DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, and 495

[CMS-0044-F]

RIN 0938-AQ84

Medicare and Medicaid Programs; Electronic Health Record Incentive Program--Stage 2

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule specifies the Stage 2 criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to qualify for Medicare and/or Medicaid electronic health record (EHR) incentive payments. In addition, it specifies payment adjustments under Medicare for covered professional services and hospital services provided by EPs, eligible hospitals, and CAHs failing to demonstrate meaningful use of certified EHR technology (CEHRT) and other program participation requirements. This final rule revises certain Stage 1 criteria, as finalized in the July 28, 2010 final rule, as well as criteria that apply regardless of Stage.

DATES: Effective dates: This final rule is effective on [insert date 60 days after the date of publication in the **Federal Register**], with the exception of the definition of "meaningful EHR user" in §495.4 and the provisions in §495.6(f), §495.6(g), §495.8, §495.102(c), and part 495 subpart D, which are effective [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER].

Applicability dates: Sections 495.302, 495.304, and 495.306 are applicable beginning payment year 2013.

Consistent with the recommendations of the HIT Policy Committee, we proposed to expand the orders included in the objective to medication (which was included in Stage 1), laboratory, and radiology. We believe that the expansion to laboratory and radiology furthers the goals of the CPOE objective, that such orders are commonly included in CPOE roll outs and that inclusion of the entry of these orders using CPOE is a logical step in the progression of meaningful use. We note that this does not require the electronic transmission of the order.

We proposed to continue to define CPOE as the provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device. The order is then documented or captured in a digital, structured, and computable format for use in improving safety and efficiency of the ordering process. We further proposed that the CPOE function of CEHRT must be used by the ordering provider or licensed healthcare professionals under his or her direction to create the first record of that order, or it would not count as CPOE. As this proposed objective limits the use of CPOE to the creation of the first record of the order (a more restrictive standard than in Stage 1), we invited public comment on whether the stipulation that the CPOE function be used only by licensed healthcare professionals remains necessary or if CPOE can be expanded to include non-licensed healthcare professionals such as scribes.

Comment: Commenters focused primarily on CPOE's value as the trigger for clinical decision support interventions. It was suggested the term be revised from computerized provider order entry to computerized order evaluation. This focus led to the suggestion by several commenters that as long as the ordering providers "signs" or otherwise authorizes the order before it is carried out this should count for CPOE. These commenters maintain that meaningful

use should not dictate any of the processes that lead up to this authorization including who enters the order into CEHRT nor what types of record of the order may exist prior to entry into CEHRT.

Response: We agree that CPOE as the trigger for CDS interventions is the primary value creating function of CPOE. However, we disagree that it is the only one. We believe automating aspects of and/or eliminating steps in the ordering process prior to final authorization of the order does reduce communication and other errors. Furthermore, it is our understanding from both commenters and our own experiences with CEHRT that many EHRs use the entry of the order as the trigger for CDS interventions and either display them again at authorization or do not display them at all at authorization. For these reasons, we continue to focus the definition and measurement of CPOE on when and by whom the order is entered into CEHRT and not on when it is authorized by the ordering provider in CEHRT.

Comment: Commenters stated that the authentication of verbal orders is already covered by the conditions of participation for hospitals at 42 CFR482.24(c)(1)(iii) which states that "[a]ll verbal orders must be authenticated based upon Federal and state law. If there is no state law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours." Meaningful use should adopt this same standard.

Response: We are not adopting this standard for two reasons. First, as this is in an incentive program, we do not believe it is logical to base a requirement for meaningful use solely on a condition of participation. Hospitals already must comply with the conditions of participation, so we believe as an incentive program meaningful use should be incentivizing behavior beyond the conditions of participation. Second, as discussed later, we are not limiting the communication of orders prior to CPOE to verbal orders so there is not a direct corollary