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U.S. COURT OF APPEALS HOLDS THAT PHYSICIANS' EMPLOYER IS PERSONALLY LIABLE FOR COSTS ASSOCIATED WITH THE H-1B PROCESS AND OBTAINING A WAIVER OF THE TWO-YEAR HOME RESIDENCY REQUIREMENT

The United States Court of Appeals for the Sixth Circuit recently held the owner and operator of several medical clinics in Tennessee (Clinics) personally liable for failing to (1) pay foreign physicians the required prevailing wage and (2) make public the required documents under H-1B regulations.

The Clinics and their owner, Dr. Mohan Kutty, hired several foreign national physicians (Physicians) who had completed graduate medical education programs in the U.S. in J-1 status. Under J-1 regulations, foreign national physicians are subject to a two-year home residency requirement, generally requiring that such physicians return to their countries of origin for a period of at least two years (Two-Year Requirement). Waivers of the Two-Year Requirement may be obtained under the Conrad-30 program, which requires foreign national physicians in J-1 status to agree to work in the U.S. in H-1B status for at least three years in an underserved area (J-1 Waiver). Physicians with a J-1 Waiver are eligible to apply for an H-1B visa. Each of the Physicians had obtained a J-1 Waiver, and the United States Citizenship and Immigration Services (USCIS) changed the visa status of the Physicians from J-1 to H-1B.

As part of the H-1B application process, Dr. Kutty, in his capacity as the Clinics' medical director, signed Labor Condition Applications (LCAs) in which he agreed, on behalf of the Clinics, to pay the Physicians at least the prevailing wage. The Clinics were required to make these LCAs available to the public. Following an audit, Dr. Kutty concluded that the Physicians were not satisfying their contractual requirements regarding patient-contact hours and began withholding the required salary from certain of the Physicians. The affected Physicians filed a complaint with the U.S. Department of Labor (DOL) claiming wage violations under the Immigration and Nationality Act (INA), and in response, Dr. Kutty fired those Physicians.

The DOL conducted an investigation into the Clinic's employment practices and held the Clinics had violated the INA by (1) failing to pay the required prevailing wages and (2) retaliating against certain of the Physicians. Further, the DOL determined that Dr. Kutty failed to make the LCAs public and wrongfully deducted the costs of the J-1 Waiver and H-1B petitions from the Physicians' pay in violation of the INA. Dr. Kutty appealed the DOL decision, and a judge ordered Dr. Kutty to pay a total of $1.14 million in fines and back wages, including costs to reimburse the Physicians for fees paid by the Physicians to obtain the J-1 Waivers and H-1B status. The judge acknowledged that the applicable law and regulations are silent as to whether employers are required to bear the costs associated with a J-1 Waiver but concluded that including such costs as "business expenses" of the employer is a reasonable interpretation of the law and regulations. The judge also concluded that Dr. Kutty should be held *personally* liable for the corporate

violations because they were willful. Dr. Kutty appealed that decision to the DOL's Administrative Review Board, which agreed with the judge, and then to the U.S. District Court for the Eastern District of Tennessee at Knoxville. On appeal, the Sixth Circuit agreed with the judge's decision.

The decision demonstrates that a court may, based upon the facts at issue, determine that an employer is responsible for fees associated with the J-1 Waiver Process. In light of this decision, physician groups may want to review any existing or potential policies and practices to ensure that all INA prevailing wage requirements are met and that the fees associated with the H-1B process are not incurred by individual physician employees.

CMS MODIFIES EHR MEANINGFUL USE REQUIREMENTS FOR 2014

The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) recently published a final rule modifying the electronic health record (EHR) Medicare and Medicaid incentive programs (EHR Incentive Programs). This final rule gives eligible professionals and eligible hospitals increased flexibility in using certified EHR technology (CEHRT) to satisfy meaningful use requirements for the 2014 reporting period and to make certain other revisions to the Incentive Programs.

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 CEHRT (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 a professional who furnishes at least 90 percent of 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 that is 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.

Implementation of the EHR Incentive Programs occurs over 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. 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).

Highlights of the final rule:

- Eligible professionals and eligible hospitals who are unable to implement EHR products that are certified pursuant to the 2014 edition of the CEHRT criteria due to delays in product availability can continue to use products that were certified under the 2011 edition of the CEHRT criteria for the 2014 reporting period. Eligible professionals and eligible hospitals may also use a combination of 2011 edition CEHRT and 2014 edition CEHRT for the 2014 reporting period. According to CMS, the purpose of this change is to give eligible professionals and eligible hospitals experiencing product availability delays more flexibility in meeting EHR Incentive Program requirements for 2014. CMS emphasizes that the delay must be attributable to vendor delays, such as a delay in releasing a 2014 edition product, not to delays caused by the eligible professional or eligible hospital, such as a delay in purchasing the product or a lack of staff or resources.
    - Because EHR products certified pursuant to the ONC's 2011 edition criteria cannot meet Stage 2 requirements, eligible professionals and eligible hospitals using 2011 edition products for the 2014 reporting period are not required to comply with Stage 2

requirements for such period. Instead, eligible professionals and eligible hospitals using 2011-certified products must comply with the Stage 1 requirements from 2013. Eligible professionals and eligible hospitals using a combination of 2011 edition and 2014 edition products can choose whether to meet the Stage 1 requirements for either 2013 or 2014 or, if the eligible professional or eligible hospital is scheduled to begin Stage 2 in 2014, the Stage 2 criteria.

    - Eligible professionals and eligible hospitals using 2014 edition products who are scheduled to begin Stage 2 in the 2014 reporting year but are unable to fully implement Stage 2 due to product availability delays can attest to the 2014 Stage 1 objectives instead.

    - The clinical quality measures that eligible professionals and eligible hospitals are required to report on for the 2014 reporting year vary based on the edition of CEHRT used by the eligible professionals or eligible hospitals.

- For eligible professionals and eligible hospitals that first became meaningful users in 2011 or 2012, Stage 2 is extended through reporting year 2016, meaning that such eligible professionals and eligible hospitals will not have to meet reporting criteria for Stage 3 until the 2017 reporting year. Stage 3 Meaningful Use criteria have not yet been released.

- An alternative measure for calculating the Stage 2 hospital objective that requires hospitals to provide electronic lab results to ambulatory providers has been finalized. The alternative measure was proposed in 2012 and is available here.

The final rule is effective October 1, 2014.

Please contact any member of the Health Law Group at Robinson+Cole if you have questions:

Lisa M. Boyle | Theodore J. Tucci | Leslie J. Levinson | Brian D. Nichols

Pamela H. Del Negro | Christopher J. Librandi | Meaghan Mary Cooper

Nathaniel T. Arden | Conor O. Duffy
