REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

PRENATAL AND OBSTETRICAL MEDICAL EDUCATION STUDY PURSUANT TO HJR 656

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 77

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

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Preface

House Joint Resolution (HJR) 656 of the 1999 Session of the General Assembly directed the Joint Commission on Health Care to evaluate ways the Commonwealth can adopt Medicaid and state employee reimbursement policies to improve medical education experiences in prenatal and obstetrical care. This resolution is shown in Appendix A. Specifically, HJR 656 directs the Joint Commission on Health Care to: (i) assess the needs and problems of each medical school's obstetrical and family practice training programs and (ii) request the assistance of and confer with the Virginia Academy of Family Physicians, the Virginia Obstetrical and Gynecological Society, the Virginia Chapter of the American College of Nurse Midwives, the Department of Medical Assistance Services, the Department of Personnel and Training, and the State Health Department.

Based on our research and analysis during this review, we concluded the following:

- Virginia's three medical schools have obstetrical/gynecological (OB/GYN) and family practice residents. There are 11 community-based family-practice residency programs in Virginia, while the OB/GYN residency programs are based primarily at the Medical College of Virginia Hospitals (MCV), the University of Virginia Health Sciences Center (UVA), and Sentara Norfolk General Hospital.

- The American College of Graduate Medical Education guidelines require that family practice residents perform a "sufficient number of deliveries." However, most family practice residency program directors surveyed by JCHC do not believe that their residents care for a sufficient number of pregnant women for maternity care training purposes.

- UVA and MCV both have a decreasing obstetrics caseload, particularly among Medicaid patients. This has financial implications for the hospitals and could threaten the ability of the residency programs to maintain their number of residency slots. The number of maternity admissions at MCV on the part of state employees or covered dependents has declined during the past three years.

- The number of OB/GYN providers participating in the Virginia Medicaid program has increased substantially since 1985. This has improved access to care, but also appears to have drawn patients away from teaching programs both at the academic health centers and in the community.

- A policy challenge for Virginia is how to encourage community providers to become more involved in teaching residents and students.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 19-20.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comments (attached at Appendix C) provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Department of Medical Assistance Services, the Department of Personnel and Training, Virginia's academic medical centers, teaching hospitals, and family practice residency programs for their cooperation and assistance during this study.

Patrick W. Finnerty
Executive Director

December, 1999

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I.
Authority for the Study

House Joint Resolution (HJR) 656 of the 1999 Session of the General Assembly directed the Joint Commission on Health Care to examine Virginia Medicaid and the state employee health benefit reimbursement policies for obstetrical care. This resolution is shown in Appendix A. Specifically, HJR 656 directs the Joint Commission on Health Care to: (i) assess the needs and problems of each medical school's obstetrical and family practice training programs and (ii) request the assistance of and confer with the Virginia Academy of Family Physicians, the Virginia Obstetrical and Gynecological Society, the Virginia Chapter of the American College of Nurse Midwives, the Department of Medical Assistance Services, the Department of Personnel and Training, and the State Health Department.

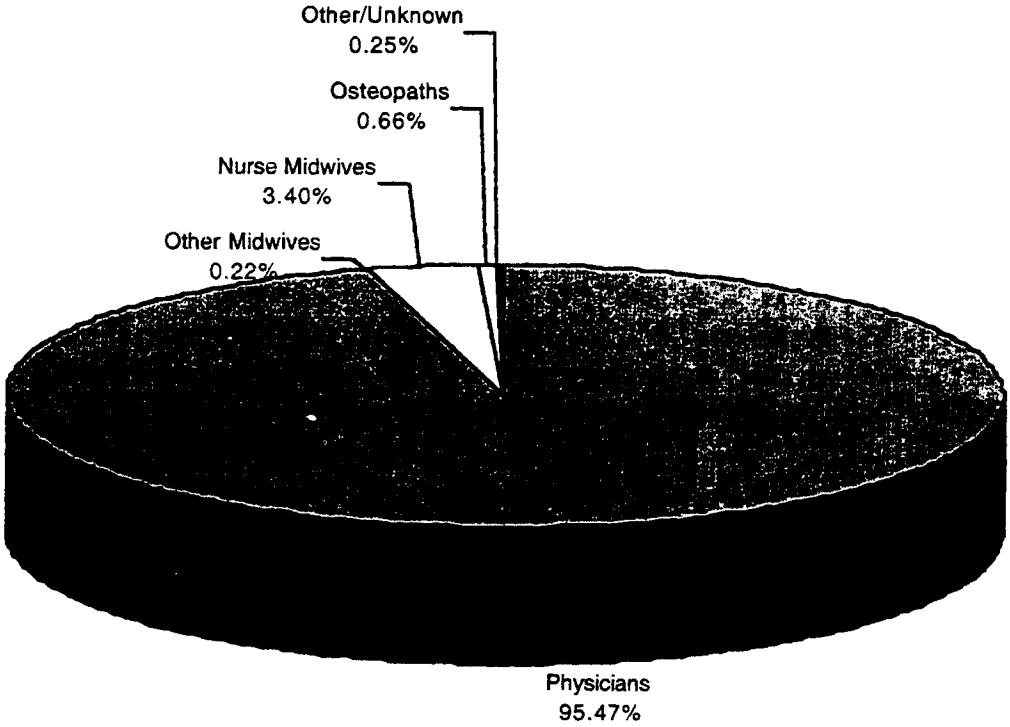
This report is composed of three sections. This section briefly discusses the authority for the study and its organization. The second section discusses background on obstetrical care in the Commonwealth. The third section discusses policy options.

II.
Overview of Obstetrical Care in Virginia

Most Infants in Virginia are Delivered by Physicians

Most infants born in Virginia are delivered by physicians. According to data provided by the Virginia Department of Health, there were 90,160 recorded births in the Commonwealth in 1996. Of these, 86,072 (95.47 percent) were attended by physicians. There were 3,063 births attended by certified nurse-midwives (3.40 percent). Other midwives (direct entry midwives) attended 199 births (.22 percent or roughly 1/5 of one percent). Osteopaths attended 599 births (.66 percent). Other attendants (relatives, police officers, fire fighters, etc.) attended 222 births (.25 percent). The attendant was unknown in five births. Figure 1 shows data on 1996 births in graphical form.

Figure 1
1996 Virginia Births by Type of Attendant



Source: Virginia Department of Health, Center for Health Statistics

Both Family Practice Physicians and Obstetricians Provide Obstetrical Services in Virginia

The two types of physicians most commonly involved in delivering infants in Virginia are obstetricians and family practice physicians. Obstetricians are physician specialists who complete a four-year residency program specializing in women's health care, including obstetrics and gynecology (OB/GYN). OB/GYN residents are involved in deliveries throughout their residency program. Family practice physicians, on the other hand, typically complete a residency program focusing on care of the entire family, which includes a rotation or rotations in obstetrics. In Virginia, this obstetrics rotation typically lasts for between 60 and 90 days total during the course of the residency, though some residents obtain more experience on an

elective basis. In addition, family practice residents gain obstetrics experience in the normal course of providing primary care for female patients.

Past Reports Have Found Limited Access to Obstetrical Services in Parts of Virginia

Several state government reports in recent years have identified access issues with regard to obstetrical services in rural or under-served areas of the Commonwealth. For example, in 1996, the Joint Commission on Health Care completed a report entitled *A Study of Access to Obstetrical Care for the Women of Rural Virginia Pursuant to SJR 331 of 1995* (SD 13, 1996). This report found that

> there are several barriers to obstetrical care in rural areas which must be addressed if Virginia is to make continued progress toward improved maternal and infant health . . . At the same time, the supply of obstetrical providers—including obstetricians, family physicians, and nurse midwives—is dwindling in rural areas, at least partly due to economic disincentives and a lack of adequate collaboration between different provider groups.

In 1998, the Perinatal/Early Childhood Subcommittee of the Maternal and Child Health Council completed a study entitled *Improving Access to Perinatal Care in Rural and Underserved Areas* (HD 9, 1998). This report found that fourteen of the state's jurisdictions had manpower and resource deficiencies for perinatal care. These fourteen jurisdictions were located among five of the state's seven Perinatal Regions. The study also concluded that there were 30 Virginia localities which were under-served due to under-utilization of services (late entry into care and poor outcomes). The involvement of family practitioners in obstetrics care has been identified as one of the strategies for improving access to obstetrical care in under-served parts of Virginia.

Involvement of Family Practice Physicians in Obstetrics in Virginia has been Limited Compared With Other States

In 1997, Virginia's three medical schools produced a report for the Governor and General Assembly entitled *Obstetrical Training of Family Medicine Residents in the Commonwealth* (SD 6, 1997). The report indicated that nationwide, 30 percent of family practice physicians "practice obstetrics to some degree." However, in Virginia eleven percent of family practitioners were involved in obstetric care as of 1997. This was reported to be one of the lowest rates in the United States. This report's findings echo the 1997 JCHC

study, which also concluded that Virginia has one of the nation's lowest rates of involvement of family practitioners in obstetrics practice.

Barriers to Family Practice Physicians Involvement in Obstetrics

A 1993 study by the Virginia Academy of Family Physicians found that reasons for the limited involvement of family practice physicians in Virginia include high malpractice costs, adverse reimbursement policies, demanding call schedules, and difficulties securing backup from obstetricians. The 1997 JCHC study found that these barriers limit the ability of family practice physicians generally to fill the gap caused by shortages of obstetrical services in parts of Virginia.

In particular, some parts of Virginia do not have a birth rate sufficient to support an obstetrician's full-time practice. The 1998 study by the Perinatal/Early Childhood Subcommittee of the Maternal and Child Health Council found that there are at least three localities (Matthews, Bath, and Highland) where the birth rate is so low as to make local provision of obstetrical services impractical. Nearby family practice physicians offer one alternative for such localities.

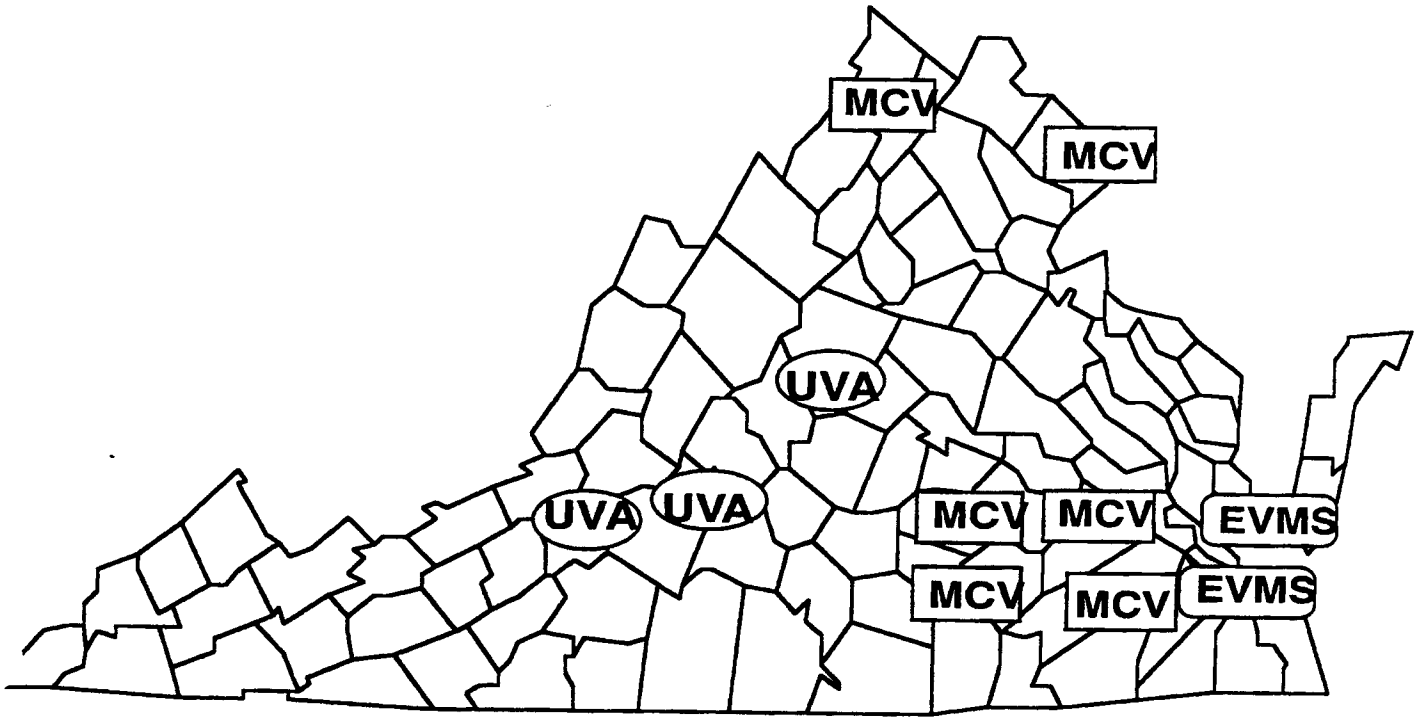
Virginia Has Eleven Community-Based Family Practice Residency Programs

There are eleven community-based family practice residency programs in Virginia (Figure 2). All of these residency programs now include an obstetrics component as part of the residency program.

Concern Exists Among Family Practice Residency Programs Regarding the Number of Obstetrics Cases Their Residents Are Exposed To

As part of this review, JCHC staff surveyed all eleven family practice residency programs (Appendix B shows a copy of the survey instrument). Responses were received from ten programs, for a response rate of 91 percent. Each residency program reported having an obstetrics rotation as part of the residency program that lasted between a minimum of sixty and ninety days (residents sometimes had the option of conducting an additional obstetrics rotation).

Figure 2
Virginia's Family Practice Residency Programs



Source: Virginia Center for Advancement of Generalist Medicine

As part of the survey, residency program directors were asked to indicate the number of maternity cases, at a minimum, they would like each resident to care for during the program's obstetrics rotation. Responses ranged from 30 to 50 cases. Residency program directors were also asked to respond to the question "do the residents in your program currently care for a sufficient number of pregnant women to sufficiently train your residents in maternity care?" All ten responses indicated "no" on this item. One "no response," however, added the notation "but we are improving."

Data Are Mixed Regarding Whether the Number of Cases Being Treated by Family Practice Residency Programs Is Increasing or Decreasing

Each residency program was also asked to indicate the total number of maternity cases cared for by their residents for each year 1996-1998. One residency program was recently established and could not report such data. One program did not have data available. Of the six programs that reported

usable data, three reported an increasing number of cases. At the same time, three programs reported a decreasing number of cases. The most significant decline in the number of cases was at the Hanover Family Physicians Residency Program, affiliated with Virginia Commonwealth University's Medical College of Virginia School of Medicine (MCV). The two other programs reporting declines were the Lynchburg Family Practice Program, affiliated with the University of Virginia, and the Blackstone Family Practice Program (affiliated with MCV).

Residency Program Accreditation Requires Having a Sufficient Number of Maternity Cases to Demonstrate Proficiency

The American College of Graduate Medical Education (ACGME) establishes guidelines for each type of medical residency program in the United States. Part of the accreditation requirements for both family practice residency programs and OB/GYN residency programs is that the program expose students to a sufficient number of obstetrics cases, including a sufficient number of deliveries.

For example, the ACGME Program Requirements for Residency Education in Family Practice state:

> The resident must be provided instruction in the biological and psychosocial impacts of pregnancy, delivery, and care of the newborn on a woman and her family. There must be a minimum of two months of experience in maternity care, including the principles and techniques of prenatal care, management of labor and delivery, and postpartum care. This must involve sufficient instruction and experience to enable residents to manage a normal pregnancy and delivery . . . When appropriate for the resident's future practice and patient care, the resident must be trained in the management of the high-risk prenatal patient. Each resident must perform a sufficient number of deliveries to ensure adequate opportunity for the achievement of competencies appropriate to family physicians.

Similarly, the ACGME guidelines for Obstetrics and Gynecology state "it is of utmost importance that each resident have sufficient independent operative and clinical responsibilities to prepare for practice in the specialty."

There Is a Trend of a Declining Number of Deliveries at Both MCV and the University of Virginia Health Sciences Center

Both the University of Virginia Health Sciences Center (UVA) and MCV have reported a trend of declining caseloads in obstetrics at their hospitals. At present, the University of Virginia supports 20 residency slots in obstetrics and gynecology (OB/GYN). MCV supports 24 slots in OB/GYN (a decrease from 32 slots at the program's peak). Both UVA and MCV expressed concern about being able to maintain their current number of residency slots, given their declining caseloads.

The Number of Medicaid Deliveries at the University of Virginia Has Decreased Significantly

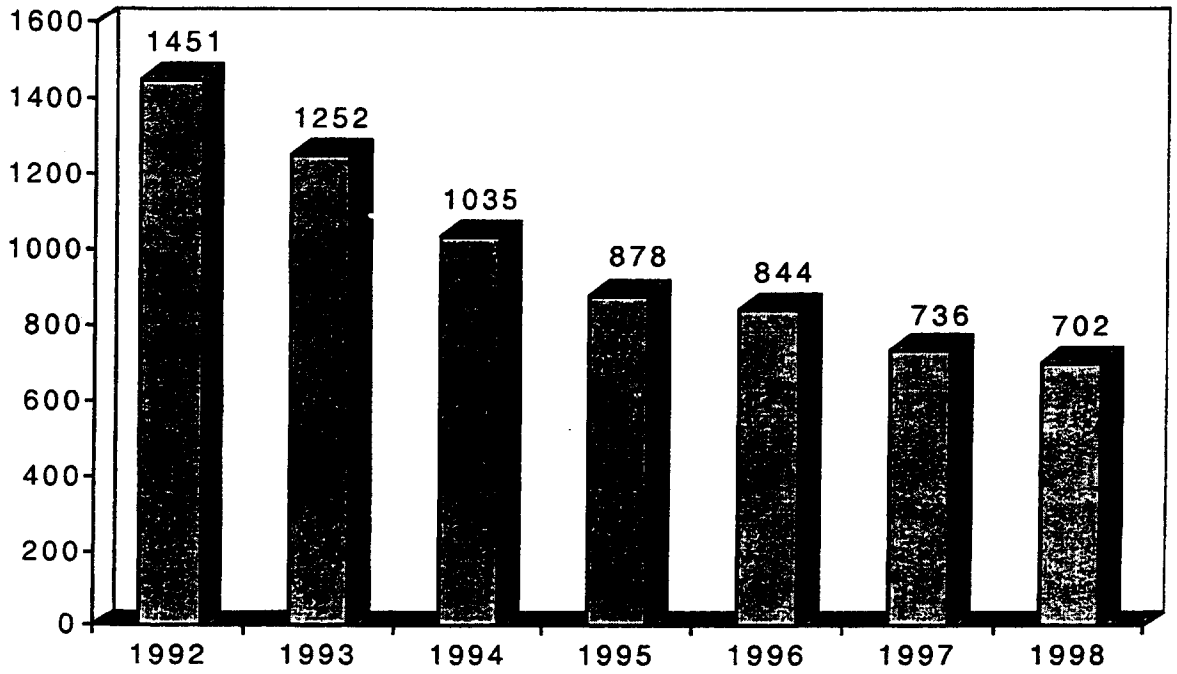
The number of Medicaid deliveries at academic health centers has decreased significantly during the 1990s. For example, at the University of Virginia Health Sciences Center, the number of Medicaid deliveries decreased from 1,451 in FY 1992 to 702 in FY 1998 (Figure 3).

The decrease in Medicaid deliveries has significant financial implications for UVA, because of the impact on disproportionate share hospital payments. In addition, the decline in the number of Medicaid deliveries at the University of Virginia Health Sciences Center (UVA) has accounted for a significant decrease in the total number of deliveries at UVA. As reflected in Figure 4, the total number of deliveries at UVA has decreased from 1,825 in FY 1993 to 1,449 in FY 1997.

The decrease in total deliveries has negative financial and educational implications for UVA. In recent years, the decline in the number of deliveries has caused the Obstetrics and Gynecology (OB/GYN) department at UVA to run a deficit of as much as $800,000. At the same time, the decline in deliveries has resulted in a corresponding decline in pediatrics case load, creating financial difficulties for that department. Regarding educational programs, the decline in the number of deliveries at UVA has strained the ability of the OB/GYN department to maintain its allotted 20 residency slots (five in each of the four years of the residency program). Decreasing patient volumes have also limited the exposure medical students have to obstetrical cases.

Figure 3

Medicaid Deliveries at the University of Virginia Health Sciences Center: FY 1992-1998

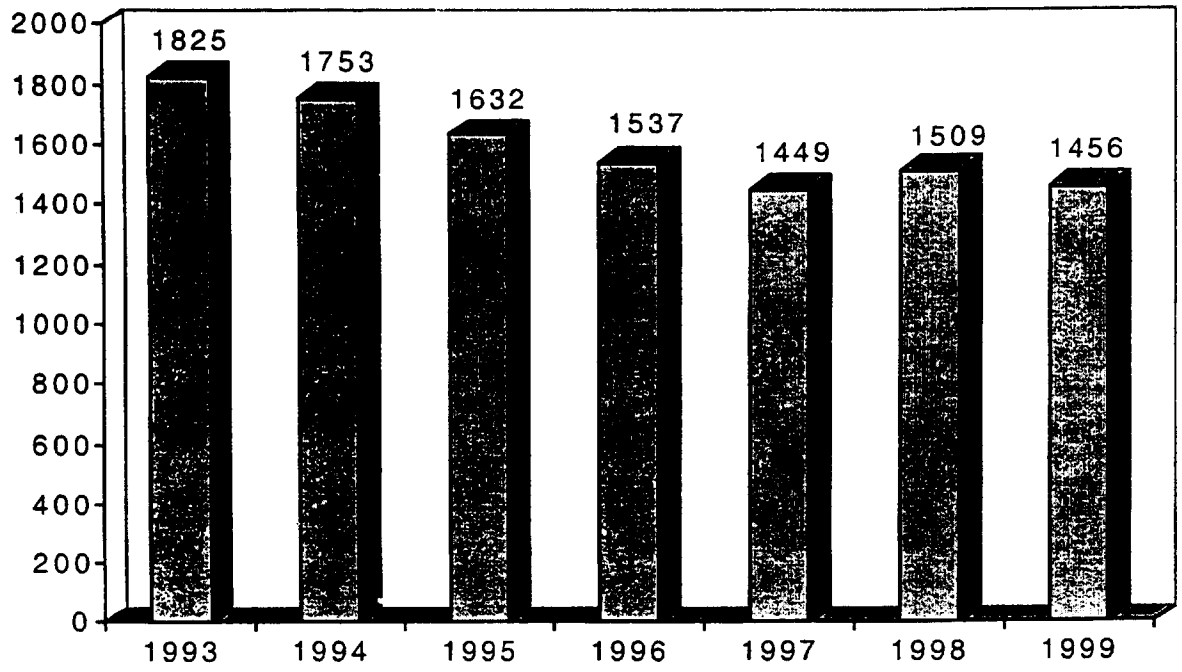


Source: University of Virginia, Department of OB/GYN.

It appears that many Medicaid obstetrics patients in the Charlottesville area are now choosing to deliver their babies at community hospitals in the area. As noted previously, Figure 3 shows that the number of Medicaid deliveries at the University of Virginia decreased significantly from 1993 to 1998. However, the number of Medicaid claims for obstetrics and prenatal care at three nearby community hospitals shows an increase from 156 total claims in FY 1993 to 463 total claims in FY 1998 (Figure 5).

Figure 4

Total Deliveries at the University of Virginia Health Sciences Center: FY 1992-1999*



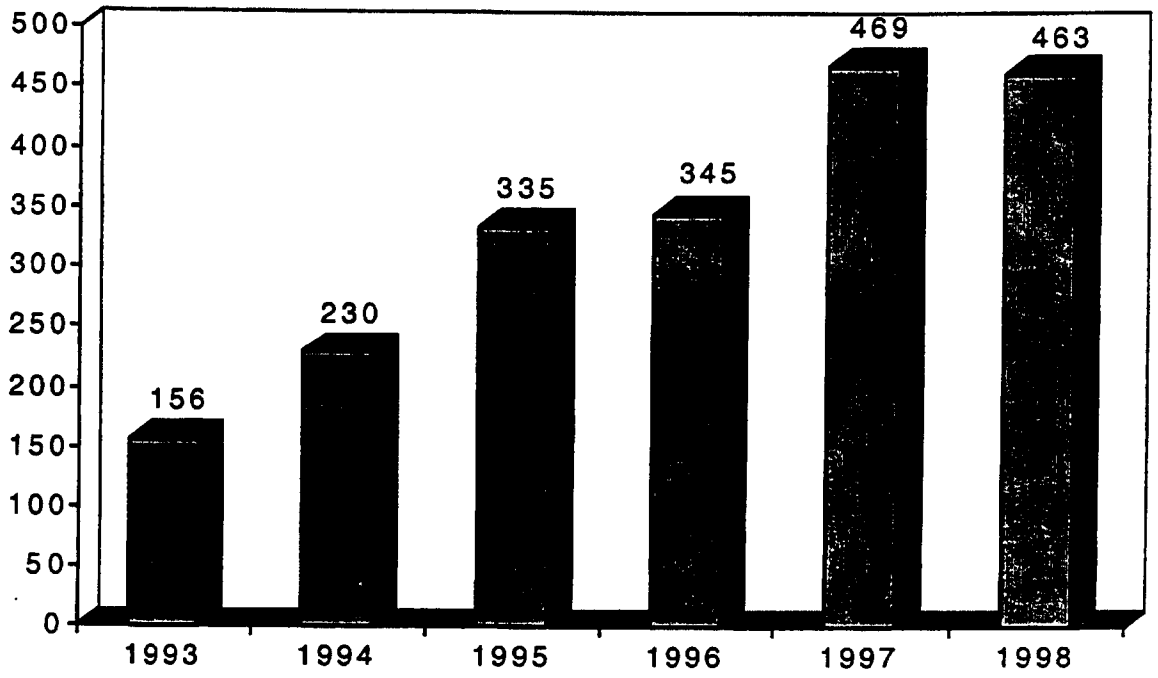
**FY 1999 is an annualized estimate based on 10 months of data for FY 1999.*
Source: University of Virginia, Department of OB/GYN.

The Number of Medicaid Prenatal and Obstetrics Claims at Virginia Commonwealth University's Medical College of Virginia Hospitals Has Decreased Significantly

Similar to the decline in the number of Medicaid deliveries at the University of Virginia's Health Sciences Center, the number of Medicaid prenatal and obstetrics claims at MCV has decreased significantly from 1772 in FY 1993 to 1077 in FY 1998 (Figure 6). At the same time, the total number of claims at four large private hospitals with obstetrics services in the Richmond Market has increased (Figure 7).

Figure 5

Number of Virginia Medicaid Claims for Obstetrics and Prenatal Care at Three Community Hospitals Near Charlottesville, Virginia: FY 1993-1998



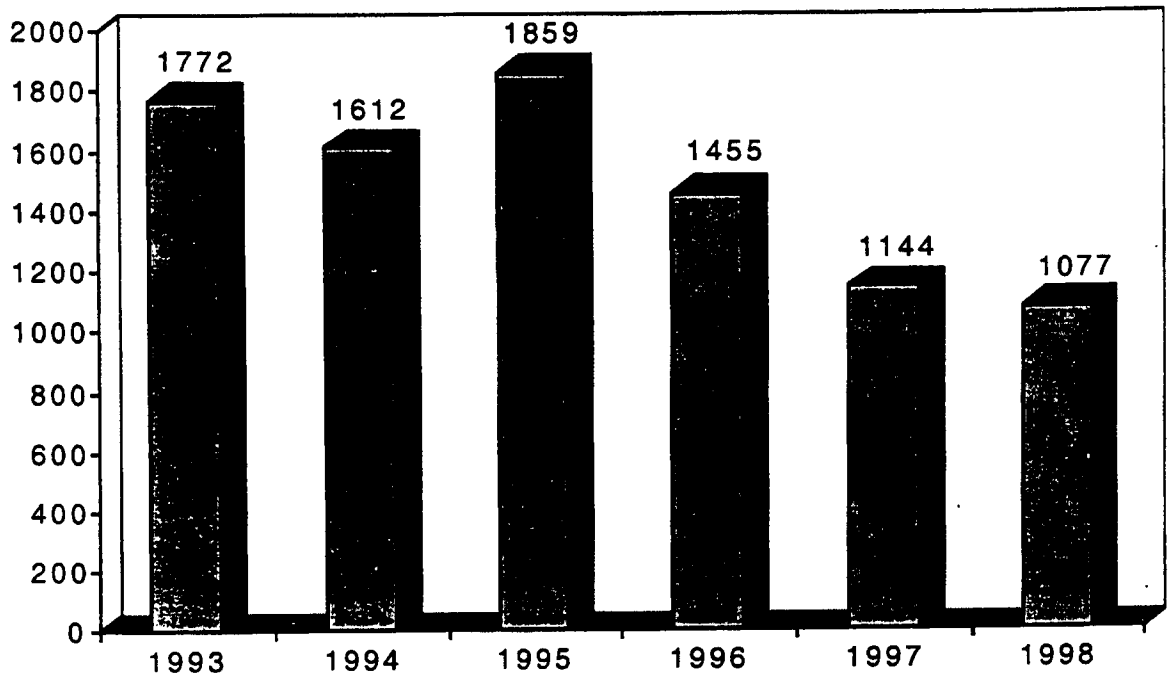
Source: Department of Medical Assistance Services.

EVMS Reports Having an Adequate Number of Cases to Train Its OB/GYN Residents

Eastern Virginia Medical School (EVMS) currently has 16 residency slots in OB/GYN. Unlike UVA and MCV, EVMS does not operate a hospital. Rather, EVMS residents practice at Sentara Norfolk General Hospital and Children's Hospital of the King's Daughters in Norfolk. The EVMS residency program in OB/GYN is based at Sentara Norfolk General.

Figure 6

Number of Virginia Medicaid Claims for Obstetrics and Prenatal Care at MCV: FY 1993-1998

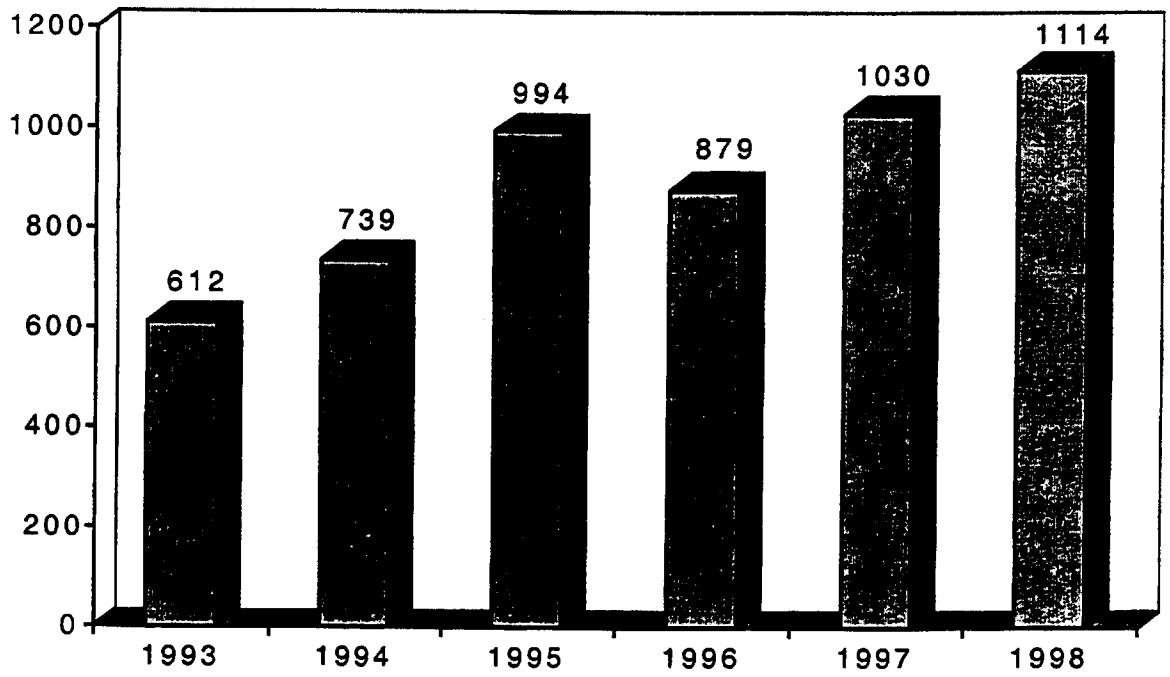


Source: Department of Medical Assistance Services.

During a structured interview with JCHC staff, EVMS's Associate Dean for Medical Education indicated that EVMS OB/GYN residents currently are exposed to an adequate number of obstetrics cases. Medicaid data for Sentara Norfolk General Hospital shows a fairly steady increase in the number of prenatal and obstetrics claims from FY 1992 to FY 1995 (Figure 8), even with the initiation of the *Options* program (voluntary Medicaid managed care) in January 1995.

Figure 7

Number of Virginia Medicaid Claims for Obstetrics and Prenatal Care at Four Private Hospitals Near Richmond, VA: FY 1993-1998



Source: Department of Medical Assistance Services.

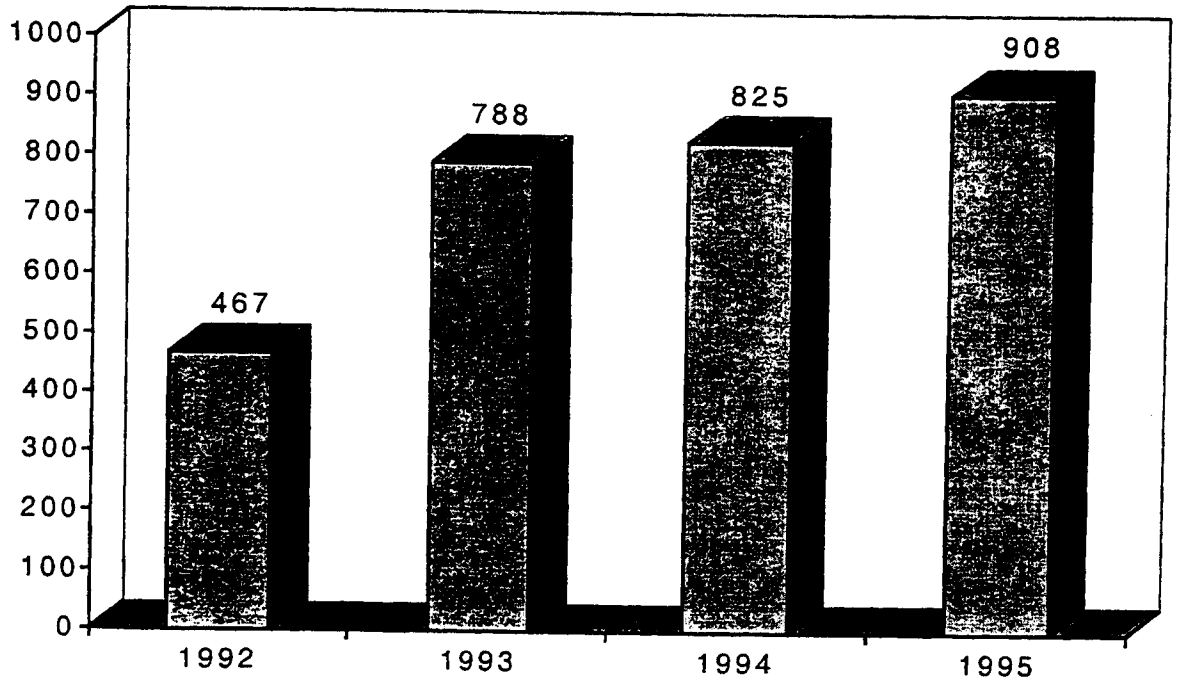
In January 1996, Medicaid's MEDALLION II (mandatory managed care) program took effect in Hampton Roads, and Medicaid recipients claims were dispersed among a number of Medicaid managed care contractors rather than being available in the Medicaid fee-for-service claims data base. Therefore, reliable Medicaid data for FY 1996-1998 are not readily available. However, EVMS's associate dean indicated that the advent of Medicaid managed care has not created a significant problem in terms of having an adequate number of teaching cases for OB/GYN residents.

Number of Medicaid Obstetrics Providers Has Increased

One explanation for the decline in the number of Medicaid obstetrics patients cared for at MCV and UVA is that the number of obstetrical providers participating in the Virginia Medicaid program has increased significantly.

Figure 8

Number of Virginia Medicaid Claims for Obstetrics and Prenatal Care at Sentara Norfolk General Hospital: FY 1992-1995

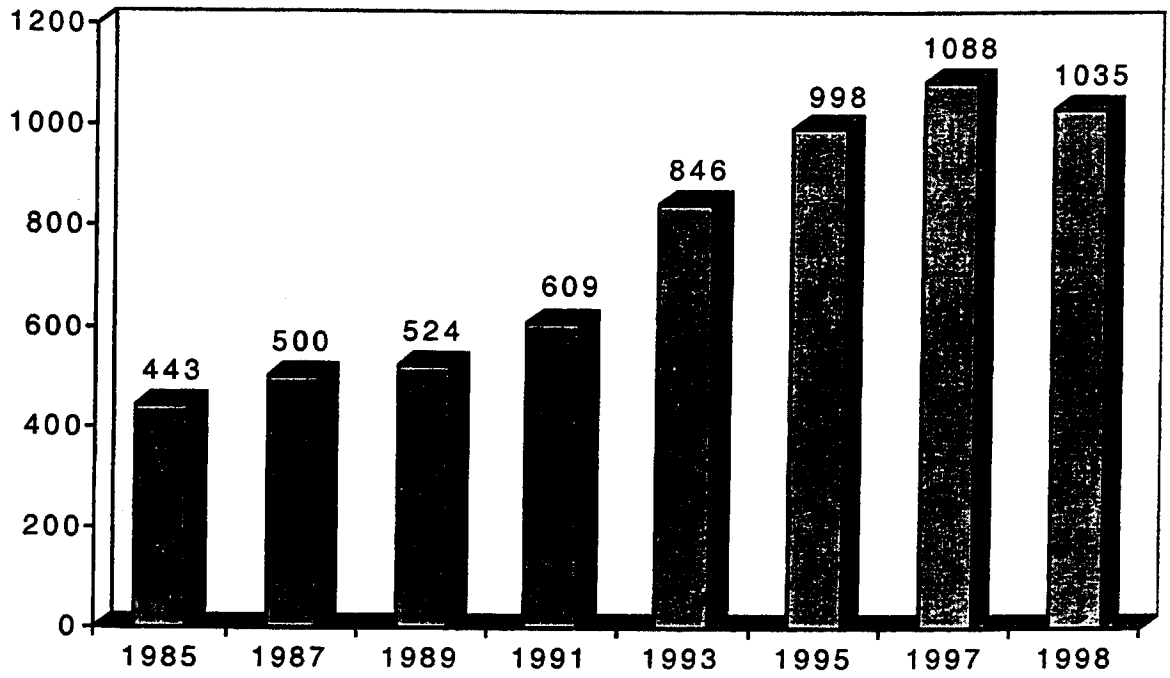


Source: Department of Medical Assistance Services.

This increase can be shown by examining the period between 1985 and 1998. According to data in the 1998 *Statistical Record of the Virginia Medicaid Program,* the number of OB/GYN providers participating in the Virginia Medicaid program increased from 443 in FY 1985 to 1,035 in FY 1998 (Figure 9). As can be seen from Figure 9, the increase was particularly striking from FY 1989 to 1997, where the number of Virginia Medicaid OB/GYN providers increased from 524 to 1,088.

Figure 9

Number of OB/GYN Providers Participating in the Virginia Medicaid Program: FY 1985 to FY 1998



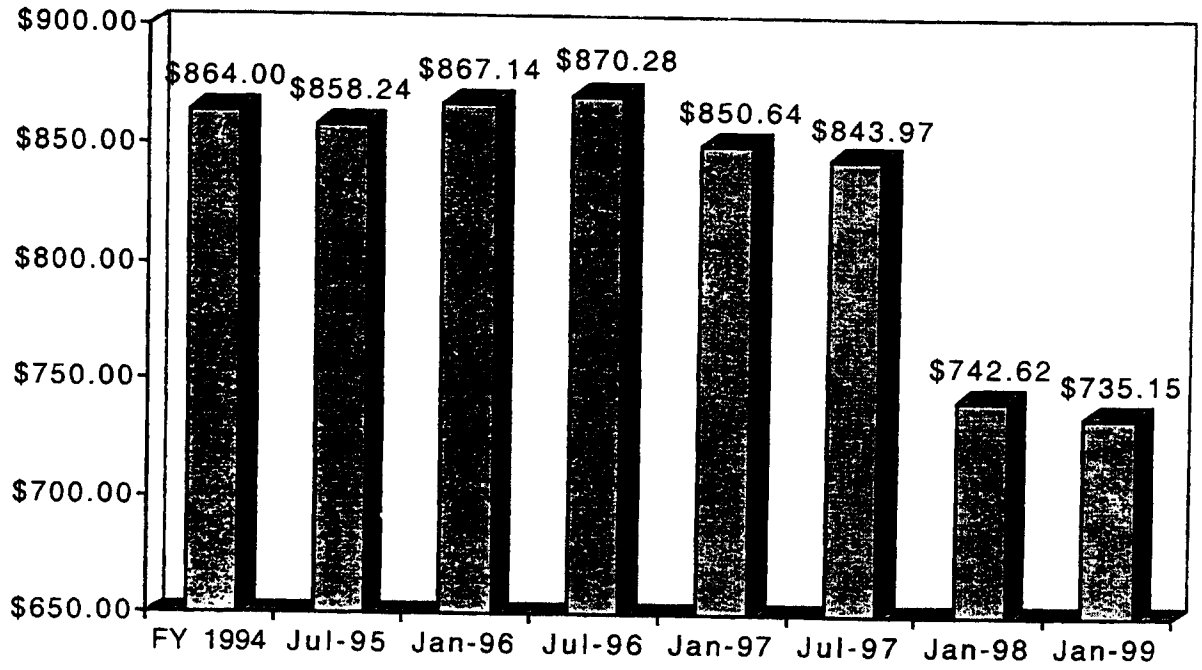
Source: 1998 Statistical Record of the Virginia Medicaid Program.

Medicaid Rates for Obstetrics Services Have Been Declining Since 1995

During this study, a number of interview subjects indicated that the increase in Medicaid rates for obstetrics services accounted for the increasing number of obstetrics providers participating in Medicaid. While this appears to have been true during the late 1980s and early 1990s, it is important to note that Medicaid reimbursement for some of the most common obstetrics-related CPT codes has actually decreased since 1995. For example, the Medicaid reimbursement for CPT Code 59410 (vaginal delivery only) has decreased from $864 in FY 1994 to $735.15 as of 1/1/99 (Figure 10).

Figure 10

Virginia Medicaid Reimbursement for CPT Code 59410 (Vaginal Delivery Only), FY 1994-Present



Source: Department of Medical Assistance Services.

Additional Medicaid Reimbursement for Supervising Residents is One Option

One option that has been suggested for increasing the number of obstetrics experiences for both family practice residents and OB/GYN residents is offering a supplement to Medicaid reimbursement for OB services in cases where the obstetrician is supervising a resident. This would provide an economic incentive for obstetricians in the community to supervise residents.

DMAS staff indicated that it is not possible to use Medicaid funds to provide additional reimbursement to obstetricians for supervising residents. DMAS's Manager of Program Services stated in a memo to JCHC staff that "Medicaid is not able to offer higher reimbursement to physicians involved in supervising residents or medical students while performing a delivery. I have

enclosed documentation from the State Plan and CFR to support this." The section of the *Code of Federal Regulations* (CFR) cited was § 447.10 Prohibition against reassignment of provider claims.

It would be possible, however, to have DMAS administer a program where a general fund supplement was paid to obstetrics providers who supervised residents (or residents and medical students). The amount of this supplement would need to be determined through focus groups with obstetrics providers in order to find a supplement level that would be a meaningful incentive. It is important to recognize that the expansion of Medicaid managed care will limit the state's ability to create incentives through Medicaid reimbursement levels.

Impact of Medicaid Managed Care

In considering policy options for this review, it is important to recognize that the expansion of Medicaid managed care (Medallion II) statewide will largely remove the role of the Virginia Medicaid program in setting rates for individual services. Rather, DMAS will establish capitation rates to pay each contracting Medicaid managed care plan per member, per month. The health plan will in turn negotiate rates with providers, which it will likely treat as proprietary information.

At present, Medallion II has already been implemented in the service areas for EVMS (Hampton Roads) and MCV (Richmond). This means that any changes made to Medicaid payment rates for OB services would not directly impact these academic health centers.

Other Possible Explanation for Increased Number of Medicaid Obstetrics Patients Being Treated by Community Providers

Besides changes in Medicaid reimbursement rates relative to other payors, other factors were identified during this review that may contribute to Medicaid obstetrics patients being treated by community providers rather than at academic health centers. The Medallion program, a managed fee-for-service program is in place for Medicaid recipients in all parts of the state not already served by Medallion II (the Medicaid managed care program). As part of Medallion, all Medicaid patients are assigned to a primary care physician (PCP). This PCP then acts as a gatekeeper or source of referrals to most specialty care.

Traditionally, academic health centers have excelled in subspecialty care, not in primary care. Therefore, the primary care networks in academic

health centers may not have been extensive enough to accommodate all of the Medicaid patients that have historically been treated in academic health centers. If a Medicaid patient selects or is assigned a community primary care physician as a PCP, then it is not illogical to expect the referral patterns from that PCP to be to specialists in the community, rather than at an academic health center. This issue was addressed to some degree in the Joint Commission on Health Care's report on the *Participation of AHCs in Managed Care Networks* (SD 25, 1999). This issue and related issues will be examined in more detail as part of Joint Commission's study of academic health centers pursuant to SJR 464 of the 1999 session of the General Assembly.

The Number of State Employee Maternity Admissions at MCV Has Decreased

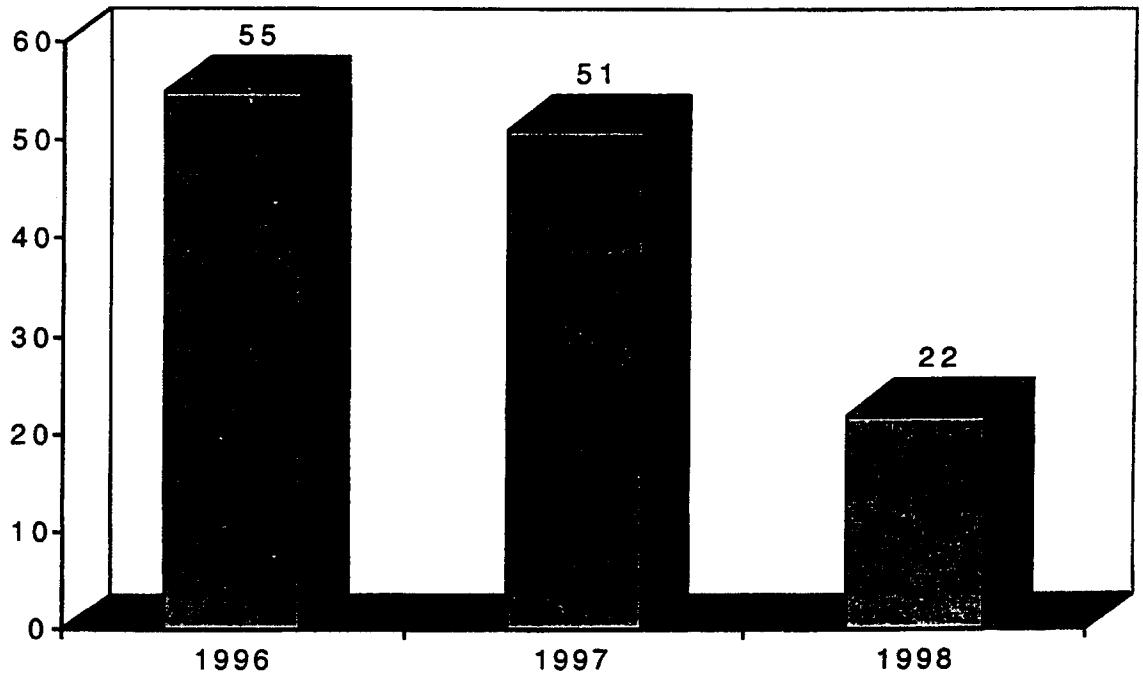
In addition to the decline in the number of Medicaid deliveries at MCV and UVA, the number of state employees delivering infants at MCV has also declined in recent years. The vast majority of state employees who receive health insurance through the State Employee Health Benefits Program are enrolled in Key Advantage (74,186 in FY 1998) or Cost Alliance (4,486 in FY 1998), which are the state's two self-insured health benefits options. As Figure 11 reflects, the number of state employees enrolled in Key Advantage or Cost Alliance with maternity admissions at MCV has declined from 55 in calendar year 1996 to 22 in 1998.

There has been a similar decline in the number of state employees enrolled in Key Advantage or Cost Alliance with maternity admissions at UVA (from 44 in 1996 to 17 in 1998). However, most of this decrease can probably be explained by the 1997 General Assembly granting the University of Virginia authority to require all of its employees to enroll in the QualChoice managed care plan rather than having the option to select Key Advantage or Cost Alliance. The University of Virginia's employees represent a significant majority of the state employees in the UVA Health Sciences Center service area.

One option for increasing the number of state employees or covered dependents who deliver infants in a teaching setting is to waive the hospitalization co-payment if the state employee delivers an infant at an academic health center or in a teaching hospital. The current co-pay for a hospital confinement for Key Advantage is $200. The co-payment for Cost Alliance is $100 per day up to a maximum of $500 per confinement. Waiving the hospitalization co-payment would provide a financial incentive for state employees and covered dependents to deliver their infant in a teaching setting.

Figure 11

State Employee Health Benefits Program Maternity Admissions at MCV: 1996-1998 (Self-Insured Programs Only)



Source: Department of Personnel and Training.

III.
Policy Options

The following policy options are offered for consideration by the Joint Commission on Health Care. These options do not represent the entire range of issues that the Joint Commission on Health Care may wish to consider with regard to HJR 656.

Option I: Take no action.

Option II: Introduce a budget amendment directing the Department of Personnel and Training (DPT) to waive the hospitalization co-payment (currently $200 for Key Advantage and $100 per day up to a maximum of $500 for Cost Alliance) for any state employee or covered family member of a state employee enrolled in Key Advantage or Cost Alliance delivering a baby at the University of Virginia Hospital or the Medical College of Virginia hospital. General funds would need to be appropriated to DPT to make up the $200 difference per case (fiscal impact to be determined by DPT but should be well under $100,000).

Option IIB: Introduce a budget amendment directing the Department of Personnel and Training (DPT) to waive the hospitalization co-payment of $200 for any state employee or covered family member of a state employee enrolled in Key Advantage or Cost Alliance delivering a baby at any Virginia teaching hospital with a residency program in family practice or obstetrics and gynecology. General funds would need to be appropriated to DPT to make up the $200 difference per case (fiscal impact to be determined by DPT).

Option III: Introduce a budget amendment appropriating general funds for the Department of Medical Assistance Services to offer a general fund supplement for physician services provided through Medicaid fee-for-service to encourage community physicians to supervise residents and/or medical students and nurse-midwifery students while

providing obstetrical services (fiscal impact to be determined during the SJR 464 study).

Option IV: Introduce a budget amendment appropriating general funds for the Department of Medical Assistance Services to offer a general fund supplement for physician services provided through Medicaid managed care plans to encourage community physicians to supervise residents and/or medical students and nurse-midwifery students while providing obstetrical services (fiscal impact to be determined during the SJR 464 study).

APPENDIX A

HOUSE JOINT RESOLUTION NO. 656

Directing the Joint Commission on Health Care to evaluate ways the Commonwealth can adopt Medicaid and state employee insurance reimbursement policies to improve medical education experiences in prenatal and obstetrical care.

Agreed to by the House of Delegates, February 7, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, Virginia's medical schools have traditionally provided most of the prenatal and obstetrical care for indigent and Medicaid patients; and

WHEREAS, the Commonwealth has significantly increased Medicaid reimbursements to participating physicians and hospitals and extended eligibility criteria to serve more pregnant women in the last several years; and

WHEREAS, physicians and nurse midwives in the private sector are serving more indigent and Medicaid pregnant women; and

WHEREAS, our medical schools, together with community-based family practice and obstetrical residency programs, have fewer appropriate opportunities to educate and train medical students, nurse midwifery students, and family practice and obstetrical residents in obstetrics; and

WHEREAS, many physicians and midwives in the private sector who render obstetrical care do not teach medical students, residents, and midwifery students; and

WHEREAS, many of Virginia's family practice and obstetrical training programs will be facing difficulty in the near future maintaining their academic accreditation through the Accreditation Council on Graduate Medical Education (ACGME) due to the low number of educational experiences; and

WHEREAS, it is advantageous to the citizens of Virginia to have highly trained new physicians and nurse midwives in prenatal and obstetrical care in the future; and

WHEREAS, modifications to the Medicaid reimbursement and state health insurance policies to include family practice and obstetrical residents and nurse midwifery students under certain conditions may help meet the educational needs of future obstetricians and assist the medical schools in maintaining their accreditation through improvements in medical education and learning opportunities in prenatal and obstetrical care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to evaluate ways the Commonwealth can adopt Medicaid and state employee insurance reimbursement policies to improve

medical education experiences in prenatal and obstetrical care. In its deliberations, the Joint Commission shall (i) assess the needs and problems of each medical school's obstetrical and family practice training programs and (ii) request the assistance of and confer with the Virginia Academy of Family Physicians, the Virginia Obstetrical and Gynecological Society, the Virginia Chapter of the American College of Nurse Midwives, the Department of Medical Assistance Services, the Department of Personnel and Training, and the State Health Department.

The Joint Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Survey of Family Practice Residency Program Directors

The Joint Commission on Health Care (JCHC) has been directed by the Virginia General Assembly to examine Medicaid and state employee health benefits program reimbursement policies to improve medical education experience in prenatal and obstetrical care. As part of the research for this study, we are conducting a fax survey of family practice residency program directors in Virginia. The results of this survey will be used to help make recommendations to the Governor and General Assembly. Please take a few minutes to complete the questionnaire and return it by **May 7, 1999.** You may mail the survey to William Murray at Suite 115, Old City Hall, 1001 East Broad Street, Richmond, Virginia 23219. If you prefer, you may fax your response to William Murray at (804) 786-5538. If you have any questions regarding this questionnaire, please contact William Murray at (804) 786-5445. Thank you for your help in completing this survey!

About Your Residency Program

1. Name of the Residency Program: _____

2. Name of the Person Completing the Survey:_____

   Title:_____ Phone Number:_____

3. How many residents does your program currently have? _____residents

4. How long does the residency program's obstetrical rotation last? *(Please check the appropriate box.)*

   ❑ 60 days

   ❑ Other length of time *(Please specify.)*_____days

Your Residents' Involvement in Maternity Care

5. How many maternity cases, as a minimum, would you like each resident to care for during the program's obstetrical rotation? *(Please fill in the blank.)*

   _____ Cases

6. How many longitudinal maternity cases, as a minimum, would you like each resident to care for during the majority of the program when the resident is not on an obstetrical rotation? *(Please fill in the blank.)* _____ Cases

7. In your view, do the residents in your program currently care for a sufficient number of pregnant women to sufficiently train your residents in maternity care? *(Please check the appropriate box).*

   ❑ Yes
   ❑ No

8. Please indicate the total number of maternity cases cared for by residents in your program for each of the following calendar years. *(Please fill in the blanks; even if you do not have data broken out by obstetrical rotation and longitudinal cases, please do fill in the blanks for total cases.)*

	cases as part of an obstetrical rotation	longitudinal cases	Total Cases
1996	_____	_____	_____
1997	_____	_____	_____
1998	_____	_____	_____

9. A. Were any of the cases noted in item 8 attended by a community physician not employed by your family practice residency program?)

   ❑ Yes *Please specify how many* _____
   ❑ No

   B. Were any of the cases noted in Item 8 attended by a nurse-midwife not employed by your family practice residency program?

   ❑ Yes *Please specify how many* _____
   ❑ No

10. How many Medicaid maternity cases did your program care for in each of the following calendar years? *(Please fill in the blanks.)*

1996 _____

1997 _____

1998 _____

11. Do you track data on the number of state employees treated? *(Please check the appropriate box.)*

- ☐ Yes *(Please complete Item 12.)*
- ☐ No *(Please skip to Item 13.)*

12. How many state employee maternity cases did your program care for in each of the following calendar years? *(Please fill in the blanks.)*

1996 _____

1997 _____

1998 _____

13. Please add any additional comments that you have regarding Medicaid and the state employee health benefits program reimbursement policies to improve medical education experience in prenatal and obstetrical care: *(Please attach additional sheets if necessary.)*

Please return completed surveys to William Murray, Joint Commission on Health Care, Suite 115, Old City Hall, Richmond, Virginia 23219. Surveys may be faxed to (804) 786-5538.

APPENDIX C

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: OBSTETRICAL EDUCATION STUDY (HJR 656)

Organizations Submitting Comments

A total of four organizations submitted comments in response to the HJR 656 report on obstetrical education.

- Christopher S. Bailey, Senior Vice President, Virginia Hospital and Health Care Association
- Juliana Fehr, C.N.M., M.S., PhD(c), Coordinator, Nurse Midwifery Education Program, Shenandoah University
- Roger A. Hofford, M.D., Associate Director, Lynchburg Family Practice Residency
- Andrew White, M.D., Residency Director, Shenandoah Valley Family Practice Residency Program

Policy Options Included in the HJR 656 Issue Brief

Option I: **Take no action.**

Option II: **Introduce a budget amendment directing the Department of Personnel and Training (DPT) to waive the hospitalization co-payment (currently $200 for Key Advantage and $100 per day up to a maximum of $500 for Cost Alliance) for any state employee or covered family member of a state employee enrolled in Key Advantage or Cost Alliance delivering a baby at the University of Virginia Hospital**

or the Medical College of Virginia hospital. General funds would need to be appropriated to DPT to make up the $200 difference per case (fiscal impact to be determined by DPT but should be well under $100,000).

Option IIB: Introduce a budget amendment directing the Department of Personnel and Training (DPT) to waive the hospitalization co-payment of $200 for any state employee or covered family member of a state employee enrolled in Key Advantage or Cost Alliance delivering a baby at any Virginia teaching hospital with a residency program in family practice or obstetrics and gynecology. General funds would need to be appropriated to DPT to make up the $200 difference per case (fiscal impact to be determined by DPT).

Option III: Introduce a budget amendment appropriating general funds for the Department of Medical Assistance Services to offer a general fund supplement for physician services provided through Medicaid fee-for-service to encourage community physicians to supervise residents and/or medical students and nurse-midwifery students while providing obstetrical services (fiscal impact to be determined during the SJR 464 study).

Option IV: Introduce a budget amendment appropriating general funds for the Department of Medical Assistance Services to offer a general fund supplement for physician services provided through Medicaid managed care plans to encourage community physicians to supervise residents and/or medical students and nurse-midwifery students while providing obstetrical services (fiscal impact to be determined during the SJR 464 study).

Overall Summary of Comments

The comments from each of the four organizations were generally favorable. The commenters agreed that ensuring adequate OB training programs for residents is essential and that additional support is needed. While there was general support for Option IIB, Options III and IV received the strongest support.

Summary of Individual Comments

Virginia Hospital and Healthcare Association (VHHA)

Christopher A. Bailey, Senior Vice President, commented that "as a general rule, VHHA believes that support for needed medical education programs, at whatever sites they are offered is an obligation that should be shared by all stakeholders. And in an environment of competitive health care market forces, such support is best provided in a fashion distinct from direct purchase of services." Mr. Bailey added that

> To the extent that there are incentives offered to either state employees or Medicaid recipients to utilize certain providers, they should be offered to all facilities participating in OB and family practice residency programs. The incentives should follow the patient as best as possible. . . the JCHC may wish to explore enhanced medical education support options directed to all facilities who develop or expand residency training programs for OB or family practice. There are mechanisms for expanding Medicaid support to institutions offering medical education programs that other states have employed. These should be fully explored before devoting exclusively state resources. . . Finally, through this or other studies, the JCHC may wish to consider mechanisms for fostering partnerships between managed care organizations, health systems and medical education programs.

Shenandoah University

Juliana Fehr, C.N.M., M.S., PhD(c), Coordinator, Nurse Midwifery Education Program, commented on the shortage of practice sites confronting nurse midwifery students in Virginia. She stated that "I would like to suggest that Option III and IV be changed to reflect the necessity for nurse-midwifery students to be supervised by certified nurse-midwives and that those supervising certified nurse-midwives will be able to have access to the general fund supplement provided through Medicaid."

Lynchburg Family Practice Residency

Roger A. Hofford, M.D., Associate Director, commented that: "The study demonstrates nicely that patients are going to community settings for their obstetrical care for many reasons. Therefore, medical education will need to follow this trend if we are to continue to have well-trained physicians and nurse midwives." Dr. Hofford supported Options II, IIb, III, and IV, with the strongest support for Options III and IV. Dr. Hofford also suggested an additional option: "to withhold or budget a percentage of capitated funding for medical education reimbursement if the Medicaid law allows this process. If educational needs were met in that market, the withhold or budget money could be distributed to the obstetrical community as determined by the local obstetrical community.

Shenandoah Valley Family Practice Residency

Andrew White, M.D., Residency Director, commented "the report clearly documents a need to ensure adequate obstetrical training for family practice and obstetrical and gynecology residents . . . Sufficient training in obstetrics is a critical part of our mission. I am therefore strongly in support of Options 3 and 4." Dr. White added that "I am confident that our residency training in obstetrics will improve by creating incentives to encourage community physicians to supervise our residents."

JOINT COMMISSION ON HEALTH CARE

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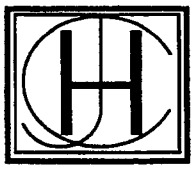

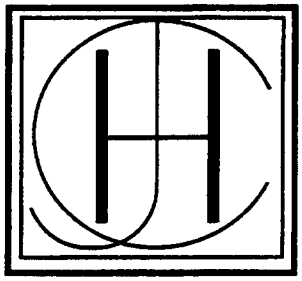

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