Improving Access to Obstetrical Care in Virginia

Presentation to the
Joint Subcommittee on Risk Management Plans

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Presentation Outline

- ☑ **Background**
- ☐ Why access to obstetrical care is a problem for Virginia
- ☐ Underlying causes of the access problem
- ☐ Issues and policies involved in access
- ☐ Potential solutions being considered in Virginia

Background

- About 100,000 babies are born each year in Virginia.
- It is estimated that between 35 and 40 percent (35,000-40,000 babies) are publicly funded through Medicaid.
- Provisional data indicate Virginia's infant mortality rate increased from 7.4% in 2002 to 7.6% in 2003 (per 1,000 live births.) This equals 766 infant deaths, the most since 1994.
- In 2002, 7,904 low weight babies were born in Virginia. Of these, 21%, or 1,653 were very low birth weight (3.3 less than 3.3 pounds)
- Low weight and very low weight babies are far more likely to need the neonatal intensive care services.
- The average cost of NICU care is 50 times higher than for babies not requiring intensive care.

Background

- Statewide problems with access to obstetrical care appear cyclical.
- The last “crisis” in Virginia was in the late 1980s. Medicaid payments were too low to attract providers and insurance companies that wrote malpractice policies left the Virginia market.
- The General Assembly took three actions at that time to address the crisis:
  - Create the Virginia Birth-Related Neurological Injury Compensation Program in 1988
  - Increase Medicaid payment rates in 1992
  - Maintain the cap on malpractice awards at 1 million.

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Why Access is a Problem

- More hospitals with less than 300 births a year are deciding to close their obstetrical services.
  - In the last 18 months, hospitals in Kilmarnock, Low Moor, Grundy, Norton, and Lebanon closed their obstetrical service and now deliver babies only in emergency rooms. The hospital in Emporia may stop deliveries after December 2004.
- More obstetricians and pediatricians are limiting new patients who are publicly-funded or uninsured.
- Obstetricians concerned about malpractice insurance premiums are discontinuing surgical back-up for family practice physicians and are no longer willing to supervise certified nurse midwives.

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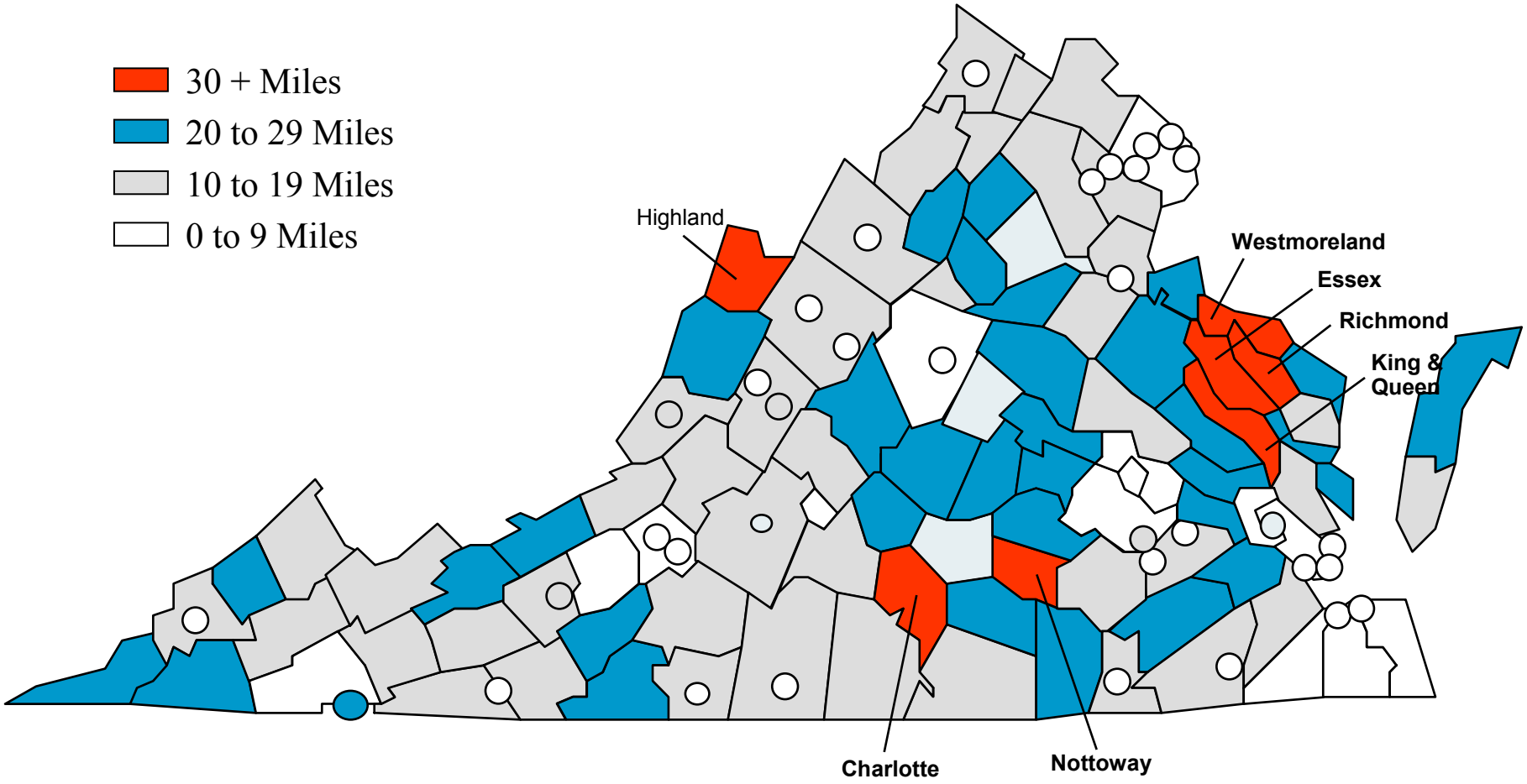
Underlying Causes of Access Problems

- Decisions by hospitals to close obstetrical services are influenced by concerns about volume of births, patient mix, reimbursement levels, liability, and standard of care expectations.
- Decisions by obstetricians to stop delivering babies are influenced by increasing costs of maintaining a practice and flat or declining revenue from public and private payers.
- Decisions by obstetricians to discontinue supervision of certified nurse midwives and discontinue surgical back-up for family practitioners are influenced by actual or perceived impact on malpractice premiums.

Underlying Causes of Access Problems

- Decisions by obstetricians and pediatricians to limit the number of publicly-funded and uninsured women in their practice are influenced by low Medicaid payment rates and patient mix.
- Decisions by women to seek pregnancy-related emergency transport are influenced by, among other factors, increasing distances to travel for delivery prenatal care and delivery services.

Average Distance Women Traveled to Deliver by Locality, CY 2002



Source: Birth certificate data maintained by the Virginia Department of Health. Includes 92,000 births; 8,000 were excluded because the women lived outside of Virginia or the self-reported zip codes were invalid.

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Issues and Policies Affecting Access

Eligibility for Medicaid and FAMIS

- The current eligibility level of 133% of federal income poverty level limits prenatal and delivery care to many low income women.
- The current exclusion of lawful permanent residents from Medicaid eligibility limits access to care.
- The current bar for undocumented residents is a barrier to this population receiving care, though Medicaid does cover their emergency deliveries.

Issues and Policies Affecting Access

Reimbursement

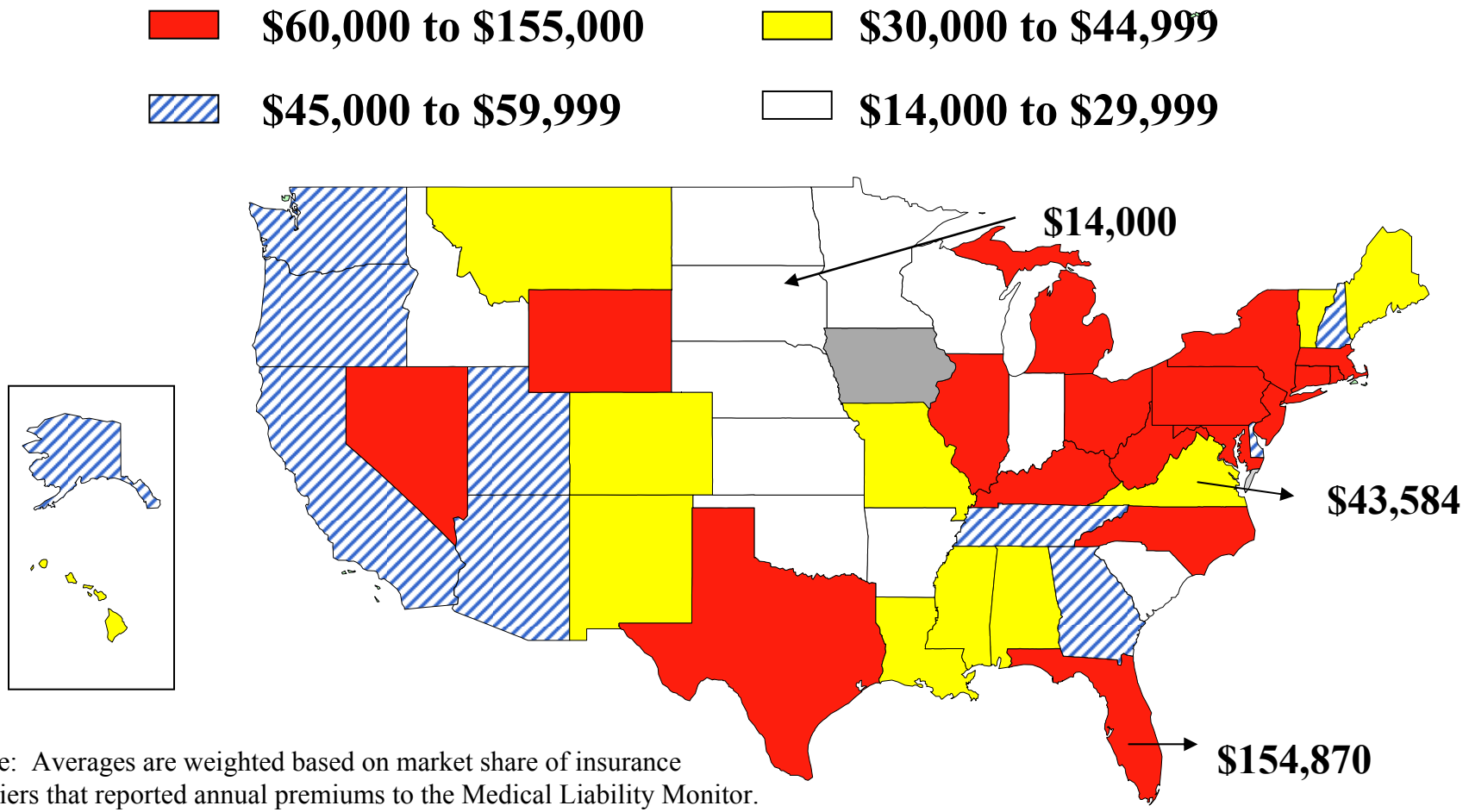
- As the largest single payer for deliveries in Virginia, Medicaid and FAMIS payment rates affect whether obstetricians and pediatricians will see pregnant women and children who are publicly funded, and how many publicly funded and uninsured women and children they will admit into their practices. Hospitals are also affected by payment rates.
- In some communities, a small number of obstetricians provide the vast majority of care to Medicaid and uninsured women, e.g. Danville. These providers are disproportionately affected by low Medicaid payment rates and maintaining a viable practice can be very challenging. A decision by such providers to leave an area or to stop delivering babies can lead to instability in access to OB.
- Governor Warner took emergency action to increase Medicaid payment rates by 34% for licensed providers of prenatal and OB care effective September 1, 2004.

Issues and Policies Affecting Access

Medical Malpractice Insurance

- Nationally, medical malpractice rates increased substantially in recent years. Between 2000 and 2002, premiums increased 15 percent for all physicians, 22 percent for OB/GYNs, and 33 percent for internists/surgeons.
- Various factors account for increased rates such as a high volume of claims losses, cyclical nature of insurance rating/premiums, reduced investment income, high reinsurance rates, and large jury awards.
- High rates affect access. Work group heard reports that physicians are closing their practices, relocating to states where insurance is more affordable/Medicaid reimbursement is higher, or they remain in practice, but stop providing high risk services such as obstetrics.

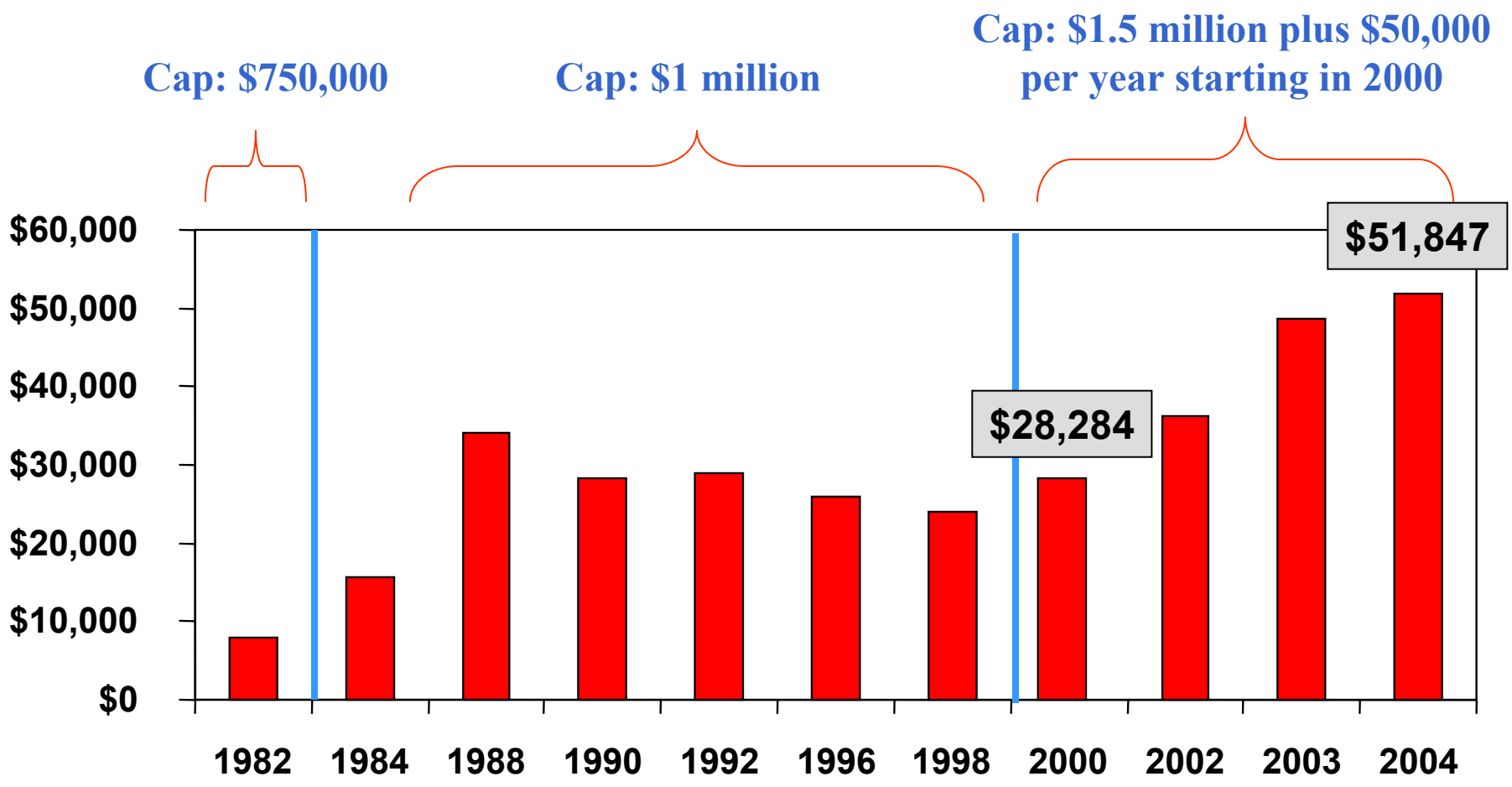
Average Medical Malpractice Rates for OB/GYNs in CY 2002



Note: Averages are weighted based on market share of insurance carriers that reported annual premiums to the Medical Liability Monitor.

Source: Virginia Bureau of Insurance.

Average Virginia Base Rates Increased 83 Percent Between 2000 and 2004



Source: Virginia Bureau of Insurance.

Issues and Policies Affecting Access

Medical Malpractice Insurance

- In 2003, concern about the increased rates prompted the Virginia Bureau of Insurance (the Bureau) to study the Virginia's medical malpractice marketplace.
- The Bureau found that sufficient competition existed in the marketplace and that physicians had numerous sources available from which to purchase insurance. The Bureau concluded that medical malpractice insurance in Virginia was more an issue of affordability than availability.

Issues and Policies Affecting Access

Medical Malpractice Insurance

- 14 states administer programs that provide obstetricians with assistance to obtain medical malpractice insurance.
- Examples of programs include market assistance, joint underwriting associations, rural practice subsidies, nonprofit medical liability association, state-supported mutual insurance company, recruit insurance companies to enter medical malpractice market in the state, patient compensation fund to pay percentage of claims physicians' policies may not cover.
- 7 states considering policy changes to relieve or decrease obstetricians medical malpractice insurance premiums.

Issues and Policies Affecting Access

Practice/Licensure

- Virginia requires certified nurse midwives to practice under physician supervision while 30 other states permit collaborative practice and 10 states do not have specific language governing the relationship. CNMs are under utilized in Virginia.
- Virginia does not allow non-nurse midwives (certified professional midwives or direct entry midwives) to practice. About 21states permit CPMs to practice legally.
- The location of birthing centers proximate to hospitals to assure emergency surgery can be performed in a timely fashion if needed is challenging after hospitals discontinue deliveries.

Issues and Policies Affecting Access

Virginia Birth-Related Neurological Injury Program

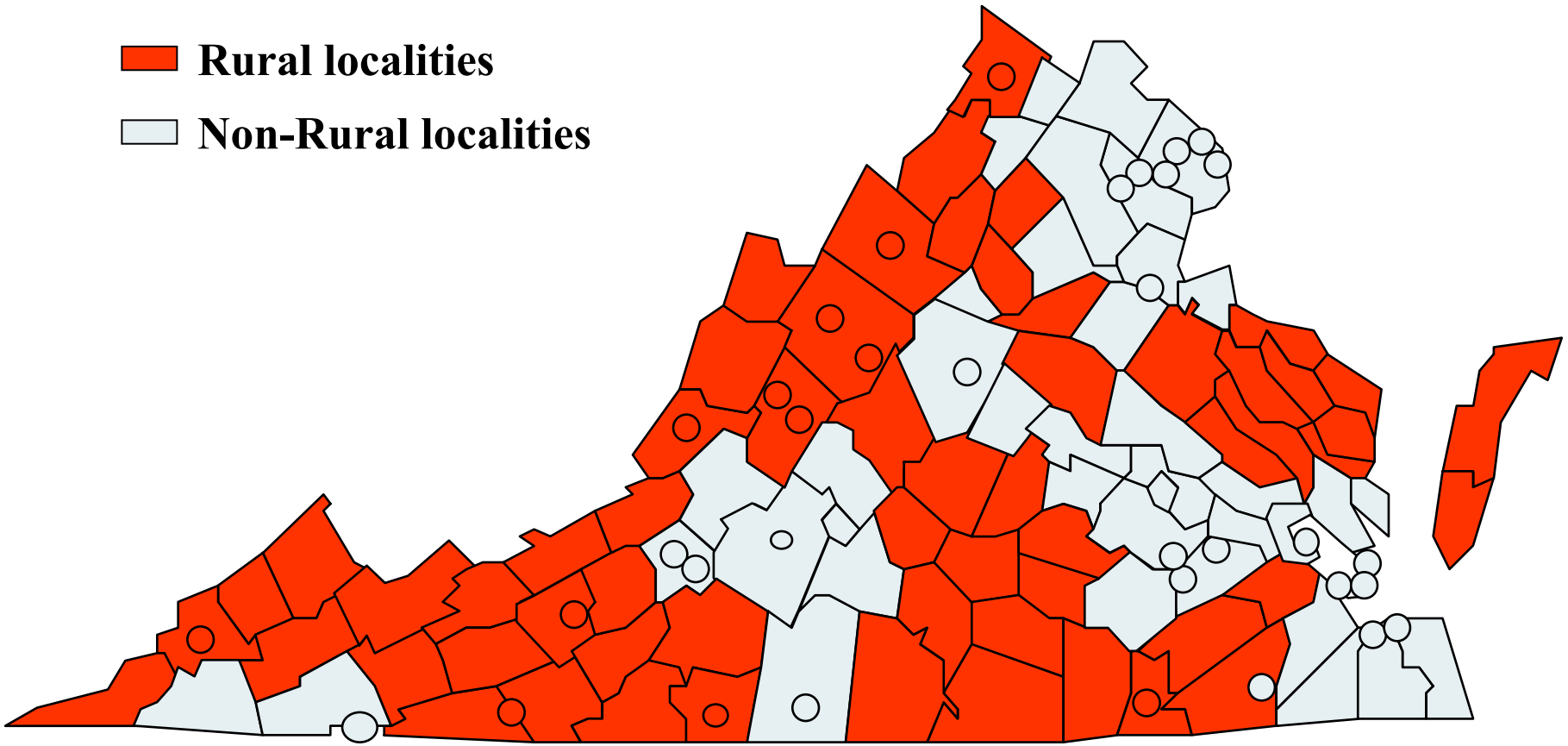
- Workers' Compensation does not utilize a standard data collection tool statewide.
- There is currently no vehicle to share the aggregate findings of case reviews to influence practice.
- The local access plans required by the VBRNIP are outdated.

Issues and Policies Affecting Access

Improving Access to Care

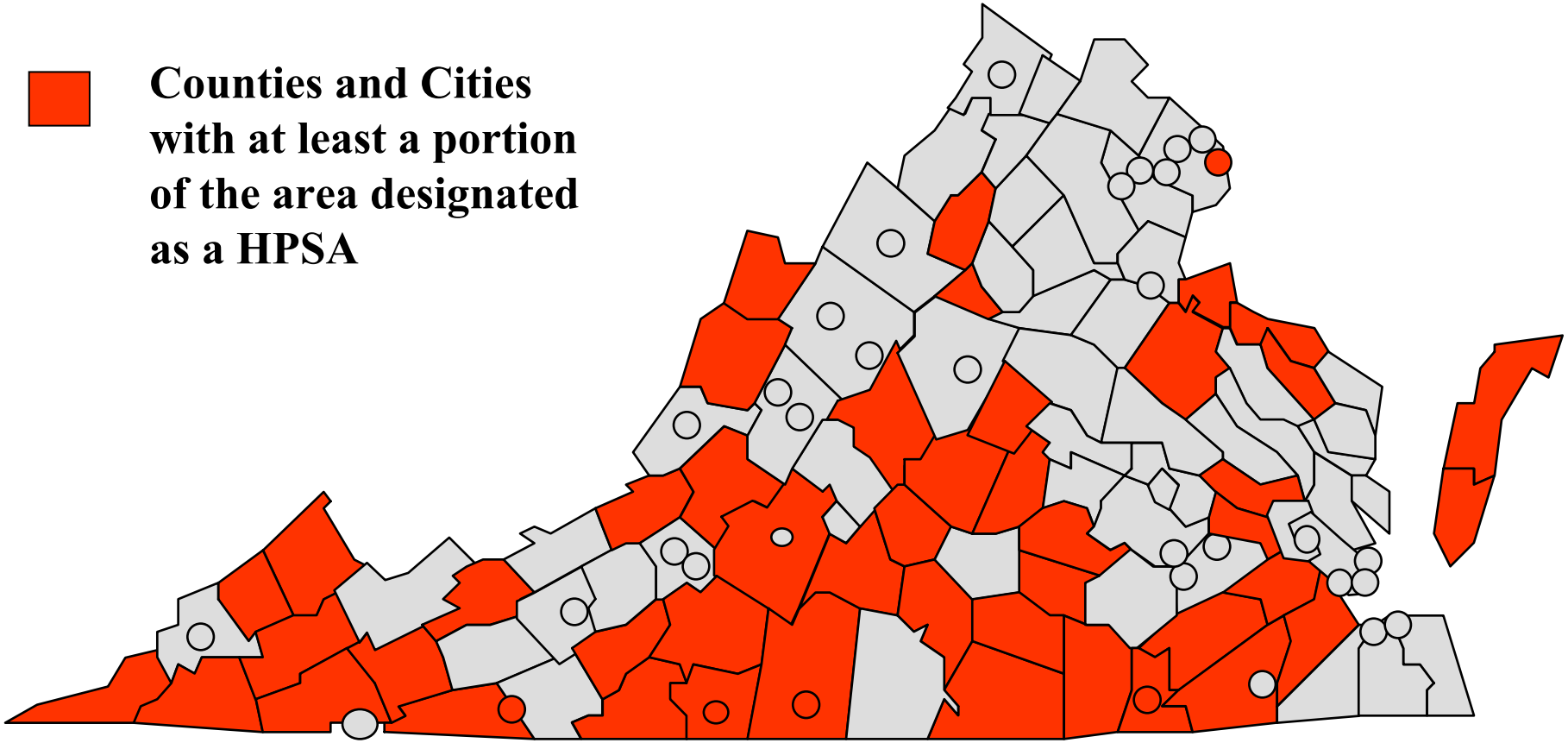
- Accessing medical records and history is difficult if the delivering physician did not monitor the patient during her pregnancy.
- There is no standardized risk screening tool to assure the right level of care and the most appropriate provider for care.
- The role of good oral health is often under emphasized during pregnancy.
- Too few physicians locate their practices in rural or underserved areas.

Rural Designations



Source: Rural designations as defined by the Office of Management and Budget.

Health Professional Shortage Areas (HPSAs)



Source: Virginia Department of Health, 2003.

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Potential Solutions Being Considered

Eligibility

- Increase eligibility for pregnant women services from 133% of poverty to 200%.
- Implement a “no wrong door” policy which allows central registration of eligible women for Medicaid and FAMIS.

Reimbursement

- Increase Medicaid reimbursement for obstetrical services, pediatric services, and hospital obstetrical services.
- Adjust the Resource-based Relative Value scale fees within the Medicaid Physician Fee Schedule annually for inflation.

Potential Solutions Being Considered

Medical Malpractice Insurance

- Reinstate the requirement that insurers report closed claims.
- Amend the *Code of Virginia* to extend the current 45-day notice requirement to 90 days when a medical malpractice insurance policy is not renewed, cancelled, or proposed premium increases exceed 25%.
- Amend the *Code of Virginia* to require all licensed insurers to allow for job-sharing under a full-time equivalent rating rule and require all licensed insurers to offer a credit for part-time practice for OB/GYNs.

Potential Solutions Being Considered

Medical Malpractice Insurance

- Request the Special Joint Subcommittee Studying Risk Management Plans to consider the feasibility of extending the Virginia Tort Claims Act to include certain obstetricians and or other licensed providers who deliver babies.
- The Division of Risk Management should establish and implement a medical malpractice insurance premium subsidy program by July 1, 2006 for certain obstetricians and other licensed providers who deliver babies.
- Eligibility for these programs should consider provider location, proportion of practice indigent and uninsured, and other factors.

Potential Solutions Being Considered

Practice / Licensure

- Implement a pilot program to use CNMs in an orchestrated statewide effort, in concert with Level III Perinatal centers, to coordinate and deliver care to areas where access is most severely limited.
- Change the *Code of Virginia* to remove the requirement that CNMs practice under supervision of a physician and insert that practice should be "collaborative“.
- Provide resources for licensed providers to improve understanding of the impact of language and cultural practices that influence a growing number of women.
- Develop a universal risk screening assessment tool and imbed in an electronic health record.

Potential Solutions Being Considered

Virginia Birth-Related Neurological Injury Program

- Collect and analyze findings of cases in the birth injury program and disseminate reports on factors that contribute to adverse birth outcomes.
- Update local access plans required under the birth injury fund at least every three years.
- Utilize a standard data collection tool to evaluate infants for inclusion in the program.

Potential Solutions Being Considered

Improving Access to Care

- Increase funds for the Virginia Department of Health to provide physician loan repayment for obstetricians who agree to practice in a Health Professional Shortage Area.
- Use technology to improve access and quality of care, e.g., telemedicine and electronic health record.

Next Steps

- Final report submitted to the Governor and General Assembly on October 29, 2004
- Budget amendments and legislation developed for consideration in the Governor's introduced budget in December.