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UPDATE
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CMS Issues Proposed Rule on Stage Two Meaningful Use

On March 7, 2012, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule (the Stage 2 Proposed Rule) regarding criteria that eligible health care professionals and eligible hospitals must meet to demonstrate meaningful use of certified electronic health record (EHR) technology under Stage 2 of the Medicare and Medicaid EHR Incentive Programs (the EHR Incentive Programs). On the same day, the Office of the National Coordinator for Health Information Technology issued proposed certification criteria for EHR-compliant systems. The Stage 2 final rule is expected to be released in summer 2012. Click here for a link to the Stage 2 Proposed Rule. To view the accompanying proposed certification criteria regulations for EHR compliant systems published by the Office of the National Coordinator click here.

The EHR Incentive Programs were established under the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009. Under the EHR Incentive Programs, eligible professionals and eligible hospitals receive incentive payments by demonstrating their meaningful use of certified EHR technology (Meaningful Use). A Medicare "eligible professional" is a doctor of medicine, osteopathy, oral surgery or dental medicine, podiatric medicine, or optometry or a chiropractor. A hospital-based professional (defined as professionals who furnish at least 90 percent of their services in an emergency room or inpatient hospital setting) is excluded from the definition of eligible professional. A Medicaid "eligible professional" is a physician, nurse practitioner, certified nurse midwife, or dentist who meets certain minimum Medicaid patient volume levels. A physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic may also qualify as a Medicaid eligible professional. A Medicare "eligible hospital" includes any hospital that is paid under the Inpatient Prospective Payment System, any Critical Access Hospital, or a hospital affiliated with a Medicare Advantage organization and services patients enrolled in plans offered by the Medicare Advantage organization. A Medicaid "eligible hospital" includes acute care hospitals that meet certain Medicaid patient volume requirements and all children's hospitals.

CMS divided implementation of the EHR Incentive Programs into three stages. To be eligible for the full amount of incentive payments, eligible professionals and eligible hospitals must demonstrate and attest to Meaningful Use at each stage. Each eligible professional and eligible hospital must begin its participation in the applicable EHR Incentive Program at Stage 1 and must do so by 2018. A Medicare eligible professional or eligible hospital can attest that it

has demonstrated Meaningful Use through Medicare's secure website while a Medicaid eligible professional or eligible hospital may do so through the applicable state's Medicaid website. Eligible professionals are required to attest to Meaningful Use and to collect and report clinical quality measures based on the calendar year while eligible hospitals and critical access hospitals must do so on the fiscal year (October 1 through September 30). The final Stage 1 Requirements were released on July 28, 2010. Stage 1 requires eligible professionals and eligible hospitals to either meet or qualify for an exclusion to required core objectives[1] and to meet five out of ten optional objectives, which Stage 1 refers to as "menu options" (collectively, the Stage 1 Requirements) to demonstrate Meaningful Use and to receive incentive payments from the EHR Incentive Programs. Eligible professionals and eligible hospitals who met the Stage 1 Requirements were able to qualify for incentive payments beginning in 2011. In the Stage 2 Proposed Rule, CMS requires eligible professionals and eligible hospitals that are meaningful users under Stage 1 to meet the Stage 2 requirements as early as 2014. Stage 3 requirements are expected to be released in early 2014.

The dollar amount of incentive payments differs for eligible professionals and eligible hospitals and also differs between the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program. An eligible professional can only receive incentive payments under one of the EHR Incentive Programs. Under the Medicare Incentive Program, eligible professionals can receive incentive payments of up to $44,000 over five years. Under the Medicaid Incentive Program, eligible professionals can receive incentive payments of up to $63,750 over six years. Certain eligible hospitals may be eligible for and receive incentive payments under both the Medicare and Medicaid EHR Incentive Programs.

Certain key provisions of the Stage 2 Proposed Rule are summarized below.

CHANGES TO STAGE 1 MEANINGFUL USE

The Stage 2 Proposed Rule revises certain Stage 1 Requirements. Compliance with certain revised Stage 1 Requirements is optional for the 2013 reporting year and required for the 2014 reporting year. However, compliance with other revised Stage 1 Requirements is required beginning in reporting year 2013.

Proposed revisions to the Stage 1 Requirements include:

- Eliminating the "exchanging key clinical information" objective (effective in reporting year 2013).
- Adding exclusions applicable to blood pressure recording and charting measures for compliance with the vital signs core objective (required for reporting year 2014).
- Replacing current objectives that require an eligible professional and eligible hospital to provide patients with an electronic copy of their health information upon request with objectives requiring that patients be provided with direct online access to their health information (required for reporting year 2014).

PROPOSED STAGE 2 MEANINGFUL USE CRITERIA

The Stage 2 Proposed Rule increases the minimum number of core objectives and menu options that eligible professionals and eligible hospitals must meet to demonstrate Meaningful Use. As proposed, an eligible professional must meet or qualify for an exclusion to 17 core objectives and meet three out of five menu options to demonstrate Meaningful Use, and an eligible hospital must meet or qualify for an exclusion to 16 core objectives and two out of four

menu options to demonstrate Meaningful Use.

CORE OBJECTIVES FOR STAGE 2

Proposed Stage 2 requirements for eligible professionals and eligible hospitals include:

- A requirement that eligible professionals and eligible hospitals use computerized provider order entry for more than 60 percent of medication, laboratory and radiology orders.
- A requirement that eligible professionals and eligible hospitals use EHR technology to record demographics for more than 80 percent of unique patients.
- A new core objective for eligible professionals to use secure electronic messaging to communicate with patients on relevant health information.
- A new core objective for eligible professionals to provide patients with the ability to view online, download, and transmit their health information within four days after such health information is available to the eligible professional.
- A new core objective for eligible hospitals to provide patients with the ability to view online, download, and transmit information about a hospital admission within 36 hours of discharge.
- A new core objective for eligible hospitals for automatically tracking medications from order to administration.

CLINICAL QUALITY REPORTING

In addition to meeting the criteria discussed above, the EHR Incentive Programs require eligible professionals and eligible hospitals to report certain clinical quality measures to demonstrate Meaningful Use. Under the Stage 1 Requirements, in calendar year 2013, eligible professionals must report 6 clinical quality measures, and eligible hospitals must report 15 clinical quality measures. To be considered a meaningful EHR user under Stage 2, CMS proposes to require that eligible professionals report 12 clinical quality measures and eligible hospitals report 24 clinical quality measures beginning in fiscal year 2014. CMS also proposes that eligible professionals and eligible hospitals entering Stage 1 in fiscal year 2014 meet these more stringent reporting requirements.

For eligible professionals, the clinical quality measures chosen will align with existing reporting requirements found in the Medicare Shared Savings Program, National Committee for Quality Assurance medical home measures, and the Children's Health Insurance Program Reauthorization Act. CMS is considering three options for clinical quality reporting by eligible professionals. Under the first option, eligible professionals would select and report 12 clinical quality measures from a list to be finalized by CMS. At least one measure must be reported from each of the following domains: Patient and Family Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Healthcare Resources, and Clinical Processes/Effectiveness (the Clinical Quality Reporting Domains). The second option would require eligible professionals to report on 11 core clinical quality measures plus one additional clinical quality measure selected by the eligible professional from a list provided by CMS. A third option applies to Medicare eligible professionals who participate in both the EHR incentive Program and the Physician Quality Reporting System, and would allow such eligible professionals to satisfy the EHR Incentive Program's clinical quality measure reporting requirement by satisfactorily reporting the Physician Quality Reporting System measures.

The Stage 2 Proposed Rule requires eligible hospitals to select and report 24 clinical quality

measures from a list of 49 clinical quality measures, with at least one such measure from each of the Clinical Quality Reporting Domains. The proposed list includes the clinical quality measures from the Stage 1 Final Rule as well as additional pediatric measures, an obstetric measure, and cardiac measures.

CMS has not yet finalized the 2014 reportable clinical quality measures for eligible professionals and eligible hospitals. The Stage 2 Proposed Rule states that, similar to Stage 1, the same Stage 2 clinical quality measures will be used for both the Medicare and Medicaid Programs. CMS states that the final reportable clinical quality measures specifications will be published on the CMS website "at or around" the time that the Stage 2 Final Rule is published.

PAYMENT ADJUSTMENTS

The HITECH Act requires downward payment adjustments (Payment Adjustments) beginning in 2015 for Medicare eligible professionals and Medicare eligible hospitals that fail to demonstrate Meaningful Use. The Payment Adjustments apply to all professionals and hospitals that meet the definition of Medicare eligible professionals and Medicare eligible hospitals, without regard to whether such professionals or hospitals participate in the Medicare EHR Incentive Program. The Payment Adjustments do not apply to professionals and hospitals that qualify for participation only in the Medicaid EHR incentive program. The Stage 2 Proposed Rule establishes the specifications for the Payment Adjustments for both eligible professionals and eligible hospitals.

Payment Adjustments for Medicare Eligible Professionals

Under HITECH and the Stage 1 Final Rule, an eligible professional's Medicare physician fee schedule payment for covered professional services is subject to the Payment Adjustment if such eligible professional is not a meaningful user of certified EHR technology for the applicable EHR reporting year. In the Stage 2 Proposed Rule, CMS proposes to set the reporting period as the calendar year two years prior to the year in which the applicable Payment Adjustment is applied. This means that, for calendar year 2015, a Medicare eligible professional who fails to demonstrate Meaningful Use in calendar year 2013 will receive only 99 percent of fees for Medicare services rendered in 2015. Such Payment Adjustments may continue at a yearly one percent reduction for each year that a provider fails to demonstrate Meaningful Use, up to a five percent reduction. CMS proposes to exempt Medicare eligible professionals who have failed to demonstrate Stage 1 Meaningful Use prior to 2014 from the 2015 Payment Adjustment provided that such eligible professionals demonstrate Stage 1 Meaningful Use during a 90-day reporting period, beginning no later than July 3, 2014, and attest to Stage 1 Meaningful Use no later than October 1, 2014.

Payment Adjustments for Medicare Eligible Hospitals

Medicare eligible hospitals other than Critical Access Hospitals that fail to demonstrate Meaningful Use will also be subject to Payment Adjustments for services rendered beginning in fiscal year 2015. In general, Medicare eligible hospitals will be subject to a 25 percent reduction in scheduled increases to the Medicare Inpatient Prospective Payment System amounts, per year, up to 75 percent of the scheduled increases. CMS proposes to set the reporting period as the fiscal year two years prior to the fiscal year in which the applicable Payment Adjustment is applied. Therefore, the applicable reporting period for a Payment Adjustment in 2015 is fiscal year 2013. Thus, an eligible hospital that attests to Meaningful Use on or before fiscal year 2013 and receives an incentive payment will not be subject to Payment

Adjustment in 2015. Similar to the proposed exemption for an eligible professional, CMS proposes to exempt a Medicare eligible hospital that demonstrates Stage 1 Meaningful Use for the first time in 2014 from the 2015 Payment Adjustment if such eligible hospital begins a 90-day reporting period no later than April 1, 2014, and attests to Stage 1 Meaningful Use no later than July 1, 2014. A Critical Access Hospital that fails to demonstrate Meaningful Use will be subject to a payment adjustment to its reimbursement for its reasonable costs.

Exceptions to Payment Adjustments

The Stage 2 Proposed Rule outlines several exceptions to the Payment Adjustment provisions for Medicare eligible professionals and Medicare eligible hospitals, which will be granted on a case-by-case basis (each, an Exception). CMS proposes Exceptions for (1) Medicare eligible professionals who practice, or Medicare eligible hospitals located, in areas without sufficient internet access, (2) new professionals or new hospitals, (3) Medicare eligible professionals and Medicare eligible hospitals unable to demonstrate Meaningful Use due to extreme, uncontrollable circumstances, and (4) Medicare eligible professionals who meet certain criteria to be established by CMS, such as lack of face-to-face or telemedicine interactions with clients, lack of follow-up with patients, and lack of control over the availability of certified EHR technology at their practice locations. CMS also proposes to require (1) Medicare eligible professionals seeking an Exception to apply for such Exception no later than July 1 of the year prior to the calendar year for which the Exception is sought and (2) Medicare eligible hospitals seeking an Exception to apply for such Exception no later than April 1 of the year prior to the fiscal year for which the Exception is sought.

LIMITED APPEALS PROCESS

The Stage 2 Proposed Rule introduces a new individual review administrative appeals process for both Stage 1 and Stage 2 Meaningful Use determinations. The appeals process is limited to (1) eligibility appeals, (2) meaningful use determination appeals after a Meaningful Use audit, provided that Medicaid eligible professionals continue to use their state's appeal process, and (3) incentive payment appeals by Medicare eligible professionals. Eligible hospitals will be required to appeal issues involving incentive payments based upon a hospital cost report with the Provider Reimbursement Review Board. Further guidance on the proposed appeals process will be posted on the CMS website before the final rule is published.

Comments for the Stage 2 Proposed Rule must be submitted by May 7, 2012, for consideration.

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[1] The Stage 1 Final rule sets forth 15 core objectives for eligible professionals and 14 core objectives for eligible hospitals.

If you have questions about any of these topics, please contact a member of Robinson & Cole's Health Law Group.

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