HITECH Act overview

The American Recovery and Reinvestment Act (ARRA) includes the HITECH Act, which is designed to accelerate the adoption of interoperable electronic health records (EHRs) and other health information technology (HIT), and to promote health information exchanges (HIEs). HITECH priority areas include:

- Electronic Health Records
- Health Information Exchanges
- Increased Privacy/Security Requirements
- Outcome Registries
- Promotion of HIT Standards and Interoperability
- Clinical Reporting

Under the HITECH Act, government expenditures through the EHR incentive program for transfer payments to Medicare and Medicaid providers (professionals and hospitals), are projected to be as high as $27.4 billion over the next 10 years.

The HITECH Act is not merely about technology implementation; it is about improving outcomes through the application and use of technology. Meaningful use is derived from this concept. The intent is to have “meaningful users” who don’t just purchase a certified system but who use it in a meaningful way to improve clinical outcomes.

The goal is for health care providers to use EHR-captured and -generated measures to monitor key policy outcomes. While the requirements for EHRs differ for eligible hospitals (EHS) and eligible professionals (EPs), they are both derived from the National Priorities Partnership convened by the National Quality Forum (NQF) in 2008 and stress achievement of the following national priorities to help focus performance improvement efforts:

- Improve quality, safety, and efficiency and reduce health disparities
- Engage patients and families
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for personal health information

Current meaningful use requirements are intended to be a starting point for improved outcomes; they will continue to evolve so that they align with emerging national priorities.

Meaningful use implementation timeline

There are three stages (I, II and III) for meeting meaningful use requirements during the five-year implementation period. Each stage has its own deadlines, associated incentives and unique set of criteria. The requirements for each stage build on the requirements of previous (or preceding) stages until 2015, when all eligible professionals and hospitals are subject to the commencement of Medicare penalties for failure to achieve meaningful use. Furthermore, there is nothing that prevents future stages of meaningful use from being enacted after 2015. Providers should try to adopt meaningful use requirements as early as possible because as the requirements increase in specificity over time, incentive payments decrease until the non-compliance penalties begin in 2015.

The criteria for Stage II of meaningful use compliance will be defined during Stage I of the implementation timeline. Similarly, Stage III will be defined during Stage II. The initial stage focuses on electronically capturing health information in a coded format. Stage II and Stage III requirements are anticipated to increase requirements related to interoperability, standards and clinical reporting.
Top Things To Know About Meaningful Use Stage I

Timing of Stages

- The timing of meeting Stages I, II and III requirements has been delayed. (The rules published on July 14, 2010 cover Stage I. Subsequent regulations will be published by the end of 2011 for Stage II and the end of 2013 for Stage III.) Specifically, the Centers for Medicare and Medicaid Services (CMS) has delayed requirements for Stage III, which are still to be determined. In addition, CMS is also prolonging the time frame required to transition from Stage I to Stage II.

Eligibility

- Eligibility criteria differ between the Medicare and Medicaid EHR incentive programs. Also, EPs can only be eligible for either Medicare or Medicaid incentives in any given year (they are allowed a one-time only switch prior to 2015) while EHs can receive both Medicare and Medicaid incentive payments simultaneously.
- Critical access hospitals are now eligible for Medicaid incentives.
- Hospital-based professionals that furnish “substantially all” (90%) of their professional services in a hospital setting are not eligible for incentives. Professionals with less than 90% hospital-based services will be eligible for Medicare or Medicaid incentives. Professionals practicing in ambulatory facilities owned by the hospital are eligible to receive incentive payments.

Medicare incentives and penalties

- In 2015, all Medicare providers who do not meet meaningful use will experience a payment reduction, regardless of whether they participated in the Medicare and Medicaid incentive programs.
- Medicare EHs and EPs must attest to achieving meaningful use on a yearly basis in order to be eligible for incentive payments for each compliant year. EPs and EHs that achieve meaningful use compliance in year one, fail in year two, but achieve compliance in year three, will lose the incentive for the year they failed. The incentive payment cannot be recouped in subsequent years.

Medicaid incentives

- Professionals and hospitals eligible for the Medicaid incentive program can begin receiving incentive payments as late as 2016. There are no decreases in payments for delaying the start date (i.e. there is no aggregate decrease in payments like the Medicare incentive program.) Furthermore, achieving meaningful use does not require demonstration in consecutive years as it does in the Medicare incentive program.
- Medicaid EPs and EHs do not need to achieve meaningful use in the first payment year – they only need to demonstrate that they are adopting, implementing, or upgrading “certified” EHR technology. The purchase of EHRs is within definition of adopting, implementing, and upgrading.

Meaningful use criteria

- The Meaningful Use measures are separated into two main criteria: Core and Menu Set Measures
  - The core set of measures are all required.
  - For the menu set of measures, all but five are required.
  - Overall, meaningful use objectives have decreased. However, the number of measures within the objectives increased from 23 to 24 for EHs. An EH must achieve 14 core measures and five of the 10 menu set measures.
  - EP objectives decreased from 25 to 20. However, the number of core measures remains the same. EPs must achieve 15 core measures and five of the ten menu set measures.
- EHs and EPs will need to demonstrate meaningful use for a continuous 90-day “reporting period” for the first payment year of incentives. The continuous 90-day “reporting period” can be anywhere within that payment year for the EP or EH. Following the first payment year, EHs and EPs will need to demonstrate meaningful use throughout the entire payment year, except for Medicaid where the reporting period for the second payment year is 90 days. There is no reporting period for adopting, upgrading, and implementing an EHR.

Emergency department

- Emergency Departments (EDs) are now included in seven of the meaningful use core measures. Examples of the core measures for EDs include CPOE and the medication allergy list.

Table 1: Stage of Meaningful Use Criteria by Payment Year

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<tr>
<th>First Payment Year</th>
<th>2011</th>
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<th>2013</th>
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<td>2011</td>
<td>Stage I</td>
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<td>2012</td>
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CPOE
- CPOE scope was reduced from all orders to include only medication orders. However, the percentage increased for EPs from 10% to 30% and decreased for EHs from 80% to 30% of unique patients with at least one medication in their history.
- The rule specifies that in Stage II (2012), CMS will expect a CPOE medication order percentage threshold of 60%.
- Excluded from the total for medication order calculations is laboratory, pharmacy, or diagnostic imaging originating orders.
- The CPOE measure does not require direct ordering physician, but can be licensed health care professional including specifically MDs, DOs, RNs, PAs, and NPs.

ePrescribing
- ePrescribing measures were reduced from 75% to 40% of permissible prescriptions. CMS recognized that some pharmacies may not be able to accept an electronic prescription. Furthermore, patients may prefer a paper prescription over an electronic copy.

Problem lists
- The requirement to use standard ICD coding or SnoMed for problem lists was removed. This allows behavioral entities, for example, to use non-standard nomenclature for care management activities.

Quality measures
- EH or critical access hospital quality measures were significantly reduced from 41 quality measures to 15 for the reporting period of 2011 and 2012. The 15 measures represent those that can be electronically captured using a certified EHR. However, while quality reporting is relaxed for Stage I, it will become more prominent in Stages II and III.
- EPs are required to report on three core quality measures. If the denominator of one or more of the core measures is equal to zero, EPs are required to report on up to three alternate core quality measures (substituting one alternate per core measure with a denominator of zero).
- They are also required to choose three additional measures from a set of 38 CQM (other than core/alternate). The EP will not be expected to report against measures of populations they do not serve.
- Reporting by attestation is required for quality measures in 2011; electronic reporting is required in 2012.

Physician reassignment
- Reassignment of incentive payment from EP to employer is not required. Hospitals may need to renegotiate contracts with providers if the hospital expects to receive the incentive payments.

Attestation
- States must comply with federal requirements. An EH or EP participating in Medicaid incentives must attest in writing that the entity is compliant to receive federal funds. Fraudulent attestation could result in prosecution under federal and state laws.
- CMS certification numbers, as they are distinguished by provider number in hospital cost reports, will still determine incentive payments to hospitals. Payments to EHs will be made to each provider of record.
- National Provider Identifier (NPI) and Tax Identification Number (TIN) will still determine incentive payments to EPs.

Privacy and Security
- EPs and EHs must conduct or review a security risk analysis, implement security updates and correct security deficiencies.
- Certified EHR Technology must enable security and privacy functionality for prescriptive requirements including access control, emergency access, audit logging, integrity of PHI, authentication and encryption.
**Smart first steps**

1. **Identify needs**

Many providers likely will need to deploy additional advanced clinical functionality and/or improve adoption of existing EHRs to receive government incentive payments. These providers typically fall into one of the following categories:

- Organizations that need to accelerate EHR functionality, deployment or modify current implementation plans/sequencing
- Large organizations that need to revise hospital or regional rollout plans to prioritize deployment based on HITECH incentives and penalties
- Organizations that need to rapidly change EHR vendors, select new vendors, and/or rapidly implement an EHR
- Organizations that still need to overcome cultural (e.g., physician incentive alignment), process and technology challenges to implement an EHR
- Organizations that need to address financial barriers to EHR adoption (e.g., access to capital and subsidizing ongoing operational costs) since the HITECH payment incentives commence post-adoption
- Organizations that need to understand the new security and privacy requirements associated with meaningful use
- Organizations that will have to implement compliance, reporting and outcome management in association with meaningful use requirements.

2. **Don’t delay planning**

Despite uncertainty around the CMS’ meaningful use regulations’ content and implementation timeline, health care providers cannot afford to delay developing a detailed road map. First and foremost, providers should decide whether their strategy is to secure incentive funds, to simply avoid getting penalized, or both. Considerations include prioritizing the timing and extent of capital expenditures, as well as selecting the approach for clinical adoption and the methods to fulfill specific requirements for meaningful use.

Providers also should remember that being designated a “meaningful user” requires that they do more than merely implement an EHR system and provide patients with electronic access to health information in a timely fashion. Organizations may need to invest in business analytics and business intelligence capabilities to help them measure and report the results of their efforts.

In addition, many clinicians may need to significantly change their workflow and patient care processes to more fully utilize an EHR in their daily patient care activities. Furthermore, meaningful use requirements are intended to ramp up in later stages, as the government expects that the resulting new processes from implementing Stage I will deliver better clinical outcomes, increased efficiency and an enhanced patient experience. Meaningful use has loftier goals than historical EHR use. Even those organizations already advanced in their EHR implementations will need to work diligently to optimize their use in order to meet the new requirements.

3. **Get plugged into state’s HIE efforts**

One of the government’s HITECH goals is the exchange of data across and between providers in a “community,” which promotes the establishment of HIEs. As part of their meaningful use planning process, providers need to determine what, if any, plans their organization, community or state has for an HIE.

**Planning for implementation**

Meeting meaningful use requirements should be a priority for a provider organization’s senior leadership. An internal team of clinical, technology and finance department representatives should establish a clear, comprehensive HITECH plan that addresses important questions such as:

- What competencies do we have?
- What capacity do we have?
- What external resources will we need?

Experience has shown that the optimal time to build the right team and access the leading resources is before a deadline looms. A meaningful use road map should include not only goals and expected outcomes, but also timelines, staffing requirements and a projection of expected capital and operating costs.
Key considerations for providers

Despite still-evolving definitions, standards and requirements, many hospitals and physicians find themselves forced to move ahead with incomplete information to meet the aggressive timelines established by the HITECH Act. Because of this, health care providers may feel like they are being asked to hit a moving target as they work to demonstrate meaningful use of certified EHRs to qualify for HITECH Act Medicare and Medicaid incentive payments.

Critical questions in the provider planning process should include:

- Have we determined the estimated HITECH incentives and penalties (including Medicaid and physician estimates)?
- Does our current timeline align with the HITECH incentives and penalties timeline?
- Do we need to reevaluate our current EHR vendor to ensure it can meet the new requirements and certification criteria?
- Do we have plans to accelerate implementation?
- What about process redesign and clinician adoption – do we have plans to deal with these common barriers?
- Do we have a full understanding of the security and privacy requirements of the HITECH Act?

Deloitte’s HITECH capabilities and qualifications

Deloitte has well-developed capabilities, extensive qualifications and a wide range of consulting services to address EHR and related provider HIT challenges. Deloitte’s HITECH solution features a cross-functional approach, including audit, consulting, tax and financial advisory services. These services include:

- Advisory Planning/Assessment Services
  - Half-day executive workshop
- Accelerated HITECH Planning Engagements
  - Scenario Planning
- Meaningful Use Assessment Engagements
  - Rapid Assessment
  - Gap Analysis
  - Measures Map
  - Recommendations
- Rapid System Selection
- EHR Implementation Services and Assistance
- Privacy and Security Services

In addition, our cross-functional team leverages work by the Deloitte Center for Health Solutions (DCHS), whose goal is to inform all stakeholders in the health care system about emerging trends, challenges and opportunities using rigorous research. Through its research, roundtables and other forms of engagement, the DCHS seeks to be a trusted source for relevant, timely and reliable insights.

Finally, Deloitte is proud to be recognized for its work with health care industry leaders:

- Health Care Consulting practice ranked #1 (4th consecutive year) among 20 professional services providers based on market share and market growth. – Kennedy Information, March 2009
- Revenue Cycle Transformation practice ranked Best in KLAS (2nd consecutive year) as part of the 2009 Top 20 Best in KLAS Awards: Software & Professional Services. – KLAS Research, December 2009
- Health Care Consulting practice ranked #1 (5th consecutive year) among the 20 largest health care management consulting firms. – Modern Healthcare, August 31, 2009

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