National
Family Planning
& Reproductive Health Association

March 15, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-0033-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: 42 CFR Parts 412, et al.; Medicare and Medicaid Programs; Electronic Health Record Incentives Program; Proposed Rule; File Code CMS-0033-P

Dear Ms. Frizzera:

The National Family Planning & Reproductive Health Association (NFPRHA) submits these comments on the Medicare and Medicaid Programs Electronic Health Record Incentives Program Proposed Rule (CMS-0033-P), published in the Federal Register on January 13, 2010. NFPRHA supports the government's investment in health information technology (HIT) and electronic health records (EHR) as a means of improving health care quality, increasing service efficiency and reducing health care costs.

NFPRHA is a vital membership organization representing the nation's dedicated family planning service providers. Our membership is made up of state and county health departments, private non-profit health centers, Planned Parenthood affiliates, hospitals, and other organizations that provide comprehensive family planning services—contraception, counseling, education and preventive health care—to millions of women and men annually. These providers often serve as the only health care provider for many of the women and men they serve, primarily low-income, uninsured and underinsured Americans.

Each year, publicly supported family planning services help women to prevent 1.9 million unplanned pregnancies, which would have resulted in 860,000 unintended births and 810,000 abortions.[1] Medicaid is the major source of funding for family planning in the United States, accounting for 71 percent of all family planning dollars spent in the U.S. in 2006, up from 20 percent in 1980.[2] Health care providers serving low-income patients often face real difficulties in accessing patient health histories because these patients often move on and off health insurance and in and out of different provider settings in the safety-net system. The use of HIT and EHRs would enable low-income family

[1] Guttmacher Institute. (2009, February). "Facts on Publicly Funded Contraceptive Services in the United States."
[2] Gold RB et al., *Next Steps for America's Family Planning Program*, New York: The Guttmacher Institute, 2009.

planning providers to better coordinate patients' care and provide services that are more specific to, and therefore more effective for, an individual patient, ultimately resulting in healthier outcomes.

Incentive payments to promote the adoption and meaningful use of HIT and EHRs are especially important to the family planning providers NFPRHA represents, many of whom operate with limited budgets and lack the financial resources to implement HIT systems. While NFPRHA fully supports the use of these incentives, it is concerned that the Proposed Rule as currently drafted could undermine NFPRHA members' ability to participate in the incentive program. With more than 8,000 publicly funded family planning centers operating in the United States,[3] many of which serve as the primary, or even only, source of health care for millions of Americans, it is critical that family planning providers be able to fully engage in the adoption and meaningful use of HIT and EHRs. NFPRHA suggests the following areas for improvement in order to ensure the participation of publicly funded family planning centers.

The Proposed Rule Does Not Sufficiently Address the Unique Structures and Systems of Publicly Funded Family Planning Centers and Systems

In the American Recovery and Reinvestment Act of 2009 (ARRA), Congress created a system of incentive payments to eligible professionals (EPs) and eligible hospitals participating in Medicare and Medicaid programs that adopt and meaningfully use EHR technology. The Proposed Rule implements that system in a way that will be functional for many health care providers around the country, but does not sufficiently address the unique needs of safety-net family planning providers and entities.

Unlike in many health systems, it is common for family planning providers to work in multiple facilities, sometimes for more than one health system. Providers may work part-time in one or more facility, and those agencies may operate in more than one state. While the Proposed Rule does contemplate the potential for providers who work in multiple facilities, it does not do so with the breadth and scope needed to ensure that family planning providers and systems can meet the proposed incentive eligibility requirements.

Publicly funded family planning systems sometimes operate in multiple states. The Proposed Rule allows states to add additional or more stringent requirements for demonstrating meaningful use. This would allow for substantial variation in the meaningful use standards EPs must meet, which will not only be confusing to EPs, facilities and systems that operate across state lines, but which could make compliance in one or more states impossible. It could also give states the opportunity to create barriers to particular health care specialties based on ideology.

Recommendation: Continuity across state lines should be encouraged. CMS should not allow states to add additional or more stringent requirements for demonstrating meaningful use. Any additional or more stringent requirements should be considered "optional" as opposed to "required."

Under the Proposed Rule, EPs can assign their incentive payments to the facility or system at which they work. In the case of family planning providers, especially ones who do not work full-time at only one facility, it is the facility (or health system)—not the individual provider—who will adopt, implement and administer HIT and EHR technology. The Proposed Rule, however, does not sufficiently address the fact that the EP's ability to meet the reporting requirements necessary to

[3] Guttmacher Institute, "Facts on Publicly Funded Contraceptive Services in the United States."

demonstrate eligibility and meaningful use will be dependent upon the facility at or system for which the provider works. EPs may choose to not assign their incentive payments to every facility or system at which they work, which could be a significant disincentive for the facility or system to help the EP comply with reporting requirements, as well as undermine the facility or system's ability to adopt and meaningfully use HIT and EHR technology at all.

Recommendation: CMS should consider the feasibility of EPs working in multiple facilities and for multiple health systems to adequately meet the incentive payment reporting requirements, in order to encourage the broadest adoption and meaningful use of HIT and EHRs possible.

The Proposed Rule Does Not Sufficiently Address Family Planning in the Clinical Quality Measures

The Proposed Rule requires EPs to submit information on clinical quality measures. The Proposed Rule does not include a family planning specialty, and therefore family planning providers would likely fall somewhere between the ob/gyn and primary care specialties.

The Proposed Rule includes nine clinical quality measures for the ob/gyn specialty. Of these, only four (related to screening for Chlamydia, breast and cervical cancer, and obesity) are relevant to a non-obstetrician. The Proposed Rule allows for providers to obtain exemptions from one or more specific measures or from selecting a specialty, however, the rule does not include a process for obtaining such exemptions.

Recommendation: The Proposed Rule should be clarified regarding exemptions from the clinical quality measures, and clear guidance should be given for providers seeking exemptions to follow.

The prevention of unintended pregnancy is an essential public health goal that should be included in the clinical quality measures. Family planning and contraceptive use are demonstrated means of preventing unintended pregnancy, and are included in the Healthy People 2020 initiative. NFPRHA suggests the following family planning measure should be included: "Percentage of sexually active clients at risk for unintended pregnancy screened, at least once annually, for use of a contraceptive method at last intercourse and method satisfaction."

Recommendation: The family planning measure should be included in the clinical quality measures for both the ob/gyn and primary care specialties.

All required clinical quality measures should be evidence-based and in line with current medical standards recommended by national professional societies. There must also be a process for updating clinical quality measures as national standards change. For example, NQF 0032, which measures the "Percentage of women 18-64 years of age, who received one or more Pap tests during the measurement year or the 2 years prior to the measurement year," is not in line with current cervical cancer screening guidelines.

Recommendation: The Proposed Rule should be modified to include a regular review of clinical quality measures and provide for the evidence-based updating of such measures.

The Proposed Rule Does Not Sufficiently Address the Unique Privacy and Confidentiality Needs of the Patients Served by Family Planning Providers

Privacy and confidentiality must lie at the heart of quality health care. NFPRHA supports the patient privacy and confidentiality protections included in the Proposed Rule, but offers suggestions for how these protections can be further strengthened.

A key issue in the provision of family planning services is that the services provided, and even the provider visit itself, be kept confidential. This is particularly important when minors are concerned, to ensure that the minor receives reproductive health care free from governmental and/or parental intrusion which could prevent the minor from seeking such services. The same need for confidentiality applies to adults, who have a legal right to keep their reproductive health care private from spouses and/or partners.

Recommendation: Key questions of who is authorized to access an EHR and who determines authorized users need to be addressed. Further, state and federal protections in place regarding minor confidentiality need to be maintained.

In order to demonstrate compliance with meaningful use criteria, the Proposed Rule requires that EPs share certain patient and health information to CMS. While the sharing of patient-identifiable information with the patient and other health care providers is understandable, there is no compelling reason to require patient-identifiable data to states or to CMS in order to prove compliance with meaningful use criteria.

Recommendation: The Proposed Rule should be modified to only require EPs to share de-identified health information for the purpose of compliance with meaningful use criteria.

The Proposed Rule states that, in order to comply with Stage 1 meaningful use requirements, EPs must provide patients who request an electronic copy of their health information with such copy within 48 hours of the patient's request. Many family planning providers, however, do not work full-time or on consecutive days at the same facility, making compliance exceedingly difficult.

Recommendation: This requirement should be changed to five business days, which would provide an appropriate amount of time for the EP to comply with the patient's request.

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NFPRHA appreciates the opportunity to comment on the Medicare and Medicaid Programs Electronic Health Record Incentives Program Proposed Rule (CMS-0033-P). Should you have any questions, please feel free to contact Robin Summers at rsummers@nfprha.org or 202-293-3114.

Respectfully submitted,

Clare Coleman
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