Quality Payment
PROGRAM

Small Practices Guide: Getting Started with Electronic Clinical Quality Measure (eCQM) Reporting

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Purpose

This resource walks through the steps needed for small practices to complete and submit **electronic clinical quality measures (eCQMs)** under the Merit-based Incentive Payment System (MIPS), whether participating as an individual, group, virtual group, subgroup, or Alternative Payment Model (APM) Entity.

A **small practice** is defined as a group that has 15 or fewer clinicians identified by their National Provider Identifier (NPI), billing under the groups Taxpayer Identification Number (TIN). To see if you have the small practice designation, visit and enter your NPI in the Quality Payment Program (QPP) Participation Status Lookup Tool.

This resource is intended to be broadly applicable, not specific to a particular performance year. Refer to Appendix A for links to the resources referenced throughout this guide that are specific to the 2025 performance year, and Appendix B for links to resources specific to the 2026 performance year.

Background

This resource focuses on **electronic clinical quality measures (eCQMs)**, one of several collection types available for reporting quality measures in MIPS.

Collection type refers to the way you collect data for a MIPS quality measure. An individual MIPS quality measure may be collected in multiple ways (i.e., may be available through multiple collection types). Each collection type has its own specification (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data.

- **Electronic clinical quality measures (eCQMs)** – Measure data are collected at the point of care in electronic health record (EHR) technology that's been certified by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC). Data are collected for all patients that qualify for the measure, not just Medicare patients. A third party intermediary may be brought in for assistance with collecting and reporting data.
- **Medicare Part B claims measures** – Measure data are reported on Medicare Part B claims when they're submitted for reimbursement. Medicare Part B claims measures can only be reported by solo practitioners and small practices (15 or fewer clinicians). Data are only reported for Medicare patients. To learn more about these measures, refer to the **Part B Claims Reporting Quick Start Guide (PDF)** (links provided in Appendix A (2025 performance year) and Appendix B (2026 performance year)).
- **MIPS clinical quality measures (MIPS CQMs)** – Measure data may be gathered from different data sources including paper and/or electronic charts. A third party intermediary may be brought in for assistance with collecting and reporting data. Data are collected for all patients that qualify for the measure, not just Medicare patients.
- **Qualified Clinical Data Registry (QCDR) measures** – QCDRs are Centers for Medicare and Medicaid Services (CMS)-approved intermediaries with the flexibility to develop and track their own quality measures. Because many QCDRs are specialty-based, QCDR measures may be more meaningful and applicable to your practice. Data are collected in a manner specified by the QCDR for all patients that qualify for the measure, not just Medicare patients.
- **Medicare CQMs** are available only to Medicare Shared Savings Program Accountable Care Organizations (ACOs) reporting the APM Performance Pathway (APP) Plus quality measure set (in contrast to MIPS CQMs that are available for reporting via traditional MIPS, MIPS Value Pathways (MVPs), and APP).

MIPS Reporting Options

There are 3 reporting options available to MIPS eligible clinicians to meet MIPS reporting requirements. If you'd like more information, review the **MIPS Reporting Options At-A-Glance for Small Practices** (find the links to this resource in Appendix A (2025 performance year) and Appendix B (2026 performance year)).

Table 1. Overview of MIPS Reporting Requirements

Traditional MIPS	MIPS Value Pathways (MVPs)	APM Performance Pathway (APP)
• The original reporting option for MIPS. • Visit the QPP website to learn more about Traditional MIPS.	• This reporting option offers clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition. • Visit the QPP website to learn more about MVPs.	• A streamlined reporting option for **clinicians who participate in a MIPS APM.** • Visit the QPP website to learn more about APP.
• You select the quality measures and improvement activities that you'll collect and report from all of the quality measures and improvement activities finalized for MIPS.	• You select an MVP that's applicable to your practice. • Then you choose from the quality measures and improvement activities available in your selected MVP. • You'll report a reduced number of quality measures and improvement activities as compared to traditional MIPS.	• You'll report a predetermined set of quality measures. • MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis
• You'll report the complete Promoting Interoperability measure set.	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).
• We collect and calculate data for the cost performance category and any applicable administrative claims measures for you.	• We collect and calculate data for the cost performance category and population health measures for you.	• Cost isn't evaluated under the APP.

Learn more

For MIPS eligibility and participation options:

Visit the How MIPS Eligibility is Determined and Participation Options Overview webpages on the QPP website.

Check your current participation status using the QPP Participation Status Tool.

For detailed information for each performance year:

Refer to the Traditional MIPS Scoring Guide, APP Scoring Guide, and MVPs Implementation Guide. These resources are updated annually and posted on the QPP Resource Library.

Small Practice Flexibilities – Quality Performance Category

We remain committed to identifying flexibilities and options to help clinicians in small practices meaningfully participate and succeed in MIPS. These flexibilities apply to all 3 MIPS reporting options (traditional MIPS, MVPs, and the APP) unless otherwise specified.

Small practices receive:

- 3 points for submitting quality measures without an available benchmark (historical or performance period) – all other clinicians receive zero points

- 3 points for submitting measures that don't meet the case minimum or data completeness requirements – all other clinicians receive zero points

6 bonus points added to the quality performance category score when at least 1 quality measure is submitted (applies to individual, group, subgroup, and APM Entity participation, but not to clinicians or groups who are scored under facility-based scoring).

eCQM Overview

Why Choose eCQMs?

eCQMs are measures specified in a standard electronic format using data electronically extracted from electronic health records (EHRs) and/or health information technology (IT) systems to assess the quality of health care provided. CMS uses eCQMs in the Quality Payment Program and other quality reporting programs.

There are several benefits of using eCQMs:

- eCQMs use clinical data enabling more accurate assessment of treatment outcomes by measured entities to assess the outcomes of treatment by measured entities.
- eCQMs use electronic standards, which help reduce the burden of manual abstraction and reporting for measured entities.
- eCQMs foster the goal of access to real-time data for point of care quality improvement and clinical decision support.

Visit the **Education tab** on the ecqihealthit.gov/ecqms/education webpage for more resources related to eCQMs.

Step 1. Determine the Status of Your Certified EHR Technology (CEHRT)

To report eCQMs under MIPS, your EHR system(s) must:

- ☐ Use technology certified by ASTP/ONC by the time eCQM data is generated for submission.
- ☐ Be updated to collect the most recent version of the eCQM measure specification.

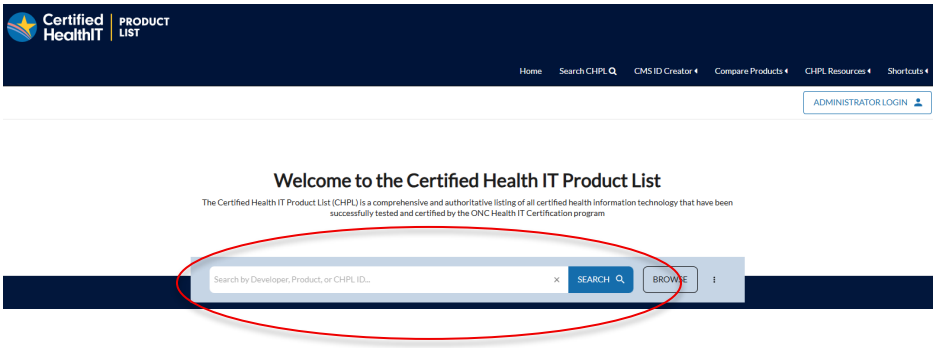
How to Check Certification Status

If your EHR or health IT module certification status shows as "active" on the Certified Health IT Product List (CHPL), it has been certified through the ASTP/ONC Health IT Certification Program.

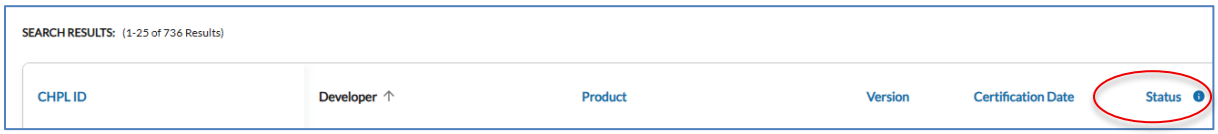
Check certification status by:

a. Navigating to the CHPL website: https://chpl.healthit.gov.

b. Entering the name of the developer, product, ONC-Authorized Certification Body (ACB) identification (ID), or CHPL ID for your EHR into the search bar.



c. Viewing the “Status column” for your EHR to learn whether your EHR’s certification is considered “active”, “decertified”, or “inactive”.



d. Interpreting the status icon. Remember: Your EHR must meet CEHRT certification from ASTP/ONC by the time eCQM data is generated for submission.

Certification Status Icon Legend

	Icon	Name	Description
Active Certificates		Active	Product is certified and in good standing.
		Suspended by ONC	Certification of the product has been suspended by ONC. While the product remains certified, the developer will be unable to update or certify new products during the suspension.
		Suspended by ONC-ACB	Product's certification is suspended because corrective action plan not completed in time. The product is still considered certified, but it is at risk of having its certification withdrawn.
Decertified Products		Terminated by ONC	The certification of the product has been terminated by ONC.
		Withdrawn by Developer Under Surveillance/Review	The certification of the product has been withdrawn by the developer while the product was under ONC-ACB surveillance or ONC direct review. It is no longer considered certified.
		Withdrawn by ONC-ACB	Product's certification is withdrawn by the product's developer's ONC-ACB. No longer considered a certified product.
Inactive Certificates		Withdrawn by Developer	Product's certification is withdrawn by the product's developer. No longer a certified product.
		Retired	Product's certification is retired as part of HHS policy. It is no longer certified.

CMS EHR Certification ID Creation

For detailed instructions on how to generate your CMS EHR Certification ID, refer to the CHPL Public User Guide (PDF, 1242KB). An example of CMS EHR Certification ID follows. This CMS EHR Certification ID represents the certified health IT products (Modules) listed below that collectively meet 100% of the Base EHR Definition for the specified CMS reporting year.

CMS EHR Certification ID: 2025CJW3RTQ1L7R

Listing 1	
Certifying Body	SLI Compliance
Product Certification #	15.05.05.3121.CHRP.01.01.1.220912
Developer	1Life Healthcare, Inc
Product Name	Chirp
Version	1.1

Listing 2	
Certifying Body	SLI Compliance
Product Certification #	15.05.05.3121.ONEL.01.00.1.220823
Developer	1Life Healthcare, Inc
Product Name	1Life
Version	1.0

What if our EHR software isn't certified at the start of the performance year?

Your EHR system may use the functionality of CEHRT to report eCQMs; however, the submitting EHR system must be certified by ASTP/ONC by the time eCQM data is generated for submission.

How do we update to the most recent version of the eCQM measure specification?

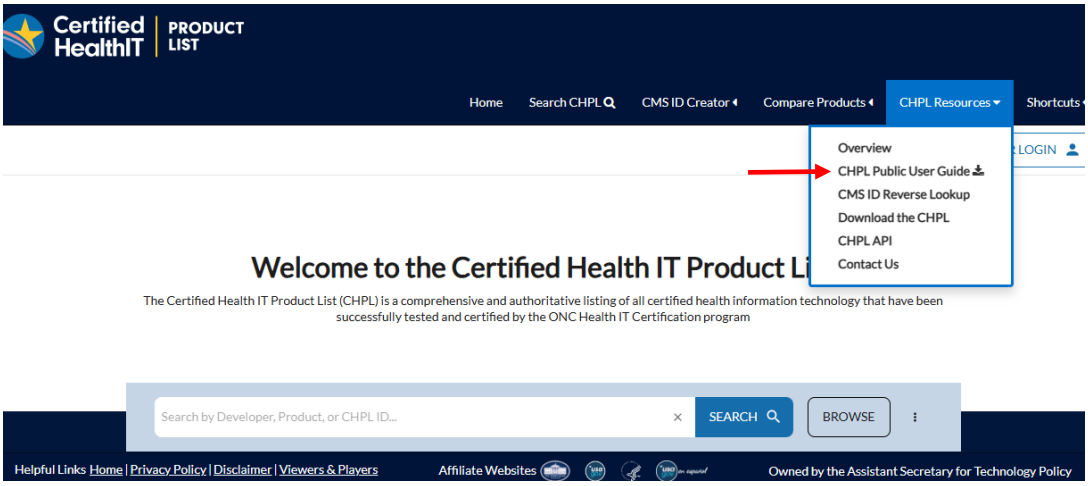
Work with your IT team to ensure your eCQM measure specifications are up to date for the current performance year (see Step 6. Review the Preparation and Implementation Checklists on the eCQI Resource Center) or contract with a third party intermediary (QCDR or Qualified Registry).

What if we use more than one EHR? Or switch EHR systems during the performance year?

If you collect data using multiple EHR systems and/or switching to a new EHR during the performance year, you'll need to aggregate your data before it's submitted. For help, work with your IT team to aggregate your data or contract with a third party intermediary (QCDR or Qualified Registry).

Where do I go for more information about the Certified Health IT Products for CMS reporting?

Refer to the CHPL Public User Guide under the CHPL Resources menu on the CHPL website.



Visit Appendix C. Next Steps to Obtain ONC Certification to learn more.

Step 2. Review Reporting Requirements for Quality Performance Category

The number of measures that MIPS eligible clinicians are required to report is determined by their reporting option. Table 2 below outlines the requirements for the quality performance category by reporting option.

Table 2. MIPS Quality Performance Category Requirements by Reporting Option

Traditional MIPS	MIPS Value Pathway (MVP)	APM Performance Pathway (APP)
• Use the Explore Measures & Activities Tool to **select 6 measures** (including 1 outcome or high priority measure) from the complete MIPS quality measure inventory. **OR** **Report 1 complete specialty measure set**. — If the specialty set includes fewer than 6 measures, you'll meet reporting requirements if you report all the measures in the specialty set. • Collect data for each measure for the 12-month performance period (January 1-December 31). • We'll evaluate you on any applicable administrative claims-based measures based on data CMS collects.	• **Select 4 quality measures** within an MVP. • Collect data for each measure for the 12-month performance period (January 1-December 31). • An MVP may include outcomes-based administrative claims measures. If you wish to be evaluated on an administrative claims measure as 1 of your 4 required measures, you'll need to indicate this in your MVP registration.	• Collect data for the original **APP quality measure set** or the **new APP Plus quality measure set** for the 12-month performance period (January 1-December 31). – Shared Savings Program ACOs must report the new APP Plus quality measure set. • Register for and administer the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS Survey measure. (Register April 1 – June 30, then collect data through December 31.) • We collect and evaluate data for 2 administrative claims-based measures if you meet the case minimum based on data CMS collects. • Learn more about the APP Quality Requirements.

Did you know? You can report a combination of collection types – Medicare Part B claims, eCQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure – to meet your quality reporting requirements.

The **MIPS Quality Measures List (XLXS)** contains a detailed list of all the available MIPS quality measures including applicable specialties and measures that may only be available for MVP reporting.

Helpful Hints and Reminders:

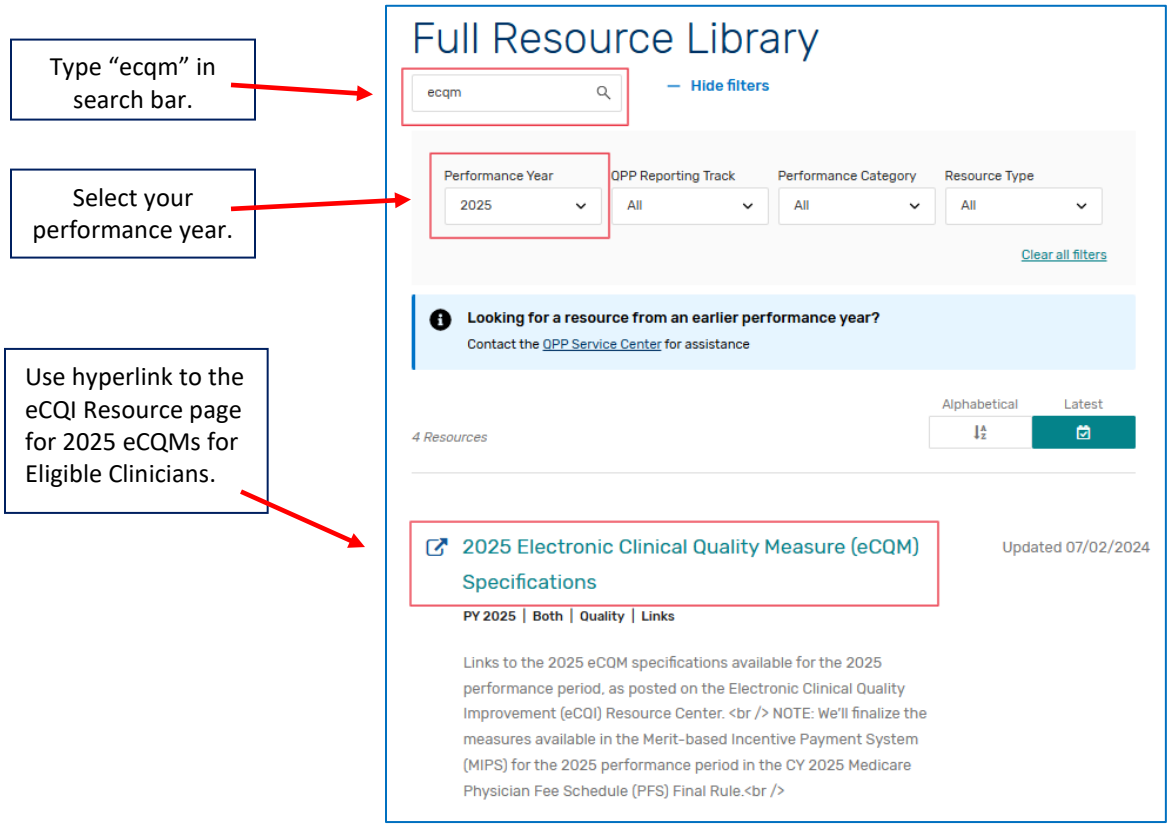
- Review your patient population to ensure you'll be able to meet the case minimum requirement (20 cases unless otherwise stated) on the quality measures you choose to report.
    - Small practices have some flexibility with the case minimum requirement and will earn 3 points for measures that don't meet the required case minimum.
- Small practices also earn 3 points for measures that don't have a benchmark.
- If you report more than the required number of quality measures, we'll pick the highest scored outcome measure and then the next highest scored measures to reach a total of 6 (traditional MIPS) or 4 (MVPs) scored quality measures.
- You can report measures from multiple collection types to meet quality reporting requirements.
    - If you submit the same measure through multiple collection types (e.g., as a Medicare Part B claims measure and an eCQM), we'll select the higher scoring collection type of the measure based on achievement points.
- You can report your quality measures through multiple submission formats (e.g., Quality Reporting Data Architecture (QRDA) III and with the support of a QCDR or Qualified Registry).

Step 3. Select Measures

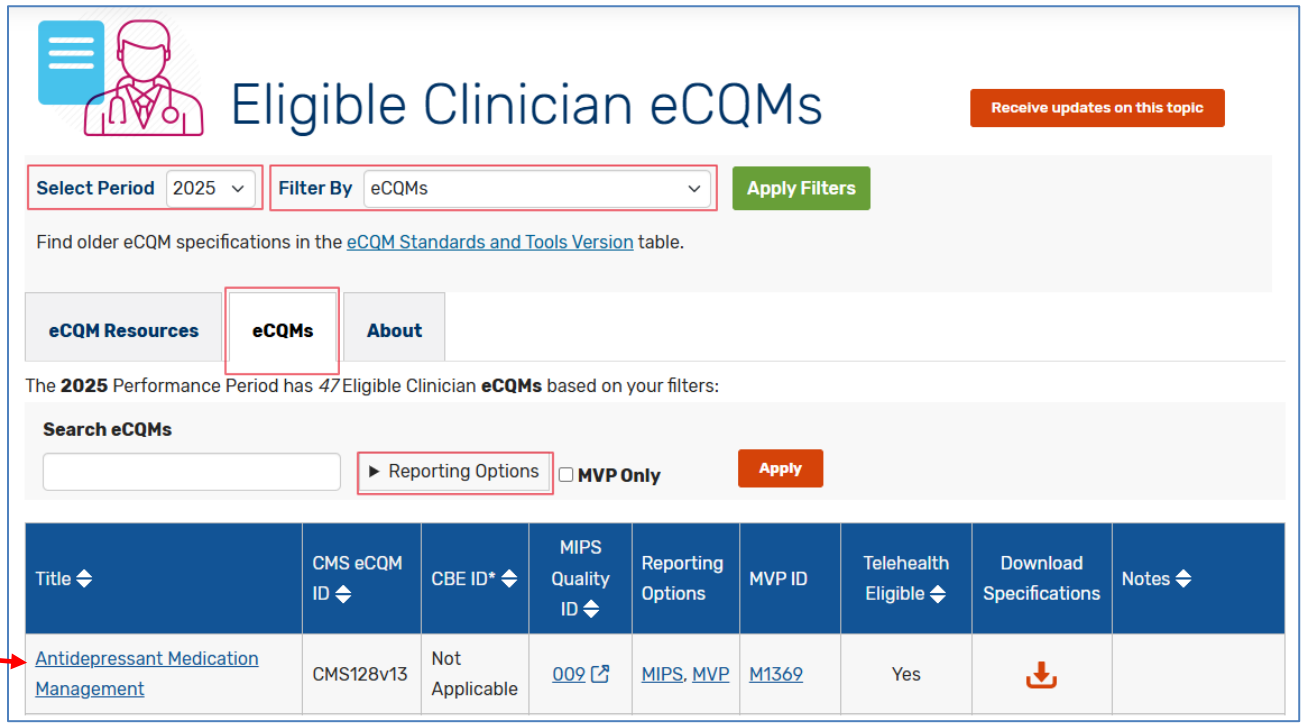
Each year CMS updates the eCQMs for potential use in quality reporting programs and publishes them on the eCQI Resource Center. We update the measure specifications annually to align with current clinical guidelines and code systems so they remain relevant and actionable within the clinical care setting.

You're required to use the most current version of the eligible clinician eCQMs as specified and intended for the applicable performance periods. You must collect and submit measure data for the 12-month **performance period**. Using the 2025 performance year as an example, the measure performance period is January 1 through December 31, 2025 (unless otherwise identified in the measure's specification).

a. Visit the QPP Resource Library for hyperlinks to the Electronic Clinical Quality Improvement (eCQI) Resource Center to access information about the eCQMs available under MIPS for the current performance period.

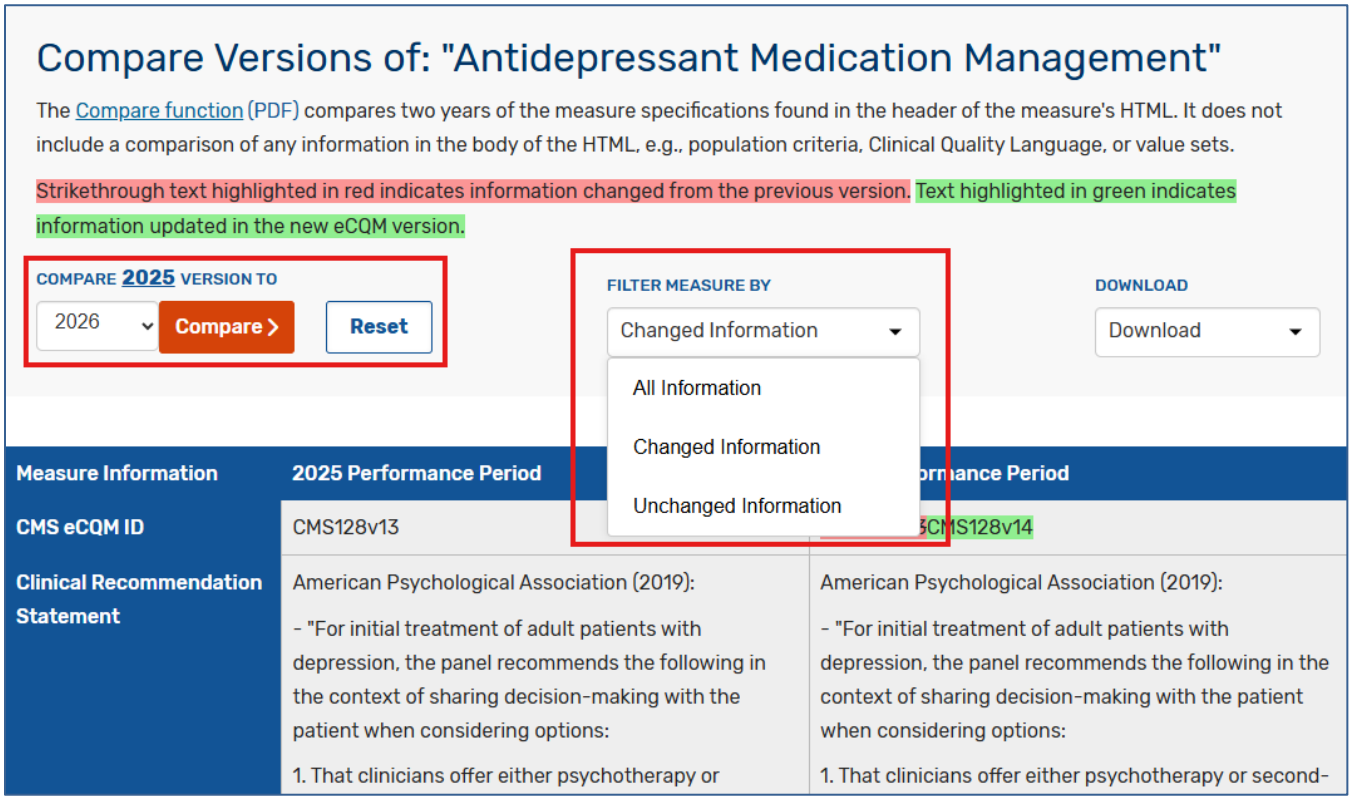


b. Filter by “eCQMs” on the [Eligible Clinician eCQMs webpage](). On this page you have option to:
   - ☐ Select performance period
   - ☐ Select Reporting Option Types (e.g., MIPS, MVP)
   - ☐ Search eCQMs by keyword or name
   - ☐ Download measure specifications which include coding requirements, workflow logic, value sets, value sets, data elements, release notes.

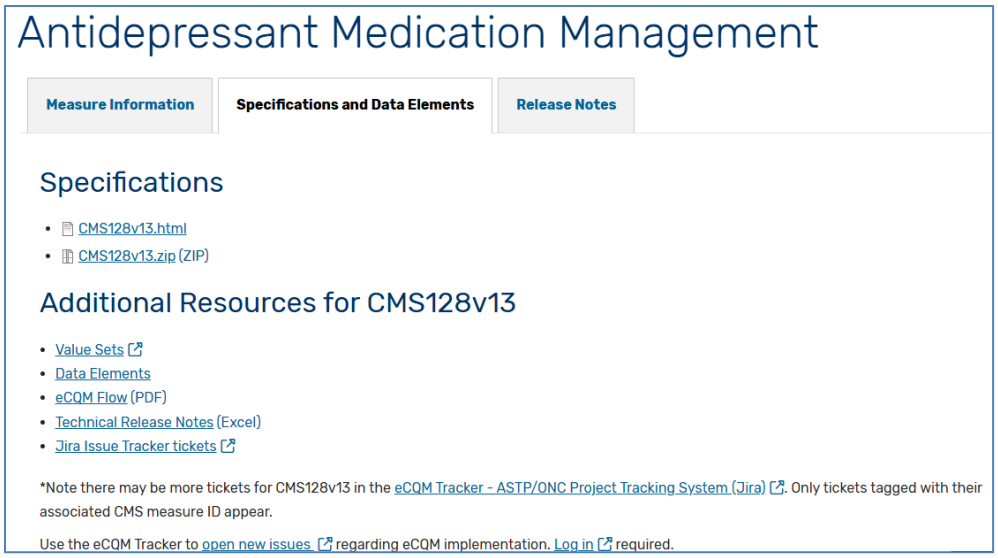


c. Click on the **measure title** to view more information.

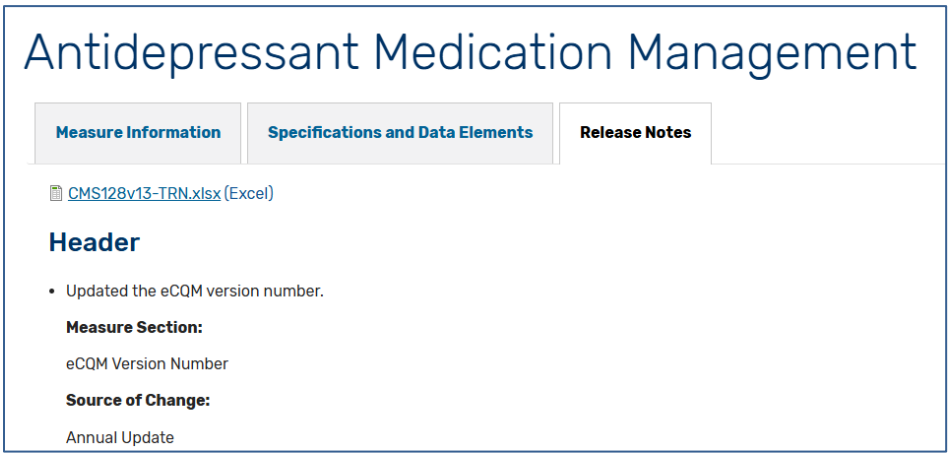
☐ From the **Measure Information tab**, use **Compare Function** to compare two years of measure specifications with option to filter by “all information, changed information, or unchanged information.” This comparison report can be downloaded.



☐ From the **Specifications and Data Elements tab**, you may link to and/or download measure specifications, value sets, data elements, eCQM flow, technical release notes and issue tracker tickets.



☐ From the **Release Notes tab**, you may view and/or download the measure's technical release notes including information by type (i.e., header, logic, value set), section (e.g., population, definition, functions, denominator exclusions), source of change (e.g., annual update, measure lead, standards/technical update).



Step 4. Decide If You'll Work with a QCDR and/or Qualified Registry

Decide if you have the capabilities to collect and submit data yourself, or if you need to work with a third party intermediary (QCDR or Qualified Registry), to support your data collection and submission.

QCDRs and Qualified Registries are entities that CMS has approved to submit data on behalf of participants for one or more of the MIPS reporting options: traditional MIPS, MVPs, and APP. This includes the ability to submit data for the quality, improvement activities, and/or Promoting Interoperability performance categories.

We've identified several questions to consider when deciding whether to work with a third party intermediary (Table 3). In addition to considering the below questions, there may be other factors or items to consider that are specific to your circumstances.

If you decide to collect and submit your own data, you will need to update your CEHRT systems and workflows to capture data according to the current performance year's specifications for the eCQMs you select. If you don't have updated CEHRT systems, or necessary processes or people in place, you may want to consider a third party intermediary that can work with you to collect and track your performance data throughout the year and can assist you with reporting to MIPS.

Important: Prior to the start of a performance year, you must have completed updating your systems and workflows to ensure you're able to meet data completeness requirements. For the 2025 performance year, for example, data completeness is defined as reporting a numerator option for at least 75% of the denominator eligible population for each eCQM you select to report. The denominator eligible patient population must be a complete representation of all available medical records, for each eCQM you select to report.

Table 3. Determine If Support is Needed for Data Collection & Reporting

Questions	Considerations
Can your EHR or IT module certification support your selected measures?	Confirm whether your EHR supports your selected measures. • Contact your EHR vendor with a list of eCQMs that you plan to collect and report before the performance period begins. If you previously collected a measure as a Medicare Part B Claims measure, you'll need to verify that your EHR can capture this measure as an eCQM and align to the measure specification accordingly. If your EHR doesn't support your selected measures, you may need to revise your selections based on the eCQMs that are available or choose another collection type.
Do you have a dedicated IT department or staff member that will be able to update your CEHRT's logic to capture denominator-eligible encounters in accordance with the eCQM specifications for your selected measures across all payers?	Measure specifications are updated each year, including the codes that qualify a patient or encounter for the measure or indicate if the quality action was performed. Your EHR vendor might update your system each year to account for changes in measure specifications. If not, you'll need to incorporate this annual review into your processes for any measures you report year-over-year. Click on the "Download Specifications" option to access the Technical Release Notes (ZIP file) for each measure on the ecqi.healthit.gov/ep-ec/ecqms website) to identify changes in the specification from the prior year. Release Notes are a great place to start when reviewing your EHR system to determine what updates need to be made.
Is there a designated team or staff member that can support any troubleshooting needed to ensure your Quality Reporting Data Architecture (QRDA) III files are properly formatted?	You can find the current QRDA III Implementation Guide for Eligible Clinicians as well as information about QRDA III specifications on the QRDA page of the eCQI Resource Center.
Are you in the process of switching to a different EHR?	If you transition from one or more EHR system(s) to another during the performance period, you'll need to aggregate the data from the previous EHR system(s) and the new EHR system into one report for the full 12-month performance period (identifying 100% of denominator-eligible instances) prior to submitting the data. Data completeness criteria must still be met (performance data – Performance Met, Performance Not Met, Exclusions – reported for at least 75% of the denominator-eligible patients/cases).

Step 5. Find a QCDR or Qualified Registry (if applicable)

Working with a QCDR or Qualified Registry

QCDRs and Qualified Registries are vetted and approved by CMS to support data collection and submission of quality measures on your behalf. QCDRs and Qualified Registries are required to support all MIPS performance categories that require data submission, with some exceptions for the Promoting Interoperability performance category.

While reporting is retrospective, you can work with third party intermediaries to implement real time quality improvement throughout the performance year. QCDRs and Qualified Registries provide performance feedback at least 4 times throughout the performance year based on the data available to them at the time. The feedback can help drive practice improvement and alert you, your group or your APM Entity of the changes needed in workflows or processes to improve performance prior to submission.

Identifying CMS Approved QCDRs and Qualified Registries

CMS publishes a list of approved organizations (with contact information, services offered, pricing, and the specific quality measures and/or QCDR measures they support) prior to the performance year.

In general, the population of approved QCDRs and Qualified Registries is fairly consistent from year to year. We encourage you to review the Qualified Postings for the current performance year to become familiar with the costs and services offered by approved QCDRs and Qualified Registries:

- **Qualified Clinical Data Registries (QCDRs) Qualified Posting (XLSX)**
- **Qualified Registries Qualified Posting (XLSX)**

The QCDR Qualified Posting and Qualified Registry Qualified Posting are updated on a monthly basis throughout the year to identify QCDRs and Qualified Registries that have been placed on remedial action and/or terminated. A QCDR or Qualified Registry can be placed on remedial action and/or terminated if CMS determines the organization isn't compliant with CMS requirements or has submitted inaccurate or otherwise unusable data.

If placed on remedial action, the QCDR or Qualified Registry must submit a corrective action plan (CAP) addressing any deficiencies and outlining steps to prevent recurrence.

- If a QCDR or Qualified Registry is placed on remedial action, you don't need to take any action unless you wish to find another QCDR or Qualified Registry that isn't on a CAP.

- If a QCDR or Qualified Registry is terminated, they're required to notify you that they won't be able to submit data for the terminated performance period. In this case, you would need to select another intermediary to submit your data or plan to submit your own data.

Best Practices for Finding a QCDR or Qualified Registry

Start by searching for QCDRs and/or Qualified Registries that support your selected reporting option, performance categories, and participation option (i.e., individual, group, subgroup, virtual group, or APM Entity).

Then review the eCQMs you wish to report to confirm they are supported by the QCDR and/or Qualified Registry you're interested in working with. Note that not all third party intermediaries support data collection for all quality measures and specialties.

Once you have identified the QCDRs and/or Qualified Registries that support the eCQMs you've selected, you can evaluate such third party intermediaries based on cost and services offered, including how you'll get your quality data to them.

- For example, if your group or APM Entity has multiple EHR systems, you may need to search for QCDRs and/or Qualified Registries that offer data aggregation services.

Lastly, contact the QCDR(s) and/or Qualified Registry(ies) directly. Note that some QCDRs and Qualified Registries will accept new clients during the performance year and into the submission period; the Qualified Postings identify the last date that a QCDR or Qualified Registry will accept new clients.

Review the **MIPS Guide to Using a QCDR or Qualified Registry (PDF)** for more detailed guidance on selecting a third party intermediary.

Step 6. Review Preparation and Implementation Checklists on the eCQI Resource Center

If you're not working with a QCDR or Qualified Registry, visit the eCQM Implementation Checklist page on the eCQI Resource Center website for technical resources to prepare for eCQM reporting. You will need to update eCQM measure specifications each performance year.

The resources are updated annually and will guide IT teams and practices to update their systems and processes with the eCQM Annual Update for the upcoming reporting and performance periods.

- ☐ Preparation Checklist
- ☐ Implementation Checklist
- ☐ eCQM Annual Update Implementation User-Guide (PDF)

Where Can I Get Help?

Contact the Quality Payment Program (QPP) Service Center by emailing QPP@cms.hhs.gov, submitting a QPP Service Center ticket, or calling 1-866-288-8292 (Monday-Friday, 8 a.m. – 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours –before 10 a.m. and after 2 p.m. ET.

People who are deaf or hard of hearing can dial 711 to be connected to a Telecommunications Relay Services (TRS) Communications Assistant.

Version History

Date	Change Description
01/26/2026	Original version
02/27/2026	Updated to include 2026 performance year resources.

Appendix A: Links to Resources for the 2025 Performance Year

- 2025 MIPS Quality Measures List (XLSX, 803KB) – A detailed list of the MIPS Quality Measures including applicable specialties and measures that may only be available for MVP reporting.

- 2025 QCDRs Qualified Posting (XLSX, 230KB) – Provides a list of the QCDRs approved for the 2025 performance year.

- 2025 Qualified Registries Qualified Posting (XLSX, 202KB) – Provides a list of the Qualified Registries approved for the 2025 performance year.

- 2025 MIPS Guide to Using a QCDR or Qualified Registry (PDF, 461KB) – Guides clinicians, groups, and/or APM Entities with the selection of a QCDR and/or Qualified Registry to support participation in MIPS for the 2025 performance year.

- 2025 Part B Claims Quality Reporting Quick Start Guide (PDF, 2MB) – Provides information about reporting quality measures through Medicare Part B claims (an alternative to eCQM reporting).

- 2025 MIPS Clinical Quality Measure Specifications and Supporting Documents (ZIP, 68MB) – Provides comprehensive descriptions of the MIPS CQMs for the MIPS quality performance category (an alternative to eCQM reporting).

- 2025 MIPS At-A-Glance Reporting Options for Small Practices (PDF, 436KB) – Provides information about the different requirements for the 3 MIPS reporting options.

Appendix B: Links to Resources for the 2026 Performance Year

- 2026 MIPS Quality Measures List (XLSX, 813KB) – A detailed list of the MIPS Quality Measures including applicable specialties and measures that may only be available for MVP reporting.

- 2026 QCDRs Qualified Posting (XLSX, 220KB) – Provides a list of the QCDRs approved for the 2026 performance year.

- 2026 Qualified Registries Qualified Posting (XLSX, 223KB) – Provides a list of the Qualified Registries approved for the 2026 performance year.

- 2026 MIPS Guide to Using a QCDR or Qualified Registry (PDF, 426KB) – Guides clinicians, groups, and/or APM Entities with the selection of a QCDR and/or Qualified Registry to support participation in MIPS for the 2026 performance year.

- 2026 Part B Claims Quality Reporting Quick Start Guide (PDF, 2MB) – Provides information about reporting quality measures through Medicare Part B claims (an alternative to eCQM reporting).

- 2026 MIPS Clinical Quality Measure Specifications and Supporting Documents (ZIP, 41MB) – Provides comprehensive descriptions of the MIPS CQMs for the MIPS quality performance category (an alternative to eCQM reporting).

- 2026 MIPS Reporting Options At-A-Glance for Small Practices (PDF, 436KB) – Provides information about the different requirements for the 3 MIPS reporting options.

Appendix C: Next Steps to Obtain ONC Certification

NOTE: The following information was adapted from healthit.gov.

Our EHR isn't certified. How can I get our EHR system certified and listed on CHPL?

Your EHR must be tested by an ONC-Authorized Testing Laboratory (ONC-ATL) and then certified by an ONC-ACB in order to be certified and listed on CHPL. Click here for a list of ONC-ATLs.

Contact your vendor to see if they're willing to go through the process of getting their product tested.

My vendor isn't planning to get their product tested/isn't upgrading their software to meet ONC certification criteria. What steps do I need to take to get CEHRT?

You may need to select another vendor/EHR system. Learn more about EHR contracts, product selection, adoption and implementation, workflow optimization and data migration by referring to the Health IT Playbook's section on EHRs.

There are several different options for how you might select a vendor. Some practices may go through the EHR implementation step and develop the selection criteria they wish to use. Others may select EHR software and then begin the planning to support the selected EHR system. Most practices will more than likely develop an initial plan to identify their key goals, conduct a vendor assessment, select an EHR system that supports their goals, and finalize their plan after the selection.

When conducting a vendor assessment, it's recommended that you complete the following steps:

1. **Assess EHR needs** – Identify your practice's high-priority needs, and EHR features, that may meet such needs and help achieve meaningful use and organizational goals.
2. **Set EHR goals** – Establish EHR goals. Goals should be specific, measurable, attainable, relevant, and time bound.
3. **Make a pros and cons list** – Make a list of pros and cons, identify potential "deal-breakers," and decide whether to have your EHR data reside in-office, on a vendor's server, or in web-based storage (cloud storage). To help in making your list, research vendor websites and speak to colleagues and/or your local Regional Extension Center.

4. **Narrow the field of vendors** – Start with the CHPL, which provides a comprehensive listing of certified EHRs and EHR modules that have been tested and certified under the ONC Health IT Certification Program. Continue to engage with colleagues and discuss their EHR experiences, contact medical societies you're a member of to ask for EHR evaluation tools and resources, and research different vendors online.
5. **Design and issue a request for information** – Gather information from vendors about their products and services. Ask for information on the vendor's organizational profile, implementation and training model, ongoing support Health Information Exchange capability and included interfaces, Meaningful Use guarantee, estimated total cost of ownership, and demonstration ability.
6. **Compare vendors** – Compare the information received from vendors. To help evaluate and compare EHRs, use the following resources:
    - Vendor Comparison and Matrix Tool (PDF, 336KB) to rate basic EHR functionalities.
    - Vendor Pricing Template (XLSX, 102KB) to compare cost differences of EHRs.
7. **Conduct demonstrations** – Schedule demonstrations with your top 2 to 5 vendors to "test-drive" the EHR products and interact face-to-face with the vendor team. Pay attention to the EHR's core functionalities, look and feel, and practice management features. In addition, walk-through clinical scenarios that are applicable to your group, with each EHR you're assessing. Use the EHR Demonstration Scenario, Evaluation, and Vendor Questions Toolkit (PDF, 602KB) to rate vendor capabilities.
8. **Contact references and schedule visits** – Ask vendors for lists of practices that have successfully implemented their EHR products. Contact the references and schedule time to visit the practices in person. Prepare a list of questions to gather lessons learned from the practice before, during, and after implementation.
9. **Select vendor/make final decision** – After establishing EHR implementation objectives, planning how EHRs will affect workflows, and conducting a vendor assessment (steps above) to narrow down the field of potential vendors, you'll be ready to select a vendor and enter the contracting phase.