As you can imagine, I’ve spent a good deal of time in the last year thinking about how I can best represent ACOG and you during my Presidential year. What are the issues you care about? What can I do to really make a difference? How can I best relate to you and relate what you care about to policymakers?

I’ve been fortunate to have a wonderful role model right in front of me every step of the way in Dr. Jerry Joseph, our Immediate Past President.

Dr. Joseph could not possibly have anticipated the urgency of his year, as health reform made its sloppy way through the U.S. Congress. But he rose to and met this challenge with calm leadership, always keeping your needs and concerns at the front of every decision and discussion. I learned the importance of leadership, decision making, and perspective.

Dr. Joseph from his first day as President wanted to open up communications between you and ACOG’s leadership. He did this through ACOG’s Legislative News that you’re reading now, and in many other ways. I saw the benefit to you and to ACOG of sharing information, asking your opinion, and learning from your experience.

Dr. Joseph inherently understood the need for us to work cooperatively in a larger community to accomplish our goals. He represented us with the Surgical Coalition, with the women’s health community, and with our foreign partners, bringing credibility to ACOG as a reliable coalition partner. I saw first-hand the tremendous influence others have and the importance of working with potential allies early and often.

Jerry also gave freely of his time to ACOG. He understood the importance of his participation in meetings with the White House and in the U.S. Congress, and his mileage programs show it. I know that his presence made an important difference.

I’m honored to be able to call Jerry a good friend. And I pledge to put these important lessons to work for you.
President Waldman Shares CDC Contraceptive-Use Eligibility Criteria with All ACOG Members

ACOG Collaborates on U.S. Version of WHO Document; Cautions on FDA Labeling; Welcomes Member Comments

On May 28, ACOG President Richard N. Waldman, MD, sent the following email to all ACOG members:

Dear Colleague,

This e-mail is to inform you of important news in family planning. Today, the Centers for Disease Control and Prevention (CDC) issued U.S. Medical Eligibility Criteria for Contraceptive Use, 2010, available as an early release in MMWR at: http://www.cdc.gov/mmwr/pdf/rr/rr59e0528.pdf

Medical Eligibility Criteria for Contraceptive Use was first developed by the World Health Organization (WHO) and is currently in its 4th edition. WHO has intended that the Medical Eligibility Criteria be adapted by individual countries, and now -- with the assistance of the American College of Obstetricians and Gynecologists -- a U.S. version is available from the CDC.

The U. S. Medical Eligibility Criteria for Contraceptive Use, 2010 provides evidence-based guidance for use of contraceptive methods by women with various medical conditions. Approximately 1,800 combinations of contraceptive method and condition are given a rating from 1 to 4:

1 = A condition for which there is no restriction for the use of the contraceptive method.

2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.

3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.

4 = A condition that represents an unacceptable health risk if the contraceptive method is used.

Most of the guidance in the U.S. version released today also appears in the global WHO guidance. However, the U.S. version adapts some of the guidance for better alignment with College recommendations and to better fit the U.S. health care system. It also includes guidance for additional conditions, such as history of bariatric surgery and rheumatoid arthritis. The College collaborated with the CDC in the development of the U.S. version, and we are completing evaluation of the final version for possible endorsement.
Fellows should be aware that guidance in the *U. S. Medical Eligibility Criteria for Contraceptive Use, 2010* sometimes may not be consistent with product labeling approved by the U.S. Food and Drug Administration and therefore may be considered off-label use.

We would welcome any comments you have on this new resource. Thank you for all you do for your patients.

Sincerely,
Richard N. Waldman, MD, FACOG
President

For More Information
Read the ACOG press release [here](#).

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**Medicare Physician Payment Update:**

21.3% Pay Cut Took Effect Yesterday;
House Passed 19-Month Fix; Senate Expected to Pass It Retroactively

Once again, both houses of Congress could not come up with a temporary or permanent fix to the Medicare physician payment system before a pay cut deadline. As a result, a scheduled 21.3% Medicare physician pay cut took effect yesterday, June 1, after Congress left town for a week-long recess.

Last Friday, as the Memorial Day recess approached, the House approved a 19-month physician pay fix with a 245-171 vote. But the vote came too late for Senate consideration. Senate Majority Leader Harry Reid (D-NV) said the Senate would take up the extender measure when the Senate returns on June 7.

The Senate is expected to pass the temporary fix by the end of next week, so the Centers for Medicare and Medicaid Services (CMS) is holding action on payments for 10 business days, in anticipation of retroactive relief.

Under pressure from fiscal conservatives in both parties, Democratic House Leaders backed off of a proposed three-year fix in a tax bill, the American Jobs and Closing Tax Loopholes Act of 2010, H.R. 4213. Instead, they proposed 19 months of relief, deferring cuts through December 2011.

Physicians would get a 2.2% boost in reimbursement for the balance of 2010, followed by a 1% update through 2011. But the Sustainable Growth Rate (SGR) formula to calculate payment would continue in the years after, meaning a 33% physician pay cut in 2012.
The SGR Repeal Campaign Continues

This uncertainty wreaks havoc on your practices and patient care. Last week Rep. Dave Camp (R-MI) entered a letter from ACOG and 13 other groups into the Congressional Record. You can read it here:
http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2010_record&page=H4177&position=all

ACOG is working hard to repeal the SGR, the flawed Medicare physician payment formula that just doesn’t work. Here’s how you can help.

1. Click on our Legislative Action Center to send an email message to your legislator; or
2. Call the Toll Free hotline set up by the American College of Surgeons and available to ACOG at 1-877-996-4464; and
3. Use our SGR Fact Sheet;

No time to write? Your contribution supports Ob-GynPAC’s SGR Repeal Campaign

Answering Your Questions: The Impact of Health Insurance Reform on You

The First in a Series

With this edition, we begin a series of questions and answers on health insurance reform, responding to some of the most common ob-gyn concerns about the effect of the new law on women’s health care. This week’s topic: Seeing more patients and other major effects of reform. The following Q&A, reprinted with permission, is excerpted from an article in the June 2010 edition of the journal OBG Management.* The journal’s Senior Editor, Janelle Yates, interviews ACOG Government Affairs Director Lucia DiVenere.

1. Is the most significant impact for ob-gyns likely to be an increase in the number of patients they will be seeing? If not, what will be the greatest impact?

Congress had many goals in mind for health reform, which is partly why it’s such an immensely complicated law. Yes, Congress wanted to increase the ranks of the insured and access to health care, and it addressed these goals with individual and employer mandates, state exchanges, and insurance reforms. But it also wanted to reform our health care system in a number of fundamental ways, some of which are designed to change the way physicians provide care to their patients.
Congress wanted to “bend the cost curve,” meaning reduce the expected rate of growth in health care spending over the long term. That doesn’t mean that 2020’s health care costs, for example, should be less than they were in 2018, but that the annual and long term rates of growth should level to sustainable rates. To accomplish this goal, Congress created an Independent Payment Commission, which may prove to be extremely powerful in reducing health care costs and can significantly affect all physicians. Increased fraud and abuse protections; experiments with new kinds of payment and delivery systems, including medical homes; and increased reliance on non-physician practitioners also fall into this category.

Congress also was determined to change health care practice, ensuring higher quality care for each health care dollar spent and consistent delivery of health care; and to kick start our health care system, especially in the physician arena, into greater and theoretically more efficient reliance on electronic health records. Medicare and Medicaid physician payments will be juggled to increase payments for E&M services and for physicians who show greater value compared to costs. Physicians will have to participate in the PQRI program in 2015 and beyond to avoid stiff penalties for nonparticipation. And electronic health records systems are required to adopt uniform standards for electronic transactions.

Congress also recognized the importance of women’s health in health reform, and included many of the provisions ACOG advocated for in our Health Care for Women, Health Care for All Campaign that defined the women’s health piece of the health reform puzzle.

One important provision guarantees direct access to ob-gyns for women, without requiring patients to receive a referral or pre-authorization from a primary care provider or their insurance company, and insurance companies cannot restrict a patient’s direct access to her ob-gyn to a certain number of visits or types of services. This was a major ACOG victory in the law.

For 20 years, ob-gyns have been waging battles in the states for direct access for their patients. Still, last year 9 states did not require insurers to allow women direct access to their ob-gyns, and 16 states allowed insurers to restrict ob-gyn visits and services.

This part of the law, which is effective this year, provides national direct access to all women in all states, and is not tied to an ob-gyn’s primary care designation.
2. **Will it be a challenge to meet the needs of these new patients? For example, will there be enough ob-gyns? Will the need for physician extenders increase? Are there other ramifications?**

Thirteen percent of all pregnant women in the US were uninsured in 2009, 20.4% of all women between the ages of 15 and 44, the childbearing years. The uninsured rate for nonelderly women in 2007 spanned from a high of 28% in New Mexico and Texas to a low of 8% in Massachusetts. Today, 42% of all pregnancies are covered by Medicaid. Women may have gotten care, even if from emergency departments at the time of labor, but clearly our nation had to do better than this.

Medicaid and new health insurance plans will be required to offer **maternity care and women’s preventive services, including mammography screening**. The exact parameters of maternity care and other types of care in the essential benefits package will be determined by the Secretary of Health and Human Services, based on the typical package offered to employees in group health plans. The idea behind the law is that many women who now are covered by Medicaid would transfer to private insurance in their state’s exchange.

**Ob-gyns will see three opportunities and challenges in this area.**

**First, the law encourages development of medical homes**, practices designed to provide and/or coordinate comprehensive patient care. State Medicaid agencies are authorized to require certain beneficiaries, including those with 2 or more chronic conditions, to join a medical home. Medicare will also experiment with medical homes and both Medicaid and Medicare medical home practices will receive additional payments. Most medical homes are expected to be family practice, internal medicine, and pediatric practices. Ob-gyn practices should look carefully at these opportunities, and consider becoming eligible as medical homes for their patients.

**Second, the law strongly encourages increased use of physician extenders, including in the area of ob-gyn.** Congress is determined to experiment with non-ob-gyn delivery care, responding to patient demands and midlevel assurances that they can deliver babies with better outcomes at significantly less cost. Our specialty’s C-section delivery rate is under intense scrutiny. Skewed studies “prove” happier and healthier deliveries in homes and other out-of-hospital locations without ob-gyn attendance. And mid-levels are offering VBACs that ob-gyns practicing in many hospitals cannot.

The law extends Medicaid payments [to] free-standing birth centers and birth attendants, and doesn’t specify which kind of practitioners can qualify as birth attendants. Free-standing birth centers can provide high quality care if appropriately accredited and with established transfer relationships with a nearby hospital. The law also doesn’t specify these criteria.
Answering Your Questions: The Impact of Health Insurance Reform on You — Cont’d

Medicare payments to certified nurse midwives come up to the same payment rate that Medicare pays physicians for the same services in January 2011, up from 65% of the physician rate. Medicare will also pay CNMs a 10% bonus if primary care services account for at least 60% of their allowed charges. And the law requires health plans in the state exchanges to pay for covered health services provided by any provider recognized under state law, whether or not the plan contracts with that individual or that type of provider. Certified professional midwives, lay midwives, are licensed in 21 states, and this provision may give them significant new entry.

At the same time, ob-gyns are stopping delivering babies at earlier points in their careers, and only 13% of family physicians deliver babies today. So we need to find ways to extend our care, and increased collaborative practice between ob-gyns and CNMs and certified midwives (CMs) may help close this gap. This increased focus on mid-levels in the law may present us with both a challenge and an important opportunity.

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More Resources
For the latest information and fact sheets on implementation of the reform law, click on ACOG’s Health Reform Center.

MLR in the States:
News of Medical Liability Reform beyond the Beltway

Utah Passes New Cap on Non-Economic Damages

The federal health reform law does not address the problem of medical liability reform, beyond some limited funding for demonstration projects on reform alternatives. In this series, we’ll take a look at what’s happening in the laboratory of the states on medical liability reform – from the status of caps on non-economic damages to the latest in innovative programs and alternatives for reform. This week: a recent success on caps.

Since 2006, only three states -- Wisconsin, Oklahoma and now Utah – have successfully passed legislation limiting non-economic awards in medical liability cases. Wisconsin and Oklahoma enacted caps in 2006 and 2009, respectively. Kudos to Utah ACOG: on March 23 of this year, Utah enacted S.B 145, legislation that amends existing Utah law in three ways:
MLR in the States:
News of Medical Liability Reform beyond the Beltway — Cont’d

Establishes a hard non-economic cap of $450,000. This applies to causes of action arising after May 15, 2010; the previous inflation-adjusted cap (currently at $480,000) will stay in effect for causes of action arising between July 1, 2002 and May 14, 2010;

Requires an affidavit of merit from a health care professional in order to proceed with an action, if there is a non-meritorious finding from the pre-litigation panel. This is a very detailed provision, effective for causes of action arising after July 1, 2010; and

Limits the liability of a health care provider, in certain circumstances, for the acts or omissions of an ostensible agent. Ostensible agents are individuals who are not agents of a health care provider, but the plaintiff reasonably believes, because the health care provider failed to take ordinary care, that the individual is an agent. A health care provider is not liable for the malpractice of an ostensible agent if the agent has privileges with the provider, meets certain insurance requirements, and other criteria. This provision is effective for causes of action arising after July 1, 2010.

For More Information
For updates and fact sheets on state issues, check on State Legislative Activities in the Advocacy section of the ACOG website.