STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

October 1, 2014

The Honorable Edward J. Kasemeyer
Chair, Senate Budget and Taxation Committee
3 West Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Normal H. Conway
Chair, House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

RE: 2014 Joint Chairmen's Report (Page 73) – Budget Code M00A: Access to Obstetrical Care

Dear Chairmen Kasemeyer and Conway:

The Department of Health and Mental Hygiene respectfully requests an extension for submission of Joint Chairmen's Report (Page 73), Access to Obstetrical (OB) Care, for Fiscal Year 2014. This request is made to allow the workgroup to gather additional data on access to OB care, including both workforce data and prenatal care data in Maryland. This data will more clearly define the access issues and be included in the final report.

We expect to submit the report by December 15, 2014. If you have any questions regarding this request, please contact Allison Taylor, Director of Governmental Affairs, at (410) 767-6481 or at allison.taylor@maryland.gov.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

cc: Allison Taylor
Mona Gahunia
Sara Cherico-Hsii
Cathy Kramer
Kathleen P. Kennedy

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 12, 2014

The Honorable Edward J. Kasemeyer
Chair, Senate Budget and Taxation Committee
3 West Miller Senate Building
Annapolis, MD 2101-1991

The Honorable Norman H. Conway
Chair, House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

RE: 2014 Joint Chairmen's Report (Page 73) – Budget Code M00A: Access to Obstetrical Care

Dear Chairmen Kasemeyer and Conway:

Pursuant to the Joint Chairmen's Report (Page 73), Access to Obstetrical Care, for Fiscal Year 2014, the Department of Health and Mental Hygiene submits this report on behalf of the Access to Obstetrical Care Workgroup.

The workgroup was comprised of 11 members, all from the medical and hospital field. Over the summer and fall of 2014, the external workgroup members examined the issue by exploring data and policy solutions, and agreed on the recommendations contained in their report.

The recommendations in the report are those of the external workgroup members, not of the Department of Health and Mental Hygiene.

The Department's perspective is grounded in the core public health goal of improving birth outcomes and reducing infant mortality.

Our perspective is shaped by several key facts:

- **Infant mortality is on the decline in Maryland.** Together, we have driven down the average infant mortality rate by 15-percent in Maryland in the past decade, with a 20-percent decline in the average rate among white infants and a 14-percent decline among African American infants. As a result of declines in infant mortality since 2007, 457 more babies in Maryland have survived.

- **The Babies Born Healthy Initiative, which currently directs resources to the jurisdictions in Maryland with the highest infant mortality rates and the highest disparities in infant mortality, is working.** Babies Born Healthy works to reduce infant mortality by focusing on three areas that span a woman's reproductive life: preconception, prenatal and interconception. It also develops strategies to ensure women are healthy before, during, and after pregnancy. In addition, Babies Born Healthy funds quality initiatives, which have reduced 39-week elective inductions, developed policies on postpartum maternal hemorrhage, and in 2015 will work to reduce primary cesarean section rates in all birthing hospitals.

- **There is evidence that residents in the State face problems with accessing prenatal care.** According to the Department's Division of Vital Statistics there has been a 32-percent increase in the number of women receiving late (third trimester) or no prenatal care. For example, the number of births to women receiving late or no prenatal care has risen from 4,668 in 2010 to 6,146 in 2012. Late access to prenatal care is a risk factor for adverse birth outcomes, including prematurity and mortality.

To continue progress on infant mortality, the Department recommends:

- **Sustained funding of the Babies Born Healthy Initiative.** Babies Born Healthy has proven to be a key initiative in improving women's health and lowering infant mortality rates in Maryland. The Department recommends that funding for this initiative continues at current levels to support programs throughout the State that are saving women and infant's lives in Maryland.

- **Funding the "use case" for improved access to telehealth for routine and high-risk pregnancies in rural and underserved areas.** Telehealth programs offer the opportunity to improve access to care in underserved communities, especially in areas where the caseload may not support full-time practices. The Department supports the proposal submitted by the Telemedicine Task Force to the General Assembly to fund a "use case" or pilot program focusing on telehealth for routine and high-risk pregnancies. This project may serve as a way to accelerate telehealth diffusion across the State and improve access to obstetrical care.

With respect to recommendations affecting tort liability, the workgroup was composed entirely of practitioners and hospitals; the workgroup did not include representatives of injured plaintiffs or their counsel. As a result, the report's recommendations do not reflect a consensus among affected parties in Maryland.

As the General Assembly considers whether to take action to try to improve birth outcomes and reduce infant mortality, I urge you to take into account both (a) the importance of incentivizing quality care (and disincentivizing negligent care); as well as (b) fairness for injured children and

their families. Before considering a birth injury fund, the Maryland General Assembly should consider input from all interested parties.

I hope this information is helpful. If you have any questions or need additional information on this subject, please do not hesitate to contact Ms. Allison Taylor, Director of Governmental Affairs, at (410) 767-6480.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Mona Gahunia, D.O.
Allison Taylor, M.P.P., J.D.
Sara Cherico, M.P.H.

Report of the

Access to Obstetrical Care Workgroup

to the

Maryland General Assembly

In Fulfillment of the Joint Chairmen's Report (Page 73)

November 2014

Executive Summary

During the 2014 legislative session, SB 0798/HB 1337 entitled "Maryland No-Fault Birth Injury Fund" was introduced. The bill ultimately did not pass, but the Joint Chairmen's Report, Page 73, requested the Department of Health and Mental Hygiene (DHMH) convene a group of interested stakeholders to study the issue of access to obstetrical care. The workgroup was given four charges in the Joint Chairmen's Report:

1. Evaluate the factors contributing to any access to obstetrical care in both urban and rural areas of the State;

2. Evaluate if this issue exists in other states, and any policies that those states engage in to reduce barriers to obstetrical care in urban and/or rural areas;

3. Review recent proposals intended to ensure access to obstetrical care in urban and rural areas including through the creation of a birth injury fund and analyze the costs and benefits of these proposals; and

4. Make recommendations on ways to address any identified barriers to obstetrical care.

The workgroup met for a series of meetings and discussions and developed a list of recommendations to address any identified barriers to obstetrical care. These recommendations are those of the external workgroup members. The Department has not taken a position on the recommendations. These recommendations include:

1. Take steps to reduce the overall burden of medical liability risk and associated costs, especially those related to the field of obstetrics, in order to safeguard women's access to critical prenatal care.

2. Conduct serious exploration of a No-Fault Birth Injury Fund as a potential solution to Maryland's medical liability climate, based on the expert testimony from Florida and Virginia program directors and published independent academic research. Further, the Maryland General Assembly should also hire an actuarial firm to conduct a financial review to determine the best way to fund the projected costs of a Maryland No-Fault Birth Injury Fund in a way that supports the long-term success of Maryland's new Medicare Waiver.

3. No attempts to raise the state's current cap on non-economic damages. Attempts to raise the state's cap on non-economic damages would adversely impact access to obstetrical care. Maryland's current medical liability environment is already prohibitive and raising or eliminating the damages cap would only make matters worse.

4. Examine additional tort reforms that improve the fairness and efficiency of the court system and leads to improved health outcomes, lower health care costs, and lower malpractice premiums in Maryland.

5. Direct the health occupations boards and other appropriate State agencies, in collaboration with providers, to develop an enhanced, comprehensive mechanism to understand workforce supply, especially in obstetrics and primary care, and require a workforce report on a regular basis.

6. In order to attract physicians to underserved communities, adequately fund the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants.

7. Continue to support telemedicine and other initiatives to help provide physicians with needed backup and subspecialty support.

Introduction

Creation of Workgroup

During the 2014 legislative session, SB 798/HB 1337 entitled "Maryland No-Fault Birth Injury Fund" was introduced. The bill ultimately did not pass, but the Joint Chairmen's Report requested the Department of Health and Mental Hygiene (DHMH) convene a group of interested stakeholders to study the issue of access to obstetrical care.

Charge of the Workgroup

The workgroup was given four charges in the Joint Chairmen's Report:

1. Evaluate the factors contributing to any access to obstetrical care in both urban and rural areas of the State;

2. Evaluate if this issue exists in other states, and any policies that those states engage in to reduce barriers to obstetrical care in urban and/or rural areas;

3. Review recent proposals intended to ensure access to obstetrical care in urban and rural areas including through the creation of a birth injury fund and analyze the costs and benefits of these proposals; and

4. Make recommendations on ways to address any identified barriers to obstetrical care.

Workgroup Membership

Non-State Workgroup Members

- Diane Vanes, Clinical Manager for Labor and Delivery and Special Care Nursery, Meritus Medical Center
- Joan Fortney, RN, BSN, MHA, CEN, Director of Nursing Resources, Director of Maternal Child Health, Meritus Medical Center
- Valerie Overton, Senior VP, Governmental Policy & Advocacy, Maryland Hospital Association
- Dr. Brian Avin, MD, Neurologist and Past President of MedChi
- Andrew J. Satin, MD, The Dorothy Edwards Professor and Director of Gynecology and Obstetrics, Obstetrician/Gynecologist-in-Chief, Johns Hopkins Hospital, Johns Hopkins Medicine
- Janyne Althaus, MD, Assistant Professor, Maternal and Fetal Medicine Division, Department of Gynecology & Obstetrics, Director of Perinatal Outreach, Johns Hopkins University School of Medicine
- Susan Kinter, BSN, JD, CPHRM, FASHRM, Vice President of Claims, Litigation & Risk Management, Maryland Medicine Comprehensive Insurance Program, University of Maryland Medical System

- Susan J. Dulkerian, MD, Medical Director of Newborn Services, Family Childbirth & Children's Center, Mercy Medical Center
- Ryan O'Doherty, Director of External Affairs, Mercy Health Services, (alternate for Dr. Dulkerian)
- Faye Royale-Larkins, Chief Executive Officer, Total Healthcare, Inc.
- Benjamin Stallings, MD, Treasurer and Board Member, Dimensions Health System

State Staff

- Mona Gahunia, DO, Chief Medical Officer, DHMH (Chair)
- Sara Cherico, MPH, Health Policy Analyst Advanced, DHMH
- Allison Taylor, MPP, JD, Director, Office of Governmental Affairs, DHMH
- Christi Megna, JD, Assistant Director, Office of Governmental Affairs, DHMH
- Diana Cheng, MD, Director, Women's Health, MCH Bureau, Surveillance and Quality Initiatives, DHMH
- Rosemary E. Murphey, MBA, RN, Deputy Director, Managed Care, HealthChoice and Acute Care Administration, DHMH
- Tricia Roddy, Director, Planning Administration, Health Care Financing

Workgroup Meetings and Materials

The workgroup held six public meetings over the course of the summer and fall of 2014 (July 22nd, August 12th, August 26th, September 10th, September 23rd, and November 17th). Interested parties in attendance were welcomed to participate in workgroup discussions and often did so. All workgroup meeting materials can be found online at: http://phpa.dhmh.maryland.gov/mch/SitePages/OB_Care_Workgroup.aspx.

Background on Access to Obstetrical Care

Access to health care means the timely use of personal health services to achieve the best health outcomes.[1] There are many complex, interrelated factors associated with a patient's ability to access care, including the physical, social, and economic conditions in which an individual lives. Three major factors influencing access to care, as outlined by the U.S. Department of Health and Human Services, include:

- Coverage. Health insurance coverage helps patients get into the health care system, and lack of adequate coverage makes it difficult for people to get the care they need. For example, uninsured individuals are less likely to receive medical care, more likely to die early, and more likely to have poor health status.[2]
- Timeliness. Timeliness is the health care system's ability to provide care at an appropriate time, and difficulties or delays in getting care, including long or difficult travel times, reflect significant barriers for patients.[3]

- Workforce. Health care professionals are a critical component of access, because they provide the services individuals need to stay healthy and treat their illnesses.

Access to health care during the preconception, prenatal, and post-partum periods is particularly important because a mother's health – before, during, and after pregnancy – affects the health of her infant. Recognizing the importance of accessing care, Governor O'Malley made access to high quality health care across a woman's lifespan an important component of his goal to reduce infant mortality and racial disparities in infant mortality across the state.

Preconception and prenatal care are important for the health of both the mother and fetus as they can help prevent complications and inform women about important steps they can take to ensure a healthy pregnancy and protect their infant.[4] Babies of mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care.[5] Health care professionals can spot and treat problems early when they see mothers regularly. Early treatment can cure many problems and prevent others. Providers also can talk to pregnant women about things they can do to give their babies a healthy start to life, such as taking folic acid to reduce the risk of neural tube defects.[6,7]

In Maryland, despite the benefits of preconception and prenatal care, the number of women receiving late or no prenatal care has been rising. In 2010 there were 4,668 births to women receiving late (third trimester) or no prenatal care, and in 2012 there were 6,146 births to women receiving late or no prenatal care.[8,9] In addition, in the most recent Maryland Pregnancy Risk Assessment Monitoring System (PRAMS) report, 42 percent of respondents did not begin prenatal care as early in pregnancy as desired because they could not get an appointment.[10]

Recognizing that the group could not tackle all of the complex factors related to access to obstetrical care in Maryland in the short amount of time allotted, and in recognition of the important role of providers in ensuring a healthy start for moms and babies, the group decided to focus its evaluation on the obstetrical care workforce. In the field of obstetrics, the workgroup identified the liability environment as one of the major factors affecting workforce and, therefore, devoted a significant portion of its effort on examining it.

Workforce

Obstetrical care workforce inadequacies have been identified as an issue nationwide.[11] There are multiple trends that negatively impact the obstetrical care workforce. The current provider population is aging and nearing retirement while the field, like other primary care specialties, suffers from poor recruitment.[12] In addition, there is attrition due to provider dissatisfaction with the quality of professional life.[13,14] For example, a study out of Kaiser Permanente Northwest examined the impact of obstetrics on physician lifestyle and found that rural family physicians and OB-GYNs who practiced obstetrics had heavier workloads than their counterparts who did not. Their mean number of professional hours was greater, and they were more likely to provide

inpatient care and be on-call than those not practicing obstetrics.[15] High malpractice premiums are another common factor contributing to provider dissatisfaction and changes to practice.[16]

There are also regional variations in the obstetrical care workforce. The American College of Obstetricians and Gynecologists issued Committee Opinion Number 586 (February 2014) on Health Disparities in Rural Women, which highlights many of the challenges women living in rural areas face when trying to access obstetrical care as well as initiatives to address these difficulties.[17] Examples of programs include the Regional Maternal and Child Health Program, sponsored by the University of Texas Medical Branch Department of Obstetrics and Gynecology, which has 16 Maternal and Child Health Clinics and 20 Women, Infants and Children (WIC) Nutrition clinics located across East and Southeast Texas, and the Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) program in Arkansas, which brings maternal-fetal medicine specialists' and genetic counselors' consultative expertise to patients and community-based physicians across the state through telemedicine.[18,19]

While reviewing the issue generally, the workgroup undertook a data collection and analysis process to assess the adequacy of Maryland's obstetrical care workforce and better inform their recommendations.

Current Status of the Obstetrical Care Workforce

The obstetrical care workforce in Maryland consists of obstetrician-gynecologists (OB-GYNs), family practice physicians, and certified nurse midwives. Data on the OB-GYN workforce was obtained from the 2009-2010 Maryland Board of Physician Licensing File and the Health Resources and Services Administration's (HRSA) Area Health Resource File (AHRF). Basic information on certified nurse midwives was obtained from the Board of Nursing. Data on family medicine physicians who deliver babies was difficult to obtain, and the group was unable to obtain or examine this information.

The workgroup found this data to be helpful, but identified a number of limitations when trying to determine if there was adequate access to providers in Maryland. As such, the workgroup was unable to definitively conclude whether there is adequate access to obstetrical care providers in Maryland.

<u>OB-GYNs</u>

There are 739 OB-GYNs licensed in Maryland serving approximately 2.98 million women. That number drops to 682 when looking exclusively at "active physicians." The definition of active physician excludes federal employees, interns, fellows, those whose primary practice location was not within Maryland, those older than 84 years old, and those with practice hours less than 8 hours per week.[A] The rate of active OB-GYNs per 10,000 women is 2.29 and the rate of active

[A] The Board of Physicians and Maryland Health Care Commission determines the definition of "active physician."

OB-GYNs per 10,000 women (ages 15-44) is 5.71. The American College of Obstetricians and Gynecologists (ACOG) also generates workforce information by state and nationally using surveys of ACOG members. Due to methodology differences, it is almost impossible to compare ACOG data with Maryland-specific licensure data. However, according to ACOG, there are 2.65 OB-GYNs per 10,000 women nationally and 5.42 per 10,000 women (ages 15-44) nationally.

Numbers and rates of OB-GYNs vary by county and specialty and reveal important nuances not detected in the general licensure data. There are three counties – Caroline, Queen Anne's, and Somerset – with no practicing OB-GYN. Individuals in the three counties likely travel to surrounding counties to receive care, or they receive care from another type of practitioner, such as a family practice physician. Additionally, while the data may indicate a significant number of OB-GYNs per capita in certain areas of the state, this may not reflect access to care because it is difficult to determine whether these physicians are actually accepting patients living in communities with higher concentrations of poverty, including those on Medicaid or the uninsured. Workgroup members raised concerns about the importance of providing access to prenatal care for this population in order to prevent an increase in negative birth outcomes and neonatal and maternal morbidity and mortality.

It is also important to look at the distribution of OB-GYN specialists available to treat women. For example, maternal and fetal medicine (MFM) specialists are high-risk pregnancy experts. MFMs treat expectant mothers with chronic health problems like diabetes, by working with other specialists in an office or hospital setting to keep the mother healthy throughout the course of her pregnancy and childbirth. MFMs also care for expectant mothers who face unexpected complications that develop during pregnancy, such as early labor, bleeding, or high blood pressure.

In Maryland, MFMs are practicing in limited areas of the state: Baltimore, Baltimore City, Howard, Montgomery, and Prince George's Counties. Access to MFM specialists may be more difficult for women in more rural areas of the state such as Western Maryland and the Eastern Shore. The breakdown of active OB-GYNs by specialty can be found in Table 1 and Table 2.

Table 1. Number of Active OB-GYNs by County and Specialty

Number of Active OB-GYNs by County and Specialty

County	Specialty						Total
	OB	OB-GYN (General)	OB-GYN (Critical Care)	OB-GYN (MFM)	OB-GYN (Reproductive)	OB-GYN (Endocrinology/Infertility)	
Allegany	0	4	0	0	0	1	**5**
Anne Arundel	1	50	0	0	0	1	**52**
Baltimore	5	98	1	1	1	3	**109**
Baltimore City	5	95	2	15	0	2	**119**
Calvert	0	9	0	0	0	1	**10**
Caroline	0	0	0	0	0	0	**0**
Carroll	0	12	0	0	0	0	**12**
Cecil	0	6	0	0	0	0	**6**
Charles	0	12	0	0	0	0	**12**
Dorchester	0	1	0	0	0	0	**1**
Frederick	5	7	0	0	0	1	**13**
Garrett	4	1	0	0	0	0	**5**
Harford	0	15	0	0	0	0	**15**
Howard	0	36	0	1	0	1	**38**
Kent	0	2	0	0	0	0	**2**
Montgomery	3	153	0	9	0	10	**175**
Prince George's	4	64	0	5	0	0	**73**
Queen Anne's	0	0	0	0	0	0	**0**
St. Mary's	0	6	0	0	0	0	**6**
Somerset	0	0	0	0	0	0	**0**
Talbot	0	7	0	0	0	0	**7**
Washington	0	9	0	0	0	0	**9**
Wicomico	0	11	0	0	0	0	**11**
Worcester	0	2	0	0	0	0	**2**
Total	**27**	**600**	**3**	**31**	**1**	**20**	**682**

Source: 2009-2010 Maryland Board of Physicians licensing File and 2010 U.S. Census Summary File 1

ACTIVE PHYSICIANS EXCLUDE FEDERAL EMPLOYEES, INTERNS, FELLOWS, AGE>84, OR PRACTICE HOURS<8 HOURS/WEEK

Prepared by HSIA/MD-DHMH 08/12/2014

Table 2. Rates of Active OB-GYNs by County and Specialty

Rates of Active OB-GYNs per 10,000 Women (all women) and per 10,000 Women (ages 15-44) by County and Specialty

County	Specialty												Total	
	OB		OB-GYN (General)		OB-GYN (Critical Care)		OB-GYN (MFM)		OB-GYN (Reproductive)		OB-GYN (Endocrinology/Infertility)			
	Women (all ages)	Women (15-44)	Women (all ages)	Women (15-44)	Women (all ages)	Women (15-44)	Women (all ages)	Women (15-44)	Women (all ages)	Women (15-44)	Women (all ages)	Women (15-44)	Women (all ages)	Women (15-44)
Allegany	-	-	1.1	2.99	-	-	-	-	-	-	0.28	0.75	**1.38**	**3.74**
Anne Arundel	0.04	0.09	1.84	4.69	-	-	-	-	-	-	0.04	0.09	**1.91**	**4.87**
Baltimore	0.12	0.3	2.31	5.91	0.02	0.06	0.02	0.06	0.02	0.06	0.07	0.18	**2.57**	**6.57**
Baltimore City	0.15	0.34	2.89	6.5	0.06	0.14	0.46	1.03	-	-	0.06	0.14	**3.62**	**8.14**
Calvert	-	-	2	5.38			-	-	-	-	0.22	0.60	**2.22**	**5.98**
Caroline	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Carroll	-	-	1.42	3.95	-	-	-	-	-	-	-	-	**1.42**	**3.95**
Cecil	-	-	1.18	3.06	-	-	-	-	-	-	-	-	**1.18**	**3.06**
Charles	-	-	1.58	3.8	-	-	-	-	-	-	-	-	**1.58**	**3.8**
Dorchester	-	-	0.59	1.72	-	-	-	-	-	-	-	-	**0.59**	**1.72**
Frederick	0.42	1.08	0.59	1.51	-	-	-	-	-	-	0.08	0.22	**1.1**	**2.8**
Garrett	2.64	7.63	0.66	1.91	-	-	-	-	-	-	-	-	**3.3**	**9.54**
Harford	-	-	1.2	3.19	-	-	-	-	-	-	-	-	**1.2**	**3.19**
Howard	-	-	2.46	6.25	-	-	0.07	0.17	-	-	0.07	0.17	**2.59**	**6.59**
Kent	-	-	1.89	5.57	-	-	-	-	-	-	-	-	**1.89**	**5.57**
Montgomery	0.06	0.15	3.03	7.75	-	-	0.18	0.46	-	-	0.20	0.51	**3.46**	**8.86**
Prince George's	0.09	0.2	1.42	3.26	-	-	0.11	0.25	-	-	-	-	**1.62**	**3.72**
Queen Anne's	-	-	-	-	-	-	-	-	-	-	-	-	-	-
St. Mary's	-	-	1.14	2.75	-	-	-	-	-	-	-	-	**1.14**	**2.75**
Somerset	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Talbot	-	-	3.54	12.08	-	-	-	-	-	-	-	-	**3.54**	**12.08**
Washington	-	-	1.24	3.36	-	-	-	-	-	-	-	-	**1.24**	**3.36**
Wicomico	-	-	2.13	5.08	-	-	-	-	-	-	-	-	**2.13**	**5.08**
Worcester	-	-	0.76	2.55	-	-	-	-	-	-	-	-	**0.76**	**2.55**
Total	**0.09**	**0.23**	**2.01**	**5.03**	**0.01**	**0.03**	**0.1**	**0.26**	**0**	**0.01**	**0.07**	**0.17**	**2.29**	**5.71**

Source: 2009-2010 Maryland Board of Physicians licensing File and 2010 U.S. Census Summary File 1

ACTIVE PHYSICIANS EXCLUDE FEDERAL EMPLOYEES, INTERNS, FELLOWS, AGE>84, OR PRACTICE HOURS<8 HOURS/WEEK

Prepared by HSIA/MD-DHMH 08/12/2014

As mentioned earlier, there are many complex factors associated with improving access to care. The workgroup felt strongly that geographic proximity to a provider does not equate to access, especially for women with health conditions that make the pregnancy higher-risk. There is some evidence in Maryland and other states to suggest that some OB-GYNs no longer perform deliveries, limit the range of services they provide, or avoid treating high-risk patients.[20] For example, a survey of physicians in Pennsylvania in 2003 found that 32 percent OB-GYNs reported stopping complex obstetrics, 6 percent stopped delivering infants, and 5 percent avoided treating high-risk patients.[21]

Since there is no comparable data in Maryland, the group looked at the number of active physicians who indicated they accept Medicaid patients and new Medicaid patients on their licensure renewal survey as a proxy. There are 448 active OB-GYNs who accept new Medicaid patients, representing 66 percent of the total active of OB-GYN population (see Table 3). However, the workgroup felt that there were important limitations to note on this data point. The licensure question does not quantify the number of new patients a provider is accepting. A more nuanced look into the number of new Medicaid patients per provider would produce more useful information.

Table 3. Number and Percentage of Active OB-GYNs Accepting Medicaid Patients

Specialty	**Total Number of Active OB-GYNs**	**Total Number of Active OB-GYNs who accept Medicaid patients**	**Percentage**	**Total Number of Active OB-GYNs who accept *new* Medicaid patients**	**Percentage**
Obstetrics	27	23	85%	23	85%
OB-GYN (General)	600	437	73%	390	65%
OB-GYN, Critical Care	3	3	100%	3	100%
OB-GYN, MFM	31	29	94%	28	90%
OB-GYN, Reproductive	1	1	100%	1	100%
OB-GYN, Endocrinology/ Infertility	20	5	25%	3	15%
Total	682	498	73%	448	66%

Source: 2009-2010 Maryland Board of Physicians Licensing File

Other Obstetrical Care Providers

Data on other obstetrical care providers was more difficult to obtain. The Board of Nursing provided information that as of June 30, 2014, there were 240 certified nurse-midwives licensed to practice in Maryland. A breakdown of this information by county was unavailable.

Family practice physicians are also an important component of the obstetrical care workforce. However, detailed information on the practice of the family practice physicians in Maryland was not easily available.

Historical Workforce Data

The workgroup also felt it was important to understand historical trends in the obstetrical care workforce, given recent concerns with the medical liability environment (discussed below). Specifically, much of the data the workgroup was able to obtain was for a time period before recent historic multi-million dollar jury awards in obstetrics malpractice cases beginning in mid-2012. The Maryland Health Care Commission referred the workgroup to the HRSA Area Health Resource Files (AHRF) to obtain this data. The AHRF uses data from the American Medical Association Physician Masterfiles.

In general, the data shows that there has been relatively little change in the number of OB-GYNs practicing general or specialty obstetrics and gynecology in the State. However, it is noteworthy that the largest decrease in the number of practicing OB-GYNs was in Baltimore City, which is also viewed in the medical and insurance communities as a jurisdiction with higher litigation risks for providers. From 1995 to 2011, the number of physicians practicing general obstetrics and gynecology dropped from 281 to 157 (see Table 4)[B] and the number of physicians practicing a specialty of obstetrics and gynecology dropped from 51 to 17 (see Table 5)[C].

[B] Data from 2009 was not available.
[C] Data from 1997 and 2009 was not available.

Table 4. OB-GYNs who Self-Identified as Practicing General Obstetrics and Gynecology and Providing Patient Care, 1995-2008, 2010-2011

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2010	2011	Difference, 1995 - 2011
MARYLAND	**903**	**897**	**929**	**923**	**913**	**910**	**946**	**907**	**915**	**938**	**940**	**901**	**915**	**912**	**940**	**939**	**36**
Allegany, MD	10	11	12	11	8	11	12	10	10	9	8	7	7	7	6	7	-3
Anne Arundel, MD	49	47	48	56	57	65	65	63	67	67	66	60	61	65	58	58	9
Baltimore, MD	93	93	111	117	113	333	199	184	185	187	193	199	199	202	188	182	89
Calvert, MD	7	7	8	7	7	7	6	7	7	8	9	9	9	9	9	9	2
Caroline, MD	0	0	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0
Carroll, MD	11	12	12	12	11	12	11	10	11	12	14	13	13	11	13	13	2
Cecil, MD	6	7	7	5	6	5	4	5	5	6	5	5	6	5	7	7	1
Charles, MD	8	10	8	8	8	7	8	8	8	4	5	5	5	6	7	7	-1
Dorchester, MD	2	2	1	1	1	1	1	1	1	1	3	3	3	3	2	2	0
Frederick, MD	10	13	13	12	12	12	12	12	13	12	11	11	12	14	10	9	-1
Garrett, MD	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Harford, MD	18	17	19	18	21	21	19	17	17	18	20	20	21	20	19	19	1
Howard, MD	55	55	60	61	63	59	60	61	64	66	67	63	67	66	72	70	15
Kent, MD	2	2	2	3	3	4	3	3	3	3	3	3	3	2	2	2	0
Montgomery, MD	227	221	228	235	243	231	258	244	256	267	263	246	254	255	260	266	39
Prince George's, MD	88	84	87	89	96	90	86	86	81	89	93	85	84	83	84	83	-5
Queen Anne's, MD	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1	1	1
St. Mary's, MD	5	5	6	6	8	10	10	10	10	9	7	6	6	5	7	8	3
Somerset, MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot, MD	7	6	7	8	7	8	6	7	7	8	6	7	7	6	8	8	1
Washington, MD	9	10	11	10	12	13	13	12	13	12	13	13	15	14	15	16	7
Wicomico, MD	14	14	15	14	15	17	16	16	15	16	16	17	15	15	15	14	0
Worcester, MD	1	1	2	3	2	4	3	2	2	2	1	1	1	1	2	1	0
Baltimore City, MD	281	280	272	247	219	0	154	148	139	141	136	127	126	123	155	157	-124

Source: HRSA. (2013) Area Health Resource Files (AHRF). MS Access Format. Data from the AHRF is pulled from American Medical Association Physician Masterfiles

Table 5. OB-GYNs who Self-Identified as Practicing a Specialty of Obstetrics and Gynecology and Providing Patient Care, 1995-1996, 1998-2008, 2010-2011

	1995	1996	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2010	2011	Difference, 1995 - 2011
MARYLAND	**136**	**135**	**142**	**138**	**136**	**133**	**134**	**130**	**129**	**133**	**137**	**145**	**141**	**131**	**132**	**-4**
Allegany, MD	2	2	2	2	2	1	1	1	0	0	0	0	0	0	0	-2
Anne Arundel, MD	4	5	5	4	6	6	7	7	8	6	7	6	6	7	7	3
Baltimore, MD	22	15	16	21	66	39	37	34	27	27	30	30	26	28	28	6
Calvert, MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Caroline, MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll, MD	1	0	0	0	0	0	0	0	1	0	0	0	1	1	1	0
Cecil, MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Charles, MD	0	0	1	1	1	1	1	1	1	2	2	2	2	1	1	1
Dorchester, MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Frederick, MD	1	2	2	2	3	3	3	3	4	4	5	4	4	6	6	5
Garrett, MD	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	-1
Harford, MD	2	2	3	3	3	2	2	2	1	1	1	1	0	0	0	-2
Howard, MD	3	2	5	4	7	6	7	6	6	7	10	11	13	12	13	10
Kent, MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery, MD	31	34	39	35	31	28	30	33	35	39	43	48	49	44	44	13
Prince George's, MD	10	10	10	11	10	9	8	7	10	11	11	11	12	9	8	-2
Queen Anne's, MD	1	1	1	1	1	1	1	1	1	0	0	1	1	0	1	0
St. Mary's, MD	0	0	0	0	0	0	0	1	1	1	1	1	1	1	1	1
Somerset, MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot, MD	3	3	3	3	2	4	4	4	4	4	4	3	2	1	1	-2
Washington, MD	2	2	2	2	2	2	3	3	4	3	3	3	2	0	0	-2
Wicomico, MD	2	2	2	2	2	2	2	2	2	2	2	3	3	2	2	0
Worcester, MD	0	0	0	1	0	0	0	0	0	1	0	0	0	2	2	2
Baltimore City, MD	51	53	51	46	0	29	28	25	24	25	18	21	19	17	17	-34

Specialties Included: Female Pelvic Medicine and Reconstructive Surgery (Obstetrics and Gynecology) (beginning in 2011), Gynecological Oncology, Gynecology, Hospice + Palliative Medicine (Obstetrics and Gynecology) (beginning in 2008), Maternal and Fetal Medicine, Obstetrics, Critical Care Medicine (Obstetrics and Gynecology), and Reproductive Endocrinology)

Source: HRSA. (2013) Area Health Resource Files (AHRF). MS Access Format. Data from the AHRD is pulled from American Medical Association Physician Masterfiles

Medical Liability Environment

In the field of obstetrics, the non-state workgroup members identified the liability environment as one of the major factors affecting workforce and, therefore, devoted a significant portion of its effort on examining it.

The field of obstetrics has one of the highest litigation rates and medical liability rates of any medical specialty.[22] There is an elevated level of liability due to, "a longer…period of filing a claim after an event that may have harmed a newborn (compared to the typical 2-year 'statute of limitation' period for other patients [3 years in Maryland]), the high cost of compensation for lifelong care needs or loss of life at the beginning of life, and the fact that OB-GYNs are at an elevated risk as practitioners within a surgical specialty."[23] In Maryland, the statute of limitations for birth injury cases is up to 21 years, compared to the statute of limitation period for other patients, which is 3 years.[24]

The threat of professional liability is a major factor in physician career dissatisfaction.[25] Increasing premiums and litigation have prompted physician retirement, relocation, or change in practice activities.[26] A 2012 survey on professional liability conducted by ACOG found that 58 percent of OB-GYNs made one or more changes to their practices between 2009-2011 as a direct result of the risk or fear of professional liability claims or litigation: 24 percent increased the number of cesarean deliveries performed, 27 percent decreased the number of high risk obstetric patients accepted, 12 percent decreased the total number of obstetric patients in their practices, and 6 percent stopped practicing obstetrics altogether.[27] According to the ACOG survey, the average age at which physicians stopped practicing obstetrics was 49 years, traditionally considered the peak potential practice time for obstetrician-gynecologists.[28]

The ACOG survey also found that at least one professional liability claim was experienced by 77 percent of obstetrician-gynecologists, with an average of 2.64 claims per physician.[29] Birth-related neurological injury claims were the most common primary allegation of an obstetric claim, with average awards of nearly one million dollars. The current environment has not only caused some doctors to leave the practice of obstetrics, but according to a survey of fourth-year residents in obstetrics and gynecology residency training programs in 2006, has also deterred many young doctors from entering the field.[30,31]

Medical Liability Environment in Maryland

The medical liability environment in Maryland continues to evolve as new cases are adjudicated. There have been a number of large jury awards stemming from birth injuries, including:

1. In June 2012, a Maryland jury awarded a $55 million judgment in a birth injury case against The Johns Hopkins Hospital, among the largest in Maryland history.[32]
2. In that same month, another Maryland jury awarded $20.9 million in a birth injury case related to a physician delivering at Washington Adventist Hospital.[33]

3. In July 2012, another jury awarded $21 million to a Glen Burnie couple whose son was born prematurely at Harbor Hospital.[34, 4]
4. In May 2013, a Maryland jury awarded $16 million in a birth injury case against Prince George's Hospital Center.[35]

Maryland's statutory cap on noneconomic damages reduced the dollar value of these jury awards, especially the second case. However, total damages awarded in cases 1 and 3 still averaged above $21 million each,[36] due to significant economic damages related to estimated life care plans, even after the noneconomic damages cap was applied.

Results from a 2013 Maryland Hospital Association (MHA) survey on medical liability found that there has been a 108-percent increase in total settlement costs for birth injury claims between 2009 and 2013, likely as a result of these large jury awards.[37] In addition, in July 2013, Maryland General Hospital closed its 100-year-old obstetrics program as a result of "financial pressures."[38]

The current liability environment in Maryland also runs counter to the goals outlined in the Maryland Medicare waiver.[39] The current liability system increases the practice of defensive medicine by encouraging health care providers to increase utilization of health services such as ordering more tests and conducting more procedures. In contrast, the new waiver contains key cost containment goals and encourages providers to reduce unnecessary utilization. The Advisory Council of the Health Services Cost Review Commission (HSCRC) recommended that the Commission "be aware of the dissonance between its cost containment goals and the current medical malpractice system, and lend its voice to the need for reforming it."[40]

The workgroup examined a series of medical liability reforms outlined in the academic literature in response to the charge to review recent proposals intended to ensure access to obstetrical care in urban and rural areas, including prevention strategies (quality improvement, shared decision making, aligning legal standard with best evidence, liability insurance coverage regulations, and enterprise liability) and redress strategies (health courts, administrative compensation systems, high-low agreements, and administrative compensation systems).[41] The workgroup focused a major portion of its time looking into birth injury funds, reflecting the original objective of SB 798/HB 1337, as described below.

[4] The defendants in the Harbor Hospital case are currently appealing the Court of Special Appeals decision affirming the Circuit Court ruling. The Maryland Hospital Association (MHA) has filed an amicus petition in the case "to address the significant threat that the opinion poses to Maryland obstetrical practices and patients' access to crucial medical services." The MHA argues that the decision "is a dangerous expansion of the potential liability of doctors and hospitals that perform deliveries," and that the decision "unreasonably interferes with the practice of medicine by compelling doctors to perform cesarean sections that are neither medically indicated nor desired by the mother. And the economic fallout of this legal error threatens to reduce many Marylanders' access to necessary obstetrical services."

Birth Injury Funds

A no-fault birth injury fund is one solution that Florida and Virginia have undertaken to address the medical liability environment in their states. At the time of its creation, in the late 1980s, the obstetrician-gynecologists who delivered babies in Florida and Virginia paid annual liability insurance premiums that were among the highest in the country.[42] The fund creates a process outside of the court system to adjudicate claims related to neurological birth injuries. Acceptance into the program is based upon a claimant meeting a legal definition of a birth-related neurological injury as opposed to the finding of malpractice by a jury. Once accepted into programs, beneficiaries receive economic compensation including, actual expenses for medical and hospital care, rehabilitation/therapy/training, family residential or custodial care, professional residential and custodial care and service, prescription drugs, special equipment and facilities, related travel expenses and lost earnings.[43]

The goal of creating such a system is to provide children and families with greater certainty and quicker access to lifetime care, rather than going through the unpredictable and costly process of litigation, which can result in no compensation. The goal is also to stabilize medical malpractice-related costs in the state.

Independent academic evaluations of the two programs generally have 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 obstetric tort environment in the state.[44] The workgroup also discussed the programs with the individual Executive Directors of the Florida and Virginia birth injury funds, who reported overall satisfaction by claimants and families and better care outcomes for children covered by the programs. During the workgroup meeting, Florida reported that the annual premium savings for all physicians is between $1,200 and $1,800/physician/year and for OB-GYNs in particular is between $62,000 and $82,000/physician/year. The Executive Directors also provided advice to the workgroup. The largest obstacles they believe a Maryland no-fault birth injury fund would face are a slow start-up and the difficulty in determining expected claims per year, which will be compounded by Maryland's current 21-year statute of limitations. The Executive Directors recommended the use of certified actuarial experts to help determine costs and funding options.

During the workgroup discussions, it was recognized that these funds will not address all of the medical liability issues in the state. For example, malpractice premiums for all specialties in Florida are still among the highest in the nation and both Florida and Virginia have pursued tort reforms since passing the no-fault birth injury fund to address medical liability issues. Furthermore, Virginia's program has experienced funding issues. Despite these limitations, the workgroup felt that a no-fault birth injury fund warrants further study by experts as part of the legislative process. The workgroup did not feel they had all the necessary expertise and time to make specific legal and policy recommendations regarding the various provisions of the fund, especially the financing of the fund.

Additionally, the Maryland Hospital Association (MHA) is conducting a concurrent task force to consider issues relevant to the creation of a birth injury fund in Maryland. MHA's Task Force on Preserving Services for Mothers and Babies reached unanimous consensus to support an injured baby compensation fund. This recommendation will be considered and acted upon by MHA's board on December 2, 2014.

Recommendations

The workgroup was charged with developing recommendations on ways to address any identified barriers to obstetrical care. The following recommendations are those of the external workgroup members. The Department has not taken a position on the recommendations.

General Statements

The workgroup recognized that the field of obstetrics is inherently risky, some birth injuries are unavoidable, and evidence-based obstetric practices will continue to evolve and influence the field. Workgroup members thought it was important to encourage the State to continue to invest in and commit to ongoing and continuous quality improvement efforts by hospitals and providers.

Rigorous quality improvement programs in Maryland are already leading to improved care and health outcomes. For example, the Maryland Perinatal/Neonatal Learning Network (previously the Perinatal Collaborative and the Neonatal Collaborative) has undertaken numerous initiatives to reduce infant harm and improve neonatal outcomes. As a result of their work, the percent of all inductions before 39 weeks without medical indication decreased from 3 percent in 2009 to less than 0.5 percent in 2013 and cesarean sections before 39 weeks without medical indication decreased from over 2 percent in 2009 to close to 0 in 2013.[45] In fiscal year 2015, the Network plans to identify strategies to reduce maternal mortality from obstetric hemorrhage and reduce neonatal cases of necrotizing enterocolitis. Another example is the B'more for Healthy Babies Initiatives, which have helped to reduce infant mortality and improve outcomes for Baltimore's families through a home visiting program, family planning initiatives, the SLEEP SAFE Initiatives, Baby Basics prenatal health literacy program, and others.

These programs improve the quality of care provided in Maryland, as well as provide direct access to important preconception and prenatal services women may otherwise be unable to obtain. Early prenatal care through such programs also helps reduce adverse outcomes for moms and babies and, thereby, avoids professional liability claims in some cases. Continued investment in these quality improvement efforts is critical because of their direct and indirect effect on access to care.

Recommendation 1: The Maryland General Assembly should take steps to reduce the overall burden of medical liability risk and associated costs, especially those related to the field of obstetrics, in order to safeguard women's access to critical prenatal care.

The workgroup agreed that, above all, medical liability risk and associated costs are the most concerning threat to access to high-quality obstetrical care in Maryland. For example, the Maryland Hospital Association has reported industry survey results showing a doubling of hospital liability costs related to birth injury legal claims since 2009.[46] In addition, independent bond rating agencies have specifically cited recent large Maryland jury awards in birth injury cases as contributing to a challenging litigious environment.[47]

Several workgroup members described the current medical liability climate as unsustainable and threatening a potential "access crisis" if additional health care providers chose to stop performing obstetrical services due to increasing medical liability risk. These members believe that more and more hospitals will discontinue obstetrics, leading to further consolidation of services in the state. Maintaining the status quo, they said, would continue to decrease access to obstetric care in vulnerable communities. The result is an increase negative birth outcomes and neonatal and maternal morbidity and mortality because women in the state are already struggling to access care.

Further, workgroup members agreed with a recent Health Services Cost Review Commission Advisory Council report which stated that: "The incentives in the current medical malpractice system can run counter to the key cost containment goals in [Maryland's recently enacted Medicare Waiver]. The current malpractice system encourages health care providers to increase utilization ... [the waiver] could be supported by reforms in the medical malpractice system… Reforms should go beyond the caps on awards for pain and suffering … to address more fundamental restructuring of the medical malpractice system."[48]

Recommendation 2: The Maryland General Assembly should conduct serious exploration of a No-Fault Birth Injury Fund as a potential solution to Maryland's medical liability climate, based on the expert testimony from Florida and Virginia program directors and published independent academic research. Further, the Maryland General Assembly should also hire an actuarial firm to conduct a financial review to determine the best way to fund the projected costs of a Maryland No-Fault Birth Injury Fund in a way that supports the long-term success of Maryland's new Medicare Waiver.

The workgroup carefully reviewed the proposed Maryland No-Fault Birth Injury Fund and similarly modeled Birth Injury Fund programs in place in Florida and Virginia since the late 1980s as well as the New York State Medical Indemnity Fund enacted in 2011. In summary, there are published academic and independent studies that indicate the Florida and Virginia programs are effective. One such study summarized the results of several studies by stating:

> "The academic evaluations, together with more recent official investigations, have found that the programs have largely achieved their principal objectives—namely, acting as a stabilizing influence on the obstetrics tort environment, improving efficiency and speed of adjudication of claims, and responding to the needs of injured children and their

> families. Specifically, the reports found that, relative to the tort system, the programs have shortened the time from claim filing to compensation and lowered overhead costs and attorneys' fees. They have also had high rates of physician participation and have decreased the number of high-cost malpractice claims brought in tort. Finally, they have resulted in lower malpractice insurance premiums for obstetrician-gynecologists, even those who do not participate in the programs."[49]

In addition to reviewing these materials, the workgroup discussed how the programs function with the individual Executive Directors of the Florida and Virginia Birth Injury Funds, who reported overall satisfaction by claimants and families and better care outcomes for children covered by the programs compared to tort. The Executive Directors also provided several specific recommended enhancements to the program model that could be implemented in Maryland.

If implemented, the unique "no-fault" structure of the program suggests that more Maryland children would receive compensation and care for birth-related neurological injuries than the number who receive benefits under the state's current fault-based tort system. The workgroup acknowledges reports by the Maryland Department of Legislative Services and Pinnacle Actuarial Resources that provides a cost estimate of what a Maryland program would cost to implement and maintain.[50]

The workgroup acknowledges that further work and research needs to be conducted in regards to the development of the details for a birth injury fund. As stated previously, the workgroup did not feel they had all of the necessary expertise and time to make specific legal and policy recommendations regarding the various provisions of the fund, especially the financing of the fund.

Recommendation 3: The Maryland General Assembly should not attempt to raise the state's current cap on non-economic damages.

Attempts to raise the state's cap on non-economic damages would adversely impact access to obstetrical care. Maryland's current medical liability environment is already prohibitive and raising or eliminating the damages cap would only make matters worse.

Recommendation 4: The Maryland General Assembly should examine additional tort reforms that improve the fairness and efficiency of the court system and leads to improved health outcomes, lower health care costs, and lower malpractice premiums in Maryland.

Recognizing that the no-fault birth injury fund represents one solution to improving the Maryland liability climate, the workgroup proposes a series of additional tort reforms. These include the following recommendations:

- **The Maryland General Assembly should institute a "cooling off" period for medical liability lawsuits:**
  This recommendation would require claimants to give health care providers 180 days written notice of intent prior to filing a medical liability lawsuit. When Massachusetts instituted health care cost control legislation in 2012, one component addressed medical malpractice reform. The legislation created a 182-day cooling off period that required the exchange of information between the plaintiff and defense to negotiate a settlement and promote early settlement.

- **The Maryland General Assembly should examine the establishment of health courts through the creation of a special court docket for medical liability cases:**
  Cases would be assigned to a judge with medical liability expertise and the case would remain with one judge throughout the entire litigation process.

- **The Maryland General Assembly should implement an apology law:**
  This would prohibit expressions of apology or regret to be used against interest in subsequent litigation.

- **The Maryland General Assembly should develop a "Safe Harbor Pilot":**
  This pilot would create a "safe harbor" for providers who follow accepted evidence-based clinical guidelines.

- **The Maryland General Assembly should update post-judgment interest:**
  This recommendation would change the legal rate of interest on a money judgment for a medical injury from 10% per year to the greater of: (1) the bank prime loan rate for the month of the date of the judgment, as published by the Board of Governors of the Federal Reserve System; and (2) or 3% per year.

- **The Maryland General Assembly should make changes to the expert witness rules:**
  Changes to the expert witness rule would include: require "to a reasonable degree of medical certainty,"; clarify that experts must be Board certified in the same field; require experts to certify that some percentage of his/her time is spent on direct patient care; require that the specific person who allegedly breached the standard of care be identified in the certificate of merit; and amend the offer of judgment rule to include attorney's and expert fees.

- **The Maryland General Assembly should eliminate the Frye standard and switch to the Daubert standard in Maryland:**

  Courts in Maryland are governed by the Frye standard, or general acceptance test, which provides that expert opinion based on a scientific technique, is admissible only where the technique is generally accepted as reliable in the relevant scientific community. In

contrast, the Daubert standard requires judges to ensure that testimony and other medical evidence are scientifically trustworthy.

Recommendation 5: The Maryland General Assembly should direct the health occupations boards and other appropriate State agencies, in collaboration with providers, to develop an enhanced, comprehensive mechanism to understand workforce supply, especially in obstetrics and primary care, and require a workforce report on a regular basis.

To begin to understand access to obstetrics providers in Maryland, the workgroup reviewed several available datasets related to current workforce supply, including statistics from the Maryland Board of Physicians, Maryland Board of Nursing, the U.S. Department of Labor, and the U.S. Department of Health and Human Services. The group found this data to be helpful, but identified a number of limitations when trying to determine if there was adequate access to providers in Maryland. Additionally, geographic proximity to a provider does not equate to access, especially for women with health conditions that make the pregnancy higher-risk. Anecdotal evidence in Maryland and other states suggest that some OB-GYNs no longer perform deliveries, limit the range of services they provide, or avoid treating high-risk patients.[51] A more enhanced, comprehensive mechanism to evaluate the adequacy of the entire obstetrical care workforce in Maryland – that captures information like practice patterns and provider preferences – is therefore an important component of improving access to obstetrical care.

The group does acknowledge that while physician workforce data is not entirely definitive, some trends are alarming, including the overall reduction of physicians delivering babies in Maryland and the reduction of practicing OB physicians in Baltimore City.

In addition, workgroup participants note that hospitals are increasingly hiring obstetricians in order to ensure access to obstetric services. The Department should establish a mechanism to monitor and report on such hiring practices. Doing so will help monitor potential medically-underserved areas, and the HSCRC would be an important partner in any such effort.

Recommendation 6: In order to attract physicians to underserved communities, the Maryland General Assembly should adequately fund the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants.

After reviewing the workforce data, the workgroup believes that more can be done to attract OB-GYNs to underserved areas of the State. Medical students are graduating with large amounts of debt, which influences their practice location. Loan repayment programs in Maryland can play an important role in attracting physicians to underserved communities, and should be adequately funded to attract more providers.

There are programs that provide loan repayment using State funds in Maryland. The Janet L. Hoffman Loan Assistance Repayment Program (LARP) provides loan repayment assistance to physician assistants, social workers, nurses, and nurse practitioners in Maryland State or local government or nonprofit agencies who provide public service to low income or underserved

residents. Awards can be up to $10,000 a year for a three-year commitment and the program is run through the Maryland Higher Education Commission.[52]

In addition there is the State Loan Repayment Program (SLRP). The SLRP in Maryland is a collaborative effort among the State and the Health Resources and Services Administration (HRSA) entities that provides primary care physicians and physician assistants in the fields of family practice, internal medicine, pediatrics, obstetrics and gynecology, and general psychiatry the opportunity to practice in a designated Health Professional Shortage Area (HPSA) while also getting funds to help pay their higher education loans. Awards are up to $25,000 per year for a two-year commitment.[53] The program receives a 1:1 match from HRSA and the state portion of the funding comes from the Board of Physicians.

Finally, in 2009, the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants (Chapter 576 of the Acts of 2009, as amended by Chapter 99 of the Acts of 2014) was established. A key component of this program is that it allows the Secretary to designate shortage areas, in addition to designated HPSAs, where eligible providers may practice. However, the legislation also created a fund to implement this program. Its key revenue source was an increase to the rate structure of Maryland hospitals under the auspices of the HSCRC. The HSCRC requires federal approval to provide payments to physicians under this program; however, the Centers for Medicare and Medicaid Services have yet to grant such authorization. The workgroup recommends investigating alternative sources to fund this critical initiative.

Recommendation 7: The Maryland General Assembly should continue to support telemedicine and other initiatives to help provide physicians with needed backup and subspecialty support.

Providing physicians with support to succeed in their communities, such as through additional telemedicine programs, may help improve recruitment and retention strategies throughout the State. As mentioned previously, a study by Kaiser Permanente Northwest examined the impact of obstetrics on physician lifestyle and found that rural family physicians and OB-GYNs who practiced obstetrics had heavier workloads than their counterparts who did not. Their mean number of professional hours was greater, and they were more likely to provide inpatient care and be on-call than those not practicing obstetrics.[54] Providing the obstetrical care workforce with needed backup support may alleviate the attrition reported in the field.

Telemedicine may also be an effective way to improve access to specialty providers in underserved areas. There may not be adequate case loads to support specialist practices in rural or underserved areas, but telemedicine may provide the opportunity to provide needed consultation to primary care providers practicing in these areas. In 2013, State law required the Maryland Health Care Commission to reconvene the Telemedicine Task Force to develop recommendations to advance telemedicine in the State. While the workgroup did not have the

opportunity to review these recommendations prior to the submission of this report, it supports the advancement of telemedicine in Maryland.

The workgroup also briefly discussed the requirement for all providers to be licensed in Maryland in order to participate in telemedicine initiatives. The workgroup reached out to the Maryland Health Care Commission and received the following information. To assist states in formulating regulations for the rapidly evolving practice of telehealth, the Federation of State Medical Boards (FSMB) and the American Medical Association (AMA) each issued guidelines in the spring of 2014.

- FSMB developed a model policy for use by state medical boards in order to remove regulatory barriers and promote widespread adoption of telemedicine technologies, which can be found here.
- AMA approved a list of guiding principles for ensuring the appropriate coverage of and payment for telemedicine services, which can be found here.

A team of State medical board representatives and the Council of State Governments also developed a framework for an Interstate Medical Licensure Compact, a licensing option for qualified physicians who practice in multiple states to be eligible for expedited licensure in all states participating in the compact. The FSMB released model legislation for physician licensure compact in September 2014, which can be found here. The workgroup believes that the General Assembly should further explore and address this issue in order to advance the use of telemedicine in the State.

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