FREQUENTLY ASKED QUESTIONS
EHR AND THE STIMULUS ACT

STIMULUS PACKAGE AT A GLANCE

- **Total Incentive Payments Available: $19 Billion**
- **Incentive payments for adopting electronic health records (EHR) start in 2011**
  - **Hospitals: Maximum base payment for 2011 adoption is $2,000,000 plus discharge-related amount for maximum of $4,370,000 (See FAQs, page four, and Appendix A)**
  - **Physicians: Maximum payment for 2011 adoption is $44,000 per physician (See FAQs, page five)**
- **Penalties for not adopting EHR start in 2015**
  - **Escalating annual reductions in Medicare payments (See FAQs, pages four to five)**

Q. What is the name of the stimulus act and when was it enacted?

A.   The American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law by the president on February 17, 2009. The health care IT provisions are referred to as the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Q. Who is entitled to incentive payments under the ARRA?

A.   Hospitals and "eligible professionals" (physicians, dental surgeons, dentists, podiatrists, and chiropractors) are entitled to payments through Medicare for the **"meaningful use of certified EHR technology."** Hospitals, physicians, dentists, certified nurse midwives, nurse practitioners, and physician assistants (with certain limitations), are entitled to incentive payments through Medicaid.

"Meaningful Use" of certified EHR technology is referred to throughout the law and this FAQ document. Though the law provides little guidance, an eligible professional or hospital should be treated as a meaningful user of EHR technology if the EHR technology is (1) meaningfully integrated into the delivery of service, which includes e-prescribing; (2) connected to a health information exchange for improving quality of care; and (3) used to submit information on clinical quality measures. On June 16, 2009, the HIT Policy Committee discussed initial recommendations regarding the definition of meaningful use, as described in the Update portion at the beginning of this document. The definition and standards are scheduled to be finalized by the end of 2009.

Q. How is ''meaningful use'' defined?

A. On July 16, 2009, the Meaningful Use Workgroup of the Health Information Technology (HIT) Policy Committee released revised recommendations for the definition of "meaningful use" of electronic health records (EHR). When finalized, the HIT Policy Committee's recommendations will provide the basis for the final rules for demonstrating the meaningful use required to receive stimulus funds. While the framework for defining meaningful use will evolve over time (the deadline for publication of the initial rules is the end of this year), the Workgroup recommendations provide the most concrete and detailed information to date regarding the software functionality and other requirements for achieving meaningful use and obtaining incentive payments through Medicare and Medicaid.

The Workgroup presented a Meaningful Use Matrix, which identifies proposed EHR functionality and standards for demonstrating meaningful use. The Meaningful Use Matrix can be found at http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_876940_0_0_18/Meaningful %20Use%20Matrix%2007162009.pdf. The Matrix identifies and defines the following categories: Policy Priorities, Care Goals, Objectives, and Measures for meeting the meaningful-use requirement. Based on a number of high-level Priorities and Goals (e.g., improving quality, safety, and efficiency of care; providing patients and families with access to health care data; and ensuring adequate privacy and security of health information), the Workgroup identified 18 Objectives for achieving the Priorities and Goals. The Matrix specifies Measures (metrics) for determining whether the Objectives have been met, thereby satisfying the meaningful-use requirement.

Objectives and Measures for 2011 are based primarily on the ability to transmit and capture data electronically in a coded format. For example, 2011 Objectives include the use of computerized physician order entry (CPOE) systems for 10% of all orders; maintaining EHR identifying medications, problem lists, drug allergies, and so forth; and recording vital signs. Measures for 2011 include metrics relating to the reporting of quality measures such as the ability to report the percentage of hypertensive patients with blood pressure under control, the percentage of smokers offered smoking-cessation counseling, and the percentage of patients older than 50 with annual colorectal cancer screening. Patient and family access Measures include the ability to track and report the percentage of patients with access to personal health information electronically and the percentage of patients with access to patient-specific educational resources.

The Workgroup recommended that the 2011 criteria apply to providers who adopt EHR and 2011, as well as to providers whose first adoption year is after 2011. Thus, a provider which is not ready to implement EHR until 2012 or 2013 will need to comply with the 2011 criteria as their initial criteria. The 2013 criteria is applicable for a provider's third year of EHR adoption.

The Matrix and other meaningful-use guidance coming out of the July 16, 2009 meeting are works in progress and will be modified and updated during the rule-making process. Nonetheless, this information provides an early indication of what it will take to show meaningful use and qualify for the stimulus payments. This guidance should be utilized as a critical and fundamental part of every provider's due diligence process in selecting, implementing, and upgrading EHR systems.

The Meaningful Use Matrix should be used as a guideline and minimum standard for any EHR system being considered by a provider. Additionally, the vendor should guarantee that its software or system will satisfy the meaningful-use requirements (or applicable portions thereof) when implemented by the provider. Given the additional visibility provided by the recommendations of the Meaningful Use Workgroup and time required to implement and commence meaningful use of an EHR system, if not already under way, providers should start the process now of selecting and implementing an EHR system or upgrading existing systems.

Additional information regarding the preliminary guidance on "meaning use" can be found in Appendix B and on Foley's EHR and the Stimulus Act Web page at www.foley.com/ehr.

Q.   How does an EHR system become certified?

A.   The Office of the National Coordinator of Health Information Technology (ONC) must adopt the initial set of certification standards by December 31, 2009. The certification standards will be recommended by a Health Information Technology Policy Committee and tested by the National Institute of Standards Technology (NIST). The ONC and NIST can look to independent organizations, such as the Certification Commission for Healthcare Information Technology (CCHIT) for guidance and appropriate certification standards. Additionally, the EHR technology must include patient demographic and clinical health information (e.g., medical history and problem lists) and have the ability to provide clinical decision support for physician order entry, to capture and query information relevant to health care quality, and to exchange electronic health information with, and integrate such information from, other sources.

> *According to a survey published March 25, 2009 in the New Journal of Medicine, only 1.5 percent of U.S. hospitals had a comprehensive electronic-records system implemented across all major clinical units; and only a little over seven percent had a basic system that included functionalities for physicians' notes and nursing assessments in at least one clinical unit.*
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> *The amount available to hospitals has been estimated to be $6 million to $7 million for a mid-sized hospital.*
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> *"U.S. Hospitals Slow to Adopt E-Records," Wall Street Journal, March 26, 2009, quoting Erica Drazen, Computer Sciences Corp.*

Q.   How much can hospitals obtain in Medicare incentive payments?

A.   Subject to certain limitations, hospitals can receive an incentive payment calculated as the sum of (1) a base amount of $2 million, plus (2) a discharge-related payment, the amount of which is then multiplied by (3) its Medicare share, and then multiplied by (4) a "transition factor."

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Q.   How much is the discharge related payment?

A.   The hospital will receive $200 for each discharge paid under the inpatient prospective payment system starting with discharge number 1,150 through discharge number 23,000.

Q.   How is the Medicare share calculated?

A.   A hospital's Medicare share is calculated according to a specified formula based on inpatient bed days attributable to individuals for whom a Part A payment may be made, and the total number of inpatient bed days in the hospital adjusted by a hospital's share of charges attributed to charity care. Critical access hospitals (CAHs) that are meaningful users of EHR are entitled to certain bonus payments.

Q.   What is the transition factor?

A.   The law provides a four-year incentive payment transition schedule. A hospital that is a meaningful EHR user can receive the full amount of the incentive payment in its first payment year, 75 percent of the amount in its second payment year, 50 percent of the amount in its third payment year, and finally, 25 percent of the amount in its fourth payment year. The first payment year for a meaningful EHR user is 2011 or, alternatively, the first fiscal year for which an eligible hospital qualifies for an incentive payment. Hospitals that first qualify for the incentive payments after 2013 can receive incentive payments on the transition schedule as if their first payment year is 2013. Hospitals that become meaningful EHR users after 2015 will not receive incentive payments.

(For more information regarding the calculation of Medicare incentive payments available to hospitals, see Appendix A, *Description Of Hospital Incentive Payment Calculations*.)

Q.   Are there penalties to hospitals that do not adopt EHR technology?

A.   Yes. Starting in 2015, eligible hospitals that are not meaningful EHR users are subject to a reduction in their annual Market Basket Adjustment update for the remaining three-quarters of the update. This reduction is implemented over a three-year period. Three-quarters of the Market Basket Adjustment percentage increase otherwise applicable for a fiscal year will be reduced by 33-1/3 percent for fiscal year 2015, 66-2/3 percent for fiscal year 2016 and 100 percent for fiscal year 2017.

Q.   What are the Medicare incentive payments available to physicians?

A.   Incentive payments for eligible professionals are based on the amount of Medicare-covered professional services furnished during the year in question. The total possible amount of the incentive payment will decrease over time. The law provides a rolling period for implementation and associated payments. For example, incentives that start in 2011 will continue through 2015, while those that begin in 2012 run through 2016. For the first year, the maximum

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payment amount is $18,000 if the eligibility criteria are met in 2011 or 2012 (and $15,000 if implemented in 2013 or 2014). The highest annual payment amount for subsequent years decreases each year to $12,000, $8,000, $4,000, and $2,000, with no payments being made after 2016. Thus, to achieve the maximum incentive payment amount, eligible professionals must adopt a meaningful use of EHR technology in 2011 or 2012, thereby qualifying for five annual payments ending in 2015 or 2016, respectively, for an aggregate maximum payment of $44,000. However, if a professional first adopts EHR technology in 2014, the maximum annual payments are $15,000, $12,000 and $8,000, for an aggregate maximum payment of $35,000.

Q.   Are hospital-based physicians entitled to incentive payments?

A.   No. The EHR incentive payments for professionals are not available to a hospital-based eligible physician such as a pathologist, anesthesiologist, or emergency physician who furnishes substantially all such services in a hospital setting using the hospital's facilities and equipment, including computer equipment.

Q.   Are there penalties for physicians who do not adopt EHR technology?

A.   For covered professional services furnished by an eligible professional during 2015 or any subsequent payment year, if the professional is not a meaningful EHR user during the previous year's reporting period, the fee schedule amount will be reduced to 99 percent in 2015, 98 percent in 2016, and 97 percent in 2017 and in each subsequent year. For 2018 and each subsequent year, if the Secretary of the Department of Health and Human Services finds that the proportion of eligible professionals who are meaningful EHR users is less than 75 percent, the applicable fee schedule amount will be decreased by one percentage point from the applicable percent in the preceding year, but in no case will the applicable percent be less than 95 percent. There is a hardship exemption if being a meaningful EHR user will result in significant hardship.

> *Starting in 2015, hospitals not adopting EHR systems are subject to a reduction of their Medicare Basket Adjustment amounts.*

Q.   What are the Medicaid incentives to physicians?

A.   The law provides for expanded funding to pediatricians, federally qualified health clinics (FQHCs), rural health clinics (RHCs), and physician assistants in physician assistant-led RHCs. The law provides up to $63,750 in federal contributions towards the adoption, implementation, upgrade, maintenance, and operation of certified EHR technology for eligible professionals. Up to 85 percent of $25,000, or $21,250, subject to a cap on average allowable costs, is provided to eligible professionals to aid in adopting, implementing, and upgrading certified EHR systems. Additionally, up to 85 percent of $10,000, or $8,500, is provided to eligible professionals for purposes of operation and maintenance of such systems over a period of up to five years.

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Q.   What are the Medicaid incentives to hospitals?

A.   Payments to hospitals are limited to amounts analogous to those specified for eligible hospitals calculated as a base amount plus an amount related to the total number of discharges for such a hospital. States may not pay more than 50 percent of the aggregate amount to a hospital in any year and must spread payments to hospitals out over at least three years.

Q.   What should hospitals and physicians do now if they have partially or fully implemented an EHR system?

A.   Health care providers that presently have some level of EHR functionality or have otherwise established a relationship with an EHR vendor should ensure the systems they are implementing are certified If the system is not certified, the provider needs to have a clear understanding of the vendor's current status of CCHIT certification, if any, and the vendor's plans for ensuring its product will be government certified when the standards are adopted. The provider must have contractual protections that provide an adequate remedy if certification is not obtained. All new system acquisition agreements must include a warranty that the system is certified. New investment in non-certified systems must be carefully analyzed from a risk perspective. Alternatively, obtaining assurance that the vendor's EHR solution will need to be modified and enhanced to become compliant in sufficient time for the provider to be a meaningful user of certified EHR technology by 2011 (the first year when incentive payments are available) may mitigate that risk, but leaves the provider exposed in the event the vendor does not deliver.

Q.   What should hospitals and physicians do now if they have not started implementing an EHR system?

A.   Providers that do not have an EHR system implementation under way should start the process now. Since the law requires a demonstration of meaningful use for the period — not just implementation — the system (or at least an initial phase meeting the certification criteria) should be implemented and in a go-live production state by the end of 2010.

Q.   Why should health care providers start now before the certification standards have been issued?

A.   Depending on the size of the organization, this process, even if it goes smoothly, can take every bit of 12 to 18 months. Large and complex systems and organizations will likely require additional time. Add the usual hiccups (or worse), delays and the substantial spike in demand for — and possible shortage of — EHR vendors and consultants, and one can easily see why it is important to start sooner rather than later in order to timely maximize the benefits under the Health Information Technology for Economic and Clinical Health (HITECH) Act. Additionally, although penalties under the law generally do not start until 2015, the amount of incentives available decrease over time, with incentive payments being less for later adopters of EHR technology.

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Q.   What can companies do to mitigate the risks associated with implementation of an EHR system?

A.   Proper planning, management and documentation are critical to a successful implementation. Significant personnel, money and time resources will be required of the organization. The risks of exceeding time and dollar budgets can be mitigated by utilizing best practices, and well-evolved documentation such as requests for proposal, strong agreements with vendors, and detailed statements of work. Project management tools should be utilized to provide structure to implementation planning and service delivery, including a detailed gap analysis identifying discrepancies between the vendor's standard solution and the organization's existing workflows and business practices.

The organization and its legal counsel should be prepared to negotiate aggressively with the vendors with respect to the project documentation. Standard vendor agreements typically provide very little protection to the customer, resulting in the customers being left without an effective remedy if the vendor does not provide the implementation services as anticipated resulting in substantial time and cost overruns. Accordingly, organizations should ensure that agreements with vendors accurately and completely document the vendors' obligations and contain appropriate tools to "self correct" if the project gets off track and remedies in the event of a breach by the vendor.

> *Hospitals with EHR systems or in the process of implementing one should work closely with their vendors to ensure the system will meet the government certification standards and requirements.*
>
> *Since the law requires "meaningful use" — and not just acquisition or implementation — hospitals which have not started the process should start now.*
>
> *Vendors understand that to be a service provider in this area they must develop and commit to providing certified solutions. Accordingly, there is no need to wait for publication of the certification requirements to hire a vendor, but care should be taken to use vendors with proven track records, given current industry standards.*

Q.   What should an organization look for in terms of contracting with an EHR vendor?

A.   Contractual protections are important to ensure providers maximize the likelihood of a successful implementation. For example, substantive commitments in the vendor's response to the RFP should be incorporated into the agreement. Minimum functionality should be identified in as much detail as possible at the time of the agreement. While some design and configuration will need to wait until the gap analysis and configuration process after the agreement is entered into, detailed minimum functional requirements are important in order to define the project time, cost, and resource requirements and enable effective management of the project. The agreement

should include appropriate representations from, and obligations of, the vendor to provide a secure system that protects and maintains the security and integrity of protected health information (PHI) and other personally identifiable information. Milestones and schedules should be included in the agreement, with credits or liquidated damages for delays.

Appropriate project management provisions should be included, addressing issues such as vendor staffing requirements, reporting, project meetings, escalation of issues and disputes, root-cause analysis for evaluating vendor failures, and appropriate service levels and remedies in the event of deficient performance by vendors. Finally, the vendor should make appropriate commitments that the system will be compliant with the government's EHR certification standards for showing meaningful EHR use at the time of implementation. Even though the certification standards will not be published until the end of this year, vendors with a firm understanding of current industry certification standards are in the best position to commit to and deliver a government certified EHR system.

Q.   Aside from considerations under ARRA, what regulatory issues in designing and implementing an EHR system?

A.   The design and implementation of EHR technology involves a number of regulatory issues for hospitals and physicians. Health care providers that implement EHR systems will need to ensure that their systems contain appropriate technical applications and features to ensure compliance with the numerous privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state privacy laws. This is particularly important given the passage of the HITECH Act's provisions within the ARRA, which impose additional requirements and penalties under HIPAA. In addition, hospitals that choose to subsidize the provision of EHR technology for physicians must structure those relationships to comply with various laws, including the federal Anti-Kickback Statute and federal Physician Self-Referral law (Stark law). The Centers for Medicare and Medicaid Services promulgated two exceptions to Stark and the Office of the Inspector General issued two safe harbors to the Anti-Kickback Statute, both of which permit, under certain circumstances, the donation of EHR technology items and services to physicians for the purpose of improving electronic prescribing and EHR capabilities.

> *The design and implementation of EHR systems will require careful consideration of various laws and rules. Significant among these are the privacy and security requirements of HIPAA as strengthened through the ARRA. For hospitals planning on subsidizing the provision of EHR technology to physicians, it also will be important to comply with the exceptions and safe harbors contained in the federal Physician Self-Referral law (Stark law) and the federal Anti-kickback Statute, which permit the donation of EHR technology items to physicians under certain circumstances. Working with knowledgeable counsel, health care providers can successfully navigate these and other regulatory barriers to achieve a successful EHR program.*

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Given that these EHR exceptions and safe harbors contain several technical requirements, and that the penalties for violating the Anti-Kickback Statute and Stark law are severe (including criminal and civil liability), it will be important to seek the assistance of counsel to design an approach that complies with these and other laws. For example, counsel should provide advice on the selection criteria for the recipients of the EHR technology, the restrictions that can be placed on the technology, and the intersection with other legal requirements such as antitrust laws, HIPAA, Internal Revenue Service tax-exempt rules, and applicable state laws.

APPENDIX A: DESCRIPTION OF HOSPITAL INCENTIVE PAYMENT CALCULATIONS

- ARRA provides stimulus payments in excess of $19 billion for the implementation of EHR systems in hospitals and physician offices.
- Incentive payments start in 2011 for hospitals that are "meaningful users" of EHR systems. The incentive amounts decrease for adopting EHR systems after 2011.
- Penalties begin in 2015 for hospitals that have not become meaningful users of EHR systems.
- Incentive amount is calculated as the "Initial Amount" multiplied by the "Medicare Share," multiplied by the "Transition Factor."
  - The **Initial Amount** equals **$2 million**, plus a **Discharge-Related Amount** of $200 for each discharge under the inpatient prospective payment system starting with discharge number 1,150 through discharge number 23,000 (which would result in **maximum amount of $4,370,000**).
  - The **Medicare Share** is calculated according to a specified formula based on inpatient bed days attributable to individuals for whom a Part A payment may be made, and the total number of inpatient bed days in the hospital adjusted by a hospital's share of charges attributed to charity care.
  - The **Transition Factor** is one for the first payment year, three-quarters for the second year, one-half for the third year, one-quarter for the fourth year, and zero for any subsequent year. Thus, a hospital that becomes a meaningful EHR user in 2011, receives 100 percent of the payment amount in year one, 75 percent in year two, and so on.
  - **Incentive Phase Out.** The incentive amount is phased out for EHR users first adopting after 2013.
- **Penalties.** A Hospital will lose a portion of its Market Basket Adjustment if it is not a meaningful user by 2015. Seventy-five percent of the Market Basket Adjustment will be reduced by a third in 2015, by two-thirds in 2016 and 100 percent in 2017 and each year thereafter.
- "The stimulus incentives are likely to cover much, but not all, of the cost — **$6 million to $7 million for a midsize hospital**." "*U.S. Hospitals Slow to Adopt E-Records*," Wall Street Journal, March 26, 2009, quoting Erica Drazen, Computer Sciences Corp.
- **Status of Hospital EHR Adoption.** According to a survey published March 25, 2009 in the New Journal of Medicine, only 1.5 percent of U.S. hospitals had a comprehensive electronic-records system implemented across all major clinical units; an additional 7.6 percent had a basic system that included functionalities for physicians' notes and nursing assessments in at least one clinical unit; and when defined without the requirement for clinical notes, a basic electronic-records system was found in 10.9 percent of hospitals (*http://content.nejm.org/cgi/content/full/NEJMsa0900592*).
- In light of the timeframes under the stimulus legislation and time to implement and become a "meaningful EHR user," hospitals need to assess now where they stand with respect to maximizing benefits and avoiding future penalties under the law.

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APPENDIX B – LEGAL NEWS ALERT: HEALTH CARE - HEALTH CARE STIMULUS UPDATE: HEALTH INFORMATION TECHNOLOGY POLICY COMMITTEE PROVIDES PRELIMINARY GUIDANCE ON "MEANINGFUL USE "

On June 16, 2009, the Meaningful Use Workgroup of the Health Information Technology (HIT) Policy Committee released its initial recommendations for the definition of "meaningful use" of electronic health records (EHR). In order to qualify for incentive payments under the health care IT portions of the American Recovery and Reinvestment Act, hospitals and physicians must demonstrate meaningful use of EHR technology. When finalized, the HIT Policy Committee's recommendations will provide the basis for the final rules for demonstrating the meaningful use required to receive stimulus funds.

While the framework for defining meaningful use will evolve over time (the deadline for publication of the initial rules is the end of this year), these initial recommendations provide the most concrete and detailed information to date regarding the software functionality and other requirements for achieving meaningful use and obtaining incentive payments through Medicare and Medicaid.

The Workgroup presented a Meaningful Use Matrix, which identifies proposed EHR functionality and standards for demonstrating meaningful use. The Meaningful Use Matrix can be found at http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_11113_872719_0_0_18/Meaningful%20Use%20Matrix.pdf. The Matrix identifies and defines the following categories: Policy Priorities, Care Goals, Objectives, and Measures for meeting the meaningful-use requirement. Based on a number of high-level Priorities and Goals (e.g., improving quality, safety, and efficiency of care; providing patients and families with access to health care data; and ensuring adequate privacy and security of health information), the Workgroup identified 21 Objectives for achieving the Priorities and Goals. The Matrix specifies Measures (metrics) for determining whether the Objectives have been met, thereby satisfying the meaningful-use requirement.

The Objectives and Measures provide the most detailed and concrete guidelines. The Matrix identifies separate Objectives and Measures for the years 2011, 2013, and 2015, which increase in functionality, sophistication, and complexity over time, indicating the government will utilize a phased approach with increased requirements implemented in two-year increments.

Objectives and Measures for 2011 are based primarily on the ability to transmit and capture data electronically in a coded format. For example, 2011 Objectives include the use of computerized physician order entry (CPOE) systems; maintaining EHR identifying medications, problem lists, drug allergies, and so forth; and the use of electronic prescribing. Measures for 2011 include metrics relating to the reporting of quality measures such as the ability to report the percentage of hypertensive patients with blood pressure under control, the percentage of smokers offered smoking-cessation counseling, and the percentage of patients older than 50 with annual colorectal cancer screening. Patient and family access Measures include the ability to track and report the percentage of patients with access to personal health information electronically and the percentage of patients with access to patient-specific educational resources. Data security and

privacy Measures include a requirement for full compliance with the HIPAA privacy and security rules and that an entity under investigation for a HIPAA privacy or security violation cannot achieve meaningful use until the entity is cleared.

Understandably so, the Objectives and Measures for 2013 and 2015 provide less detail than those for 2011. Recommendations for 2013 include the use of computers for clinical decision support at the point of care; managing chronic conditions using patient lists and decision support; and measuring inappropriate use of imaging (e.g., MRI for acute lower-back pain). For 2015, the Workgroup's recommendations include the use of multimedia support (e.g., X-rays); access for all patients to personal health records populated in real time; and measuring clinical outcome, efficiency, and safety measures.

Because the requirements ramp up over time, providers will benefit from adopting EHR sooner rather than later. The Matrix and other meaningful-use guidance coming out of the June 16, 2009 meeting are works in progress and will be modified and updated during the Committee and rule-making process. Nonetheless, this information provides an early indication of what it will take to show meaningful use and qualify for the stimulus payments. This guidance should be utilized as a critical and fundamental part of every provider's due diligence process in selecting, implementing, and upgrading EHR systems.

The Meaningful Use Matrix should be used as a guideline and minimum standard for any EHR system being considered by a provider. Additionally, the vendor should guarantee that its software or system will satisfy the meaningful-use requirements (or applicable portions thereof) when implemented by the provider. Given the additional visibility provided by the recommendations of the Meaningful Use Workgroup and time required to implement and commence meaningful use of an EHR system, if not already under way, providers should start the process now of selecting and implementing an EHR system or upgrading existing systems.

Additional information regarding the EHR implementation process can be found on Foley's EHR and the Stimulus Act Web page at www.foley.com/ehr.

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