November 30, 2015

The Honorable Lawrence J. Hogan, Jr.

The Honorable Thomas V. Mike Miller, Jr.

The Honorable Michael E. Busch

Department of Legislative Services

Legislative Services Building

90 State Circle

Annapolis, MD 21401-1991

RE: Report on Access to Obstetric Services in Maryland- MSAR#: 10583

Dear Governor Hogan, Mr. President and Mr. Speaker:

In accordance with Senate Bill 187, introduced during the 2015 legislative session, the Maryland Hospital Association is submitting this report which addresses access to obstetric services in Maryland on behalf of the work group convened to study this issue.

CC: The Honorable Catherine Pugh

The Honorable Joan Carter Conway

The Honorable Ulysses Currie

The Honorable Guy Guzzone

The Honorable Nancy King

The Honorable Susan Lee

The Honorable James Mathias

The Honorable Karen Montgomery

The Honorable Anthony Muse

The Honorable Shirley Nathan-Pulliam

The Honorable Thomas Middleton

The Honorable Peter Hammen

Sarah Albert, Legislative Services

MARYLAND WORK GROUP TO STUDY ACCESS TO OBSTETRIC SERVICES

MSAR#: 10583, SB 187, CH. 329, 2015

DECEMBER 1, 2015

MARYLAND WORK GROUP TO STUDY ACCESS TO OBSTETRIC SERVICES

LEGISLATIVE CHARGE

Senate Bill 187 (Appendix A), sponsored by Senator Catherine Pugh and passed during the 2015 legislative session, authorized the Maryland Hospital Association (MHA), in consultation with the Secretary of Health & Mental Hygiene (DHMH), the health occupations boards, the Governor, and other stakeholders determined appropriate by MHA, to establish a work group to study access to obstetric services in Maryland.[1] The work group's charge: develop a mechanism to evaluate the number and locations of obstetrical health care workers, practice patterns, provider preferences, and other relevant factors, and make recommendations on the enactment of legislation that would provide incentives to increase the availability of obstetric care throughout the state. The bill calls for the work group to submit a report to the Governor and specified committees of the General Assembly by December 1, 2015.[2]

WORK GROUP

After consultation with the Health Secretary, MHA convened a work group of 17 organizations:

Anne Arundel Medical Center
Governor's Workforce Investment Board
Holy Cross Hospital
Johns Hopkins Bayview Medical Center
Maryland Affiliate of the American College of Nurse-Midwives
Maryland Section of the American Congress of Obstetrics and Gynecology
Maryland Association for Justice
Maryland Department of Health & Mental Hygiene
Maryland Hospital Association
Maryland Nurses Association
Maryland Rural Health Association
Maryland State Medical Society
Medical Mutual Liability Insurance Society of Maryland
MedStar Health
Mercy Medical Center
Mid-Atlantic Association of Community Health Centers
University of Maryland Shore Regional Health

The list of participants from each organization is in Appendix B; the work group met four times from June through October 2015.

DEFINING OBSTETRICAL SERVICES

Because some think of obstetrics solely as the delivery of babies, the work group began its deliberations by agreeing to define obstetrical services as:

- Preconception counseling
- Prenatal care
- Labor and delivery

[1] Ch. 329 of the Laws of Maryland of 2015
[2] Modified from the Fiscal and Policy Note on Senate Bill 187, Department of Legislative Services, Maryland General Assembly

- Access to high-risk specialists (e.g., perinatologist)
- Postpartum care

While not every practitioner provides all of these services, the specialty includes all of them.

In calendar year 2014, Maryland's 32 birthing hospitals delivered 67,356 babies.[3] Individually, the number of deliveries ranged from 263 at Garrett County Memorial Hospital to 8,805 at Holy Cross Hospital. Additional births also may also have occurred in free-standing birthing centers or in the mothers' homes. It will be important to monitor the presence and availability of free-standing birthing centers moving ahead.

The obstetrics unit at Chester River Hospital Center in Chester River closed in 2014 after the announcement that the only remaining obstetrician in the county would cease delivering babies. In 2013, Maryland General Hospital closed its obstetrics unit because of rising costs and a decline in deliveries by more than half in five years, from 1,200 to 570. University of Maryland Shore Regional Health System in Easton lost one of the two obstetrical groups providing service at that hospital at the end of 2014. In 2013, Peninsula Regional Medical Center in Salisbury dropped from a Level III to a Level II hospital, providing less complex perinatal care services. Most recently, on October 11, 2015, the Maternal and Child Health Unit at Laurel Regional Hospital in Laurel closed. This recent trend of service cutbacks and closures is of significant concern and should be closely tracked. In addition, in January 2014, Maryland implemented a new hospital payment system unique in the nation, in which hospitals are no longer paid per patient, but instead use global budgeting. Hospitals' annual revenue is capped and all patients must be cared for within that constraint. Its impact on care delivery, specifically obstetrical care, is being examined.

Measuring the availability of obstetrical services is difficult. There are at least two problems with the available data sources. The first relates to definitions as the medical specialty is obstetrics *and* gynecology (OB-GYN) and data sources combine both. However, some physicians practice only gynecology, while others practice both obstetrics and gynecology. More challenging, the percentage of time spent practicing in one area versus another is unknown. Using data from 2012-13, the Maryland Board of Physician Licensing identified 724 physicians in OB-GYN, and claims data from the Health Services Cost Review Commission's records for calendar year 2014 indicate that 832 physicians provided care for one or more obstetrical patients in hospitals. The vast majority of physicians who provided care in hospitals are OB-GYNs; however, some may be in family practice. The Maryland section of the American College of Obstetricians and Gynecologists estimates there are 867 OB-GYN physicians in the state, although no information shows the percentage of time devoted to obstetrics. Counties with the fewest physicians in the specialty were Caroline, Somerset, and Worcester, with zero, Dorchester has one and Queen Anne's has two. As a result, the data that might allow a count of actual physicians delivering babies in Maryland are unclear.

The second problem with the available data sources relates to measuring the amount of time clinicians spend practicing medicine. The data available are effectively "head counts" – tallying the number of individuals, for example those licensed to deliver care, or those registered within a particular specialty. These data do not indicate how many hours any of those clinicians actually spend caring for patients. Any number of OB-GYNs, for example, may be licensed, but no longer practicing medicine. Others may be practicing on a part-time basis. What is missing from these data

[3] Calendar Year 2014 Health Services Cost Review Commission Public Use File

is the ability to measure the aggregate hours of care available, or create a "full-time equivalent" concept that would measure true professional capacity.

In addition, no comprehensive source of data on the age of physicians practicing obstetrics was identified, so it is also difficult to determine how many physicians might retire in coming years.

Similarly, it is difficult to determine how many medical residents training in OB-GYN plan to primarily practice obstetrics. In addition to physicians, 290 certified nurse-midwives[4], also provide obstetrical services in Maryland. With four OB-GYN residency programs in the state, roughly 23 residents complete training each year. Some have gone on to advanced subspecialty training in gynecology, while others have left to practice in other states. Retention in Maryland has varied from 16 percent to 55 percent, depending on the program. Once again, it is difficult to determine the number of full-time equivalents practicing obstetrics[5]. As Maryland Board of Nursing data do not show how many nurse-midwives are actively providing patient care, or whether they are full-time or part time.

RECOMMENDED MECHANISM FOR ASSESSING ACCESS

Given these data limitations, the work group at its first two meetings identified a multitude of factors that impact access to obstetrical services. The factors are multi-dimensional and include patients' demographic and socioeconomic characteristics, the number and distribution of physicians and nurse-midwives providing obstetrical care, health insurance status and benefits covered, location and capacity of hospitals and birthing centers, reimbursement rates, and the medical liability climate. Taken together, the 57 factors identified by the work group constitute a mechanism by which to assess access to obstetrical care in Maryland (see *Mechanism for Assessing Access to Obstetrical Care* grid below).

The list is extensive and several factors have no readily available source of timely data. As such, the work group prioritized the following six factors to be the most immediate and important for which accurate, timely data should be developed and available. Each of these elements is incorporated within the larger grid below in the section referenced in parentheses.

- Delivery rate by county (demographic data)
- Prenatal care availability, including time of first visit (capacity factors)
- Number and distribution of facilities providing obstetrical services, including hospitals, birthing centers, and professional offices (capacity factors)
- Number and distribution of obstetrical care practitioners, including the share of time devoted to providing obstetrical services (capacity factors)
- Reimbursement rates for obstetrical services paid by commercial insurers and the Medicaid program (reimbursement rates)
- Professional liability insurance availability and cost (liability insurance and cost)

Data on these six factors should be multi-year measures, not point-in-time measures, and should demonstrate trends and projections that could anticipate diminishing access.

[4] American College of Nurse-Midwives (ACNM) State Fact Sheet: Maryland

[5] Maryland American Congress of Obstetrics & Gynecologists' data, as presented by Dr. Clark Timothy Johnson M.D.

Factors	Description of Data Source	Source	Frequency and Lag	Publically Available	Potentially Available	Unavailable
Demographic Data						
Women of Child Bearing Age Rate (By County)	Estimated Maryland Total Population by Age Group, Region and Political Subdivision, Maryland	Maryland Vital Statistics Annual Report	2012	✓		
Fertility Rate (By Age)	General Fertility Rates and Birth Rates by Age of Mother, Race of Mother, Region, and Political Subdivision, Maryland, July 1, 2012-All Races	Maryland Vital Statistics Annual Report	2012	✓		
Delivery Rate (By County)	Births by Age, Race and Hispanic Origin of Mother, Region, and Political Subdivision, Maryland, 2012-All Races	Maryland Vital Statistics Annual Report	2012	✓		
Incidence of Adverse Birth Outcomes	ICU Placement, Low Birth Weight, Indicator of Infant Currently Alive	DHMH PRAMS Report	2015; 2 year lag	✓		
Socio-Economic Factors Impacting Access to Obstetrical Care						
Educational Level (Maryland)	High school graduate or higher, percent of persons age 25+, and bachelor's degree or higher, percent of persons age 25+	U.S. Census Bureau	2009-2013	✓		
Educational Level Achieved by Women (by county)	Educational attainment by sex for adults 18 + by county/Educational attainment for women age 15-50 who have given birth in the last 12 months by county	American Community Survey	2014	✓		
Income Level Achieved by Women (by county)	Median Earnings In The Past 12 Months (In 2014 Inflation-Adjusted Dollars) By Sex By Work Experience In The Past 12 Months For The Population 16 Years And Over With Earnings In The Past 12 Months	U.S. Census Bureau	2014	✓		
Percent of Residents for whom English is not their First Language in Maryland	Language other than English spoken at home, participant age 5+	U.S. Census Bureau	2009-2013	✓		
Literacy in Maryland	Indirect estimate of percent lacking Basic prose literacy skills and corresponding credible intervals in all counties	National Center for Education Statistics	2003	✓		
Health literacy in Maryland	Statistics on health literacy rates by women in the state	UM Horowitz Center for Health Literacy			✓	
Immigration Status	Percentages of immigrants and their children, particularly those of Hispanic and Asian descent, in Maryland	American Immigration Council	May 2015	✓		
Insured/Uninsured	Statistics on health coverage status; can be stratified by immigration status	American Community Survey; Survey of Income and Program Participation	2015	✓		
Capacity Factors Impacting Access to Obstetrical Care						
Number and distribution of facilities providing obstetrical services, including hospitals, birthing centers, and professional offices	Hospitals, obstetrical services units, physicians	HSCRC, MHCC, and Md. Bd. of Physicains	2015	✓		
Scope of Service for Obstetrician Services in Maryland (Various Levels)	Zip code analysis of obstetric care	HSCRC	CY14	✓		
Location of Available Services, by Provider and/or Facility	Location of hospitals, licensed obstetrical services units, physicians	HSCRC, MHCC, and Md. Bd. of Physicains	2015	✓		
Number of Nurse Midwives in Maryland	Percentage of births attended by Certified Nurse-Midwives and Certified Midwives	Board of Nursing			✓	
Number of Maternal Fetal Medical Specialists in Maryland	Physicians licensed as MFM specialists in the state	Md. Bd. of Physicians	2015	✓		
Number of Non-Nurse Midwives in Maryland*	Not yet available					
Number of Family Practice Physicians delivering babies in Maryland	Family medicine physicians who have obstetric privleges to deliver	HSCRC, Md. Bd. of Physicians, Hospitals	2015		✓	
Number of Obstetricians in Private Practice in Maryland	Number of community obstetricians not on staff or employed by a hospital	HSCRC, Md. Bd. of Physicians, Hospitals	2015		✓	
Number and distribution of obstetrical care practitioners, including the share of time devoted to providing obstetrical services	Actual employee hours performing clinical obstetric services	Hospitals	2015	✓		
Number of Laborists delivering babies in Maryland	Number of physicians who only deliver babies but do not provide other obstetric care such as prenatal care	HSCRC, Md. Bd. of Physicians, Hospitals	2015		✓	

Factors	Description of Data Source	Source	Frequency and Lag	Publically Available	Potentially Available	Unavailable
Prenatal Care Availability	Measure of appointment wait times	Johns Hopkins Study: ACOG Grant - Clark Johnson, MD	TBD		✓	
Total Number of Prenatal Visits	Maryland Facility Worksheet for the Certificate of Live Birth	DHMH Vital Statistics			✓	
Average Timing of First Visit	Average time of first prenatal visit	DHMH	May 2015, 3 year data lag	✓		
Number of privileged doctors in Birthing Centers	Number of unique NPIs delivering at a hospital	HSCRC	CY14	✓		
Number of Resident Fellows per Birthing Center	Number of trainees at ob residency programs	ACOG	2015		✓	
Average Resident/Fellow Retention in Maryland	Number of trainees that elect to stay in Maryland post-training	ACOG	2015		✓	
Number of Bassinets	Self-reported AHA Annual Hospital Statistics	AHA	2014	✓		
Number of NICUs	Number of obstetrical services units that qualify as NICUs	MHCC	2015	✓		
Fragility/ Vulnerability						
Number of obstetricians per facility	Number of unique NPIs delivering by hospital	HSCRC	CY14	✓		
Percent bassinet capacity for top 10 birthing center	Self-reported AHA Annual Hospital Statistics	AHA	2014	✓		
Private community providers more than 30 minutes away from the next nearest provider	Distribution of community providers by zip code analysis	MHCC	2015	✓		
Reimbursement Rates in Maryland						
Obstetricians · Medicaid · Commercial	APCD for MCOs. FFS from Medicaid Physician Fee Schedule. APCD	DHMH	2015; one quarter lag	✓		
Certified Nurse Midwives · Medicaid · Commercial	APCD for MCOs. FFS from Medicaid Physician Fee Schedule. APCD	DHMH	2015; one quarter lag	✓		
Maternal Fetal Medical Specialists · Medicaid · Commercial	APCD for MCOs. FFS from Medicaid Physician Fee Schedule. APCD	DHMH	2015; one quarter lag	✓		
Non-Nurse Midwives* · Medicaid · Commercial	Not yet available					
Family Practice Physicians · Medicaid · Commercial	APCD for MCOs. FFS from Medicaid Physician Fee Schedule. APCD	DHMH	2015; one quarter lag	✓		
Liability Insurance and Costs						
· Availability · Price	Number of claims opened against a provider that make them uninsurable Cost per Birth	MIA, Office of Health Claims Arbitration MIA			✓	
Liability Climate	Medical Malpractice Payout Analysis	Diedrich Healthcare	2015	✓		
Obstetrician Malpractice/ Liability Costs	The cost of obtaining liability coverage for the provision of obstetrical services	MIA			✓	
Non-Nurse Midwife Malpractice/ Liability Costs	The cost of obtaining liability coverage for non-nurse midwives	MIA			✓	
Nurse Midwife Malpractice/ Liability Costs	The cost of obtaining liability coverage for certified nurse midwives	MIA			✓	
Obstetricians in Private Practice Malpractice/ Liability Costs	The cost of obtaining liability coverage for private community physicians	MIA			✓	
Maternal Fetal Medical Specialist Malpractice/ Liability Costs	The cost of obtaining liability coverage for maternal fetal specialists	MIA			✓	
Hospital Cost of Liability per Birth	The liability cost attributed to each birth	Hospitals			✓	

*Non-Nurse Midwives are currently set to commence practice beginning Fall 2016

WORK GROUP RECOMMENDATIONS FOR LEGISLATION

As requested, the work group has identified a set of legislative recommendations. For each recommendation, the vote tallies (supported, opposed, abstained) of the 16 participants at the September 29 meeting are shown. DHMH abstained from taking a position on all recommendations. These recommendations may require funding, by either reallocating existing resources or providing new funding. However, the method by which to fund these recommendations was beyond the scope of this work group and therefore not addressed.

The recommendations presented encompass three areas: improving access, promoting better health and improving available data. The work group considered recommendations in all three areas important to resolving the issues faced in Maryland. Recommendations in the area of ***Access*** seek to mitigate immediate threats to the availability of care: insufficient payment for providers, rising liability risk and cost, and an insufficient supply of practitioners that can, through specific steps, be improved. Recommendations in the area of ***Better Health*** underscore the importance of early prenatal care and prevention to help ensure that limited obstetrical care resources are used efficiently. Recommendations in the area of ***Data*** include implementing the mechanism created by the work group to measure access to obstetrical care in Maryland, as well as other steps to ensure there is an accurate, sensitive and dynamic means of understanding the factors affecting access to obstetrical care and that state leaders have the data needed to act before a crisis occurs.

Access

The work group recommends the following approaches to expand the state's existing obstetrical capacity and ensure its stability:

- **Increase Medicaid reimbursement for obstetricians and certified nurse-midwives.** Maryland's Medicaid reimbursement rate for physicians is among the lowest in the nation. The state should look for opportunities to increase these reimbursements. *(Supported: 15; Opposed: 0; Abstained:1)*

- **Mitigate liability risk and cost for providers.** Increasing medical liability costs in obstetrics represent a significant threat to access. The work group recommends the establishment of a No-Fault Birth Injury Fund to stabilize medical liability costs and provide a clear and critical incentive for hospitals to continue to provide this vital community service. Such a fund would provide direct, timely compensation, medical care and other services, without the uncertainty of protracted litigation, to children who suffer a devastating birth injury. In addition, providers covered by the fund would receive a credit discount on medical liability premiums, a direct incentive to continue practicing obstetrics. *(Supported: 13; Opposed: 1; Abstained: 2).* Separate statements supporting their views have been submitted by Medical Mutual Liability Insurance Society of Maryland, a group representing the majority of the Access to Obstetrical Care work group members and the Maryland Association for Justice. (Appendix C, D and E).

- **Encourage collaboration among certified nurse-midwives and obstetricians.** Support the themes of the joint statement of the American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives that promotes evidence-based practice models provided by OB-GYNs and certified nurse-midwives (Appendix F). Both organizations believe that health care is most effective when it occurs in a system that

facilitates communication across settings and among providers. *(Supported: 15; Opposed: 0; Abstained: 1).*

- **Increase funding for Maryland's loan assistance repayment program and ensure issuance of available funds, starting with obstetricians.** Loan assistance programs have been successful in other states in attracting and retaining physicians. The Maryland Loan Assistance Repayment Program provides loan repayment funds to physicians, physician assistants, and medical residents who agree to serve for two years in a federally designated health professional shortage area, medically underserved area, or state-designated health professional shortage area. Encourage the Maryland Higher Education Commission to issue funds to their full extent, with priority given to obstetric providers. *(Supported: 15; Opposed: 0; Abstained: 1)*

- **Explore the potential of a Maryland obstetrical residency track that would require service in state-designated health professional shortage areas.** Modeled after federal programs, introducing medical residents to more remote or underserved areas can increase the chances that they would choose to practice there. *(Supported: 13; Opposed: 2; Abstained: 1)*

Better Health

- **Similar to the work of Baltimore's B'More for Healthy Babies initiative, work with hospital emergency departments to determine best practices for using CRISP to link pregnant women with prenatal care.** This can improve access to and reduce the need for certain types of obstetrical services by making sure women get prenatal care at the right time and in the right place. As is being piloted in Baltimore, use the state's health information exchange (the Chesapeake Regional Information System for our Patients or CRISP) to provide information to emergency departments on a patient's use of prenatal care. As the pilot proceeds, consider investigating the use of CRISP in urgent care centers to do the same. *(Supported: 12; Opposed: 2; Abstained: 2)*

- **Expand the function of Maryland's "211" non-emergency call system for use as an information source to connect women with prenatal care, and use public service announcements to create awareness of the available assistance.** *(Supported: 14; Opposed: 0; Abstained: 2)*

- **As needed, the Maryland Health Care Commission should update the state health plan, which has not been updated in the area of obstetrics since 2005.** *(Supported: 13; Opposed: 0, Abstained: 2)*

Data

- **Approve policies or enact legislation to annually collect the data elements recommended in this report.** The work group believes current data are insufficient to accurately capture the state of access to obstetrical care in Maryland. Taken together, the recommended data elements can constitute a mechanism that would allow the state to evaluate access to obstetrical care on an ongoing basis. The data should be collected and, more important, compiled in a way that allows for an annual snapshot as well as trending.

These data can inform the development of relevant policy. *(Supported: 14; Opposed: 1; Abstained: 1)*

- **Improve the completeness and timeliness of Maryland's All Payer Claims Database.** Consisting of insurance claims filed in Maryland, this source can provide a better understanding of access to obstetrical services. For example: it could be used to estimate the level of activity of an obstetrical service provider by using the number of claims filed per provider. It also could be used to glean greater insight into the status of patients seeking obstetrical care. The following types of analyses could be performed:

  - Number (%) of pregnant women, as well as "high-risk" pregnancies by provider type/hospital/county/region
  - Number (%) of types of deliveries (vaginal, C-section, VBAC) by provider type/hospital/county/region
  - Demographics description (age, zip code or county of residence, race, ethnicity, preferred language, type of insurance coverage, and relationship to policyholder)
  - Further analyses for Medicaid-eligible cases
  - Based on the institutional services file, describe primary diagnoses, co-morbidities based on secondary diagnoses, Diagnosis Related Groups (DRGs), billed charges and allowed amount (for inpatient, outpatient, ED services)
  - Based on the professional services file, determine primary diagnosis for each claim, co-morbidities for each claim (up to 10 diagnosis codes in file), place of service for each claim, zip code where service was provided, procedure code, category of service, practitioner providing service (especially to determine any type of prenatal care), amount billed, amount paid
  - Description of the providers using the provider directory file, the field in which the practitioner is licensed, credentials, practitioner/supplier specialty, and multi-practitioner health care organization
  - The database also could be used to obtain National Practitioner Identifier numbers for providers providing obstetrical care. This information can be matched against physician licensing data from the Maryland Board of Physicians to obtain provider age, which can then be grouped and a zip-code analysis performed to determine the age distribution of providers in different regions

This can aid gap analyses to guide and support policy recommendations. Additional support for the Maryland Health Care Commission to maintain this data source may be needed. *(Supported: 14; Opposed: 0; Abstained: 2)*

- **Measure the vulnerability of access to obstetrical care in Maryland.** The data that exist today help paint a current picture, but are not as helpful in understanding to what degree access may be at risk. The financial industry has used this approach, creating bank "stress tests" to determine the ability of a bank to deal with an economic challenge. Researchers at the North Carolina Rural Health Research Center at the University of North Carolina at Chapel Hill have developed a stress test for rural hospitals, including predictors of those at risk of financial distress or closure. A similar measure should be developed for Maryland to determine the fragility of access to obstetrical care in the state. *(Supported: 14; Opposed: 0; Abstained: 2)*

- **Conduct studies to better understand access to prenatal care in Maryland.** One helpful, ongoing study would measure the time it takes to secure a prenatal appointment in areas across the state. This is important but difficult work. Modeled after national studies, Maryland should study the time required to secure a prenatal appointment and the variability in doing so by region and insurance status *(Supported: 15; Opposed: 0; Abstained: 1).* Another helpful study would conduct qualitative research to better understand why women do not access prenatal care or access it late in their pregnancy. By directly working with this population, stakeholders may be able to better understand the barriers faced by these women that are not apparent in the quantitative data with the goal of developing more tailored solutions. The work group believes that access to prenatal care is critical and should be better measured.

CONCLUSION

Maryland is a leader in the transformation of health care, with a focus on providing the right care, at the right time, in the right setting. It is a priority to ensure Marylanders have access to obstetrical services as health care evolves and community needs change. It is also imperative that a process is in place to compile, monitor and measure critical data to act on the above legislative recommendations. It is the belief of this work group that doing both can assure Maryland's mothers that their health, and the health of their babies, is paramount in our state, and that the obstetrical care that is so important to the delivery of a healthy baby will be there for them when they need it.

APPENDICES:

A: SB 187

B: List of Work Group Participants

C: No-Fault Birth Injury Fund – Statement of Medical Mutual Liability Insurance Society of Maryland

D: No-Fault Birth Injury Fund – Statement of a group representing the majority of Access to Obstetrical Care work group members

E: No-Fault Birth Injury Fund – Statement of the Maryland Association for Justice

F: Statement of the Maryland Department of Mental Health and Hygiene

G: ACNM - ACOG Joint Statement

SENATE BILL 187

J1, J2 5lr1041

By: **Senators Pugh, Conway, Currie, Guzzone, King, Lee, Mathias, Montgomery, Muse, and Nathan–Pulliam**

Introduced and read first time: February 2, 2015
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 13, 2015

CHAPTER _____

AN ACT concerning

~~Governor's Workforce Investment Board –~~ Workgroup to Study Access to Obstetric Services

FOR the purpose of ~~requiring~~ authorizing the ~~Governor's Workforce Investment Board to coordinate~~ Maryland Hospital Association, in consultation with the Secretary of Health and Mental Hygiene, health occupations boards, the Governor's Workforce Investment Board, and certain other entities and parties, to establish a workgroup to study access to obstetric services in the State ~~by developing~~; requiring the workgroup to develop a certain mechanism to evaluate certain factors and to make certain recommendations; requiring the workgroup to report to the Governor and certain committees of the General Assembly on or before a certain date ~~each year~~; and generally relating to ~~the Governor's Workforce Investment Board and~~ a workgroup to study access to obstetric services.

~~BY adding to~~
~~Article – Labor and Employment~~
~~Section 11–505.2~~
~~Annotated Code of Maryland~~
~~(2008 Replacement Volume and 2014 Supplement)~~

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That ~~the Laws of Maryland read as follows~~:

~~**Article – Labor and Employment**~~

~~**11–505.2.**~~

~~**(A) THE GOVERNOR'S WORKFORCE INVESTMENT BOARD SHALL COORDINATE WITH THE SECRETARY OF HEALTH AND MENTAL HYGIENE, THE HEALTH OCCUPATIONS BOARDS, AND OTHER PARTIES AS DETERMINED APPROPRIATE BY THE BOARD TO ESTABLISH A WORKGROUP TO STUDY ACCESS TO OBSTETRIC SERVICES IN THE STATE BY DEVELOPING A COMPREHENSIVE MECHANISM TO EVALUATE:**~~

~~**(1) THE NUMBER AND GEOGRAPHIC LOCATIONS OF OBSTETRICAL HEALTH CARE WORKERS IN THE STATE;**~~

~~**(2) PRACTICE PATTERNS;**~~

~~**(3) PROVIDER PREFERENCES; AND**~~

~~**(4) OTHER FACTORS DETERMINED TO BE RELEVANT BY THE WORKGROUP.**~~

~~**(B) ON OR BEFORE DECEMBER 1 OF EACH YEAR, THE WORKGROUP SHALL SUBMIT A REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, TO THE SENATE EDUCATION, HEALTH, AND ENVIRONMENTAL AFFAIRS COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE ON THE FINDINGS OF THE BOARD.**~~

(a) The Maryland Hospital Association, in consultation with the Secretary of Health and Mental Hygiene, the health occupations boards, the Governor's Workforce Investment Board, the Medical Mutual Liability Insurance Society of Maryland, the Maryland Association for Justice, the Maryland Affiliate of American College of Nurse–Midwives, and other parties as determined appropriate by the Maryland Hospital Association, may establish a workgroup to study access to obstetric services in the State.

(b) The workgroup shall develop a comprehensive mechanism to evaluate:

(1) the number and geographic locations of obstetrical health care workers in the State;

(2) practice patterns;

(3) provider preferences; and

(4) other factors determined to be relevant by the workgroup.

(c) The workgroup shall make recommendations for enactment of legislation that would provide incentives to increase the availability of obstetric care services throughout the State.

(d) On or before December 1, 2015, the workgroup shall submit a report to the Governor and, in accordance with § 2–1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee on the findings and recommendations of the workgroup.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2015.

Approved:

_____

Governor.

_____

President of the Senate.

_____

Speaker of the House of Delegates.

Work Group to Study Access to Obstetric Services
Roster 2015

Anne Arundel Medical Center
Henry Sobel, M.D.
Department Chair, Women's &
Children's Health

DHMH
Mona Gahunia, M.D.
June - August
Chief Medical Officer

Sara Cherico-Hsii, MPH
September - November
Health Policy Analyst-Advanced
Office of the Secretary

Governor' Workforce Investment Board
Diane Pabich
Deputy Director

Holy Cross Hospital
Judith Rogers
President

John Hopkins Bayview Medical Center
Richard Bennett, M.D.
President

Maryland Affiliate of American College of Nurse-Midwives
Erin Wright
Chair

Maryland American Congress of Obstetrics & Gynecologists
Clark Timothy Johnson, M.D. MPH
ACOG Maryland Section Legislative Chair

Maryland Association for Justice
George Tolley, III
Attorney-at-Law

Maryland Hospital Association
Carmela Coyle
President & CEO

Maryland Nurses Association
Cathy Gibson

Maryland Rural Health Association
Colenthia Malloy
CEO, Greater Baden Medical Services

MedChi
Robert Atlas, M.D.
Asst. Professor of Obstetrics, Gynecology & Reproductive Sciences at University of Maryland School of Medicine

Medical Mutual Liability Insurance Society of Maryland
Cheryl Matricciani
Senior Vice President

MedStar Health
Larry Smith
Vice President, Risk Management

Mercy Medical Center
Scott Spier, M.D.
Senior Vice President, Medical Affairs &
Chief Medical Officer

Mid-Atlantic Association of Community Health Centers
Cyrus Lawyer, M.D.

University of Maryland Shore Regional Health
Christopher Parker
Regional Senior Vice President/
Chief Nursing Officer

MEDICAL MUTUAL
Liability Insurance Society of Maryland

October 2, 2015

Work Group to Study Access to Obstetric Services
c/o Jennifer Witten, Director Governmental Policy & Advocacy
Maryland Hospital Association
6820 Deerpath Road
Elkridge, MD 21075

Dear Colleagues:

Re: Medical Mutual's Comments re: No-Fault Birth Injury Fund Recommendation

The Work Group to Study Access to Obstetric Services intends to include language in its final report recommending the creation of a No-Fault Birth Injury Fund (the "Fund"), but specifically voted at its September 29, 2015 meeting to exclude funding guidelines that were agreed to by the proponents of the legislation during the 2015 Session of the Maryland General Assembly. As this was a material part of the erosion of the 2014 Fund bill, Medical Mutual felt it necessary for the Work Group to address this issue in its final report. The omission of the funding source creates real concerns for us and has forced us to abstain from voting on this portion of the final report language. We did not vote for it since the removal of the funding source language leaves a known large and controversial issue unaddressed. We did not vote against it, as verbal assurances on funding sources were given that these would be honored. We are now left to evaluate the language that may be included in future legislation to determine our position.

In 2014 Medical Mutual was unable to support the Fund legislation because while the Fund was of primary benefit to hospitals and the entire populace, approximately two-thirds of the funding was placed on the physicians of Maryland through a 2.5% surcharge on all direct written medical liability premiums and a $7,500 annual assessment on all licensed physicians. This funding mechanism was problematic as it placed a considerable financial burden on the physician community with absolutely no evidence of any proportional benefit.

During the 2014 Interim, the Maryland Hospital Association convened a workgroup of constituent hospitals to identify a feasible funding source for the Fund. The workgroup recommended funding through Maryland's All-Payer Model, and Fund legislation was reintroduced in 2015 to reflect the change in funding. Although the legislation did not move forward, Medical Mutual supported the efforts of the Maryland Maternity Access Coalition and testified in support of the legislation.

225 International Circle / Box 8016 / Hunt Valley, Maryland 21030
410-785-0050 / 800-492-0193 / FAX: 410-785-2631
mmlis.com

Medical Mutual wants to be clear that it does support the concept of the Fund. We recognize the devastating effect that huge verdicts and settlements are having on Maryland hospitals, and certainly know the stress it is placing on physicians. We believe such a Fund could have a positive impact on Maryland citizens, as demonstrated by similar state no-fault funds, and would help maintain access to obstetric care throughout the State. Further, recoveries for these very significant cases are based on whether or not there was, in fact, negligence, which leaves many with no avenue for financial assistance. Even when compensation is provided, it is significantly reduced by substantial legal fees. A no-fault fund would relieve the randomness of litigation and provide access to needed services regardless of negligence.

As a mutual company, Medical Mutual is owned by its physician policyholders and strives to offer available and affordable medical professional liability insurance. Given the history of the variances in sources of funding and possible negative impact on our physician insureds, we respectfully abstained from voting on the Fund recommendation in the Work Group's final report.

Sincerely,

Cheryl F. Matricciani

Cheryl F. Matricciani
Senior Vice President – Underwriting Operations,
General Counsel and Secretary

Medical Liability Incentives:
Support for the No-Fault Birth Injury Fund

Increasing medical liability costs in the field of obstetrics represent a significant threat to access to obstetrical care in the state[1]. Maryland's hospitals and providers support the establishment of a No-Fault Birth Injury Fund to address the problem[2].

It is the majority consensus view of this workgroup—authorized by the General Assembly[3] to study access to obstetric services in Maryland—that the stabilization of medical liability costs associated with implementation of a No-Fault Birth Injury Fund would provide a clear and important incentive for hospitals to continue to provide this vital community service. In addition, providers covered by the fund would receive a credit discount on medical liability premiums[4], a direct incentive to continue practicing obstetrics.

At the same time, a No-Fault Birth Injury Fund would provide direct, timely compensation, medical care and other needed services to children who have suffered a devastating birth injury without the uncertainty of protracted litigation. Independent academic evaluations[5] of similar programs in other states have generally found that the programs have responded to the needs of injured children and their families, improved the efficiency and speed of adjudication of claims, and have stabilized the liability environment.

Therefore, given the workgroup's statutory charge to make recommendations to the Maryland General Assembly for *"legislation that would provide incentives to increase the availability of obstetric care services,"* the workgroup supports and recommends the 2014 Department of Health and Mental Hygiene Access to Obstetrical Care recommendation for legislature to conduct serious exploration[6] of a No-Fault Birth Injury Fund combined with expert testimony from the program directors of Florida[7] and Virginia[8] model programs and certified actuarial financial projections, as part of the normal legislative process during the 2016 legislative session.

The Maryland Association for Justice, one member of this workgroup representing Maryland's trial lawyers, disagrees and opposes the creation of a No-Fault Birth Injury Fund.[9]

Henry Sobel, M.D.	Anne Arundel Medical Center
Judith Rogers	Holy Cross Hospital
Richard Bennett, M.D.	Johns Hopkins Bayview Medical Center
Erin Wright	Maryland Affiliate of the American College of Nurse-Midwives
Clark Timothy Johnson, M.D.	Maryland American College of Obstetrics & Gynecology
Carmela Coyle	Maryland Hospital Association
Colenthia Malloy	Maryland Rural Health Association
Robert Atlas, M.D.	MedChi
Cheryl Matricciani	Medical Mutual Liability Insurance Society of Maryland (see Appendix C)
Larry Smith	MedStar Health
Scott Spier, M.D.	Mercy Medical Center
Cyrus Lawyer, M.D.	Mid-Atlantic Association of Community Health Centers
Christopher Parker	University of Maryland Shore Regional Health

[1] Maryland Department of Health & Mental Hygiene Report of the Access to Obstetrical Care Workgroup to the Maryland General Assembly, November 2014, Page 15: http://dlslibrary.state.md.us/publications/JCR/2014/2014_73.pdf
[2] Maryland Hospital Association, 2015 position paper: http://www.mhaonline.org/docs/default-source/position-papers/2015/sb-585-birth-injury-fund.pdf?sfvrsn=11
Testimony of MedChi, The Maryland State Medical Society: http://www.medchi.org/sites/default/files/SB0585.pdf
[3] Chapter 329, Acts of 2015: http://mgaleg.maryland.gov/2015RS/chapters_noln/Ch_329_sb0187T.pdf
[4] Virginia Birth-Related Neurological Injury Compensation Program, Website Information for OBGYN/Physician Participating Providers: http://www.vabirthinjury.com/obgyns-physicians/
[5] Siegal, G., Mello, M., and Studdert, D. (2008) "Adjudicating Severe Birth Injury Claims in Florida and Virginia: The Experience of a Landmark Experiment in Personal Injury Compensation," American Journal of Law and Medicine 34: 494.: http://www.hsph.harvard.edu/wp-content/uploads/sites/487/2012/10/FLVA_PDF.pdf
[6] Maryland Department of Health & Mental Hygiene Report of the Access to Obstetrical Care Workgroup to the Maryland General Assembly In, November 2014, Page 1: http://dlslibrary.state.md.us/publications/JCR/2014/2014_73.pdf
[7] The Florida Birth-Related Neurological Injury Compensation Association: http://www.nica.com/
[8] The Virginia Birth-Related Neurological Injury Compensation Program: http://www.vabirthinjury.com/
[9] Maryland Association for Justice 2015 position paper: https://www.marylandassociationforjustice.com/index.cfm?pg=Committee-Legislative

MARYLAND ASSOCIATION FOR JUSTICE, INC.
Formerly the Maryland Trial Lawyers Association
6240 OLD DOBBIN LANE, SUITE 100, COLUMBIA, MD 21045
(410) 872-0990 • FAX (410) 872-0993 • E-MAIL: info@marylandassociationforjustice.com

October 30, 2015

SB 187 Workgroup to Study Access to Obstetric Services in Maryland
c/o Jennifer Witten, Director, Government Policy and Advocacy
Maryland Hospital Association
6820 Deerpath Road
Elkridge, Maryland 21075

Re: MAJ's Comments re: "Birth Injury Fund" Recommendation

Dear Colleagues:

Although the SB 187 Workgroup was not charged with considering tort reform, some members of the Workgroup insisted from the outset that the Workgroup's final report must include a recommendation for a "No-Fault Birth Injury Fund." The Maryland Association for Justice opposed that recommendation, for the reasons that follow.

Recommending a birth injury fund is a rush to judgment. The Workgroup's report confirms that "current data are insufficient to accurately capture the state of access to obstetrical care in Maryland." To that end, the Workgroup endorsed the collection of critical data "that would allow the State to evaluate access to obstetrical care on an ongoing basis."

MAJ believes that it is irresponsible for the Workgroup to recommend radical changes to Maryland's tort system before the critical data needed to evaluate the state of access to obstetrical services has been collected, tabulated and examined.

A birth injury fund would cost many millions of dollars, without any clear solution for how to pay for it. Based on the most reliable estimates, a birth injury fund would cost hundreds of millions of dollars annually. The Workgroup failed to reach a consensus for how to pay for those costs, overwhelmingly rejecting a proposal that a birth injury fund should be paid for by hospitals (the funding mechanism proposed in the last legislative session).

Under earlier proposals, the costs of a birth injury fund would be borne by Maryland's small businesses and working class families, in the form of higher health insurance costs. MAJ opposes any funding mechanism that would increase costs to Maryland's small businesses and working class families.

A birth injury fund is not supported by any available data. Although insufficient data exists to evaluate the state of access to obstetrical care in Maryland, the existing data is *very favorable* for Maryland as compared to other states.

For example, Maryland has a relative surplus of active physicians. According to data published biannually by the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC), Maryland consistently ranks second in the nation in the number of active physicians *per capita*. In contrast, both Virginia and Florida rank below the national average in this metric.

Further, Maryland has a relative surplus of obstetricians, with 32% more obstetricians *per capita* than the national average, according to data published by the American Congress of Obstetricians and Gynecologists, a nationwide association of OB/GYNs. Maryland has a relative surplus of physicians, including obstetricians, compared to other States because Maryland has long been a place where health care professionals want to live, work, and raise their families.

Plainly, enacting a so-called "birth injury fund" will not attract more obstetricians. According to ACOG, both Virginia and Florida rank below the national average in obstetricians *per capita*, despite having created birth injury funds decades ago.

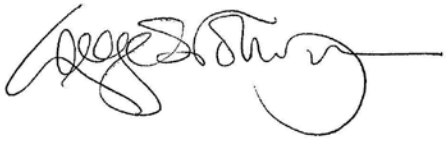
By every metric, therefore, the available data today shows that Maryland is a national leader in access to obstetrical care, with more active physicians and obstetricians *per capita* than the national average – and far more than either Virginia or Florida.

Maryland's market for obstetrical malpractice insurance is stable. Obstetrical malpractice insurance rates have been declining steadily, due in part to increased competition among insurers. For the past several years, many Maryland obstetricians received significant premium discounts and credits, making their insurance coverage even less expensive. In contrast, for example, obstetrical malpractice insurance in Florida costs up to $190,000 for a standard $1M/$3M policy – ranking Florida among the most expensive malpractice insurance markets in the country. Plainly, a birth injury fund won't bring down insurance costs.

A no-fault system would be more dangerous for patients. When malpractice occurs, the civil justice system provides for accountability in a public forum. By eliminating public accountability, a no-fault birth injury fund removes an important incentive for health care providers to use appropriate care.

As the largest statewide specialty bar association in the State of Maryland, the Maryland Association for Justice is comprised of trial attorneys whose mission includes a dedication to protecting and improving the State's civil justice system. For the reasons stated in this letter, we respectfully oppose the Workgroup's recommendation for a birth injury fund.

Sincerely,



George S. Tolley III
Maryland Association for Justice

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Lawrence J. Hogan, Jr., Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

November 5, 2015

Workgoup to Study Access to Obstetric Services
c/o Jennifer Witten, Director Governmental Policy & Advocacy
Maryland Hospital Association
6820 Deerpath Road
Elkridge, MD 21075

Dear OB Access Workgroup Members,

Thank you for the opportunity to participate in the Workgroup to Study Access to Obstetric Services. During the final meeting on October 27, 2015, Sara Cherico-Hsii, the Department of Health and Mental Hygiene's (Department) representative on the workgroup, shared a number of comments and edits to the workgroup's proposed recommendations after a thorough vetting within the Department. While some of the Department's proposed changes were adopted, there were two overarching issues which were not adopted for inclusion in the final report. The Department is submitting this letter to ensure its full views are reflected in the final report and on the record.

The workgroup has put forth a number of recommendations designed to meet the legislative charge to "develop a comprehensive mechanism to evaluate the number and geographic locations of obstetrical health care workers, practice patterns, provider preferences, and other relevant factors." In line with the majority view of the workgroup, the Department recommends that a university-based research center or private consulting company complete this work on behalf of the state. It is our position that this additional work be carefully scoped out and, that the development of this mechanism, as proposed by the workgroup, is not viable with existing resources at the Department.

While the majority of the workgroup decided the final report should not include any reference to the cost of these recommendations, the Department respects the majority's position, but believes cost is an important factor to consider when adopting recommendations. Therefore, should the General Assembly choose to pass legislation related to these findings, the Department recommends that additional financial and programmatic resources be allocated.

The workgroup also recommended increasing Medicaid reimbursement for obstetricians and certified nurse midwives. Maryland has among the highest rates of cesarean deliveries in the country. In line with the collaborative work underway by the Department, Maryland Hospital Association and Maryland Patient Safety Center Perinatal-Neonatal Quality Collaborative to reduce non-medically indicated cesarean deliveries in Maryland, the Department recommends a more measured approach to reducing the c-section rate in Maryland. Should a discussion about payment continue, the Department's position is that Medicaid should consider aligning with the collaborative work underway, focused on changes to appropriately incentivize providers to lower the rates of

early-elective deliveries and cesarean births and increase the number of vaginal births after cesarean. This is in line with the emphasis on high quality, value-based care that is being promoted by the Centers for Medicare and Medicaid Services across all health systems transformation work. These types of alternative payment models are more in line with national trends and are more likely lead to improved health outcomes for Medicaid beneficiaries.

The Department is committed to improving access to obstetrical care throughout the State and appreciates the opportunity to collaborate with the workgroup on this topic. We look forward to future opportunities for collaboration and thank you in advance for considering this information.

If you have additional questions, please contact Allison Taylor, Director of Government Affairs at allison.taylor@maryland.gov.

Sincerely,

Van T. Mitchell
Secretary

College Statement of Policy

As issued by the College Executive Board

This document was developed jointly by the American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists.

JOINT STATEMENT OF PRACTICE RELATIONS BETWEEN OBSTETRICIAN-GYNECOLOGISTS AND CERTIFIED NURSE-MIDWIVES/CERTIFIED MIDWIVES[1]

The American College of Obstetricians and Gynecologists (the College) and the American College of Nurse-Midwives (ACNM) affirm our shared goal of safe women's health care in the United States through the promotion of evidence-based models provided by obstetrician–gynecologists (ob-gyns), certified nurse-midwives (CNMs), and certified midwives (CMs). The College and ACNM believe health care is most effective when it occurs in a system that facilitates communication across care settings and among providers. Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients. Quality of care is enhanced by collegial relationships characterized by mutual respect and trust, as well as professional responsibility and accountability.

Recognizing the high level of responsibility that ob-gyns and CNMs/CMs assume when providing care to women, the College and ACNM affirm their commitment to promote the highest standards for education, national professional certification, and recertification of their respective members and to support evidence-based practice. Accredited education and professional certification preceding licensure are essential to ensure skilled providers at all levels of care across the United States.

The College and ACNM recognize the importance of options and preferences of women in their health care. Ob-gyns and CNMs/CMs work in a variety of settings including private practice,

[1] Certified Nurse-Midwives (CNMs) are registered nurses who have graduated from a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME) and have passed a national certification examination administered by the American Midwifery Certification Board, Inc. (AMCB), formerly the American College of Nurse-Midwives Certification Council, Inc. (ACC). Certified Midwives (CMs) are graduates of a midwifery education program accredited by ACME and have successfully completed the AMCB certification examination and adhere to the same professional standards as certified nurse-midwives. Obstetrician–gynecologists (ob-gyns) pass a national certification exam administered by the American Board of Obstetrics and Gynecology or Osteopathic Board and enter ongoing Maintenance of Certification.

community health facilities, clinics, hospitals, and accredited birth centers.[2] The College and ACNM hold different positions on home birth.[3] Establishing and sustaining viable practices that can provide broad services to women requires that ob-gyns and CNM/CMs have access to affordable professional liability insurance coverage, hospital privileges, equivalent reimbursement from private payers and under government programs, and support services including, but not limited to laboratory, obstetrical imaging, and anesthesia. To provide highest quality and seamless care, ob-gyns and CNMs/CMs should have access to a system of care that fosters collaboration among licensed, independent providers.

---

[2] A birthing center within a hospital complex, or a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, the Joint Commission, or the American Association of Birth Centers [From *Guidelines for Perinatal Care*, Sixth Edition. 2007. American College of Obstetricians and Gynecologists and the American Academy of Pediatrics].

[3] ACNM Home Birth Position Statement (http://www.midwife.org/siteFiles/position/homeBirth.pdf); Planned home birth. Committee Opinion No. 476. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:425–8. (http://www.acog.org/publications/committee_opinions/co476.cfm)

Approved by Executive Board of the American College of Obstetricians and Gynecologists
Approved by Board of Directors of the American College of Nurse-Midwives
February 2011