policies and procedures concerning effective communication to DOJ for review;
- Use a designated assessment tool in consultation with a patient or companion, to evaluate the type of appropriate auxiliary aid and service that will be provided, including its timing, duration, and frequency;
- Make its determinations concerning auxiliary aids within certain time periods while maintaining a comprehensive log of all such determinations;
- Ensure that its use of VRI services are effective by providing a dedicated high-speed connection that delivers high-quality video and audio;
- Notify individuals in advance if Beaumont Health wishes to use VRI instead of an onsite interpreter;
- Collect data on its interpreter response times;
- Conduct comprehensive training for designated "ADA Personnel" and its larger workforce; and
- Provide written reports of compliance to DOJ, including the number of complaints received by Beaumont Health concerning effective communication.

Importantly, though Beaumont Health was not required to pay compensatory damages as a part of this settlement, a court may award damages and attorney's fees where it is shown that a health system acted with deliberate indifference to the rights of deaf or hard-of-hearing individuals.[18] Note that a plaintiff alleging ineffective communication under the ADA need not show "actual deficient treatment"; rather, showing that the failure to offer an appropriate auxiliary aid "impaired the patient's ability to exchange medically relevant information" with staff may be sufficient.[19]

Similarly, in July 2019, the HHS Office for Civil Rights (OCR) entered into a Voluntary Resolution Agreement with an orthopedic practice in Maryland for its alleged failure to provide a qualified interpreter to a deaf child seeking rehabilitation services.[20]

The increase in litigation and enforcement makes clear that this area of health care law requires renewed and sustained attention from health systems. Health systems should continue to devote the resources and training necessary to provide equal access to patients with disabilities, including auxiliary aids and services to deaf or hard-of-hearing patients.

Litigation: Accessibility of Electronic Health Information and Websites

In keeping with a wider litigation trend, health care providers face an increase in disability-discrimination claims based on inaccessible electronic health information, including websites. For example, in January 2019, two complaints were filed under Section 1557, Section 504, and Title III of the ADA by the same law office against two large health systems in Florida.[21] Both complaints alleged the health systems failed to provide patients who are blind full and equal access to the systems' programs, services, and activities. Specifically, the complaints alleged the systems failed to provide accessible electronic health information through their publicly available websites. The plaintiffs in both actions sought injunctive relief, damages, and attorney's fees and costs. Though these complaints were resolved, they highlight the growing risk to health care providers in this area.

The first trend in this area that will be familiar to most health systems is the increase in litigation and compliance issues related to the provision of auxiliary aids and services to deaf or hard-of-hearing patients.

Disability Discrimination and the Opioid Crisis

The nation's opioid crisis intersects with disability-discrimination issues as well. In fact, in response to the national opioid crisis, OCR launched a public education campaign on the civil rights protections surrounding access to treatment for opioid addiction.[22] As part of this effort, OCR prepared several educational guidance documents, including fact sheets on *Nondiscrimination and Opioid Use Disorder*[23] and on *Drug Addiction and Federal Disability Rights Law*.[24] These documents make clear that "drug addiction, including an addiction to opioids, is a disability under Section 504 of the Rehabilitation Act . . . and Section 1557 of the Affordable Care Act, when the drug addiction substantially limits a major life activity."

In early 2019, DOJ announced a settlement agreement with a privately owned medical facility in Virginia that was found to have regularly turned away prospective new patients who lawfully took controlled substances to treat their medical conditions—including medications used to treat opioid use disorders.[25] The settlement agreement required the provider to adopt nondiscrimination policies, train staff on its nondiscrimination obligations, report on compliance, and pay $30,000 in damages to the complainant and $10,000 to the United States as a civil penalty. The agreement also required the provider to agree to not apply standards or criteria to prospective patients that would have the effect of screening out individuals with disabilities, including those based on an opioid disorder.

Health care providers should carefully consult these new guidance materials to ensure their patient populations do not face discriminatory burdens in accessing treatment for opioid use disorders or are otherwise discriminated against on account of such a disorder.

Courts Continue to Address Novel Legal Questions Under Section 1557

It is also worth noting that courts nationwide continue to address novel legal questions under Section 1557, including in the disability-discrimination context.

For example, in a putative class-action claim for disability-discrimination under Section 1557 and Section 504 of the Rehabilitation Act, the Sixth Circuit recently held that a claim for disparate-impact discrimination is not available under Section 1557 when based on a "ground" of discrimination prohibited by Section 504 (i.e., disability).[26] In the words of the court: "The Affordable Care Act prohibits discrimination based on several grounds. But it does not change the nature of those grounds any more than it adds a new form of discrimination, say discrimination based on political perspective, to the law. By referring to four statutes, Congress incorporated the legal standards that define discrimination under each one."[27]

This opinion appears to conflict with an earlier federal district court decision ruling that Section 1557 created a new cause of action subject to a new, single legal standard.[28] The ultimate resolution of this question (the appropriate interpretation of Section 1557) will have significant consequences for health systems as it could increase the number and types of causes of action available to private parties.

It is also worth noting that courts nationwide continue to address novel legal questions under Section 1557, including in the disability-discrimination context.

In January 2020, the Fifth Circuit recognized a circuit-split on whether emotional distress damages are available to plaintiffs under Section 1557 and Section 504.[29] The Fifth Circuit ruled that such damages are unavailable, though the court recognized that the Eleventh Circuit previously held the opposite under Section 504.[30] The resolution of this question will likewise impact the extent of liability that health systems could face under Section 1557.

Conclusion

Thirty years after the passage of the ADA, the health care industry continues to face challenges concerning disability discrimination. For most systems, these challenges include the provision of effective auxiliary aids and services through the use of VRI or in-person ASL interpreters. However, through renewed attention to their compliance obligations and litigation risks, health care systems can continue their work in ending disability discrimination in health care while pursuing health equity for all.

ENDNOTES

1. The text of Section 1557 reads in relevant part:

   > [A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

   Pub. L. No. 111–148, § 1557, 124 Stat. 119, 260 (2010) (codified as amended at 42 U.S.C. § 18116).

2. *See* 45 C.F.R. § 92.5. Throughout, this article cites to and discusses the current version of the regulation promulgated by the Department of Health and Human Services (HHS) under Section 1557, even though HHS has proposed to revise that regulation in several respects. For purposes of

In keeping with a wider litigation trend, health care providers face an increase in disability-discrimination claims based on inaccessible electronic health information, including websites.

this discussion, however, HHS has proposed to revise little of the regulation's mandates concerning disability discrimination. An excellent overview of HHS' proposed revisions to the regulation may be at https://www.healthaffairs.org/do/10.1377/hblog20190525.831858/full/.

3. 28 C.F.R. § 36.105. The definition of a "physical or mental impairment" is in turn also broad. *See* 28 C.F.R. § 36.105.
4. HHS, Section 1557: Frequently Asked Questions, https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs.pdf (last accessed on Feb. 18, 2020).
5. 45 C.F.R. § 92.202.
6. 45 C.F.R. § 92.4.
7. 45 C.F.R. § 92.8(a)(2).
8. 45 C.F.R. § 92.202 (citing to 28 C.F.R. § 35.160)).
9. Dep't of Justice (DOJ), The Americans with Disabilities Act: Title II Technical Assistance Manual, § II-7.110 (1993), https://www.ada.gov/taman2.html (emphasis added); *see also Bonnette v. D.C. Court of Appeals*, 796 F. Supp.2d 164, 182 (D.D.C. 2011); 81 Fed. Reg. at 31421.
10. 45 C.F.R. § 92.4.
11. 45 C.F.R. § 92.202 (citing 28 C.F.R. §§ 35.160-164.).
12. 45 C.F.R. § 92.204.
13. *See* Letter from Jocelyn Samuels, HHS Office for Civil Rights (OCR), Guidance and Resources for Electronic Information Technology: Ensuring Equal Access to All Health Services and Benefits Provided Through Electronic Means, Dec. 21, 2016, https://www.hhs.gov/sites/default/files/ocr-guidance-electronic-information-technology.pdf.
14. Web Content Accessibility Guidelines (WCAG) 2.1 (June 5, 2018), https://www.w3.org/TR/WCAG21/.
15. DOJ, Civil Rights Division, and HHS OCR, *Access to Medical Care for Individuals with Mobility Disabilities* (July 2010), https://www.hhs.gov/sites/default/files/ocr/civilrights/understanding/disability/adamobilityimpairmentsgudiance.pdf.
16. *See, e.g., Rosario v. St. Tammany Parish Hosp. Serv. Dist., No. 1*, 2019 WL 1766983 (E.D. La., Apr. 22, 2019); *Silva v. Baptist Health South Fla., Inc.*, 303 F. Supp. 3d 1334 (S.D. Fla. 2018).
17. U.S. Attorney for the Eastern District of Michigan, Press Release, U*.S. Attorney's Office Reaches Agreement with William Beaumont Hospital to Resolve ADA Investigation Regarding Effective Communication*, Nov. 13, 2019, https://www.justice.gov/usao-edmi/pr/us-attorney-s-office-reaches-agreement-william-beaumont-hospital-resolve-ada.
18. *See, e.g., Puerner v. Hudson Spine and Pain Med. P.C.*, 2018 WL 4103491 (S.D.N.Y. Aug. 28, 2018).
19. *See, e.g., Silva v. Baptist Health S. Fla., Inc.*, 856 F.3d 824, 829 (11th Cir. 2017).
20. *See* Voluntary Resolution Agreement, https://www.hhs.gov/about/news/2019/07/24/maryland-orthopedic-practice-agrees-provide-deaf-6-year-old-qualified-interpreter.html.
21. *See Gil v. Mayo Clinic Jacksonville*, 3:19-CV-00015 (MD. Fla. Jan. 3, 2019); *Price v. Baptist Health Sys., Inc.*, 3:19-CV-00132 (M.D. Fla. Jan. 30, 2019).
22. HHS, Press Release, OCR Launches Public Education Campaign About Civil Rights Protections in Response to the National Opioid Crisis, Oct. 25, 2018, https://www.hhs.gov/about/news/2018/10/25/ocr-launches-public-education-campaign-about-civil-rights-protections-in-response-to-the-national-opioid-crisis.html.
23. OCR, *Nondiscrimination and Opioid Use Disorders Fact Sheet*, https://www.hhs.gov/sites/default/files/fact-sheet-nondiscrimination-and-opioid-use.pdf.
24. OCR, *Fact Sheet: Drug Addiction and Federal Disability Rights Laws*, https://www.hhs.gov/sites/default/files/drug-addiction-aand-federal-disability-rights-laws-fact-sheet.pdf.
25. DOJ, Press Release, *Justice Department Researches Settlement with Selma Medical Associates Inc. to Resolve ADA Violations* (Jan. 31, 2019), https://www.justice.gov/opa/pr/justice-department-reaches-settlement-selma-medical-associates-inc-resolve-ada-violations.
26. *See Doe v. BlueCross BlueShield of Ten., Inc.*, 926 F.3d 235, 239 (6th Cir. 2019).
27. *Id.*
28. *See Rumble v. Fairview Health Servs.*, 2015 WL 1197415, at *10-11 (D. Minn. Mar. 16, 2015) ("Here, looking at Section 1557 and the Affordable Care Act as a whole, it appears that Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status.").
29. *Cummings v. Premier Rehab Keller, P.L.L.C.*, No. 19-10169, 2020 WL 400189, at *1 (5th Cir. Jan. 24, 2020).
30. *See id.*

Andrew (Drew) C. Stevens is an Associate in Arnall Golden Gregory LLP's Litigation and Intellectual Property practice groups and focuses on complex commercial litigation involving intellectual property, health systems, and real property. Drew also counsels and represents hospitals and health systems on compliance and in litigation under Title III of the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and Title VI of the Civil Rights Act of 1964, and in civil rights investigations brought by the Department of Justice and the Office for Civil Rights at the Department of Health and Human Services.

AHLA thanks the leaders of the Health Care Liability and Litigation Practice Group for contributing this feature article: *Kristen McDonald, Jones Day (Chair); Scott Grubman, Chilivis Grubman Dalbey & Warner LLP (Vice Chair—Educational Programming); Lindsey Lonergan, Navicent Health Inc (Vice Chair—Educational Programming); Kirstin Ives, Falkenberg Ives LLP (Vice Chair—Member Engagement); Steven Hamilton, McGuireWoods LLP (Vice Chair—Publishing); and Kara Silverman, Arnall Golden Gregory LLP (Vice Chair—Publishing).*

It's the little things

A few cents here and a few cents there – it all adds up.

At PYA, we uncover the little things before they become big things. When it comes to compliance, we analyze every detail, no matter how small.

For nearly four decades, our experts have helped the nation's leading healthcare organizations make "cents" of regulatory compliance and avoid potentially costly oversights. We help you spot problems before your bottom line feels them.

A Note on AHLA's 2020 Annual Meeting

S. Craig Holden
AHLA President-Elect
Chair, 2020 Annual Meeting

Traditionally, it is the role of the President-Elect to introduce AHLA's upcoming Annual Meeting and our plans for the program, scheduled to begin this year on June 29 in San Diego, CA. I would talk about the many charms of San Diego, including the beautiful weather, the zoo, Balboa Park, the USS Midway, and the numerous other attractions in the area. I would also tell you about the wonderful reception venue we have chosen at the Prado at Balboa Park, a national historic landmark originally built for the 1915-1916 Panama–California Exposition. I would wax poetic about the beautiful artwork, sculptures, and fountains at the Prado. I would then go on to tell you of the wonderful networking opportunities that come with attendance at the Annual Meeting.

But these are not normal times. The unfortunate reality of the COVID-19 crisis makes an in-person meeting of this size untenable at this time, so AHLA has decided to convert the Annual Meeting to a virtual format. While we must defer the opportunity to see old friends and colleagues in person, AHLA will still be able to provide the excellent cutting-edge educational content that you have come to expect from the Annual Meeting. Many of you may have already experienced this virtual format, which was rolled out with our Health Care Transactions program in April.

For those of you new to virtual programs, here is how they work. The speakers pre-record their presentations and are available when their presentations air during the virtual program for an online attendee chat with all the other participants. The attendee chat provides a venue to ask questions of the speakers, share perspectives, expand on the ideas discussed, and connect with other attendees.

We have an excellent Annual Meeting Planning Committee consisting of Tim Blanchard, Greg Demske, Greg Duckett, Anne Hance, Ann Hollenbeck, Cindy Reisz, and Myra Selby. They have already begun adapting this excellent in-person program to a virtual program format. Our In-House Counsel Program Planning Committee, consisting of Greg Matis (Chair), Ryan Keith, Rich Korman, Precious Gittens, and Sheea Sybblis, are also hard at work adapting their program to a virtual format.

We will have two fascinating keynote speakers, both of whom will speak on potential reforms to the health care system. Marty Makary, MD, is a health policy expert, surgeon, and Professor of Public Health at Johns Hopkins University. His bestselling book *The Price We Pay* advocates for a new movement of relationship-based clinics that spend time with patients to address the social, economic, and lifestyle determinants of health. Amitabh Chandra, PhD, is the Malcolm Wiener Professor of Social Policy and director of health policy research at the Harvard Kennedy School of Government. Dr. Chandra focuses on comprehensive health care reforms that could insure the uninsured, improve quality of care, and eliminate the perverse incentives that currently drive up costs.

The always popular "Year in Review" with Bob Homchick, Kristen Rosati, and Jack Schroder will provide attendees with the highlights of all areas of health law from the last year. This year will be the swan song for Jack, who has shared his wit and knowledge with us in the "Year in Review" for over 20 years. He will be greatly missed. The program will also have breakout sessions that will allow attendees to take a deeper dive into areas that interest them most. Sessions will focus on transactional issues, Medicare and Medicaid reimbursement, tax, privacy and security, antitrust, fraud and compliance, labor and employment, information technology, and ethics.

Finally, a word of thanks to all of you working with your health care clients on the front lines confronting this crisis. As health law professionals we are fortunate that almost everything we do can be done remotely. Many cannot work remotely, and it is good for all of us to take a moment to recognize them. This, of course, includes our medical professionals and first responders who freely take risks to save others. It also includes many in less visible roles: the food warehouse workers, the trash collectors, and many others who go out every day and do the jobs that keep our society functioning. We owe them all a great debt of gratitude. I close with the recent words of Queen Elizabeth II: "I hope in the years to come, everyone will be able to take pride in how they responded to this challenge."

In-House Counsel Program July 9 and July 16, 2020

PLANNING COMMITTEE

Greg J. Matis
Chair
Intermountain Healthcare
Salt Lake City, UT

F. Ryan Keith
Aetna Inc.
Louisville, KY

Rich Korman
Avera Health
Sioux Falls, SD

Precious M. Gittens
Senior Director
Compliance Investigations
Fresenius Medical Care
North America
Waltham, MA

Sheea Sybblis
Senior Counsel
Boehringer Ingelheim
Pharmaceuticals Inc.
Ridgefield, CT

Thanks to our Sponsor

NTRACTS
Contracts Without Complications

AHLA's In-House Counsel Program and Annual Meeting are hallmarks of the Association's educational mission, and attendance has become a tradition for many members. This year, the programs will be virtual and although we will not be gathering in San Diego as orginally planned, the programs will include the high quality content that our members need and expect.

The In-House Counsel Program is designed to address the educational needs of those who serve as in-house counsel across the health care industry and to provide networking opportunities so that you can talk with and learn from your colleagues. We recognize that in-house counsel have tremendous pressure on their schedules. We are offering content on two different days in order to make participating more mangeable. All presentations will also be available on-demand and continuting education credits are available for live and on-demand sessions.

During the opening kick-off session, a panel of experts will look into their "Crystal Ball for a New Decade: Keys to In-House Success in the 20's." With a fast-paced format, they will examine every aspect of the in-house counsel experience and look forward to the key issues of the 2020's, and the skills and attributes necessary to navigate the increasingly complex and rapidly evolving health care ecosystem.

Breakout sessions will help you prepare to advise your organizations on business issues and address legal and regulatory issues faced by in-house counsel.

Topics of interest include:

- Managing the Array of Employee Medical Accommodation Issues in the Workplace
- What is Artificial Intelligence and Why in Health Care?
- The Role of the Board of Directors in Monitoring Quality
- Contracting for Privacy: Trends and Tips for Contracting in an Ever-Changing Technological Landscape
- Getting to Yes: Executing a Successful Campaign to Launch a High Profile Health Sector Initiative

Annual Meeting
June 29 - July 1, 2020

PLANNING COMMITTEE

S. Craig Holden
Chair
Baker Donelson
Baltimore, MD

Timothy P. Blanchard
Blanchard Manning LLP
Orcas, WA

Gregory E. Demske
Office of the Inspector General
U.S. Department of Health and Human Services
Washington, DC

Gregory M. Duckett
Senior Vice President & Chief Legal Officer
Baptist Memorial Health Care Corporation
Memphis, TN

Anne W. Hance
SVP, General Counsel and Chief Privacy Officer
Blue Cross Blue Shield of Tennessee
Chattanooga, TN

Ann T. Hollenbeck
Jones Day
Detroit, MI

Cynthia Y. Reisz
Bass Berry & Sims PLC
Nashville, TN

Myra C. Selby
Ice Miller LLP
Indianapolis, IN

The Annual Meeting will, as always, feature the informative and entertaining "Year in Review." Bob Homchick, Kristen Rosati, and Jack Schroder won't have any trouble identifying new and interesting laws, regulatory developments, and enforcement efforts to cover.

We are also pleased to have two keynote speakers. Marty Makary, MD, is a health policy expert, surgeon, and Professor of Public Health at Johns Hopkins University. His bestselling book *The Price We Pay* advocates for a new movement of relationship-based clinics that spend time with patients to address the social, economic, and lifestyle determinants of health. Amitabh Chandra, PhD, is the Malcolm Wiener Professor of Social Policy and director of health policy research at the Harvard Kennedy School of Government. Dr. Chandra focuses on comprehensive health care reforms that could insure the uninsured, improve quality of care, and eliminate the perverse incentives that currently drive up costs.

The Annual Meeting will also feature breakout sessions on cutting edge topics covering all areas of health law and for all segments of the health care industry. The program includes sessions on topics such as:

- Pharmacy Benefits
- An Opportunity for Change: The Opioid Crisis, the Evolving Legal Landscape, and What Lies Ahead
- COVID-19 and Emergency Preparedness
- Recent Developments in Labor and Employment for the Health Law Professional
- Fraud and Abuse Hot Topics
- Legal Ethics
- Administrative Litigation after Allina, Kisor, and the Census Case
- Telehealth Update

AHLA Annual Membership Meeting
June 29 at 11:00-11:15 AM EST

Keynote Speakers

Amitabh Chandra
Professor of Public Policy
Director of Health Policy Research
Harvard Kennedy School
of Government

Marty Makary, MD
Surgeon and Professor of Public Health, Johns Hopkins
Author of *The Price We Pay*

Sponsor List

Thank you to the following companies for sponsoring the In-House Counsel Program and Annual Meeting:

If your law firm is interested in being a sponsor for this event please contact veshleman@americanhealthlaw.org.

Reception Sponsors

Thank you to the following law firms for their sponsorship:

Baker Donelson

Baird Holm LLP

BakerHostetler

Bass Berry & Sims PLC

Benesch Friedlander Coplan & Aronoff LLP

Blanchard Manning LLP

Bradley Arant Boult Cummings LLP

Bricker & Eckler LLP

Coppersmith Brockelman PLC

Crowell & Moring LLP

Davis Wright Tremaine LLP

Dentons US LLP

Epstein Becker & Green PC

Faegre Drinker Biddle & Reath LLP

Foley Hoag LLP

Hall Render Killian Heath & Lyman PC

Hooper Lundy & Bookman PC

Husch Blackwell LLP

King & Spalding LLP

Lane Powell

Manatt Phelps & Phillips LLP

McDermott Will & Emery LLP

Mintz Levin Cohn Ferris Glovsky and Popeo PC

Nelson Mullins Riley & Scarborough LLP

Ogletree Deakins Nash Smoak & Stewart PC

Perkins Coie LLP

Plunkett Cooney

Post & Schell PC

Ropes & Gray LLP

Squire Patton Boggs

Waller Lansden Dortch & Davis LLP

Wilentz Goldman & Spitzer PA

Member News

HORNE LLP, one of the nation's top 100 accounting and business advisory firms, welcomes **Albert "Chip" Hutzler, JD, MBA, CVA** as a Director on the firm's health care team. Based out of the firm's Nashville, TN office, Mr. Hutzler helps clients navigate various health laws, including Stark, Anti-Kickback, False Claims Act, HIPAA, EMTALA, IRS Regulations, and state and local health care laws. Hutzler joins the firm with more than 20 years of previous experience as a financial analyst and 25 years as an attorney. He is a published author and regular speaker on health care and legal compliance issues.

Author Thanks

AHLA would like to thank Editors **Kim Harvey Looney, Glenn P. Prives, and Deborah Farringer**, and Authors **Mazen Asbahi, Adam Cella, Lymari Martinez Cromwell, John W. Dawson IV, Alexis J. Gilman, J. Andrew Goddard, Jay Hardcastle, Justin R. Hickerson, Rick Hindmand, Johnathan D. Holbrook, Lauren B. Jacques, Jason J. Krisza, Nathan H. Lykins, Lauren B. Patterson, Michael F. Schaff, Neil B. Krugman, Susan V. Sidwell, G. Scott Thomas, Rodrigo N. Valle, Kimberly S. Veirs,** and **John R. Washlick** for their work in publishing *Health Care Transactions Manual: Understanding the Consequences of the Health Care Deal*. This new publication is the ideal guide for gaining an understanding of the legal landscape, and for managing the risks involved in structuring health care deals. For more information, visit www.lexisnexis.com/hctm.

Member Spotlight

Avery Schumacher, MHA
Associate
Bricker & Eckler LLP
Columbus, OH
aschumacher@bricker.com

What book is on your nightstand?

Eleanor Oliphant is Completely Fine by Gail Honeyman. It is a quirky novel exploring a wonderfully weird fictional character's struggles with friendship, mental illness, and life in general. I don't want it to end!

What is your favorite meal to cook for friends?

Grilled steak loaded nachos. Perfect for a cookout, and pairs well with margaritas!

What was your first/worst/most interesting job?

My worst job was selling knives for a multi-level marketing direct sales company for a couple of months in college. As a people person, the bright side was getting to meet all of my college friends' relatives. I am told they still ask about me. One of my first and most interesting jobs was working at the Cleveland Zoo, where I met my husband.

What movie have you watched multiple times?

All of the *Marvel Avengers* movies. Also, I just re-watched *I am Legend*, which I have seen a number of times...not a great choice for quarantine life unless you are looking to lean in to your anxiety.

What was your best vacation?

A two-week road trip around the U.S. before starting my current position. My husband, dog, and I visited six national parks and a number of major U.S. cities. My favorite park was Bryce Canyon National Park, in Utah.

Would you like to be featured in our new Member Spotlight section? Please contact agreene@americanhealthlaw.org. We'd love to hear from you!

AHLA Gives Back: Moot Court

AHLA Gives Free Membership and Other Prizes to Students at Ninth Annual Health Law Regulatory and Compliance Competition

The American Health Law Association was present to support the future of health law at the University of Maryland Francis King Carey School of Law, which hosted the Ninth Annual Health Law Regulatory and Compliance Competition on February 22, 2020. Nearly 40 students on 15 teams participated in the competition, representing 12 law schools from across the country.

This unique and innovative competition challenged law students to navigate the complex regulatory landscape of health law, including compliance with health care regulations and FDA law. The competition required teams of two to three students to analyze a hypothetical fact pattern involving various interactions between health care stakeholders and entities participating in several health care activities that necessitate regulatory and compliance oversight. The fact pattern was given to teams the day of the competition, and students had approximately 90 minutes to analyze the problem. Teams then presented their findings and recommendations to a panel of practicing regulatory and compliance attorneys.

Judges included AHLA Executive Vice President/CEO David S. Cade as well as 35 attorneys, health insurance specialists, health policy analysts, and compliance officers.

AHLA provided free membership to all 40 students participating. In addition, AHLA contributed the following prizes to the winning teams:

- Complimentary registration to AHLA's Annual Meeting for the 1st place team members
- Complimentary registration to AHLA's Fundamentals of Health Law program for the 2nd and 3rd place team members

- Stipend for some of the winners to help underwrite travel and lodging expenses
- AHLA's *Fundamentals of Health Law* publication

Congratulations to the winning law students and schools:

First Place

University of Pennsylvania Law School
Philadelphia, PA
Sophie Beutel
Marissa Fritz
Simone Hussussian

Second Place

American University Washington College of Law
Washington, DC
Meghan Browder
David Cohen

Third Place

American University Washington College of Law
Washington, DC
Brittney Hall
Lauren Sager

Volunteer Recognition February 2020

Programs and Distance Learning

In-Person Programs

Physicians and Hospitals Law Institute

A.G. Alexander, Department of Health and Human Services

Kelly R. Anderson, Baptist Health

Gordon J. Apple, Law Offices of Gordon J Apple PC

Anne D. Armstrong, Intermountain Healthcare

Mazen Asbahi, McDonald Hopkins LLC

Franklin D. Beahm, Beahm & Green

Joseph Beemsterboer, U.S. Department of Justice

Scott Bennett, Coppersmith Brockelman PLC

Annapoorani Bhat, PYA

Amanda M. Brown, Veralon Partners

Carolyn Buppert, Law Office of Carolyn Buppert

Justin Burk, HCA Healthcare

Michael R. Callahan, Katten Muchin Rosenman LLP

Gary L. Cantrell, DHHS Office of the Inspector General

Daniel O. Carroll, Schenck Price Smith & King LLP

Justin Chamblee, Coker Group

Richard Y. Cheng, DLA Piper LLP (U.S.)

Anthea R. Daniels, Akron Children's Hospital

David A. DeSimone, CentraState Healthcare System

Thomas Dutton, Jones Day

Andrea M. Ferrari, HealthCare Appraisers Inc

John Fink, ECG Management Consultants

Ellen Flynn, Vizient

David M. Glaser, Fredrikson & Byron PA

Lisa Marie Gora, Wilentz Goldman & Spitzer PA

Adam H. Greene, Davis Wright Tremaine LLP

Gerald M. Griffith, Jones Day

Nancy J. Griswold, DHHS Office of Medicare Hearings and Appeals

Scott R. Grubman, Chilivis Grubman Dalbey & Warner LLP

Jeanna Palmer Gunville, Polsinelli PC

Jennifer L. Gurevitz, CHRISTUS Health

Elizabeth R. Hammack, University Hospitals

Matthew C. Hans, Polsinelli PC

Thomas H. Hawk III, King & Spalding LLP

Pamela E. Hepp, Buchanan Ingersoll & Rooney PC

Tizgel K.S. High, LifePoint Health

Melissa Hill, Federal Trade Commission

Rick Hindmand, McDonald Hopkins LLC

Elizabeth F. Hodge, Akerman LLP

David S. Holtzman, CynergisTek Inc

Robert G. Homchick, Davis Wright Tremaine LLP

Rachael A. Honig, US Attorney's Office, District of New Jersey

Thora A. Johnson, Venable LLP

Matthew Josephson, US Attorney's Office, Southern District of Georgia

Julie E. Kass, Baker Donelson Bearman Caldwell & Berkowitz PC

Brian S. Kern, Acadia Professional

Kristy M. Kimball, Holland & Hart LLP

Adam Klein, ECG Management Consultants

Mark Adam Knee, DHHS Office of the National Coordinator for Health Information Technology

Mark S. Kopson, Plunkett Cooney

Marilyn Lamar, Liss & Lamar PC

Kim Harvey Looney, Waller Lansden Dortch & Davis LLP

Tony R. Maida, McDermott Will & Emery LLP

Brigid M. Maloney, Lippes Mathias Wexler Friedman LLP

Patricia A. Markus, Nelson Mullins Riley & Scarborough LLP

Richelle D. Marting

Joe Miller, Mintz Levin

Haavi Morreim, College of Medicine University of Tennessee Health Science Center

Anna-Liisa Mullis, Brownstein Hyatt Farber Schreck LLP

Karen Nelson, DLA Piper LLP (U.S.)

Gerard M. Nussbaum, Zarach Associates LLC

Anjana D. Patel, Epstein Becker & Green PC

Antonia A. Peck, Womble Bond Dickinson

Mindy Phillips, SSM Health

Eric J. Plinke, Dinsmore & Shohl LLP

Michaela D. Poizner, Baker Donelson Bearman Caldwell & Berkowitz PC

James Max Reiboldt, Coker Group

Erika Riethmiller, University of Colorado Health

Vicki L. Robinson, DHHS Office of the Inspector General

Kim H. Roeder, King & Spalding LLP

Kristen B. Rosati, Coppersmith Brockelman PLC

Andrew D. Ruskin, Morgan Lewis & Bockius LLP

Jay Sanders, PBC Advisors LLC

Michael F. Schaff, Wilentz Goldman & Spitzer PA

Jack S. Schroder, Alston & Bird LLP

Michael R. Schulze, Sullivan Stolier Schulze LLC

Daniel F. Shay, Alice G Gosfield & Associates PC

Patrick D. Souter, Gray Reed & McGraw LLP

Jessica E. Stack, Veralon Partners

Kim C. Stanger, Holland & Hart LLP

Sadie Sullivan, SCL Health

Andrew B. Wachler, Wachler & Associates PC

John R. Washlick, Buchanan Ingersoll & Rooney PC

Emily H. Wein, Foley & Lardner LLP

Scott A. Weinstein, McDermott Will & Emery LLP

Paul H. Westfall, UnityPoint Health

Eric D. Whitman, Atlantic Health System, Oncology Service Line

Stephanie D. Willis, Crowell & Moring LLP

Brent Wilson, University of Utah

Lisa Ohrin Wilson, Centers for Medicare & Medicaid Services

Cynthia F. Wisner, Trinity Health

Seth M. Wolf, University Hospitals

Paul Wong, NERA Economic Consulting

Kristen McDermott Woodrum, BakerHostetler

Opt-In to AHLA's Volunteer Pool by Completing Your Volunteer Profile

AHLA has revised the volunteer process. To opt-in to the Volunteer Pool and complete your Volunteer Profile, visit www.american-healthlaw.org/volunteer. This will help us know what kind of volunteer opportunities you are interested in. Going forward, you will receive email alerts when we think you'll be a good fit for a new volunteer opportunity.

AHLA has a wonderful tradition of members sharing their expertise and insight with each other. Members generously donate their time and energy through speaking, writing, and other service to the organization. Volunteers are the heart of the Association—thank you for all you do!

Long Term Care and the Law

Philip J. Anderson, Buchanan Ingersoll & Rooney PC

Andrew Baird, Encompass Health

Barbara S. Barrett, Reliant Care Management Company LLC

David C. Beck, Signature HealthCARE LLC

Joseph L. Biancullli, Health Care Lawyers PLC

Denise Bloch, Lathrop GPM

Timothy J. Cesar, Brookdale Senior Living

Saurabh Chandra, Northwell Health

David Chess, Tapestry Telehealth

Tara J. Clayton, Willis Towers Watson

Michael H. Cook, Liles Parker PLLC c/o Michael Cook

Tara A. Cope, Vi Living

Christy Tosh Crider, Baker Donelson Bearman Caldwell & Berkowitz PC

John D. Dailey

Amy Dalton, PYA PC

Jane Elisabeth Danner, Volunteers of America National Services

William A. Dombi, National Association for Home Care & Hospice

Barbara J. Duffy, Lane Powell PC

Ericka Fang, Kaufman Borgeest & Ryan LLP

Randall R. Fearnow, Quarles & Brady LLP

Janet K. Feldkamp, Benesch Friedlander Coplan & Aronoff LLP

Tracy M. Field, Parker Hudson Rainer & Dobbs LLP

Joel S. Goldman, Hanson Bridgett LLP

Joseph M. Greenman, Lane Powell PC

Bruce R. Grindrod, Provider Partners Management Services

Jeanna Palmer Gunville, Polsinelli PC

Terrill Johnson Harris, Fox Rothschild LLP

Colin Harrison, Wilson Getty LLP

Marian J. Hayden, Cull & Hayden PSC

Kaitlin E. Hazard, United States Attorney's Office

L. Drew Hickey, Bolen Robinson & Ellis LLP

Jennifer L. Hilliard, Arnall Golden Gregory LLP

David Nathaniel Hoffman, Columbia University

Alan C. Horowitz, Arnall Golden Gregory LLP

Lilly S. Hummel

Annaliese Impink, SavaSeniorCare Consulting LLC

Mark A. Johnson, Hooper Lundy & Bookman PC

Chad Jungman, Sanford Health/The Evangelical Lutheran Good Samaritan Society

Cory Kallheim, LeadingAge Inc

Paul Killeen, Golden Living Companies

Kevin Koronka, Husch Blackwell LLP

Clay T. Lee, Epstein Becker & Green PC

Ari J. Markenson, Winston & Strawn LLP

Anna F.C. Munoz, Brookdale Senior Living Inc

M. Daria Niewenhous, Mintz Levin Cohn Ferris Glovsky & Popeo PC

Emily M. Park, Husch Blackwell LLP

Marit Peterson, Minnesota Elder Justice Center

Mario Pinto, U.S. Department of Health and Human Services, Office of the Inspector General

Clifton Porter II, American Health Care Association

Helen E. Quick, Locust Point Capital

Mark E. Reagan, Hooper Lundy & Bookman PC

Adrian B. Rios, BKD CPAs & Advisors

William Alvarado Rivera, AARP Foundation

Robert Rode, Voigt Rode Boxeth & Coffin LLC

Carol Rolf, Rolf Goffman Martin Lang LLP

Darryl Ross, Mariner Health Care

Sara A. Rudow, AHCA

Timothy Ryan, AccentCare Inc

Gabriela Sanchez, Lane Powell PC

Paula G. Sanders, Post & Schell PC

Arielle Schmeck, JTaylor

Judith Schwarz, End of Life Choices New York

James F. Segroves, Reed Smith LLP

Jack W. Selden, Bradley Arant Boult Cummings LLP

Suzanne Sheldon-Krieger, SSM Health at Home and Post-Acute Care

Kara Gordon Silverman, Arnall Golden Gregory LLP

Tejinder Singh, Goldstein and Russell PC

Kim C. Stanger, Holland & Hart LLP

Liz Steffen, Promedica Health System

Karl E. Steinberg, Mariner Health Care

Daniel Z. Sternthal, Baker Donelson Bearman Caldwell & Berkowitz PC

Sandra A. Tamez, Fair Housing Council of Greater San Antonio

William D. Troutt, Harvest Inc

Elizabeth P. Tyler, Tyler & Wilson

Amy Vandenbroucke, National POLST

Alissa M. Vertes, HealthPRO Heritage

Susan M. Voigt, Voigt Rode Boxeth & Coffin LLC

Natalie A. Waites, Civil Fraud Section, U.S. Department of Justice

Christine J. Wilson, Tyler & Wilson

David R. Wright, Centers for Medicare and Medicaid Services

Mark A. Yost Jr., Lewis Brisbois Bisgaard & Smith LLP

Educational Calls

Payers, Plans, and Managed Care Practice Group Educational Call

Eric Beane, Unite U.S.

Kate McDonald, McDermott Will & Emery LLP

Life Sciences Practice Group Educational Call

Hillary Noll Kalay, University of California

Christine Anne Moundas, Ropes and Gray

Jackie Olson, Life Sciences Practice Group

Webinars

2020 Telemedicine Webinar Series, Part III: Telemedicine Reimbursement: Medicare, Medicaid, and commercial coverage

Jody Erdfarb, Wiggin and Dana LLP

Laura Koman, Jones Day

Sunny Joy Levine, Foley & Lardner LLP

Tamara Alexander Lynch, NYU Langone Health

2020 Telemedicine Webinar Series, Part IV: Structuring and Payment for Remote Patient Monitoring Services

Jennifer R. Breuer, Faegre Drinker Biddle & Reath LLP

Marshall E. Jackson Jr., McDermott Will & Emery LLP

Steven J. Lokensgard, Faegre Drinker Biddle & Reath LLP

Carrie Nixon, Nixon Law Group LLC

Autism and Other Emotional and Intellectual Disability Services: Current Transactions, Reimbursement Landscape and Landmark Litigation

Anthony Ahee, Honor Equity

Jodi Bouer, Bouer Law LLC

Jason Cowart, Zuckerman Spaeder LLP

Keith Laabs, Carolina Center for ABA and Autism Treatment

Daniel Unumb, Autism Legal Resource Center LLC

2019 Novel Coronavirus, Part II: Health Care Provider Legal Preparedness

Delphine P. O'Rourke, Duane Morris LLP

Mark Ross, Hospital and Health System Association of Pennsylvania

Gregory Sunshine, Centers for Disease Control and Prevention

Sarah E. Swank, Nixon Peabody LLP

AI and Health Law, Part I: Overview—Myth Versus Reality

Scott Bennett, Coppersmith Brockelman PLC

Kathleen Blake, American Medical Association

Rene Y. Quashie, Consumer Technology Association

Mel Tully, Nuance

Compensation under Management Agreements for Joint Venture

Gerald M. Griffith, Jones Day

Jonathan Helm, VMG Health

Rowena Regalado Manlapaz, University of California

Federal False Claims Act: A Year in Review

R. Ross Burris III, Polsinelli PC

Lindsey Lonergan, Navicent Health Inc

Rebekah N. Plowman, Arnall Golden Gregory LLP

Publications, Resources, and Periodicals

AHLA Connections

Regulating the Future of Artificial Intelligence

Carolyn Victoria Metnick, McDermott Will & Emery LLP

Dina B. Ross, Dina B. Ross Law Offices

The Challenges of Applying Health Information Privacy Laws to the Development of Artificial Intelligence

Adam H. Greene, Davis Wright Tremaine LLP

Medical Frontiers in AI Liability

Allie Cohen, DLA Piper LLP

Danny Tobey, DLA Piper LLP

The Importance of Female Mentorship in the Practice of Law

Julia E. Cassidy, Faegre Drinker Biddle & Reath LLP

Embrace Your "Squiggly Line" Journey

Ashley L Thomas, Morris, Manning & Martin

AHLA Weekly

340B Drug Program Year in Review and 2020 Predictions

Robert Daley, Polsinelli PC

William Galvin III, Polsinelli PC

Julius W. Hobson, Polsinelli PC

Lidia M. Niecko-Najjum, Polsinelli PC

Julie Shroyer, Polsinelli PC

Kyle Anthony Vasquez, Polsinelli PC

CMS Issues Final Rule to Implement SUPPORT Act Coverage and Reimbursement of Opioid Treatment

Zachary Ernst, K & L Gates LLP

Rebecca M. Schaefer, K & L Gates LLP

First Publicly–Disclosed Prosecution Under EKRA

Scott R. Grubman, Chilivis Grubman Dalbey & Warner LLP

What Health Care Response Teams Need to Know About Ransomware

Barry Mathis, PYA

Who Is the General Counsel's Client? An Important Development

Michael W. Peregrine, McDermott Will & Emery LLP

Joshua Rogaczewski, McDermott Will & Emery LLP

Key Considerations for Catholic Hospital Mergers

Anna Marie Sossong, Johnson Duffie Stewart & Weidner

Journal of Health & Life Sciences Law

Vol. 13 No. 2 (February 2020)

A. Lee Bentley

Paul E. Dwyer, McElroy Deutsch Mulvaney Carpenter LLP

Sheila W. Elston

Elicia Grilley Green, Bradley Arant Boult Cummings LLP

Marilyn E. Hanzal

Thomas Wm. Mayo, Southern Methodist University Dedman School of Law

Jason P. Mehta, Bradley Arant Boult Cummings LLP

Wendi Campbell Rogaliner, Bradley Arant Boult Cummings LLP

Clint D. Watts, Metro East Office Park

Podcasts

2020 Outlook for Teaching Hospitals and Academic Medical Centers

Craig Hunter, Coker Group

Heather H. Pierce, Association of American Medical Colleges

Kristen B. Rosati, Coppersmith Brockelman PLC

2019's Biggest Antitrust Developments and What to Expect in 2020

John D. Carroll, King & Spalding LLP

Alexis J. Gilman, Crowell & Moring LLP

Fraud and Abuse: Takeaways from Recent Fraud Settlements Involving Patient Assistance Programs

Shana Goetz, Berkeley Research Group

Kevin E. Raphael, Pietragallo Gordon Alfano Bosick & Raspanti LLP

Matthew E. Wetzel, GRAIL

Fraud and Abuse: Use of Digital Forensic Services in Defending Government Investigations

Kevin E. Raphael, Pietragallo Gordon Alfano Bosick & Raspanti LLP

Gregory Russo, Berkeley Research Group LLC

Matthew E. Wetzel, GRAIL

Launching Your Career in Health Law, Part 2

Amy Simmons, Epstein Becker & Green PC

Thomas Wronski, Thomas Wronski + Associates Inc

The Lighter Side of Health Law

Norman G. Tabler Jr., Faegre Baker Daniels LLP (Ret.)

Practice Group Alerts

PA Superior Court Holds Physician Credentialing File Is Not Protected by State Peer Review Privilege

Avery Schumacher, Bricker & Eckler LLP

Practice Group Briefings

Beyond Quality and Safety: How Patient Safety Organizations Impact Business and Financial Outcomes

Janice Suchyta, Seyfarth Shaw LLP

Physician Compensation and Compliance: More Than Just the Individual Components

Kimberly A. Mobley, Sullivan Cotter and Associates Inc

Wesley Roland Sylla, Hall Render Killian Heath & Lyman PC

Bartt Warner, VMG Health

Practice Group Bulletins

Exploring Parental Rights, Medical Profes–sionals' Opinions, & Medical Futility Laws

Laura Hoffman, Seton Hall University School of Law

FDA to Convert Some NDAs to BLAs on March 23, 2020

Lindsay P. Holmes, BakerHostetler

Lee H. Rosebush, BakerHostetler

Marc Wagner, BakerHostetler

Lions, Tigers, and Contracts, Oh My: Lessons Learned in Implementing a Contract Management Process

Stella M. Ghattas, Children's National Hospital

Practice Group Toolkits

What Hospitals Need to Do to Prepare for a Coronavirus Outbreak: Overview and Checklist

Delphine P. O'Rourke, Duane Morris LLP

Matched Mentors and Mentees

Mentors

Brett McNeal, Lexington Medical Center

Tamala Choma, LA Care Health Plan

Andrea Barach, Emerald Shelter Group

Mentees

Roopa Chakkappan, Hodgson Russ LLP

Suzanne Burke, Northern Light Health

Thomas Faragoi, United States Army Medical Command Office of Soldiers' Counsel

Upcoming Live Webinars

Focus On Compliance

May 5

Medicaid Payment Reform – Uncertain Future of Supplemental Payments

May 6

Hearing Rights for Advanced Practice Professionals

May 7

Crisis or Opportunity? Hospitals Serving Special Populations and the Legal Challenges of Integrated, Accountable and Coordinated Care, Part I: Convergence and Collaboration

May 8

Health Information and Technology Practice Group Educational Call *(Open only to members of the Practice Group.)*

May 12

Lessons Learned from a CIA: From Implementation through Exit

May 13

State AG Enforcement Actions Against Health Providers

May 14

Cutting Edge Issues and Trends in Health Care Fair Market Value, Part II: Designing Transitional Compensation Models During the COVID-19 Pandemic

May 19

AI and Health Law, Part IV: Privacy and Security

May 20

Health Care Systems: Navigating the Tax Consequences for Nonprofit and For-Profit Structures

May 21

What Every Health Lawyer MUST Know About Working iwth Protection and Advocacy Agencies

June 2

Deploying Resources to Drive Value-Based Care: Potential Opportunities and Stumbling Blocks in Light of Stark/AKS Proposals

June 3

Medical Staff, Credentialing, and Peer Review Practice Group Educational Call *(Open only to members of the Practice Group.)*

June 4

Crisis or Opportunity?: Hospitals Serving Special Populations and the LEgal Challenges of Integrated, Accountable and Coordinated Care, Part II: Data or Bust

June 9

CCPA in Healthcare

June 10

Fraud and Abuse in the Age of Coronavirus: Current and Future Federal Criminal and Civil Enforcement Actions

June 11

Medicare Advantage Risk Adjustment: Legal Issues for MA Plans, Providers, and Vendors

June 17

Value-Based Payments in Public and Not-for-Profit Hospitals in the Age of COVID-19

June 18

Cutting Edge Issues and Trends in Health Care Fair Market Value, Part III: Advanced Practice Providers—How the COVID-19 Pandemic Changed he Utilization and Deployment of APPs

In-Person Events

June 29-July 1

Virtual Annual Meeting

July 9 and 16

Virtual In-House Counsel Program
Ntracts has provided sponsorship in support of this program.

September 30-October 2

Fraud and Compliance Forum
Renaissance Harborplace Hotel
Baltimore, MD

October 22-23

Tax Issues for Health Care Organizations
Crystal Gateway Hotel
Arlington, VA

November 5-6

Health Plan Law and Compliance Institute
Chicago Marriott Magnificent Mile
Chicago, IL

November 11-13

Fundamentals of Health Law
Renaissance Chicago Hotel
Chicago, IL

For more information on all AHLA events and to register, go to www.americanhealthlaw.org/education-events or call (202) 833-1100, prompt #2.

Quick Tips on Navigating the New Website

As part of AHLA's rebrand, we launched a new website in March to improve your experience and engagement with us. The new features are designed to enhance and streamline overall functionality, as well as personalize your experience on the website and tailor AHLA content to you based on your interests and areas of practice. Below are some of the main features of the new website that were developed with you in mind.

Main Menu Navigation

The robust main menu from the old website has been incorporated into the new website with a few additional enhancements:

- **Top Utility Menu** – Access important AHLA services like Dispute Resolution, the AHLA Career Center, and the AHLA/LexisNexis Bookstore, from anywhere on the website. From time to time, other important resources will be highlighted, such as the currently featured Health Law Hub: Coronavirus Pandemic.
- **Practice Groups** – In the third column, quickly access the most recent Practice Group publications.
- **Communities** – In the third column, see the most recent discussions so you can quickly join the conversation.

Greater Personalization on the Home Page

When you log into the new website, the home page adjusts to your interests:

- **Practice Groups** – Below the main menu, quickly jump to your Practice Group Topical Libraries to view the latest news and analysis and upcoming webinars.
- **Registrations** – Below your Practice Groups, quickly jump to any upcoming in-person programs or webinars for which you are registered.
- **Recent Health Law Headlines and Education and Events** – Both areas show content relevant to you based on your Practice Group enrollment and content preferences. Over time, this area of the website will become more and more tailored to you, providing you with quick access to the content you find most interesting and relevant.
- **News and Analysis from Your Practice Groups** – Towards the bottom of the home page, view the latest publications and resources from your Practice Groups.

Practice Group Content

Each Practice Group page has a newly formatted Topical Library that shows all content produced by the Practice Group in date order, beginning with the most recent. However, you can quickly filter the content to display:

- **News and Analysis** – Recent PG Alerts, Bulletins, and Briefings, and articles from AHLA member publications such as *Health Law Weekly* and *Health Law Connections*, published by the Practice Group.
- **Webinars and Educational Calls** – Upcoming distance learning events planned by the Practice Group.
- **Resources** – In-depth reference tools like Toolkits and Surveys.
- Additionally, on the right rail of the page, you'll find quick access to Volunteer Opportunities, any associated Affinity Groups, and recent discussions from related Communities.

Can't Find What You're Looking For?

We're here to help! If you are struggling to find a resource or encountering any other issues with our website, please email us at webmaster@americanhealthlaw.org and we will be happy to assist you.

AHLA Speaking of Health Law

COVID-19 PODCASTS

AHLA is dedicated to helping our members and the public stay up to date on new developments on the coronavirus pandemic. Our podcasts feature speakers on the front lines of the COVID–19 response and target the most pressing issues the health care legal community is facing.

COVID–19 GC ROUNDTABLE—PART 3

In the third podcast in this series with hospital general counsel on the front lines of the coronavirus pandemic, Sarah Swank, Counsel, Nixon Peabody LLP, speaks with Elizabeth Trende, Senior Associate General Counsel, Ohio State University Medical Center, Aletheia Lawry, Associate General Counsel, HonorHealth, and Brian White, General Counsel and Vice Chancellor for Legal Affairs, University of Kansas, about the challenges their health systems are facing—including staffing, budget, and operational issues—and how they are dealing with those challenges.

ANTITRUST COLLABORATIONS IN LIGHT OF COVID–19

In this podcast, Monica Noether, Vice President, Charles River Associates, talks to Robert Canterman, senior attorney, Health Care Division, FTC Bureau of Competition, and Peggy Ward, Partner, Jones Day, about the types of health care provider collaborations likely to happen in response to the COVID-19 pandemic. The podcast discusses limits to the appropriate scope of coordination, available agency guidance for providers seeking to form collaborations, and examines what key issues FTC staff will consider when evaluating proposals. Sponsored by Charles River Associates.

RURAL HEALTH CARE AND COVID–19

In this podcast, attorney Ellie Bane speaks with Vonne Jacobs, Principal and Founder, Pharos Healthcare Consulting, Delphine O'Rourke, Partner, Duane Morris, Andrea Ferrari, Partner, HealthCare Appraisers, Michael Watters, Chief Legal Officer and General Counsel, Essentia Health, and Steve Clapp, President and CEO, Strategic Healthcare Advisers, about how rural health care providers are dealing with the challenges presented by the coronavirus pandemic. The speakers share stories of how rural providers are facing these challenges, and discuss issues such as limited resources and supplies, staffing and capacity issues, and the future of rural health care.

PREPARING FOR PATIENT SURGES DUE TO COVID–19: WHAT COUNSEL NEED TO KNOW—PART 2

In Part 2 of this podcast series on what counsel need to know to prepare for patient surges due to COVID-19, Andrea Ferrari, Partner, HealthCare Appraisers, speaks with Tom Donohoe, Vice President & Deputy General Counsel, SCL Health, and Melissa Markey, Hall Render Killian Heath & Lyman PC. The podcast covers issues related to resource allocation, including incremental supply contracts, redeployment, and supply chain issues. Sponsored by HealthCare Appraisers.

Listen Now!

Listen on Apple Podcasts | GET IT ON Google play | buzzsprout

AHLA's Online Career Center will allow you to:

Manage Your Career:

- Search and apply to more health law jobs than in any other job bank.
- Upload your anonymous resume and allow employers to contact you through the AHLA Career Center's messaging system.
- Set up Job Alerts specifying your skills, interests, and preferred location(s) to receive email notifications when a job is posted that matches your criteria.
- Access career resources and job searching tips and tools.
- Have your resume critiqued by a resume-writing expert.

Recruit for Open Positions:

- Post your job in front of the most qualified group of health law professionals in the industry.
- Promote your jobs directly to candidates via the exclusive Job Flash email.
- Search the anonymous resume database to find qualified candidates.
- Manage your posted jobs and applicant activity easily on this user-friendly site.

For more information and to start the journey to enhance your career or organization, please visit the AHLA Career Center at https://careercenter.americanhealthlaw.org.

Online Career Center Snapshot

2945+
Employers

895+
Job Seekers

15+
Open Positions

VIEWPOINT/WRITERS' GUIDELINES

Health Law Connections must retain full copyright or an unlimited license before publishing. Factual accuracy and opinion contained in articles published in Health Law Connections are the responsibility of the authors alone and should not be interpreted as representing the views or opinions of the Association. AHLA is a non-partisan educational organization that does not take positions on public policy issues and instead provides a forum for an informed exchange of views. Guidelines available at www.americanhealthlaw.org/connections or contact editorial@americanhealthlaw.org.

Health Law Connections (ISSN1949-9035) is published monthly (12 times a year) by the American Health Law Association (AHLA), 1620 Eye Street, NW, 6th Floor, Washington, DC 20006-4010. The price of an annual subscription for AHLA members ($45) is included inseparably in their dues. Annual subscription for non-members is $105. Title registered U.S. Pat. And TM office ©2020 by AHLA, Periodicals postage paid at Washington, DC, and additional mailing offices. All rights reserved. Printed in the United States.

MISSION

The Mission of the American Health Law Association is to provide a collegial forum for interaction and information exchange to enable its members to serve their clients more effectively; to produce the highest quality non-partisan educational programs, products, and services concerning health law issues; and to serve as a public resource on selected health care legal issues.

AHLA Diversity+Inclusion Statement

In principle and in practice, the American Health Law Association values and seeks to advance and promote diverse and inclusive participation within the Association regardless of gender, race, ethnicity, religion, age, sexual orientation, gender identity and expression, national origin, or disability. Guided by these values, the Association strongly encourages and embraces participation of diverse individuals as it leads health law to excellence through education, information, and dialogue.

PRINTED ON RECYCLED PAPER

POSTMASTER: Send address changes and circulation inquiries to: AHLA, 1620 Eye Street NW, 6th Floor, Washington, DC 20006-4010.

AHLA's Guide to Health Care Legal Forms, Agreements, and Policies

THIRD EDITION © 2020

TOOLS DEVELOPED BY PRACTICING ATTORNEYS TO SOLVE REAL-WORLD PROBLEMS

AHLA's Guide to Health Care Legal Forms, Agreements, and Policies is designed to help you work more efficiently and accurately by providing hundreds of documents, checklists, and policies you can tailor to your clients' needs.

MAP FOR YOUR DAY-TO-DAY WORK

This revised *Guide* represents the cumulative work of scores of health care attorneys and other professionals who share their real-time, practical experience with colleagues. With the wealth of sample tools contained in the *Guide*, and forms readily available to download, users will have a go-to source for readily extracting and adapting material needed in their day-to-day work.

BROAD COVERAGE

Now with three volumes of material, *AHLA's Guide to Health Care Legal Forms, Agreements, and Policies* offers an unprecedented collection spanning many areas of coverage, including: transactions, corporate compliance, facility operations, fraud and abuse, governance, health information, contracting, labor and employment, physician practices, reimbursement, and more.

NEW IN THE THIRD EDITION

- Content has been divided into three convenient volumes for easier handling.
- Material is organized into 15 chapters with clearly defined subsections for easier access to material.
- More than 90 new resources have been added—AHLA expanded its reach, by reviewing and selecting sample forms and policies from outside sources, including professional associations, health care providers, and legal experts.
- All forms are now conveniently available online for download as Microsoft Word files.

Table of Contents

Your New AHLA Membership Benefits

We are excited to announce that AHLA's new membership model has been rolled out and we have converted your membership to its new membership level that most closely aligned with your current member category and work setting, as well as your number of Practice Group enrollments.

Our commitment to providing high-quality educational offerings and career-building opportunities will not change with this roll out. And, your annual membership anniversary and renewal dates, which are based on the month you joined AHLA, are also not changing.

However, this new membership model now offers you a more personalized membership experience by allowing you to choose a membership level that fits your educational needs and professional goals. Please take a moment to browse your membership level below and our frequently asked questions to better understand your new benefit package.

View Your Membership Level at **https://my.americanhealthlaw.org/** in the myAHLA Portal under My Account, My Membership.

View Frequently Asked Questions at **http://www.americanhealthlaw.org/membershipmodel**

Membership Levels

Benefits:	Full **$269**	Enhanced **$369**	Premium **$499**
AHLA Communities discussion groups	✓	✓	✓
AHLA Connections monthly magazine (digital and print)	✓	✓	✓
Journal of Health & Life Sciences Law (digital)	✓	✓	✓
Substantive health law eNewsletter subscriptions – *AHLA Weekly* – *Health & Life Sciences Law Daily* – *Newsstand on State Health Law Issues*	✓	✓	✓
ONE Practice Group of your choice with automatic enrollment in associated Affinity Group(s)	✓	✓	✓
Enrollment in ALL Task Forces	✓	✓	✓
Member pricing for live Webinars ($50 savings), Programs ($175 savings), and Publications (varies)	✓	✓	✓
FREE subscription to the Health Law Archive upon joining, with discounted renewal in subsequent years	✓	✓	✓
An additional Practice Group of your choice (TWO total)		✓	✓
One FREE live Webinar per year PLUS discounts on subsequent live Webinars ($100 total savings per live webinar)		✓	✓
Discounts for Programs ($225 total savings per Program)		✓	✓
Deeper discount when renewing Health Law Archive in subsequent years		✓	✓
Access to ALL 16 Practice Groups			✓
Educational pass offering UNLIMITED access to all live Webinars			✓
Deeper discounts for Programs ($275 total savings per Program)			✓
FREE access to the HealthLaw Archive			✓