STAGE 2 MEANINGFUL USE: CMS AND ONC RELEASE PROPOSED RULES

On February 23, 2012, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule for Stage 2 of the Electronic Health Record Incentive Program. The proposed rule augments the certification criteria for Meaningful Use incentive payment, adds reporting requirements for clinical quality measures (CQM) and changes the schedule for payment adjustments. It also confirms the November 30, 2011, announcement by the U.S. Department Health and Human Services (HHS) that eligible hospitals and physicians that adopted and became meaningful users of Certified Electronic Health Records Technology (EHRs) during 2011 will not have to meet the Stage 2 criteria for Meaningful Use until 2014, one year later than originally promulgated in the federal EHR Incentive Program regulations.

CMS Stage 2 Changes

CMS proposes to maintain the same core and menu structure for Stage 2. However, under Stage 2, providers must meet or qualify for an exclusion of an increased number of core and menu objectives. The following changes to existing Stage 1 criteria are proposed:

- Changes to the denominator of computerized provider order entry (CPOE) (Stage 1 Optional, Stage 2 Required);
- Changes to the age limitations for vital signs (Stage 1 Optional, Stage 2 Required);
- Eliminating the "exchange of key clinical information" core objective from Stage 1 to "transitions of care" core objective requiring electronic exchange of summary of care documents in Stage 2 (Effective in Stage 2); and
- Replacing the "provides patients with an electronic copy of their health information" objective with "view online, download and transmit" core objective (Effective in Stage 2).

Clinical Quality Measures

The proposed rule also sets out Stage 2 reporting requirements for clinical quality measures. In order to qualify for incentive payments under the EHR Incentive Program, providers are required to report on specified CQMs. CMS proposes a set of measures that align Stage 2 CQMs with existing quality programs, such as the Physician Quality Reporting System, Medicare Shared Savings Program, National Council for Quality Assurance, measures proposed under the Children's Health Insurance Program Reauthorization Act, Inpatient Quality Reporting and The Joint Commission's hospital quality measures. The proposed rule would require eligible professionals to report 12 CQMs and eligible hospitals and critical access hospitals to report 24 CQMs. CMS is soliciting public comment on the two mechanisms of electronic CQM reporting in an effort to reduce the administrative burden on providers for quality reporting.
Payment Adjustments

Any provider that demonstrates meaningful use in 2013 can avoid payment adjustment in 2015 when the adjustments are required to take effect, according to the proposed rule. Similarly, any provider that first demonstrates meaningful use in 2014 can avoid penalty if they meet the attestation requirement for hospitals by July 3, 2013, and October 3, 2014, for eligible professionals. The proposed rule also provides for the following three categories of exceptions to the payment adjustment: (1) lack of internet access or barriers to obtaining IT infrastructure; (2) a time-limited exception for newly practicing eligible professionals who otherwise would be unable to avoid payment adjustment; and (3) unforeseen circumstances, such as natural disasters (that would be handled on a case-by-case basis). CMS is soliciting public comment on additional criteria for exceptions.

ONC Proposed Rule

On February 24, the Office of National Coordinator for Health Information Technology (ONC) released its proposed rule detailing standards, implementation specifications and certification criteria required to achieve meaningful use of EHRs beginning in 2014. The ONC’s rule complements the CMS proposed rule and revises EHR criteria for ONC’s permanent certification program enhancing care coordination, patient and family engagement, interoperability and the security, safety and efficacy of EHR technology.

Publication Date; Deadline for Comment

Both proposed rules will appear in the March 7, 2012, Federal Register, with each agency seeking comments until 60 days after publication. If you need assistance in preparing comments to CMS and/or ONC related to these proposed rules or with any other aspect of Meaningful Use, please contact Lynn Sessions at lsessions@bakerlaw.com or 713.646.1352 or John S. Mulhollan at jmulhollan@bakerlaw.com or 216.861.7484.

HEALTH PLAN FLEXES ITS MUSCLE: PROVIDERS FACE OUT-OF-NETWORK CHALLENGES

In a recent lawsuit filed in Harris County, Texas, Aetna Health Insurance, Inc., took on the issue of out-of-network discounts provided by physicians and other facilities to the patient financial obligation (copayment and deductible requirements), as well as the tie between the out-of-network discount to ownership interests held by physicians in the out-of-network facility. Tension between the hallmarks of managed care -- volume and steerage in the creation of tightly managed delivery networks -- and freedom of choice and medical professional decision-making have existed for some time, but rarely is there a lawsuit that so directly confronts the multiple issues associated with the provision of out-of-network care and the various parameters associated with the delivery of such care.

In the case filed by Aetna against certain physician owners and the surgical hospital itself, the health plan alleges that the physicians breached their existing specialist provider agreements with Aetna by referring Aetna patients for certain procedures to the surgical hospital outside the Aetna network. The physicians have agreements with Aetna as part of the physician network, and the provisions of the specific contract with such physicians are at issue. Allegations include failure to disclose to patients the physician ownership interest in the surgical hospital, failure to disclose the discounts to the patient financial obligations of copayment and deductibles that are usually higher when patients choose to access an out-of-network provider, tortious interference of contract by the hospital and various allegations of insurance fraud, including conspiracy to overcharge Aetna beneficiaries.

Important issues in the case include the terms of the Specialist Physician Agreement that the physicians allegedly are bound to follow, including a term that would require
physicians to render services to members only at network hospitals or providers. The higher charges associated with the billing out of network also are at issue in the case, as is the determination of what constitutes "usual and customary" reimbursement in the instance of out-of-network payments.

The filing of this case highlights the importance of provider review of existing and future contracts with health plans to ensure that highly restrictive network provisions do not otherwise prohibit physicians or other providers from making referrals or arrangements consistent with their best professional medical judgment, even if such judgment includes treatment at an out-of-network facility or provider. Additionally, the case highlights the importance of disclosure regarding the investment interest of the respective physician in a facility, even if such investment interest itself otherwise complies in all respects with applicable laws regarding investment. Disclosures of discounts to the patient copayment or deductible to a rate equivalent to an in-network benefit also are at issue, and the case highlights the importance of such disclosure.

Providers that adopt an "out-of-network" strategy should beware of this case and the definitive pressure that health plans are willing to exert in the name of managed care. Failures in negotiations with health plans that exert financial pressures to accept payments and other tactics utilized to force providers to accept network rates undoubtedly will be at issue in the case. Texas law has long avoided clarity in the instance of out-of-network access to care, and lawyers and providers should keep a watchful eye on this case.

For more information regarding the complaint filed or out-of-network services, please direct inquiries to Susan Feigin Harris at sharris@bakerlaw.com or 713.646.1307.

**DEFINING "ESSENTIAL HEALTH BENEFITS": HHS GUIDANCE OFFERS SOME ANSWERS**

Our understanding of the meaning of "essential health benefits" under healthcare reform grows as HHS continues to issue guidance. On February 17, 2012, HHS released a series of frequently asked questions (FAQs) to explain the Essential Health Benefits Bulletin issued December 16, 2011 (Bulletin). According to HHS, the Bulletin provides information on the Department's regulatory approach for defining essential health benefits, and the FAQs supplement the information contained in the Bulletin.

The FAQs feature 22 questions and answers on topics, including essential health benefit benchmark plans, the dates and procedures by which states must select their benchmark plans, the intersection of essential health benefits and state-mandated benefits, whether essential health benefits can be limited in scope and/or duration and whether essential health benefits will include preventive health services and be subject to the federal mental health and substance abuse parity rules.

While the guidance helps create a clearer picture of the meaning of essential health benefits, the FAQs are sure to give rise to more questions. We are well positioned to assist you in discerning how this guidance or healthcare reform in general will affect your health benefit plans or policies. Please contact Jennifer A. Mills at jmills@bakerlaw.com or 216.861.7874 or Susan Whittaker Hughes at shughes@bakerlaw.com or 216.861.7841 for more information.

**MEDICARE REASSIGNMENT: PHYSICIANS ARE RESPONSIBLE FOR FAILING TO MONITOR ASSIGNEE BILLINGS**

As part of the Office of the Inspector General's (OIG) efforts to hold physicians more accountable, the OIG recently warned physicians that they may be liable for false claims submitted by entities to which they reassign their right to bill Medicare and receive Medicare payments. This is an important issue for physicians to consider given the potential liability and broad use of reassignments. Seventy-seven percent of Medicare practitioners reassign their Medicare benefits to at least one third party. See Reassignment of Medicare Benefits, OIG Report OEI-07-08-00180 (October 2009).

The OIG's warning follows a recent settlement with eight physicians who reassigned their rights to receive Medicare payments to a number of physical medicine companies in exchange for Medical Directorship positions. The OIG asserted that the physical medicine companies, using the eight physicians' reassignments, filed claims for services supposedly provided by the physicians when in fact the services were provided by unsupervised, unlicensed "technicians," including retail cashiers and massage therapists. The physicians did not personally render or directly supervise any services.
Because the physicians did not monitor the services billed by the physical medicine companies under the physician payment reassignments, the companies were able to improperly and falsely bill Medicare using the physicians’ supplier numbers. The OIG concluded that the physicians were an integral part of the scheme due to their failure to monitor the claims filed by the companies and pursued their liability under the Civil Monetary Penalties Law.

Given the OIG’s position in this case and in the Alert, we recommend that physicians carefully monitor the services billed using their reassigned supplier numbers. The OIG also noted that a physician who reassigns his or her right to bill Medicare and receive Medicare payments has the right to access the entity’s billing information with respect to services the physician is alleged to have performed. In addition, the OIG stated that physicians should have unrestricted access to claims submitted by an entity for services that the entity billed using the physicians’ reassigned provider number to provide added assurances that services are properly billed. Finally, when leaving an entity, a physician should update his or her reassignment information with CMS.

For more information, please contact Robert M. Wolin, rwolin@bakerlaw.com or 713.646.1327.

MEDICARE HEARING AND APPEALS: OMHA CENTRALIZES ALJ HEARING DOCKET

Effective January 17, 2012, the Office of Medicare Hearing and Appeals (OMHA) implemented a centralized docketing system requiring ALJ hearing requests related to Qualified Independent Contractor (QIC) decisions nationwide to be submitted to a Centralized Docketing Office in Cleveland, rather than OMHA field offices. According to the recently released HHS Annual Performance Report and Performance Plan for Fiscal Year 2013, OMHA is over capacity for the number of manageable claims each ALJ can adjudicate while still maintaining program integrity. Establishing the centralized docketing division will assist in addressing OMHA’s workload by providing a standardized process for the equitable distribution of case assignments across OMHA’s four field offices.

According to sources at the Centralized Docketing Office in Cleveland and other field offices, ALJs generally will be assigned cases on a rotating basis regardless of the provider’s geographic location. That being said, because three of the four field offices are located on the east coast, some consideration may be given to filtering west coast appeals to the west coast office to minimize time difference issues.

Reconsideration instructions now should include directions to submit the ALJ hearing requests to Centralized Docketing. Forwarding the appeal requests to individual field offices can result in a delay; our understanding is that the field office mail room will forward those hearing requests back to Ohio for official assignment and docketing. Providers should be aware of these new directions, instruct staff accordingly and update procedures as necessary.

For more information, please contact Ameena N. Ashfaq, aashfaq@bakerlaw.com or 713.646.1329.

2011 YEAR IN REVIEW: SPOTLIGHT ON THE HEALTHCARE TAX CONTROVERSY AND TAX-EXEMPT FINANCING TEAMS

Advocating Client Interests With FICA Tax Refunds

For more than six years, lawyers from Baker Hostetler’s Healthcare and Tax Controversy teams have represented academic medical centers in test cases challenging the Internal Revenue Service’s (IRS) staunchly defended position that FICA taxes must be paid on stipends provided to medical residents. In March 2010, the IRS administratively conceded that long-debated issue, making it possible for other academic medical centers around the country to recover these taxes for tax periods prior to April 1, 2005. To date, the IRS has processed claims and issued refunds to only a very few academic medical centers, and the IRS has not identified a specific timetable for payments of the claims.

CMS recently provided instructions to teaching hospitals about how the refunds should be properly reported on Medicare cost reports. We have assisted our academic medical center clients in these ongoing negotiations and compliance with detailed refund procedures.

Representing Clients in a Sluggish Financing Marketplace

Baker Hostetler continued its representation of hospital systems, long-term care facilities, senior living facilities and other issuers of tax-exempt debt as they struggled through another challenging year with wide shifts in the market. We advised clients on a wide range of covenant compliance issues. We assisted these clients in negotiations with letter of credit
banks and other credit and liquidity support providers, presentations to Bond Trustees and Rating Agencies and compliance with their ongoing disclosure requirements. We also represented clients on entering into new swaps and terminating existing swaps.

While the number of new tax-exempt issues continues to be at historically new lows, the Baker Hostetler Healthcare Financing Team successfully completed several financings, representing either the borrower or the underwriter in these completed transactions and with others currently in process.

WEBCAST: IRS SCHEDULE H FOR HOSPITALS AND HEALTHCARE ORGANIZATIONS

Baker Hostetler is pleased to announce that two of our attorneys, Christopher J. Swift and William J. Culbertson, will be featured speakers in a webcast on Schedule H of IRS Form 990 for Hospitals and Healthcare Organizations. The event, hosted by the Knowledge Congress, is designed to give tax preparers for hospitals and healthcare organizations a greater understanding of the latest filing requirements.

Registration is free for the first 30 Baker Hostetler clients to register and only $25 for clients who register after the first 30. All attendees can obtain two hours of continuing legal education credit (where applicable) for $49.

We hope you can join us!

Monday, March 19, 2012 • 12:00 - 2:00 p.m. (ET)

See full invitation for more information or to register.

REGISTER NOW

PUBLICATION NOTICE

The Health Law Update will not be published on Thursday, March 15, 2012. Our regular publication schedule will resume on Thursday, March 29, 2012.

EVENTS CALENDAR

March 6

Cleveland partner Tom Campanella will speak on "Hot Issues in Health Care Policy" at the Ohio University College of Osteopathic Medicine in Athens, Ohio.

March 11

Cleveland partner Tom Campanella will speak on "The Future of Health Care" at the 27th Annual Conference of the North Central Academy of Podiatric Medicine in Cleveland, Ohio.

March 15

Cleveland partner Tom Campanella will speak on "Accountable Care Organizations: What’s New and What’s Next?" at the Chief Executive Officer Meeting of the Physician Insurers Association of America in Scottsdale, Arizona.

March 28

Houston counsel Lynn Sessions will speak on an enterprise approach to healthcare data breaches at a webinar sponsored by the American Health Lawyers Association.

March 29 & 30

Houston partner Scott McBride will speak on "Quality: Payment Enforcement" at the Institute on Medicare and Medicaid Payment Issues program sponsored by the American Health Lawyers Association in Baltimore, Maryland.
April 3

Cleveland partner Tom Campanella will speak on "Evolution of the U.S. Healthcare System: How Did We Get Here and Where Are We Going?" at the Baldwin-Wallace College MBA Association in Berea, Ohio.

April 12

Houston partner Susan Feigin Harris will speak on "New Payment Arrangements, CMS Initiatives, What’s Happening in the Marketplace and What Do You Need to Know?" at the University of Texas School of Law 24th Annual Health Law Conference in Houston, Texas.

April 13

Houston counsel Lynn Sessions will speak on "Health Care Lawyers’ Guide to Data Privacy/Breaches: Best Practices, Risk Management and Responses" at the University of Texas School of Law 24th Annual Health Law Conference in Houston, Texas.

May 11

Houston counsel Lynn Sessions will speak on "Lessons From Cutting-Edge Transactions in Healthcare and Life Sciences -- HIPAA/HITECH Compliance" at the Current Issues in IP Contracting Conference in Houston, Texas.

June 5

Houston counsel Lynn Sessions will speak on HIPAA/HITECH, HHS scrutiny and business associate liability at the Cyber Security Annual Conference sponsored by NetDiligence in Philadelphia, Pennsylvania.