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Relief for Eligible Professionals? Proposed Stage 2 Meaningful Use Rule Includes Important (Potential) Exceptions

By: James B. Wieland and Joshua J. Freemire

Eligible professionals who have been frustrated by the requirements of the Electronic Health Record (EHR) Incentive Program (the "Program" or "Meaningful Use") were offered some (potential) relief in CMS's new proposed rule for Stage 2 of the Program. Providers interested in the new potential exceptions (which could help them avoid penalties, or ease reporting burdens) should review these important provisions and comment as appropriate.

Since the Program's inception, certain professionals (especially those in specialties or situations that offer minimal patient contact, such as radiology, pathology; or employed physicians who have little control over their patient contact or the records system they must use) have been frustrated by the Program's "all or nothing" standards. An eligible professional must meet each and every Program requirement (which may be impossible for some types of otherwise eligible professionals) or the professional will both lose the ability to collect the Program's substantial incentive payments and face penalties (which could be triggered as early as 2013) for failing to meaningfully use certified EHR technology as required. Hospital-based professionals are not eligible and, accordingly, are exempt from both Program incentives and penalties. Hospital-based professionals are those who provide 90 percent or more of their covered services in a hospital setting (inpatient hospital or emergency room). For professionals, all of this is decided on a calendar-year-by-calendar-year basis. The Stage 2 proposed rule offers at least the potential for some exceptions for professionals in these difficult positions.

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On March 7, 2012, CMS published a proposed rule providing standards and guidance for Stage 2 of the Medicare and Medicaid EHR Incentive Program [PDF]. The CMS rule was issued in conjunction with Stage 2 certification standards developed by the Office of the National Coordinator for Health Information Technology (ONC) [PDF]. Stage 2 of the Program is currently slated to begin no earlier than 2014 (for participants who met the Program's Stage 1 requirements in 2011 or 2012). Both of the proposed rules are dense with detail, and should be reviewed closely by interested parties. Comments on both proposed rules are due by 5 p.m. on May 7, 2012.

The bulk of the proposed rule is devoted to proposing new standards and measures applicable in future years of Stage 1 and Stage 2. This article, however, will focus on those provisions that will either a) potentially exempt certain groups of professionals from the 2015 payment adjustments for a failure to comply with Program requirements or b) change the method in which professionals will report on Program compliance. [The authors offer a broader overview of these provisions in "*Proposed Stage 2 Meaningful use Rule Worth a Close Read; Proposed Rule also Affects Stage 1 for 2013 and 2014*," an article discussing the entire Stage 2 rule.]

Payment Provisions

The proposed rule provides the first description of how the 2015 payment adjustments will be applied, several potential exceptions, and a request for comments regarding both ineligible hospital-based professionals and eligible professionals who are currently unable to meet Program requirements.

2015 Payment Adjustments

Program incentives, provided to those who meaningfully use EHR technology in conformance with program requirements, begin to transition to "payment adjustments" (penalties) for those who fail to meaningfully use EHR technology in 2015. The proposed rule provides that the determination of who will receive a payment reduction (of 1 percent) in 2015 will actually be made as early as 2013. A program participant who receives an incentive in 2013 will not face a payment adjustment in 2015. An eligible professional who does not receive an incentive payment for the 2013 year, however, may face a payment adjustment in 2015. The

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proposed rule provides an exception, however, for professionals who have never before attested to program requirements (including during 2013). For these first-time attesters, CMS has proposed permitting a 90-day reporting period during 2014, which, ror professionals, would mean the last possible date to register and attest (and avoid a payment adjustment) would be October 1, 2014.

With regard to the payment adjustments, the proposed rule also discusses the statutory provision that permits the Secretary, beginning in 2018, to reduce payments to noncompliant professionals by an additional 1 percent in the event it is determined that less than 75 percent of all eligible professionals meet program requirements. In no event, however, may the applicable payment percentage be reduced beyond 95 percent of the otherwise allowable reimbursement. Taking this into account, the proposed rule notes that the payment percentages for noncompliant professionals could be reduced to 96 percent in 2018 and 95 percent in 2019 and beyond. For professionals who are currently unable to attest because of practice limitations, these payment reductions certainly represent serious concerns. The proposed rule, however, sets out several types of exceptions, including, importantly, the potential for an exception based on a professional's specialty.

Payment Adjustment Exceptions

The rule proposes three distinct payment adjustment exception categories. In each case, CMS has proposed a basic reason for the exception, and requests comments.

- *Insufficient Internet Access*: The rule proposes excepting professionals that practice in an area without "sufficient Internet access." Entities hoping to claim this exception must demonstrate a lack of Internet access in the year two years prior to the payment adjustment year (with applications submitted by July 1 of the calendar year prior to the payment adjustment year). CMS explained that the exception requests, in this case, would be reviewed on a case-by-case basis to determine the reasons for the lack of Internet connectivity and to determine if such lack truly caused a hardship.
- *New Providers*: The rule proposes excepting *new providers*. For professionals, this exception would last for two years from the date they "begin practicing." It

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would also require the submittal of an application, the timing of which, according to the proposed rule, will be addressed in the future.

- *Extreme Circumstances*: The rule proposes excepting professionals that fail to meet Program requirements due to "extreme circumstances" (such as a natural disaster, a hospital or practice closure, or an EHR vendor going out of business). Professionals who wish to claim this exception would be required to submit an application to be reviewed on a case-by-case basis by the same deadlines as the exception for insufficient internet access.

In addition to these three proposed exceptions, CMS is soliciting comments on (but not yet proposing) an exception that would give relief from payment adjustments to professionals whose practice structures mean that they:

1. **Lack face-to-face or telemedicine interaction with patients.** As CMS explained, the Program requirements are based, in large part, on the assumption that professionals will have face–to-face interaction with patients. A lack of these interactions and a lack of a need for follow-up care (addressed in the next criteria) makes compliance with many Program requirements extremely difficult, if not impossible. As CMS noted, this is especially true for certain types of professionals (CMS noted radiologists and pathologists, but there are others as well) who typically never interact with a patient, but rather provide analysis and reports to other physicians.
2. **Lack follow-up with patients.** The Stage 2 Program requirements include requirements that physicians interact online with their patients and transmit information online (such as to a PHR). CMS has acknowledged that lacking a need to follow-up directly with a patient will make these requirements difficult to fulfill.
3. **Lack control over the availability of EHR technology.** Certainly for employed professionals, the availability of EHR technology, the type of EHR technology, and the means by which EHR technology is required to be used may be beyond an individual professional's control. CMS has acknowledged that this can provide a barrier to meeting Program requirements.

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The proposed rule notes that none of these three criteria, on its own, "constitutes insurmountable hardship." When all are present, however, CMS has acknowledged that these issues may "pose a substantial obstacle to achieving meaningful use." CMS is considering a two-year exemption for professionals that meet these criteria, but is also considering an exception that would not be time-limited by regulation. CMS notes, however, that by statute, no professional can receive an exception that lasts more than five years. Finally, CMS specifically requested comment on whether such an exception should be considered on an individual basis, or whether it should be granted on an "across-the-board" basis to certain specialties (such as pathologists and radiologists). Professionals who have faced obstacles to meeting Program requirements, including those described, should take advantage of this opportunity to share their concerns with CMS by providing comments on the proposed rules.

Interestingly, CMS also notes that it believes that certain specialties will soon find it easier to attest based on the spread of EHR technology and health information exchanges. According to CMS, the spread of this technology will "reduce the barriers faced by specialties [with less EHR technology] over time as other providers may be providing the necessary data for these specialties to meet meaningful use." This single sentence suggests that CMS may be amenable to permitting some professionals to attest based on data entered into a patient's record *by other professionals who would also attest based on the entry of that same data*. If true, that position would reflect a change from other, more informal CMS guidance (and even other provisions in the proposed rule) that appear to indicate that, generally, each professional must meet or fail to meet Program requirements based on that professional's own use of Certified EHR Technology. Along with this surprising sentence, CMS requested comments on "how soon EPs who [meet the criteria described above for a possible exception] would reasonably be able to achieve meaningful use."

Hospital-based Professionals

Along with its discussion of eligible professionals who may be unable to meet Program requirements, the proposed rule also addresses ineligible professionals who may, in fact, be able to meet program requirements. Specifically, the proposed

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rule requests comments regarding "hospital-based" professionals who, if eligible, could meet program requirements and qualify for incentive payments.

As many are aware, the much debated definition of a *hospital-based professional* was finalized by a legislative compromise that was unsatisfactory to many providers who practice in hospital settings. As a result of the compromise, professionals who perform the majority of their services in a hospital environment are not permitted to take part in the EHR Incentive Program. In explaining the reasoning behind this decision, CMS has often cited the "double-counting" of hospital patients (by both the professional and the hospital) and the "double-payment" (paying both the professional and the hospital for a system purchased by the hospital) that could result from alternative definitions. The proposed rule notes that CMS has received many comments on this issue, noting specifically that some provider groups may operate within a hospital environment, but use their own separate and separately purchased EHR technology.

CMS has specifically requested detailed comments on this issue, including, where appropriate, documentation supporting the assertion that specialized hospital units are using separate and separately purchased EHR technology. This information will be reviewed to determine whether a new policy on certain hospital-based professionals would be appropriate. In the event of such a policy, the proposed rule notes that "additional attestation elements would be required" (including, presumably, an attestation that there has been no double-counting and will be no double-payment) and noted that attesting professionals would be subject to audit and False Claims Act penalties.

Changes to Eligible Professional Reporting Obligations

In addition to the payment concerns described above, the proposed rule also proposes changes to the reporting structure that could affect many eligible professionals.

Clinical Quality Measure (CQM) Reporting

The rule proposes extensive, and detailed, changes to the Program's use of Clinical Quality Measures (CQMs). Notably, time periods for reporting CQMs are clarified,

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comments are solicited on nearly 175 proposed CQMs, and CMS provides a detailed explanation of the process that will be used to change and update CQMs. Participants specifically tasked with CQM management or reporting should consult the rule's detailed guidance on the subject, including the extensive list of new or changed CQMs. (77 Fed. Reg. at 13742–63.) Of special note, eligible professionals should review the three alternative methods that CMS proposes (and specifically request comments on) for eligible professionals to report CQMs. (77 Fed. Reg. at 13745–48.) Two of these proposed options would require professionals to select and report on a certain number of core and menu set measures. The last option, however, would seek to align the EHR Incentive Program's CQM reporting with that required under the Physician Quality Reporting System (PQRS). This happens to also be the same system that is now linked to the eRx (electronic prescribing) Incentive Program. Under this third option, professionals who reported as required under PQRS using Certified EHR Technology would satisfy the EHR Incentive Program's CQM reporting requirements.

Group Reporting to Demonstrate Meaningful Use

The proposed rule explains that, eventually, CMS hopes to move away from attestation as a method of demonstrating meaningful use and towards more automated, direct reporting options through EHR technology itself. At this point in time, however, CMS does not believe the available technology will support such direct reporting sufficiently to end the need for attestation. As a step towards direct reporting in the future, however, the rule proposes that group practices may submit a single batch file for all group members, rather than requiring individual attestation through the Program website.

Group members' compliance with Program requirements would still be measured on an individual basis — the new submission process would not permit averaging for instance, or any similar combining of statistics. Similarly, the batch reporting would not include CQMs. It would, however, permit any two or more professionals associated with a group practice under one tax ID number to submit a single batch file of core and menu set compliance data rather that submitting each professional's data separately. The individual professional's incentive payment would be

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automatically assigned, under this option, to the group's tax ID number (selected during program registration).

It is worth noting that CMS is not altering any other related requirements for professional reporting — eligible professionals still must demonstrate that 50 percent of their encounters took place in a setting with EHR technology. CMS is not proposing, however, any minimum participation threshold for the group reporting option — a professional remains responsible for collecting all required data, but may report that data as part of a group batch report even in the event only 5 percent (or less) of the professional's patient encounters took place with that particular group.

Importantly, CMS also specifically requested comments on a "group reporting option that allows groups an additional reporting option in which groups report for their EPs [as] a whole rather than broken out by individual EP." CMS has provided an extensive list of questions that it believes would be relevant with regard to such an option (77 Fed. Reg. at 13766), and professionals or other interested parties are encouraged to provide comments in response to assist CMS in its analysis of such a more extensive group reporting option.

Ober|Kaler's Comments

Comments on the proposed rule are not only requested but are vital, given some of the proposed changes discussed here. Professionals (and entities that employ or contract with professionals) should review the above-described provisions closely, and provide comments or objections to CMS as appropriate. CMS, with regard to Stage 1, proved receptive to provider comments, especially concerning the burdens associated with meeting certain objectives and the time necessary to implement complete EHR technology and properly adjust facility and office work-flow. There is no reason to believe that CMS's generally receptive attitude toward thoughtful and well-presented provider comments will not hold true during the finalization of Stage 2 standards. For some professionals, the development (or failure to develop) appropriately inclusive exceptions could mean the difference between eligibility for substantial incentive payments, or facing substantial downward payment adjustments.

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