

Not So Fast – Why It Pays to Wait Until FY 2012 on Meaningful Use

The registration process and reporting period for meaningful use (MU) officially commenced on January 3, 2011. Over 14,000 providers have registered to date and many more are ramping up efforts to meet MU criteria and collect federal incentives in Fiscal Year (FY) 2011. However, rushing out the gates in FY 2011 is extremely risky and not advisable. This note highlights three key reasons for waiting until FY 2012 to first demonstrate meaningful use.

Three Key Reasons for Waiting until FY 2012

Compressed, unreasonable timeline for achieving Stage 2: The final rule states that hospitals first demonstrating MU in FY 2011 will need to achieve Stage 2 by FY 2013 (Oct 1, 2012) as per Option 1 in the staging table in Figure 1. Furthermore, hospitals must demonstrate MU requirements for the entire year in Stage 2 as opposed to the 90-day reporting period for the first year that a hospital is a meaningful user.

Unfortunately, the final rule defining Stage 2 requirements will not be finalized until mid-2012, leaving hospitals that first demonstrate MU in 2011 with less than 6 months to meet Stage 2 by October 1, 2012. This will be an unattainable leap for providers, especially because Stage 2 is being positioned as a step down from Stage 3, not a step up from Stage 1, comprising enhancements to Stage 1 requirements in addition to a host of new, more complex criteria and clinical quality measures.

Furthermore, hospitals will be dependent on their vendors’ abilities to rapidly develop, test, and seek certification for the Stage 2 EHR capabilities, further impeding provider Stage 2 MU achievement in the short timeframe after the final Stage 2 definition is released. In contrast, waiting to first demonstrate MU until FY 2012 (Option 2) will afford hospitals almost 18 months to migrate from Stage 1 to Stage 2 (see Figure 1 for staging schedule), allowing adequate time to acquire, implement, and adopt the required capabilities for Stage 2.

Figure 1: Stage of Meaningful Use by Payment Year

| First Payment Year* | Stage of Meaningful Use | | | | |
|---------------------|-------------------------|---------|----------------|----------------|------|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| 2011 (Option 1) | Stage 1 | Stage 1 | Stage 2 | Stage 2 | TBD |
| 2012 (Option 2) | | Stage 1 | Stage 1 | Stage 2 | TBD |
| 2013 | | | Stage 1 | Stage 2 | TBD |
| 2014 | | | | Stage 1 | TBD |
| 2015 | | | | | TBD |



* Based on the Federal Fiscal Year i.e. Federal FY 2011 = Oct 1, 2010 to Sept 30, 2011.
Source: Meaningful Use Final Rule, “Medicare and Medicaid Programs: Electronic Health Record Incentive Program,” CMS, available at: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>

No incentives lost for starting in FY 2012: In order to maximize the incentive collection across all four payment years (Medicare incentives for hospitals end in 2016), hospitals must demonstrate Stage 1 of meaningful use no later than July 2013 (see Figure 2) and continue to successfully demonstrate subsequent MU stages on the schedule highlighted in Figure 1. This means that hospitals have no early mover financial advantage for achieving MU in FY 2011 (other than the net present value of the incentives!). However, while there is no financial upside for achieving MU in FY 2011, hospitals run the risk of forfeiting their Medicare incentives in FY 2013 and beyond if they fail to successfully demonstrate future stages. Therefore hospitals are better off delaying reporting on MU till FY 2012 (i.e., Oct 1, 2011 to Sept 30, 2012) so that they have adequate time to prepare for Stage 2 (by Oct 1, 2014 for hospitals first achieving MU in FY 2012), safeguarding their ability to maximize their incentive collection.

Figure 2: Breakdown of Potential Incentive Payout by Adoption Year for Typical Hospital**

| | | Adoption Year | | | | |
|-------------------|-------|---------------|----------|----------|----------|----------|
| | | 2011 | 2012 | 2013 | 2014 | 2015 |
| Payout by Year | 2011 | \$ 2.9 M | - | - | - | - |
| | 2012 | \$ 2.2 M | \$ 2.9 M | - | - | - |
| | 2013 | \$ 1.4 M | \$ 2.2 M | \$ 2.9 M | - | - |
| | 2014 | \$ 720 K | \$ 1.4 M | \$ 2.2 M | \$ 2.2 M | - |
| | 2015 | - | \$ 720 K | \$ 1.4 M | \$ 1.4 M | \$ 1.4 M |
| | 2016 | - | - | \$ 720 K | \$ 720 K | \$ 720 K |
| | Total | \$ 7.2 M | \$ 7.2 M | \$ 7.2 M | \$ 4.3 M | \$ 2.2 M |

** Typical Hospital for this example assumed to have 20,000 discharges, 40% Medicare share and 10% Medicaid share

Building with a more complete information set: CMS and ONC have already released several FAQs and clarifications on demonstrating various meaningful use requirements. Undoubtedly, more are on the way based on the challenges and pitfalls faced by providers who attempt to achieve MU in FY 2011. Some of these clarifications could significantly impact hospital MU plans and strategies. Furthermore, across the coming months, the HIT Policy Committee will evaluate the initial results of the MU program and provide recommendations for Stage 2 and some Stage 3 requirements. Herein lies the late mover advantage for hospitals—those providers that wait to demonstrate MU until FY 2012 will not only benefit from lessons learned by

the early movers but will also have greater visibility into future requirements, enabling appropriate planning in a timely manner.

In fact the same rationale and recommendations hold true for hospitals aiming to collect Medicare incentives for their physician practices. Similar to hospitals, physicians also have to achieve Stage 2 of meaningful use by Jan 1, 2013 (physician MU schedules are based on the Calendar Year (CY)) if they first demonstrate meaningful use in CY 2011. Making the leap to Stage 2 in 6-9 months after the release of the final Stage 2 rule will be impossible for most practices for the reasons discussed above. Furthermore, Medicare eligible physicians do not lose any incentives for reporting on meaningful use in CY 2012 instead of CY2011. So waiting to report on MU till CY 2012 for physician practices – owned or supported by affiliation – is strongly recommended.

Action Items

ACRONYM KEY

CMS

Centers for Medicare & Medicaid Services

CY

Calendar Year

EHR

Electronic Health Record

FY

Fiscal Year

HIT

Health Information Technology

MU

Meaningful Use

ONC

Office of the National Coordinator for Health Information Technology

- Collect Medicaid incentives in 2011:** Hospitals should collect the “adopt, implement, or upgrade” incentives available under the Medicaid program as soon as their states are ready. These incentives, available only in the first year that a provider participates in the Medicaid program, do not require demonstration of meaningful use. Furthermore, Medicaid does not penalize hospitals for failing to demonstrate MU in the second year of the Medicaid program, so there is no downside to collecting from Medicaid now.
- Don’t let the delayed reporting period hamper the momentum:** With clinicians and executives all focused on achieving meaningful use in 2011, IT executives should capitalize on the momentum to conduct dry-run compliance audits aimed at identifying and addressing any performance gaps before starting the reporting period in FY 2012.
- Focus on driving universal adoption of all Stage 1 requirements:** Recognizing that Stage 2 will demand higher performance levels on all Stage 1 requirements and make all menu set (i.e., optional requirements from Stage 1) mandatory in Stage 2, providers should use this time to drive organization-wide adoption of all core and menu set requirements. This will also help reduce the burden of meeting some of the Stage 2 requirements. Furthermore, focusing on improving documentation for Stage 2 and 3 can also support organizational efforts to improve clinical documentation for the migration to ICD-10.
- Start planning for Stage 2 requirements:** Providers must track all developments on Stage 2 requirements and start incorporating those signals into their MU planning now, instead of waiting until all the criteria are finalized in mid-2012. At this time, the HIT Policy Committee has released for comment a draft matrix comprising Stage 2 and some Stage 3 requirements, accessible at: http://healthit.hhs.gov/media/faca/MU_RFC%202011-01-12_final.pdf