The Incentive Roadmap®

The Meaningful Use of Certified Technology: Stage 1
A Manual for Medical Practices

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Disclaimer

Every effort has been made to ensure that the information in this manual is accurate. As the Centers for Medicare & Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Program is still subject to legislative changes, regulatory definitions, clarification and guidance there is no claim that the information contained is complete, comprehensive or that it contains no inaccuracies. Under no circumstances shall the principals involved in the creation of this document be liable for any incidental, indirect, consequential or special damages of any kind, or any damages whatsoever, including, without limitation, those resulting from, expected incentives, whether or not advised of the possibility of such damage, arising out of or in connection with the use of this manual.
About Jim Tate

Jim Tate is a nationally recognized expert on the CMS EHR Incentive Program, certified technology and meaningful use objectives. Jim brings a unique combination of skills to successfully address the complex and changing issues surrounding the CMS EHR incentives for the “meaningful use of EHR certified technology” for Stage 1 and beyond. He is an accomplished project manager in the development and implementation of both EHR and Practice Management systems and has worked with over 50 Health Information Technology vendors. He has led numerous implementations in the United States and Asia.

Jim founded and serves as President of EMR Advocate, LLC. which provides extensive consulting services to physicians, EHR vendors, developers and other stakeholders in the Health Information Technology industry. EMR Advocate has actively supported more than 40 Ambulatory and Inpatient EHR vendors in their Certification projects since 2006. Jim has a multi-decade background in clinical workflow management and has been directly involved for the past 5 years in the due diligence, planning and implementation of electronic health records. He has consulted with physician groups, software vendors and other industry entities. His knowledge and ability to see and address both provider and vendor concerns allow him to bring extraordinary value to his clients.

Jim is committed to the proper use of technology to improve health care. Jim presents frequently at national HIT conferences, is active on HIT blogs and webinar presentations. He is sought after by the investment community for his input on the trends and direction of the HIT industry.

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Contents

Preface ........................................................................................................................................... 4
Which Program Should I Select? ..................................................................................................... 8
  Medicaid Incentive Program ........................................................................................................ 11
  Medicare Fee-for-Service Incentive Program ........................................................................... 13
  Medicare Advantage Incentive Program ..................................................................................... 15
Becoming a Meaningful User ......................................................................................................... 17
  Definition of Stage 1 Meaningful Use ....................................................................................... 17
  Required Criteria ....................................................................................................................... 18
  Stage 1 Meaningful Use Objectives: the details ........................................................................ 24
Certified Technology .................................................................................................................... 30
Registering for Incentive Programs and Documenting Meaningful Use .................................. 33
Your Incentive Road Map: Step by Step ...................................................................................... 36
  G - Getting prepared, Gathering information, and Gap analysis ........................................... 36
  E - Educate .................................................................................................................................. 36
  T – Timeline ................................................................................................................................ 37
  R - Research systems .................................................................................................................. 38
  E - Execute system purchase or updates .................................................................................. 38
  A - Apply implementation plan ................................................................................................. 38
  D - Data Security ....................................................................................................................... 38
  Y - Year of Payment 2011 ......................................................................................................... 39
Resources ....................................................................................................................................... 40
  Timeline of the ARRA/HITECH Act .......................................................................................... 40
  Acronyms .................................................................................................................................... 41
  Frequently Asked Questions ....................................................................................................... 43
  Internet Resources ...................................................................................................................... 47
Preface

“For years, health policy leaders on both sides of the aisle have urged adoption of electronic health records throughout our health care system to improve quality of care and ultimately lower costs. Today, with the leadership of the President and the Congress, we are making that goal a reality.”

~ HHS Secretary Kathleen Sebelius, July 13, 2010, announcing the Final Rules pertaining to EHR adoption.

It came out of the blue. For years the adoption of Electronic Health Records (EHR) had stagnated and the use of the EHRs by physicians had reached a plateau of about 25%. Suddenly, in the midst of the greatest global economic upheaval in a generation was the passage of a massive stimulus bill (ARRA) by the Federal Government. Buried in that legislation was the impetus to fund, promote and support the ‘meaningful use of certified technology’ by the nation’s health care system. The Health Information Technology for Economic and Clinical Health Act (HITECH) was born, and health care delivery was destined to change forever. The requirement to use health information technology (HIT) in the delivery of health care in the United States has become a matter of national policy with the passage of the American Recovery and Reinvestment Act (ARRA) in 2009. A purpose of the act is to improve patient care, health care quality and clinical outcomes, specifically when it applies to the treatment of Medicare and Medicaid beneficiaries. In fact, the HITECH provisions of ARRA make an explicit connection between the “Meaningful Use” of EHRs and the transformation of health care for Medicare and Medicaid recipients. The ARRA earmarks billions of dollars of federal stimulus money for payments to providers who successfully implement and use HIT. In addition to the incentives payments that are tied to the implementation and use deadlines of health information technology, there are also long-term reimbursement penalties for those who fail to meet the requirements.

Implementing an Electronic Health Record system is a challenge even in the best of circumstances. The cost of the technology, the alteration of the workflow and the learning curve make the transition one of the most difficult undertakings of a medical practice. Making the technology work is another challenge, as it requires a significant investment in business and clinical process changes as well as the collaboration and mobilization of a wide range of
stakeholders. The concentration of these technologies is therefore extremely limited and uneven across the industry. Today in the United States, it is estimated that less than one third of physicians use an EHR.

The terms Electronic Medical Record (EMR) and Electronic Health Record (EHR) are often used interchangeably, but there is a distinct difference. The National Alliance for Health Information Technology (NAHIT) defines an EMR as "an electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization." An EHR is defined as "an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization." So for the sake of simplicity we could say an EMR is a patient’s health record that resides within one organization, and an EHR is a health record that spans two or more organizations and contains information from multiple sources.

Having an Electronic Health Records system in a medical practice is just one of the aspects of the HITECH incentives. Providers must ensure that the EHR system they implement and use meets the certification requirements for HITECH. They must also demonstrate “meaningful use,” or the ability to use the EHR to effectively support specific clinical activities. The requirements are organized around achieving a national health policy to:

- 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

The complete CMS EHR Incentive Program is separated into three different stages. Each one of the stages has its own deadlines, incentives and distinct requirements. In order to appreciate the full scope of the incentive program and the objectives of meaningful use, individual providers must be able to share data and information with other organizations across the continuum of care. This will obviously require the development of various health information exchanges (HIE) that facilitate interaction and interoperability of HIT implementations in disparate organizations and among many stakeholders.
Essentially, therefore, in order to qualify for any of the incentives that will be available during the life of the CMS incentive programs, physicians must be using “certified Electronic Health Records technology” in a “meaningful manner.” While the widespread use of EHRs in the United States is inevitable, it will do the clinician a great deal more to obtain certified EHR technology as early as feasibly possible.

Under the provisions of the Health Information Technology for Economic and Clinical Health Act, or HITECH, the federal incentives program will be made available to the Eligible Professionals (EP) who adopt an EHR and demonstrate their use in ways that can improve quality, safety and effectiveness of care. The providers that are deemed eligible for the program can receive substantial incentives through either Medicare or Medicaid in the following manner:

- Under Medicare, they can receive up to $44,000.00 over a five (5) year period or
- Under Medicaid, they can receive up to $63,750.00 over a six (6) year period

**Incentive Payments**

Once the provider has attained the appropriate certified software that is able to perform all of the required functionality that is required, they will need to meet the “meaningful use” criteria with respect to the use of that software.

If the EP meets the “meaningful use” requirements utilizing software that meets criteria standards (HHS certification), the provider will be eligible to receive incentive payments based on a specific schedule. CMS has stated that under the Medicare program EPs can expect to receive their incentive payment within 15-46 days after successful submission of their attestation of “meaningful use of certified EHR technology”. Theoretically, for 2011 a Medicare EP could meet the requirements during January-March 2011, apply in April, and receive $18,000 in May.

**Why should a practice choose Electronic Health Records?**

Aside from the obvious incentives that are available through the program, there are a number of advantages of having electronic health records. For example, they can make a patient’s health information available when and where it is needed, as it is not locked away somewhere else; they can bring a patient’s total health information together in one place; they can support better follow-up information for patients; they can improve patient and provider convenience – patients can have their prescriptions ordered and ready before they leave the office; they can link
information with patient computers to point to additional resources – patients can be more informed and involved; and they can improve safety through their capacity to bring all of a patient’s information together and identify potential safety issues.

**Enrollment**

CMS has announced that the Provider Enrollment, Chain and Ownership System (PECOS) records will be used to verify Medicare enrollment prior to making Medicare Electronic Health Records incentive payments. Individual enrollment must be in PECOS, so providers are encouraged to act now if they do not have an enrollment record in this system.

If a provider enrolled in Medicare prior to November 2003, and that provider has not updated his or her Medicare enrollment information, that physician does not have an enrollment record in PECOS. These physicians and clinicians are encouraged, therefore, to establish their records with PECOS. The instructions about how to enroll can be found online on the Tips to Facilitate the Medicare Enrollment Process page located at [www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll).

If a provider enrolled in Medicare after November 2003, or if they enrolled before November 2003 and has updated his or her Medicare enrollment information since November 2003, then no further action is required.
Which Program Should I Select?

The first decision in your Incentive Roadmap® is the selection of the initial incentive program in which to participate. **Without a doubt the incentive program of choice for most Eligible Professionals (EPs) is Medicaid.** The Medicaid option provides the potential of a significantly higher incentive ($63,750 vs. $44,000) than Medicare during the life of the incentive program. Notably, the Medicaid program is also the only one available to Nurse Practitioners, Certified Nurse-Midwives, and some Physician Assistants. Additionally, the Medicaid program actually allows for a first year potential incentive of up to $21,250 without the demonstration of meaningful use! In the first year of participation in the Medicaid program there is no reporting period. The requirement is for the adoption, implementation, and/or upgrade to certified EHR technology.

There are two incentive programs, Medicare (Medicare FFS or Medicare Advantage) and one under Medicaid. An EP can only participate in one at a time. During the life of the incentive program an EP may switch programs one time.

**How to Use this Flow Chart**

The following flow chart, from CMS, is designed to help Eligible Professionals (EPs) determine whether the Medicare or Medicaid Electronic Health Record Incentive Programs is most appropriate. A Medicaid EP may also be eligible for the Medicare incentive and should follow the path of answering no to the question of Medicaid patient volume to determine Medicare eligibility. An EP who qualifies for both programs may only participate in one program. EPs eligible to receive EHR incentive payments under Medicare or Medicaid will maximize their payments by choosing the Medicaid EHR Incentive Program.
By answering these 4 questions the flow chart will navigate you to your eligibility status.

1. Did you perform 90% of your services in an inpatient hospital or emergency room hospital setting?
2.Were at least 30% of your services furnished to Medicaid patients in an outpatient setting (20% requirement for pediatricians)?
3. Did you practice predominantly in a Federally Qualified Health Center or Rural Health Clinic with a 30% needy individual* patient volume threshold?
4. Do you treat Medicare patients?

*Section 1903(t)(3)(F) of the Act defines needy individuals as individuals meeting any of the following three criteria: 1. They are receiving medical assistance from Medicaid or the Children’s Health Insurance Program (CHIP) 2. They are furnished uncompensated care by the provider 3. They are furnished services at either no cost or reduced cost based on a sliding scale.
**Medicaid vs. Medicare**

There are some distinct differences between the Medicare and Medicaid incentive programs. The CMS information in the following chart below provides a clear view of the significant variations in the two programs.

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Government will implement (will be an option nationally)</td>
<td>Voluntary for States to implement (may not be an option in every state)</td>
</tr>
<tr>
<td>Payment reductions begin in 2015 for providers that do not demonstrate meaningful use</td>
<td>No Medicaid payment reductions</td>
</tr>
<tr>
<td>Must demonstrate MU in year 1 and every subsequent year to qualify for the incentives</td>
<td>Can qualify for incentive payments after adopting, implementing or demonstrating MU in the first participating year. Required to demonstrate MU in each subsequent year to qualify for incentive</td>
</tr>
<tr>
<td>Maximum incentive is $44,000 for EPs (bonus for EPs in HPSAs)</td>
<td>Maximum incentive is $63,750 for EPs</td>
</tr>
<tr>
<td>MU definition is common for Medicare</td>
<td>States can adopt certain additional requirements for MU</td>
</tr>
<tr>
<td>Last year a provider may initiate program is 2014; Last year to register is 2016; Payment adjustments begin in 2015.</td>
<td>Last year a provider may initiate program is 2016; Last year to register is 2016.</td>
</tr>
<tr>
<td>Eligible Providers: Doctor of Medicine of Osteopathy, Doctor of Dental Surgery or Dental Medicine, Doctor of Podiatric Medicine, Doctor of Optometry, Chiropractor</td>
<td>Eligible Providers: Physicians, Nurse Practitioners, Certified Nurse-Midwives, Dentists, Physician Assistants working in a FQHC or RHC that is led by a PA.</td>
</tr>
</tbody>
</table>
Medicaid Incentive Program

Eligibility

For Medicaid, an Eligible Professional (EP) is defined as:

- Physician
- Nurse Practitioner (NP)
- Certified Nurse Mid-Wife (CNM)
- Dentist
- Physician Assistant (PA) working in a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) that is so led by a PA
  - Must not be Hospital-based
  - This rule does not apply to EPs who are practicing predominately in a FQHC/RHC

The Medicaid EP must meet one of the following criteria:

- Have a minimum of 30% Medicaid patient volume
- Have a minimum 20% Medicaid patient volume and is a pediatrician
- Practice in a Federally Qualified Health Center or Rural Health Clinic and have a minimum 30% patient volume that is attributed to needy individuals

Incentive Payments and Schedules

Medicaid EPs are eligible for up to $63,750 in incentives by achieving specific requirements in calendar years from 2011 to 2021 and adopting by 2016. The Medicaid program differs for the Medicare in a significant way. Under the Medicare program incentives are based on the meaningful use of certified technology. Incentives are received only after the actual adoption and meaningful use of the technology. For the Medicaid program, the HITECH Act provides incentive payments to eligible Medicaid providers to adopt, implement or upgrade to certified EHR technology. The Medicaid incentive includes funding to facilitate the purchase and implementation of the allowable cost of the technology and therefore the Year 1 payment could be $21,250 followed in Years 2 through 6 with an incentive of $8,500. The maximum incentive over 6 years is $63,750 and the incentives are the same regardless of the start year. For Medicaid EPs with a minimum 20% Medicaid patient volume, but less than 30%, the Year 1 incentive would be $14,166 for Year 1 and $5,667 for Years 2 through 6.
The following table shows the maximum yearly payments for Medicaid meaningful users.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$21,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
</tr>
<tr>
<td>2017</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2018</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2019</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2020</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2021</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>Total</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
</tr>
</tbody>
</table>

There are two potential approaches to the establishment of Medicaid eligibility. The first is the managed care/medical home approach; the second is the patient volume threshold. The volume criteria vary and are indicated in the following table:

<table>
<thead>
<tr>
<th>Entity</th>
<th>Minimum 90-day Medicaid Patient Volume Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>30%</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>20%</td>
</tr>
<tr>
<td>Dentists</td>
<td>30%</td>
</tr>
<tr>
<td>Certified nurse midwives</td>
<td>30%</td>
</tr>
<tr>
<td>Physician Assistants when practicing at an FQHC/RHC led by a physician assistant</td>
<td>30%</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>30%</td>
</tr>
</tbody>
</table>

Or the Medicaid EP practices predominantly in an FQHC or RHC - 30% “needy individual” patient volume threshold.
Other Things to Consider about Incentive Payments in the Medicaid Program

- Incentives are over 6 years
- There is no bonus for HPSAs
- Incentives are the same regardless of the EPs start year.
- 2018 is the last year to begin to receive a payment
- Incentives continue through 2021
- EPs may skip a year and still be eligible for payment

Medicare Fee-for-Service Incentive Program

Under the Medicare Incentive Programs, an EP can be eligible depending on their designation as either a Fee-for-Service or Medicare Advantage provider. The incentives for FFS are based on a percentage of fees while the incentives for a MA provider are based on participation in a MA organization.

Eligibility

Not every provider or clinician will be eligible to receive the incentives through the program. For Medicare, an Eligible Professional (EP) is defined as:

- Doctor of Medicine or Osteopathy
- Doctor of Dental Surgery or Dental Medicine
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Chiropractor
  - The EP must not be hospital-based for participation in the program
Incentive Payments and Schedules

The following table shows Medicare Fee-for-Service incentive payments for EPs that become meaningful users in years 2011 to 2015. The last year to begin incentive payments is 2014 while the last year to receive incentive payments is 2016.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015 and later</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$18,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>$12,000</td>
<td>$18,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$15,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$12,000</td>
<td>$0</td>
</tr>
<tr>
<td>2015</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$0</td>
</tr>
<tr>
<td>2016</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
<td>$44,000</td>
<td>$44,000</td>
<td>$39,000</td>
<td>$24,000</td>
<td>$0</td>
</tr>
</tbody>
</table>

It is important to understand that the incentive payments are per EP and not per practice. If your practice has 4 Medicare EPs and all met MU Stage 1 in 2011 the total incentive would be $72,000 for that year. Over the life of the program the incentive could be $176,000.
Medicare Advantage Incentive Program

Eligibility

A Medicare Advantage Eligible Professional (EP) potential incentive is not based on the Fee-for-Service basis but rather their participation in a MA organization. The incentive payments go to the MA organization, not the individual EPs. To qualify Medicare Advantage EPs must meet the role requirement for Medicare eligibility above, and also meet one of two other requirements:

- Must furnish, on average, at least 20 hours/week of patient-care services and be employed by the qualifying MA organization
- or -
- Must be employed by, or be a partner of, an entity that through contract with the qualifying MA organization furnishes at least 80 percent of the entity’s Medicare patient care services to enrollees of the qualifying MA organization

Incentive Payments and Schedules

For those health care providers who serve in the Health Provider Shortage Areas, or HPSA, there are additional 10% bonuses on top of the Medicare base incentive. The following table shows the maximum incentive payments for the HPSA EP. The years of adoption and payments are the same as the Medicare Fee-for-Service payments.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Yr that EP Becomes EHR User in a HPSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>2011</td>
<td>$19,800</td>
</tr>
<tr>
<td>2012</td>
<td>$13,200</td>
</tr>
<tr>
<td>2013</td>
<td>$8,800</td>
</tr>
<tr>
<td>2014</td>
<td>$4,400</td>
</tr>
<tr>
<td>2015</td>
<td>$2,200</td>
</tr>
<tr>
<td>2016</td>
<td>$2,200</td>
</tr>
<tr>
<td>Total</td>
<td>$48,400</td>
</tr>
</tbody>
</table>
Other Things to Consider about Incentive Payments in the Medicare Program

- Incentives are based on Fee-for-Service allowable charges or, in the case of Medicare Advantages EPs, meeting the requirements of participation in a MA organization.
- Under the Fee-for-Service Medicare program, the payment incentive amount is equal to 75 percent of an EP’s Medicare physician fee schedule allowed charges. To be eligible for the maximum 2011 or 2012 incentives, the EP would need to have $24,000 in Medicare claims.
- Maximum incentives are obtained by starting in 2011 or 2012. If you become a meaningful user after 2012 you will receive incentive money but you will not be able to obtain the maximum amount.
- For their first year in the program, EPs are only required to meet the MU criteria for 90 consecutive days to be eligible for the incentives. It doesn’t matter if your first year in the program is 2011 or 2014, the requirement is only for 90 consecutive days for that initial year of participation.
- For EPs that meet the meaningful use criteria:
  - Payment will begin on a calendar year basis, effective January 1, 2011
  - Payments will be issued 15-46 days after successful attestation for 2011, as early as May, 2011
  - For 2011, the payment cycle is monthly; however, only one single payment per year will be provided.
Becoming a Meaningful User

Definition of Stage 1 Meaningful Use

‘Meaningful Use’ is a phrase that reflects the requirement that the certified technology is actually used in a manner that promotes health care delivery. This objective was assigned to the Office of the National Coordinator (ONC) and the Centers for Medicare and Medicaid Services (CMS) through the American Recovery and Reinvestment Act of 2009 (ARRA). The overall design is to be used by health care providers to improve the quality, safety and efficiency of the health care system.

A Working Definition of Meaningful Use

“The proposed rule would define the term Meaningful Electronic Health Records User as an Eligible Professional (EP) or Eligible Hospital (EH) that, during the specified reporting period, demonstrates meaningful use of certified Electronic Health Records technology in a form and manner consistent with certain objectives and measures presented in the regulation. These objectives and measures would include use of certified Electronic Health Records technology in a manner that improves quality, safety and efficiency of health care delivery, reduces health care disparities, engages patients and families, improves care coordination, improves population and public health, and ensures adequate privacy and security protections for personal health information.”

Essentially, there are three components of Meaningful Use:

- Use of Certified Electronic Health Record in a meaningful manner, such as e-prescribing or providing a patient with an electronic copy of their clinical record
- Use of Certified Electronic Health Record Technology for Electronic Exchange of health information to improve the quality of health care
- Use of Certified Electronic Health Record Technology to submit Clinical Quality Measures (CQM) and other measures as selected by the Secretary of HHS
Required Criteria

The CMS Final Rule specifies the initial criteria that Eligible Professionals (EP) must meet to demonstrate meaningful use and qualify for incentive payments. The CMS rule includes both a Core Set of criteria that all providers must meet to qualify for payments while also allowing a provider choice of a Menu Set of additional criteria. The CMS rule outlines a phased and flexible approach to implement the requirements for demonstrating meaningful use. This approach initially establishes criteria for meaningful use based on currently available technological capabilities and providers’ practice experience. CMS will also establish graduated criteria for demonstrating meaningful use through future rulemaking, consistent with anticipated developments in technology and providers’ capabilities.

Meaningful Use is separated into three stages. **Stage 1** goes into effect on January 1, 2011, to be replaced by **Stage 2** in 2013, and then **Stage 3** in 2015. Stage 1 has been fully defined, whereas Stages 2 and 3 have not yet been defined.

What to expect in **Stages 2 and 3**:

- Increased e-prescribing and CPOE use
- Incorporated structured lab results
- E-transmission of patient care summaries
- All optional Stage 1 criteria will be required
- All thresholds and exclusions to be re-evaluated

The Reporting Period is 90 days for the first year and then the full year in subsequent years. Reporting is completed through attestation for 2011. All EPs must successfully achieve the 25 Objectives (5 may be deferred) and the Clinical Quality Measures, as defined below.

For Stage 1, providers will need to report their performance on two types of measures:

1. **Clinical Quality Measures**: These measures support the ability to determine how meaningful use and other initiatives have improved the care that patients receive. These measures will be reported for each provider. For Stage 1, Medicare requires providers to report on three core measures (alternate core measures may substituted) and three additional measures that vary according to the provider’s specialty of care are chosen by the EP.
2. **Health IT Functionality Measures:** These measures will indicate how well a provider is using the EHR.

3. For Stage 1 meaningful use, there are 25 provider measures. Most of these measures require the provider to meet a certain target. Some of the required measures show how well the patient’s information can be shared with other health care systems.

**Clinical Quality Measures (CQM)**

**Clinical Quality Measurement is defined by CMS** to “consist of measures of processes, experience, and/or outcomes of patient care, observations or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care.” Quality Measures for meaningful use will be reported as a percentage. One example of such a reportable percentage would be for “Preventive Care and Screening: Influenza Immunization for Patients = 50 Years Old”. The denominator would be all patients 50 years old or over. The numerator would be the number of these patients that received an influenza immunization during the flu season (September through February.). The resulting percentage would be the QM to be reported.

**Details of CQM Reporting**

- In 2011, EPs will be required to submit CQM data to CMS or to the states by attestation.
- In 2012, EPs will be required to electronically submit CQM data to CMS or to the States. The actual process on how this electronic submission will occur has not been fully determined.
- Core, Alternate Core and Additional CQM sets for EPs
  - EPs report on three required core CQMs and if the denominator of one or more of the required core measures is zero, then the EPs are required to report results for up to three alternate core measures
  - EPs must select three additional CQM from a set of 38 CQM (other than the core/alternate core measures)
  - In sum, EPs report on six total measures: three required core measures (substituting alternate core measures when necessary) and three additional measures
Meaningful Use and Denominators

There are two types of percentage-based measures that are included to reduce the burden of demonstrating meaningful use by removing the need for a manual review of charts.

1. Denominator is equal to all patients seen or admitted during the Electronic Health Record reporting period, regardless of whether their records are kept using certified Electronic Health Record Technology.

2. Denominator is equal to the actions or subsets of patients seen or admitted during the Electronic Health Record reporting period. The denominator only includes patients, or actions taken on behalf of those patients, whose records are kept using certified Electronic Health Record Technology.

Clinical Quality Measures for Stage 1

The table below identifies the 3 required Core Set measures, the 3 Alternative Core Set measures and the 38 measures from the Additional Set, of which the EP must select 3.
<table>
<thead>
<tr>
<th>Clinical Quality Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Set</strong></td>
</tr>
<tr>
<td>• Hypertension – Blood Pressure Management</td>
</tr>
<tr>
<td>• Preventive Care and Screening Measure Pair – (a) Tobacco Use Assessment and (b) Tobacco Cessation Intervention</td>
</tr>
<tr>
<td>• Adult Weight Screening and Follow-up</td>
</tr>
<tr>
<td><strong>Alternative Core Set</strong></td>
</tr>
<tr>
<td>• Weight Assessment and Counseling for Children and Adolescents</td>
</tr>
<tr>
<td>• Preventive Care Screening – Influenza Immunizations for Patients 50 Years Old or Older</td>
</tr>
<tr>
<td>• Childhood Immunization Status</td>
</tr>
<tr>
<td><strong>Additional Set Clinical Quality Measures: EPs must achieve 3 of the following 38</strong></td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
</tr>
<tr>
<td>• Hemoglobin A1c under Poor Control</td>
</tr>
<tr>
<td>• Hemoglobin A1c Control (&lt;8.0%)</td>
</tr>
<tr>
<td>• Blood Pressure Management</td>
</tr>
<tr>
<td>• Low Density Lipoprotein (LDL) Management and Control</td>
</tr>
<tr>
<td>• Urine Screening</td>
</tr>
<tr>
<td>• Foot Exam</td>
</tr>
<tr>
<td>• Eye Exam</td>
</tr>
<tr>
<td><strong>Diabetic Retinopathy</strong></td>
</tr>
<tr>
<td>• Communication with the Physician Managing Ongoing Diabetes Care</td>
</tr>
<tr>
<td>• Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</td>
</tr>
<tr>
<td><strong>Oncology / Cancer</strong></td>
</tr>
<tr>
<td>• Cervical Cancer Screening</td>
</tr>
<tr>
<td>• Breast Cancer Screening</td>
</tr>
<tr>
<td>• Colorectal Cancer Screening</td>
</tr>
<tr>
<td>• Breast: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive</td>
</tr>
<tr>
<td>• Colon: Chemotherapy for Stage III Colon Cancer patients</td>
</tr>
<tr>
<td>• Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients</td>
</tr>
<tr>
<td><strong>Asthma</strong></td>
</tr>
<tr>
<td>• Asthma Pharmacologic Therapy</td>
</tr>
<tr>
<td>• Asthma Assessment</td>
</tr>
<tr>
<td>• Use of Appropriate Medications for Asthma</td>
</tr>
<tr>
<td><strong>Prenatal Care</strong></td>
</tr>
<tr>
<td>• Screening for Human Immunodeficiency Virus (HIV)</td>
</tr>
<tr>
<td>• Anti-D Immune Globulin</td>
</tr>
<tr>
<td><strong>Heart Failure</strong></td>
</tr>
<tr>
<td>• Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
</tr>
<tr>
<td>• Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
</tr>
<tr>
<td>• Warfarin Therapy Patients with Atrial Fibrillation</td>
</tr>
<tr>
<td><strong>Ischemic Vascular Disease</strong></td>
</tr>
<tr>
<td>• Blood Pressure Management</td>
</tr>
<tr>
<td>• Use of Aspirin or Another Anti-thrombotic</td>
</tr>
<tr>
<td>• Complete Lipid Panel and LDL Control</td>
</tr>
<tr>
<td><strong>Coronary Artery Disease</strong></td>
</tr>
<tr>
<td>• Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)</td>
</tr>
<tr>
<td>• Drug Therapy for Lowering LDL-Cholesterol</td>
</tr>
<tr>
<td>• Oral Anti-Platelet Therapy Prescribed for Patients w/ CAD</td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>• Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation</td>
</tr>
<tr>
<td>• Controlling High Blood Pressure</td>
</tr>
<tr>
<td>• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement</td>
</tr>
<tr>
<td>• Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment</td>
</tr>
<tr>
<td>• Low Back Pain: Use of Imaging Studies</td>
</tr>
<tr>
<td>• Chlamydia Screening for Women</td>
</tr>
<tr>
<td>• Appropriate Testing for Children with Pharyngitis</td>
</tr>
<tr>
<td>• Pneumonia Vaccination Status for Older Adults</td>
</tr>
<tr>
<td>• Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies</td>
</tr>
</tbody>
</table>
Details of the Core and Menu Sets (Objectives)

The Core Objectives comprise basic functions that enable Electronic Health Records to support improved health care. These include the tasks that are essential to creating any medical record, including the entry of basic data, such as a patient’s vital signs and demographics, active medications and allergies. Others include up-to-date problem lists of current and active diagnoses as well as smoking status.

Other core objectives include functionality that supports the transition to an efficient clinical workflow that begins to realize the true potential of the Electronic Health Record to improve the safety, quality, and efficiency of care. These features help clinicians make better clinical decisions – and avoid preventable errors.

In addition to the core elements, the rule created a second group – a menu of 10 additional tasks, from which the provider may defer any 5 (at least 1 Public Health objective must be chosen) to implement in 2011. This gives providers flexibility in choosing their path toward full EHR implementation and meaningful use.

Meaningful Use Criteria – Core Set

Providers are required to meet all criteria in this set. However, if some of these core objectives are not applicable to an EP’s practice (Example: Chiropractors that do not ePrescribe, Psychiatrists that do not record vitals, etc.) they may exclude those measures and substitute alternatives from the Menu Set.

1. Computerized physician order entry (CPOE)
2. Drug-drug and drug-allergy interaction checks
3. Maintain an up-to-date problem list of current and active diagnoses
4. E-Prescribing (eRx)
5. Maintain active medication list
6. Maintain active medication allergy list
7. Record demographics
8. Record and chart changes in vital signs
9. Record smoking status for patients 13 years or older
10. Report ambulatory clinical quality measures to CMS/States
11. Implement one clinical decision support rule
12. Provide Patients with an electronic copy of their health information, upon request
13. Provide clinical summaries for patients for each office visit
14. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
15. Protect electronic health information
Meaningful Use Criteria – Menu Set

Provider must meet a minimum of 5 criteria (must include ‘Capability to submit electronic data to immunization registries/systems’ and/or ‘Capability to provide electronic syndromic surveillance data to public health agencies’) and may defer up to 5 criteria in this set

1. Drug-formulary checks
2. Incorporate clinical lab test results as structured data
3. Generate lists of patients by specific conditions
4. Send reminders to patients per patient preference for preventive/follow up care
5. Provide patients with timely electronic access to their health information
6. Medication reconciliation
7. Capability to submit electronic data to immunization registries/systems
8. Capability to provide electronic syndromic surveillance data to public health agencies
9. Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
10. Summary of care record for each transition of care/referrals
Stage 1 Meaningful Use Objectives: the details

In order to achieve meaningful use, one has to understand the final objectives, the final measures and the exclusions to the final rule. Not all of the meaningful uses have exclusions to their rules, but of the 15 that are mandatory, 6 of them have exclusions.

Core Set

- **Use computerized provider order entry for medication orders** directly entered by any licensed healthcare provider who can enter orders into the medical record per state, local and provider guidelines
  
  - Final Measures: more than 30 percent of all unique patients with at least one (1) medication in their medication list seen by the EP have at least one (1) medication order entered using CPOE
    
    - **Exclusions:** Any EP who writes fewer than one hundred (100) prescriptions during the Electronic Health Record reporting period is excluded from this rule

- **Implement drug-drug and drug-allergy interaction checks**
  
  - Final Measures: the EP has enabled this functionality for the entire Electronic Health Record reporting period.
    
    - **Exclusions:** None

- **Maintain an up-to-date problem list of current and active diagnoses**
  
  - Final Measures: more than 80% of all unique patients seen by the EP have at least one (1) entry or an indication that no problems are known for the patient recorded as structured data
    
    - **Exclusions:** None

- **Generate and transmit permissible prescriptions electronically (eRx)**
  
  - Final Measures: more than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified Electronic Health Record Technology
    
    - **Exclusions:** Any EP who writes fewer than one hundred (100) prescriptions during the Electronic Health Record reporting period is excluded from this rule
• **Maintain an active medication list**
  o Final Measures: more than 80% of all unique patients seen by the EP have at least one (1) entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
    ▪ **Exclusions:** None

• **Maintain active medication allergy list**
  o More than 80% of all unique patients seen by the EP have at least one (1) entry (or an indication that the patient has no known medication allergies) recorded as structured data
    ▪ **Exclusions:** None

• **Record all of the following demographics:** Preferred language, Gender, Race, Ethnicity, Date of Birth
  o More than 50% of all unique patients seen by the EP have demographics recorded as structured data
    ▪ **Exclusions:** None

• **Record and chart changes in vital signs:** height, weight, blood pressure; calculate and display the Body Mass Index; plot and display growth charts for children 2-20 years, including BMI
  o Final Measures: More than 50% of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data
    ▪ **Exclusions:** Any EP who either sees no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice

• **Record smoking status for patients 13 years or older**
  o Final Measures: more than 50% of all unique patients 13 years or older seen by the EP have smoking status recorded as structured data
    ▪ **Exclusions:** Any EP who sees no patient 13 years or older

• **Report ambulatory clinical quality measures** to CMS or, in the case of Medicaid EPs, the States
  o Final Measures: Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified (or in the case of Medicaid, the States)
    ▪ **Exclusions:** None
• Implement one (1) clinical decision support rule
  o Finale Measures: Implement one (1) clinical decision support rule
    ▪ Exclusions: None

• Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request
  o Final Measures: more than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days
  o Exclusions: Any EP than has no requests from patients or their agents for an electronic copy of patient health information during the Electronic Health Record reporting period

• Provide clinical summaries for patient for each office visit
  o Final Measures: clinical summaries provided to patients for more than 50% of all office visits within 3 business days
    ▪ Exclusions: Any EP who has no office visits during the Electronic Health Record reporting period

• Capability to exchange key clinical information (for example, problem list, medication list, allergies and diagnostic test results) among providers of care and patients authorized entities electronically
  o Final Measures: Performed at least one (1) test of certified Electronic Health Record technology’s capacity to electronically exchange key clinical information
    ▪ Exclusions: None

• Protect electronic health information created or maintained by the certified Electronic Health Record technology through the implementation of appropriate technical capabilities
  o Final Measures: Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process
    ▪ Exclusions: None
Menu Set

- **Implement drug-formulary checks**
  - Final Measures: The EP enabled this functionality and has access to at least one (1) internal or external formulary for the entire Electronic Health Record reporting period
    - **Exclusions:** None

- **Incorporate clinical lab-test results** into Electronic Health Record as structured data
  - Final Measures: more than 40% of all clinical lab tests results ordered by the EP during the Electronic Health Record reporting period whose results are either in a positive/negative or numerical format are incorporated in certified Electronic Health Record technology as structured data
    - **Exclusions:** An EP who orders no lab tests whose results are either in a positive/negative or numerical format during the Electronic Health Record reporting period

- **Generate lists of patients by specific conditions** to use for quality improvement, reduction of disparities, and outreach
  - Final Measures: generate at least one (1) report listing patients of the EP with a specific condition
    - **Exclusions:** None

- **Send reminders to patients** per patient preference for preventive/follow up care
  - More than 20% of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the Electronic Health Record reporting period
    - **Exclusions:** An EP who has no patients 65 years or older or 5 years old or younger with recorded maintained using certified Electronic Health Record technology

- **Provide patients with timely electronic access to their health information** (including lab results, medication lists, allergies) within 4 business days of the information being available to the EP.
  - Final Measures: at least 10% of all unique patients seen by the EP are provided timely (available to the patient within 4 business days of the information updated in the certified Electronic Health Record technology) electronic access to their health information, subject to the EP’s discretion to withhold certain information
- **Exclusions:** Any EP that neither orders nor creates any of the information listed at 45 CFR 17-.304(g) during the Electronic Health Record reporting period

- **Perform medication reconciliation**
  - **Final Measures:** The EP performs medication reconciliation for more than 50% of all transitions of care in which the patient is transitioned into the care of the EP
  - **Exclusions:** An EP who was not the recipient of any transitions of care during the Electronic Health Record reporting period

- **Capability to submit electronic data to immunization registries** or immunization information systems and actual submission according to applicable law and practice
  - **Final Measures:** Performed at least one (1) test of certified Electronic Health Record technology's capacity to submit electronic data to immunization registries and follow up submission if test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically)
  - **Exclusions:** An EP who administers no immunizations during the Electronic Health Record reporting period or where no immunization registry has the capacity to receive the information electronically

- **Capacity to submit electronic syndrome surveillance data** to public health agencies and actual transmission according to applicable law and practice
  - **Final Measures:** Performed at least one (1) test of the certified Electronic Health Record technology's capacity to provide electronic syndrome surveillance data to public health agencies and follow up submission if test is successful (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically)
  - **Exclusions:** An EP does not collect any reportable syndrome information on their patients during the Electronic Health Record reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically

- **Identify patient-specific education resources** using certified Electronic Health Record technology and provide those resources to the patient if appropriate
  - **Final Measures:** more than 10% of all unique patients seen by the EP are provided patient-specific resources
  - **Exclusions:** None
• **Provide a summary care record** for each transition of care or referral
  
o  Final Measures: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals
  
  ▪ **Exclusions:** An EP who neither transfers a patient to another setting nor refers a patient to another provider during the Electronic Health Record reporting period
Certified Technology

The Office of the National Coordinator (ONC) has created a certification process to ensure that the users of electronic health information technology will be using systems that meet the identified standards for security, interoperability, and functionality. Therefore, ONC has established a program to review and approve entities as Authorized Testing and Certifying Bodies (ACTBs). These ACTBs will certify vendor products to ensure that the EHR software is able to demonstrate the required functionality for the various Stages of meaningful use.

The current status of the process to achieve certified technology for Health Information rests on a foundation of three rules that have been issued by the ONC through the Department of Health and Human Services (HHS).

March 10, 2010, Federal Register 45 CFR Part 170
HHS / ONC - Proposed Establishment of Certification Programs for Health Information Technology; Proposed Rule

From the summary text: “This rule proposes the establishment of two certification programs for purposes of testing and certifying health information technology. While two certification programs are described in this proposed rule, we anticipate issuing separate final rules for each of the programs. The first proposal would establish a temporary certification program whereby the National Coordinator would authorize organizations to test and certify Complete Electronic Health Records (EHRs) and/or EHR Modules, thereby assuring the availability of Certified EHR Technology prior to the date on which health care providers seeking the incentive payments available under the Medicare and Medicaid EHR incentives Program may begin demonstrating meaningful use of Certified EHR Technology. The second proposal would establish a permanent certification program to replace the temporary certification program. The permanent certification program would separate the responsibilities for performing testing and certification, introduce accreditation requirements, establish requirements for certification bodies authorized by the National Coordinator related to the surveillance of Certified EHR Technology, and would include the potential for certification bodies authorized by the National Coordinator to certify other types of health information technology besides Complete EHRs and EHR Modules.”

June 24, 2010, Federal Register 45 CFR Part 170
HHS / ONC - Establishment of the Temporary Certification Program for Health Information Technology; Final Rule

From the summary text: “This final rule establishes a temporary certification program for the purposes of testing and certifying health information technology. The National Coordinator will utilize the temporary certification program to authorize organizations to test and certify Complete Electronic Health Records (EHRs) and/or EHR Modules,
thereby making Certified EHR Technology available prior to the date on which health care providers seeking incentive payments available under the Medicare and Medicaid EHR Incentive Programs may begin demonstrating meaningful use of Certified EHR Technology.”

July 28, 2010 Federal Register 45 CFR Part 170
HHS / ONC - Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology; Final Rule

From the summary text: “Adopted certification criteria establish the required capabilities and specify the related standards and implementation specifications that certified electronic health record (EHR) technology will need to include to, at a minimum, support the achievement of meaningful use Stage 1 by eligible professionals, eligible hospitals, and/or critical access hospitals (hereafter, references to “eligible hospitals” in this final rule shall mean “eligible hospitals and/or critical access hospitals”) under the Medicare and Medicaid EHR Incentive Programs. Complete EHRs and EHR Modules will be tested and certified according to adopted certification criteria to ensure that they have properly implemented adopted standards and implementation specifications and otherwise comply with the adopted certification criteria.”

The ONC has established both a Temporary and Permanent Certification Program as a foundation for the certification process. The Temporary Certification Program outlines the current certification program in place until the permanent program is established. This Temporary Program has been put in place to quickly get the process up to speed to make sure that certified technology will be available prior to January 2011, the beginning of the incentive program for EPs. It is anticipated the Temporary Program will transition to the Permanent Program in 2012.

The actual testing and certification of the technology will be done by organizations that have applied, met the stringent requirements, and received approval from the ONC to test and/or certify EHR technology. The ONC is working with the National Institute of Standards and Technology (NIST) to develop the specific test procedures and methods that will be used. The organizations that receive ONC approval will be called, “Office of the National Coordinator for Health Information Technology Authorized Testing and Certification Bodies” (ONC-ATCBs). With ONC oversight they will test and certify that complete Electronic Health Records and Electronic Health Records modules are compliant with the standards, implementation specifications, and the certification criteria that are now finalized.
With the finalization of the certification standards, technology vendors are aware of the specific requirements and can develop and modify their software to meet the functional and security criteria for Stage 1. Through the temporary certification process, vendors will apply and submit their technology for testing and certification. Once a product has successfully been tested and receives certification, it will be listed on the ONC website where a Certified HIT Products List (CHPL) will be maintained. This list will contain all of the certified Complete EHRs and EHR Modules that meet the definition of Certified EHR Technology. Recertification will be required for Stages 2 and 3 due to the increased functionality and requirements.

ONC has officially begun approving organizations that will be allowed to test and certify both EHR modules (a module can meet one MU criteria) and Complete EHRs (designation for EHRs that meet all MU criteria) under the Temporary Program. It is expected that there will be numerous ONC-ATCBs. For a current list of ONC-ATCB organization visit the HHS Health IT web site at: http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__onc-authorized_testing_and_certification_bodies/3120.

Likewise, technology vendors have begun applying for testing to obtain certification for their products. Those applications that are successful and obtain certification will also be reported to the ONC and listed on the HHS Health IT web site as the Certified HIT Product List (CHPL). The list can be found at this address: http://onc-chpl.force.com/ehrcert
Registering for Incentive Programs and Documenting Meaningful Use

To Participate in the Incentive Programs

All providers who wish to participate in the Incentive Programs must:

- Be eligible under the provisions of the Incentive Programs
- Register via the Electronic Health Record Incentive Program Website
- Be enrolled in Medicare FFS, MA, or Medicaid (FFS or Managed Care)
- Have a National Provider Identifier (NPI)
- Use Certified Technology
- Be enrolled in PECOS

Registration Requirements Include the Following

- Name of the Eligible Professional (EP)
- National Provider Identifier (NPI)
- Business Address and Business Phone
- Taxpayer Identification Number (TIN) to which the provider would like the Incentive Payments made
- Selection of either Medicare or Medicaid for the EP
- State Selection for Medicaid Providers

For Medicare Advantage, the following must be met

- Furnish, on average, at least 20 hours a week of patient-care services and be employed by the Qualifying MA Organization, or
- Furnish, on average, at least 20 hours a week or patient care services and be employed by, or be a partner of, an entity that through contract with the Qualifying MA Organization furnishes at least 80% of the entity’s Medicare patient care services to enrollees of the Qualifying MA Organization, and
- 80% of Provider services are provided to enrollees of the MAO
Potential Participation in both the CMS EHR Incentive Program and Other Programs:

- Medicare Physician Quality Reporting Initiative (PQRI) – the physician is eligible for the CMS Electronic Health Records Incentive Program if they are also eligible under the provisions of the Incentive Program (See Who is Eligible under the 2 Programs (Medicare and Medicaid))
- Medicare Electronic Health Record Demonstration (EHR Demo) – the physician is eligible for the CMS Electronic Health Records Incentive Program if they are also eligible under the provisions of the Incentive Program (See Who is Eligible under the 2 Programs (Medicare and Medicaid))
- Medicare Care Management Performance Demonstration (MCMP) – the physician is eligible if the practice is eligible under the provisions of the Incentive Program
- Electronic Prescribing (eRx) Incentive Program – If the EP chooses to participate in the Medicare Electronic Health Records Incentive Program, they cannot participate in the Medicare eRx Incentive Program simultaneously in the same program year. If the EP chooses to participate in the Medicaid Electronic Health Records Incentive Program, he or she can participate in the Medicare eRx Incentive Program simultaneously

What are the Next Steps?

- During the Summer and Fall of 2010: There will be an Outreach Program and an Education Campaign for the Electronic Health Records Incentive Programs and CMS will issue State Medicaid Directors policy guidance on the Implementation of the Medicaid Electronic Health Records Incentive Program
- Early 2011: EPs can register for the Medicare and Medicaid Electronic Health Records Incentive Programs
- More information is available at CMS’s EHR Incentive Programs website: http://www.cms.gov/EHRIncentivePrograms
Timeline for the Incentive Program for EPs

- Fall of 2010: Certified Electronic Health Record Technology will be available and listed on the ONC website
- January 2011: Registration for the Electronic Health Record Incentive Programs begins
- January 2011: For Medicaid Providers, States launch their programs, if they so choose to do so (participation by the States is voluntary)
- April 2011: Attestation for the Medicaid Electronic Health Record Incentive Program begins
- May 2011: Medicare Electronic Incentive Payments begin
- February 29, 2012: Last day for the EPs to register and attest to receive an Incentive Payment for CY 2011
- 2015: Medicare Payment Adjustments begin for EPs that are not meaningful users of Electronic Health Record Technology
- 2016: Last year to receive a Medicare Electronic Health Record Incentive Payment, and also the last year to initiate participation in the Medicaid Electronic Health Record Incentive Program
- 2021: Last year to receive Medicaid Electronic Health Record Incentive Payment
Your Incentive Road Map: Step by Step

GET READY

Every Eligible Professional will need to determine if, when, and how they will implement an EHR system that will help them become a “meaningful user of certified EHR technology”. The preparation and planning will be just as important as the actual implementation, training and meaningful use of the system. The following will help you GET READY to become a meaningful user, and become eligible for the CMS incentives.

G- Getting prepared, Gathering information, and Gap analysis

To help you get from where you are now to where you want to go (eligibility for the maximum CMS EHR Incentive Program) you need a roadmap, an Incentive Roadmap®. It is critical to: Assemble your Incentive Team, Give the team members responsibilities, Get buy in from your team and your staff, and Know what you are doing now.

The Incentive Team should include (at a minimum) the Practice Manager or Administrator, at least one physician and a nurse or other clinician. It is important that the Team be made up of staff members with different types of expertise. Decisions will need to be made that will be based on such disparate issues as patient reimbursement mix, budgetary constraints, established clinical workflow and current technology capability. There should be an identified Team Leader, who maintains overall responsibility for the Incentive RoadMap® and brings together the resources to develop an incentive strategy and keep it on track.

An early step for the Incentive Team will be the performance of a gap analysis to compare your current status of technology, functionality, and security with the established and known criteria to become a Stage 1 “meaningful user of certified EHR technology”.

E - Educate

Become familiar with the goals, regulations and options in the CMS Incentive Program by reviewing relevant information from your medical society, professional association, CMS web site and other pertinent and trusted sources. There is a great deal of confusion and misinformation about the Incentive Program, so pay close attention to the source of any information you receive. If necessary obtain the services of a trusted consultant with expertise in clinical workflow, EHR technology and the requirements of the Incentive Program. Since the
Incentives are determined and achieved on a provider, not practice, basis. It is important to make a determination as to which program (Medicare vs. Medicaid) would be most beneficial for a particular EP to choose. Appropriate program (Medicare vs. Medicaid) selection is paramount. For some medical practices, the appropriate choice may be to have some EPs in the Medicare program while others are in the Medicaid program. A careful analysis of the options is important at this point in the planning. The correct decision could be worth tens of thousands of dollars per provider during the life of the Incentive Program.

Review the 25 Meaningful Use requirements, objective, and criteria. This is where strategic planning can really pay off. For 2011 each EP need only achieve 20 of the 25 meaningful use requirements. That would include the 15 that make up the “Core Set” and 5 of the 10 from the “Menu Set”. The “Core Set” may contain requirements that are inappropriate for a particular EP (example: eRx for a Chiropractor) and therefore those can be skipped and replaced with another choice from the “Menu Set”. Some of the items in the “Menu Set” are very easily achieved while others are quite difficult. There is definitely some “low hanging fruit” here that can assist your Incentive Roadmap®.

**T – Timeline**

Timing is a critical element to consider in several ways. By becoming an EP and entering the program in either 2011 or 2012 maximum incentives can be achieved. If you wait until 2013 or later under the Medicare program, you will experience a decrease in your incentives. In the case of Medicaid, there is no such reduction in the Medicaid program and starting as late as 2016 still brings the opportunity for maximum incentives.

An integral part of your strategic planning is the development of a timeline based on current capabilities and processes. This involves the establishment of a timeframe with related goals for achieving meaningful use compliance. Establish, in writing, specific timelines, milestones, action steps, and responsibilities. Determine which meaningful use criteria are already being met, which are not, and what workflow modifications and/or technology must be achieved to reach incentive eligibility.
**R - Research systems**

Review your current technology and determine the presence or absence of “certified technology”. Verify if you currently have the “certified technology” to support Stage 1 meaningful use or whether it must be obtained or upgraded to HHS certified versions. If you are already using an EHR that has received HHS Stage 1 certification, you are well on your way to achieving your goals. If your practice is not yet using an EHR, immediately begin the process of performing the due diligence to select, implement and begin using the EHR. The process of system selection, implementation, training, work flow adjustment and becoming a meaningful user of the EHR can very easily take 12 months or longer.

**E - Execute system purchase or updates**

A thorough assessment of the hardware and software you need will help you build your list of what must be obtained. Do you currently have an EHR? If you don’t, what is your timeline for due diligence, system selection, implementation and training? Do you need to buy computers or obtain broadband internet capability? What has to been purchased or leased? What contracts need to negotiated? Once you have fully answered these questions you will be able to move ahead with you implementation plan.

**A - Apply implementation plan**

Assign responsibility to Incentive Team members to begin internal and external discussions, with vendors and stakeholders, to set expectations and address concerns. Begin to address each objective of Stage 1 meaningful use that you have identified by strategic selection as achievable (each EP will need 20 of 25) and categorize into one of three groups: 1) Functionality not present; 2) Functionality present but not currently used; 3) Functionality present and implemented to Stage 1 level.

**D - Data Security**

The need to protect electronic health information is paramount. You must guard the confidentiality and integrity of the electronic health record. This is best accomplished by a robust process that could includes hardware (UPS, mirrored servers, etc.), software (anti-virus and anti-malware software, etc), secure network connections (encrypted Wi-Fi, etc.), established
security procedures (offsite backup storage, administrative user controls, etc.), and an ongoing and systematic review to identify and mitigate potential risks.

One Core Objective of Stage 1 meaningful use is the requirement to: “Conduct or review a security risk analysis per CFR 164.308 (a) (1) of the certified EHR technology and implement updates and correct identified security deficiencies as part of its risk management process”. This is not as intimidating as it first seems. A great source for information about building your security and privacy program is: *The Information Resource Guide for Implementing the HIPAA Security Rule* which is located at [http://csrc.nist.gov/publications/nistpubs/800-66-Rev1/SP-800-66-Revision1.pdf](http://csrc.nist.gov/publications/nistpubs/800-66-Rev1/SP-800-66-Revision1.pdf). It even includes a Sample Contingency Plan Template which can be easily modified to create your own plan. If, during your security review, any deficiencies are identified, correction action should be taken and documented.

**Y - Year of Payment 2011**

The final details for registering and enrolling in the CMS EHR Incentive Program for 2011 are still being determined. However, the process is expected to include the following:

- Register at the EHR Incentive Program website in early January 2011
  - The name of the EP
  - The National Provider Identifier (NPI)
  - Business address and business phone
  - Taxpayer Identification Number (TIN) to which the provider would like their incentive payment made
  - Selection of the Medicare or Medicaid program
  - If the EP is choosing the Medicaid program, a state will be selected.
- Be a meaningful user of certified EHR technology (Medicare) or (in the case of Medicaid) adopt implement, or upgrade to certified technology in 2011
- Medicare EPs must be enrolled in PECOS
- In the Medicaid program the EPs must supply information related to patient volume
Resources

Timeline of the ARRA/HITECH Act

- February 2009: President Obama signs the American Recovery and Reinvestment Act (ARRA/HITECH) into law.
- March 2010: ONC releases Certification Program proposed rule
- June 2010: Temporary Certification Final Rule published in Federal Register
- July 2010: CMS and ONC Final Rules published in Federal Register
- August 2010: First two ONC-ATCBs named
- Fall of 2010: Certified Electronic Health Record Technology will be available and listed on the website
- January 2011: Registration for the Electronic Health Record Incentive Programs begins
- January 2011: For Medicaid Providers, States launch their programs, if they so choose to do so (participation by the States is voluntary)
- April 2011: Attestation for the Medicaid Electronic Health Record Incentive Program begins
- May 2011: Medicare Electronic Incentive Payments begin
- February 29, 2012: Last day for the EPs to register and attest to receive an Incentive Payment for CY 2011
- 2015: Medicare Payment Adjustments begin for EPs that are not meaningful users of Electronic Health Record Technology
- 2016: Last year to receive a Medicare Electronic Health Record Incentive Payment, and also the last year to initiate participation in the Medicaid Electronic Health Record Incentive Program
- 2021: Last year to receive Medicaid Electronic Health Record Incentive Payment
Acronyms

ACO – Accountable Care Organization
API - Application Programming Interface
ASP - Application Service Provider
ATCB - Authorized Testing and Certification Body
ATNA - Audit Trail and Node Authentication
BHIE - Bidirectional Health Information Exchange
CAH - Critical Access Hospital
CBO - Community-Based Organization
CCR - Continuity of Care Record
CDA - Clinical Document Architecture
CDO - care delivery organization
CDR - Clinical Data Repository
CDS - clinical decision support
CDSS - clinical decision support system
CFR - Code of Federal Regulations
CHC - Connected Healthcare Community
CHR - Community Health Records
CLIA - Clinical Laboratory Improvement Amendments
CMIO - Chief Medical Information/Informatics Officer
CMV - Controlled Medical Vocabulary
CPOE - Computerized physician order entry
DBE - Documenting by exception
EH – Eligible Hospital
EMR/EHR - electronic medical/health record
EP – Eligible Professional
FACA - Federal Advisory Committee Act
FHA - Federal Health Architecture
FIPS - Federal Information Processing Standards
FOA - Funding Opportunity Announcement
FOSS - Free and Open Source/Solutions Software
FQHC - Federally Qualified Health Center
HIE - Health Information Exchanges
HIM - Health Information Management
HIO - Health Information Organization
HIPAA - Health Insurance Portability and Accountability Act
HIT - Health Information Technology
HITECH - Health Information Technology for Economic and Clinical Health Act
HPSA - Health Professional Shortage Areas
ICE - Integrated Community EHR
IFR - Interim Final Rule
IT - Information Technology
LOINC - Logical Observations Identifiers, Names, Codes
MA – Medicare Advantage
MCMP – Medicare Care Management Performance Demonstration
MU – Meaningful Use
MITA - Medicaid Information Technology Architecture
NCVHS - National Committee on Vital and Health Statistics
NHIN - Nationwide Health Information Network
NP – Nurse Practitioner
NPI – National Provider Identifier
NPRM - Notice of Proposed Rulemaking
NLP - Natural Language Processing
OMB - Office of Management and Budget
ONC - Office of the National Coordinator
ONC-ATCB - ONC Authorized Testing and Certification Body
ONCHIT - Office of the National Coordinator for Health Information Technology
PA – Physician Assistant
PACS - picture archiving and communication systems
PCMH - Patient-Centered Medical Home
PECOS - Provider Enrollment, Chain, and Ownership System
RHC – Rural Health Clinic
PHI - Personal Health Information or Protected Health Information
RHQDAPU – Reporting Hospital Quality Data for Annual Payment Update
PHR - Personal Health Record
PMS - Practice Management System
PPS – Prospective Payment System (Medicare Part A)
PQRI - Physician Quality Reporting Initiative
RHIO - Regional Health Information Organizations
SaaS - Software-as-a-Service product
SDO - Standards Development Organization
TIN – Taxpayer Identification Number
Frequently Asked Questions

The most authoritative source for clarification and guidance on the CMS EHR Incentive Program is from the Department of Health and Human Services (HHS). They have established a Frequently Asked Questions web site where you can easily search for answers to common questions as well as the ability to submit your own questions. The website is located at: http://questions.cms.hhs.gov/app/home. Below are some common Q/As from that site.

Q. How will EPs apply for Incentives under the Medicare and Medicaid Electronic Health Record Incentive Program?
A. Information on registration for EHR incentive programs will be available toward the end of 2010 on the CMS website at http://www.cms.gov/EHRIncentivePrograms. Registration for the Medicare EHR Incentive Program will begin in January 2011 and will be available online. Registration for the Medicaid EHR Incentive Program may also begin in January 2011, but the timing will vary by State.

Q. What if my Electronic Health Record System costs much more than the government will pay? May I request more funds?
A. The Medicare and Medicaid EHR Incentive Programs provide incentives for the meaningful use of certified EHR technology. Under the Medicaid program, there is also an incentive for the adoption, implementation, or upgrade of certified EHR technology in the first year of participation. The incentives are not a reimbursement of costs, and maximum payments have been set.

Q. Who is responsible for demonstrating meaningful use of certified Electronic Health Record Technology, the vendor or provider?
A. To receive an EHR incentive payment, the provider (Eligible Professional (EP), eligible hospital or critical access hospital (CAH)) is responsible for demonstrating meaningful use of certified EHR technology under both the Medicare and Medicaid EHR incentive programs.

Q. If I already have an Electronic Health Record that has been certified by the Certification Commission for Healthcare Technology (CCHT), will I have to buy a new system if the government mandates that only EHRs that meet a higher certification level are considered certified EHRs?
A. All EHRs will need to be certified for the EHR Incentive Programs by an Office of the National Coordinator for Health Information Technology Authorized Testing and Certification Body (ONC-ATCB). ONC-ATCBs will test and certify that complete EHRs and EHR modules are compliant with the standards, implementation specifications, and certification criteria adopted by the Secretary of Health and Human Services. It is expected that the first EHRs will be certified in the fall of 2010.

Q. When will the Centers for Medicare & Medicaid Services (CMS) begin to pay Medicare and Medicaid electronic health record (EHR) incentives to Eligible Professionals (EPs)?
A. CMS expects that Medicare incentive will begin to be paid in May 2011. Medicaid incentives will be paid by the States and will also begin in 2011 but the timing will vary by State. Under the Medicaid EHR Incentive Program, incentives can also be paid for the adoption, implementation, or upgrade of certified EHR technology.

Q. Can EPs assign their EHR incentive?
A. Under Medicare, Eligible Professionals (EPs) may choose to assign their incentive payments to their employer or entity with which the EP has a contractual arrangement. Under Medicaid, EPs also can choose to assign their incentive payments to their employer or to other state-designated entities.

Q. What is the maximum incentive an eligible Professional (EP) can receive under the Medicaid Electronic Health Record (EHR) Incentive Program?
A. EPs who adopt, implement, upgrade, and meaningfully use EHRs can receive a maximum of $63,750 in incentive payments from Medicaid over a six year period (Note: There are special eligibility and payment rules for pediatricians). EPs must begin receiving incentive payments by calendar year 2016.

Q. If an Eligible Professional (EPs) is currently receiving an incentive payment for e-prescribing under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), are they also eligible to receive incentive payments under the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program?
A. The American Recovery and Reinvestment Act of 2009 specifically states that under the Medicare EHR Incentive Program, EPs cannot receive a payment under both the MIPPA E-Prescribing Incentive Program and the Medicare EHR Incentive Program for the same year.
However, EPs may receive payments from both the MIPPA E-Prescribing Incentive Program and the Medicaid EHR Incentive Program for the same year.

Q. Are physicians who practice in hospital-based ambulatory clinics eligible to receive Medicare or Medicaid electronic health record (EHR) incentive payments?
A. A hospital-based Eligible Professional (EP) is defined as an EP who furnishes 90% or more of their services in either inpatient or emergency department of a hospital. Hospital-based EPs do not qualify for Medicare or Medicaid EHR incentive payments.

Q. Can Eligible Professionals (EPs) receive electronic health record (EHR) incentive payments from both the Medicare and Medicaid programs?
A. Not for the same year. If an EP meets the requirements of both programs, they must choose to receive an EHR incentive payment under either the Medicare program or the Medicaid program. After a payment has been made, the EP may only switch programs once before 2015.

Q. What is the maximum electronic health record (EHR) incentive an Eligible Professional (EP) can earn under Medicare?
A. EPs who successfully demonstrate meaningful use certified EHR technology as early as 2011 or 2012 may be eligible for up to $44,000 in Medicare incentive payments spread out over five years. EPs who predominantly furnish services in a Health Provider Shortage Area (HPSA) are eligible for a 10 percent increase in the maximum incentive amount.

Q. What is the reporting period for Eligible Professionals (EPs) participating in the electronic health record (EHR) incentive programs?
A. For demonstrating meaningful use through both the Medicare and Medicaid EHR Incentive Programs, the EHR reporting period for an EP's first year is any continuous 90-day period within the calendar year. In subsequent years, the EHR reporting period for EPs is the entire calendar year. Under the Medicaid program, there is also an incentive for the adoption, implementation, or upgrade of certified EHR technology, which does not have a reporting period.

Q. What is the earliest date the payment adjustments will start to be imposed on Medicare Eligible Professionals (EPs) and eligible hospitals that do not demonstrate meaningful use of certified electronic health record (EHR) technology?
A. Medicare payment adjustments will begin in 2015 for EPs and eligible hospitals that do not demonstrate meaningful use of certified EHR technology. There are no payment adjustments associated with the Medicaid provisions under Section 4201 of the American Recovery and Reinvestment Act of 2009.

Q. How will the public know who has received EHR incentive payments under Medicare and Medicaid EHR Incentive Program?
A. As required by the American Recovery and Reinvestment Act of 2009, CMS will post the names, business addresses, and business phone numbers of all Medicare EPs and who receive EHR incentive payments.

Q. If an EP meets the criteria for both the Medicare and Medicaid electronic health record (EHR) incentive programs, can they choose which program to participate in?
A. Yes. EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs must elect the program in which they wish to participate when they register. After the initial designation, EPs can only change their program selection once after they have received payment before 2015.

Q. What safeguards are in place to ensure that Medicaid electronic health record (EHR) incentive payments are used for their intended purpose?
A. Like the Medicare EHR incentive program, neither the statute nor the CMS final rule dictate how a Medicaid provider must use their EHR incentive payment. The incentives are not a reimbursement and are at the providers’ discretion, similar to a bonus payment.

Q. Are Medicaid EPs and eligible hospitals subject to payment adjustments or penalties if they do not adopt electronic health record (EHR) technology or fail to demonstrate meaningful use?
A. There are no payment adjustments or penalties for Medicaid providers who fail to demonstrate meaningful use.

Q. Can EPs in the U.S. Territories (Puerto Rico, Guam, Virgin Islands, Northern Mariana Islands, and American Samoa) qualify for electronic health record (EHR) incentive payments?
A. Yes, EPs in the U.S. Territories can receive EHR incentive payments under both the Medicare and Medicaid EHR Incentive Programs as long as they meet the applicable
requirements. EPs must choose whether to participate in the Medicare or Medicaid EHR Incentive Program.

Q. Can EPs in Washington, D.C. receive electronic health record (EHR) incentive payments?
A. Yes, EPs in the District of Columbia can receive EHR incentive payments under the Medicare or Medicaid program as long as they meet the program's requirements. EPs in D.C. are subject to the same requirements as EPs in the 50 States and thus may not concurrently receive payments from both the Medicare and Medicaid EHR Incentive Programs.

Internet Resources

Links

The Official Web Site for the Medicare and Medicaid EHR Incentive Programs: This site provides up-to-date, detailed information about the Electronic Health Record (EHR) incentive programs. Use the tabs to the left to find additional information regarding various aspects of the program. http://www.cms.gov/ehrincentiveprograms/

Regional Extension Center Program: This ONC site provides detailed information about the 60 organizations that received grants to operate a REC. http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__rec_program/1495

Healthcare.gov is an HHS web site “designed to help you, your family, your business, your parents and grandparents, and your neighbors and friends get the information you need to make the best choices about your health care.” http://www.healthcare.gov/

The Healthcare Information Technology Standards Panel (HITSP): A cooperative partnership between the public and private sectors. The Panel was formed for the purpose of harmonizing and integrating standards that will meet clinical and business needs for sharing information among organizations and systems. http://www.hitsp.org/

HHS Regulations: Department issued regulations to implement laws and develop policies and guidance for industry, state and local governments, and other organizations. The topics of Health Information Technology Standards, Additional Laws & Regulation, and Policies & Guidelines are included. http://www.hhs.gov/policies/index.html

HHS Health Information Privacy site providing information on HIPAA: http://www.hhs.gov/ocr/privacy

ONC Meaningful Use: One of the areas of the ONC web site, providing up to date information on MU. http://healthit.hhs.gov/portal/server.pt?open=512&objID=2996&mode=2
Associations

American Medical Association (AMA) - http://www.ama-assn.org/
Medical Group Management Association (MGMA) - http://www.mgma.com
The American Health Information Management Association (AHIMA) - http://www.ahima.org/
College of Healthcare Information Management Executives (CHIME) - http://www.cio-chime.org/

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ONC Certified Technology

1. ONC-ATCB (Authorized Testing and Certification Body):
   http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__onc-authorized_testing_and_certification_bodies/3120
2. CHPL (Certified HIT Product List): http://onc-chpl.force.com/ehrcert