

HLB

HOOPER, LUNDY & BOOKMAN, P.C.
HEALTH CARE LAWYERS



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HLB Sues California on Behalf of Hospitals Challenges CMS Approval of Draconian Medi-Cal Rate Cuts

On November 1, Hooper, Lundy & Bookman (“HLB”) filed a complaint in federal court on behalf of the California Hospital Association (“CHA”) in an attempt to halt an untenable cut in reimbursement to hospitals that provide skilled nursing care to the state’s most vulnerable populations.

“The state of California is preparing to unleash a reduction of unprecedented magnitude in the rates that hospitals are compensated for providing skilled nursing care to Medi-Cal beneficiaries” said Lloyd Bookman, lead attorney representing CHA. The rate cut, which will drop rates by between 23-25% percent from current payment levels was enacted by the State Legislature, “all in the name of budgetary savings.” The payment reduction, which was approved by the Centers for Medicare and Medicaid Services (“CMS”) in late October, effectively rolls back reimbursement to 2008 levels, less an additional 10 percent, for hospital skilled nursing units, call distinct part nursing facilities (DP/NFs).

CMS approved this draconian cut in reimbursement despite numerous state and federal court rulings finding such that similar cuts were enacted and implemented by California in violation federal Medicaid law and despite the state’s wholly unconvincing showing that that the rate reduction will not adversely affect access to hospital skilled nursing care for Medi-Cal beneficiaries.

“This massive payment reduction will almost immediately threaten the ability of many hospitals to continue to operate skilled nursing units,” Bookman said. “When these units are forced to close, it will, at worst, create significant gaps in access to such services for Medi-Cal beneficiaries, particularly those residing

in already medically underserved, rural areas. At best, the cut will cause significant delay in patients obtaining needed services.” Bookman further predicted that patients will be forced to remain in costly acute care settings, or transferred to freestanding facilities with less capacity to handle the kind of complex patients that are typically treated in DP/NFs.

Primary Allegations

- Allegations in the complaint filed by HLB include :
- The rate cut results in hospitals being improperly deprived of their privately enforceable right to be free of government imposed takings of private property without just compensation that is guaranteed under the U. S. Constitution and the California Constitution.
 - The rate reduction violates federal Medicaid law in that the rate reduction will effectively prevent many Medi-Cal beneficiaries from obtaining needed skilled nursing care with reasonable promptness.
 - The rate reduction will effectively dictate that skilled nursing care is being covered and reim-

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bursed under Medi-Cal in a manner that is not in the best interests of patients for several reasons, including, for example, :

- o Closure or reduction in services by DP/NFs will often require patients to be placed in facilities that are very distant from patient and family residences.
- Neither the California Legislature nor the Department of Health Care Services adequately considered the factors of efficiency, economy, quality of care and access to services prior to enacting and/or moving seeking to implement the rate reduction, as required by federal Medicaid law.
- CMS did not follow the binding rulings of the U.S. Ninth Circuit Court of Appeals in evaluating and ultimately approving the rate cut.
- The rates as reduced are not reasonably related to provider costs, but, on average, reimburse only about 60% of hospital costs..

Based on the allegations in the complaint, CHA will seek a preliminary injunctive relief, which will prohibit the State from applying the rate reduction to DP/NF providers. The federal district court is expected to hear argument on the CHA's injunction request on December 19, 2011.

In addition to cuts approved for DP/NFs, CMS also approved rate reductions for several other services, including a 10 percent reduction from current Medi-Cal reimbursement for physicians, pharmacies and pediatric dental care.

For additional information, please contact Lloyd Bookman or Jordan Keville in Los Angeles at 310.551.8111, or Felicia Sze in San Francisco at 415.875.8500.

Arbitration Choices to Keep in Mind

By Michael Houske

All health care providers should be aware of two recent developments that could impact future arbitration agreements between providers and payors of health care services.

First, the United States Supreme Court, in *AT&T Mobility v. Concepcion*, held that a waiver of class action arbitration contained in an arbitration agreement was not unconscionable. Based on this ruling, providers may seek class action arbitration waivers in all

new contracts with payors. Accepting such provisions means giving up the right to get the benefit from class actions that may be filed by others, and thus, could require each provider to actively pursue litigation themselves on issues that otherwise could be handled through the class action mechanism.

Second, the American Arbitration Association ("AAA") has developed a special set of rules for handling arbitrations involving payor-provider health care disputes, which among other things (1) expressly provide that all arbitrations under these rules will not be shared with others, and (2) will not have any res judicata, collateral estoppel or precedential effect. The result would be to inhibit the ability of providers to share or extend the results of good arbitration determinations against a payor that might commit the same pattern of wrongdoing against others. It seems to us that in most situations these new AAA rules are far more beneficial to payors, and far more detrimental to providers. Therefore, our general recommendation to providers would be to reject any proposed arbitration clause that selects the AAA's special payor-provider arbitration rules, and either use the rules of a different arbitration association, or use the AAA's standard Commercial rules.

AT&T Mobility v. Concepcion

With the rise of provisions in contracts requiring parties to waive their rights to class actions in arbitration, states enacted laws to restrict these class action waiver provisions. In support of the federal policy favoring arbitration, however, the United States Supreme Court negated state efforts to restrict class action waivers in arbitration agreements. The Court has held that class action arbitration waivers are not unconscionable, and are enforceable. This ruling appears to apply to all types of contracts, including arms-length agreements between businesses and between companies and consumers. The Court's holding virtually ensures that many more proposed arbitration agreements will contain class action arbitration waivers.

In *AT&T Mobility v. Concepcion* (2011) 131 S. Ct. 1740, the Supreme Court was faced with a class action arbitration waiver contained in consumer cell phone contracts with Cingular Wireless, predecessor of AT&T Mobility. A group of consumers brought a class action alleging fraud because the cell phone

service being offered in the contracts supposedly included a free cell phone, which did not turn out to be free because the consumers were charged sales tax on the phone. AT&T moved to enforce the arbitration provision in the contract which allowed arbitration in a “individual capacity, and not as a plaintiff or class member in any purported class action or representative proceeding.” The plaintiffs opposed the motion to compel by arguing that, under California law, the arbitration agreement was unconscionable because it disallowed class wide arbitration procedures.” The Supreme Court ruled for AT&T.

According to the Supreme Court, the purpose of the Federal Arbitration Act is to ensure the enforcement of arbitration agreements so as to streamline proceedings, and to require the availability of class-wide arbitration would bring into the arbitration all the cost, delay, procedural formalities and unfair settlement pressures of class litigation that Congress did not envision in enacting the FAA in 1925. The Court’s decision in *AT&T Mobility v. Concepcion* was in the context of a consumer agreement, but the practical impact of the holding will be a proliferation of class action waivers in almost every contract containing an arbitration provision to resolve disputes.

Based on this ruling, payors may include provisions in their contracts with providers requiring that the providers waive their rights to class action arbitrations. Providers are not required to accept these class action waivers. In the alternative, a provider may wish to at least negotiate a fair trade from the payor in exchange for waiving the right to arbitrate. But it is important to realize that class action waivers actually can increase the likelihood of needing to use litigations, by forcing each provider to actively pursue legal action, rather than benefiting as an unnamed class member.

AAA’s Special Payor-Provider Health Care Rules

The AAA has developed a special set of rules for handling arbitrations involving payor-provider disputes. Absent an agreement to use these special rules, the default rules for an arbitration provision that refers to the AAA would be the AAA’s Commercial Rules. Nonetheless, the AAA is asking providers who file arbitration demands whether they want to use these

rules or not. Our general view at this time is that the new special rules are tilted toward payors, that health care providers should NOT agree to accept them, and should instead either use the AAA’s Commercial Rules, or seek to use the rules of another arbitration association.

There are at least two key provisions in the new rules that lead to this conclusion. First, the new special rules contain an express provision that the outcome of an arbitration conducted pursuant to them is to be confidential. In contrast, the AAA’s Commercial Rules are silent on the issue of confidentiality. Thus, under the Commercial Rules, absent an express provision in the arbitration agreement to the contrary, a provider who wins an arbitration has the ability to share the results with other providers. This can benefit providers whether they win arbitrations, or whether other providers win arbitrations on conduct by payors that are repeated elsewhere. Moreover, although either side can win in an arbitration, our experience has been that providers who pursue arbitration against payors are far more likely to prevail.

Second, the new rules expressly preclude using the results of an arbitration for *res judicata*, collateral estoppel or precedential effect. This means that a good result in arbitration for a provider could not be used against the losing payor, whether by the same provider, or by other providers. In contrast, the standard Commercial rules are silent on the issue.

We strongly suspect that the new AAA payor-provider dispute rules were drafted at the suggestion of and/or with strong input by payors, who want to suppress the results of the growing body of arbitration outcomes against them. Once again, the likely outcome of these new rules would be to increase the potential for legal actions, by forcing the same issues to be arbitrated over and over.

HLB attorneys have extensive experience advising clients on dispute resolution provisions like arbitration, both in the contract negotiation stage, and when disputes arise.

For additional information, please contact Daron Tooch or Glenn Solomon in Los Angeles at 310.551.8111.

Electronic Health Records Incentive Programs: The Issue of Assignment*

The Health Information Technology for Clinical Health Act of 2009 (“HITECH Act”) created the Medicare and Medicaid Electronic Health Records (“EHR”) Incentive Programs, which provide funding in the form of “incentive payments” to healthcare providers that successfully demonstrate the “meaningful use” of certified EHR technology.¹

Providers are required to meet a series of measures and thresholds on an annual basis in order to qualify for incentive payments.² Hospitals may participate in both the Medicare and Medicaid incentive programs, whereas “eligible professionals” or “EPs” must choose to participate in either the Medicare incentive program or the Medicaid incentive program, with the opportunity to switch between programs once before 2015.³

This article will cover the basics of EHR assignment, a contractual mechanism by which a hospital may - through an agreement with the EP- obtain the assignment of the incentive payments that would otherwise go directly to eligible professionals working for the hospital and seeing patients of the hospital outside of the inpatient setting.⁴ In this way, assignment is a good option for hospitals seeking to recoup part of the significant costs associated with implementing an EHR system.

When Assignment May Be Appropriate

Many hospitals have already devoted significant amounts of time to selecting, purchasing, and installing certified EHR technology in order to qualify for incentive payments as a hospital. If a hospital also provides certified EHR technology to any non-hospital based EPs, for example through the installation of certified ambulatory EHR technology in its outpatient or community clinics, the hospital may be able to seek assignment of the EPs’ incentive payments.

As a practical matter, if the hospital incurs the entire cost of installing EHR technology, and assists the individual EP with demonstrating meaningful use each year, the hospital and the EP may feel that assignment is an appropriate way for the hospital to recoup some of the costs associated with equipping its clinics

and physicians with certified EHR technology. As assignment is voluntary, however, some EPs may simply not wish to enter into assignment agreements, opting instead to keep some or all of the EHR incentive payments, particularly where the EP has a contentious relationship with the hospital or where the EP feels that he or she is losing money based on decreased productivity while the EHR system is being implemented.

Issues for Hospitals to Consider when Contemplating Assignment

If a hospital wishes to approach its EPs about the issue of assignment, the hospital should consider the following questions:

Question 1: What must the hospital do to qualify EPs for incentive payments?

By now, many hospitals have already consulted with their legal counsel to determine whether they can qualify as a hospital for incentive payments under the Medicare and/or Medicaid incentive programs.⁵ If so, the next step is typically for the hospital to discuss EHR with its technical support personnel and with the physicians and other healthcare professionals who will be using the EHR to provide services to hospital patients. Hospitals should purchase technology that has been (or will be) certified by the Office of the National Coordinator for Health Information Technology.⁶

A hospital that cannot qualify for the incentive payments as a hospital can still implement EHR technology for its individual providers and then attempt to obtain the assignment of the EHR incentive payments that would otherwise go directly to the EPs.

Question 2: Do the physicians or other health professionals who are using the hospital’s EHR technology qualify for either incentive program?

As explained above, EPs must choose between participating in the Medicare incentive program and the Medicaid incentive program. Because EPs have a one-time option to change from one program to the other before 2015, any assignment agreement should be flexible enough to address both programs.⁷

The incentive programs for individuals apply only

*A version of this article originally appeared in the September, 2011 issue of ABA Health eSource newsletter and is reprinted with permission.

to non-hospital based healthcare professionals. A “hospital-based” professional provides 90 percent or more of his or her covered professional services in either an inpatient hospital setting (Place of Service 21) or an emergency room (Place of Service 23).⁸

In addition, to qualify for the Medicare incentive program, the physician must be paid under the Physician Fee Schedule, and be a doctor of medicine, osteopathy, dental surgery, dental medicine, podiatry, optometry or chiropractor who is legally authorized to practice his or her profession under state law.⁹ An EP who demonstrates meaningful use under the Medicare program can potentially receive up to a total of \$44,000 in incentive payments.¹⁰ The Medicare incentive payments are based on charges, and are calculated by taking 75 percent of the estimated allowed charges for professional services furnished by the EP during the payment year.¹¹

To qualify for the Medicaid incentive program, the EP must not be hospital based¹², and can be either a physician or a non-physician practitioner (dentist, certified nurse-midwife, nurse practitioner, or a physician assistant if the PA is practicing in a PA-led rural health clinic or federally qualified health clinic), and have at least 30 percent Medicaid volume.¹³ An EP who demonstrates meaningful use under the Medicaid incentive program can potentially receive up to a total of \$63,750.¹⁴ The Medicaid incentive payments are based on costs, which are defined as Year 1 costs associated with the purchase and initial implementation or upgrade of certified EHR technology and support services, including training, as necessary for adoption and initial operation; and costs after Year 1 associated with operation, maintenance, and use of certified EHR technology.¹⁵ The incentive payments are equal to 85 percent of the net average allowable costs.¹⁶

It is not yet clear how each state will choose to calculate “costs” and whether those costs will only include costs to the EP, or costs to the entity that provided the EP with the technology.¹⁷ Accordingly, before the hospital and EP agree that the EP will participate in the Medicaid incentive program, a legal analysis of the relevant state EHR rules is advisable. For example, California recently published an FAQ on its Medi-Cal EHR website stating that there is no minimum spending amount required, meaning that an eligible professional who qualifies for the Medicaid EHR in-

centive program will receive the full amount as long as he or she demonstrates the adoption, implementation, or upgrade of certified EHR technology for the first year, and the meaningful use of EHR technology for subsequent years.¹⁸

Question 3: Is Assignment of the Incentive Payments to the Hospital Legally Permitted?

An EP may assign his or her incentive payment to an employer or entity with which the EP has a valid contractual arrangement allowing the entity to bill for the EP’s services.¹⁹

Under Medicare, assignment may be made to an entity that bills under group and physician numbers as part of that entity’s management services, even where the physicians are independent contractors, as long as the entity meets the applicable regulatory requirements, meaning that the entity furnishes billing and collection services to the EP and:

- (a) The entity receives the payment under an agency agreement with the EP,
- (b) The entity’s compensation is not related in any way to the dollar amounts billed or collected,
- (c) The entity’s compensation is not dependent upon the actual collection of payment,
- (d) The entity acts under payment disposition instructions that the EP may modify or revoke at any time, and
- (e) The entity, in receiving the payment, acts only on behalf of the EP.²⁰

Accordingly, a legal analysis should be done to ensure that a contractual arrangement that fulfills these requirements already is or will be in place. The parties can agree to such an arrangement as part of the assignment language related to the EHR incentive payments.

Under the Medicaid incentive program, an EP may also reassign incentive payments to “an entity promoting the adoption of certified EHR technology.” This term is defined as:

State-designated entities that are promoting the adoption of certified EHR technology by enabling oversight of the business, operational and legal issues involved in the adoption and implementation of certified EHR technology or by enabling the exchange and use of electronic clinical and administrative data between participating

ministrative data between participating providers, in a secure manner, including maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by eligible providers.²¹

States must establish methods of designating such entities. No more than 5 percent of the incentive payment may be retained by the entity for costs not related to certified EHR technology, or the support services including maintenance and training that is for, or is necessary for, the operation of the technology.²²

Additional Considerations

In both the Medicare and Medicaid programs, assignment must be voluntary and may be made only to one entity.²³ In other words, EPs are not required to assign their incentive payments to the hospital, even if the hospital provides them with EHR technology.²⁴ In addition, the assignment must be compliant with the applicable Medicare laws, rules, and regulations, including, without limitation, those related to fraud, waste, and abuse, specifically federal anti-kickback and Stark statutes.

Functionally, the assignment process can begin as early as when an EP first enrolls in the incentive programs via the CMS website, at which time the EP can enter the employer or taxpayer identification number that will receive the EP's EHR incentive payment.²⁵

Suggested Assignment Language

Assignment language can take several forms. If there is already a contract in place, such as an employment or independent contractor agreement between the hospital and EP, the assignment language can become an amendment to that contract. If a contract is about to be executed, the assignment language can become part of the body of the contract itself, or an exhibit to the contract. Or, if the parties prefer to handle EHR issues outside of an existing contract, the assignment language can take the form of a freestanding agreement between the hospital and the EP.

At a minimum, the assignment language should address the following issues:

(1) If the EP designates the hospital's TIN, the entire incentive payment will go to the hospital. If

the parties wish to work out any sharing or subsequent distribution of the incentive payment, the assignment language should address this.

(2) The parties may agree that the hospital will furnish the documentation necessary for the EP to establish meaningful use each year.

(3) The parties may also wish to agree that the EP will consult with the hospital prior to enrollment in order to determine which incentive program will yield the higher possible payments.

(4) The assignment language should state, accurately, whether the hospital expects to be designated as an "entity promoting the adoption of certified EHR technology."²⁶

(5) The contract should state, accurately, whether there is or will be a valid contractual arrangement allowing the hospital to bill for the EP's services.²⁷

(6) The parties may wish to specify that the EP will submit all of the required forms and certifications for obtaining the incentive payments. The hospital may agree to assist the EP with completing and submitting those forms, and even assist the EP with the initial enrollment process, during which time the EP will designate the hospital's TIN.

(7) The term of the assignment provisions should be addressed, particularly if the assignment language is contained in an exhibit or amendment to an existing contract. If the duration of the incentive program will extend beyond the expiration date of the original contract, care should be taken to articulate clear terms for the assignment language.

Conclusion

As each hospital selects, purchases, and installs EHR technology, it will incur significant costs. Assignment, where possible, is an excellent opportunity for hospitals to recoup some of these costs. Accordingly, as each hospital plans the implementation of its EHR program, it should consider the feasibility and appropriateness of assignment, and discuss the issues articulated above with its legal counsel, physician staff members, and technology experts.

For additional information, please contact John Hellow in Los Angeles at 310.551.8111; Steven Phillips, Paul Deeringer or Felicia Sze in San Francisco at 415.875.8500; Kitty Juniper in San Diego at

619.744.7300; or Robert Roth in Washington, D.C. at 202.587.2590.

¹ 75 Federal Register (“Fed. Reg.”) 44314, 44315-44316 (July 28, 2010).

² 42 Code of Federal Regulations (“C.F.R.”) §§ 495.6, 495.8.

³ 42 C.F.R. § 495.10(e)(2).

⁴ 42 C.F.R. § 495.10(f).

⁵ The eligibility requirements for hospitals are set forth for the Medicare program at 42 C.F.R. § 495.102, and additional requirements for the Medicaid program are set forth at 42 C.F.R. § 495.304(e).

⁶ Information about the certified EHR technology is available on the ONC website at: <http://onc-chpl.force.com/ehrcert>.

⁷ 42 C.F.R. § 495.10(e)(2).

⁸ 42 C.F.R. § 495.4; 75 Fed. Reg. at 4442; “Medicare & Medicaid EHR Incentive Program: Basics for Eligible Professionals, July 14, 2011 National Provider Call” Slide 3, available here: www.cms.gov/EHRIncentivePrograms/Downloads/NPC_Basics_EPs.pdf. Place of service codes are set forth in the Medicare Claims Processing Manual. POS 21 is an Inpatient Hospital, which is defined as a “facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.” POS 23 is an Emergency Room – Hospital, which is defined as a “portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.” Medicare Claims Processing Manual, Chapter 26, Section 10.5. On the CMS-1500 claims form, the POS code is entered into Field 24B. *Id.* at Section 10.4.

⁹ 42 C.F.R. § 495.100.

¹⁰ 42 C.F.R. § 495.102(b).

¹¹ 42 C.F.R. § 495.102(a)(1). The Medicare “allowed charge” is the lesser of the actual charge or the Medicare physician fee schedule amount. 75 Fed. Reg. at 44442. The “estimated allowed charges” are based on claims submitted no later than 2 months after the end of the payment year. 42 C.F.R. § 495.102(a)(2); 75 Fed. Reg. at 44442-44443. If EP has multiple practices, allowed charges are determined based on claims submitted for EP’s covered professional services across all such practices. See 42 C.F.R. § 495.102(a)(2).

¹² States will make the determination based on an EP’s Medicaid claims data from the prior fiscal or calendar year. EPs will be notified of hospital-based status “no later than early in each payment year.” 75 Fed. Reg. at 44441-44442. This requirement does not apply to EPs practicing predominantly in an FQHC or RHC.

“Predominantly” occurs when the clinical location for over 50% of the EP’s total patient encounters over a period of 6 months occurs in an FQHC or RHC. 42 C.F.R. §§ 495.304(d), 495.302.

¹³ 42 C.F.R. § 495.304(b) and (c). There are two exceptions to the volume requirement. First, pediatricians need only a 20% Medicaid volume. 42 C.F.R. § 495.304(c)(2). Second, eligible professionals practicing in a Federally Qualified Health Center or a Rural Health Center must have a 30% volume of “needy individuals,” which are defined as those meeting any of the following three criteria: (i) receiving medical assistance under Medicaid or Children’s Health Insurance Program (CHIP), (ii) furnished uncompensated care by the provider, or (iii) furnished services at no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay. 42 C.F.R. §§ 495.304(c)(3), 495.302.

¹⁴ 42 C.F.R. § 495.102.

¹⁵ 42 United States Code (“U.S.C.”) § 1396b(t)(3)(C)(i).

¹⁶ 42 C.F.R. § 495.310(a).

¹⁷ The 85% figure is derived from statute. Per 42 U.S.C. § 1396b(t)(6)(B), CMS will pay no more than 85% of the net allowable costs, and the provider will be responsible for the remaining 15%. CMS indicated in the EHR Final Rule that states should consider costs to the entity providing the technology when calculating the EP’s 15% responsibility. As an example, CMS stated that if an EP is an employee of an FQHC and the FQHC provides the technology, it is “assumed” that the employer contributed the 15% of net allowable costs on behalf of the employee. 75 Fed. Reg. at 44493-44494. It is not clear whether CMS would treat an FQHC differently from a hospital for these purposes. Although the Federal Register language implies that an employer’s provision of EHR technology may count toward net allowable costs, it is not clear whether the costs to that employer will count in the initial calculation of costs that forms the basis of the EP Medicaid incentive payment formula. That is a decision that CMS appears to have left up to each individual state. For information on California, please see Footnote 18.

¹⁸ <http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/FAQ.pdf>.

¹⁹ 42 C.F.R. § 495.10(f)(1).

²⁰ 42 C.F.R. §§ 424.73, 495.10(f).

²¹ 42 C.F.R. § 495.302.

²² 42 C.F.R. § 495.310(k).

²³ 42 C.F.R. §§ 495.10(f)(3); 495.332(c)(9)(ii).

²⁴ 42 C.F.R. § 495.10(f), 495.332(c)(9)(ii).

²⁵ CMS EHR Incentive Programs: Attestation, available here: https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp.

²⁶ 42 C.F.R. § 495.302.

²⁷ 42 C.F.R. § 495.10(f)(1).

C A L E N D A R

December	1	LACBA Health Law Section Event Managed Care in California: Current Battles and Future Solutions, Los Angeles David Hatch is Program Chair, Charles Oppenheim moderates & Amanda Hayes co-presents <i>Developing Trends in Managed Care Litigation: Perspectives from Health Plan and Provider Counsel.</i>
	6	CHA Behavioral Health Symposium Steven Lipton presents <i>EMTALA & Behavioral Health Care.</i>
	7	HLB Web Seminar: Electronic Health Record Incentive Programs: What Providers Need to Know to Maximize Their Potential for Medicare and Medicaid Incentive Payments Abigail Wong Grigsby presents and Stephen Phillips Moderates
	14	G2 Intelligence Laboratory Sales & Marketing Conference, Chandler, AZ David Henninger speaks on <i>Legal Landmines in Lab and Pathology Sales and Marketing.</i>
	15	Progressive Health Care Conferences Charles Oppenheim presents a webinar on <i>ACOs and Alternatives.</i>
January	4-8	National Continuing Legal Education Conference Snowmass, CO Robert Roth presents on <i>Health Care Reform.</i>
	17	Hospital Council of Northern & Central California, Central Valley Region Program Steven Lipton Presents <i>EMTALA and California Involuntary Detention Laws.</i>

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