

14 questions (and answers) about health reform and you

➡ The Patient Protection and Affordable Care Act has ramifications for ObGyns and their patients. ACOG's director of government affairs answers our questions about the law.

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With passage of the Patient Protection and Affordable Care Act earlier this year, big changes are afoot in the way Americans practice medicine. In a plethora of articles, blogs, and broadcast spots, the media have focused on what the new law portends for the average employee, employers, and the uninsured—but what, exactly, does it entail for ObGyns and their patients?

To find an answer to that overarching question—and 13 others—we invited Lucia DiVenere, director of government relations at the American Congress of Obstetricians and Gynecologists, to join us in an extended discussion of the law and its ramifications. She offered insight into ACOG's extensive lobbying efforts on behalf of women and the specialty and described **the many ways ObGyn care will change in the near and proximal future**, focusing on questions that you might find yourself asking, including:

- Will I see a lot more patients?
- What reforms are woman-specific?
- How will my practice change?

You can find out more about ACOG's "Health care for women, health care for all" campaign and access a wealth of information and analysis of this new law, including a downloadable patient FAQ, by clicking on ACOG's Health Reform Center on the ACOG home page, www.acog.org, or at www.acog.org/departments/dept_notice.cfm?recno=11&bulletin=5202.

- Which of my services will be fully covered?
- Will expanded coverage improve birth outcomes?
- Is "femaleness" a preexisting condition?
- What happened to tort reform?
- Is the system repairable?

1 Will ObGyns see a lot more patients?

OBG MANAGEMENT: The most talked about change the new law heralds is the addition of roughly 32 million people to the insurance rolls. Is the most significant impact of the legislation for ObGyns likely to be an increase in the number of patients they will be seeing?

Lucia DiVenere: Congress wanted to increase the ranks of the insured and expand access to health care, and it addressed these goals with individual and employer mandates, state exchanges, Medicaid expansion, and insurance reforms.

But that isn't the most significant change in store for us. Congress 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.

For example, Congress wanted to "bend the cost curve"—to reduce the expected rate of growth in health care spending over the long term. That doesn't mean that health care costs in 2020 will be less than they were in 2018, but it does mean that annual and long-term growth rates should level off and become



Lucia DiVenere

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sustainable. To accomplish this goal, Congress created an Independent Payment Advisory Commission, which may prove to be extremely powerful in reducing health care costs and is likely to significantly affect *all* physicians. Greater protections against fraud and abuse, experiments with new kinds of payment and delivery systems, including “medical homes,” and increased reliance on nonphysician practitioners—all included in the law—are also expected to reduce costs.

OBG MANAGEMENT: What other changes are coming?

DiVenere: Congress was determined to alter the *practice* of health care, ensuring higher quality for each dollar spent and consistent delivery of care. It also sought to kick-start our health care system—especially in the physician arena—into greater and, theoretically, more efficient reliance on electronic health records (EHR). Medicare and Medicaid physician payments will be juggled to increase reimbursement for E&M services and for physicians who provide greater value in

relation to cost. Physicians will be required to participate in the Physician Quality Reporting Initiative (PQRI) program in 2015 and beyond to avoid stiff penalties. And EHR systems are required to adopt uniform standards for electronic transactions.

2 What reforms are woman-specific?

OBG MANAGEMENT: What initiatives are planned for the care of women, in particular?

DiVenere: Congress recognized the importance of reforming women’s health and included many provisions advocated by ACOG in our “Health care for women, health care for all” campaign.

Probably the most important of these provisions is the guarantee of direct access to ObGyn care without need of a referral or pre-authorization from a primary care provider or insurance company. Nor can an insurance company restrict a patient’s direct access to her ObGyn to a certain number of visits or types of services.

This was a major ACOG victory. For 20 years, ObGyns have been waging battles in the states for direct access for patients. Last year, nine states did not require insurers to grant women direct access to ObGyns, and 16 states allowed insurers to restrict ObGyn 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 ObGyn’s primary care designation.

Another area of reform concerns maternity care. In 2009, 13% of all pregnant women in the United States were uninsured, as were 20.4% of all women between the ages of 15 and 44, the childbearing years. The uninsured rate for nonelderly women in 2007 ranged 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 have been able, usually, to gain access to some kind of care—sometimes in emergency departments at the time of labor—but the nation clearly needs to do better.

Medicaid and new 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 (HHS), based on the typical package offered to employees in group health plans. The idea behind the law is that many women who are now covered by Medicaid will transfer to private insurance in their states' exchanges.

3 How will ObGyn practice change?

OBG MANAGEMENT: What are some of the opportunities and challenges ObGyns will encounter?

DiVenere: There are three key areas of challenge and opportunity:

- **Development of the “medical home.”**

A medical home is a practice designed to provide and coordinate comprehensive patient care. State Medicaid agencies are authorized to require certain beneficiaries, including those who have two 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, or pediatric care providers, but ObGyn practices can participate, too. ObGyns should look carefully at the opportunities this paradigm provides and consider having their practice designated as a medical home.

- **Increased use of nonphysician providers.** The new law strongly encourages this practice, including in the ObGyn specialty. Congress is determined to experiment with non-ObGyn deliveries in response to patient demand and midlevel assurances that nonphysicians can deliver babies with better outcomes at significantly lower cost. Our specialty's cesarean delivery rate is under intense scrutiny. Skewed

studies “prove” happier and healthier deliveries in homes and other out-of-hospital locations without an ObGyn in attendance. And midlevel practitioners are offering vaginal birth after cesarean delivery in many cases where ObGyns are restricted by hospital rules.

- The law extends Medicaid payments to free-standing birth centers and birth attendants and does not specify which kinds of practitioners can qualify as birth attendants. Free-standing birth centers can provide high-quality care if they are appropriately accredited and have an established transfer relationship with a nearby hospital. The law does not specify these criteria, either.
- **Increasing payments to nonphysicians.** Medicare payments to certified nurse midwives (CNMs) will reach the rate paid to 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 practitioner recognized under state law, whether or not the plan contracts with that individual or type of provider. Certified professional midwives (lay midwives) are licensed in 21 states, and this provision may give them significant new entry.

ObGyns stop delivering babies at increasingly early points in their career, and only 13% of family physicians deliver babies today. So we need to find ways to extend our care—and increasing collaborative practice between ObGyns and CNMs and certified midwives may help close this gap. The increased focus on midlevel providers in the law may present us with both a challenge and an important opportunity.

4 What services will be fully covered now?

OBG MANAGEMENT: Beginning this year, health plans will be required to provide a



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minimum level of coverage without cost-sharing for preventive care and screenings for women, among others. What will this requirement encompass?

DiVenere: Congress emphasized prevention in the reform law as part of its strategy to bend the cost curve, investing in prevention in order to reduce higher spending on illness.

Beginning in September 2010, all plans—including those that existed before this law was passed—must cover preventive health services without any patient cost sharing, whether copayments or deductibles. These services include women's preventive care and screening included in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), even if they are more extensive than services recommended by the Centers for Disease Control and Prevention (CDC) and US Preventive Services Task Force (USPSTF). Breast cancer screening, mammography, and prevention services are covered as though the November 2009 USPSTF recommendations suggesting limits on mammography screening for certain age groups did *not* exist.

The mammography screening coverage was a big win for ACOG. We worked closely with Senator Barbara Mikulski (D-Md.) on this amendment, and it was the first Democratic amendment offered. It passed on the Senate floor during a contentious floor fight.

ACOG continues to recommend screening mammography every 1 to 2 years for women 40 to 49 years old; annual screening for women 50 and older; clinical breast examination every year for women 19 years and older; and regular breast self-examination.

The Senate bill that was brought to the floor would have limited women's preventive care to USPSTF recommendations only. Working with Senator Mikulski, we made sure that women younger than 50 will be covered for mammography every 1 to 2 years.

OBG MANAGEMENT: Are there other important benefits for women included in the law?

DiVenere: Yes. One provision will improve research, screening, and treatment for postpar-

tum depression, a signature issue of ACOG President Gerald F. Joseph Jr., MD, during his presidential year. ACOG and Dr. Joseph worked closely with Senator Bob Menendez (D-NJ) to introduce the Moms Act and win its inclusion in the health reform law.

Under this section, HHS will:

- conduct research into the causes of, and treatments for, postpartum conditions
- create a national public awareness campaign to increase knowledge of postpartum depression and postpartum psychosis
- provide grants to study the benefits of screening for postpartum depression and postpartum psychosis
- establish grants to deliver or enhance outpatient, inpatient, and home-based health and support services, including case management and comprehensive treatment services for women with or at risk of postpartum conditions.

5 Will expanded coverage improve birth outcomes?

OBG MANAGEMENT: Do you expect that guaranteed coverage of pregnancy will increase the number of women who seek prenatal care—as opposed to waiting until labor begins—to see a doctor? Will guaranteed coverage of pregnancy improve birth outcomes over the long term?

DiVenere: Those are certainly the goals. And guaranteed coverage of pregnancy was one of ACOG's essential elements in health care reform. Prenatal care has been shown to save \$3 for every \$1 spent in the Medicaid program and continues to be the primary way to identify problems during pregnancy, giving ObGyns the opportunity to assess and manage the risk of preterm labor and other threats to the health of the mother and baby.

The health reform law recognizes that better prenatal care can lead to healthier babies—both in its coverage of maternity and preventive care, and by new Medicaid coverage of smoking-cessation counseling and family planning, both beginning this year.



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Medicaid will now cover the costs of diagnostic, therapeutic, and counseling services, as well as pharmacotherapy for pregnant women covered by Medicaid, at no cost to the patient. Before health reform passed, only 24 states reimbursed ObGyns and other physicians for smoking-cessation counseling for pregnant women. Five states didn't cover any smoking-cessation services at all.

Also beginning this year, states can provide family planning services to nonpregnant women up to the same eligibility levels to which they cover pregnant women, without the need to apply for federal waivers or permission. Forty-five states extend Medicaid coverage to pregnant women who have incomes above the regular Medicaid eligibility levels, from a low of 150% to a high of 300% of the federal poverty levels.

Before this new law, 27 states had federal waivers to provide family planning to women who had an income above the Medicaid eligibility levels, most of them at or near 200% of the federal poverty level. Eleven of these waivers expire this year.

6 Is femaleness a “preexisting condition”?

OBG MANAGEMENT: During the debate on health reform, many people claimed, somewhat facetiously, that female sex has been a preexisting condition. The new law will ensure that patients can't be dropped by their insurance company—or denied coverage—for arbitrary or unfair reasons, such as preexisting conditions. How are these changes likely to affect women and their ObGyns?

DiVenere: The insurance reforms in the new law are very important to women and to ObGyn practices. In fact, the prohibition on preexisting conditions was a top priority of ACOG's “Health care for women, health care for all” campaign, and Congress included this provision with women's health in mind.

Many members of Congress were shocked to learn that it was not unusual for insurers to deny coverage to women who were pregnant, who had had a previous cesarean

delivery, or who had been the victim of domestic violence at some point in their history. In fact, almost any medical history, genetic information, disability, or current health condition was grounds for denial of coverage.

Women were also often charged higher premiums than men for the same coverage. And insurance companies would sometimes require waiting periods for coverage—sometimes as long as 9 months.

All of these practices are outlawed by the health reform law, which prohibits plans from using preexisting condition exclusions to deny children coverage as of September 1, 2010 and adults as of January 1, 2014. Beginning on January 1, 2014, women cannot be denied coverage due to pregnancy, previous cesarean delivery, or domestic violence, or medical history, among many other reasons.

Effective March 23, 2010 and ending January 1, 2014, a high-risk pool insurance program has been created for people who have been uninsured for 6 months and who have a preexisting condition. Funding for the temporary risk pool is capped at \$5 billion.

Insurers in the small and individual markets and in the exchanges cannot discriminate on the basis of medical history or other variables; may only charge limited premium differentials for age, family size, and smoking, but not for gender; and cannot mandate a waiting period longer than 90 days.

Insurance plans that were in existence *before* enactment must comply with reforms on waiting periods; lifetime limits; rescission; extension of dependent coverage; uniform explanation of coverage; and loss ratio reporting and premium rebates. Group grandfather plans must also comply with restrictions on annual limits and preexisting conditions.

All these protections should benefit ObGyn practices by ensuring coverage and continuity of care for their patients.

7 What happened to tort reform?

OBG MANAGEMENT: No tort reform was included in the law. Why not?

DiVenere: The law authorizes HHS to award \$50



As of January 2014, health insurance plans cannot use preexisting condition exclusions to deny women coverage due to pregnancy, previous cesarean delivery or domestic violence, or medical history, among other reasons

million over 5 years, up to \$500,000 per state, to develop, implement, and evaluate alternative medical liability reform initiatives that meet several specific criteria. Medical liability protections under the Federal Tort Claims Act are extended to officers, governing board members, employees, and contractors of free clinics.

We at ACOG were very disappointed that Congress didn't take a serious step toward medical liability reform in this bill. Liability reform was one of ACOG's five essential elements of health reform, and its absence from the final bill was a prominent reason why we ultimately "reluctantly opposed" passage. We, and the rest of the House of Medicine, were clear that health reform wouldn't work without meaningful medical liability reform.

ACOG supports caps on noneconomic damages and other reforms in California and Texas law. We also support testing alternatives, including health courts, alternative dispute resolution, "Sorry Works!" programs, and birth injury compensation funds. But this part of the health reform law requires that tests be linked to patient safety, an association that is impossible to establish in cases of neonatal encephalopathy. The law also requires that patients be allowed to opt out of a system if they choose to go to court. Both of these requirements hamper the development of meaningful alternatives for the ObGyn specialty.

8 Is the system repairable?

OBG MANAGEMENT: Can the US health care system be fixed in one fell swoop?

DiVenere: ACOG pursued two integral missions in reform efforts: improving women's health and advocating for practicing ObGyns. Our mission in women's health included guaranteed maternity care, important insurance reforms, and direct access to ObGyns. Our mission in regard to practicing ObGyns included the protection of ultrasonography, the reform of medical liability laws, and repeal of the Medicare sustainable growth rate, along with an array of other issues, all of which were shared by the entire House of Medicine.

We see these missions as integral; Congress saw them as separable. We were largely successful on the women's health side of the ledger. But Congress responded to the House of Medicine issues with little interest.

We believe that we can fulfill our mission to women's health only if the issues of practicing ObGyns are addressed in the process. You can't build a new health care system on a broken medical liability system or a broken Medicare physician payment system, and we still have both. We have a lot more work to do on these issues and the myriad of other issues that need to be addressed. This is really just the beginning of health reform.

9 Has PQRI regained the limelight?

OBG MANAGEMENT: The Medicare quality reporting incentive payments under the Physician Quality Reporting Initiative (PQRI) have been extended. In fact, physicians will be penalized, beginning in 2015, if they do not participate. Are the incentive payments a good thing for ObGyns?

DiVenere: Yes, a big change is coming in this program. ObGyns who participate in PQRI will be eligible to receive bonus payments of 1% in 2011 and 0.5% from 2012 to 2014. Payments will be *reduced* by 1.5% in 2015 and by 2.0% in 2016 for physicians who don't participate in the PQRI program.

Beginning in 2012, PQRI participation becomes a meaningful use qualifier for EHR grants.

In 2011 to 2014, physicians who complete Maintenance of Certification (MOC) are eligible for an additional 1% bonus in 2011 and 0.5% bonus in 2012 to 2014. Data on a physician's quality measures must be submitted on the physician's behalf by the MOC program. After 2014, the Secretary of HHS can add MOC completion to the quality measures used for the value-based payment modifier. The American Board of Obstetrics and Gynecology hasn't yet qualified its MOC for this part of the program.

ObGyn participation in the PQRI pro-



The law authorizes Health and Human Services to award \$50 million over 5 years for the development, implementation, and evaluation of alternative medical liability reform initiatives

gram is very limited (less than 10%). While only about 25 of the 215 PQRI quality measures apply to ObGyn care, most are easily applicable, and a physician needs to report on only three to five measures to qualify for the program.

The very low participation rate is likely because many ObGyn practices just didn't think the incentive payment was worth the trouble. They may need to rethink that math once they're faced with payment cuts in 2015.

ObGyns should also be aware that the Secretary of HHS, with input from stakeholders, will set up a Physician Compare Web site (modeled after the program that already exists for hospitals) using PQRI data. Data will be made public on January 1, 2013, comparing physicians in terms of quality of care and patient experience.

The Secretary must ensure that the data are statistically valid and risk-adjusted. In addition, the physician must be given time to review the information before it becomes public, and data must ensure appropriate attribution of care when multiple physicians and other providers are involved. The Secretary must also give physicians timely performance feedback.

For all these reasons, ACOG is working with the physician community to make a number of improvements to the PQRI program, doing our best to make it as easy as possible for our members to participate and benefit.

10 What effect will the expansion of Medicaid have on ObGyn practice?

DiVenere: Starting in 2014, the same year that state exchanges are expected to be established, Medicaid eligibility will be broadened to cover all individuals younger than 65 years who have incomes up to 133% of the federal poverty level. All newly eligible adults will be guaranteed a benchmark benefit package that provides the essential health benefits.

States that have already expanded eli-

gibility to adults who have incomes up to 100% of the federal poverty level will receive a phased-in increase in the federal medical assistance percentage so that, by 2019, they will receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later). And states have the option to expand Medicaid eligibility to childless adults as of April 1, 2010, but will receive their regular federal medical assistance percentage until 2014.

Although these changes will broaden the range and increase the number of individuals who will be eligible for Medicaid, the effect on ObGyn practice remains to be seen, especially as pregnant women who were covered by Medicaid at income levels above 133% of the federal poverty level transition off of Medicaid and into private health insurance offered in the exchanges.

Today, about 38% of all ObGyns accept Medicaid gynecologic patients, and 44% accept Medicaid obstetric patients. Medicaid accounts for 18% of revenues of the average ObGyn practice.

11 Will the extension of benefits to young adults have a measurable impact on ObGyn practice?

DiVenere: Congress included two provisions to target "young immortals," young adults who don't think they need health insurance because they're young and healthy and never need to see a doctor. Many young adults are not offered employer-based health insurance, and many see no advantage in buying coverage that they don't expect to use. But we all know that someone pays when any uninsured person falls sick or has an accident that necessitates medical care.

Beginning this year, adult children as old as 26 years can go onto their parents' health insurance plan. In addition, catastrophic plans will soon be available to individuals younger than 30 who want to purchase a higher deductible plan through their state exchange or on the individual and small group markets. These catastrophic plans are



The Health and Human Services Secretary will set up a Web site, using PQRI data, that compares physicians in terms of quality of care and patient experience

not required to include the essential benefits package, including maternity care. Nevertheless, both of these provisions should be helpful to ObGyn practices.

12 Will the mandate for employers to provide health insurance affect many ObGyns?

DiVenere: The employer mandate takes effect in 2014, when employers with more than 50 employees, at least one of whom receives a premium tax credit, are required to offer health insurance coverage to employees or be assessed a range of fees. Employers that have 50 or fewer employees are exempt from this requirement.

In 2007, 75% of ObGyn practices had fewer than 42 full-time employees, with an average number of full-time employees, including physicians, of 34.4. So this mandate should not apply to the average ObGyn practice.

A range of small business tax credits for employers that contribute at least 50% of the cost of coverage for their employees will also be available, with credits phasing out as the size of the firm and the average employee wage increase.

13 Who will benefit from the Medicare geographic payment adjustments?

DiVenere: The increased Medicare geographic practice cost index (GPCI) payments and new Frontier payments won't affect many ObGyns nationally, but they are likely to affect most ObGyns in the related rural locations.

The law reestablishes the national average floor on Medicare's GPCI for physician work. In 2010 and 2011, Medicare makes a separate adjustment for the practice expense portion of physician payments that will benefit physicians in rural and low-cost areas.

Beginning in 2011, a third adjustment will increase the practice expense GPCI for physicians in frontier states. A frontier state

is one in which at least half of its counties have populations smaller than six people per square mile. Frontier states are expected to be Montana, North Dakota, South Dakota, Utah, and Wyoming.

Physicians in 51 localities in 42 states, Puerto Rico, and the Virgin Islands will benefit from the two practice expense adjustments.

ObGyns should also know about two other payment changes:

- The HHS Secretary will create and apply to Medicare provider payments a value-based modifier that will result in higher Medicare payments for high-quality, low-cost physicians and lower payments for high-cost, low-quality physicians. The modifier is to be based on a composite quality score and a composite cost score determined by measures selected by the HHS Secretary and endorsed by a consensus organization. This change begins with 2015 Medicare payments and applies only to physicians in 2015. In 2017, it will also apply to other health professionals.
- Effective immediately, the HHS Secretary has the authority to increase or decrease Medicare relative values, and payments for services, with special attention focused on:
 - services that have high growth rates
 - services that have seen substantial changes in the practice expense or work components
 - services for which new technology has reduced costs
 - instances in which multiple codes are frequently billed for a single service
 - codes that have not been reviewed since implementation of the resource-based relative value scale (RBRVS).

ObGyns who participate in Medicare will start receiving individual physician resource use reports in 2012. These reports will compare per capita utilization of physicians (or physician groups) with the utilization rate of physicians who see similar patients. Reports are required to be risk-adjusted



The Health and Human Services Secretary now has authority to increase or decrease Medicare relative values, and payments, for services

and standardized to take into account local health-care costs.

14 Do you expect the law's requirements for "administrative simplification" to reduce overhead and increase efficiency?

DiVenere: Don't we all hope so.

The bill contains several requirements such as:

- establishment of a standardized claim form
- streamlining of claims processing
- improvement of interoperability to allow for more electronic information sharing.

These changes will not be implemented until 2013 at the earliest.

Today, about 34% of all ObGyn practices use electronic health records. The system-wide benefits of health information technology (HIT) can be many. Insurers can save by reducing unnecessary tests. Patients can benefit from better coordination of care and fewer medical errors. But these advantages don't necessarily translate into savings or revenue for physician practices.

Instead, physicians face Medicare and private insurance payment cuts. Little assistance is available for the investment in HIT. And uncertain interoperability standards and rapid technological changes can very quickly make this year's investment obsolete. Many physicians in solo and small practices are understandably reluctant to take the HIT plunge.

The initial cost of purchasing HIT for a small practice is typically at least \$50,000 per physician. Physicians face additional, ongoing costs in staff training and hardware and software updates as well. And many physicians see significant efficiency losses for months and sometimes years after upgrading to an electronic health record system.

Still, with interoperable, shareable

electronic records, all physicians treating a particular patient can have the full story. A patient's paper record kept in her physician's office shows only a slice of her medical history, potentially missing important information from the patient's other physicians, including allergies to medication, test results, and the results of particular therapies.

Without a shared electronic record, a physician relies on the recollection of each patient, which is often unintentionally incomplete. A patient may be uncertain about the name or dosage of a medication, fail to remember the date of a screening examination, or lack results of lab tests ordered by another physician.

A physician's access to the full story with shareable electronic records is important to the care of all patients and can be particularly relevant for patients who have inconsistent contact with health care providers. Often, these patients get care in various settings, including physician offices, community clinics, and emergency departments. Because these patients tend to have a higher incidence of chronic disease, they may greatly benefit from the sharing of medical information.

Clearly, Congress wants to move us to full adoption of HIT. Beginning in 2013, all plans must comply with a uniform standard for electronic transactions, including eligibility verification and health claims status.

In 2014, uniform standards must allow automatic reconciliation of electronic funds transfers and HIPAA payment and remittance; use standardized and consistent methods of health plan enrollment and claim edits; use unique health plan identifiers to simplify and improve routing of health care transactions; and use standard electronic claims attachments.

Uniformity and standardization can help address one of the major roadblocks to physician adoption of health information technology. 📍



Only about 34% of all ObGyn practices use electronic health records today