REPORT OF THE
SECRETARY OF HEALTH AND HUMAN RESOURCES

Report of the Governor's Work Group on Rural Obstetrical Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Office of the Governor

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October 29, 2004

The Honorable Mark R. Warner
Governor, Commonwealth of Virginia
State Capitol, 3rd Floor
Richmond, Virginia 23219

Dear Governor Warner:

I am pleased to submit the Final Report of the Governor's Work Group on Rural Obstetrical Care. Since submitting our interim report to you on July 1, the Work Group undertook an ambitious agenda of research and assessment. We heard testimony in town hall meetings, during a statewide video conference, and through e-mail, from more than 1,000 concerned Virginians.

The Final Report presents a series of recommendations in six key policy areas: eligibility; reimbursement; insurance; evidence-based practice and licensure; birth injury; and access to care. The Work Group believes action is needed on several fronts to have a meaningful and enduring impact on improving access to prenatal, obstetrical, and pediatric services.

Thank you again for the opportunity to chair the Rural Obstetrical Services Work Group. The range of ideas and perspectives your appointees expressed enhanced the recommendations we present to you through this final report. I also want to thank the members of the General Assembly on the Work Group, who actively participated in the dialogue and provided valuable insight.

The staff support from the Governor's Policy Office, Bureau of Insurance, Department of Medical Assistance Services, and the Virginia Department of Health was superb.

Sincerely,

Jane H. Woods
Secretary of Health and Human Resources
Chair, Rural Obstetrical Services Work Group

cc: The Honorable Vincent F. Callahan, Jr.
Chairman, House Appropriations Committee

The Honorable John H. Chichester
Chairman, Senate Finance Committee

The Honorable Phillip A. Hamilton
Chairman, House Committee on Health, Welfare, and Institutions

The Honorable H. Russell Potts, Jr.
Chairman, Senate Committee on Education and Health

The Honorable Harvey B. Morgan
Chairman, Joint Commission on Health Care

The Honorable William H. Leighty, Chief of Staff
Office of the Governor

William Murray, Deputy Policy Director
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Patrick W. Finnerty, Director
Department of Medical Assistance Services

Robert B. Stroube, MD, MPH, Commissioner
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Bureau of Insurance

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ACKNOWLEDGEMENTS

I want to thank Governor Warner for his leadership in creating the Work Group on Rural OB Care and for his support in taking emergency action to improve reimbursement based on our interim report and to thank the General Assembly for including budget language concerning the importance of this issue.

The work represented in this report would not have been possible without the sustained effort of the many dedicated members of the Governor's Work Group on Rural OB Care. To the entire Work Group, Virginians owe a debt of gratitude. In particular, Senator Hanger and Delegates Morgan, Pollard, and Hurt were active contributors to the deliberations that produced the recommendations contained in the report. I am particularly grateful that so many of the Work Group members who are health care providers took time from patient care to assist us in providing an essential perspective. I also want to acknowledge the leadership provided by subcommittee chairs Mark Rubin, Chris Bailey, Dr. Jerry Lucas and Dr. Bill Nelson.

The Work Group was the beneficiary of valuable information, data, and analysis from a number of organizations without whose assistance this report's recommendations could not have been crafted. Specifically, the support of Virginia Health Information, Inc., Virginia Hospital and Healthcare Association, Bureau of Insurance, March of Dimes, Virginia Department of Medical Assistance Services and Virginia Department of Health was critical to our success.

I am deeply appreciative of the dedication and professionalism of staff that supported the Work Group. Bill Murray in the Governor's Office lent wise counsel and assistance in the process at key points in the group's deliberations. He personally traveled to distant parts of the state to hear first hand from stakeholders. Lyn Hainge, who drafted this report to fulfill the requirements for a graduate study at George Mason, had no idea what she was signing on for. Lyn did a great job of integrating the work of the subcommittees into a very readable and well-organized document.

Eric Lowe and Carol Howard from the Bureau of Insurance provided the Work Group with valuable insight into the very complex issue of medical malpractice insurance. Pat Finnerty and his staff in the Department of Medical Assistance Services, including Cheryl Roberts, Wayne Turnage, Kelly Gent, Steve Ford, Adrienne Fegans, Carla Russell, Gerald Craver, and Chris Schroeder provided support of the highest quality to the subcommittees and also organized the logistical support for the town hall meetings. The Virginia Department of Health provided phenomenal support for this effort. Dr. David Suttle, Joan Corder-Mabe, and Joe Hilbert helped the Work Group to successfully navigate the myriad of important issues and factors that influence the quality of prenatal, obstetrical, and pediatric care. I also want to thank Julie Pettry for her support in so many ways from meeting logistics to producing minutes of the Work Group's decisions to final production of this report.

I also owe many thanks to the staff in my office for the enduring support and encouragement they provide me daily.

Finally, I want to thank our State Health Commissioner, Dr. Robert Stroube, for loaning me Jeff Lake to work on this initiative. Jeff's ability to maintain positive and balanced professional relationships with stakeholders and his commitment to finding common ground contributed substantially to the Work Group maintaining its momentum and reaching consensus on the key issues contained in this report.

Jane H. Woods
Secretary of Health and Human Resources

EXECUTIVE SUMMARY

Almost 100,000 babies are born every year in Virginia. These children represent the future generation of our state's leaders. All Virginians have a vested interest in assuring a statewide health care system that includes ready access to care that is of high quality, accessible, and affordable for pregnant women and infants who need it. Assuring a statewide system of prenatal, obstetrical, and pediatric care supports society's goal that all infants are born full-term and healthy.

Healthy babies start life with an advantage in terms of readiness to learn, productivity, and quality of life. Such an advantage benefits not only individuals, but also the Commonwealth. By assuring that we have a statewide system of care, Virginia secures a competitive economic benefit from two perspectives. First, Virginia is better able to attract companies and a work force that includes young families who use these services. Second, more full-term, healthy births reduce the number of babies born who require neonatal intensive care. It has been estimated that neonatal intensive care is as much as fifty times more expensive than a birth not requiring this level of care. Between 35 and 40 percent of Virginia's 100,000 births each year are paid for by the State through its Medicaid program.

The challenges faced by babies born at very low birth weights (less than 3.3 pounds) often follow them throughout life. The result is that a larger than expected number of these children experience delay in speech, motor, and cognitive development that influence not only a child's readiness to learn and earn, but also is associated with higher than average life time health care expenditures.

Virginia's statewide system of prenatal, obstetrical, and pediatric care is unraveling. The effects have already been felt most acutely in rural areas and suburban and urban communities are now experiencing problems for many women seeking this care. Many have termed the concurrent stresses on the system of care a "crisis." Inadequate reimbursement, increasing medical malpractice premiums, and growing numbers of uninsured, have led to fewer services and women traveling greater distances to use the services that remain.

Several small community hospitals have stopped providing obstetrical care and now deliver babies only in their emergency rooms for patients who present with delivery imminent. More patients than ever are finding it necessary to use ambulances as the way to get to the hospital where they will deliver because of the distance involved. Obstetricians have stopped providing coverage for family practice physicians willing to deliver babies or have stopped supervising certified nurse midwives. Others have limited their care to gynecologic procedures as a way to reduce their malpractice insurance premiums. Reports have circulated that obstetricians are leaving to practice outside Virginia. Pediatric practices have closed in underserved areas and others have limited their Medicaid participation. Consumers, providers, payers, and insurers have struggled with what should be done to stabilize and improve access to quality prenatal, obstetrical, and pediatric services.

In March 2004, Governor Warner issued Executive Directive 2 (ED2), which created the Governor's Work Group on Rural Obstetrical Care. He charged the group with four duties:

1) Review relevant executive branch policies that may serve as an impediment to providing needed care in rural areas of the Commonwealth;
2) Develop the executive branch response to legislatively mandated studies and coordinating the executive branch's response to and work with any other study groups examining similar issues;
3) Review best practices in other states; and
4) Make policy recommendations as may seem appropriate to the Governor and General Assembly regarding improving access to care in rural areas.

The Governor appointed Secretary of Health and Human Resources Jane Woods to Chair the Work Group.

In May 2004, the General Assembly adopted budget language in Item 298 directing the Secretary of Health and Human Resources to report on the availability of obstetrical services in the Commonwealth and identify any areas of the Commonwealth where there is inadequate access to such services. The report is to include information on the factors contributing to inadequate access to services; the availability and affordability of malpractice insurance for obstetricians; any specific problems regarding access to obstetrical care for Medicaid and Family Access to Medical Insurance Security (FAMIS) enrollees; as well as an assessment of the degree to which these factors may be contributing to the lack of access to obstetrical care in certain areas of the Commonwealth. The Secretary is to make recommendations on actions that can be taken to improve access to obstetrical care throughout the Commonwealth.

This report addresses both these mandates. Membership on The Governor's Work Group on Rural OB Care was expanded to include General Assembly members as well as individuals and organizations that represented communities and interests in urban and suburban areas. The work group was committed to feedback from stakeholders and offered the opportunity for public comment at each of its four meetings, through six town hall meetings around the state, during a statewide video conference at 25 locations, and via a public e-mail address monitored daily. We heard from more than 1,000 Virginians between May and mid-October.

The Work Group issued an Interim Report on July 1, 2004. Based on recommendations in that report, the Governor provided emergency authority and funding, effective September 1, 2004, for the Department of Medical Assistance Services (DMAS) to increase the Medicaid payment rates for outpatient Obstetrical and Gynecological services by 34 percent through the emergency regulation process.

The work group offers recommendations across six policy areas including eligibility for services, reimbursement levels, medical malpractice, license/scope of practice, birth injury, and improving access to care. While diverse in their opinions as to both causes and solutions to stabilize and improve our current situation, Work Group members are unanimous in their view that action is needed on several fronts for a meaningful and enduring improvement in access to prenatal, obstetrical, and pediatric services.

The report is organized by these six policy areas and is introduced by background material the Work Group believes is essential to understanding the context in which prenatal, obstetrical, and pediatric services are delivered in the Commonwealth today. The report also includes appendices and citations for readers who wish to more fully examine the source data on which the Work Group's recommendations are based.

Finally, the Work Group believes that further work is needed to establish measures that assess the impact of the investment and policies we are advancing in this report. Examples of such metrics include: stemming the tide of sole community hospitals deciding to discontinue providing obstetrical services; reducing travel time for women who need prenatal and obstetrical care; improving participation by licensed providers in the Medicaid and FAMIS programs; enhancing compliance with recommended prenatal and EPSDT services, and ultimately leading to healthier babies and children. A report on whatever measures are ultimately adopted should be made to the Governor and General Assembly every two years.

RECOMMENDATIONS

Recommendation # 1 (Eligibility)

- Increase the income standard for pregnant women to 200 percent of the federal poverty level (FPL). Women between 133 percent FPL and 200 percent FPL will be enrolled in SCHIP to leverage federal funds (66 percent federal share versus basic Medicaid program federal share of 50 percent).
- Implement the "no wrong door" program which allows central registration of all eligible women within 10 days of applications for either Medicaid or SCHIP (FAMIS).

Recommendation # 2 (Eligibility)

- DMAS should study the feasibility of extending Medicaid emergency services to cover prenatal care for lawful permanent residents and to extend similar services to undocumented women to the extent permitted by federal law.
- DMAS shall report its findings to the Secretary of Health and Human Resources no later than December 1, 2005.

Recommendation # 3 (Eligibility)

The Subcommittee recognizes the need for adequate dental and substance abuse services available for pregnant women in the Medicaid and FAMIS programs and recommends that DMAS fund these services due to their impact on successful gestation and delivery.

Recommendation # 4 (Reimbursement)

Beginning July 1, 2005, the Medicaid Physician Fee Schedule for OB/GYN services should be increased by 8.14 percent above the schedule that became effective September 1, 2004. This applies to all licensed providers who bill under these codes. This increase would bring the total increase for OB/GYN services to 44.91 percent, compared to the July 1, 2004, payment levels, and would make Medicaid payment rates for these services equal to the "Medicare equivalent."

Recommendation # 5 (Reimbursement)

Beginning July 1, 2005, the Medicaid Physician Fee Schedule for Pediatric services should be increased by 44.91 percent above the schedule currently in effect. (This applies to all licensed providers who bill under these codes.) This increase would make Medicaid payment rates for these services equal to the "Medicare equivalent."

Recommendation # 6 (Reimbursement)

DMAS should increase Medicaid inpatient hospital payment rates for obstetrical-related services by 33.33 percent effective not later than July 1, 2005, and earlier if the Governor determines that emergency funding is indicated. This increase would ensure that Medicaid hospital payments for obstetric services were sufficient to cover Medicaid allowable costs in the aggregate.

Recommendation # 7 (Reimbursement)

Beginning July 1, 2005, the Resource Based Relative Value Scale (RBRVS)-based fees within the Medicaid Physician Fee Schedule should be adjusted annually for inflation.

Recommendation # 8 (Medical Malpractice)

Amend §38.2-231 of the *Code of Virginia* to extend the current 45-day notice requirement to 90 days when a medical malpractice insurance policy is not renewed or is cancelled, or the insurer proposes a premium increase of more than 25 percent.

Recommendation # 9 (Medical Malpractice)

Amend Title 38.2 of the *Code of Virginia* to require insurers to report "closed claims" as previously required under repealed § 38.2-2228. Include language that allows insurers to report the information electronically to the Bureau of Insurance.

Recommendation # 10 (Medical Malpractice)

Request that the Special Joint Subcommittee Studying Risk Management Plans pursuant to Senate Bill 601 consider the feasibility of extending the provisions of the Virginia Tort Claims Act to selected licensed providers of obstetrical and gynecological services. This request will be made by letter from the Secretary of Health and Human Resources to the Chairman of the Joint Subcommittee.

Recommendation # 11 (Medical Malpractice)

Amend Title 38.2 of the *Code of Virginia* to require all licensed insurers to have in place a rule allowing job-sharing under a full-time equivalent rating rule and that all licensed insurers be required to offer a credit for part-time practice for licensed providers of obstetrical and gynecological services.

Recommendation # 12 (Medical Malpractice)

- Establish a medical malpractice insurance premium subsidy program for sole community hospitals and licensed providers of obstetrical services whose practice includes a specified percentage of uninsured and Medicaid patients. The program would be administered by the Department of Treasury's Division of Risk Management and implemented by July 1, 2006.
- In the second year of the program, the Division of Risk Management shall work with the physician community to develop a provision whereby licensed OB providers would have to follow evidence-based practice guidelines in order to qualify for the subsidy. The Division of Risk Management shall submit a report to the Governor, and the Chairman of the Senate Finance Committee, the Senate Education and Health Committee, the House Appropriations Committee, and the House Health, Welfare and Institutions Committee by October 1, 2005, outlining how it proposes to implement and administer the subsidy program.
- Include $2,000,000 GF and language in the Appropriation Act to authorize and implement this program.

Recommendation # 13 (Practice/Licensure)

Promote a model of prenatal, delivery, and postnatal care that is centered on evidence-based health care practices and outcomes. Wherever possible, evidence-based health care should be incorporated into decisions making or changing health policy.

Recommendation # 14 (Practice/Licensure)

- To encourage the practice of evidence-based prenatal and obstetrical care, all obstetrical providers licensed in the Commonwealth of Virginia should follow the Guidelines for Perinatal Care adopted jointly by the American College of Obstetrics and Gynecology and the American Academy of Pediatrics (for physicians) or The Standards of Midwifery Practice (for Certified Nurse Midwives), if these Guidelines are consistent with good clinical judgment.
- The Secretary shall request that the 2005 General Assembly adopt a joint resolution acknowledging the importance of these Guidelines and encouraging appropriate professional associations to disseminate these guidelines to their members.

Recommendation # 15 (Practice/Licensure)

- Health care organizations and appropriate state agencies should explore opportunities to develop an electronic health record system to support evidence-based practice and that complies with HIPAA and other national standards.
- The Secretary of Health and Human Resources shall work with agencies within the Secretariat to link public and private providers and health systems to maximize resources and experience and shall report to the Governor by December 15, 2005.

Recommendation # 16 (Practice/Licensure)

- A universal risk screening assessment tool for pregnant women should be developed and incorporated into the electronic record system.
- VDH should take the lead in developing this tool in consultation with academic medical centers, community hospitals, obstetricians, certified nurse midwives and others as needed.

Recommendation # 17 (Practice/Licensure)

- VDH should implement, in one or more pilot sites, an alternative system of prenatal and obstetrical services in areas that are experiencing severe problems in accessing such care. The purpose of the pilots is to demonstrate the effectiveness of a new practice paradigm among obstetric providers designed to increase access to high quality pregnancy-related care.
- Each pilot project will be overseen by one or more obstetricians at a Level III Perinatal Center and will also assure that certified nurse midwives work in collaboration with physicians in close proximity to the midwives' practice.
- In the pilots, Certified Nurse Midwives (CNMs) would practice in collaboration and consultation with physicians in close proximity who would agree to be a referral source as stipulated in a mutually agreed protocol consistent with the evidence-based practice.
- VDH should convene stakeholders including, but not limited to, obstetricians, family practitioners, and licensed nurse midwives to define the protocol to be used in the pilot not later than September 1, 2005. The protocol will determine, among other things, how "collaboration and consultation" will be defined for the pilots.
- For pilot sites that elect to include birthing centers as part of the system of care, these centers must be in close enough proximity to a health care facility equipped to perform emergency surgery if needed. Any birthing center that is part of the pilot licensure must, at minimum, maintain membership in National Association of Childbearing Centers (NACC) and annually submit the following information to the State Health

Commissioner: 1) a survey of birth center operations, 2) outcome indicators and 3) data presented according to the NACC Uniform Data Set. Consideration should be given to establishing state regulations for licensure of birthing centers.

- The licensing of birth centers, if implemented, is not intended to alter in any way existing provisions of the Certificate of Public Need. Pilot site(s) are encouraged to include the use of telemedicine in the execution of their pilot project(s.)
- VDH shall report to the Secretary of Health and Human Resources in December 2007 on outcomes of the pilots and recommend any additional regulatory or administrative revisions needed.

Recommendation # 18 (Practice/Licensure)

Amend the *Code of Virginia* to allow Certified Nurse Midwives (CNMs) to practice with physician collaboration, consultation, and referral statewide by eliminating language that requires supervision for CNMs.

Recommendation # 19 (Birth Injury Fund)

A uniform data collection tool should be adopted by the Workers' Compensation Commission for use by consultants evaluating medical records to determine whether children should be admitted to or denied access to the Virginia Birth-Related Neurological Injury Compensation Program. The form shall reflect criteria that are consistent with the existing provisions of the Virginia Birth-Related Neurological Injury Compensation Program and is intended to assist in assuring that decisions are as consistent as possible across the Commonwealth, recognizing that there are subtle differences in individual cases that require the exercise of medical judgment.

Recommendation # 20 (Birth Injury Fund)

Virginia Department of Health (VDH), the Board Of Medicine (BOM), University of Virginia, Virginia Commonwealth University, Medical College of Virginia, and Eastern Virginia Medical School, in collaboration with stakeholder organizations, shall develop a process and mechanism to: 1) collect and analyze their findings from Birth-Related Injury Compensation Program cases admitted on or after July 1, 2005, and 2) shall work with perinatal provider organizations to develop and disseminate reports on the factors in obstetrical care that contribute to adverse birth outcomes.

Recommendation # 21 (Birth Injury Fund)

BOM and VDH should fully implement the recommendations from the Joint Legislative Audit and Review Commission (JLARC) in its November 2002 "Review of the Virginia Birth-Related Neurological Injury Compensation Program" that call for routinely interviewing the claimant families about the events surrounding the births and notifying them about the outcome of the medical reviews.

Recommendation # 22 (Birth Injury Fund)

- VDH, through its health districts, shall initiate, and update as needed, (but not less frequently than every three years), memoranda of agreement with appropriate local obstetrical providers as specified by the Virginia Birth-Related Neurological Injury Compensation Program.
- The purpose of these agreements is to develop a plan to improve access for low income and uninsured women.

Recommendation # 23 (Improving Access to Care)

- Appropriate $440,000 GF annually to VDH to provide additional loan repayment specifically for licensed physicians providing OB/GYN services who agree to practice for a specified period of time in an area designated as having a shortage of physicians providing OB/GYN services.
- Work through Virginia's Congressional delegation to encourage federal designation of shortage areas specifically for obstetricians while assuring that such a carve-out from the current primary care category does not negatively impact federal designation of Health Professional Shortage Areas.

Recommendation # 24 (Improving Access to Care)

Support the use of telemedicine to increase access to university-based and other clinics perinatal services. VDH and DMAS should collaborate to develop strategies to assist communities and other entities to aggressively pursue funding for telemedicine. By December 1, 2005, these agencies shall report to the Secretary of Health and Human Resources on the number of additional telemedicine sites that have been added or increases in the use of existing telemedicine sites.

Recommendation # 25 (Improving Access to Care)

- Increase the availability of pre and post-natal care by VDH allocating new general funds appropriated in FY 06 specifically for that purpose to local health departments in areas identified as under served and to those districts whose current funding level does not permit them to provide direct care.
- To assure these funds are utilized, VDH should eliminate the requirement for local match funds for this particular use.

Recommendation # 26 (Improving Access to Care)

The Committee recognizes that a wide range of knowledge levels exists among Virginians regarding the components of good perinatal care, and that effective communication must incorporate variable health literacy levels as well as the cultural and linguistic characteristics of the audience (s). Therefore the Committee recommends that VDH should:

- Develop and implement a statewide outreach/education/public awareness campaign, incorporating culturally and linguistically appropriate materials, including but not limited to the topics of: options for prenatal care, birth choices, breastfeeding and the importance of dental care for pregnant women.
- Assure that relevant materials are translated via appropriate translation protocols and posted on the VDH website, available for download.
- Encourage the availability of interpreter services at all points of service.

- Encourage cultural competence training for health care providers, whether via continuing education or, in conjunction with the Council on Higher Education in Virginia, as part of the curriculum for students in the allied health professions at state-supported institutions.
- Work with the Board of Dentistry to establish a statewide outreach program targeting dentists and dental hygienists, with the objective of improving the oral health of pregnant women and babies.
- Distribute (including availability on the website) materials that encourage non-English speaking patients to learn English and identify local community learning opportunities.

Recommendation # 27 (Improving Access to Care)

Appropriate $120,000 GF over a two year period to support the Virginia Tech Transportation Institute project assessing the feasibility of statewide human services transportation programs. Case studies developed through the project should focus on areas of the state identified by the ED2 Work Group that appear to have the most significant distance/travel requirements to access obstetric services. The Institute shall submit an interim report of its findings to the secretary of Health and Human Resources not later than December 1, 2005, to be reviewed to determine if additional funding is necessary to improve access to obstetrical care.

Summary of Estimated Fiscal Impact of the Proposed Recommendations				
		SFY 2006 Fiscal Impact ($millions)		
Recommendation	**Description**	**GF**	**NGF**	**Total**
1	Increase the income standard for pregnant women to 200 percent of the federal poverty level (using SCHIP funds).	5.3	10.4	15.7
4	Increase the Medicaid Physician Fee Schedule for OB/GYN by 8.14 percent above the schedule that became effective September 1, 2004, the total increase for OB services to 44.91 percent. This amount includes the amount the Governor allocated to support September 2004 increase of 34%.	10.33	10.44	20.77
5	Increase the Medicaid Physician Fee Schedule for Pediatric services by 44.91 percent above the schedule currently in effect.	27.34	29.09	56.43
6	Increase Medicaid inpatient hospital payment rates for obstetrical-related services by 33.33 percent.	11.0	11.0	22.0
7	Adjust the Resource Based Relative Value Scale (RBRVS)-based fees within the Medicaid Physician Fee Schedule annually for inflation.	5.24	5.50	10.74
12	Include $2,000,000 GF and language in the Appropriation Act to implement a medical malpractice subsidy program.	2.0	0	2.0
24	Appropriate $440,000 GF annually to VDH to provide additional loan repayment for licensed physicians providing OB services in an area designated as having a shortage of physicians providing OB services.	0.44	0	0.44
25	Fund local health departments to provide prenatal services.	1.0	0	1.0
27	Appropriate $120,000 GF over a two year period to support the Virginia Tech Transportation Institute project.	0.12	0	0.12
Total		62.77	66.43	129.20

Historical Context

The Commonwealth has a compelling interest in maintaining a health care system that is adequate to assure that babies born in Virginia begin life as healthy as possible.

Access to obstetrical care appears to be cyclical. The last major disruption in obstetrical care occurred in the latter half of the 1980's when Medicaid reimbursement rates were too low to attract providers and insurance companies that wrote malpractice policies were leaving the Virginia market. It was considered a crisis in the *availability* of medical malpractice insurance, and the General Assembly took three actions at that time to address the crisis:

- Increased Medicaid payment rates
- Created the Virginia Birth-Related Neurological Injury Compensation Program
- Maintained a "cap" on medical malpractice awards

Furthermore, the issue of access to obstetrical care has been the subject of several studies or legislation by the General Assembly during the intervening years. This includes such actions as:

- Continued medical malpractice reform
- Continuation of caps on awards for medical malpractice
- A report on the Virginia Birth-Related Neurological Injury Compensation Program done by the Joint Legislative Audit and Review Commission (2002) and
- The establishment of a joint subcommittee which is currently studying issues surrounding risk management plans (SB 601)

Unlike the 1980's, the current crisis in obstetrical care is in large measure a result of issues related to *affordability* of remaining in practice, in particular higher medical malpractice premiums, increasing numbers of Medicaid and uninsured patients, and inadequate Medicaid reimbursement. Of the nearly 100,000 babies born each year in Virginia, between 35 and 40 percent are enrolled in Medicaid or FAMIS (Family Access to Medical Insurance Security - the Commonwealth's child health insurance program).

In the last 18 months, several sole community hospitals in Virginia have discontinued their obstetrical services and now deliver babies only in their emergency rooms when a woman presents with delivery being imminent:

- Bon Secours St. Mary's Hospital, Norton (November 2003)
- Russell County Medical Center, Lebanon (November 2003)
- Rappahannock General Hospital, Kilmarnock (March 2004)
- Alleghany Regional Hospital, Low Moor (April 2004)
- Buchanan General Hospital, Grundy (July 2004)
- Southern Virginia Regional Medical Center, Emporia (may discontinue obstetrical services in January 2005.)

Formation and Process of the Work Group

To address this problem, Governor Warner signed Executive Directive 2 (Appendix A), which directed the Secretary of Health and Human Resources (the Secretary) to convene and chair the Rural Obstetrical Services Work Group.

The Secretary was also directed to evaluate the obstetrical crisis in Item 298 of the 2004-2006 Appropriation Act. The Appropriation Act language (Appendix B) expands the review of obstetrical care to all areas of the state. Due to the similarity of the issues and to prevent duplication of efforts, the Secretary hereby issues one report to meet both the Executive Directive and Appropriation Act requirements.

The Governor appointed a Work Group which ultimately included 36 members (Appendix C). The Work Group was first convened on May 5, 2004, and held subsequent full meetings on June 9, September 2 and September 27, 2004. The membership included, among others, members of the Virginia General Assembly, physicians (including obstetricians, family practitioners, pediatricians, and neo-natologists), a certified nurse midwife, a certified professional midwife, trial attorneys, and representatives from state and local governments, non-profit organizations, the academic health centers, health care systems and provider and health plan associations. Staff support for the Work Group was provided by the Virginia Department of Health (VDH), the Department of Medical Assistance Services (DMAS), and the Bureau of Insurance (BOI.) The final report was drafted by graduate student at George Mason University.

To assure that input was received from affected stakeholders and interested members of the public, the Work Group held six town hall meetings during the month of July, 2004. Over 300 individuals attended, and their testimony provided important perspective to the work. Common themes were repeated through all of the sessions:

- Rising practice costs related to medical malpractice premiums and stagnant Medicaid reimbursement are creating significant pressure on physicians and hospitals that threatens access to care in several areas across the state.
- A combination of increasing Medicaid revenue and providing relief from the double digit annual increases in medical malpractice premiums would stabilize Virginia's system of prenatal, obstetrical and postnatal service delivery.
- Virginia's current requirement that certified nurse midwives work under the supervision of a physician restricts the role that these midwives could play in improving access to care, especially in rural areas.
- Changes are needed in Virginia's Medicaid program to expand eligibility for pregnant women.
- Greater support is needed for practitioners who provide a disproportionate level of care to the indigent, especially to health care providers who care largely for non-English speaking patients.
- Legalization for certified professional midwives
- Access to home birth services

The members embarked on an ambitious research agenda to evaluate four specific issues that directly influence the availability and affordability of obstetrical care: 1) quality of care, 2) reimbursement, 3) medical malpractice, and 4) barriers to access. To facilitate this work, the Secretary assigned four subcommittees to address each of these issues. (Committee membership, staff support, and a summary of committee meeting schedules may be found in Appendix D.)

An Interim Report was issued on July 15, 2004, and contained two Preliminary Recommendations:

> The Governor should provide emergency authority and funding for the Department of Medical Assistance Services to increase the Medicaid physician payment rates for Obstetrical and Gynecological services by 44.91 percent through the emergency regulation process.
>
> The Department of Medical Assistance Services should increase the income standard to allow pregnant women up to 200 percent of the federal poverty limit to be eligible for Medicaid benefits.

In response to the Work Group's interim report, Governor Warner issued emergency regulations on August 12 that increased Medicaid payments for outpatient obstetrical care by 34 percent, effective September 1, 2004.

Each subcommittee continued its deliberations after the Interim Report and made a series of recommendations to the Work Group. A consensus process resulted in 27 recommendations. In a few instances, the subcommittees or the Work Group, discussed issues but did not either issue specific recommendations or the recommendations were not endorsed by the Work Group. Key elements of the deliberations concerning these issues are included in this document (see Medical Malpractice Section and Licensure/Practice). Two members asked that their dissent with specific recommendations be included in the report and these statements are included in Appendix E.

The Work Group reached consensus at its September 27, 2004, meeting and the Secretary held a statewide via video-conference in 25 local health departments throughout the state on October 18, 2004, to hear public comment on the final 27 recommendations.

These final recommendations are the product of multiple strands of research combined with expert testimony and public comment. They are arrayed in six policy areas:

- Eligibility,
- Medicaid Reimbursement,
- Medical Malpractice Insurance,
- Practice & Licensure,
- Birth Injury Fund, and
- Improving Access to Care

Taken together, they present both short and long term approaches to assuring that quality, appropriate, timely, obstetrical care is routinely and reliably available throughout the Commonwealth.

Background

Obstetrical[1] (OB) providers throughout the Commonwealth are experiencing serious challenges to maintaining their practices, however, the impact of these conditions is most keenly felt in rural areas. Therefore some background on the location of rural areas, rural hospital OB unit closings, and the impact of travel time/distance to obtain OB care may be useful.

Rural Localities; Travel Distance

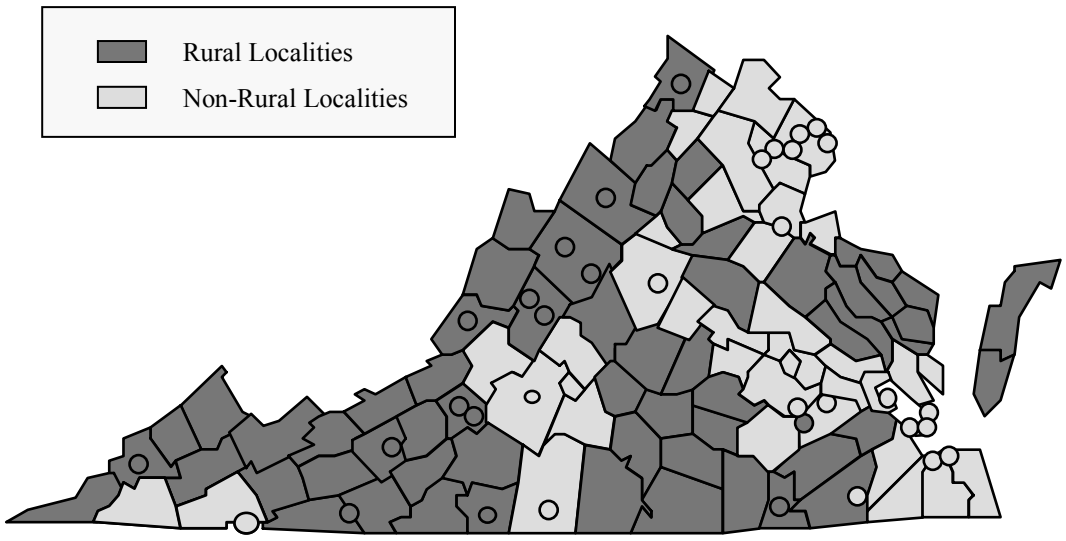
Based on the definition of rural used by the Office of Management and Budget (OMB)[2], there are 73 rural localities in Virginia, including several independent cities such as Galax, Martinsville, and Harrisonburg (see Figure 1). The OMB is in the process of implementing a new methodology for determining a rural area based on commuting trends using the 2000 Census. Using the new methodology, as many as 17 localities would no longer be considered rural. However, since the new methodology has not yet been implemented, the Work Group considered all 73 localities rural.

[1] Obstetrical care, as used in this report, includes prenatal care, labor and delivery, and post-partum services for the mother and her child.

[2] OMB defines areas as "rural" by exclusion, that is, if an area is not considered a "metro" area, it is therefore "rural." Its most recent standards were released in January, 1980 and may be found at http://www.nal.usda.gov/ric/faqs/ruralfaq.htm.

Figure 1

Rural Designations in Virginia



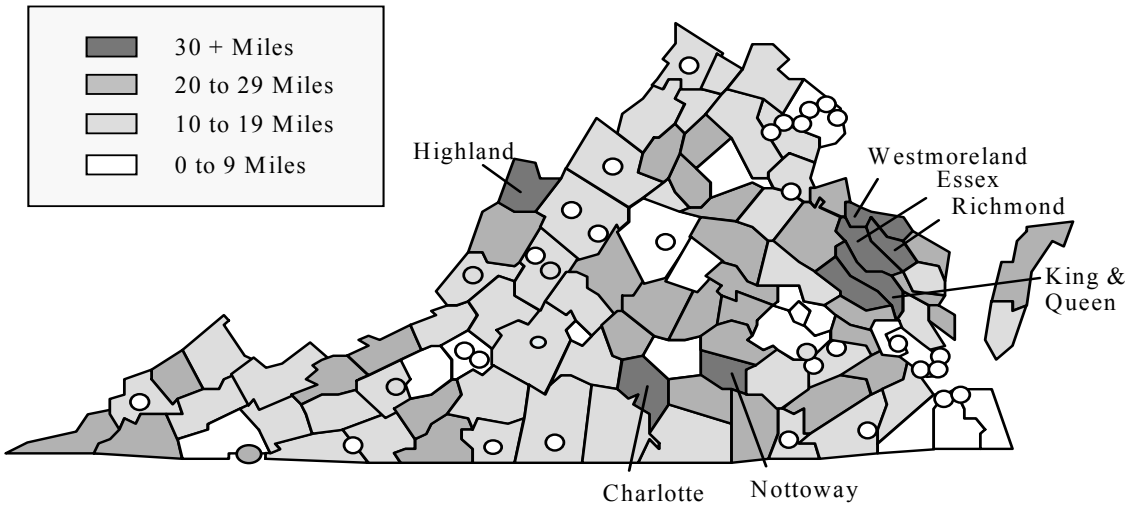
Source: Office of Management and Budget.

In 2002, there were 99,235 live births in Virginia[3], of which 17 percent (or 16,870) were to women who lived in rural localities. As shown in Figure 2, women who resided in urban localities almost exclusively delivered their babies in urban localities. However, 65 percent of women who resided in rural localities, or approximately 10,966 women, delivered their babies in urban localities. Many of these women may live on the edge of an urban locality, and are therefore not traveling far to access care in the urban area.

[3] Source: Virginia Bureau of Vital Statistics

Figure 2

Average Distance Women Traveled to Deliver by Locality
One-Way Trip, CY 2002



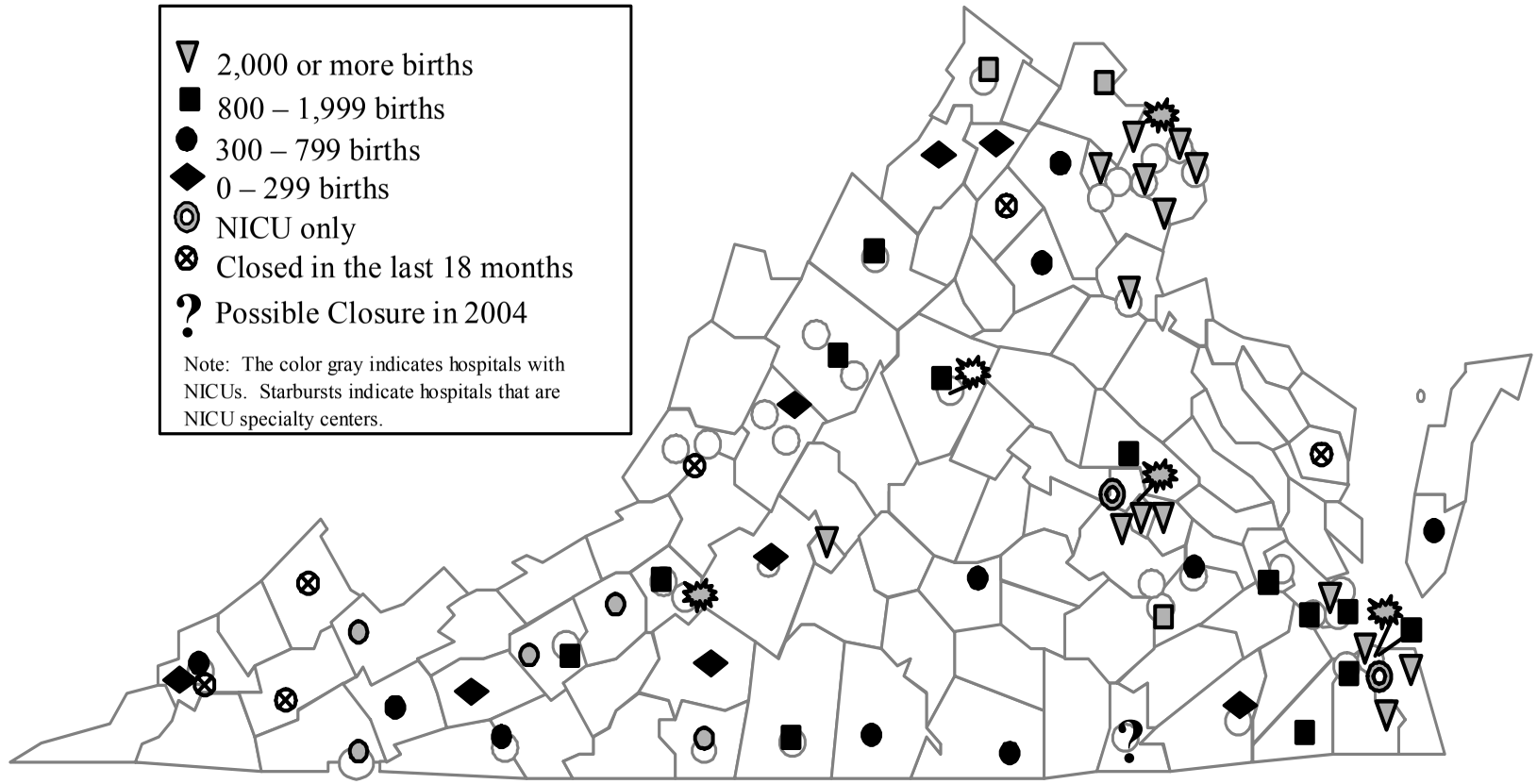
Note: Birth certificate data maintained by the Virginia Department of Health. Includes 92,000 births; 8,000 were excluded because the women lived outside of Virginia or the self-reported zip codes were invalid. Distance is from the center of the zip code of the mother's residence to the center of the zip code of the facility location.

For the remaining 5,900 births, however, the distance the mother was required to travel to deliver in 2002 was often at least 20 miles each way and, in at least seven rural communities, was more than 60 miles each way.

Figure 3 (next page) shows the location of Virginia hospitals with obstetrical services as of the end of 2002. Six of the indicators on that map (circles with an "x" in the middle) indicate the five OB units that had been suspended or eliminated during the last 18 months and the one additional service (in Emporia) which, as of this writing, is scheduled to close in December, 2004. Therefore the travel times shown in Figure 2 *do not take into account the further increased travel time* that will be required of these women with the closing of those OB units. The locations of those hospitals are indicated on Figure 3, indicating that some of the very areas where women faced the most significant travel to deliver in 2002 have again been faced with even greater distances to cover. Given that the moment at which complications and/or labor begin are frequently unpredictable, and also given the feedback received (see Improving Access to Care section) that the greater the distance to travel, the greater the probability that prenatal care will not be accessed, travel distance to and from sites of service has a significant impact on access to obstetrical care.

Figure 3

Virginia Hospitals with Obstetrical Services



Note: Between 800 and 1,999 births occurred at the University of Virginia Health System in Charlottesville.
Source: Virginia Hospital and Healthcare Association

Virginia Hospitals with Obstetrical Services

2,000 or more births

Inova Fairfax Hospital, Falls Church – 10,772
CJW Medical Center (Johnston-Willis and Chippenham), Richmond – 3,851
Inova Fair Oaks Hospital, Fairfax – 3,694
Henrico Doctors' Hospital-Forest, Richmond – 3,671
Mary Washington Hospital, Fredericksburg – 3,327
Inova Alexandria Hospital, Alexandria – 3,326
Virginia Hospital Center, Arlington – 3,218
Chesapeake General Hospital, Chesapeake – 3,057
Carilion Roanoke Community Hospital, Roanoke – 2,730
Sentara Norfolk General Hospital, Norfolk – 2,640
Riverside Regional Medical Center, Newport News – 2,588
Reston Hospital Center, Reston – 2,446
Sentara Virginia Beach General Hospital, Virginia Beach – 2,337
Bon Secours St. Mary's Hospital, Richmond – 2,335
Potomac Hospital, Woodbridge – 2,321
Virginia Baptist Hospital, Lynchburg – 2,315
Sentara Leigh Hospital, Norfolk – 2,158
VCU Health System, Richmond – 2,119
Prince William Hospital, Manassas – 2,058

800-1,999 births

Winchester Medical Center, Winchester – 1,998
Rockingham Memorial Hospital, Harrisonburg – 1,814
Loudoun Hospital Center, Leesburg – 1,777
Martha Jefferson Hospital, Charlottesville – 1,694
University of Virginia Health System, Charlottesville – 1,317
Southside Regional Medical Center, Petersburg – 1,225
Mary Immaculate Hospital, Newport News – 1,159
Bon Secours Maryview Medical Center, Portsmouth – 1,135
Danville Regional Medical Center, Danville – 1,112
Augusta Health Care, Fishersville – 1,057
Obici Hospital, Suffolk – 996
Sentara CarePlex Hospital, Hampton – 962
Bon Secours Memorial Regional Medical Center, Mechanicsville – 912
Bon Secours DePaul Medical Center, Norfolk – 906
Carilion New River Valley Medical Center, Radford – 873
Lewis Gale Medical Center, Salem – 864
Sentara Williamsburg Community Hospital, Williamsburg – 846
WV City Hospital, Berkeley – 897
TN Wellmont Bristol Regional Medical Center, Sullivan – 866
TN Wellmont Holston Valley Medical Center, Sullivan – 1,085
TN Johnson City Specialty Hospital, Washington – 878
TN Johnson City Medical Center Hosital, Washington – 1,379

300-799 births

Johnston Memorial Hospital, Abingdon – 611
Montgomery Regional Hospital, Blacksburg – 596
Memorial Hospital, Martinsville – 560
John Randolph Medical Center, Hopewell – 537
Shore Memorial Hospital, Nassawadox – 500
Halifax Regional Hospital, South Boston – 498
Fauquier Hospital, Warrenton – 493
Community Memorial Healthcenter, South Hill – 375
Twin County Regional Healthcare, Galax – 369
Clinch Valley Medical Center, Richlands – 371
Norton Community Hospital, Norton – 346
Culpeper Memorial Hospital, Culpeper – 341
Southside Community Hospital, Farmville – 311
Smyth County Community Hospital, Marion – 302
WV Bluefield Regional Medical Center, Mercer – 785
WV Jefferson Memorial, Jefferson – 396
WV Greenbrier Valley Medical Center, Greenbrier – 441
WV Princeton Community Hospital, Mercer – 376
TN Indian Path Medical Center, Sullivan – 728
TN Sycamore Shoals Hospital, Carter – 390

0-299 births

Wythe County Community Hospital, Wytheville – 269
Southampton Memorial Hospital, Franklin – 268
Wellmont Lonesome Pine Hospital, Big Stone Gap – 268
Warren Memorial Hospital, Front Royal – 265
Rappahannock General Hospital, Kilmarnock – 254
Stonewall Jackson Hospital, Lexington – 247
Carilion Franklin Memorial Hospital, Rocky Mount – 228
Shenandoah Memorial Hospital, Woodstock – 213
Bedford Memorial Hospital, Bedford – 176
Alleghany Regional Hospital, Low Moor – 169
Southern Virginia Regional Medical Center, Emporia – 168
Buchanan General Hospital, Grundy – 107
Pulaski Community Hospital, Pulaski – 107
Bon Secours St. Mary's Hospital, Norton – 78
Russell County Medical Center, Lebanon – 58
WV Grant Memorial Hospital, Grant – 253
WV Summers County ARH, Summers – 2
WV Welch Community Hospital, McDowell – 101

NICU Only

Children's Hospital, Richmond
Children's Hospital of The King's Daughters, Norfolk

NOTE: Hospitals in bold type have NICUs. Hospitals in bold blue type have subspecialty NICUs. Hospitals in bold red type have specialty NICUs. Alleghany Regional Hospital, Bon Secours St. Mary's Hospital, Buchanan General Hospital, Rappahannock General Hospital and Russell County Medical Center have closed their OB facilities in the past 18 months. Southern Virginia Regional Medical Center is unsure on how long it will continue to provide OB services.

Virginia data compiled by Virginia Health Information (VHI) and the Virginia Department of Health.

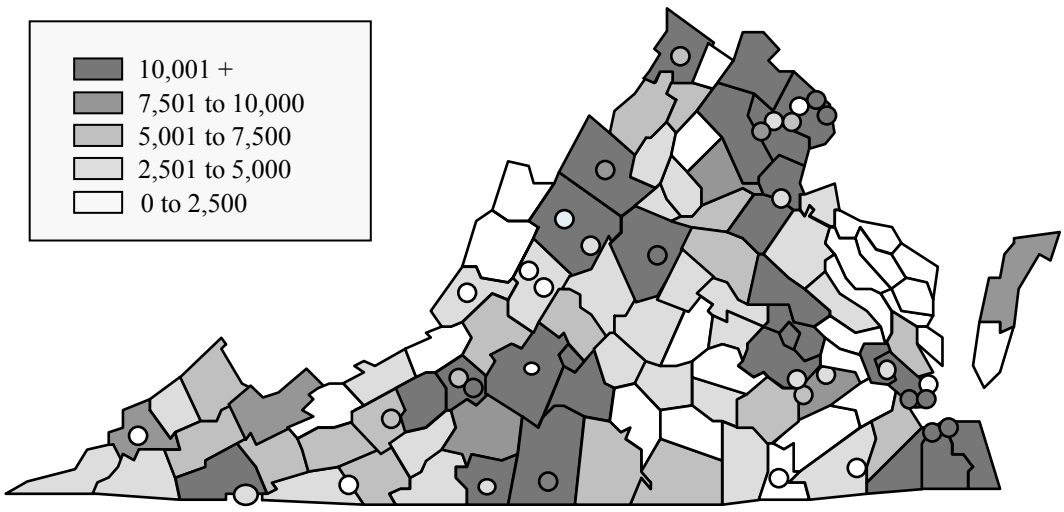
Figure 3, Part 2

Impact of the Indigent Population

Another complicating factor at work in these areas is the significant number of women of childbearing age who are either uninsured or enrolled in Medicaid. Medicaid currently covers women who are up to 133 percent of the Federal Poverty Limit (FPL). Using Virginia Census data it is estimated that there are 163,000 Virginia women age 16-44 with income between 133-200 percent of poverty. Using average statewide birth rates, it is estimated that 10,800 of these women will give birth or experience natural fetal death in a given year. The estimated uninsured rate for non-elderly women is 24 percent (based on the Urban Institute and Kaiser Commission estimates).

Figure 4

Population of Women Ages 15-44
By Locality, 2000



Source: United States Census Bureau, 2000 Census.

Applying this rate to the cohort of pregnant women it is estimated that 2,600 are likely to be uninsured. Figure 4 demonstrates the number of women of childbearing age, by county; Figure 5 indicates the percent of those women who are Medicaid enrollees.

Figure 5

Population of Women Ages 15-44 Enrolled in Medicaid By Locality, FY 2003

Source: Department of Medical Assistance Services and the United States Census Bureau, 2000 Census.

The high proportion of the uninsured and Medicaid enrollees in rural areas puts stress on the service delivery system for several reasons. First, as the uninsured are unable to pay for prenatal care they then must rely on public health departments and free clinics for care. Second, while Medicaid is a stable payer source the Medicaid reimbursement rates for those services are significantly lower than those of other insurers. Third, rural areas have a disproportionately higher Medicaid and uninsured caseload. Fourth, except for the recent increase enacted by Governor Warner, the Medicaid reimbursement rates have not been increased for the past ten years despite the increasing costs of providing service, in particular, the recently skyrocketing cost of medical malpractice insurance.

Expanded eligibility for Medicaid is expected to decrease the number of uninsured women in need of obstetrical care, thereby reducing some of the financial burden on local providers. Increasing rates for Medicaid reimbursement will further address providers' financial concerns.

ELIGIBILITY

Background for Medicaid Eligibility Recommendation

Medicaid is the primary payer for obstetrical services in Virginia, and on average, pays for 30 to 40 percent of all deliveries or approximately 35,000 births each year in the Commonwealth. Despite its dominant role in financing obstetrical care for low-income women, a substantial number of women have too much income to qualify for Medicaid but insufficient income to access care or private health insurance. For these women, lack of health insurance is clearly a barrier to obtaining medical services, including obstetrical care.

Current Medicaid Eligibility for Pregnant Women

Pregnant women are one of the mandatory categorically needy groups that states are required to include under their Medicaid plans. States are required to cover pregnant women with family income equal to or less than 133 percent of the federal poverty level (FPL) and have the option of providing coverage at higher income levels. Table 1 shows FPL income limits at 133 percent and 200 percent of the FPL based on selected family sizes.

Table 1
Federal Poverty Income Limits [4]

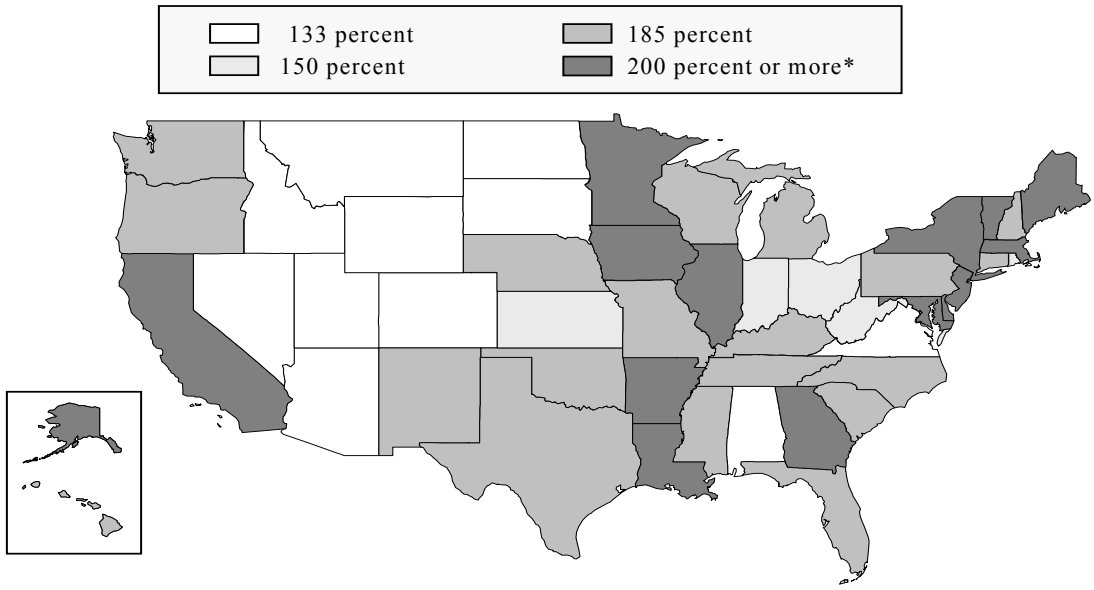
Family Size	Federal Poverty Level Yearly Income Limits	
	133% FPL	**200% FPL**
1	$12,383	$18,620
2	16,612	24,980
3	20,842	31,340
4	25,071	37,700
5	29,300	44,060
6	33,530	50,420
7	37,759	56,780
8	41,989	63,140

Virginia Medicaid currently covers pregnant women up to 133 percent of FPL and the Commonwealth has not yet elected to expand coverage to a higher income group through Medicaid. As Figure 6 shows, only 10 other states provide coverage to a similar income group as Virginia for pregnant women. The remaining states cover pregnant women up to a higher income level.

[4] Per Federal Register, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338.

Figure 6

State Coverage of Pregnant Women



Source: "Preventing Recent Progress on Health Coverage for Children and Families: New Tensions Emerge," Kaiser Commission on Medicaid and the Uninsured, July 2003, page36.

Expanding Eligibility for Pregnant Women

Help may be found, however, via the State Child Health Insurance Program (SCHIP), a federal program that provides matching funds to states to expand health care coverage to children. Virginia's SCHIP-funded program is called the Family Access to Medical Insurance Security (FAMIS). Federal regulations allow SCHIP (FAMIS) dollars to be used to expand coverage for pregnant women of all ages. While SCHIP is not an entitlement program as is Medicaid, this type of expansion would enable Virginia to increase the income requirement from the current minimum 133 percent to 200 percent of the federal poverty level, with two thirds of the cost borne by federal funds.

The interim report of this Workgroup recommended such an expansion. Furthermore, with support from the State Coverage Initiative (SCI) grant funded by the Robert Wood Johnson Foundation, DMAS staff have been laying the policy and systems groundwork for this change pending General Assembly approval. DMAS is requesting a waiver from the federal government to allow the use of SCHIP funds, which were earmarked for coverage of children, to expand this coverage to pregnant women over age 19. (Pregnant women over the 133 percent FPL but under age 19 are currently covered under the SCHIP program.) This waiver proposal also includes a proposal to make it easier to subsidize the coverage of children with access to health insurance through their parents' employer.

Increasing the income standard for pregnant women is expected to cover approximately 1,600 additional deliveries in the first year. The total annual cost is estimated to $15.7 million. Since these women could be covered using SCHIP funds, the federal government's share would

be approximately two thirds and the State share would be one third of the total cost. This is a higher federal match rate than would be provided through Medicaid.

Reducing Other Barriers to Care

In addition to expanding income requirements, access to care may be improved by streamlining Medicaid's administrative and enrollment practices. By federal law, a State must make an eligibility determination for a Medicaid applicant within 45 days after a 14 page application is filed. Virginia however, provides an expedited eligibility process for pregnant women and processes their applications within 10 days. Currently, it is the common practice in many local Department of Social Services (DSS) offices to require the full set of applications (as others services e.g. food stamps may be provided). As a result, a personal appearance at a DSS enrollment site, which can potentially lead to waiting in line for a lengthy period of time, may be required in order to start that 45 day "clock." This is a significant barrier for those who are the "working poor," that is, they must choose between spending time at work and earning the day's wages, or waiting in line to apply for these benefits and losing income. In addition, this delay means that many women are not receiving timely prenatal care while the application process is being completed

SCHIP has built a successful enrollment/application that is fondly called the "no wrong door" process. This allows the applicant to use either the SCHIP Central Processing Unit (CPU) or DSS in order to file an application for Medicaid or FAMIS. The process is streamlined so that applications are completed in 10 days. Using this collaborative process the Warner Administration has enrolled over 103,000 children. Building upon this expedited process, DMAS is proposing to expand its FAMIS CPU to include the "no wrong door" policy and allow all pregnant women to have a centralized point of application and eligibility determination. Applications may be initiated via a telephone call, and eligibility will be determined within 10 days of receipt of a completed application. The availability of the CPU provides women multiple points of entry. If a pregnant woman contacts the CPU after she schedules her first doctor's appointment, eligibility will be determined by the time she goes to the appointment.

Expansion of the eligibility requirements for Medicaid and streamlining the administrative process of determining eligibility should remove some barriers to access to health care for pregnant woman. Obtaining insurance coverage will allow appropriate and timely prenatal care, resulting in improved birth outcomes. The increased enrollment for both prenatal care and for deliveries will also help assure that providers receive reimbursement for their services provided to those previously uninsured. Given these positive changes, additional adjustments to the program, such as allowing presumptive eligibility, appear unnecessary at this time.

Recommendation # 1

Increase the income standard for pregnant women to 200 percent of the federal poverty level (FPL). Women between 133 percent FPL and 200 percent FPL will be enrolled in SCHIP to leverage federal funds (66% federal share versus basic Medicaid program federal share of 50%).

Implement the "no wrong door" program which allows central registration of all eligible women within 10 days of applications for either Medicaid or SCHIP (FAMIS).

Clarification of Newborn Eligibility for Medicaid

Newborns born to Medicaid enrollees, including those born to non–citizen women whose labor and delivery emergency services are covered by Medicaid, are considered eligible from the date of birth. No application is required to be filed on behalf of the child. The local eligibility worker only needs to be informed of the child's name, date of birth and gender in order to enroll the child in Medicaid. Therefore, there should be no gap in coverage once the local DSS office is notified.

Emergency Services for Lawful Permanent Residents and Undocumented Women

The number of families of diverse countries and cultures continues to grow, as evidenced by the growth in the foreign-born population in Virginia. Between the 1990 and 2000 Census, the foreign-born population grew from five percent to eight percent of the population in the Commonwealth[5]. This trend is not limited to urban areas alone; in many rural communities, up to five percent of the population is now foreign-born, with a handful of rural communities with 10 percent of their population born outside of the United States (see Figure 22).

It is therefore no surprise that an increase in both lawful permanent residents and undocumented aliens, who may not have access to obstetrical care or any other form of health care, has put additional stress on the system. The actual number of undocumented aliens (individuals not legally present in Virginia) living in Virginia is not available. However, the Immigration and Naturalization Service estimates that the number of undocumented aliens in Virginia grew from 55,000 in 1996 to 103,000 in 2000. This is a growth of 87 percent in four years.

These individuals do not have access to Medicaid or FAMIS, except for emergency services. Pre-natal care is not available to them, potentially resulting in greater risk for poor (and, likely, more costly) birth outcomes. For providers of obstetric services, there are an increasing number of women for whom such service must be provided but for whom no vehicle is available through to obtain reimbursement. Finding the appropriate methodology to increase opportunities for reimbursement is complex, however, and will require further study.

[5] 2003 Joint Legislative Audit and Review Commission report on the "Acclimation of the Foreign-Born Population

Recommendation # 2

DMAS should study the feasibility of extending Medicaid emergency services to cover prenatal care for lawful permanent residents and to extend similar services to undocumented women to the extent permitted by federal law.

DMAS shall report its findings to the Secretary of Health and Human Resources no later than December 1, 2005.

The Importance of Dental Services

A growing body of research supports an association between the oral health status of the mother who has periodontal disease (inflammatory gum disease) and unfavorable birth outcomes associated with preterm low birth weight. The potential impact of periodontal diseases on preterm birth and low birth weight was initially demonstrated by the research of Offenbacher et al. (1996) which documented that women who have low birth weight infants as a consequence of either preterm labor or preterm, premature rupture of membranes tend to have more severe periodontal disease than mothers of full-term, normal birth weight infants.[6] A study at the University of Alabama Perinatal Emphasis Research Center supported the findings of Offenbacher and documented a significant correlation between generalized periodontitis and preterm delivery.[7]

Additional studies include:

- Periodontal disease may contribute to adverse outcomes of pregnancy through a chronic oral inflammatory bacterial infection, which produces substances that may harm the fetus.[8]
- The role of prostaglandins and cytokines in the link between preterm birth, low birth weight, and periodontal diseases is supported by findings from a study at the University of North Carolina.[9]
- The National Institute of Health is currently supporting clinical trials at seven universities to continue investigations to determine if oral infections pose a potential risk factor for pre-term labor and low birth weight babies. The results of this "cause and effect" research through a large controlled clinical intervention will not be available for some time.
- It is well documented that oral and dental problems associated with pregnancy may include decay due to changes in diet or poor oral hygiene, pregnancy induced gingivitis due to increased hormonal levels, tooth erosion due to nausea and vomiting, or periodontal hyperplasia or granuloma.[10] [11] [12] [13] [14] [15] [16]

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[6] Offenbacher S, Katz V, Fertik G, Collins J, Boyd D, Maynor G, et al. Periodontal infection as a possible risk factor for preterm low birth weight. J Periodontol 1996;67(10Suppl):1103-13.

[7] Jeffcoat MK, Geurs NC, Reddy MS, Cliver SP, Goldenerg RL, Hauth JC. Periodontal infection and preterm birth: results of a prospective study. J Am Dent Assoc 2001;132(7):875-80.

[8] Offenbacher S, Katz V, Fertik G, Collins J, Boyd D, Maynor G, et al., op. cit.

[9] Offenbacher S, Jared HL, O'Reilly PG, Wells SR, Salvi GE, Lawrence HP, et al. Potential pathogenic mechanisms of periodontitis associated pregnancy complications. Ann Periodontol 1998;3(1):233-50.

[10] Hunter L, Hunter B. Oral Healthcare in Pregnancy and Infancy (Chapter 3: Oral and Dental Problems Associated with Pregnancy, pp27-34). Macmillan Press Ltd.: London, 1997.

[11] American Dental Association, Pregnancy and Oral Health, brochure. 1998.

A 2001 study, "The Virginia Health Access Survey" by the Virginia Health Care Foundation showed that 55 percent of uninsured Virginians do not visit a dentist regularly, versus 23 percent of Virginians with dental insurance. According to the report, "Women's Health Virginia 2004" nearly 35 percent of women in Virginia reported having no dental insurance. This data was analyzed from the 2002 Behavioral Risk Factor Surveillance System.

The Importance of Substance Abuse Services

Key informant interview responders (See Practice & Licensure section) and Work Group members both identified the issues of substance use during pregnancy as having a negative impact on pregnancy outcomes. A 2004 survey conducted by the Virginia Department of Health and Department of Mental Health, Mental Retardation and Substance Abuse Services revealed that only 35 percent (n=581) of providers indicated they screened their pregnant patients for substance use. In state fiscal year 2003, there were 483 substance-exposed infants reported to the Community Services Boards in Virginia, and it may well be possible that that number would have been higher had more comprehensive screening occurred. In 1999 the National Household Survey on Drug Abuse estimated that nationally, 7.6 percent of pregnant women used an illicit drug during their pregnancy. While the actual numbers will vary depending upon the population, it is anticipated that annually in Virginia over 760 women will use illegal substances during pregnancies.

Research indicates that alcohol and tobacco have the most harmful effects of all substances on the developing fetus, including growth deficiencies, increased risk of Sudden Infant Death Syndrome, and alcohol related, neuro-developmental deficits including mental retardation and childhood hyperactivity[17].

Recommendation # 3

The Subcommittee recognizes the need for adequate dental and substance abuse services available for pregnant women in the Medicaid and FAMIS programs and recommends that DMAS fund these services due to their impact on successful gestation and delivery.

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[12] Gunay H, Dmoch-Bockhorn K, Gunay Y, Geurtsen W. Effect on caries experience of a long-term preventive program for mothers and children starting during pregnancy. Clinical Oral Invest 1998;2:137-142.
[13] Brambilla E, Felloni A, Gagliani M, Malerba A, Garcia-Godoy F, Strohmenger L. Caries prevention during pregnancy: Results of a 30-month study. JADA 1998 July;Vol. 129: 871-877.
[14] Muramatsu Y, Takaesu Y. Oral Health Status related to subgingival bacterial flora and sex hormones in saliva during pregnancy. Bull. Tokyo Dent. Coll. 1994 August; 35(3): 139-151.
[15] Little JW, Fallace DA, Miller CS & Rhodus NL. Dental Management of the Medically Compromised Patient. 5th Edition. Mosby: St. Louis, 1997.
[16] Raber-Durlacher JE, van Steenbergen TJM, van der Velden U, de Graaff J, Abraham-Inpijn L. Experimental gingivitis during pregnancy and post-partum: Clinical, endocrinological and microbiological aspects. Journal of Clinical Periodontology 1994; 21: 549-558.
[17] Britt, G.C., Ingersoll, K.S. and Schnoll, S.H. (1999). "Developmental Consequences of Early Exposure to Alcohol and Other Drugs", in *Sourcebook on Substance Abuse, Vol. 1, Epidemiology Development, Etiology, and Evaluation.*

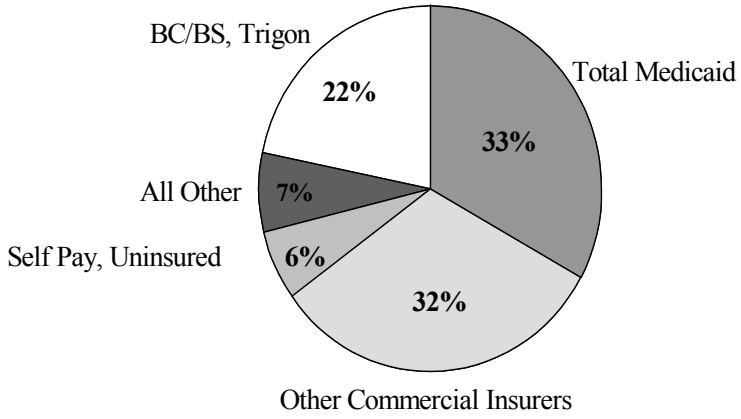
MEDICAID REIMBURSEMENT

Background

Reimbursement is considered one of the most critical issues affecting access to obstetrical care in Virginia. Medicaid is a significant payer for obstetrical services in Virginia, and on average, pays for an estimated 30 to 40 percent of all deliveries (see Figure 6). This translates into over 30,000 births each year in the Commonwealth.

Figure 7

2002 Virginia Births by Payer
All Hospitals

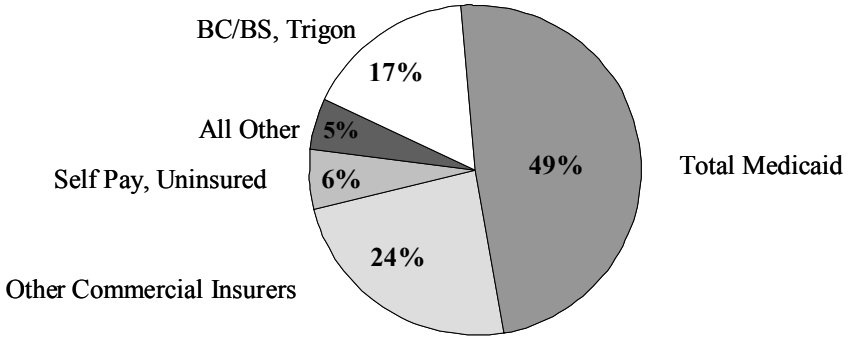


Source: Virginia Hospital and Healthcare Association analysis of Virginia Health Information and Department of Medical Assistance Services data.

These percentages are estimated to be even higher in rural communities where the economic conditions often foster increased reliance on Medicaid and charity care. Figure 7 provides estimates of these percentages based on selected rural hospitals.

Figure 8

2002 Virginia Births by Payer
Selected Rural Hospitals

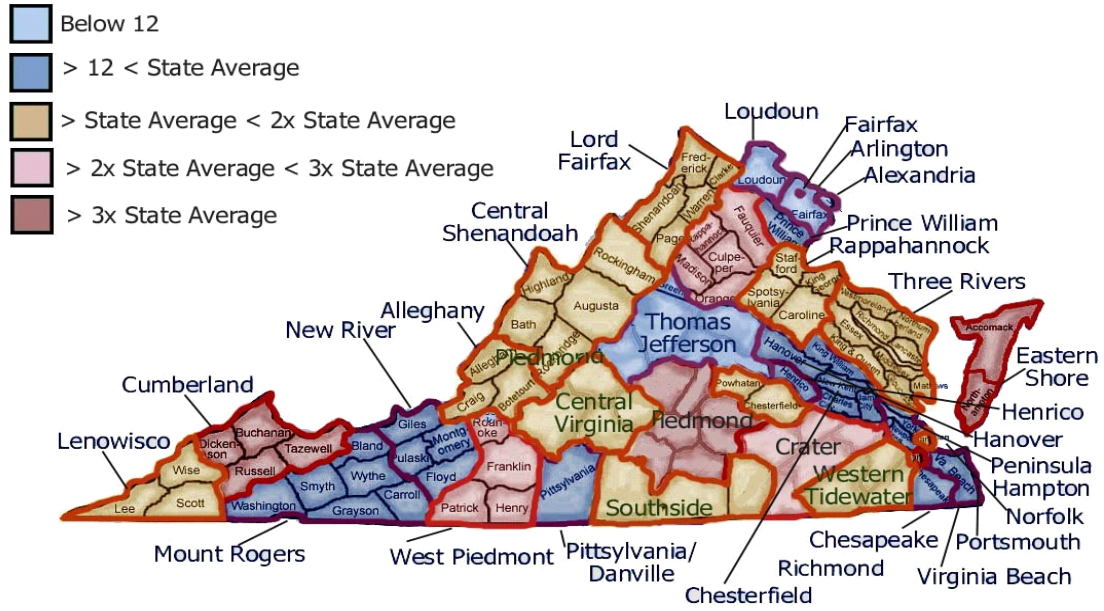


Source: Virginia Hospital and Healthcare Association analysis of Virginia Health Information and Department of Medical Assistance Services data.

Difficulties in access to OB services also exist because it remains difficult to recruit and retain physicians of any kind – and particularly these specialists - in rural areas. For example, Figure 8 compares Medicaid enrolled women (excluding FAMIS), 15 years old and over, to the number of active OB providers in the same region. Deficit areas are defined in relation to the state average of 25 clients/provider. The potential for severe access problems is defined as having a ratio that is three times greater than the state average.

Figure 9

Access to OB/GYN Providers Statewide



Note: This analysis compares Medicaid enrolled women (no FAMIS), 15 years old and over, to active OB/GYN providers. The map presents deficit areas relative to the state average.

This heavy dependence upon Medicaid for payment of healthcare costs for pregnant women is particularly challenging given the current environment. The cost of conducting business, whether for a hospital or individual provider, has steadily increased over the past ten years. Medical malpractice rates, in particular, have skyrocketed during the last three years (see the Medical Malpractice Insurance section). However, Medicaid payment rates for obstetrical services have remained stagnant during that time. In fact, the Medicaid provider fee schedule is intended to keep overall payments approximately level from year to year, that is, it is not routinely adjusted for inflation.

Furthermore, Medicaid rates are typically much lower than those of other payers (such as Medicare and commercial insurance). For example, using the rates effective on June 1, 2004, Medicaid reimbursement rates for professional services (physicians and other practitioners) were only about 69 percent of the "Medicare equivalent" payment rates[18]. While robust commercial rate information is not available due to the proprietary nature of the data, best available estimates place Medicaid reimbursement at approximately 60 percent of the average commercial insurance payment rate for major obstetrical procedures.

[18] Medicare is not typically known for certain services, such as obstetrical care, due to the age of the majority of those covered under Medicare. However, in developing its payment methodology, Medicare developed an "All-Payer" system, which still encompasses the full range of procedure codes, whether they have little or no utilization, or are not covered under the Medicare program. While the Medicaid program utilizes the Medicare methodology in part, the Medicaid methodology differs significantly due to other adjustments. Because of this, comparisons are made on the basis of an estimate of what Medicare would pay (the "Medicare equivalent") for a particular service, not the actual Medicare rate, as the two actual rates are difficult to compare directly.

Reimbursement Rates for Obstetrical (OB) Services

One of the two preliminary recommendations in the Work Group's Interim Report, issued in July 2004, was that the Medicaid Physician Fee schedule be increased by approximately 45 percent for OB services. The 45 percent figure (actually 44.91 percent) represented the increase needed to bring Medicaid rates up to the "Medicare equivalent" rate.

In response to the recommendation, Governor Warner directed DMAS to implement a 34 percent increase to OB professional rates. DMAS staff, as well as staff of the Medicaid-contracted managed care organizations (MCOs), focused energies to get the regulations developed, rates set and loaded, and information out to the providers. The newly increased rates were effective September 1, 2004, for both the fee-for-service and managed care programs under Medicaid.

This was a major step toward improving reimbursement levels for these services, and set Medicaid rates for these services at about 93 percent of the Medicare equivalent rates (compared to approximately 69 percent under the prior rate schedule). However, the goal of the 45 percent increase was not met.

Recommendation # 4

> Beginning July 1, 2005, the Medicaid Physician Fee Schedule for OB services should be increased by 8.14 percent above the schedule that became effective September 1, 2004. This applies to all licensed providers who bill under these codes. This increase would bring the total increase for OB services to 44.91 percent, compared to the July 1, 2004, payment levels, and would make Medicaid payment rates for these services equal to the "Medicare equivalent."

The estimated fiscal impact of Recommendation 4 in SFY 2006 is $20.77 million ($10.33 GF and $10.34 NGF).

Reimbursement Rates for Pediatric Care Givers

Obstetrical care is only one half of the issue; the need for access to pediatric care begins from the time of delivery. Continuing his long and established commitment to children, Governor Warner placed resources into the recruitment and enrollment of children. As a result, over 103,000 children have been enrolled into the Medicaid and Family Access to Medical Insurance Security (FAMIS) child health insurance programs. This effort has received national attention and the Commonwealth has received accolades from child advocates across the nation as well as in national studies on the success of the program. This enrollment effort, too, is only half of the answer. Once enrolled, there must be providers willing to include these children in their panels. The enrollment success will be jeopardized unless the Commonwealth can continue to provide medical care to these children, well child visits, screenings and treatment for special heath care needs.

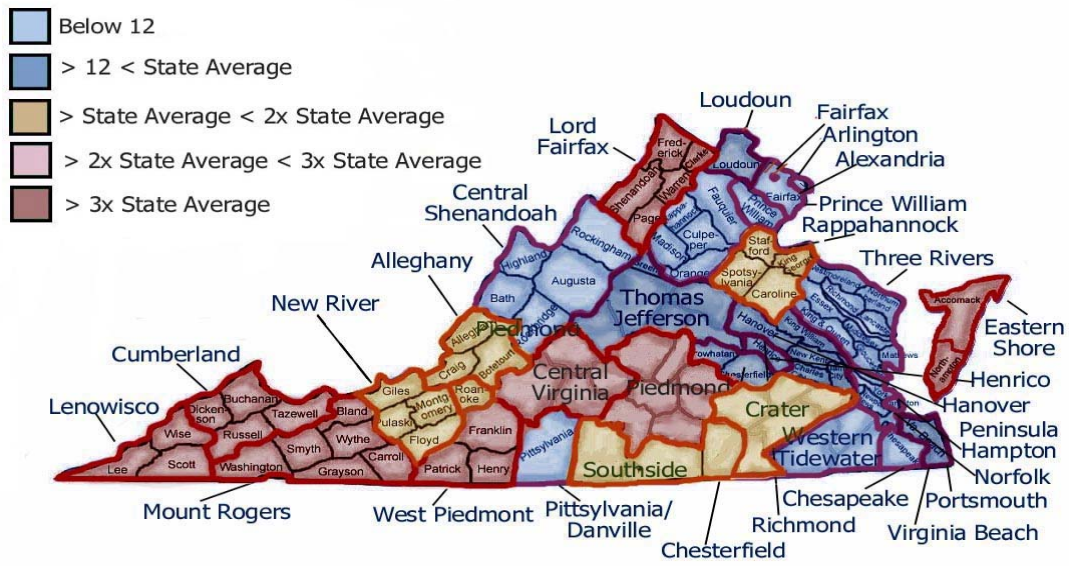
For the same reasons reimbursement has affected access to OB care (low Medicaid payment coupled with high Medicaid utilization for this specialty), plus the additional impact of the State's significant effort to enroll eligible children into Virginia's Medicaid and FAMIS programs, it is possible that a crisis in access to pediatric care has already emerged in some areas and is on the cusp of emerging in many others.

Similar to the dynamics for the obstetricians, rural pediatric groups are also experiencing the financial strain of large Medicaid caseloads. While the larger medical centers can provide tertiary and some specialty care, the local pediatric practices are expanding both in size and complexity. The Virginia Pediatric Association has described how several rural pediatric practices are closing. The latest was a large practice in Rockingham, which closed its panel to Medicaid and the uninsured. There is also another office in the southwest that is scheduled to close soon. Several other groups are beginning to close their panels in efforts to keep the practices viable. As a result the children are having extraordinarily long wait times for appointments and less flexibility in their choice of providers.

Figure 10 illustrates some of the difficulties. It compares the availability of children's services for Medicaid[19] and FAMIS children up to 21 years of age to the number of Pediatricians and Family Practitioners in that region. The table and map present deficit areas relative to the state average. As the Figure shows, these areas cover a significant portion of the Commonwealth.

Figure 10

Access to Pediatric Providers Statewide



Note: This analysis compares non-MCO Medicaid and FAMIS children up to 21 years of age to the number of Pediatricians and Family Practitioners. . The map presents deficit areas relative to the state average.

[19] Non-MCO Medicaid children only.

Fees for pediatric services, like those for OB, are not adjusted for inflation from year to year, and have not had an inflationary increase for over a decade. Under the fee schedule in effect currently, pediatric rates are similarly set at approximately 69 percent of the Medicare equivalent rates. By design, budget neutrality is applied from year to year to stem the growth in overall expenditures for physician services, including pediatrics.

Barbara Kahler, MD, a practicing pediatrician in Mechanicsville, VA, explained it this way:

The easiest way for me to explain Medicaid reimbursements is like this: if you've got a service that you charge $100 for, and a subsection of your clientele only pays you $60 for that service, you can only have a certain percent of people doing that before you start to lose money, and then you can't stay in business. That magic percent for most pediatricians is between 15 percent and 20 percent.

After 14 years of practicing in Kilmarnock, VA, a rural area on Virginia's Eastern Shore, the percentage of Medicaid enrollees in Dr. Kahler's practice had reached nearly 40 percent. Despite the need for a pediatrician in that community, despite the fact that her practice treated between 10,000 – 15,000 children annually, she closed the practice and left the area in 2002 because the insufficient Medicaid reimbursements made the practice economically infeasible. Despite her preference to practice in Kilmarnock, she now treats children in Mechanicsville, VA, a one hour and twenty minute commute from her Kilmarnock home.

It would be irresponsible to focus attention so narrowly on the mother while the child may be faced with a similar access to care issue once mother and newborn leave the hospital after delivery.

Recommendation # 5

> Beginning July 1, 2005, the Medicaid Physician Fee Schedule for Pediatric services (Evaluation and Management Codes for children under age 21) should be increased by 44.91 percent above the schedule currently in effect. (This applies to all licensed providers who bill under these codes.) This increase would make Medicaid payment rates for these services equal to the "Medicare equivalent."

The estimated fiscal impact of Recommendation #5 in SFY 2006 is $56.43 million ($27.34 GF and $29.09 NGF).

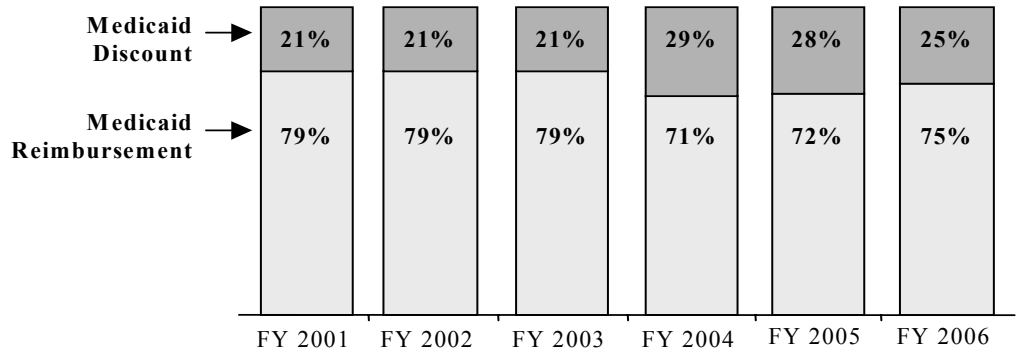
Reimbursement Rates for Hospitals

Hospitals also provide a significant amount of care to pregnant women. The vast majority of deliveries are performed in the hospital setting, and this requires significant staffing levels and carries with it significant costs for hospitals providing obstetrical services around the clock, every day of the year.

Medicaid reimbursement is below cost for hospitals as well. In fact, while hospitals do get annual adjustments for inflation, Medicaid's methodology of reimbursement for hospital services includes a "discount" from estimated costs; that is, the inpatient hospital payment methodology uses a formula to calculate a payment rate for services below estimated costs. As shown in Figure 11, in state fiscal years (SFYs) 2001, 2002 and 2003, this discount was approximately 21 percent.

Figure 11

Trend in Medicaid Reimbursement to Hospitals
FY 2001 to 2006



Source: Department of Medical Assistance Services.

In general terms, this meant that hospitals were reimbursed for only 79 cents on every dollar associated with the costs of service for Medicaid patients (there are other payment streams that supplement the operating payments somewhat, but it is well-established that private hospitals, in general, are reimbursed below the cost of care for Medicaid patients). The discount rose to 29 percent in SFY 2004, 28 percent in 2005 and is scheduled to go down to 25 percent in SFY 2006. This clearly has an impact on a hospital's budget, particularly one with higher than average Medicaid utilization, as it must make up un-reimbursed costs related to Medicaid in other ways in order to continue providing services to its entire patient population.

For many rural hospitals that have relatively low volume in their obstetrical units, these low payment levels, coupled with the fixed costs associated with staffing and equipping a delivery unit 24 hours a day, seven days a week, pose a significant problem for a hospital's bottom line. The hospitals that find a way to continue to provide these vital community services rely heavily on cross-subsidization from other services and other payer types, or even from local government funding in some cases.

Others make a different choice. James M. Holmes, Jr., President/Chief Executive Officer of Rappahannock General Hospital, put it this way: *With continued losses from low reimbursement rate,[combined with the rising cost of malpractice insurance] the belt just kept getting tighter and tighter. We didn't and still don't want to be in a position where we jeopardize the rest of the hospital to provide OB services to our community.* Rappahannock General Hospital, which had delivered 254 babies in 2002, closed its OB service in March 2004.

While the problem may be more acute in rural hospitals, some action is required to improve payment levels for all hospital providers of obstetrical services. These providers should be paid at least at the estimated cost of the services.

Recommendation # 6

> Medicaid inpatient hospital payment rates for obstetrical-related services should be increased by 33.33 percent effective no later than July 1, 2005, and earlier if the Governor determines that emergency funding is indicated. This increase would ensure that Medicaid hospital payments for obstetric services were sufficient to cover Medicaid allowable costs in the aggregate.

The estimated fiscal impact of Recommendation #6 in SFY 2006 is $22.0 million ($11.0 million GF and $11.0 million NGF).

Inflationary Adjustments to Professional Fees

One of the root causes of the continuing disconnect between Medicaid reimbursement and that of other payers such as Medicare is the fact that Medicaid rates are not routinely adjusted to account for inflation. It is possible that if Medicaid rates for professional services were indexed annually for some inflationary affect, the crisis in obstetrics and pediatrics might be mitigated if not avoided entirely. Improvements made now to provider reimbursement levels[20] will be minimized in the future if the same trends – rising costs of providing service and stagnant reimbursement levels - remain in place.

Appendix F shows the decline in reimbursement rates for the past ten years.

In order to avoid or mitigate future crises caused, in part, by poor Medicaid reimbursement levels, the entire list of service codes (not just OB and Pediatrics) should be adjusted annually for inflation

Recommendation # 7

> Beginning July 1, 2005, the Resource Based Relative Value Scale (RBRVS)-based fees within the Medicaid Physician Fee Schedule should be adjusted annually for inflation.

The estimated fiscal impact of Recommendation # 7 in SFY 2006 is $10.7 million ($5.24 GF and $5.50 NGF).

[20] This is not intended to apply to hospitals, which receive an inflationary adjustment each year as directed by regulation.

Table 2 summarizes the estimated fiscal impact of all reimbursement-related recommendations.

Table 2
Estimated Fiscal Impact of the
Proposed Reimbursement Recommendations

Recommendation	Description	SFY 2006 Fiscal Impact ($millions) GF	NGF	Total
4	Beginning July 1, 2005, the Medicaid Physician Fee Schedule for OB/GYN services should be increased by 8.14 percent above the schedule that became effective September 1, 2004. This applies to all licensed providers who bill under these codes. This increase would bring the total increase for OB services to 44.91 percent, compared to the July 1, 2004, payment levels, and would make Medicaid payment rates for these services equal to the "Medicare equivalent."	10.33	10.44	20.77
5	Beginning July 1, 2005, the Medicaid Physician Fee Schedule for Pediatric services (Evaluation and Management Codes for children under age 21) should be increased by 44.91 percent above the schedule currently in effect. (This applies to all licensed providers who bill under these codes.) This increase would make Medicaid payment rates for these services equal to the "Medicare equivalent."	27.34	29.09	56.43
6	Medicaid inpatient hospital payment rates for obstetrical-related services should be increased by 33.33 percent effective no later than July 1, 2005 and earlier if the Governor determines that emergency funding is indicated.	11.0	11.0	22.0
7	Beginning July 1, 2005, the Resource Based Relative Value Scale (RBRVS)-based fees within the Medicaid Physician Fee Schedule should be adjusted annually for inflation.	5.24	5.50	10.74
	Total	46.5	48.5	95.0

MEDICAL MALPRACTICE INSURANCE

The Medical Malpractice Crisis at the National Level

According to some observers, a "crisis" exists in the medical malpractice insurance market because dramatically increasing insurance premiums are forcing physicians to either close their practices, relocate to states where insurance is more affordable, or stop providing certain high risk services (such as obstetrics, radiology, emergency medicine, and surgery) to their patients.[21] However, there is little consensus as to the severity of the malpractice insurance problem, its solution, or the role that government should perform in addressing this issue.[22]

Since the late 1990s, there have been dramatic increases in the premium rates that healthcare providers pay insurance carriers for medical malpractice liability insurance. For example, the Congressional Budget Office (CBO) reported in 2004 that liability premiums for all physicians increased approximately 15 percent on average between 2000 and 2002. The CBO further reported that the increases during this time were "even more dramatic for certain specialties: 22 percent for obstetricians/gynecologists and 33 percent for internists and general surgeons."[23]

The rapid growth in medical malpractice insurance premiums has attracted the attention of both government and private sector organizations, both of which have commissioned numerous studies to determine the causes of, and solutions to, the escalating cost of malpractice insurance. The American Medical Association cites "runaway" jury awards as the main factor responsible for the growth in insurance rates.[24] However, a selection of studies on this issue was reviewed and no single factor was found that appears to account adequately for the sharp rise in insurance premiums. Rather, the studies suggested that insurance premium growth has resulted from the confluence of several factors that caused insurance carriers to have fewer funds available to pay for malpractice claims.

For example, two studies released by the General Accounting Office (GAO) in 2003[25] were examined. The GAO reported in these studies that high claims losses, a less competitive business climate, reduced investment income, and high reinsurance rates were factors that had contributed to the rapid growth in malpractice premiums since the late 1990s. In particular, the

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[21] The rates that insurance carriers charge physicians vary across and within states. For example, a large insurer in Arizona charged premium rates of $14,247 for the internal medicine specialty, $44,005 for general surgery, and $57,593 for OB in 2003 across the entire state. In contrast, a large insurer in Virginia charged premium rates in Arlington of $11,707 for internal medicine, $43,072 for general surgery, and $52,400 for OB, and $7,428, $26,972, and $32,493, respectively, for these same specialties in Richmond.

[22] National Governor's Association, *Addressing the Medical Malpractice Insurance Crisis*, (December 5, 2002).

[23] U.S. Congress, Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice*, (Washington D.C.: January 8, 2004).

[24] American Medical Association, Statement of the American Medical Association to the Subcommittee on Wellness and Human Rights, Committee on Government Reform, U.S. House of Representatives, (Washington, D.C.: October 1, 2003).

[25] U.S. General Accounting Office, Medical Malpractice Insurance: *Multiple Factors have Contributed to Increased Premium Rates*, GAO-03-702 (Washington, D.C.: June 27, 2003), and *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836, (Washington, D.C.: August 8, 2003).

GAO found that claims losses were the greatest single factor contributing to the dramatic growth in premiums. In fact, the GAO reported that losses representing both the payments that carriers made to plaintiffs to resolve claims and the legal costs associated with defending claims increased 18.7 percent on average for insurance carriers between 1998 and 2001. However, the GAO was unable to determine the specific causes of the losses due to the lack of comprehensive data at the national and state levels. The GAO also found that insurance carriers increased rates in response to decreased investment income. Malpractice carriers experienced decreases in their investment income as interest rates on bonds, which generally make up about 80 percent of their investment portfolios, fell between 1998 and 2001. As a result, carriers were forced to increase premium rates in order to have enough income available to cover costs. In addition, the GAO found that many carriers failed to increase premiums during the 1990s due to the competition that existed in the market. This decision prevented many carriers from generating enough revenue to cover their costs, forcing them to become insolvent, thus reducing the competitive pressure on premium rates. Finally, the GAO found that reinsurance rates for malpractice carriers increased, thus raising their overall costs. This prompted them to increase premiums in order to generate additional revenue.[26]

Studies conducted by the CBO, Weiss Rating, Inc. (a private insurance rating company), and an Emory University researcher[27] were also considered. These studies, too, indicated that multiple factors were responsible for the recent escalation in medical malpractice premiums. For example, the CBO reported that increased malpractice awards and lower investment income were factors that prompted many carriers to increase premiums. Weiss Rating found that the cyclical nature of the business cycle, medical cost inflation, and a decline in investment income had contributed to increased malpractice premiums. Finally, a study conducted by Emory University researcher Kenneth Thorpe found that multiple factors such as malpractice claims, business cycle trends, declining investment income, reinsurance costs, and a lack of competition in the malpractice insurance market had contributed to increased malpractice costs.

To assess the extent to which states perceive an actual medical malpractice crisis, and to determine if they have taken steps to assist physicians with obtaining malpractice insurance, a telephone survey of all 50 state insurance bureaus was conducted. The results of the survey are presented in Table 3.

Staff from 45 insurance bureaus participated in the survey, representing a 90 percent response rate. The survey revealed that 84 percent of the insurance bureaus reported that their states had not declared a medical malpractice crisis, while 16 percent had declared a crisis. Fifty-three percent of the respondents reported that OBs in their states have difficulty obtaining insurance coverage. The respondents most often stated that cost and availability were the main reasons why OBs have difficulty obtaining coverage. A majority of the respondents also reported that their states do not offer programs to assist OBs with obtaining insurance, while 29 percent reported that their states do provide assistance programs. Joint underwriting associations

[26] Reinsurance is insurance that malpractice carriers use to spread the risk associated with their insurance policies.
[27] Weis Ratings, Inc. *The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage* (Palm Beach Gardens, FL: June 3, 2003), and Kenneth E. Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms," *Health Affairs*, vol. 23, issue 4, (2004): 20-30.

were most often reported as the assistance programs that states offered.[28] Seventy-nine percent of the respondents reported that their states were not planning to implement any programs in the near future to relieve or decrease medical malpractice insurance rates.

Table 3
Results of the Survey of State Insurance Agencies

Survey Question	Yes	No
Has your state declared that it has a medical malpractice crisis? (n=44)	16%	84%
Are you aware of any difficulties that OBs experience in obtaining medical malpractice insurance in your state? (n=45)	53%	47%
Does your state administer any programs that provide OBs with assistance to obtain medical malpractice insurance? (n=45) Examples of State Programs: Arizona: Market assistance program that provides a list of insurance providers that write policies for physicians who have difficulty purchasing malpractice insurance. Florida: Joint Underwriting Association. Kansas: Joint Underwriting Association. Indiana: Indiana Residual Malpractice Authority (similar to a Joint Underwriting Association) provides insurance to physicians who have difficulty obtaining coverage. Maine: Rural medical access program for OBs who practice in medically underserved areas provides $5,000 to $10,000 in malpractice insurance coverage. Nevada: Formed a nonprofit medical liability association to provide insurance coverage to physicians who have difficulty obtaining insurance. New Jersey: Developing reform proposal to provide subsidy for premiums. Oregon: Special fund covers 80% of insurance fees for OBs who practice in rural areas, and it also covers 60% of the insurance fees for general practitioners who perform OB services. South Carolina: Joint Underwriting Association. Texas: Market resource program that provides physicians with telephone counseling, the Texas Medical Liability Trust (a statutorily created non-profit organization) provides physicians with insurance, developed a program to recruit insurance companies to the state. Washington: Joint Underwriting Association. West Virginia: Formed West Virginia Physicians Mutual Insurance Company to provide malpractice insurance to physicians in the state. Wisconsin: Developed a patient compensation fund that pays a percentage of the medical malpractice claims that the physicians' policies may not cover.	29%	71%
Is your state considering any policy changes to relieve or decrease OBs insurance rates? (n=39)	21%	79%

Source: Subcommittee staff survey of state insurance agencies.

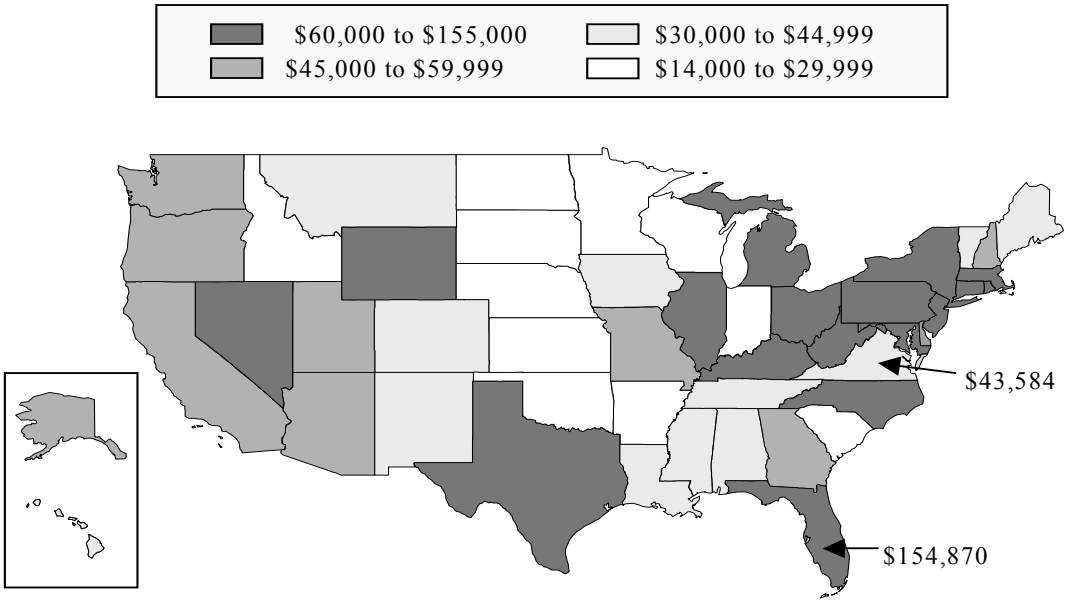
OB insurance rates were also reviewed as part of this study (Figure 1 and Table 4). Average 2002 OB medical malpractice insurance premiums by state were obtained from the Virginia Bureau of Insurance (BOI). BOI staff calculated average rates based on data collected from two sources: the National Association of Insurance Commissioners' annual insurance carrier statement filings and the Medical Liability Monitor's annual insurance rate survey. Readers should note that because not all insurance carriers responded to the Medical Liability

[28] A Joint Underwriting Association (JUA) is a statutorily created organization of insurance companies that provide professional liability coverage to health-care providers who cannot conveniently obtain medical professional liability insurance in the private market.

Monitor's rate survey, the averages presented in Figure 12 (Appendix G contains the premiums for each state) were weighted by BOI staff based on the market share held by the carriers that responded to the survey. The weighted average rates should not be interpreted as the actual rates that OBs paid for coverage in each state.

Figure 12

Average OB/GYN Malpractice Premiums
CY 2002



Note: Averages are weighted based on the market share held by the insurance carriers that reported annual premiums to the Medical Liability Monitor.
Source: Data obtained from the Virginia Bureau of Insurance.

There is considerable variance in the cost of medical malpractice insurance for OBs during 2002, with weighted average premiums ranging from just over $14,000 (South Dakota) to almost $155,000 (Florida). The highest annual malpractice insurance rates were paid by OBs who were located primarily in the Northeast. Midwestern states, for the most part, have low rates. In contrast, Virginia is ranked 21st in weighted average premiums (South Dakota ranked 1st, with the lowest average premium), with OBs paying $44,000 on average for malpractice coverage during this time.

Comparing medical malpractice premiums only provides one of the factors explaining affordability, as it does not take into account the income OBs earn for providing services to their patients. If physicians in one state have, on average, higher revenue from many payers, then having a higher medical malpractice premium than another state may not automatically mean that the higher premium is less affordable. Comparing average medical malpractice premiums as a percent of average physician revenue would complete the comparison. However, staff do not have access to average revenue information nationally. Therefore, while the information presented in Figure 12 is valuable, it is only part of the full picture.

Trends in Medical Malpractice Premiums in Virginia

Virginia's medical malpractice market began to change in late 1999 and early 2000. The Bureau of Insurance (BOI) began to see insurers file rate increases for the first time since the mid-1990s. Additionally, the availability of malpractice insurance changed with the following events:

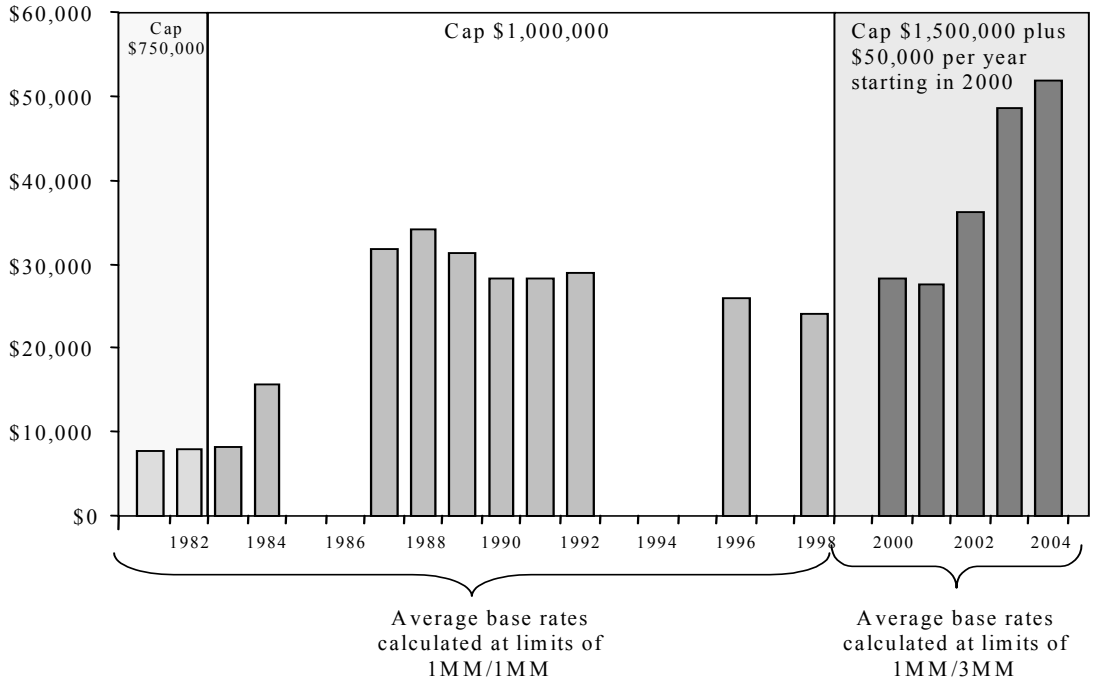
- Suspension of PHICO's license in September of 2001,
- St. Paul's withdrawal from the medical malpractice market in December of 2001,
- The suspension of Lawrenceville's license in early 2002,
- Princeton Insurance Company's withdrawal from Virginia in March of 2003, and
- The financial difficulties and eventual demise of the Doctors Insurance Reciprocal, Risk Retention Group, and the Reciprocal of America in January of 2003.

While Figure 12 provides a one-time "snapshot" of weighted average premiums across the country in 2002, Figure 13 illustrates the changes in premiums paid by OBs in Virginia over the past five years. As seen in Figure 12, rates remained relatively stable in the early to late 1990s; however, significant increases were seen in 2002, 2003, and 2004. The average statewide OB base rate in Virginia increased from $36,282 in 2002 to $51,847 in 2004.

The factors discussed above and the recent rate increases prompted BOI to initiate several studies of the malpractice insurance marketplace in Virginia. In May of 2003, BOI requested its consulting actuary to review the medical malpractice insurance rates that licensed insurers were charging physicians in order to determine whether the rates were excessive. The results of this study indicated that the rates charged by the major licensed writers of physicians' and surgeons' professional liability coverage in Virginia were generally within the indicated benchmark ranges of rates and consequently appeared to be adequate and not excessive. The study further indicated that the rates for OB and neurosurgeon specialties appeared to be reasonable. BOI continues to monitor the rates filed for physicians and surgeons and will ask its consulting actuary to update its rate analysis in 2005.

Figure 13

Average Statewide OB/GYN Base Rates



Source: Various House Documents, the Medical Liability Monitor and actual insurance company filings made with the Bureau of Insurance

At the same time, BOI also requested its consulting economist to analyze the medical malpractice insurance market to determine whether sufficient competition exists in the marketplace to continue to allow the rates to be regulated under Virginia's "file and use" statute, meaning that insurers may use the rates once they have been filed with the Bureau. The results of this study indicated that there was competition in the physicians' and surgeons' professional liability insurance market in Virginia. The study further indicated that rates for physicians' and surgeons' professional liability insurance should continue to be regulated under the "file and use" statute.

BOI also conducted a study in 2003 to determine whether a medical malpractice Joint Underwriting Association (JUA) should be established. The Bureau's findings did not indicate that there was an availability problem with medical malpractice coverage. In fact, the most prevalent problem for health care providers appeared to be affordability rather than availability of coverage. Consequently, BOI did not recommend activating a JUA. (This issue is discussed in further detail later in this section of the report.)

BOI staff reported that there are seven licensed medical malpractice insurance carriers seeking to write new business for physicians. Additionally, there are numerous alternate market sources, such as surplus lines insurers, risk retention groups, and purchasing groups seeking to write new business for physicians in Virginia. This information, combined with the information

on premium increases here in Virginia, seems to confirm that the problems faced in Virginia are more an issue of affordability than availability.

Recommendations

During its deliberations, the Medical Malpractice Subcommittee reviewed and discussed potential actions to improve the status and affordability of medical malpractice insurance. These included discussions of policy terms, closed claim reporting requirements, expansion of the utilization of the Tort Claims Act, coverage for part time or job share situations, and the possibility of a medical malpractice insurance premium subsidy. Each is described, in turn, below.

Notice of Premium Increase, Non-Renewal, or Cancellation: Among their concerns about medical malpractice insurance, many physicians have expressed concern that when their policies were cancelled or non-renewed, an inadequate amount of time was given to allow the opportunity to shop for a new policy before the expiration of the old policy. The current notice requirement for cancellation or non-renewal is 45 days. Because the application process for medical malpractice insurance can be lengthy, physicians believe additional time to find new insurance is warranted. Additionally, some physicians have complained that they did not receive enough notice of large increases in renewal premiums to enable them to budget for the increases or to shop for a more competitive premium. The current notice requirement is 45 days, and this is actually a notice of an increase in the filed *rates* rather than a notice of a *premium* increase.[29]

The Work Group recommends that insurers provide a 90-day notice to insureds when canceling or non-renewing a medical malpractice professional liability policy instead of the current requirement to provide policyholders 45 days notice. Additionally, it recommends that a 90-day notice be provided whenever the renewal *premium* is being increased more than 25 percent (rather than the current requirement that notice be provided when the *rate* is increased more than 25 percent). Due to the extended notice requirement, insurers should *not* be required to advise the insured of the specific reason that the renewal premium is increasing more than 25 percent. Instead, the notice should state that the insured may contact the insurer or the agent for the specific reason for the increase.

This proposal would require insurers to provide the policyholder advance notice whenever the renewal *premium* increases over 25 percent. Although this notice will contain general information, it will advise the policyholder to contact the agent or the insurer for the specific reason for the increase, and it will allow the policyholder additional time to shop for other coverage or prepare for the additional increase in the renewal premium.

[29] The premium is calculated based on a number of factors, only one of which is the filed rate. Other factors include debits and/or credits under an experience rating plan or schedule rating plan, claims made maturity factors, changes in territory, changes in policy limits or exposure, etc.

Recommendation # 8

Amend §38.2-231 of the *Code of Virginia* to extend the current 45-day notice requirement to 90 days when a medical malpractice insurance policy is not renewed or is cancelled, or the insurer proposes a premium increase of more than 25 percent.

Closed Claim Reporting: One of the variables affecting medical malpractice insurance rates may be the upward trend of medical malpractice claims filed against physicians in Virginia. The National Practitioner Data Bank public data file provided information for settled or adjudicated claims for all physician specialties combined, however, it provides no detail on the specialty of the physician against whom the claim is made, nor does it provide any information on claims closed without payment.

The Work Group believes that this information is necessary in order to examine both the insurance rate increases filed by insurers with the BOI and to provide detailed information regarding the legal climate in Virginia. Additionally, detailed closed claim information may assist in determining whether or not tort reforms are effective in holding down claim costs, with a corresponding reduction in malpractice premium rates.

Therefore the Work Group recommends that the requirement for insurers to report "closed claims" as previously required under § 38.2-2228 (repealed in 1996) should be re-instituted. This reporting will provide the information necessary to enable the Bureau of Insurance to analyze claim trends and/or claim reserving practices.

Recommendation # 9

Amend Title 38.2 of the *Code of Virginia* to require insurers to report "closed claims" as previously required under repealed § 38.2-2228. Include language that allows insurers to report the information electronically to the Bureau of Insurance.

Virginia Tort Claims Act: The Virginia Tort Claims Act is codified in §8.01-195.1 et seq. of the *Code of Virginia*. In sum, the Virginia Tort Claims Act limits the liability of the Commonwealth, its agencies (i.e., departments, institutions, authorities, instrumentalities, board or other administrative agency of the Commonwealth) and employees (i.e., any officer, employee or agent of any agency or any person acting on behalf of any agency in an official capacity), and certain transportation districts for damages in certain cases. For negligent or wrongful acts or omissions of any covered employee that occur on or after July 1, 1993, the Virginia Tort Claims

Act limits the Commonwealth's liability to $100,000 or the maximum limits of any liability policy maintained to insure against such negligence or other tort, whichever is greater.

The feasibility of including certain OB physicians and/or other providers under the protections of the Virginia Tort Claims Act was considered as a means of reducing the burden of rising malpractice insurance costs. Currently, the provisions of the Virginia Tort Claims Act apply only to those individuals or entities acting on behalf of the Commonwealth. While physicians working for local health departments and other Commonwealth agencies are covered under the Act, its provisions do not extend to physicians in private practice. To do so would represent a major departure from the current intent and purpose of the law. Moreover, expanding the list of covered entities beyond those acting directly on behalf of the Commonwealth would set a precedent, and perhaps an expectation, for other private individuals or groups to secure the same protections. In addition, expanding the scope of the Virginia Tort Claims Act to include other persons or groups also would have a fiscal impact on the Commonwealth as it would become responsible for negligent acts of a greater number of persons or groups.

As with a premium subsidy program, coverage under the Virginia Tort Claims Act could be limited to those physicians and/or other providers who treat a certain percentage of Medicaid or uninsured patients. However, if coverage under the Virginia Tort Claims Act applied only to certain births (e.g., Medicaid births), and the physician or other provider still needed to maintain medical malpractice insurance coverage for other births, it is unclear how much of an overall benefit would be realized in terms of lower malpractice insurance costs.

Despite the concerns noted above, the Work Group believes the potential of including certain OB physicians and/or other providers under the Virginia Tort Claims Act should be explored in greater detail. Specifically, the Work Group recommends that this issue be considered by the Special Joint Subcommittee Studying Risk Management Plans pursuant to Senate Bill 601 of the 2004 Session of the General Assembly.

Recommendation # 10

> Request that the Special Joint Subcommittee Studying Risk Management Plans pursuant to Senate Bill 601 consider the feasibility of extending the provisions of the Virginia Tort Claims Act to selected licensed providers of obstetrical and gynecological services. This request will be made by letter from the Secretary of Health and Human Resources to the Chairman of the Joint Subcommittee.

Mandating Insurers to Offer Separate Coverage for Physicians Practicing "Part-Time" or In "Job-Share" Situations: During the course of this study, information was received that a number of OBs who desired to practice on a part-time basis or to work in a job-sharing arrangement were unable to do so because of prohibitively high malpractice premiums.

Information was gathered as to whether or not insurers have rules regarding job sharing or whether they charge the same premiums for part-time practitioners as they do for full-time practitioners. Licensed insurers have rules on file with the BOI allowing a practice to insure a

full-time equivalent (FTE) position staffed by two or more practitioners. This means that several practitioners can work the equivalent number of hours as a full-time practitioner but would only have to pay a premium equivalent to that of one full-time practitioner. Additionally, insurers have rules on file allowing credits for physicians practicing on a part-time basis. BOI staff is conducting a survey of the licensed writers in Virginia to determine the extent of eligibility of OBs for FTE rating, and whether or not OBs qualify for credits if they practice on a part-time basis and will report the results prior to the end of the year.

However, the Work Group agreed that the provision of rural obstetrical services would be enhanced if OBs interested in practicing on a part-time or job-sharing basis were not required to pay a premium equal to that of a full-time practitioner. It therefore recommends that all licensed insurers be required to have in place a rule allowing job-sharing under a full-time equivalent rating rule and that all licensed insurers be required to offer a credit for part-time practice for OBs.

Recommendation # 11

> Amend Title 38.2 of the *Code of Virginia* to require all licensed insurers to have in place a rule allowing job-sharing under a full-time equivalent rating rule and that all licensed insurers be required to offer a credit for part-time practice for licensed providers of obstetrical and gynecological services.

Medical Malpractice Insurance Premium Subsidy: As discussed earlier in this report, the cost of medical malpractice insurance has increased markedly in recent years. One action that may improve the affordability of medical malpractice insurance is a premium subsidy program that would help offset a portion of the premium.

A premium subsidy program could be administered in a variety of ways. Extensive discussions were conducted on this topic, and considered a wide array of issues about how best to structure such a program. These included:

- Would a premium subsidy be provided statewide to all OB physicians or limited to those providers in certain "stressed" or underserved areas of the Commonwealth?
- If a subsidy were limited to "stressed" or underserved areas, what criteria or other factors would be used to identify these areas?
- Would the subsidy be limited to OBs who follow certain evidence-based practice guidelines that are associated with better birth outcomes? Would there be other physician practice requirements?
- Would other OB providers (e.g., nurse midwives) be eligible for the premium subsidy?
- Would hospitals be eligible for the subsidy? If so, would all hospitals be eligible or would eligibility be limited to sole community provider hospitals?
- How much of a subsidy would be provided? Would all providers receive the same subsidy or would the amount vary based on certain factors?

- Would the subsidy be available every year, or only during certain years when providers face steep premium increases?
- What would be the funding source for the subsidy program?
- How would the subsidy program be administered?

These considerations led to a recommendation that the Commonwealth establish a premium subsidy program as a means of making medical malpractice insurance more affordable for sole community hospitals and those OB physicians who provide care to a certain percentage of Medicaid and uninsured patients, and would be consistent with the work being undertaken under Senate Bill 601.

Recommendation # 12

Establish a medical malpractice insurance premium subsidy program for sole community hospitals and licensed providers of obstetrical services whose practice includes a specified percentage of uninsured and Medicaid patients. The program would be administered by the Department of Treasury's Division of Risk Management and implemented by July 1, 2006.

In the second year of the program, the Division of Risk Management shall work with the physician community to develop a provision whereby licensed OB providers would have to follow evidence-based practice guidelines in order to qualify for the subsidy. The Division of Risk Management shall submit a report to the Governor, and the Chairman of the Senate Finance Committee, the Senate Education and Health Committee, the House Appropriations Committee, and the House Health, Welfare and Institutions Committee by October 1, 2005, outlining how it proposes to implement and administer the subsidy program.

Include $2,000,000 GF and language in the Appropriation Act to authorize and implement this program.

Senate Bill 601 (2004 Session of the General Assembly) and the Special Joint Subcommittee Studying Risk Management Plans

The 2004 Session of the General Assembly passed Senate Bill (SB) 601 which requires the Division of Risk Management within the Department of the Treasury to develop a risk management plan for physicians and sole community hospitals who meet certain criteria and requirements. The effective date of the plan requirement is July 1, 2006. The legislation also established the Special Joint Subcommittee Studying Risk Management Plans.

The Special Joint Subcommittee is studying various issues regarding medical malpractice insurance including: (i) the availability and affordability of medical malpractice liability insurance for physicians and hospitals in the Commonwealth; (ii) the practices of medical malpractice liability insurance carriers related to the establishment of premiums and the determination of increases in such premiums and the impact that the medical malpractice liability insurance climate is having on patient access to quality healthcare and on the ability of patients to recover damages from the settlement or verdict of a medical malpractice action; (iii) the potential impact of the new risk management program on the private sector; and (iv) the insurance-related programs established in other states to ensure the availability and affordability of medical malpractice liability insurance for physicians and hospitals within their jurisdictions and the feasibility and practicability of establishing such programs within the Commonwealth. The Special Joint Subcommittee is to report its findings and recommendations no later than December 1, 2004.

The activities and actions of the Special Joint Subcommittee Studying Risk Management Plans are related very closely to the issues that were addressed by the Medical Malpractice Subcommittee. As of the writing of this report, the Special Joint Subcommittee Studying Risk Management Plans had met twice and had not completed its study. The activities and recommendations of this Special Subcommittee should be monitored, coordinated with the Governor's Work Group on Obstetrical Care, and incorporated into the overall response of the Commonwealth to the problem of affordability of medical malpractice insurance.

Issues Considered with no Recommendation

The following issues were reviewed but no further action was recommended at this time.

Potential Changes to "Tail Insurance" Requirements: Another issue impacting the cost of malpractice insurance for OBs is the cost of purchasing "tail insurance," that is, an unlimited duration extended reporting period endorsement. A claims-made policy only covers claims that are reported during the policy period or during the extended reporting period. Consequently, "tail" insurance is necessary when a claims-made policy is cancelled or not renewed by the physician or the insurance company. If the new insurer provides "prior acts" coverage (coverage for claims that occurred prior to the inception date of the policy), then the physician does not need to purchase "tail" coverage from the old insurer. However, if the new insurer does not provide prior acts coverage, the physician must purchase an endorsement from the old insurer that extends the time allowed to report claims under the old policy.

In Virginia, insurers issuing medical malpractice policies are required to offer "unlimited" tail coverage. However, in addition to the "unlimited" tail, insurers may also offer "limited" tail coverage of any duration. No recommendation is being made at this time because Bureau staff is unable to provide information regarding the potential impact of insurers being able to offer less than an unlimited tail per the language in the Claims Made Regulation which is not effective until January 1, 2005. BOI is surveying insurers and will report its findings prior to the end of the year.

Joint Underwriting Association: Joint Underwriting Associations (JUAs) are entities established to ensure that a certain type of insurance is available in the marketplace. Typically, JUAs are established to address the *availability* of coverage rather than the *affordability* of

coverage. In Virginia, there are provisions in the *Code of Virginia* regarding JUAs for basic property insurance (§ 38.2-2708), commercial liability insurance (§ 38.2-2900, et seq.), and medical malpractice insurance (§ 38.2-2801, et seq.).

In Virginia, § 38.2-2801 of the *Code of Virginia* provides that in order to activate a Medical Malpractice JUA, the State Corporation Commission must find that medical malpractice insurance cannot be made reasonably available in the voluntary market for a significant number of any class type, or any group of health care providers. The BOI conducted a study in 2003 to determine if a JUA should be activated in the Commonwealth to make medical malpractice insurance available. The study was conducted pursuant to SB 1316 of the 2003 Session of the General Assembly.

BOI conducted five surveys in its investigation of the availability of medical malpractice insurance in the voluntary market in Virginia. Surveys were sent to hospitals, nursing homes, and physicians to determine if they were experiencing difficulty in obtaining medical malpractice insurance. Surveys were also sent to insurance companies and insurance agencies to ascertain who was writing new business and what types of restrictions were being placed in the market. BOI also held meetings with physicians throughout the state, and reviewed the number and types of complaints from medical providers that the Bureau's Property and Casualty Consumer Services Section received.

BOI's findings did not indicate that a significant number of any class, type or group of health care providers could not obtain medical malpractice coverage in the voluntary market. Accordingly, the Bureau did not recommend that a JUA be activated.

One of the current statutory requirements regarding a medical malpractice JUA is that it be actuarially sound and self-supporting with no subsidization from other lines of insurance. In its report to the Governor and the General Assembly, the Bureau noted that if this requirement was removed through legislative action, the JUA would not have to be self-supporting and a portion of the financial burden could be shifted from the health care providers covered under the JUA to all liability insurers, and subsequently to the insurance buying public at large. This could have a positive effect on medical malpractice insurance premiums. However, the ultimate effect of such a change would be that policyholders of other various types of insurance would be subsidizing the cost of medical malpractice insurance for the providers covered under the JUA.

The potential of establishing a JUA for medical malpractice insurance was considered as part of this study. However, given that the current dilemma in medical malpractice insurance is the *cost* and *not the availability* of coverage, it is recommended that such a course of action not be pursued at this time. The appropriateness of eliminating the current requirement that the JUA be self-supporting, and whether the cost of medical malpractice coverage through the JUA should be subsidized by the insurance buying public at large were also considered, but no action was recommended.

Consideration of Limitations on Medical Malpractice Awards

During the past three decades, states have adopted various types of tort reform legislation in an attempt to improve the availability and affordability of medical malpractice insurance and to limit liability pressure on providers. According to the GAO, tort reform is generally used by states to limit the number of malpractice claims and to reduce insurance premiums. Some observers argue that tort reforms will lower overall health care costs by reducing the tendency of physicians to practice defensive medicine, which consists of the over-utilization of certain tests or procedures to reduce exposure to malpractice liability. Examples of tort reform measures adopted by states include:

- placing limits (or caps) on the amount that may be awarded to plaintiffs for economic, non-economic, and punitive damages awarded in malpractice suits;

- placing limits on the fees charged by plaintiffs' lawyers;

- establishing pretrial screening panels to evaluate the merits of claims made by plaintiffs before proceeding to trial; and

- abolishing "joint and several liability" to ensure that damages are recovered from defendants in proportion to their degree of responsibility, not their ability to pay.

There is no consensus among researchers as to what long-term effect caps on non-economic damages will have on medical malpractice. Supporters of caps argue that such limitations will reduce malpractice insurance premiums by preventing excessive awards. In contrast, opponents of caps argue that other factors affect premium growth and that the caps will only result in under-compensation for severely injured patients.

The impact of tort reforms on medical liability premiums was recently examined by the CBO, GAO, Weiss Ratings, and Emory University researcher Kenneth Thorpe. The CBO concluded in its 2004 report that "restrictions on malpractice liability can indeed reduce total awards and thereby lead to lower premiums for malpractice insurance." The GAO reported in 2003 that premiums grew more slowly in states with caps on monetary awards for non-economic damages compared to states without such caps. However, Weiss Ratings found evidence suggesting that while caps reduced the amount of money awarded by juries in malpractice suits, they did not prevent insurance carriers from increasing their premiums. In fact, Weiss Ratings determined that states with non-economic damage caps experienced sharper increases in median annual premiums between 1991 and 2002 than states without such caps. In contrast, Thorpe reported that premiums in states which cap non-economic damages were 17 percent lower than premiums in states that did not cap such damages. However, Thorpe argued that additional research needs to be conducted before it can be determined whether non-economic damage caps are socially desirable and promote the deterrence goals of the U.S. liability system. Nevertheless, it should be noted that the GAO stated in its 2003 report that:

> [a]dequate data do not exist that would allow us and others to provide definitive answers to important questions about the market for medical malpractice insurance, including an explanation of the

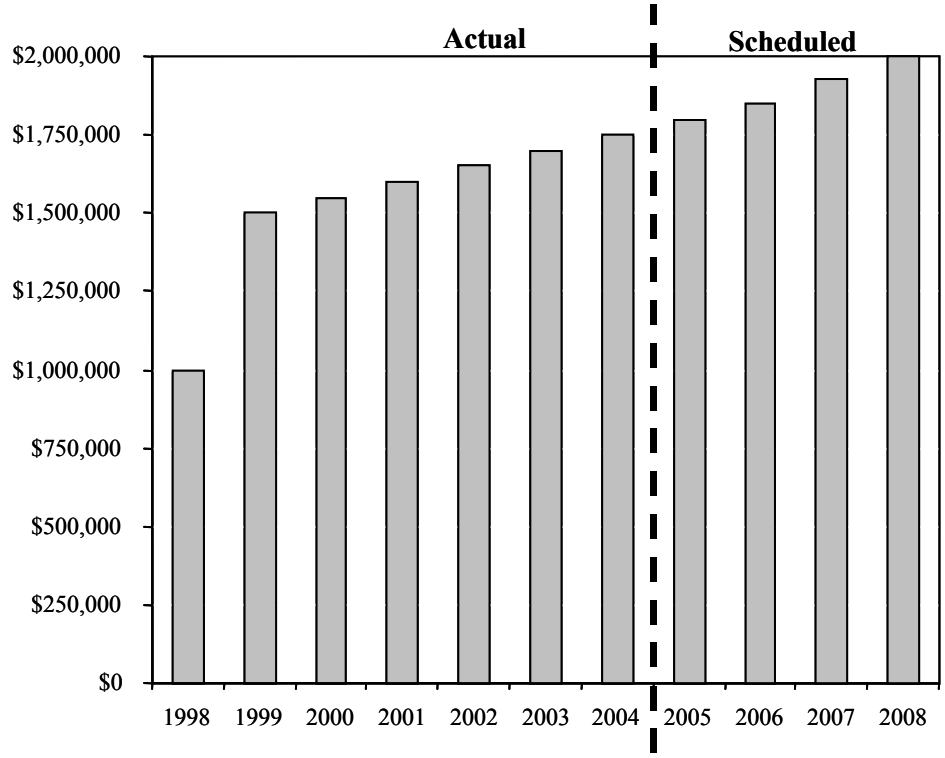
causes of rising losses over time and the precise effect of tort reforms on premium rates.[30]

In Virginia, caps are imposed on economic, non-economic, and punitive damages in medical malpractice cases. In 1976, the General Assembly enacted legislation that established a $750,000 cap on economic and non-economic damages in response to the medical malpractice crisis that occurred in the early 1970s. Subsequent legislation was enacted in 1983 and 1999 that increased the damage cap to $1 million and to $1.5 million respectively. The 1999 legislation allowed the damage cap to increase $50,000 annually (with two final increases of $75,000 beginning in 2007) until 2008 when the cap is scheduled to reach $2 million. (See Figure 14) The legislature has not considered revising the State's damage caps since 1999 and no additional increases in the caps are scheduled to occur after 2008. The General Assembly established a cap on punitive damages in 1987. No caps have been placed on attorney fees; however, the 2003 General Assembly did consider a proposal to limit attorney fees in malpractice cases.[31] The Virginia Supreme Court twice considered the legality of the State's malpractice law and has held both times that it does not violate the U.S. or Virginia constitutions.[32]

[30] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Premium Rate Increases*, GAO-03-836 (Washington, D.C.: June 27, 2003).
[31] House Bill 2520 was introduced during the 2003 General Assembly; however, it was passed by indefinitely by the legislature.
[32] *Etheridge v. Medical Center Hospitals,* 237 Va. 87, 376 S.E.2d 525 (1989) and *Pulliam v. Coastal Emergency Service,* 257 Va. 1, 509 S.E.2d 307 (1999).

Figure 14

Chronology of Virginia's Medical Malpractice Liability Damage Caps for Economic and Non-Economic Damages



Note: A cap on punitive damages was enacted in 1987.
Source: Virginia Bureau of Insurance.

The above information was reviewed and the arguments both for and against reducing Virginia's cap on medical malpractice awards were discussed. No consensus resulted from these discussions, and therefore no action is recommended.

PRACTICE & LICENSURE

Quality of Care

The Commonwealth has a compelling interest in maintaining a health care system that is adequate to assure that babies born in Virginia begin life as healthy as possible. This is particularly true because, of the nearly 100,000 babies born here annually, between 30 and 45 percent are enrolled in Medicaid.

One of the two outcome indicators most commonly associated with the quality of obstetrical care is low birth weight. Low birth weight is a factor in 65 percent of infant deaths worldwide, and low birth weight babies are at risk for serious health problems and long term disabilities. They are far more likely to need the intensive and costly services of a neonatal intensive care unit (NICU), which have been reported to be as much as 50 times greater than an uncomplicated delivery. In 2002, 7,904 low weight babies (less than 5.5 pounds) were born in Virginia. Of this total, 21 percent, or 1,653, were classified as very low birth weight (less than 3.3 pounds).

The other outcome indicator associated with the quality of OB care is infant mortality rate. In Virginia, the infant mortality rate has risen slightly, from 7.4 percent per 1,000 births in 2002 to 7.6 percent in 2003[33]. This translates into 766 infant deaths in 2003, the largest number in any year since 1994.

Several considerations may play a role in affecting outcomes in Virginia, including assessments of the adequacy of prenatal care, standards of practice, the state of evidence-based practice and the need for timely and uniform communication of clinical information

Prenatal Care

Despite the fact that prenatal care is considered the bedrock of maximizing good birth outcomes, there is no widely accepted standard indicator of the quality of the care that is rendered. There is a standard regarding the *number* of prenatal visits but it *does not address* the *content or quality of the care* that is rendered. Nevertheless, it is one available method for capturing some information that may be applicable to considerations of the quality of care.

The American College of Obstetricians and Gynecologists (ACOG) recommends that women enter prenatal care in the first trimester (conception to 13 weeks of gestation), continue prenatal care monthly until 28 weeks, have visits every two weeks after that until the last month when they should be seen weekly. Following this schedule would result in 13 prenatal visits.

Applying the ACOG Guideline of 13 prenatal visits to Virginia births, staff reviewed the average number of prenatal visits and the entry into prenatal care in the first trimester by city and county for the past four years using birth certificate data available (2000, 2001, 2002, 2003). The average number of prenatal visits was not discriminating and did not show any significant

[33] Source: Virginia Department of Health

variance. In fact, it appeared all cities and counties were doing very well in that the average number of prenatal visits was 9 or above with the majority averaging 11 or more visits.

Although it, too, is not a measure of the quality of care provided, the Kotelchuck Index is considered an indicator of the adequacy of *utilization* of prenatal care. Also known as the Adequacy of Prenatal Care Utilization (APNCU) Index, it goes beyond a simple average of the number of prenatal visits. Using two crucial elements obtained from birth certificate data, it indexes the time when prenatal care began (initiation) and the number of prenatal visits from when prenatal care began until delivery (received services). It then classifies the adequacy of initiation as follows: pregnancy months 1 and 2, months 3 and 4, months 5 and 6, and months 7 to 9.

To classify the adequacy of received services, the number of prenatal visits is compared to the expected number of visits for the period between when care began and the delivery date. The expected number of visits is based on the ACOG prenatal care standards for uncomplicated pregnancies and is adjusted for the gestational age when care began and for the gestational age at delivery. A ratio of observed to expected visits is calculated and grouped into four categories: Inadequate (received less than 50% of expected visits), Intermediate (50%-79%), Adequate (80%-109%), and Adequate Plus (110% or more).

Aggregate scores of all women from each city and county in Virginia were reviewed and categorized either as adequate, adequate plus, intermediate or inadequate. Figure 15 shows the percent of women receiving inadequate prenatal care as defined by the Kotelchuck Index in 2003[34].

Figure 15

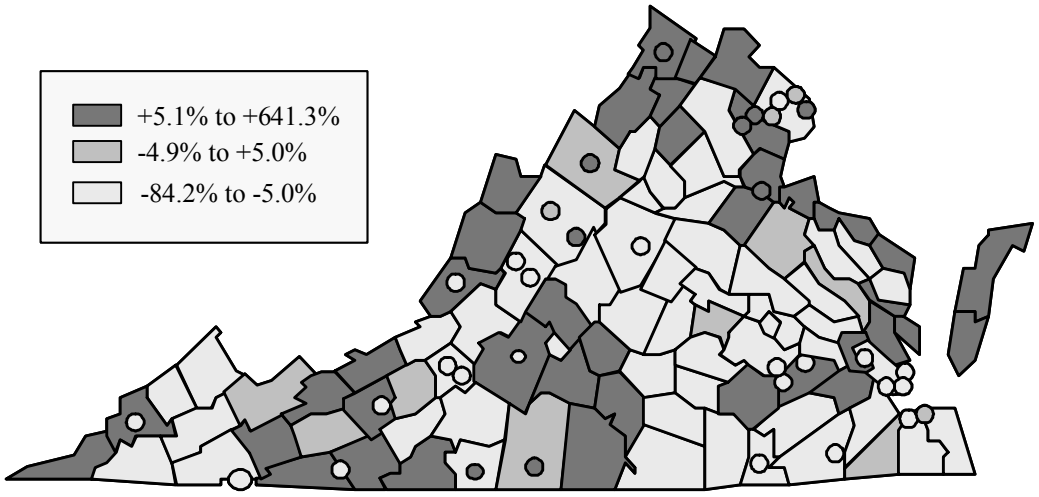
Percent of Births with Inadequate Prenatal Care by Locality, 2003

Source: Virginia Department of Health.

[34] If the information from the birth certificate was unknown, it was not used in this analysis.

The Kotelchuck Index was then applied for each year from 2000 – 2003, and the changes recorded. From this analysis, it was noted that 61 localities (Figure 16) experienced an increase in the proportion of women receiving inadequate care between 2000 and 2003. Those counties are shown on the following map.

Figure 16
Change in Proportion of Births with Inadequate Prenatal Care by Locality, 2003



Source: Virginia Department of Health.

Many of those regions are the very same ones already shown to be losing providers and service facilities.

Perceptions of Quality of Care

Another component of quality of care is the perceptions of those who provide the care. In order to assess current perceptions of the quality of obstetrical care in Virginia, the Subcommittee conducted confidential interviews with 30 key stakeholders in the areas with the highest inadequacy ratings in 2003 (see Figure 16). These individuals included hospital physician and nursing leadership, a pediatrician, obstetricians, Resource Mother Coordinators, and other administrative leaders in health care organizations. A summary of the survey and results may be found in Appendix J.

Only eight respondents (27 percent) offered a positive assessment of the quality of care. Most of the comments received identified improvements such as:
The key informant interview respondents identified a continuing problem for providers to have sufficient time to interact with pregnant women and balance all of the other administrative tasks in managing a busy practice. Issues related to obtaining and sharing medical records were raised

by several respondents: In order to provide quality services, it is necessary to have this information readily available, particularly for patients who may see one provider for prenatal care and then travel a considerable distance for delivery at a different site with a different provider. Lack of available supportive services such as mental health services, dental services, adequate transportation and patient education was identified by many interview respondents and workgroup members as interfering with provision of care.

Evidence-Based Practice

As stated earlier, although there is a perceived relationship between quality of care and such outcome indicators as low birth weight and infant mortality, and although there are indicators of care based on the number of prenatal visits, there is no widely accepted standard indicator of the quality of the care that is rendered. There are, however, guidelines for practice.

In 1983, the American College of Obstetricians and Gynecologists (ACOG)[35], in collaboration with the American Academy of Pediatrics (AAP), jointly published the first edition of *Guidelines for Perinatal Care.* Now in its fifth edition these joint ACOG/AAP guidelines have become a cornerstone of obstetrical practice in the nation. The guidelines are intended for use by all providers of care for pregnant women and their newborns in both community and hospital settings. These guidelines include general guidelines for perinatal clinical practice for both ambulatory and inpatient settings, minimum staffing standards, physical lay-out, necessary equipment, chain of decision-making command, common terms and definitions, and a hierarchy of levels of care.

The most current scientific information, professional opinion and clinical practices have been used to create the *Guidelines for Perinatal Care*. It is updated and released periodically. Information is continually updated through the publication of policy statements and technical bulletins by ACOG to respond to the rapidly evolving technologies and changes in practice.

The scientific literature which might be used to support standards of practice has grown exponentially in the last fifty years and can overwhelm providers. The most common reason that evidence-based practices are not used is lack of awareness and or access. With the assistance of the federal government and professional organizations, and the use of the Internet, resources for evidence-based practice are becoming more available.

The Agency for Healthcare Research and Quality (AHRQ), formerly known as the Agency for Health Care Policy and Research, part of the U.S. Department of Health and Human Services, no longer develops guidelines for clinical practice but promotes the National Guidelines Clearinghouse (NGC). This clearinghouse is a partnership with the American Medical Association and the American Association of Health Plans that develops clinical practice guidelines, which are based upon the best available evidence. Other professional groups have also developed similar resources.

There are now several online databases, such as the Cochrane Library[36], or books such as *Evidence-Based Obstetrics* which are databases of studies with a critical review of the strength of

[35] See information on the ACOG website at http://www.acog.org/
[36] Information about the Cochrane Library may be found at http://www.cochrane.org/index0.htm

the evidence for a clinical intervention or treatment. Also, the Clinicians Handbook of Preventive Services[37], is a helpful information and practical tool for adopting a systematic approach to the delivery of clinical preventive services with the understanding that improved delivery of clinical preventive services can help resolve discrepancies in health indicators such as pregnancy outcomes.

Continuing patient care interventions and treatments based upon provider preference or tradition is insufficient in the current environment. It is realistic to expect all obstetrical providers to practice using evidence-based principles and knowledge from the literature.

Recommendation # 13

Promote a model of prenatal, delivery, and postnatal care that is centered on evidence-based health care practices and outcomes. Wherever possible, evidence-based health care should be incorporated into decisions making or changing health policy.

Recommendation # 14

To encourage the practice of evidence-based prenatal and obstetrical care, all obstetrical providers licensed in the Commonwealth of Virginia should follow the Guidelines for Perinatal Care adopted jointly by the American College of Obstetrics and Gynecology and the American Academy of Pediatrics (for physicians) or The Standards of Midwifery Practice (for Certified Nurse Midwives), if these Guidelines are consistent with good clinical judgment.

The Secretary shall request that the 2005 General Assembly adopt a joint resolution acknowledging the importance of these Guidelines and encouraging appropriate professional associations to disseminate these guidelines to their members.

Electronic Health Record

Concerns persist that some medical errors could be prevented by the simple sharing of information in a timely manner. The need for such information sharing is particularly relevant to obstetrical care in Virginia because it is essential that the obstetrical care provider who attends the delivery understands the prenatal history of the women he/she serves. Furthermore, many women in the Commonwealth, particularly those in regions where hospital OB services are closing, or those who do not have insurance or whose citizen status prevents coverage through

[37] Accessible at http://www.vnh.org/PreventionPractice/TableOfContents.html

Medicaid, receive prenatal services from one provider and have their delivery attended by a different provider. Key informant interviews conducted by the Quality of Care Subcommittee emphasized that this was of particular concern in Virginia. (A more detailed description of this study may be found in the Access to Care section, and in Appendix J.)

The U.S. medical care system could more fully utilize technology to document and manage health care delivery. High costs, medical errors, variable quality, administrative inefficiencies, and poor coordination could all be improved with the use of electronic medical record documentation and communication.

Ready access to electronic health records (EMR) does not exist currently. Less than five percent of physicians are estimated to be using electronic medical records and few of these can exchange information.[38] The American Medical Association supports the concept[39] of the EMR but does express concern about costs. The Institute of Medicine states that the private sector could be expected to fund a substantial portion of the cost but a national system of computerized health information and data sharing is needed to develop the key components and infrastructure. No state has created such an electronic health care network.

President Bush has outlined a plan to ensure that most Americans have electronic records within the next 10 years. The President's Health Information Technology Plan will address the longstanding preventable errors, uneven quality of care, and rising costs in the nation's health care system. Last year the President asked the Institute of Medicine to design a standardized model of an electronic medical record and the Department of Health and Human Services expects to have a model ready this year.

In the President's 2005 proposed budget there are funds to be available for demonstration projects that will test the effectiveness of use of this information technology and establish best practices for more widespread adoption. Grants were awarded this past summer to several projects to begin this work.

[38] Hawryluk, M. (Feb. 9, 2004). Government pushes for electronic medical record standards. Amednews.com
[39] Ibid.

Recommendation # 15

Health care organizations and appropriate state agencies should explore opportunities to develop an electronic health record system to support evidence-based practice and that complies with HIPAA and other national standards.

The Secretary of Health and Human Resources shall work with agencies in the Secretariat to link public and private providers and health systems to maximize resources and experience and shall report to the Governor by December 15, 2005.

Universal Risk Assessment Tool

Just as an electronic health record assists providers in collecting and sharing information in a timely and accurate way, so the adoption of a universal risk assessment tool simplifies the collection and sharing of patient information among providers and, in some cases, with insurers. The current situation of multiple forms and processes significantly limits the ability of providers (and payers) to work together and creates unnecessarily complex and burdensome administrative requirements.

At least two states have responded to these problems by forming coalitions of insurers to develop a single, simple method for simultaneous identification and risk assessment. The implementation of a universal (i.e., uniform) risk assessment tool has led to significant improvements. By reducing the administrative burden on providers, and in some cases linking the URA to authorization for care, payers, providers, and patients in these states have all benefited.

The centerpiece of this process is a single URA form which should demonstrate the following characteristics:

Uniformity – There should be ONE format, agreed upon and used by all parties.

Simplicity– While there are many possible factors one might want to assess, we believe a simple tool will lead to a greater yield than a complex one. This will no doubt mean compromises in content.

Multipurpose – The URA should serve as a way to identify patients early in pregnancy, assess risk, and authorize care.

Low Administrative Burden – The process of completing and submitting the form to the payer should be as simple as possible. The goal is to reduce the administrative burden on providers and thereby enhance the value of the URA.

Actionable – The URA should lead to meaningful action on the part of payers and providers.

There are various methods and purposes of measuring risks and simplifying the process is commendable. Public health officials collect and analyze information about specific populations. A good example is the Pregnancy Risk Assessment Monitoring System (PRAMS). Initiated in 1987, it is a grant funded program administered by the Centers for Disease Control and is now in 32 states and one city. PRAMS[40] includes four indicators designed to capture socio demographic group differences, multivitamin use, postnatal check up for newborns, and postpartum contraceptive use. Over the long term, PRAMS data enables states to gather information regarding maternal behaviors and experiences and thereby monitor trends, predict outcomes, increase the understanding of the relationship between behavior and health outcomes, evaluate programs and policy, and monitor progress towards Healthy People 2010 Objectives.

Standard formats for capturing, recording and appropriately sharing patient information are a necessary component of both the URA and the EMR. When the same assessment methodology is applied, a standard "language" for assessment and communication of health and health risks is created, and enables faster more accurate transmission of information with less investment of administrative time.

Recommendation # 16

A universal risk screening assessment tool for pregnant women should be developed and incorporated into the electronic record system.

VDH should take the lead in developing this tool in consultation with academic medical centers, community hospitals, obstetricians, certified nurse midwives and others as needed.

Current Practice Paradigm

The current model for delivering obstetrical care to pregnant women in Virginia involves prenatal care with a local obstetrician or family physician and delivery at the local hospital. The convergence of multiple pressures, including the high cost of medical malpractice insurance, low reimbursement rates, and low volume has resulted in the loss of providers in rural areas. These factors, combined with hospital reimbursement issues, have resulted in the recent closure of several hospital OB services in rural areas. When these units close and the physicians leave the area, a community could also lose providers of prenatal care, postnatal care, and gynecological services. The women who live in these communities and those who live in other communities where hospital obstetrical units are threatened need another option to access care.

The current financial climate and delivery volume do not support hospitals with obstetrical units in every community. However, through a well coordinated matrix of health

[40] MMWR. 11/14/03."Surveillance for selected maternal behaviors and experience before, during and after pregnancy."52.(SS11).1-14

departments, birth centers, Level III Perinatal Centers, academic medical centers, and other hospitals, complete obstetrical access could be expanded to "stressed" areas in Virginia. Moving to a new and expanded paradigm of service delivery in Virginia will take substantial time and resources. Therefore, as a first step, Virginia should develop a pilot program to explore and evaluate a new model of care.

Pilot of a New Practice Paradigm

As described earlier in this report, there are several areas of Virginia where access to obstetrical care is stressed. Women in these stressed areas may travel a considerable distance to receive prenatal care or to deliver their babies. Hospital obstetrical units in these areas have closed or are facing potential closure. To address this situation, Virginia should consider expanding the current service delivery model to include a comprehensive approach including Level III Perinatal Centers, academic medical centers, regional health centers, other hospitals, birth centers staffed with certified nurse midwives in collaboration with obstetricians and family practitioners, telemedicine, telemetry, improved methods of maternal transport, mobile prenatal care units, and 24-hour telephone access.

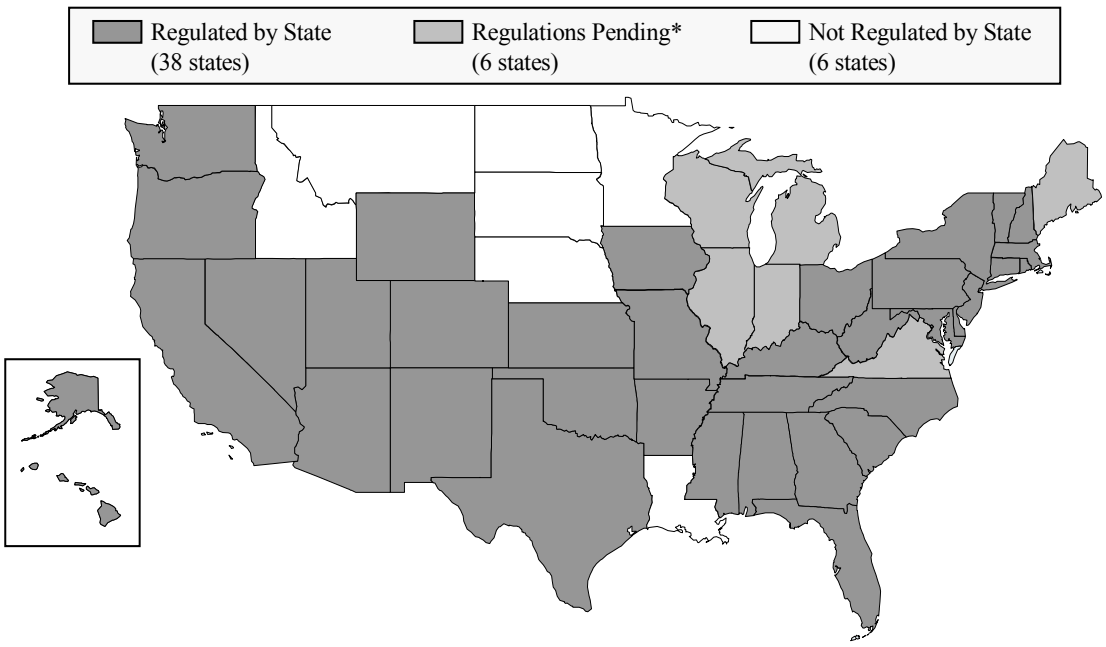
There are substantial benefits of collaborating with Level III Perinatal Centers[41], particularly those located in academic health centers, for the purposes of this pilot program. They have the necessary equipment and experience in serving rural sites with telemedicine and telemetry, and provide access to a complete staff of perinatologists and neonatal specialists. In addition, academic medical centers have experience conducting the type of research necessary to evaluate the results of the pilot program.

Sites for the provision of prenatal and postnatal care for this pilot would be recruited from free clinics, community health centers, and health departments in the identified, stressed areas. A team composed of an obstetrician, certified nurse midwives, nurse practitioners, and social workers would provide prenatal and postnatal services on a scheduled basis at these sites as well as throughout the community in mobile teams. Delivery services would be available by the team of practitioners at a regional birthing center for low-risk births (in-hospital or free-standing), and at the Level III Perinatal Center, academic medical center or other regional acute care hospital for high-risk births.

[41] Designation as a Level III Perinatal Center requires adherence to a set of service standards as set forth in §§32.1-12 and 32.1-127 of the *Code of Virginia*. It is a voluntary designation. There are currently five Level III Perinatal Centers in Virginia: University of Virginia Medical Center, Medical College of Virginia, Eastern Virginia Medical School / Sentara Norfolk General Hospital, Carilion Hospital and Inova Fairfax Hospital.

Figure 17

Regulation of Birth Centers



Source: National Association of Child Bearing Centers, 2001.

Birth centers have been used nationwide to provide additional access to obstetrical care. Thirty-eight states currently regulate birth centers (see Figure 17); however, Virginia does not have regulations for this model. The birth center model focuses on the collaboration of a variety of providers, including physicians and certified nurse midwives, to provide care to low risk women in an environment that is less costly than a hospital bed. According to the National Association of Childbearing Centers, a birth center is:

> . . . a homelike facility, existing within a healthcare system with a program of care designed in the wellness model of pregnancy and birth. Birth centers are guided by principles of prevention, sensitivity, safety, appropriate medical intervention, and cost effectiveness. Birth centers provide family-centered care for healthy women before, during and after normal pregnancy, labor and birth.

The New England Journal of Medicine reported the outcomes for the care of over 11,800 women who were admitted in labor to 84 birth centers nationwide[42]. The results showed a zero maternal mortality rate and an infant mortality rate of 1.3 per 1000 births; these results are comparable to studies of similar, low risk births in hospitals.

There are two birth centers currently operating in Virginia. The Midwifery Center at DePaul is part of Bon Secours Hampton Roads Health Services in Norfolk; BirthCare &

[42] Rooks, J.P., Weatherby, N.L., Ernst, E.K.M., Stapleton, S., Rosen, D., Rosenfeld, A. "Outcomes of Care in Birth Centers: the National Birth Center Study," *New England Journal of Medicine*, 1989; 321: 1804-1811.

Women's Health Ltd. is located in Alexandria. The latter is a freestanding birth center that is licensed in Maryland and accredited by the Commission for the Accreditation of Birth Centers. The Midwifery Center at DePaul provides a homelike environment in the safety of the hospital. Certified nurse midwives monitor and support the health of the mother and baby throughout the pregnancy. A collaborative relationship exists with obstetricians to whom women who are considered high-risk or who develop complications during labor and delivery are transferred.

The BirthCare & Women's Health Ltd. is owned and operated by certified nurse midwives who have relationships with several consulting physicians. The birth center provides the full spectrum of care to women in Virginia, Maryland, and the District of Columbia. According to the executive director, the center provides care to a diverse group of women in terms of the insurance and socio-economic status. It is important to note that because Virginia does not license birth centers, this center may not enroll as a Medicaid provider and receive reimbursement for services to Medicaid pregnant women. Virginia should consider following the lead of 38 other states and regulate birth centers.

The partnership between a Level III Perinatal Center and a birth center would establish a service delivery mechanism that provides different levels of delivery care based on risk. Therefore, a comprehensive program of identifying risk in a timely, efficient manner is necessary. A triage program should be incorporated into the pilot program to be used in emergency and non-emergency situations. One example of triage, which is employed in Florida, is a nurse practitioner or nurse midwife conducting a home visit for a woman in early labor to evaluate whether she is ready to be transported to the birth center, or for high risk situations, to the regional perinatal center.

The goal of exploring this new paradigm of service delivery is to increase access to prenatal, delivery, and postnatal care for women in the Commonwealth. In addition, the pilot would have the following positive impacts:

- Education and learning time in the prenatal care and post natal care setting will be maximized.
- Local access to prenatal and post natal care will be improved.
- Women in underserved areas with low risk pregnancies will have access to affordable, cost-effective delivery options at regional birthing centers.
- Women with high risk pregnancies will have access to trained and experienced staff in a regional medical centers center.
- Maximum leverage of funding will be possible through effective use of a mobile team that will provide prenatal care, post natal care, and deliveries in a regional birthing center.
- Staff costs will be reduced through use of lower cost care providers.
- A controlled pilot will allow the Commonwealth to gain experience with alternative methods of serving pregnant women in rural areas.
- A controlled and well supervised pilot will allow the Commonwealth to assess the quality, safety, and economic advantages of using birthing centers and midwives in collaborative practice to provide cost effective care to underserved areas.
  An essential part of the pilot program is evaluating the success of the model.

Specifically, the following measures should be evaluated during and after the administration of the pilot program:

- Evidence-based outcomes
- Cost-effectiveness
- Utilization
- Access to care

Therefore the Work Group makes the following recommendations regarding a pilot project to explore this new paradigm of care.

Recommendation # 17 (Practice/Licensure)

VDH should implement, in one or more pilot sites, an alternative system of prenatal and obstetrical services in areas that are experiencing severe problems in accessing such care.

The purpose of the pilots is to demonstrate the effectiveness of a new practice paradigm among obstetric providers designed to increase access to high quality pregnancy-related care.

Each pilot project will be overseen by one or more obstetricians at a Level III Perinatal Center and will also assure that certified nurse midwives work in collaboration with physicians in close proximity to the midwives' practice.

In the pilots, Certified Nurse Midwives (CNMs) would practice in collaboration and consultation with physicians in close proximity who would agree to be a referral source as stipulated in a mutually agreed protocol consistent with the evidence-based practice.

VDH should convene stakeholders including, but not limited to, obstetricians, family practitioners, and licensed nurse midwives to define the protocol to be used in the pilot not later than September 1, 2005. The protocol will determine, among other things, how "collaboration and consultation" will be defined for the pilots.

For pilot sites that elect to include birthing centers as part of the system of care, these centers must be in close enough proximity to a health care facility equipped to perform emergency surgery if needed. Any birthing center that is part of the pilot licensure must, at minimum, maintain membership in National Association of Childbearing Centers (NACC) and annually submit the following information to the State Health Commissioner: 1) a survey of birth center operations, 2) outcome indicators and 3) data presented according to the NACC Uniform Data Set. Consideration should be given to establishing state regulations for licensure of birthing centers.

The licensing of birth centers, if implemented, is not intended to alter in any way existing provisions of the Certificate of Public Need. Pilot site(s) are encouraged to include the use of telemedicine in the execution of their pilot project(s.)

VDH shall report to the Secretary of Health and Human Resources in December 2007 on outcomes of the pilots and recommend any additional regulatory or administrative revisions needed.

Licensure of Certified Nurse Midwives

Certified nurse midwives (CNM) are licensed in Virginia to provide obstetrical care to women under the supervision of a physician. CNMs are nationally certified to provide well women gynecological care as well as prenatal, delivery, and postnatal care in hospitals, birthing centers, and home environments. In Virginia, certified nurse midwives typically provide delivery care in a hospital setting. According to the American College of Nurse-Midwives[43] (ACNM), as of September 2002, there are 180 CNMs licensed in Virginia and there are 101 nurse midwifery practice sites in Virginia.

Certified nurse midwives are considered "licensed nurse practitioners" in Virginia. The *Code of Virginia* § 54.1-2957.01(D)(2) states:

> "In the case of certified nurse midwives, the supervising physician either shall regularly practice in the location in which the certified nurse midwife practices, or in the event that the certified nurse midwife has established a separate office, the supervising physician shall be required to make periodic site visits as required by regulations promulgated pursuant to this section."

The Virginia Administrative Code (18VAC90-30-120) states:

> "A licensed nurse practitioner shall be authorized to engage in practices constituting the practice of medicine in collaboration with and under the medical direction and supervision of a licensed physician."

According to the American College of Nurse-Midwives, certified nurse-midwives are registered nurses who have graduated from a nurse-midwifery education program accredited by the American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA) and have passed a national certification examination to receive the professional designation of certified nurse-midwife. Midwifery practice is based on the Core Competencies for Basic Midwifery Practice, The Standards for the Practice of Nurse-Midwifery, and the Code of Ethics promulgated by the American College of Nurse-midwives. In addition, midwifery education is based on an understating of health sciences theory and clinical preparation that shapes knowledge, judgment, and skills deemed necessary to provide primary health care management to women and newborns. (Summary information available in Appendix H.)

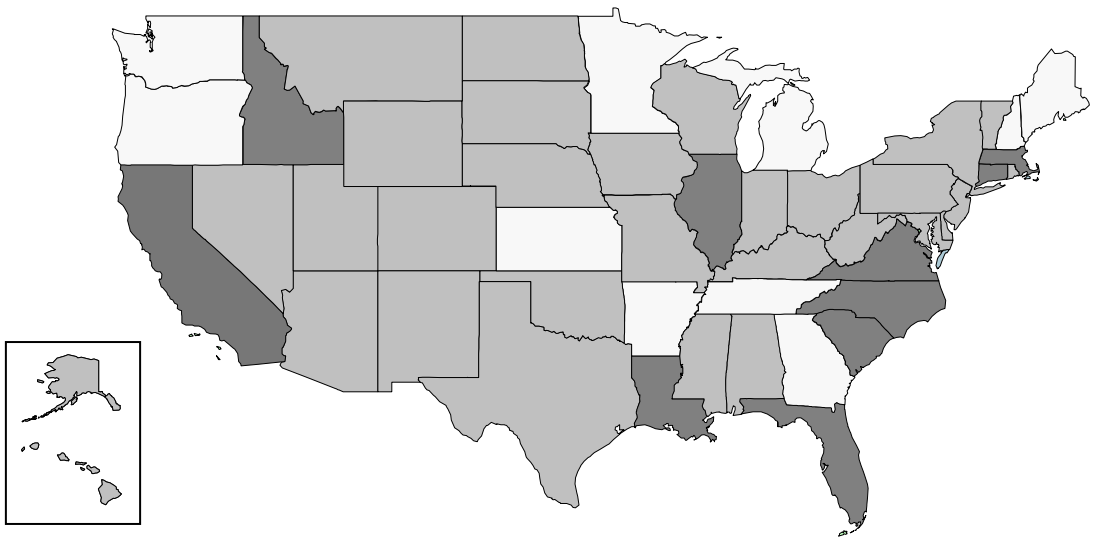
Along with Virginia, ten other states require CNMs to practice with physician supervision or direction (see Figure 18). However, thirty states allow CNMs to practice with physician collaboration, consultation and/or referral. There are several practical differences between the two types of relationships. Under Virginia's current model, a physician must agree to supervise a certified nurse midwife in order for the midwife to practice; however, there is no

[43] More information available at http://www.acnm.org/

financial incentive for the physician. In fact, there is a financial disincentive, as the physician's medical malpractice insurance increases as he or she takes on the liability of the midwife. CNMs argue that it is difficult to find physicians who are willing to act as supervising physician; as a result, many are unable to practice as midwives.

Figure 18

Regulation of Certified Nurse Midwives Nationally



* CNM works with physician supervision and/or direction
** CNM works with physician collaboration, consultation, and referral
Source: "A Handbook of State Laws and Regulations," American College of Nurse-Midwives, 2002.

By changing the statutory language requiring physician supervision for certified nurse midwives to collaboration, consultation, and referral, it is expected that the number of providers available to serve pregnant women would increase. The nature of the relationship supports the midwifery model, where midwives refer high risk cases (whether identified early in pregnancy or during labor and delivery) to an obstetrician. A substantial amount of research has found that outcomes for pregnant women who receive care from certified nurse midwives are comparable to similar women who receive care from OBs.

According to "Midwifery care, social and medical risks factors and birth outcomes in the USA"[44], birth certificate data from 1991 was examined for all single vaginal births between 35 and 43 weeks. The purpose of this study was to determine if there are significant differences in birth outcomes and survival for infants delivered by CNMs compared with those delivered by physicians; and whether these differences, if they existed, remained after controlling for sociodemographic and medical risk factors. Sociodemographic risk factors controlled for were maternal age, race, education, marital status, birth order, month of pregnancy prenatal care began, and gestational age. Medical risk factors controlled for were

[44] MacDorman, M.F, Singh, G.K., Epidemiology Community Health, 1998, 52:310-317

hydramnios/oligohydramnios, abruptio placenta, breech/malpresentation, fetal distress, precipitous labor (< three hours), premature rupture of membranes (> twelve hours), and seizures during labor. In this particular study, the risk of neonatal mortality was 33 percent lower for births attended by CNMs. In addition, the risk of delivering a low birth weight infant was 31 percent lower for CNM attended births and the mean birth weight was 37 grams heavier for CNM attended births. Finally, the infant mortality rate was 19 percent lower for CNM attended births. CNMs provide a safe option in maternity care services in the United States.

According to "outcomes of intended home births in nurse-midwifery practice: a prospective descriptive study"[45], the reported outcomes of intended home births in nurse-midwifery practices demonstrate safe, high-quality care. Reports on the outcomes of 1,404 women enrolled for care showed that only 9.1 percent of women were transferred to the hospital during labor or postpartum. In addition there was no maternal mortality noted and for women giving both at home, the neonatal mortality rate was 1.8/1000. The study found that only 1.1 percent of infants were transferred to the hospital.

A substantial amount of testimony regarding eliminating physician supervision as a way to expand access to OB care in some areas was provided by many consumers and midwives during the Work Group's town hall meetings

Recommendation # 18

Amend the *Code of Virginia* to allow Certified Nurse Midwives (CNMs) to practice with physician collaboration, consultation, and referral statewide by eliminating language that requires supervision for CNMs.

Certified Professional Midwives (CPM)

Certified professional midwives (CPM), also referred to as direct-entry midwives (DEMs), are not licensed to practice in Virginia. Prior to 1977, DEMs were permitted to practice in Virginia and were licensed by the Department of Public Health. In 1977, Virginia stopped issuing new permits, but allowed already permitted midwives to continue practicing. The last permitted DEM stopped practicing in 2002. Seventeen other states either prohibit CPMs from practicing or the statute is unclear. Eighteen states do regulate the practice of CPMs and 11 states permit the practice of DEMs without regulation. (See Appendix I).

CPMs are nationally certified to provide prenatal, delivery, and postnatal services in the home environment. The North American Registry of Midwives (NARM) recognizes that the education of a certified professional midwife is composed both of a didactic and clinical experience. All of the Midwifery Education Accreditation Council (MEAC) accredited programs are three years in duration. The didactic component takes approximately two years. The clinical component of the educational process must be at least one year in duration and equivalent to

[45] Murphy, P.A., Fullerton, J., Obstetrics and Gynecology, 1998, 92:461-470.

1350 clinical contact hours under the supervision or one or more preceptors. Admission requirements to an accredited program include a high school diploma with pre-requisite college level courses including human anatomy and nutrition. NARM requires recertification every three years. To be re-certified, the certified professional midwife is required to complete 30 continuing education contact hours during a three-year period. These must include five contact hours of peer review. (See Appendix H for comparison with Certified Nurse Midwives.)

Certified Professional Midwife Outcome Data

According to the "Planned Home Births: Outcomes Among Medicaid Women in Washington State" by the Washington State Department of Social and Health Services, the rates of poor birth outcomes are very low among the women who delivered at home or in birthing centers. In addition, when outcomes are compared for women who received some prenatal care from a licensed midwife and delivered their baby in a hospital, the rates of poor outcomes are generally higher than for women delivering in non-hospital settings or for the general Medicaid population. One of the most striking findings of the study includes the fact that the very low rates of poor birth outcomes among women delivering at home or in birthing centers and the very high rates of in-hospital delivery for infants with poor birth outcomes born to women who received prenatal care from licensed midwives. It should be noted that the high rates of in-hospital delivery for infants with poor birth outcomes suggest that their mothers were selectively transferred at some point during pregnancy or labor. In summary, the results of this study are consistent with a large body of literature, which has documented the safety of planned home birth for low risk women when attended by a trained provider. Finally, it is unclear whether these findings account for patient acuity.

The research study "Licensed mid-wife attended, out-of-hospital births in Washington State: are they safe?"[46] found that it was just as safe to have a baby outside of the hospital, under the care of a licensed midwife, as to have a hospital delivery with doctors or Certified Nurse-Midwife in attendance. In this study, the authors compared out-of-hospital births, attended by licensed midwives, to those attended by doctors and CNMs. The out-of-hospital midwife deliveries were less likely to produce low-birth weight babies. When looking at only low-risk mothers, licensed midwives and certified nurse-midwives were both less likely to deliver low-birth weight babies than doctors. As before, it is unclear whether these findings account for patient acuity.

Certified Nurse Midwife Educational Requirements

According to the American College of Nurse-Midwives, certified nurse-midwives are registered nurses who have graduated from a nurse-midwifery education program accredited by the American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA) and have passed a national certification examination to receive the professional designation of certified nurse-midwife. Midwifery practice is based on the Core Competencies for Basic Midwifery Practice, The Standards for the Practice of Nurse-Midwifery, and the Code of Ethics promulgated by the American College of Nurse-midwives. In addition, midwifery education is based on an understating of health sciences theory and clinical preparation that shapes

[46] Janssen, P.A., Holt, V.L., Myers, S.J., Birth, 1994, September 21 (3): 141.8

knowledge, judgment, and skills deemed necessary to provide primary health care management to women and newborns.

CNM Outcome Data

According to "Midwifery care, social and medical risks factors and birth outcomes in the USA"[47], birth certificate data from 1991 was examined for all single vaginal births between 35 and 43 weeks. In this particular study, the risk of neonatal mortality was 33% lower for births attended by CNMs. In addition, the risk of delivering a low birth weight infant was 31% lower for CNM attended births and the mean birth weight was 37 grams heavier for CNM attended births. Finally, the infant mortality rate was 19% lower for CNM attended births. It is unclear whether these findings account for patient acuity.

According to "outcomes of intended home births in nurse-midwifery practice: a prospective descriptive study"[48], the reported outcomes of intended home births in nurse-midwifery practices demonstrate safe, high-quality care. Reports on the outcomes of 1,404 women enrolled for care showed that only 9.1 % of women were transferred to the hospital during labor or postpartum. In addition there was no maternal mortality noted and for women giving both at home, the neonatal mortality rate was 1.8/1000. The study found that only 1.1 % of infants were transferred to the hospital.

The work group acknowledges that based on testimony it received, many consumers would like to have the option of a home birth attended by a certified professional midwife. The Work Group considered the option of recommending licensure for Certified Professional Midwives but did not recommend that such action be taken at this time. Instead the Work Group chose to focus its recommendations on certified nurse midwives who are already licensed in Virginia.

[47] MacDerman, M.F, Singh, G.K., Epidemiology Community Health, 1998, 52:310-317
[48] Murphy, P.A., Fullerton, J., Obstetrics and Gynecology, 1998, 92:461-470.

BIRTH INJURY FUND

The Virginia Birth-Related Neurological Injury Compensation Program was reviewed to determine if any modifications should be made to it in light of the current status of obstetrical care. This review included, in particular, the report on that program done by the Joint Legislative Audit and Review Commission (JLARC) in 2002.

Background[49]

In the mid-1970s Virginia, along with the rest of the nation, experienced its first medical malpractice crisis. As a result of this crisis, almost all states enacted some changes in their tort systems. Most notable among the changes in Virginia was a cap placed on the total amount recoverable in medical malpractice lawsuits.

By the mid-1980s another medical malpractice crisis was looming, heightening interest in additional tort law changes. The early to mid-1980s saw increasing medical malpractice lawsuits, increasing malpractice insurance premiums, and decreasing insurance availability. This situation led to a "crisis" in obstetrics, in which physicians were reportedly eliminating obstetrical care from their practices. Rural areas of Virginia were particularly affected by this situation, with some counties having no obstetrical services available. Several changes in tort law were subsequently enacted, including the Virginia Birth-Related Neurological Injury Compensation Act. This act, passed in 1987, established a unique framework, separate from the court system, for addressing one of the most severe and costly types of medical injuries - birth injuries. Virginia was the first state in the nation to develop a birth injury compensation plan completely removed from the tort system. The only other state to enact a birth injury program is Florida.

The goal of the birth injury act was to alleviate the medical malpractice insurance availability crisis for obstetricians. At its simplest description, the birth injury program was intended to remove malpractice lawsuits from the court system and provide for an alternative way of compensating the plaintiff for his or her medical-related injury. Infants severely injured at birth were singled out for this approach because lawsuits associated with these cases have a relatively high rate of success and the successful cases tend to result in large monetary awards.

To be eligible for the program, an infant must meet the definition in the act for a birth-related neurological injury, and the obstetrical services must have been performed by a physician or at a hospital that specifically participates in the birth injury program. The program was designed as a "no-fault" system of compensation, and therefore decisions regarding acceptance into the program are not based on a finding of malpractice

Administration of the Birth-Related Neurological Injury Compensation Program (birth injury program) involves the program staff and two State agencies, the Workers' Compensation Commission, which conducts hearings and determines eligibility, and the State Corporation Commission, which has certain financial responsibilities. The funding of benefits comes from

[49] Much of the introductory material in this section is taken directly from the January, 2002 Report on the Birth Injury Fund done by the Joint Legislative Audit and Review Commission at the direction of its Commissioner.

four main sources: assessments on participating physicians, participating hospitals, non-participating physicians, and insurers in Virginia.

Decisions regarding admission into the program are based upon expert physician review by obstetrical specialists located at the three medical schools in the Commonwealth [University of Virginia, Medical College of Virginia and Eastern Virginia Medical School]. There have been concerns raised by the faculty at the medical schools on the lack of guidance or uniformity of how these cases are reviewed and reported. In the last two years, obstetrical physician leaders have developed a form, which included four areas to be used in chart review and a standardized reporting opinion. This form was submitted for adoption by the Birth-Related Neurologically Injured Infant Program but was rejected by the Workers' Compensation Commission [the agency responsible for conducting hearings and determining eligibility for those seeking entry into the program] and the Court of Appeals. There has been criticism that the form did not reflect the consensus of the medical community and was a partisan effort to limit the number of children admitted into the program. Currently, there is no tool that would allow for a thorough and comprehensive review of individual cases using consistent criteria. Faculty reviewers from the medical schools typically spend ten to fifteen hours reviewing cases without any compensation for their departments.

By delivering a baby in a participating hospital and/or through a participating physician, the baby's family automatically waives the right to bring a medical malpractice lawsuit against the participating physician or hospital if the baby incurs a birth injury that meets the definition in the *Code of Virginia* § 38.2-5002 . The program was also intended to completely restructure the way injured infants are compensated for their injuries by eliminating the lump sum awards common in malpractice awards and instead, providing payment on a reimbursement basis, after collateral sources are used.

Around the same time as the medical malpractice crisis, the State was experiencing a problem regarding obstetric care for indigent women. To help alleviate this problem, language was included in the birth injury act to require doctors, as a requirement for participation in the program, to work with the Commissioner of Health in developing a program to provide obstetrical care to indigent women and to subsequently participate in its implementation.

The birth injury program had an immediate impact on medical malpractice insurance availability in Virginia because, once the program was created by the General Assembly, one of the major malpractice insurers immediately lifted its moratorium on writing new policies for obstetricians/gynecologists. This action helped ameliorate the lack of available insurance experienced prior to the program's creation due to another insurer's withdrawal from the Virginia market. While this short-term impact is clear, the program's long-term impact is less clear. It appears that the program has had mixed success in meeting all of its objectives.

Virginia's significant changes to the tort system (notably the malpractice award cap), along with a relatively low malpractice claims record, made the State an attractive market for medical malpractice insurance companies in the 1990s. It appears that the birth injury program played a role in creating this situation both by minimizing claims for severely birth-injured children and by helping to keep intact the medical malpractice award cap. As a result, obstetricians in Virginia were able to obtain malpractice insurance at lower rates than their counterparts in many other states. To a lesser extent all physicians benefited from the lower level

of indemnity incurred by malpractice insurers. Although malpractice premiums have increased significantly in the past few years, this does not negate the fact that the malpractice cap and birth injury program appear to have had a positive effect on claims costs and subsequent malpractice premiums.

At the same time, the birth injury program has directly benefited some participating physicians because they avoided medical malpractice lawsuits. Others have benefited from insurance discounts for participation that exceeds the assessment paid for participating in the program. In other words, they benefit financially simply by participating in the program.

Because a number of concerns have been raised about this program during its 15-year existence, the Joint Legislative Audit and Review Commission (JLARC) conducted a *Review of the Virginia Birth-Related Neurological Injury Compensation Program* in 2002. This evaluation focused on whether the program was achieving its intended purpose and included information on the claimants, benefits, funding and impact. The report concluded with 33 recommendations for the General Assembly. The legislature passed a bill to address some of them in 2003 legislative session.

Current Status

The rationale for the birth injury program was that by stabilizing medical malpractice premiums for obstetric providers and reducing their exposure to lawsuits, they would decide to continue practicing obstetrics in the State. With the recent occurrences in the closing of obstetrical units in smaller rural hospitals and the number of obstetricians discontinuing obstetrical services, it appears that although it had helped stabilize malpractice premiums in the past, the program's existence does not appear to have a significant impact on the availability of obstetric services in the State.

Section 38.2-5004 of the *Code of Virginia* directs the Board of Medicine and the Virginia Department of Health (VDH) to review all birth injury petitions submitted to the Program. The Board of Medicine is required to assess whether the physician(s) involved in the petitioner's birth provided substandard care that would warrant disciplinary action by the Board of Medicine. VDH reviews the petition to determine whether the hospital and its staff provided inadequate medical care that should impact the hospital's licensure. It was found during this review that minimal investigations of the circumstances surrounding the birth events were conducted. In the vast majority of cases, the agencies read the petitions but conducted no further investigations. From the review of parents participating in the program, there was a lack of timely responses from the program concerning these deliberations. Two of the JLARC report recommendations specifically addressed these concerns:

- As part of their reviews of birth injury petitions, the Board of Medicine and the Virginia Department of Health should routinely interview the claimant families on the events surrounding the births.

- The Board of Medicine and the Virginia Department of Health should routinely notify each claimant family concerning the outcome of the respective medical reviews.

The cases reviewed by the program represent the most devastating outcomes associated with childbirth. The circumstances and patient factors examined in each of these cases would identify clinical practices that need to be reviewed and possibly changed. Communications of these lessons learned to the broader audience of obstetrical providers has not been a component of the program.

Finally, the impact of the program on obstetric services to indigent women is unclear. As directed in the birth injury act, VDH implemented plans in 1988 for ensuring indigent women had access to obstetric services. However, there is no indication that the plans have ever been updated. Data from the Department of Medical Assistance Services suggests a generally increasing level of obstetric coverage for women with Medicaid coverage. However, this trend does not appear to be related to the provisions of the birth injury act, given that no action has been taken since the late 1980s regarding the birth injury act's indigent care provisions.

These conditions should be remedied, as follows:

Recommendation # 19

A uniform data collection tool should be adopted by the Workers' Compensation Commission for use by consultants evaluating medical records to determine whether children should be admitted to or denied access to the Virginia Birth-Related Neurological Injury Compensation Program. The form shall reflect criteria that are consistent with the existing provisions of the Virginia Birth-Related Neurological Injury Compensation Program and is intended to assist in assuring that decisions are as consistent as possible across the Commonwealth, recognizing that there are subtle differences in individual cases that require the exercise of medical judgment.

Recommendation # 20

VDH, the BOM, University of Virginia, Virginia Commonwealth University, Medical College of Virginia, and Eastern Virginia Medical School, in collaboration with stakeholder organizations, shall develop a process and mechanism to: 1) collect and analyze their findings from Birth-Related Injury Compensation Program cases admitted on or after July 1, 2005, and 2) shall work with perinatal provider organizations to develop and disseminate reports on the factors in obstetrical care that contribute to adverse birth outcomes.

Recommendation # 21

BOM and VDH should fully implement the recommendations from the Joint Legislative Audit and Review Commission (JLARC) in its November 2002 "Review of the Virginia Birth-Related Neurological Injury Compensation Program" that call for routinely interviewing the claimant families about the events surrounding the births and notifying them about the outcome of the medical reviews.

Recommendation # 22

VDH, through its health districts, shall initiate, and update as needed, (but not less frequently than every three years), memoranda of agreement with appropriate local obstetrical providers as specified by the Virginia Birth-Related Neurological Injury Compensation Program.

The purpose of these agreements is to develop a plan to improve access for low income and uninsured women.

IMPROVING ACCESS TO CARE

Improving access to obstetrical care is a complex issue, including financial considerations as well as behavioral ones. The following five recommendations represent responses to a variety of additional barriers felt, to varying degrees, throughout the Commonwealth.

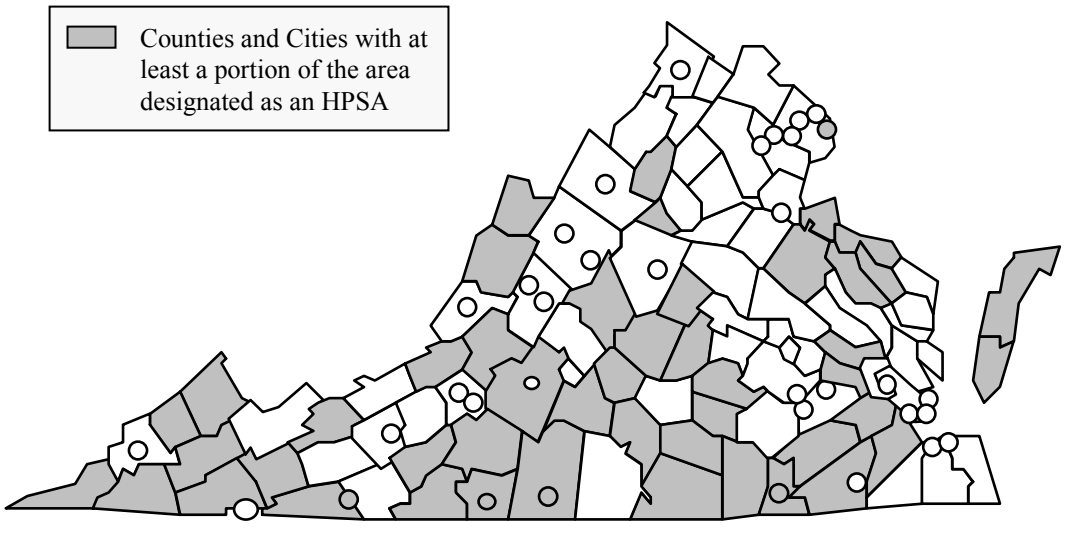
Improving Recruitment of Physicians

Medical Scholarship/Loan Repayment Programs: As those involved in rural health already know, it is difficult to recruit and retain physicians in a rural area. The practice opportunities are fewer, the "on call" demands are higher because there are fewer physicians to share the coverage, the income scale is lower, the opportunities for continuing medical education are fewer and harder to access, and the lifestyle is decidedly different from that in an urban or suburban area. Special efforts to support and assist these communities will stabilize the current critical situation and create a firmer foundation for the future.

The Work Group believes that there is a need for increased incentives for OBs to practice in underserved areas, particularly via providing more assistance in the form of medical school loan repayment. A mechanism for providing such incentives already exists in the Commonwealth, but it does not specifically target OBs and its funding is insufficient to the task.

Figure 19

Virginia Health Professional Shortage Areas (HPSAs)



Source: Virginia Department of Health, 2003.

Section 32.1-122.20 of the *Code of Virginia* requires the Commissioner of VDH to direct the Commonwealth's activities and programs to recruit and retain health care providers for underserved populations and those areas of the state that have been designated as Health

Professions Shortage Areas (HPSAs).[50] Figure 19 illustrates the current localities in the Commonwealth that are designated as HPSAs.

Graduating medical students and other health care practitioners who receive scholarships or loan repayment awards typically are required to practice in an underserved area (i.e., HPSA) for a given period of time. There are several such scholarship and/or loan repayment programs, including programs administered by the federal and state governments. The federal programs include the National Health Services Corps loan repayment program and the J-1 Visa program, both of which place various types of health care providers in HPSAs. In addition, VDH administers a medical scholarship and loan repayment program. Item 306 A of the 2004 Appropriation Act provides a total of $780,964 for this program. The Appropriation Act language allows VDH to make scholarship and loan repayment awards as well as pay for one-time salary bonuses and travel expenses. Because loan repayment has been found to be a more effective incentive than a scholarship, the Appropriation Act also directs VDH to gradually phase out the scholarship awards and move to a total loan repayment-focused incentive program.

While OBs are eligible to receive financial incentives to locate in a HPSA under the current VDH programs, the Work Group believes that additional dollars should be devoted to this purpose as a means of attracting a greater number of OBs to areas of the Commonwealth with limited access to obstetrical care. Specifically, the Work Group recommends that an additional $440,000 be appropriated to VDH each year to provide loan repayment specifically for OB physicians who agree to practice in a HPSA. (The total amount is approximately equal to one year's tuition and fees (roughly $22,000) for 20 OBs.) VDH would administer the OB loan repayment dollars in the same fashion as the current medical loan repayment program.

Recommendation # 23

Appropriate $440,000 GF annually to VDH to provide additional loan repayment specifically for licensed physicians providing OB services who agree to practice for a specified period of time in an area designated as having a shortage of physicians providing OB services.

Work through Virginia's Congressional delegation to encourage federal designation of shortage areas specifically for obstetricians while assuring that such a carve-out from the current primary care category does not negatively impact federal designation of Health Professional Shortage Areas.

Telemedicine

Telemedicine is the real time two-way transfer of medical information for the purposes of medical diagnosis and treatment using an interactive audio/video connection. Telemedicine can

[50] HPSAs are federal designations, and are calculated based on a formula that includes number of physicians, number of residents, travel time to provider locations, and other variables.

improve access to health care by making medical services more readily available and reducing travel time for the patient, both of which are major considerations in rural area. Via a real time, interactive audio/video connection, the patient and medical practitioner at a rural practice site are connected with a medical specialist a considerable physical distance away. This connection allows the specialist to observe the patient, diagnose and prescribe treatment. Telemedicine is currently used in numerous areas of medical care including radiology, dermatology, cardiology, and psychiatry. Over the years, significant progress has been made in telemedicine equipment in improving the image quality and sound while costs for the equipment have decreased considerably. Telemedicine is utilized not only in hospitals and physician offices but schools, prisons, and homes.

Recommendation # 24

Support the use of telemedicine to increase access to university-based and other clinics perinatal services. VDH and DMAS should collaborate to develop strategies to assist communities and other entities to aggressively pursue funding for telemedicine.

By December 1, 2005, these agencies shall report to the Secretary of Health and Human Resources on the number of additional telemedicine sites that have been added or increases in the use of existing telemedicine sites.

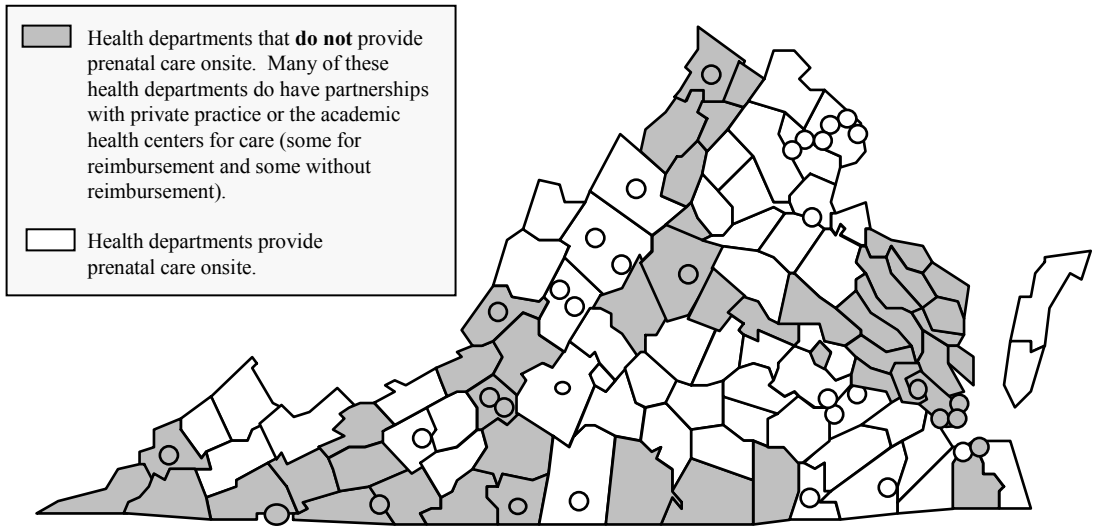
Additional Funding for Local Health Departments

Local health departments are funded by a combination of state general funds and local matching funds. The match rate that determines the balance of State and local government funds varies across the state, and they are based on the locality's financial indicators. Localities in the Piedmont Health District contribute funds at the lowest match rate of 28.9 percent and localities in the Northern Virginia and Virginia Beach Health Districts have the highest match rate at 45 percent. Therefore, rural local health departments may be limited by the ability of local governments to contribute. This becomes problematic in rural areas where local governments have limited funding: the same areas where obstetrical coverage is a problem.

Just over half of the local health departments in Virginia provide prenatal care onsite. In some of these health departments, the services are offered free of charge, while others charge based on a sliding scale. As shown in Figure 20, many of the health departments that do not provide prenatal care onsite at the health departments are located in identified stressed areas. These departments are already established in the community, and while many of them have arrangements with local providers to offer services either free of charge or on a sliding scale, the women must be referred. They do not have the funding resources to provide care, and funding from their local governments is not likely. Since local funding is limited, the only remaining option for these departments is to provide supplemental State general funds outside of the cooperative budget formula, specifically directed to provision of pre and postnatal care.

Figure 20

Health Department Provision of Prenatal Care



Source: Community Health Services 2004 Survey of Prenatal Care conducted by the Department of Health.

Recommendation # 25

Increase the availability of pre and post-natal care by VDH allocating new general funds in the amount of $1 million annually beginning July 1, 2005, specifically for that purpose to local health departments in areas identified as under served and to those districts whose current funding level does not permit them to provide direct care.

To assure these funds are utilized, VDH should eliminate the requirement for local match funds for this particular use.

Education / Public Awareness / Culturally and Linguistically Appropriate Care

It has been reported in the literature that women who seek early and continuous prenatal care will usually have better pregnancy outcomes. However, the survey done by the Quality of Care Subcommittee (see summary in Appendix G) revealed that, in the regions of Virginia with the highest rates of inadequate prenatal care, lack of awareness of the importance of prenatal care was identified as one of the key reasons why women fail to seek early and continuous prenatal care. That lack of understanding may be the result of lack of information, the inability to understand the information provided, differing cultural beliefs, or a combination of those factors.

Health Literacy

According to the National Adult Literacy Survey (NALS),[51] 21 percent of Americans are functionally illiterate, that is, they read at the fifth grade level or lower and also find it difficult to understand oral instructions. Individuals who meet this description are found in all socio-economic brackets and in both urban and rural areas, although the proportion in rural and/or economically depressed areas is typically higher. The study further explains that 67 percent of these individuals have never told their spouses that they cannot read and 19 percent have never told anyone. The difficulty applies to all social classes and includes college graduates as well as those who never completed high school. This translates into 90 million patients and $73 billion dollars in extra healthcare costs that result from behaviors such as not keeping appointments (because they did not understand the schedule information or were unable to read the printed reminder), inability to find the clinic/office (because they could not read the address and/or read a map), and/or failure to take medications correctly (42 percent of those surveyed did not understand the meaning of "empty stomach").

A study done at the University of Virginia in 2000[52] revealed that 63 percent of respondents had some literacy barrier and 51 percent of those (31 percent of the total) were functionally illiterate.

The Center for Quality at the Health Resources and Services Administration has also studied this issue extensively[53], and has made multiple recommendations to providers regarding how to improve communication with functionally illiterate patients. These recommendations include specific methodologies for communicating with these patients, both orally and in print, to optimize their ability to understand and comply with health care instructions.

Limited English Proficiency

According to the Year 2000 Census, the number of minority and/or foreign-born individuals in the United States is growing rapidly. In Virginia, both the number of foreign-born and the number who self-assess as speaking English "less than very well" nearly doubled between 1990 – 2000. The Joint Legislative Audit and Review Commission (JLARC), in its 2003 report on the Acclimation of Virginia's Foreign-Born Population, highlights the following facts:

- Between 1990 and 2000, Virginia experienced an 83 percent increase in the number of its foreign-born residents. As of 2000, there were over 570,000 foreign-born residents in Virginia
- Virginia's foreign-born residents increased from two percent of the State's population in 1970 to eight percent in 2000
- Virginia ranks 11th in the nation in the number of foreign-born residents

[51] NALS was conducted in 1992 for the US Department of Education by the Educational Testing Service, and is considered the most accurate portrait of literacy in the United States..

[52] Source: Claudette Dalton, MD, Assistant Dean & Director, Community-Based Medical Education, University of Virginia Medical School

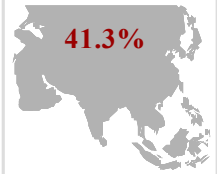
[53] See information at HRSA website: http://www.hrsa.gov/quality/healthlit.htm

As Figure 21 illustrates, the foreign-born in Virginia come from a variety of countries and bring a wide variety of languages, cultures and belief systems. For example, also from the JLARC report:

Figure 21

Emigration of the Foreign Born Population

The 570,279 Foreign-Born Persons Currently Residing in Virginia Emigrated From . . .

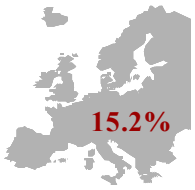


Asia
235,374

Korea	6.5%
Philippines	6.4
India	5.4
Vietnam	5.4
China	4.1
Pakistan	2.4
Other	11.1
Asia	**41.3%**

Latin America
189,809

El Salvador	9.6%
Mexico	5.7
Bolivia	2.7
Peru	2.4
Guatemala	2.1
Other	10.8
Latin America	**33.3%**



Europe
86,615

United Kingdom	3.5%
Germany	3.4
Other	8.3
Europe	**15.2%**

Africa
42,509

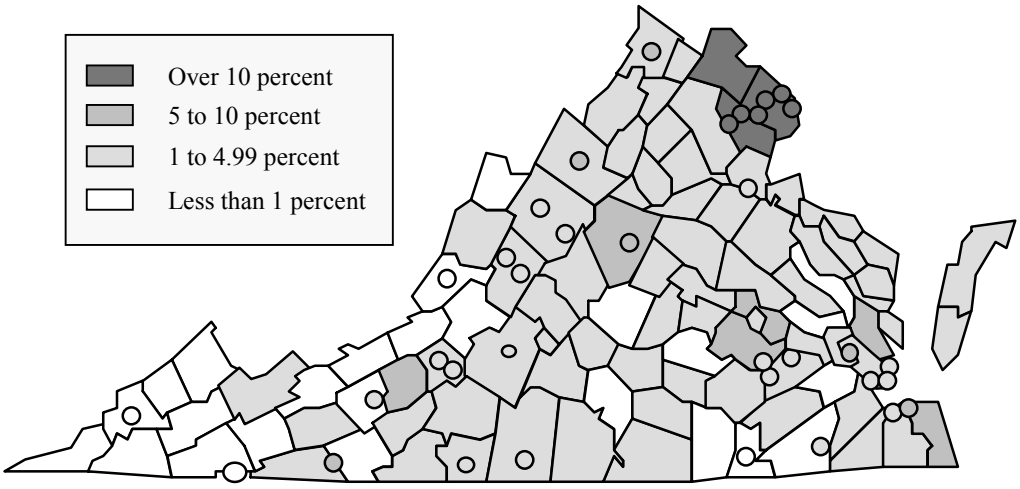
Ethiopia	1.4%
Ghana	1.0
Other	5.1
Africa	**7.5%**

Source: "Virginia's Foreign-Born Population, Presentation to the Governor's Conference on Covering the Uninsured: Workplace Diversity Section" Joint Legislative Audit and Review Commission, 2004.

Just a few years ago, the vast majority of these individuals lived in Northern Virginia. Today, they are spread across the Commonwealth to a much greater degree (see Figure 22).

Figure 22

Percent of Population in Virginia's Localities that is Foreign-Born 2000 Census



Source: "Virginia's Foreign-Born Population, Presentation to the Governor's Conference on Covering the Uninsured: Workplace Diversity Section" Joint Legislative Audit and Review Commission, 2004.

Language and cultural barriers inhibit quality obstetric care due to ineffective communication between providers and patients. In an effort to mitigate barriers to access to obstetrical services, medical providers in Virginia should be culturally competent and culturally sensitive. To achieve this, interpreter and translation services[54] must be available and providers must receive the appropriate training.

Encourage Availability of Translation and Interpreter Services

Large medical provider practices in major population centers typically provide access to translation and interpreter services. However, it appears that smaller medical provider practices do not have the resources to provide access to translation services consistently. This is consistent in the states surveyed by Barriers to Access Subcommittee: in nine out of the 11 states surveyed, translation services were not provided statewide. (See Appendix K). The Guidance on the Civil Rights Act of 1964 indicates that where federal dollars fund programs, those programs must provide interpreter services.

In addition to services being available for communication at the point of service, information disseminated by state government agencies should be accessible in multiple languages. DMAS, VDH, the March of Dimes and the National Women's Health Information Center all provide some educational, multi-lingual materials, primarily in Spanish. Some private organizations post useful, multi-lingual information on their web sites. Statewide efforts, however, are not comprehensive or coordinated. Accordingly, it is recommended that Virginia develop oral and written communication and education

[54] Interpretation refers to the transmission of messages either between two oral languages or between an oral language and sign language. Translation refers to the transmission of messages between two documents via written language.

materials about prenatal, delivery, and postnatal care, which incorporate cultural and linguistic differences among ethnic groups in the Commonwealth. As part of this effort, Virginia should develop a state sponsored web site with professionally translated documents that is maintained by an assigned state agency. The website should be regularly reviewed to ensure relevance and accuracy of information.

While translation and interpreter services are essential for mitigating barriers to access, the state should also support proficiency in the English language. Therefore, educational information and materials should be distributed through providers' offices that inform patients on learning English. These educational materials should identify learning opportunities and educational resources available to impacted populations in the community. The materials should be made available to download from the state-sponsored website previously discussed.

Support Provider Training

Virginia's medical and nursing schools recognize the need to educate providers in cultural sensitivity and competency. However, medical school and nursing school curriculum across the state are not consistently providing this education. As shown in Appendix L, there are some Virginia schools that do not require this type of training. In addition, a staff review of the curriculum for schools showed that it varies considerably among schools. Therefore, it is recommended that Virginia schools require consistent cultural sensitivity and competency training.

Six of the 11 states surveyed by staff provide publicly funded training on cultural competency and translation services for providers of prenatal, delivery, or postnatal services to low-income women. Virginia provides no statewide funding for similar medical provider training. Given the substantial increase in the number of foreign-born residents of Virginia, it is essential that this type of training is offered statewide.

Recommendation # 26

The Committee recognizes that a wide range of knowledge levels exists among Virginians regarding the components of good perinatal care, and that effective communication must incorporate variable health literacy levels as well as the cultural and linguistic characteristics of the audience (s). Therefore the Committee recommends that VDH should:

- Develop and implement a statewide outreach/education/public awareness campaign, incorporating culturally and linguistically appropriate materials, including but not limited to the topics of: options for prenatal care, birth choices, breastfeeding and the importance of dental care for pregnant women.

- Assure that relevant materials are translated via appropriate translation protocols and posted on the VDH website, available for download.

- Encourage the availability of interpreter services at all points of service.

- Encourage cultural competence training for health care providers, whether via continuing education or, in conjunction with the Council on Higher Education in Virginia, as part of the curriculum for students in the allied health professions at state-supported institutions.

- Work with the Board of Dentistry to establish a statewide outreach program targeting dentists and dental hygienists, with the objective of improving the oral health of pregnant women and babies.

- Distribute (including availability on the website) materials that encourage non-English speaking patients to learn English and identify local community learning opportunities.

Improve Transportation Systems

Adequate transportation is necessary to ensure access to prenatal, delivery, and postnatal care. Transportation may be by personal vehicle, taxi, van, ambulance, public transit or other means and may be provided by a family member, neighbor, volunteer, public agency or private entity. While transportation is usually considered a supportive service, inadequate transportation can directly impact the delivery of an obstetric service such as prenatal care and serve as a barrier to satisfactory health care.

Medicaid programs are required to cover transportation for obstetric care and other covered services. The Virginia Medicaid program utilizes a transportation broker for managing requests for non-emergency transportation and reimbursement to transportation providers. The

Virginia Medicaid program is spending about $48 million this year for non-emergency transportation. Private health plans do not cover non-emergency transportation.

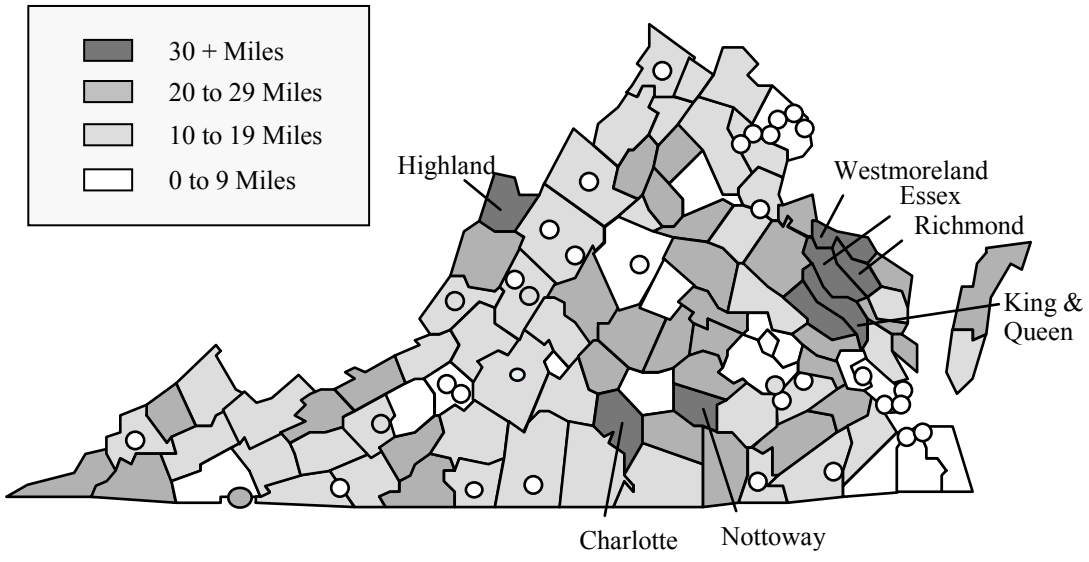
Pregnant women in some localities in Virginia are traveling considerable distances to deliver their children. As shown in Figure 23, women in stressed areas are already traveling, on average, over 30 miles to deliver, and even more women may be faced with the need to do so as more hospital services close. It is important to note that in some areas of the state, 30 miles could equate to over an hour driving time.

In general, human services transportation is considered a "patchwork" system meaning transportation varies considerably by community. Localities have different levels of resources for human services transportation, some areas have placed a priority on transportation coordination, and the urban/suburban/rural characteristics of a locality will also influence the available transportation.

The federal government, through the Federal Transit Administration, has taken an interest in human services transportation through the "United We Ride" program. This program, through the use of resource assessment tools, grants and other means, seeks to improve human services transportation coordination. Virginia recently submitted a grant request under this program for $35,000 to inventory the state's human service transportation system. The lead agency in this effort is the Department of Rail and Public Transportation.

Figure 23

Average Distance Women Traveled to Deliver by Locality
One-Way Trip, CY 2002



Note: Birth certificate data maintained by the Virginia Department of Health. Includes 92,000 births; 8,000 were excluded because the women lived outside of Virginia or the self-reported zip codes were invalid. Distance is from the center of the zip code of the mother's residence to the center of the zip code of the facility location.

The Virginia Tech Transportation Institute is currently in the early stages of an assessment of Virginia's human services transportation system. This includes identifying transportation resources and gaps in service, determining best practices in communities, and developing a plan for coordination of transportation. Part of the "United We Ride" grant is coordination with the Virginia Tech project in the form of a summit or symposium on transportation. The state should support this effort by providing general funding and requesting that access to obstetrical care be considered as part of the Virginia Tech assessment.

Recommendation # 27

Appropriate $120,000 GF over a two year period to support the Virginia Tech Transportation Institute project assessing the feasibility of statewide human services transportation programs. Case studies developed through the project should focus on areas of the state identified by the ED2 Work Group that appear to have the most significant distance/travel requirements to access obstetric services. The Institute shall submit an interim report of its findings to the Secretary of Health and Human Resources not later than December 1, 2005, to be reviewed to determine if additional funding is necessary to improve access to obstetrical care.

COMMONWEALTH OF VIRGINIA

OFFICE OF THE GOVERNOR

Executive Directive 2

Importance of the Issue

Prenatal, obstetrical, and labor and delivery services are a critical component of any modern society's health care system. Prenatal care, obstetrical and labor and delivery services in a community help ensure healthy babies.

A complex combination of factors ranging from third party reimbursement to malpractice insurance premiums has limited the availability of this care in certain rural areas of the Commonwealth. Most recently, this problem has occurred in the Northern Neck, though problems with access to care in rural areas have also developed in Southside and Southwest Virginia.

By virtue of the authority vested in me as Governor under Article V of the *Constitution of Virginia* and under the laws of the Commonwealth, including but not limited to Chapter 1 of Title 2.2, I hereby create the Governor's Work Group on Rural Obstetrical Care.

The Work Group

The Work Group will initially consist of 17 members. Additional members may be appointed by the Governor at his discretion. The Work Group will be chaired by the Secretary of Health and Human Resources. The group shall include but shall not be limited to representatives of: the Virginia Hospital & Healthcare Association; the Medical Society of Virginia; the American College of Obstetrics and Gynecology, Virginia Chapter; the Virginia Trial Lawyers Association; and other entities as determined by the Governor. Staff support will be provided by

the Office of the Governor, the Office of the Secretary of Health and Human Resources, the Department of Health, and the Department of Medical Assistance Services.

Responsibilities of the Work Group

The Work Group will be responsible for the following:

1) Reviewing relevant executive branch policies that may serve as an impediment to providing needed care in rural areas of the Commonwealth;
2) Developing the executive branch's response to legislatively mandated studies and coordinating the executive branch's response to and work with any other study groups examining similar issues;
3) Reviewing best practices in other states;
4) Making policy recommendations as may seem appropriate to the Governor and General Assembly regarding improving access to care in rural areas.

The Work Group shall also examine other issues as may seem appropriate.

Reporting Requirements

The Work Group shall issue a preliminary report to the Governor by July 1, 2004 and a final report to the Governor by October 1, 2004. The preliminary and final reports shall also be provided to the Chairmen of the House Appropriations Committee; the House Committee on Health, Welfare, and Institutions; the Senate Committee on Finance; the Senate Committee on Education and Health; and the Joint Commission on Health Care.

Effective Date of the Executive Directive

This Executive Directive shall be effective upon its signing and shall remain in full force and effect until March 13, 2005, unless sooner amended or rescinded by further executive directive.

Given under my hand this 13th day of March 2004.

Mark R. Warner, Governor

APPENDIX B

2004 – 2006 Appropriation Act Language

Item 298 of the 2004-2006 Appropriation Act:

"The Secretary of Health and Human Resources, in cooperation with the Bureau of Insurance in the State Corporation Commission, shall report on the availability of obstetrical services in the Commonwealth and identify any areas of the Commonwealth where there is inadequate access to such services. The report shall include information on (i) the factors contributing to inadequate access to services; (ii) the availability and affordability of malpractice insurance for obstetricians; (iii) any specific problems regarding access to obstetrical care for Medicaid and Family Access to Medical Insurance Security enrollees; and (iv) an assessment of the degree to which these factors may be contributing to the lack of access to obstetrical care in certain areas of the Commonwealth. The report shall make recommendations on actions that can be taken to improve access to obstetrical care throughout the Commonwealth. The Secretary shall provide the report to the Chairmen of the House Appropriations and Senate Finance Committees and the Joint Commission on Health Care by November 1, 2004."

APPENDIX C

Executive Directive 2
Work Group Membership

The Honorable Jane H. Woods
Secretary of Health and Human Resources

Theodore (Tray) F. Adams, III
Partner
Troutman Sanders

Robert Agee, M.D.
Womens Health Center

Deren E. Bader, CPM, DrPH
Maternal & Child Health Consultant

Christopher S. Bailey
Sr. Vice President
Virginia Hospital and Health Care Association

Thomas (Tom) S. Bridenstine
Principal Insurance Market Examiner
State Corporation Commission

Robin M. Broughman
Chief Nursing Officer
HCA Healthcare

Warren E. Callaway, FACHE
President/CEO
Danville Reg. Med. Ctr.

Rebecca J. Davis, Ph.D.
Executive Director
VA Rural Health Association

Doug H. Gray
Executive Director
Virginia Association of Health Plans

Gary R. Gutcher, M.D.
Professor of Pediatrics, Chair of Neonatal/Perinatal Medicine
MCV

Robert T. Hall
Trial Attorney
VA Association of Trial Attorneys (VTLA)

The Honorable Emmett W. Hanger, Jr.
Member, Senate of Virginia
24th District

Jack L. Harris
VA Trial Lawyers Assoc.

Woodrow (Woody) Harris
Local Government

William N.P. Herbert, M.D.
Professor of OB & Gyn, Chair Dept. of OB and GYN
UVA

Robert A. Hofford, M.D.
Director of Family Practice Residency Program
Carilion Health Systems

B. H. Hubbard, III
Chairman, Board of Directors
Rappahannock General Hospital

Ann Hughes
Director of Legislative Affairs
Medical Society of Virginia

The Honorable Robert Hurt
Member of the Virginia House of Delegates
16th District

Elisabeth B. Hutton, RN, Ph.D.
March of Dimes

JoAnne Jorgenson, RN, MPH
Deputy Director
Fairfax Health District

Jerry A. Lucas, MD
OB/GYN

Rod V. Manifold
Executive Director
Central VA Health Services

Matthew J. Meleski
Vice President
Network Management Southern Health Services, Inc.

The Honorable Harvey B. Morgan
Member of the Virginia House of Delegates
98th District

William (Bill) R. Nelson, M.D.
Health Director
Chesterfield Dept Health

Megan P. Padden
Director of Medicaid
Sentara Health Management

R. Ray Pate, Jr.
President & Chief Executive Officer
NCRIC Group, Inc.

Melina Perdue, RN, MBA, CAN
Senior Vice President
Carilion Health System

The Honorable Albert C. Pollard, Jr.
Member of the Virginia House of Delegates
99th District

Mark E. Rubin
Mediator/Trial Lawyer
The McCammon Group

Linda Cook Sawyer
Nurse Manager
Twin County Regional Healthcare

John W. Seeds, M.D.
Chairman, Obstetrics and Gynecology
MCV

Juliana van Olphen Fehr, C.N.M., Ph.D.
Coordinator, Nurse-Midwife
Shenandoah Univ.

John B. Willey, M.D.
Private Practice
Winchester

APPENDIX D.1

Barriers to Access Subcommittee

	Subcommittee Members
William (Bill) Nelson, MD - Chair	Health Director, Chesterfield Department of Health
John Willey, MD	OB, Winchester, VA
Megan Padden	Director, Medicaid, Sentara (Optima) Family Care
Woody Harris	City of Emporia, Emporia, VA
Elisabeth Hutton, RN, PhD	March of Dimes
Deren Bader, CPM, PhD	Maternal & Child Health Consultant
Joanne Jorgensen, RN	Deputy Director, Fairfax Health District
Rebecca Davis, PhD	Executive Director, Virginia Rural Health Association
Juliana Fehr, PHD	Coordinator, Nurse Midwifery Program, Shenandoah University
	Staff
Bryan Tomlinson	DMAS, Director, Division of Health Care Services
Kelly Gent	DMAS, Division of Policy
John Kenyon	DMAS, Division of Policy
Jeff Nelson	DMAS, Division of Policy
Gerald Craver	DMAS, Division of Policy
Daniel Plain	DMAS, Division of Health Care Services
Kristin Paccione	DMAS, Division of Health Care Services

Subcommittee Meeting Schedule	Members Attending	
May 18, 2004 10 AM-Noon Virginia Hospital and Healthcare Association (VHHA)	Bill Nelson Megan Padden John Willey Rebecca Davis	Julian Fehr Deren Bader (Phone) Joanne Jorgenson (Phone) Elisabeth Hutton
June 4, 2004 10 AM-Noon (VHHA)	Bill Nelson Elisabeth Hutton Julian Fehr (Phone) Joanne Jorgenson	Megan Padden (Phone) John Willey (Phone) Rebecca Davis (Phone) Deren Bader (Phone)
July 8, 2004 10 AM-Noon (VHHA)	Bill Nelson Rebecca Davis Megan Padden	Rebecca Davis (Phone) Joanne Jorgenson Juliana Fehr (Phone)
August 23, 2004 10 AM-3 PM (VHHA)	Bill Nelson Joanne Jorgenson John Willey (phone) Woody Harris	Juliana Fehr Megan Padden Elisabeth Hutton
August 30, 2004 10 AM–3 PM (VHHA)	Bill Nelson Julian Fehr Megan Padden	Deren Bader (Phone) John Willey Elisabeth Hutton

APPENDIX D.2

Reimbursement Subcommittee

	Subcommittee Members
Chris Bailey-Chair	Senior Vice President, Virginia Hospital and Healthcare Association
Robert Agee, MD	
Robin M. Broughman	Chief Nursing Officer, HCA Healthcare
The Honorable Emmett W. Hanger	Member of the Virginia Senate - 24th District
Jack L. Harris	Virginia Trial Lawyers Association
Roger A. Hofford, M.D.	Director, Family Practice Residency Program, Carilion Health Systems
Ann Hughes	Director of Legislative and Political Affairs, Medical Society of Virginia
Rod V. Manifold	Executive Director, Central Virginia Health Services
Matthew J. Meleski	Vice President, Southern Health Services Inc.
	Staff
Cheryl J. Roberts	DMAS, Deputy Director, Programs & Operations
Steve Ford	DMAS, Health Care Reimbursement Manager
Carla Russell	DMAS, Health Care Reimbursement Specialist
Adrienne Fegans	DMAS, Program Operations Administrator

Subcommittee Meeting Schedule	Members Attending	
May 5, 2004 Meeting at Virginia Hospital & Healthcare Association (VHHA) (immediately following full Work Group)	Chris Bailey Robin Broughman Jack Harris Roger Hofford	Rod Manifold Matthew Meleski
May 18, 2004 10:30 AM – 12:30 PM VHHA	Chris Bailey Robin Broughman Jack Harris	Roger Hofford Rod Manifold
June 2, 2004 – via conference call 10:30 AM – 12:00 PM	Chris Bailey Robin Broughman Jack Harris Roger Hofford	Rod Manifold Matthew Meleski
June 9, 2004 – Meeting at VHHA (immediately following full Work Group)	Chris Bailey Robert Agee Robin Broughman	Jack Harris Rod Manifold
June 15, 2004 – via conference call 9:30 AM – 11:30 AM	Chris Bailey Robert Agee Jack Harris	Rod Manifold Matthew Meleski Roger Hofford
August 11, 2004 – Meeting at VHHA 1:00 PM – 3:00 PM	Chris Bailey Jack Harris	Ann Hughes Matthew Meleski
August 23, 2004 – via conference call 10:00 AM – 12:00 PM	Chris Bailey Robert Agee Jack Harris Roger Hofford	Ann Hughes Rod Manifold Matthew Meleski

APPENDIX D.3

Medical Malpractice Subcommittee

Subcommittee Members	
Mark Rubin - Chair	Mediator, The McCammon Group
Doug H. Gray	Executive Director, Virginia Association of Health Plans
Theodore F. ("Trey") Adams, III	Partner, Troutman Sanders
Warren E. Callaway, FACHE	President, CEO, Danville Regional Medical Center
Robert T. Hall	Trial Attorney, Virginia Association of Trial Attorneys
The Honorable Robert Hurt	Member, Virginia House of Delegates
The Honorable Harvey Morgan	Member, Virginia House of Delegates
R. Ray Pate, Jr.	President & CEO, NCRIC Group, Inc.
The Honorable Albert C. Pollard, Jr.	Member, Virginia House of Delegates
John W. Seeds, MD	Chairman, OB, VCU

Staff	
Eric Lowe	BOI, Senior Insurance Analyst
Patrick Finnerty	DMAS, Director
Carol Howard	BOI, Principal Insurance Market Examiner
Wayne Turnage	DMAS, Director, Policy & Research Division
Kelly Gent	DMAS, Policy & Research Manager
Gerald Craver	DMAS, Policy Analyst, Policy & Research Division

Subcommittee Meeting Schedule	Members Attending	
May 5	Mark Rubin	Delegate Pollard
(as part of a meeting of the full Work Group)	Warren Callaway	John Seeds
Virginia Hospital & Healthcare Association	Doug Gray	
(VHHA)	Robert Hall	
May 18	Mark Rubin	Delegate Morgan
Meeting & conference call, 2:00 – 4:00 PM	Warren Callaway	Delegate Pollard
State Corporation Commission (SCC)	Doug Gray	John Seeds
	Robert Hall	
June 9	Trey Adams	Delegate Pollard
(as part of a meeting of the full Work Group)	Doug Gray	John Seeds
(VHHA)	Delegate Morgan	
August 24	Mark Rubin	Robert Hall,
Meeting & conference call,	Trey Adams	Delegate Pollard
9:00 AM – 2:30 PM	Doug Gray	
SCC		
September 2	Warren Callaway	Delegate Pollard
(following a meeting of the full Work Group)	Doug Gray	John Seeds
(VHHA)	Delegate Hurt	
September 8	Mark Rubin	Delegate Hurt
Meeting & conference call, 9:00 AM – 1:30 PM	Warren Callaway	Delegate Morgan
SCC	Doug Gray	Delegate Pollard
	Robert Hall	

APPENDIX D.4

Quality of Care Subcommittee

	Subcommittee Members
Jerry A. Lucas, MD - Chair	OB & Chair, Obstetrics Department Chippenham Memorial Hospital Richmond, VA
Thomas S. Bridenstine	Principal Insurance Market Examiner, SCC
Gary R. Gutcher, MD	Professor of Pediatrics, Chair of Neonatal/Perinatal Medicine, MCV
William N. P. Herbert, MD	Professor of OB & GYN, Chair of Dep't. of OB, UVA
B.H. Hubbard, III	Chairman, Board of Directors, Rappahannock General Hospital
Melina Perdue, RN, MBA, CAN	Senior Vice President, Carillion Health System
Lynda Cook Sawyer, RNC, MBA	Director, Women's Health Services, Twin County Regional Healthcare

	Staff
David Suttle, MD	VDH Office of Family Health Services
Joan Corder-Mabe Director	Director, Division of Womens' and Infants' Health, VDH
Joe Hilbert	Executive Advisor, VDH

,

Subcommittee Meeting Schedule	Members Attending	
May 14, 2004 (teleconference)	B.H. Hubbard Linda Sawyer	Tom Bridenstine
June 9, 2004	Tom Bridenstine	Linda Sawyer
September 3, 2004	Tom Bridenstine William Herbert Melina Perdue	Linda Sawyer Jerry Lucas

APPENDIX E.1

Dissenting Opinion of the Medical Malpractice Subcommittee Report

R. Ray Pate, Jr.

September 27, 2004

I am the President and Chief Executive Officer of NCRIC Group, Inc., a health care financial services company headquartered in Washington, D.C. NCRIC Group, through its subsidiaries, provides medical professional liability insurance and practice management services to more than 4,000 physicians in the mid-Atlantic region, including Virginia. I appreciate the opportunity to offer my thoughts concerning the recommendations offered in the Medical Malpractice Subcommittee Report.

I am concerned about the recommendation that would direct the Virginia General Assembly to pass legislation requiring all licensed insurers to have in place a rule allowing job-sharing under a full-time equivalent rating rule and that all licensed insurers be required to offer a credit for part-time practice for OBs. Though NCRIC already offers these options to its healthcare providers, these options are offered according to the specific needs of certain healthcare providers. Therefore, I am concerned that the state would be regulating an insurance provision that should be best left to the discretion of the medical professional liability insurance carrier. Additionally, members of the Subcommittee are hopeful that this recommendation will result in an immediate decrease in the cost of a medical liability premium. However, if a healthcare provider was previously covered by a medical liability premium based upon a full-time practice, this new premium would only gradually decrease based upon the exposure of the full-time practice. Moreover, it is likely that a premium based upon job-sharing under a full-time equivalent rating rule or a part-time practice would increase in cost based upon a healthcare provider's infrequency of providing health care.

Additionally, many of the recommendations offered in this report would immediately help healthcare providers to afford the increasing cost of their medical liability premiums. However, the recommendations do not address the primary cause of the medical liability crisis seen in Virginia: escalating costs of medical liability claims. In addition to medical liability reform already in place in Virginia, passage of legislation similar to California's Medical Injury Compensation Reform Act (MICRA) of 1975 would, over a longer period of time, bring stability to medical liability premiums, help premiums to be more affordable for healthcare providers, and increase accessibility of healthcare providers to all Virginia citizens, while still ensuring that patients are compensated fairly for their injuries.

APPENDIX E.2

Dissenting Opinion
Delegate Albert Pollard
September 27, 2004

My dissent from the Medical Malpractice Subcommittee Report is not because I believe any conclusion is incorrect. Indeed, they are all valid. However, the core recommendation that a subsidy be established to help cover premiums in impacted areas is a *de facto* admission that the rest of the medical system is balanced and properly functioning. It presumes the primary fault with our OB system is that not enough tax dollars have been injected into the system.

As a rational outside observer this seems to be a ludicrous conclusion. Of course, it seems only natural that if you put the doctors, the insurers, and the lawyers at the table and ask them to solve the problem, the only thing they will be able to agree on is that the taxpayers should give the docs money so that they can give that money to the insurer so that they can give more money to the lawyers. Creating an insurance premium subsidy alleviates the symptom without curing the problem.

Indeed, it seemed the best way to engage subcommittee members into participation was to throw out a proposal which gored their particular ox. A perfect example of this was the discussion of shortening the statute of limitations for "tail" insurance. The only folks truly engaged were the trial lawyers.

And, when an idea was floated to bring doctors under the Virginia Tort Claims Act (an idea, which in its broader form, neither the insurance companies nor the lawyers were too crazy about) the argument was made that it would create a "two-tier system". In fact, if you have to travel an hour and a half to receive obstetrical coverage, a "two tier system" already exists.

The job of any constituency is, of course, to protect its interests, but in a committee this attitude only creates watered-down solutions. Thus, we were never able to have the honest discussion needed to examine larger picture solutions.

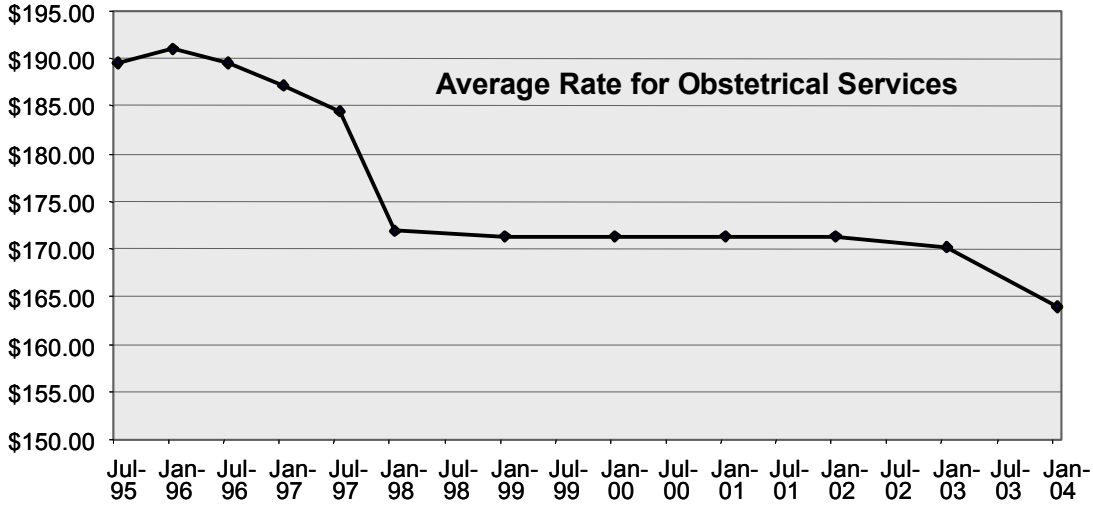
The problem is not one solely of slick lawyers, incompetent doctors or greedy insurance companies. Lawyers play a valuable role when a doctor has truly done something wrong, and insurance companies must have a hard edge to maintain their solvency. But, the problem is certainly beyond that which our recommendations have touched.

In short, we failed to alter the status quo which brought us to the table.

I firmly believe that the subcommittee's recommendations would have been different if the folks representing the same constituencies that were at the table were also seven months pregnant and living in Reedville or Highland Springs.

Appendix F

Trend in Medicaid Physician Payment Rates 1995 to 2004



Note: Department of Medical Assistance Services analysis. Average rates are based on CPT codes 59000-59871 and 76805-76828 weighted by 2003 claims experience.

APPENDIX G

Average OB Premiums (CY 2002)

STATE	Weighted Average
Florida	$154,870
Texas	$98,338
West Virginia	$91,903
Nevada	$91,314
Michigan	$90,443
Massachusetts	$84,566
Illinois	$80,607
Ohio	$80,489
New York	$79,096
Maryland	$76,288
Pennsylvania	$72,602
New Jersey	$71,590
Connecticut	$69,499
Kentucky	$67,738
North Carolina	$61,978
Rhode Island	$61,943
Wyoming	$61,166
Utah	$59,108
Missouri	$52,455
Arizona	$50,361
Delaware	$50,064
California	$48,391
Washington	$48,274
Georgia	$46,903
Alaska	$46,218
Oregon	$46,049
New Hampshire	$46,003
Tennessee	$45,936
Montana	$44,337
Virginia	**$43,584**
Hawaii	$42,928
Mississippi	$41,320
Alabama	$38,848
Iowa	$37,900
New Mexico	$35,915
Louisiana	$33,719
Vermont	$33,318
Maine	$33,310
Colorado	$32,055
South Carolina	$28,883
Wisconsin	$27,670
Arkansas	$25,487
Idaho	$25,028
North Dakota	$24,887
Kansas	$24,741
Indiana	$22,966
Nebraska	$18,376
Minnesota	$17,485
Oklahoma	$17,272
South Dakota	$14,166
Source: Virginia Bureau of Insurance.	

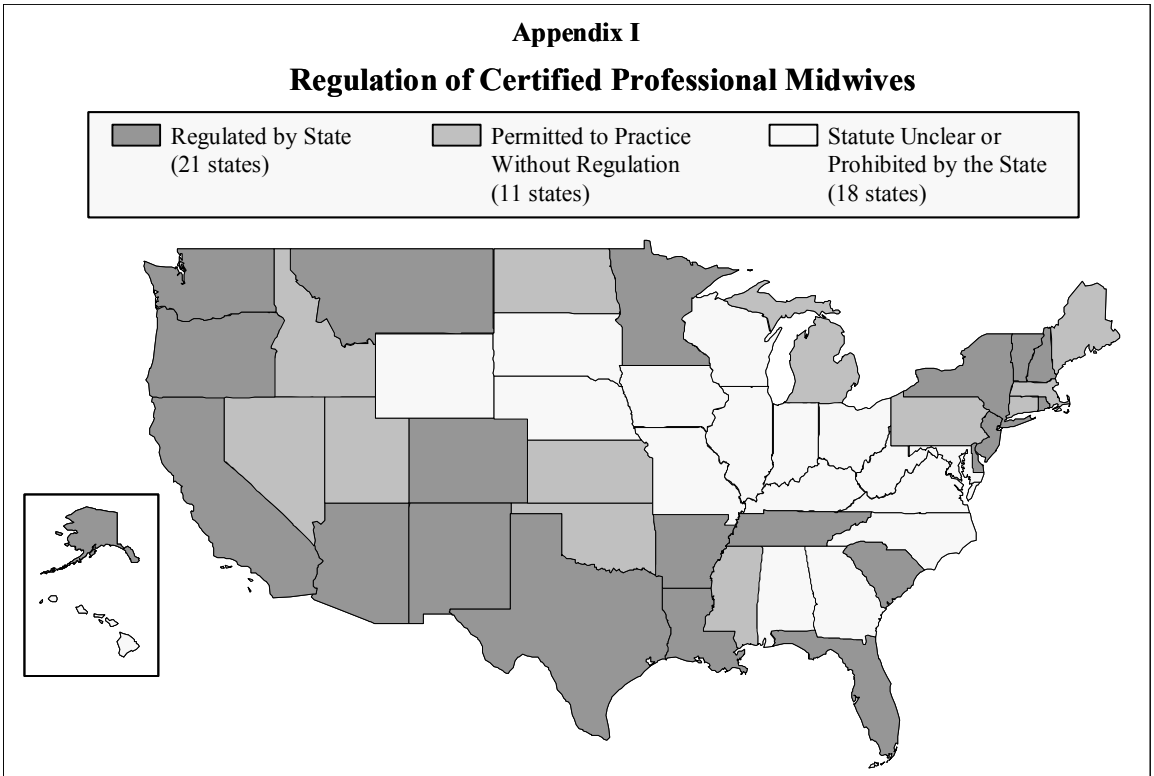
APPENDIX H

Certified Nurse Midwives, Certified Professional Midwives and Lay (Direct Entry) Midwives		
Licensed, Certified Nurse Midwives	**Certified Professional Midwives**	**Lay Midwives**
Hold a license as a registered nurse	Not recognized in Virginia; recognized in 17 other states.	No licensure or permit (permit process managed by VDH repealed by 2003 General Assembly)
Minimum graduate degree level of education accredited by state and national programs	Specialized training in midwifery practice in accredited programs by the U.S. Department of Education	May or may not have formal training; usually mentoring training with another midwife; on the job training
Clinical standards based on competency based education which means passing is determined upon minimum number of the various exams completed such as attend at least 20 births, perform 15 new antepartum visits, 20 newborn exams, 20 postpartum visits etc. Minimum clinical hours may vary nationally but the school in Virginia requires at least 600 clinical hours.	Clinical standards based on competency based education which means passing is determined upon minimum number of the various exams such as attend at lest 20 births, 75 prenatal exams, 20 newborn exams, and 40 postpartum exams. The clinical component of the educational process must be at least one year in length and equivalent to 1350 clinical hours under the supervision of one or more preceptors.	No formal standards
Certified by the American College of Nurse Midwives Certification Council; mandatory continuing education required for renewal	Certified by the North American Registry of Midwives (NARM); mandatory continuing education required for renewal	No certification
Practices under medical direction, supervision and collaboration as required by nurse practice act	Not recognized in Virginia;	Practices independently in some states but illegal in Virginia
Required to practice in accordance with the Standards for the Practice of Nurse Midwifery as defined by the American College of Nurse Midwives and the Virginia Nurse Practice Act	Reported by CPMs to be available but not confirmed	Unknown
Practice in hospital, physician practices, homes, HMOs, health departments, military settings, and birth centers	Practice in out of hospital settings including home settings and birth centers; the CPM is the only national credential that requires knowledge and experience in out-of-hospital settings.	Practice in home settings
May have application for licensure denied or revoked based on fraud and deceit, conviction of a felon or on other grounds set forth in the code; complaints handled by the Department of Health Professions	Not licensed in Virginia; not regulated; if certified by NARM are accountable to a peer review process in response to a complaint	Not recognized by Virginia and not regulated; complaints would be handled through the Department of Health Professions of the Attorney General's office depending upon the nature of the complaint
Malpractice offered by insurance companies	Reported by CPMs but unconfirmed	None
Included in the Birth-Related Injury Fund	Not eligible to participate in the Birth-Related Injury Fund	Not eligible
Limited prescription writing privileges; authorized to prescribe Schedules 111 through V1 under a practice agreement with the supervising physician and as approved by the Board	Unknown	No

APPENDIX I

Appendix I

Regulation of Certified Professional Midwives



Source: Midwives Alliance of North America (MANA), the Midwifery Education and Accreditation Council (MEAC) and the North America Registry of Midwives (NARM).

APPENDIX J

Summary of Key Informant Interviews

In August, 2004, the Quality of Care Subcommittee conducted confidential key informant interviews with 30 stakeholders in the areas with the highest prenatal care inadequacy ratings in 2003 (See Figure 15). These individuals included hospital physician and nursing leadership, a pediatrician, obstetricians, Resource Mother coordinators, and other administrative leaders in health care organizations.

The questions are shown in **bold type** and are followed individually by a summary of general themes and responses.

1) How would you describe the quality of obstetrical (prenatal and delivery) care being delivered in your community? If less than desired, what are the contributing factors interfering with delivering quality care? Please give examples:

Only a few respondents offered a positive assessment of the quality of care. For example:

- For the most part physicians are well aware of the standards of OB care and provide good quality of care both prenatal and intrapartal care.
- The quality of prenatal care and delivery care in our community is excellent. Care is available to all who seek service.
- Most of my patients appear to be satisfied with their current obstetric care.
- The quality of obstetrical care in our community is generally outstanding. The physicians are competent and current in practice following ACOG guidelines utilizing evidenced based practice.
- The quality of care being delivered in this perinatal region meets and even exceeds ACOG standards in many instances in the community hospitals and the health department. Unfortunately, accessing this quality health care system is becoming more difficult throughout the region.

Most of the comments received were critical, in a variety of ways, of the quality of care provided:

- Women often see a different provider each time they go to the physician. Care is not individualized. The physician sees 25-40 patients a day, which equals 5-15 minutes of actual time with the client.
- Emotional, spiritual, psychological, and family needs are not typically addressed except to prescribe antidepressants or other medication. Cesarean rates are increasing. There are rarely nutrition screens and consults, psychological or social screens, drug screens, etc. For instance, postpartum depression is rarely addressed until the woman has a full-blown case. Postpartum breastfeeding rates remain at low levels.
- Midwifery care has been shown to reduce preterm labor, low birth weight infants, obstetrical interventions, and increase breastfeeding rates. Typically, midwifery care also reduces the cost of maternity care. Women do not have the option of midwifery care in

most areas of the state with the exception being in some of the larger urban areas such as Alexandria and Richmond.

- Lack of dental care is a major issue for pregnant women in Southwest Virginia. There are not enough dentists who accept Medicaid and most will not treat pregnant women with any type of insurance. Poor dental hygiene and dental infections are associated with premature birth, the leading cause of infant mortality
- Another factor is lack of social programs to assist with smoking cessation, parenting skills, job skills, and post-partum depression. The social services departments are overburdened, paper work gets lost, and so unless a client is very savvy and stays on top of her own case, she may not get the services for which she is qualified.
- Sometimes it is difficult to obtain appropriate medical records on a patient's condition or a family member's condition (even with consent) from a non-referring institution. Misinterpretation and fear regarding the Health Information Portability and Accountability Act (HIPPA) of 1996 has created barriers to efficient and full sharing of patient health information. This has lead to duplicate testing or missed opportunities for testing. In the case of certain genetic tests, detection rates can be compromised when accurate medical records are not available.
- The rising number of non-citizen residents in certain areas of the state is impacting the quality of care. The Latino population does not necessarily see prenatal care as a necessity. This growing population presents more challenge for physicians and hospitals with language barriers and lack of resources.
- Health district staff serves a growing group of the uninsured. This includes both the undocumented and others who do not qualify for health insurance. As physicians and hospitals stop serving these groups, the burden falls to the health districts to provide services for which they cannot be reimbursed and with budgets that are already strained.
- If women do not seek prenatal care regularly, the quality of that care suffers. Reasons by women for not seeking care: they have no car, are afraid of getting lost in a strange city, are afraid to drive in snow or other bad weather, do not have money to pay for public transportation, have no one to look after their older children, have no money to pay the babysitter that they do have, cannot afford to take off an entire day from work for a doctor’s appointment, or do not want to travel up to two hours to see a physician for ten minutes.
- There are many social issues in these women’s lives which interfere with seeking prenatal care: housing, jobs, violence both in the home and their environment, substance abuse, education, and their personal priorities
- Many women feel they have no control or say in their care. Often they are rebuked if they do have expectations different from the physician or hospital or too many questions. Therefore they do not look forward to appointments, follow the physician’s plan of care, and blame the healthcare provider if there is a bad outcome because that is the person “in control”.
- The patients with the most complaints tend to be those who must attend the OB Clinic because their preferred OB does not accept Medicaid. Complaints I hear about the OB Clinic are that patients do not feel that their care is individualized (e.g., staff do not review records or quickly respond to personal concerns) and that the waiting time to see a physician can be hours.
- Referring physicians often do not provide us with detailed enough medical records prior to the patient's appointment at the Prenatal Diagnostic Center. The medical records are incomplete or difficult to read. For this reason, we cannot always tell if certain tests have

been performed in a pregnancy or even offered. A related problem is that it is sometimes very difficult to obtain appropriate medical records on a patient's condition or a family member's condition (even with consent) from a non-referring institution.

- The quality of maternity care in my community may be adversely affected by too much medical intervention in pregnancy and birth. Medical interventions like misuse of anesthesia, ill advised inductions, and overuse of IVs, electronic fetal monitoring and bed rest for labor can contribute to the high cesarean rate and poor perinatal outcomes.

2) Are pregnant women in your community knowledgeable of what should be included in quality prenatal care? What are the women reporting to you?

The responses to this question were decidedly mixed:

- This depends largely, but not entirely, on education, socioeconomic status and cultural attitudes. Many women do not know what is included in quality care. Supporting this further is that few women, especially indigent, women participate in childbirth classes.
- Regardless of economic status and education level, most of my patients rely heavily upon their obstetrician to offer and order the appropriate prenatal screens/tests for them. The patients who tend to be more critical about their current care are those who have experienced abnormal test results or adverse
  pregnancy outcomes in the past. In such cases, they are more likely to decline tests that they feel are unnecessary. However, it is rare for a patient to request a test that has not been offered by their physician. I believe that this is mostly because it was not offered by their physician in the first place, so the patients are not aware that the test exists.
- The majority of patients are very informed about quality prenatal care. They give good feedback at prenatal classes and through patient surveys and focus groups.
- The populations we serve appear knowledgeable as indicated by our low rate of no prenatal care. Patients present the labor asking appropriate questions and consent to procedures for themselves and their newborns to ensure quality care.
- As there is really no “lay” definition of quality prenatal care, we would say that a good number are not knowledgeable about what should be included.

3) Should the Board of Health adopt statewide guidelines for obstetrical practice? Should they be the national standards as referenced by AAP/ACOG in Guidelines for Perinatal Care? Does Virginia need to develop/create Virginia guidelines? How should standards be enforced? By whom?

- Reponses were mixed but overall, most of the respondents asked did not see a need to create a Virginia set of guidelines or standards. It was felt that physicians and midwives should be responsible for the care they provide. The national guidelines published by the provider groups were referenced as being acceptable and currently available guidelines.
- Of greater importance is statewide uniformity in the delivery of prenatal care to uninsured women in each locality.
- VDH should consider adapting its standards for maternity care to conform with ACOG guidelines.
- The Board of Medicine, the hospitals, and the health department should continue to enforce their own guidelines which are in place.

4) How would you describe the efficacy of the referral system in your area for women needing high-risk obstetrical care?

- Overall, most respondents reported satisfactory referral networks in their areas. There were a handful of respondents who reported issues such as a lack of perinatalogists, overwhelming caseloads for obstetrical providers, and coverage at the hospital for high-risk delivery care. The issue of travel distances for patients was identified again as a barrier for women obtaining these services.

5) What recommendations including solutions or suggestions do you have to address the issues you have identified?

- Take steps to encourage the practice of nurse midwives.
    - Remove the "supervisory physician" requirement in the Nurse Practice Act that has hindered the practice and growth of nurse midwifery practice in the state. They need to be "independent licensed practitioners" –independent not meaning practicing by oneself, but rather allowed to practice interdependently with other health care providers, each responsible for his/her own work. They need to work in concert with physicians, each providing service in his/her area or expertise
    - The Bureau of Insurance should promulgate regulations on the type of malpractice insurance coverage sold to physicians and hospitals in Virginia.
        - Malpractice insurance companies should not be allowed to penalize hospitals or physicians who work with nurse-midwives either in a supervisory, collaborative, or consultant role, unless the nurse-midwife is an employee of the hospital or physician.
        - Non-profit hospitals and hospital systems, which are tax-exempt, should be required to have malpractice insurance that allows CNMs to collaborate with their physicians.
    - Encourage the availability of medical malpractice insurance for physicians and nurse midwives to provide homebirth services. There is currently no liability insurance available for homebirth attended by physicians or nurse midwives.
    - Establish a Board of Midwifery instead of the Joint Boards of Nursing and Medicine to regulate midwifery practice. In the past, proposals have been made to regulate midwifery through a Joint Board of Nursing and Medicine. However, the practice of midwifery, while overlapping in some areas with medicine and nursing, is different than both and is often misunderstood by nurses and physicians.
    - Provide incentives to physicians who utilize midwifery services.
    - If hospitals and private physicians are unwilling to consult, collaborate, and take referrals from nurse midwives, perhaps a statewide consultation/referral system should be set-up to handle nurse midwife clients.
- Establish a statewide outreach program targeting dentists and dental hygienists concerning dental care for pregnant women, with the objective of reducing the incidence of dental infection among pregnant women.
- Expand the range of choices women have in obtaining pre-natal care. They should be able to make choices about who provides their care, or place of birth. They should be

offered programs that will assist them with smoking cessation, job skills, parenting skills, exercise, or childbirth preparation. Faith-based programs, birth center care, and group prenatal care should be promoted. Co-pays and sliding scale charges could be part of these programs.

- Solicit the help from the faith-based organizations and churches to participate in the governmental programs designed to increase access to obstetrical care.
- Increase the Medicaid payments for licensed counselors, and nutritionists who provide the other "wrap-around services for low-income women. Again faith-based or community birth centers would increase community contact with those women needing additional emotional and social support.
- Increase Medicaid reimbursement to physicians and hospitals.
- Upgrade the Medicaid transportation system (Medicaid Cabs) so that dependable transportation is not an issue.
- Either fund or increase funding to successful programs that are currently serving indigent women so that they may have healthier pregnancies, for example Breathe Easy Baby, Forty Weeks to Grow, Resource Mothers, Healthy Families, Beds and Britches, Partners in Perinatal Care, Community Voices, Regional Perinatal Councils and Fetal and Infant Mortality Review.
- Make prenatal care services a requirement, not an option, for all local health departments either through direct services or collaboration with local providers, hospitals, or other local clinics.
- Recommend that the high-risk centers offer more satellite clinics. Support the use of teleconference visits or outreach clinic visits through the university perinatal services.
- Provide more interpreters in health clinics and physician offices.
- Increase education/networking with referring physicians and institutions to assure referrals are appropriate.
- Expand Medicaid eligibility to 200 percent FPL, regardless of national origin or length of time spent in the US
- Reform the insurance industry to regulate skyrocketing insurance premiums
- Many programs are designed to meet the same needs. Combine programs at the local level to address the identified needs and issues: affordable housing, employment, education, violence and substance abuse.
- Dedicate resources to obtain media coverage including billboards, TV and radio, and newspaper to bring attention to need for early care and the availability of care.
- Facilitate recruitment of additional OB physicians with incentives to practice in rural areas.
- Develop alternative birthing facilities in rural areas where delivery facilities are over 45 miles in travel distance.

APPENDIX K

CULTURAL/SOCIAL BARRIERS TO ACCESS
Summary of Survey of 11 Jurisdictions

On July 16, 2004, staff to the Barriers to Access Subcommittee surveyed ten states and the District of Columbia on questions related to Cultural/Social Barriers to Access. The questions are listed below; the answers appear on the following table.

1. Are publicly funded translation services available for low-income women receiving prenatal, delivery, or postnatal services?
2. Is publicly funded training on cultural competency and sensitively translation services available for providers of prenatal, delivery, or postnatal services to low-income women?
3. Do low-income pregnant women have access to multi-lingual providers?
4. Do pregnant women who are undocumented aliens have access to prenatal, delivery, and postnatal care?

	Question 1	Question 2	Question 3	Question 4
District of Columbia	Yes	Yes	Yes, in all areas of the state	Yes, in all areas of the state
Florida	Yes	No information provided	Yes, in some areas of the state	Yes, in all areas of the state
Georgia	No information provided	No information provided	No information provided	No information provided
Maryland	Yes	Yes	Yes, in some areas of the state	Yes, in all areas of the state
Massachusetts	Yes	Yes	Yes, in some areas of the state	Yes, in some areas of the state
Michigan	No	No	Yes, in some areas of the state	Yes, in some areas of the state
North Carolina	Yes	Yes	Yes, in some areas of the state	Yes, in all areas of the state
Oklahoma	Very Limited	Very Limited	Yes, in some areas of the state	Yes, in some areas of the state
Tennessee	Very Limited	Very Limited	Very Limited	Very Limited
Texas	Yes	Yes	Yes, in some areas of the state	Yes, in all areas of the state
West Virginia	No	No	Yes, in all areas of the state	Yes, in all areas of the state

APPENDIX L

SURVEY OF CULTURAL COMPETENCE AND RELATED STUDIES AT EDUCATION INSTITUTIONS IN VIRGINIA

During July, 2004, staff to the Barriers to Access Subcommittee surveyed educational institutions in Virginia, requesting information regarding classes related to studies in cultural competence. The responses are shown below; blank spaces indicate schools from which no response was obtained.

	Required Classes	Elective Classes
Medical Schools		
Eastern Virginia Medical School	No	No
University of Virginia	Yes	Yes
Virginia Commonwealth University*	Yes	Yes
Virginia College of Osteopathic Medicine	Yes	No
* VCU currently has a committee reviewing cultural competencies, with a report due in December		
Nursing Schools		
George Mason University	Yes	No
James Madison University	Yes	Yes
Liberty University	Yes	Yes
Old Dominion University	Yes	
Radford University	Yes	Yes
University of Virginia	Yes	Yes
Virginia Commonwealth University	No	No
Shenandoah University	Yes	Yes
J. Sargeant Reynolds Community College	Yes	No
Northern Virginia Community College	No	No