HHS Proposes Information Blocking Provider Disincentives

On Monday, October 30, the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) published a proposed regulation specifying the appropriate disincentives for health care providers that the HHS Office of Inspector General (OIG) has determined committed information blocking.

This new proposed regulation focuses on health care providers that are also Medicare-enrolled providers or suppliers. CMS uses the term health care providers in the proposed regulation and outlines disincentive proposals for: eligible clinicians (ECs) or groups functioning under the Promoting Interoperability (PI) Performance Category of the Merit-based Incentive Payment System (MIPS); eligible hospitals (EHs) or critical access hospitals (CAHs) in the Medicare PI Program; and health care providers as an Accountable Care Organization (ACO), ACO participant, or ACO provider or supplier under the Medicare Shared Savings Program (MSSP). If OIG determines that a provider has committed information blocking, CMS would use its payment policies to implement the disincentives as well as restrict participation in MSSP. Public comments on this Proposed Regulation are due January 2, 2024.

This effort complements the regulation published earlier this year that defines the specifics around the civil monetary penalties (CMPs) for other regulated actors for information blocking violations: health IT developers, health information exchanges, and health information networks.

It is important to note that information blocking by health care providers includes an element of intent. The standard of intent for health care providers is that a "provider knows that such practice is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information." This is different from the standard applied to the other regulated actors.

OIG also has discretion to choose which information blocking complaints to investigate. The agency expects to prioritize investigation of information blocking complaints that: resulted in, are causing, or have the potential to cause patient harm; significantly impacted a provider's ability to care for patients; were of long duration; and caused financial loss to Federal health care programs, or other government or private entities. These priorities are consistent with the priorities that OIG identified for the other regulated actors, but may evolve as OIG gains more experience investigating information blocking.

ECs or Groups Functioning Under the PI Performance Category of MIPS

Under the proposal, a MIPS EC deemed by OIG to have committed information blocking (during the calendar year (CY) of the referral of that determination from OIG) would result in that clinician earning a zero score in that performance category. A MIPS EC that is not a meaningful user of certified electronic health record technology (CEHRT) cannot satisfy the MIPS PI requirements and would earn a score of zero for this performance category.

The PI Performance Category is typically 25 percent of the total final composite MIPS Performance Score—a clinician's final score determines the payment adjustment applied to MIPS Eligible Clinicians' Medicare Part B claims for covered professional services during the applicable MIPS payment year. More information on the functioning of MIPS is available online at: https://qpp.cms.gov/.

Given that PI is only one of the four MIPS performance categories (PI, Quality, Improvement Activities, and Cost) in the Quality Payment Program, the regulation notes that the actual financial impact experienced by a MIPS EC would vary from applying this disincentive. It would depend on the assigned weight as well as the MIPS EC's performance in all four MIPS Performance Categories. A MIPS EC's final score determines whether the EC earns a negative, neutral, or positive payment adjustment factor that will be applied to the amounts otherwise paid to the MIPS EC under Medicare Part B.

Applying the weights for the performance categories from CMS for CY 2024, a score of zero in PI would mean that the maximum final score a MIPS EC could achieve, if they performed perfectly in the three remaining performance categories, would be 75 points.

HHS used actual payment and MIPS data from the CY 2021 Performance Year to analyze the range of potential disincentive amounts. The agency used simulated disincentive amounts for all ECs on an individual basis by applying zero points for the PI Performance Category portion of the MIPS score. Initially, HHS assessed the overall payment to ECs as well as the portion of the payment that was based on a positive or negative adjustment based on their MIPS score. The agency then varied the MIPS score based on lower scores on the PI Performance Category portion, determined the change in positive or negative adjustment amount, and recalculated the payment under Medicare Part B. CMS projections include:

	Median Individual Disincentive Amount	**95% Range of Disincentives (the 2.5th to 97.5th percentile)**
Estimated - All ECs (includes individuals and those in a group)	$686	$38 to $7,184

	Group Disincentive Amount	**95% Range of Disincentives (for Group Sizes Ranging from Two to 241 Clinicians)**
Estimated - Median Group Size of Six Clinicians	$4,116	$1,372 to $165,326

	Per-Clinician Disincentive Amount	**Group Disincentive Amount**
Estimated – Median-Sized Group of Six Clinicians with a 75th Percentile Per-Clinician Disincentive Amount	$1,798	$10,788

It is important to note that CMS is using the date of the OIG referral instead of the date of the information blocking occurrence to apply a disincentive. Thus, CMS would apply the proposed disincentive to the MIPS payment year associated with the CY in which OIG referred its determination to CMS. For example, if OIG referred its determination that a MIPS EC committed information blocking in CY 2025, then CMS would apply the disincentive for the 2027 MIPS payment year.

The proposal also emphasizes that a MIPS EC is "reinstated" in the next CY and eligible to earn a MIPS PI Performance Category score, absent another referral of an information blocking determination by OIG in that CY.

CMS is not proposing disincentives for ECs who are not participating in the PI component of MIPS, e.g., those that meet the small practice exception, are non-patient facing, and where their PI component is automatically reweighted. Similarly, at this time, CMS is not proposing disincentives for physicians who are not MIPS eligible (unless they are a provider under the MSSP). However, ECs who choose to submit PI data and void the performance category reweighting would be subjected to a disincentive if found to be an information blocker.

EHs or CAHs in the Medicare PI Program

Much like ECs, if OIG determines an EH or CAH committed information blocking, those institutions would not be considered a meaningful user of CEHRT in an EHR reporting period, and therefore subject to a disincentive. An EH subject to this disincentive would not be able to earn three quarters of the inpatient prospective payment system (IPPS) annual market basket increase associated with qualifying as a meaningful EHR user. Moreover, a CAH subject to this disincentive would have its payment reduced to 100 percent of reasonable costs, a reduction from the 101 percent of reasonable costs it is eligible for in that specific year.

The precise dollar impact of EH and CAH disincentives will vary, but CMS expects it will act as a deterrent to information blocking given that it would reduce what that provider could have earned if it met other requirements under the Medicare PI Program. In the Proposed Regulation, CMS conducted a simulation to apply the proposed disincentive amount to a 3.2 percent market basket adjustment factor. An EH subject to a reduction of three quarters of that percentage increase would be left with a 0.8 percent market basket increase, and CMS estimated a median disincentive amount of $394,353, and a 95 percent range of $30,406 to $2,430,766 across EHs. The value of the reduction in the market basket increase would be larger in dollar terms for hospitals with greater base IPPS payments.

For EHs, CMS is proposing to apply the disincentive to the payment adjustment year that occurs two years after the calendar year when the OIG makes its referral. For CAHs, CMS would apply the downward adjustment to the payment adjustment year that is the same as the calendar year when the OIG referral occurs.

It is also important to note that if an EH or CAH was otherwise not considered a meaningful user of CEHRT during the applicable EHR reporting period due to another aspect of its Medicare PI Program performance, imposing the disincentive would result in no additional impact on that facility during its applicable payment adjustment year. In addition, if multiple information blocking violations were identified for an institution as part of an OIG determination (including over multiple years), each determination by OIG would only affect an EH or CAH's status as a meaningful user of CEHRT in a single EHR reporting period during the CY when the information blocking determination was referred by OIG.

Health Care Providers as an ACO, ACO Participant, or ACO Provider or Supplier under the Medicare Shared Savings Program

CMS proposes that a provider that is an ACO, ACO Participant, or ACO Provider or Supplier under MSSP, and is determined by OIG to have committed information blocking, is not allowed to participate in the Program for at least one year. The agency notes that may result in a provider being removed from an ACO or prevented from joining an ACO; and in the instance where a health care provider is an ACO, such a determination from OIG would prevent the ACO's participation in MSSP.

To participate in Shared Savings, an ACO is required to define its methods and processes to coordinate care across and among health care providers both inside and outside the ACO and have a written plan to "encourage and promote use of enabling technologies for improving care coordination for beneficiaries." Before the start of an MSSP Agreement Period and before each performance year thereafter, ACOs must certify that the ACO (including its ACO participants and ACO provider/suppliers) complies with the MSSP requirements. CMS emphasizes in the proposed regulation that an ACO entity that receives an information blocking determination would not be following these requirements.

The period of time of the disincentive would be at least one performance year. CMS could determine that it would be appropriate for the period to exceed one year if OIG has made any subsequent determinations of information blocking. CMS states in the proposal that it would be unlikely to impose a disincentive greater than one year if the information blocking occurred in the past and there was evidence that the information blocking had stopped. CMS would also look at whether the ACO entity put in place safeguards to prevent future instances of information blocking.

CMS concluded that applying the disincentive prospectively is the most appropriate timing, as it would be impractical and inequitable for the agency to apply the disincentive retrospectively or in the same year in which CMS received a referral from OIG. Applying the disincentive to a historical performance year or a performance year contemporaneous to the OIG's determination would unfairly affect other ACO participants that did not commit the information blocking and likely were not aware of the information blocking. Ultimately, the agency proposed to apply the disincentive no sooner than the first MSSP Performance Year after it receives an information blocking referral determination from OIG. CMS would prevent an entity from becoming or joining an ACO if it's program integrity screening reveals that any part of the ACO had engaged in information blocking.

CMS noted in the Proposed Rule that it is contemplating an alternative approach where a provider could participate in MSSP if a significant amount of time (for example, 3 to 5 years) had elapsed between the occurrence of the information blocking and OIG's determination, and the provider had given assurances in the form and manner specified by CMS that the issue had been corrected and appropriate safeguards had been put in place to prevent its reoccurrence.

The rule also proposes that an ACO may be able to appeal the application of an information blocking disincentive in the Shared Savings Program. Under certain conditions, ACOs may be able to appeal the removal or denial of a health care provider from an ACO participant list as a result of the information blocking referral by OIG as well as the denial of the ACO applicant's application or termination of the ACO's participation agreement. It is important to note that the underlying information blocking determination made by OIG would not be subject to the Shared Savings Program's reconsideration process.

Request for Information on Additional Appropriate Disincentives

The Proposed Regulation emphasizes that it is a first step that centers on available authorities impacting certain health care providers that furnish a broad array of services to large numbers of Medicare beneficiaries and other patients. The included Request for Information (RFI) focuses on additional appropriate disincentives that the agencies should consider for providers in future rulemaking. HHS believes optimal deterrence of information blocking calls for imposing appropriate disincentives on all health care providers determined by OIG to have committed information blocking. They are particularly looking for input on possible disincentives for providers not implicated by the disincentives already proposed. HHS urges input to identify specific providers, additional associated potential disincentives using authorities under applicable Federal law, and providers that HHS should prioritize when establishing additional disincentives.

Additional Points

HHS believes that it is important to promote transparency about how and where information blocking is impacting the nationwide health IT infrastructure. As a result, the Proposed Regulation includes details about publicly posting on ONC's website the information related to providers that have been subject to a disincentive. A provider's name, business address, the practice found to have been information blocking, the disincentive applied, and where to find additional publicly available information about the information blocking determination would be posted on ONC's website. However, some providers functioning in certain programs may have the right to review information before it is posted, so it is important to note that the public posting of this information is governed by existing statutory rights from those programs.

Moreover, a provider that also meets the definition of another regulated actor under information blocking (certified health IT developer, health information network or health information exchange), may be subject to information blocking CMPs as described in the regulation published earlier this year.

The AMA will submit comments which are due January 2, 2024.