26 May 2011

Healthcare Colleagues,

Alcatel-Lucent asked our friends at Axial Exchange, our software partner that improves continuity of care through clinical information sharing, if we could distribute the following Executive Summary of the Meaningful Use Final Rule they developed. This clear summary translates over 800 pages of government rule making into understandable decision points. It has been reviewed for accuracy by global health-care law firms and big-four accounting firms.

For leaders of healthcare organizations the Final Rule is old news and most of you have conducted your own discovery and interpretation of the Rule, but as organizations move broadly towards implementation, we felt this document was valuable in communicating the implications deeper into your organization.

Alcatel-Lucent works every day with IT departments in hospitals, hospital systems, health insurance payors and physician service groups and we still see a need for education around the Meaningful Use topic. We hope this document can help.

You may be wondering why the leader in global networking feels compelled to distribute information about the meaningful use of health information.

Alcatel-Lucent has been working for years with Healthcare leaders such as UPMC, Advocate, the Centers for Medicare and Medicaid (CMS), Blue Cross/Blue Shield, the Center for Connected Medicine and many other healthcare organizations around the world and we are convinced that dynamic communications remains the missing link between the silos of information that drive this information driven industry.

Alcatel-Lucent has helped enabled the rich connected consumer experience we enjoy everyday by providing AT&T, Sprint, Verizon and many other service providers with their core technology in wireless and fixed broadband. We have worked closely with our customers to deliver solutions that enable knowledge workers to inexpensively and ubiquitously leverage the universe of information available in the cloud. No other industry has a greater concentration of knowledge workers than the US healthcare industry and we see the movement towards "meaningful use" as a crucial step in connecting these knowledge workers with the information they need to transform the healthcare industry to a truly Connected Hospital.

Thank you Axial Exchange for letting us share this information with the industry.

Regards,

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Axial exchange

Alcatel·Lucent Research

Meaningful Use Final Rule

Summary and Analysis for Executives of Acute Care Hospitals

The Centers for Medicare and Medicaid Services (CMS) issued the "final rule" specifying Meaningful Use requirements for eligible medical entities in July of 2010. Buried in this 862-page document are critical elements that Axial believes will be pivotal to the success of acute care hospitals that aspire to achieve Meaningful Use in a cost-effective manner.

The purpose of this document is to:

- Provide a basic overview of Meaningful Use
- Offer a roadmap for navigating the 862-page final rule document
- Synthesize the key points of each section of the final rule – along with page numbers for quick reference
- Offer recommendations that enable hospital executives to move forward with actionable next steps

THE BASICS

The 2009 American Recovery and Reinvestment Act (ARRA) included a program meant to stimulate the meaningful adoption and use of Electronic Health Record (EHR) systems among health care providers. This program, called the Health Information Technology for Economic and Clinical Health (HITECH) Act, enables health care providers who demonstrate "Meaningful Use" of EHR technology to collect incentive payments through Medicare and Medicaid reimbursement premiums. In July 2010, the Centers for Medicare and Medicaid Services (CMS) issued the "Final Rule" on the requirements for Meaningful Use.

Each of the three core requirements for meaningful use listed below has an associated set of underlying requirements:

Three Requirements for Meaningful Use

Use of certified EHR technology in a meaningful manner

EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care

Using certified EHR technology, provider submits to the Secretary information on clinical quality measures and other such measures selected by the Secretary

Meaningful Use requirements are divided into three sequential stages. Stages One and Two are scheduled to last two years each, while the timeline for Stage Three has yet to be determined. The Final Rule provides the definition for Stage One requirements only, but provides general program themes for all three stages:

The Focus of each Meaningful Use Stage

Stage One: Electronically capturing structured health data

Stage Two: Exchanging health data among unaffiliated providers

Stage Three: Patient-centered healthcare and population health

Stage One Meaningful Use requirements include a set of core requirements "Core Set" and optional requirements "Menu Set", of which five must be satisfied. The below table provides an overview of Stage One requirements for Acute Care Hospitals.

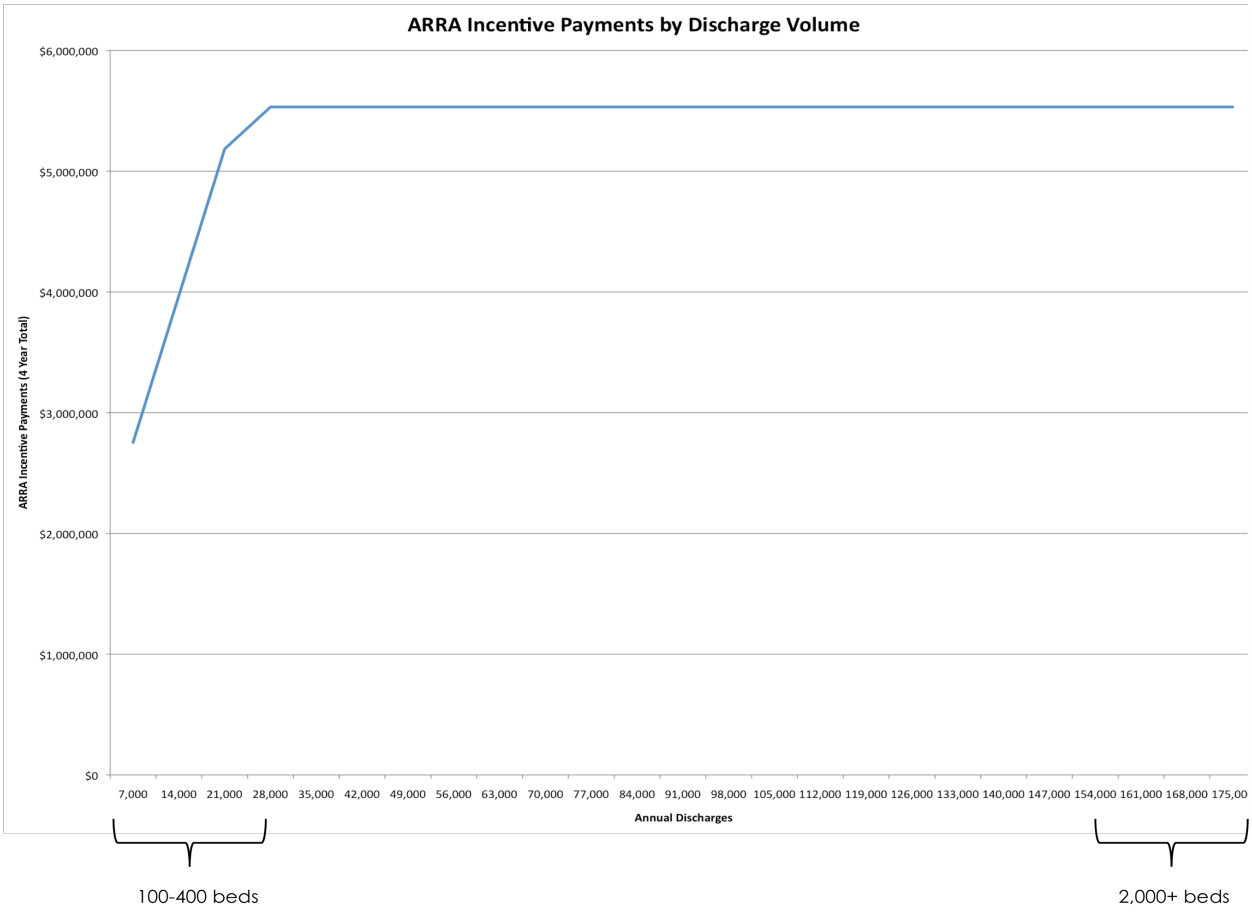
Core Set (All Required)	**Menu Set (Pick 5)**
- Electronically capture: demographics, smoking status, vitals, medication lists, medication-allergy list, and problem lists	- Generate a list of patients by condition
- CPOE for medication orders	- Drug-formulary checks
- Drug-drug, drug-allergy checks	- Advanced directives for >65 yr olds
- Clinical Decision Support	- Structured lab data in EHR
- Clinical Quality Measures	
	- Educational resources
- Electronic copy of health record	
- Electronic copy of discharge instructions	
	- Medical reconciliation
- Exchange key clinical information with 3rd party	- Summary of Care Record for transition
	(Pick at least one)
- Implement systems to protect confidentiality and security of patient data	- Submit to immunization registry
	- Submit syndromic surveillance data
	- Submit labs to public health agency

EHR Certification
To qualify as a Meaningful User, providers must use certified EHR technology. The Final Rule establishes a Temporary Certification Program, whereby the Office of the National Coordinator for Health Information Technology (ONC) within the US Department of Health and Human Services (HHS), will approve several organizations that will conduct the certification testing. These organizations, called ONC-Authorized Testing and Certification Bodies (ONC-ATCB) will be authorized to test and certify both complete EHR systems as well as EHR modules.

Incentive Payments
The formula for calculating hospital incentive payments is based on i) hospital patient volume, ii) the percentage of that volume that is attributed to Medicare, Medicaid, and charity, and iii) an adjustment based on the payment year.

Note that, for the purpose of calculating hospital patient volume, the incentive payment formula caps total discharges at 23,000. Larger hospitals as well as hospital systems that operate under a single CMS Certification Number (CCN) will often have much greater discharge volume than 23,000 over a single operating year. As a result of the limit on discharge volume in the formula, these organizations may receive a relatively small incentive payment as a percentage of total operating costs.

The chart below illustrates estimated incentive payments based on eligible discharge volume. The chart assumes 16.5% Medicare, 16.5% Medicaid, and 5% charity care.



Timeline Overview

February 2009:	ARRA, including the HITECH Act, signed into law by President Obama
December 2009:	Interim Final Rule released
June 2010:	Temporary Certification Program established
July 2010:	Final Rule released
September 2010:	Initial ONC-ATCB's expected to be approved for certification testing
October 2010:	Beginning of first year (federal fiscal year) to earn incentive payments
May 2011:	Earliest payment date for first year incentives
October 2015:	Last year to qualify as a meaningful user before penalties begin

FINAL RULE DOCUMENT STRUCTURE

Section	Description	Page Numbers
I. Program Rules and Definitions	Provides the legislative context for the program, definition of terms, timelines, and basic ground rules for participating.	13-51
II. Stage One Criteria	Provides a detailed explanation of each of the Stage One Criterion.	52-231
III. Quality Measures	Lists the superset of quality measures and outlines the reporting requirements.	231-341
IV. Demonstration of Meaningful Use	Outlines the processes by which meaningful use is demonstrated.	342-367
V. Medicare Fee-For-Service Incentives	Details the FFS incentive payment formulas and program structure	368-462
VI. Medicare Advantage Incentives	Details the MA incentive payment formulas and program structure	463-515
VII. Medicaid Incentives	Details the Medicaid incentive payment formulas and program structure	516-639
VIII. Collection of Information Requirements	Provides the context for collection requirements	639-701
IX. Regulatory Impact Analysis	Estimates the impact that Meaningful Use initiatives will have on providers	702-750

Note: We have intentionally abbreviated the Table of Contents from the Final Rule document in order to facilitate navigation and comprehension.

I. Program Rules and Definitions: Key Content

Pages	Question	Answer
13-14	What prior legislation does ARRA/HITECH impact?	ARRA amends Titles XVIII and XIX of the Social Security Act HITECH adds a new section to the Public Health Service Act
23	Can a hospital participate in both Medicare and Medicaid programs?	Eligible Professionals (EPs) must choose one program, but hospitals may participate in both
23-25	What is the timing of the programs?	They are based on the federal fiscal year starting in October. Medicare counts all years following the first as payment years whereas Medicaid allows for non-consecutive payment years.
44	What is a "Meaningful EHR User"?	A "Meaningful EHR User" is one who achieves 3 goals through the EHR: • Demonstrates use of EHRs in a meaningful manner • Demonstrates connectivity of the EHR to effectively provide health information exchange that enables care coordination, improved public health, etc • Submits clinical quality and other measures to the Secretary using the EHR
34	What is the focus of Stage One?	At the high level, Stage 1 focuses on electronic capture of information. It specifies challenging metrics for EHR adoption and, to a lesser extent, CPOE. It also specifies fundamental functionality but more lenient metrics to enable communication of that information to other providers and agencies
35	What is the focus of Stage Two?	Although subject to change, Stage 2 requirements (due in late 2011) should increase the stringency of the metrics in Stage 1 (particularly with regards to CPOE) while specifying new functionality and/or more challenging metrics around information exchange between unaffiliated providers and EHR systems. Stage 2 may also focus more broadly on all outpatient hospital settings, not just the ER.
36	What is the focus of Stage Three?	Stage 3 will focus mostly on patient-centered healthcare and population health, including: patient-centered information exchange, patient access to self-management tools, and robust decision support for population health and national high-priority conditions.
47	What is the role of the States?	Not all rule-making is centralized, e.g.,: • In Stage 1, States will have the leeway to tailor Stage 1 requirements as it pertains specifically to public health objectives and registries • States will govern the distribution of Medicaid incentive payments • States may set some additional criteria to meet MU in the State
50	Do hospitals need to qualify for both Medicare and Medicaid programs?	Hospitals eligible for both Medicare and Medicaid incentive payments need only to satisfy Medicare requirements to receive guaranteed incentive payments for both Medicare and Medicaid. A hospital that does not meet State requirements will still receive these incentive payments.

I. Program Rules and Definitions: Our Recommendations

1. Mid-sized Acute Care Hospitals that already have an EHR should attempt to qualify for Stage One Meaningful Use incentives in the first year for the following reasons:

- The bar for Stage One is relatively low. Stage One is focused on capturing basic clinical data that is within the current capabilities of most EHR users. The Stage One clinical exchange requirements can be met with minor workflow and system adjustments.
- Qualifying early for Stage One gives Acute Care Hospitals sufficient time to plan for the more rigorous exchange of structured data that is expected in Stage Two.
- CMS has stated that it reserves the right to modify **Stage One** requirements after year FY2011.
- A mid-sized Acute Care Hospital with roughly 30% Medicare and Medicaid patient volume stands to earn roughly $1,500,000 incentives in 2011 from Stage One. (see Axial's interactive calculator)

2. Large acute care hospital systems or IDNs should perform a system and workflow scan to determine if they already meet Stage One Meaningful Use requirements and are able to report against them with current systems. If so, then these large organizations should move forward with Stage One Meaningful Use. If the cost of achieving Stage One Meaningful Use, including people costs, exceeds $2,000,000 then these hospital systems should consider waiting until 2012 or later as a target for Stage One Meaningful Use for the following reasons:

- Year One incentive payments may be less than the costs of achieving them. (See Axial's interactive calculator)
- By delaying the Meaningful Use program for one year or more, these hospital systems can plan a roll-out of both Stage One and Stage Two requirements in one system-wide project.

3. Acute Care Hospitals should focus their efforts on preparing for Medicare requirements, which are generally more rigorous than are Medicaid requirements. Moreover, qualifying for Medicare automatically qualifies a hospital for Medicaid.

II. Stage One Criteria: Key Content

Pg. #	Question	Answer
54	What is the requirement for certified technology?	Meaningful Use must be accomplished using Certified technology. ONC has set up a temporary certification program that will be administered by several authorized testing bodies, which are expected to begin testing this falll.
72, 156, 185, 202, 217	What are the five health outcome policy priorities?	1. Improve quality, safety, efficiency and reducing health disparities (p72) 2. Engage patients and their families in healthcare (p156) 3. Improve care coordination (p185) 4. Improve population and public health (p202) 5. Ensure adequate privacy and security protections for personal health information (p217)
65, 67	What is the basis for calculating reports on Stage One achievements?	(critical) While certain measures are based on eligible patients who are already in a certified EHR, several are based on the total eligible population, implying that hospitals will need a process for measuring non-electronic transactions to calculate measures.
61	What are the exceptions for reporting?	(critical) The public health reporting measures do not require "real data" at this stage; dummy data that is structured like real data is all that is required, and only if there is at least one agency that can accept electronic submissions. In addition, many measures have minimum thresholds – if hospitals do not meet these requirements, then they only need to attest that they do not meet the requirement. These exclusions count towards the number of requirements that the hospital needs to satisfy.

II. Stage One Criteria: Our Recommendations

1. For planning purposes, Stage One requirements should be organized by Core/Menu as well as by the health policy outcome that they support.

Health Outcome Policy Priorities	Core Set (All Required)	Menu Set (Pick 5)
Improving quality, safety, efficiency and reducing health disparities	- Demographics, smoking status, vitals, medication lists, medication-allergy list, and problem lists captured electronically - CPOE for medication orders - Drug-drug, drug-allergy checks - Clinical Decision Support - Clinical Quality Measures	- Generate a list of patients by condition - Drug-formulary checks - Advanced directives for >65yr olds - Structured lab data in EHR
Engage patients and their families in healthcare	- Electronic copy of health record - Electronic copy of discharge instructions	Educational resources
Improve care coordination	Exchange key clinical information with 3rd party	- Medical reconciliation - Summary of Care Record for transition
Improve population and public health	*Must include at least one of the three listed in the Menu set*	- Submit to immunization registry - Submit syndromic surveillance data - Submit labs to public health agency
Ensure adequate privacy and security protections for personal health information	Implement systems to protect confidentiality and security of patient data	

II. Stage 1 Criteria: Our Recommendations (continued)

2. For planning purposes, requirements should be organized by Core/Menu as well as the specific reporting requirement.

	CORE								
Requirement (page # of calc)	**CPOE (83)**	**Vitals (119)**	**Smoking Status (124)**	**e-copy of record (164)**	**e-copy of discharge instructions (169)**	**Problem Lists (94)**	**Med List (99)**	**Med Allergy List (107)**	**Demos (114)**
Numerator	Unique patients w/ >=1 med order using CPOE	Unique patients from denominator >=1 entry of ht, wt, blood pressure	Unique patients from denominator w/ smoking status recorded as structured data	# patients from denominator that receive e-copy	# patients from denominator that receive e-copy	Unique patients from denominator with problem list entry recorded as structured data	Unique patients from denominator with medication recorded as structured data	Unique patients from denominator with medication allergy recorded as structured data	Unique patients from denominator with all demo elements recorded as structured data
Denominator	Unique patients w/ >=1 med	Unique patients > 2 yrs old seen	Unique patients > 13 yrs old seen	# of patients that make request	# of patients that make request	Unique patients seen	Unique patients seen	Unique patients seen	Unique patients seen
Threshold	>30%	>50%	>50%	>50%	>50%	>80%	>80%	>80%	>50%
Denominator only includes patients already in EHR?	Yes	Yes	Yes	Yes	Yes	No	No	No	No
Only during reporting period?	Yes	Yes	Yes	Yes (for requests up to 4 days before end of period)	Yes	Yes	Yes	Yes	Yes

II. Stage 1 Criteria: Our Recommendations (continued)

2. (Continued) For planning purposes, requirements should be organized by Core/Menu as well as the specific reporting requirement.

	MENU				
Requirement (page # of calc)	Advanced Directives (128)	Structured Lab Data (133)	Medical Reconciliations (197)	Summary Care Record for Transition (201)	Edu Resources (184)
Numerator	Unique patients from denominator with advanced directive entry recorded as structured data	# of labs from denominator whose results are incorporated as structured data	Number of transitions of care from denominator where med reconciliation was performed	Number of transitions of care from denominator where summary of care record was provided	Unique patients from denominator who are provided edu resources
Denominator	Unique patients >= 65 yrs old seen	Unique patients seen for whom lab is ordered where result is +/- or number	Number of transitions of care for which provider was receiving party	Number of transitions of care for which provider was transferring or referring party	Unique patients seen
Threshold	>50%	>40%	>50%	>50%	>10%
Denominator only includes patients already in EHR?	Yes	Yes	Yes	Yes	No
Only during reporting period?	Yes	Yes	Yes	Yes	Yes

The final reporting type involves one-time tests (clinical exchange, immunization to registry, labs to public health, surveillance to public health)

3. Acute Care Hospitals should run these one-time tests with sample data as soon as possible for reporting purposes. Once the transmission attempt has been made with sample data, Stage One Meaningful Use has been satisfied and hospitals can pursue transmissions to these parties on a timeline that suits competing priorities.

III. Clinical Quality Measures: Key Content

Pg. #	Question	Answers
235	Does the veracity of the data need to be attested?	Yes - whereas the measures need to be calculated by the EHR, the accuracy and completeness of numerators and denominators need to be attested manually
244, 254	What is the overlap with NQF?	(critical) All 15 of the finalized clinical quality measures for Stage 1 (2011 and 2012) are selected from those endorsed by NQF and have current electronic specifications as of the date of this final rule
245	What is the overlap with PQRI?	The measures currently have some overlap with PQRI – in the future, the aim is to create a single reporting infrastructure that aligns both sets of measures
245	What is the overlap with RHQDAPU?	None of the finalized measures overlaps with RHQDAPU – in the future, these measures are expected to incorporated into RHQDAPU and both sets of measures are expected to be fully aligned
249	What is the overlap with CHIPRA?	Four of the measurements are redundant to CHIPRA – in the future, it is hoped that both sets of measures can be aligned as applicable
296	What proposed measures were not finalized?	Tables 8 and 9 list all the measures that were proposed but did not make it into the final set of rules for Stage 1 – these measures will be considered for future rulemaking as they are further developed and electronically specified
302	Are there measurement thresholds?	No - for each measure, hospitals need to report values, however (unlike EHR meaningful use measures) there are no threshold or performance requirements
303	What are the finalized Clinical Quality Measures?	Table 10 on pg. 303 specifies the finalized clinical quality measures for hospitals, including identifier, title, description, developer and specifications for each measure. See Figure 3 below.
309	What are the qualifications for Medicare/Medicaid?	These 15 measures apply to the Medicare and Medicaid incentive programs, i.e., there are no additional clinical quality measures to submit for either program
310	What are the measurement exceptions?	Unlike EHR meaningful use measure, there are no exemptions – however hospitals may report "0" values where no patients/cases met the measurement criteria
330	Does patient-level data need to be reported?	No - for Stage 1, only aggregate level data needs to be reported as there is no secure standard for patient-level data as yet
333-337	What are the methods of submission?	The primary method of submission of the data and attestation for 2011 will be a CMS-designated portal, through which data can be uploaded in a standardized format, likely CDA. Other submission mechanisms being explored include submission through HIEs/HIOs and through registries. Technical specifications for submission will be posted on or before July 1, 2011
340	How will electronic submission work?	Certified EHR technology will be able to electronically transmit clinical quality measures under the PQRI Registry XML Specification

III. Clinical Quality Measures: Our Recommendations

1. Acute care hospitals should perform a capabilities scan to ensure that they are currently meeting the current electronic specifications for NQF.

2. Review the proposed measures that did not make it into the Final Rule. Before the end of FY2012, perform a capabilities scan to determine i) whether or not you are able to report on those measures and ii) the cost estimate of upgrading workflows and systems to capture and report on those measures.

3. Speak with your EHR vendor to ensure that your system is capable of transmitting via the PQRI Registry XML Specification.

Summary of Finalized Stage One Clinical Quality Measures for Hospitals

1.	Emergency Department Throughput – admitted patients Median time from ED arrival to ED departure for admitted patients
2.	Emergency Department Throughput – admitted patients – Admission decision time to ED departure time for admitted patients
3.	Ischemic stroke – Discharge on anti-thrombotics
4.	Ischemic stroke – Anticoagulation for A-fib/flutter
5.	Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset
6.	Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
7.	Ischemic stroke – Discharge on statins
8.	Ischemic or hemorrhagic stroke – Stroke education
9.	Ischemic or hemorrhagic stroke – Rehabilitation assessment
10.	VTE prophylaxis within 24 hours of arrival
11.	Intensive Care Unit VTE prophylaxis
12.	Anticoagulation overlap therapy
13.	Platelet monitoring on unfractionated heparin
14.	VTE discharge instructions
15.	Incidence of potentially preventable VTE

IV. Demonstration of Meaningful Use: Key Content

Pg. #	Question	Answer
346	How will attestation work?	One-time attestation will be required following the EHR reporting period for a given payment year. The hospital will need to identify the EHR they are using and the results of the measures reported through EHR, with manual attestation for the numerators and denominators
346	What is the reporting mechanism for Medicare?	Reporting will happen through a secure mechanism, such as claims-based reporting or an online portal. In later stages, this will be replaced by an electronic submission directly from the EHR. CMS will issue further guidelines in the near future
346	What is the reporting mechanism for Medicaid?	States will inform CMS as part of the State Medicaid HIT plans which they will submit
355	How do we avoid duplication of payments?	To coordinate with States and avoid duplication of payment, CMS will institute a single National Level Repository (NLR) - accessible by CMS, contractors, and the States - which would include: • Whether the hospital is a Meaningful User • The remittance date and amount of any incentive payments to the hospital • Other information TBD

IV. Demonstration of Meaningful Use: Our Recommendations

1. Assess your organization's capability to implement a reporting system for monitoring progress towards Meaningful Use. This reporting system should be extensible and leveraged over several years.

2. Request a copy of your state's Medicaid HIT plan and review for reporting requirements. Remember that if you are planning to become a Meaningful User under the Medicare program, you will automatically qualify to become a Meaningful User under the Medicaid program.

3. Submit your demonstration reports as soon as they are ready. Avoid submissions close to the FY deadline as heavier volumes during that time may delay payments.

V. Medicare Fee-For-Service Incentive Payment Program: Key Content

Pg. #	Question	Answer
390-391	What types of hospitals are eligible?	"Eligible hospitals" refers to the definition in the Social Security Act in 1886(d)(1)(B), and generally includes hospitals located in any of the 50 states or the District of Columbia. As such hospitals in Puerto Rico are excluded, while hospitals in Maryland are included even though they are not currently paid under CMS IPPS. (critical) Hospitals and hospital units excluded from IPPS (and hence the final rule) include psychiatric, rehabilitation, long term care, children's, and cancer hospitals
396	What is the formula for incentives?	(critical) The formula for Medicare reimbursement includes 4 factors: • A base amount of $2M • An additional variable amount of $200 per annual acute care discharge, with minimum and maximum eligible discharges of 1150 and 15,000 • An adjustment based on the share of hospital patients who are Medicare eligible: this is the estimated Medicare FFS and managed care inpatient bed days divided by the total inpatient bed days, modified by charges for charity care and swing bed days (e.g., for SNF care) • An adjustment made for the transition factor, which would equal 1 in the first payment year and decrease by 0.25 each of the next three years provided that the first payment year occurs before 2014. If hospitals are not prepared to meet Meaningful Use by the 2013 payment year, then the potential annual incentive payments will decrease with the transition factor, as shown on Table 14 on page 431 •
399-402	What tools are available to calculate incentives?	(critical) CMS Form 2552 (Hospital and Hospital Health Care Complex Cost Report) will be finalized in time for the 201 Payment Year and provide a worksheet for calculating payments. Refer to the Axial Incentive Calculator to calculate the incentive payments your hospital can expect to receive. Hospital discharge (and other data) will be determined based on the most recently filed 12-month cost report as the basis for determining the hospital's preliminary incentive payment once the hospital has qualified as a Meaningful User. Final incentive payments will be based on cost report for the hospital fiscal year that begins after the beginning of the payment year.
406	What is the eligible patient population for incentives?	The Medicare share fraction includes the sum of the inpatient-bed-days attributable to patients covered by Medicare FFS and those attributable to individuals enrolled with a Medicare Advantage organization.
391	How are incentives allocated across hospitals?	Incentive payments are based on the CMS Certification Number (CCN), also called the OSCAR number. Thus multiple hospitals who report under one CCN number will only be entitled to payments as if they were a single hospital.

V. Medicare FFS Incentive Payment Program: Our Recommendations

1. Calculate your expected payments using the Axial Incentive Payment Calculator. Exclude psychiatric, rehabilitation, long term care, children's, and cancer hospitals. Note that this is an estimate to be used for planning purposes. The official worksheet for calculating payments is CMS Form 2552.

2. Note that patient volume portion of the formula caps per discharge payments at 23,000 discharges during the reporting period. Larger hospitals and hospital systems will greatly exceed this number. These institutions should consider a slower Meaningful Use roll-out if a decelerated project plan is more cost effective given competing internal priorities.

VI. Medicare Advantage (MA) Incentive Payment Program: Key Content

Pg. #	Question	Answer
463	What is the definition of eligible entities?	Medicare Advantage incentives apply to organizations recognized as Health Maintenance Organizations (HMOs) as defined in 2791(b)(3) of the PHS Act.
474	Are there thresholds for eligibility?	No - MA-affiliated hospitals may not receive MA EHR incentive payments as long as >1/3 of the hospitals discharges or bed-stays of Medicare patients are eligible for FFS incentive payments; i.e., hospitals cannot receive payments through both the FFS and MA EHR incentive programs
495	How will the MA program be administered?	Only ~50 MA-affiliated hospitals are expected to be eligible for MA payments. In light of the low number of hospitals, incentive payments will be administered and delivered to MA-affiliated hospitals through the FFS incentive program.
	When is the preliminary list of eligible hospitals due?	MA organizations will need to provide a preliminary list of affiliated hospitals by June 2011 in order to receive incentives for 2011. Final lists will be due 60 days after the close of the payment year
503, 509	Are MA-affiliated hospitals required to submit Clinical Quality Measures?	No - MA-affiliated hospitals are not required to submit clinical quality measures (pg. 503) for Stage 1 as they already do so through a number of other programs
494	Will MA-affiliated hospitals need to capture EHR Meaningful User measures?	Yes - A "catch" for MA-affiliated hospitals is that they do not typically capture the right level of Meaningful Use data required for the FFS incentive program, but they will need to capture and report this data or suitable proxies (e.g., discharges vs. bed-stays) in order to receive incentives
496	Is an audit trail required?	Yes - MA organizations need to maintain evidence of compliance to the MA EHR incentive program for 10 years

VI. MA Incentive Payment Program: Our Recommendations

1. Hospitals cannot participate in both the Medicare FFS and the MA programs. Determine which program is most appropriate for your organization.

2. If you are applying for the MA program, verify that your institution is capturing the required Meaningful Use data.

3. Ask your EHR vendor if they are capable of generating audit logs that cover the MA program requirements.

VII. Medicaid Incentive Payment Program: Key Content

Pg. #	Question	Answer
516	Are states eligible for Federal Financial Participation?	State Medicaid Programs are eligible for Federal financial participation (FFP) for administering Medicaid incentive program, including 100% FFP payment towards the incentives themselves, and 90% towards G&A costs
522-526	What is the definition of eligible entities?	Acute Care and Children's Hospitals are the only two institutional providers that may receive incentives. The term "Acute Care Hospitals" is defined as "those hospitals with an average patient length of stay of 25 days or fewer, with a CCN that falls in the range of 0001-0879 or 1300-1399" - this encompasses general short-term hospitals, cancer hospitals, and critical access hospitals. "Children's hospitals" refers to hospitals with CCNs in the range 3300-3399 and predominantly treat individuals under 21 years of age.
520	What are the threshold requirements for Medicaid patient volume?	While Acute Care Hospitals must have at least a 10% Medicaid patient volume for each year for which the hospital seeks an EHR incentive payment, Children's Hospitals do not have volume thresholds
538	How is eligible patient volume calculated?	For calculating eligible hospital patient volume, Medicaid encounters include services rendered to an individual as per inpatient discharges or ED days where Medicaid (or a Medicaid demonstration project) paid for all or part of the service, or for all or part of the premiums, co-payments and/or cost sharing
539	Can States modify the calculations?	Yes - States may offer alternatives regarding the methodology used to establish patient volume - which can then be adopted by the Secretary so that it may be used in other states as well
548	Who are the other eligible entities?	The State may pay other entities promoting the adoption of EHR technology, subject to approval by the Secretary. Such entities may include, among others, ONC-funded Regional Extension Centers
575, 585	What are the demonstration requirements?	In Year 1 of Meaningful Use, hospitals must demonstrate that they engaged in efforts to adopt, implement or upgrade EHR technology - there is no reporting period, and demonstration is through attestation, and States will implement processes to combat fraud and abuse. In Year 2 the hospital must demonstrate Meaningful Use for a 90-day period; in subsequent years, the reporting period increases to 12 months. Hospitals who have already adopted/expect to adopt EHRs prior to Year 1 can demonstrate MU in both years 1 and 2, for a 90-day and 12-month period respectively

VII. Medicaid Incentive Payment Program: Our Recommendations

1. Determine Medicaid volume over the last 3-5 years and use this information to forecast expected Medicaid volumes. Volumes must be at least 10%.

2. Estimate your incentive payment using the AXIAL Incentive payment calculator. Remember to include Acute Care and Children's hospitals.

3. Note that patient volume portion of the formula has a limit of 23,000 discharges during the reporting period. Larger hospitals and hospital systems will greatly exceed this number. These institutions should consider a slower Meaningful Use roll-out if a decelerated project plan is more cost effective given competing internal priorities.

4. If you are planning to participate in both Medicare and Medicaid programs, ensure that you move beyond the Medicaid requirements to "adopt, implement, and upgrade" EHR systems, as Medicare requires demonstration of meaningful use in year one.

VIII. Collection of Information Requirements: Key Content

Pg. #	Question	Answer
639-701	What is the role of the EHR in reporting burden estimates?	It is expected that the measurements will be generated automatically by the EHR, and the "reporting burden" in this section primarily involves attestation time
649, 666	What is the estimated burden in terms of time?	The total time burden is expected to be between 9hrs 42min and 12hrs 42min per hospital, depending on which Menu Set criteria the hospital expects to report on for Stage 1
649, 666	What is the estimated burden in terms of costs?	Based on a mean hourly expense of $59.98 (mean hourly rate for attorneys based on the May 2008 Bureau of Labor Statistics), the higher end of the total cost burden is expected to 12hrs 42min x $59.98 = $761.75
649	What is the estimated burden for the core set?	The reporting burden for the Core Set only is expected to be 9hrs 12min, or $551.82 based on attorney fees of $59.98 per hour
660	How long is the security risk analysis and related security update implementations expected to take?	While most individual measures are expected to typically take 10 minutes to an hour to complete, the information security criteria (i.e., "conduct or review a security risk analysis and implement security updates as necessary") is expected to take 6 hours
667, 677	What is the estimated burden for registration?	The estimated time for registration in 2011 for an EHR incentive payment would be less than 0.5hrs. The time taken for MA organizations to identify affiliated hospitals for CMS is 3 hrs, and to attest to the Name, Location and NPI of affiliated hospitals would be 0.5 hrs
683	What is the estimated time required for attestation?	Hospitals are expected to take up to 0.5hrs to attest to minimum threshold requirements for Medicaid incentive payments
695	What is the appeals process?	States will be required to have a process to enable providers to appeal incentive payments, amounts, eligibility determinations, and demonstration of adoption and/or meaningful use of certified EHR technology

VIII. Collection of Information Requirements: Our Recommendations

1. We believe that the estimates of the time and cost of reporting contained in the Final Rule assume perfectly running systems, clean data, and optimized workflow. Under these optimal conditions, reporting is a simple process of running queries and publishing results. We encourage clients to budget sufficient time to achieve this state of readiness, which could take substantial investment for many institutions.

2. Clients should prepare a use-case driven security testing plan that covers a variety of threats.

3. Clients should consider "reporting dashboards" for internal use throughout the year. These dashboards can be used to gauge progress against requirements and can serve to provide early warnings of negative late stage surprises.

IX. Regulatory Impact Analysis: Key Content

This section, covering pages 702 to 750, of the Final Rule mentions other initiatives at CMS/ONC that complement the final rule (e.g., the EHR certification program, Medicare payment adjustments, etc) and discusses the qualitative benefits and burdens of EHR adoption. It specifically mentions two salient views:

- Hospitals can expect to spend $1M-$100M to install an EHR (with an average of $5M), plus another $1M annually for maintenance, upgrades and training

- Hospital adoption of EHRs is expected to be between 95.6% on the low end and 100% on the high end within the next decade.

It concludes, however, that it is impossible to tell, in advance, what will be the precise impact of this legislation on incentive program costs and timing of EHR adoption. As the discussion focuses on the estimated costs to the Medicaid/Medicare programs, a list of all the finalized rules (pgs. 759-862), and the broad impact on the healthcare landscape – rather than on tactical aspects relevant to hospital executives – we do not focus on any specific insights here.

IX. Regulatory Impact Analysis: Our Recommendations

1. Clients should create cost estimates, inclusive of in-house labor, not only for initiatives related to meaningful use, but also for other major initiatives in the project queue.

2. Project cost and return (ROI/NPV) estimates should be run for a variety of project start times. This enables institutions to understand the leverage among projects that share common scope as well as the leverage of projects that have clear dependencies.

3. Overall prioritization should not only be evaluated on risk and return (ROI/NPV) of implementation, but also on the downside risk and potential savings associated with a decision not to implement a project.

About The Authors

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About Axial Exchange, Inc.

Axial Exchange designs continuity-of-care software that bridges the information gap that exists between hospitals and those that provide post-discharge care.

When a patient visits a hospital or emergency department, Axial's software captures clinical details and transforms an otherwise unwieldy chart into an easy-to-read clinical summary that is viewable on smart phones and web browsers. These summaries are designed for specific stakeholders such primary care physicians, medical home case managers, safety net providers, and others. Summaries are delivered as soon as they are available at the hospital so that providers outside of the hospital can prepare for a smooth transition of care.

By providing timely continuity-of-care, patient outcomes improve and unprofitable readmissions are avoided. For physicians practicing outside the hospital, more time is spent treating patients rather than gathering details related to hospital visits. For hospitals that rely on area physicians for inpatient referrals, providing this service to area physicians can provide a strong economic return.

For More Information

For more information about Axial, including a demo of our solution, please contact us through any of the following:

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