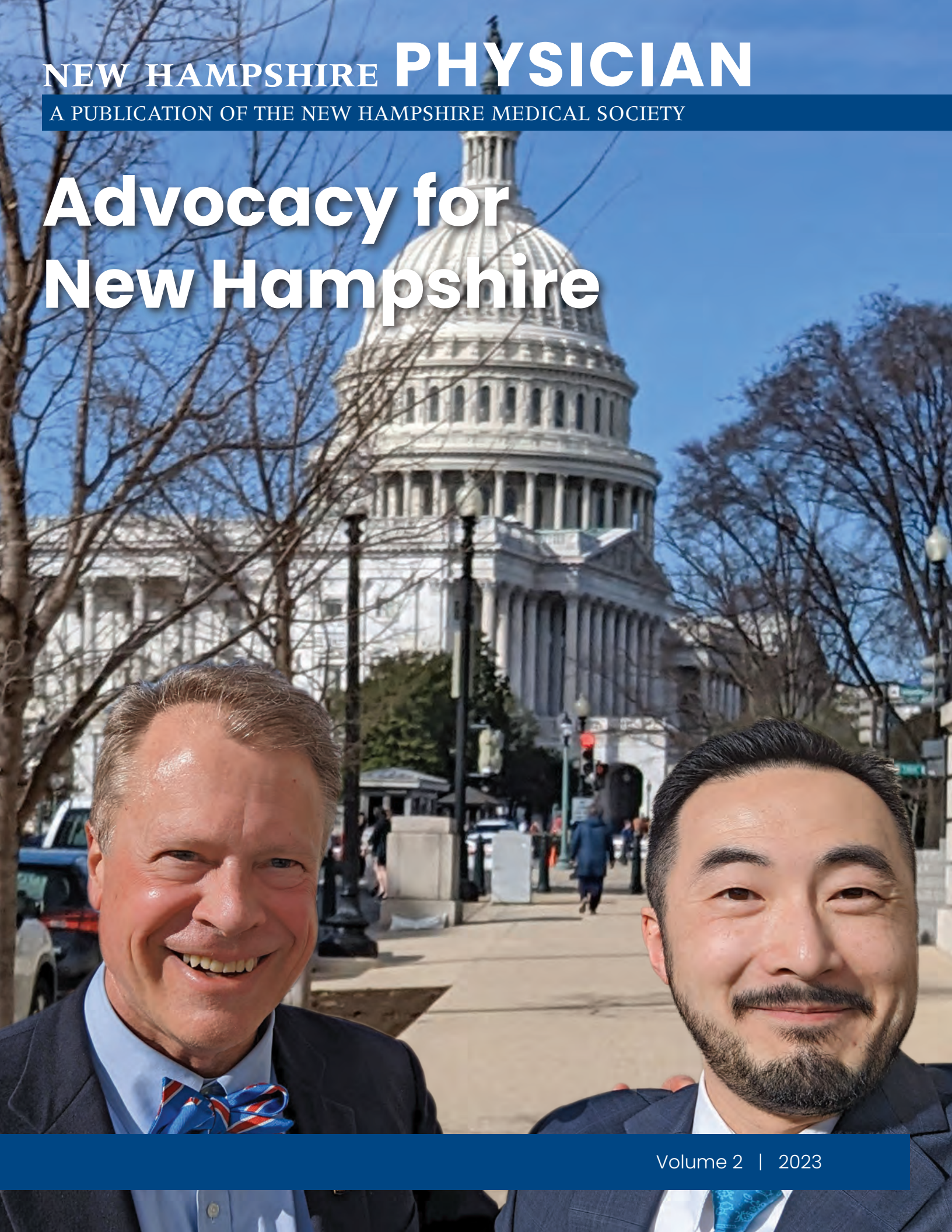
NEW HAMPSHIRE PHYSICIAN
A PUBLICATION OF THE NEW HAMPSHIRE MEDICAL SOCIETY

Advocacy for New Hampshire



Volume 2 | 2023

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Please note that NH Physician magazine is transitioning to a quarterly schedule. Look for your next issue in late August.

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Editor

Do you or a colleague need help?
The New Hampshire Professionals' Health Program (NH PHP) is here to help!
The NH PHP is a confidential resource that assists with identification, intervention, referral and case management of NH physicians, physician assistants, dentists, pharmacists, nursing licensees, veterinarians, chiropractors, dieticians, licensed drug and alcohol counselors, mental health practitioners, midwives, optometrists, podiatrists and psychologists who may be at risk for or affected by substance use disorders, behavioral/mental health conditions or other issues impacting their health and well-being. NH PHP provides recovery documentation, education, support and advocacy – from evaluation through treatment and recovery.
For a confidential consultation, please call Dr. Molly Rossignol @ (603) 491-5036 or email **mrossignol@nhphp.org**.

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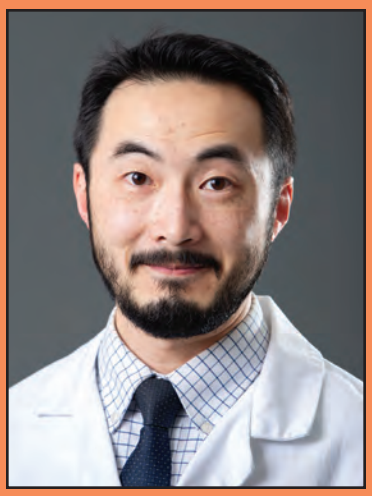


Eric Loo, MD
NHMS President

President's Perspective

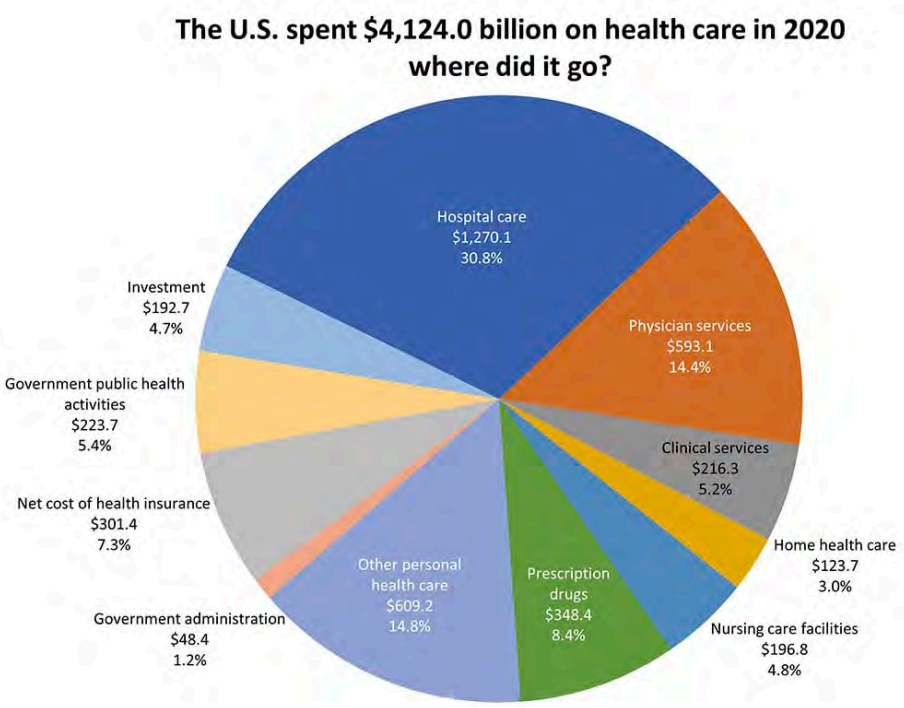
Conversations about Physician Reimbursement

Compensation and salaries are sensitive subjects to broach for everyone. For physicians, the optics around asking for fair compensation are relatively poor. The general public has no meaningful understanding of U.S. healthcare economics due to the complex and opaque bureaucracy regulating our practice environment. Physicians, being the most visible representatives of our healthcare system, have been easy targets to malign. It's not uncommon for members of the general public to think that physician salaries are a major contributor to the steep increase in healthcare costs, and to derisively view our advocacy efforts as 'one-percenters asking for even more money'.

We've consistently struggled for the last several years through last-minute stop gap measures to mitigate otherwise devastating Medicare reimbursement cuts. Momentum is building towards another legislative attempt to stabilize the Medicare physician payment system. Conversations about our reimbursement will be at the forefront again, so I decided to write this article to help frame things for you… just in case you find yourself being asked for commentary on the matter!

We have been struggling with Medicare reimbursement cuts year after year…

We have been struggling with Medicare reimbursement cuts year after year, but the physician payment system still remains on an unsustainable path that threatens patient access to our services. These cuts are in addition to two decades of stagnant payment rates. According to the AMA, when adjusted for inflation in practice costs, the value of Medicare physician pay fell 22% from 2001 – 2021. This number would have been higher if the 9.1% inflation seen in 2022 were included into their calculus. Unlike all other Medicare providers, physicians have been denied an automatic yearly inflation-based payment update.



A few years ago, Congress did deign to provide a much-needed reimbursement bump to evaluation and management (E/M) CPT codes, but this move created more instability in the medical community. Due to flawed budget neutrality rules, providers who do not utilize E/M codes in their practices have seen progressive and unwanted cuts to Medicare reimbursement, often resulting in overall losses between 10 – 20%.

Although our practices have tangibly suffered from this flawed system, we know that the reduction in reimbursement for our services has not meaningfully helped to curtail total healthcare spending. As mentioned, there are many under the false assumption that physician salaries account for a majority of healthcare expenditures. Although physicians do help direct how healthcare monies are spent, we are not the principle beneficiaries of it. A pie-chart from a recent AMA policy research perspective shows that reimbursement for physician services accounted for about $14.4% of all monies spent by the U.S. on healthcare in 2020. When you consider that about half of this typically goes towards overhead, physician net take-home pay accounts for <10% of national healthcare expenditures. This amount has stayed fairly consistent in reports from varying sources over the last several years as well. Our salaries aren't a large enough portion of total health care costs for physician reimbursement cuts to significantly curb health care spending. According to Princeton healthcare economist Uwe Reinhardt, "…doctors' net take-home pay (that is, income minus expenses) amounts to only about 10 percent of overall health care spending. So if you cut that by 10 percent in the name of cost savings, you'd only save about $26 billion. That's a drop in the ocean compared with overhead for insurance companies, billing expenses for doctors' offices, and advertising for drug companies. The real savings in health care will come from these expenses"5. Recall that $4,124 billion was spent on health care in 2020…
Medical school tuition costs in the U.S. are much greater than for overseas trainees, and many of our graduates start practice deeply in debt. Malpractice insurance rates in the U.S. are the highest in the world. We traverse mountains of administrative red tape to provide care for the infirm, and the burdens are only growing. The reality is that more cuts in the midst of high inflation, workforce shortages, and rising physician burnout will harm patient access to care. This will disproportionately impact small, independent, and rural practices, as well as those who service low-income or other marginalized patient communities. It is imperative that we advocate for fair reimbursement for our work.

With that - if you do find yourself in a conversation about physician reimbursement, I hope this provided you with some helpful perspective! ■

Reference:

1 Rama A. (2022) Policy Research Perspectives – National Health Expenditures, 2020: Spending Accelerates Due to Spike in Federal Government Expenditures Related to the COVID-19 Pandemic. American Medical Association. https://www.ama-assn.org/system/files/prp-annual-spending-2020.pdf

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3 Young A, et al. A Census of Actively Licensed Physicians in the United States, 2016. J Med Regul. 2017; 103(2): 7-21.

4 Norbeck TB. Drivers of Health Care Costs. Mo Med. 2013; 110(1): 30-34.

5 Beam, C. (2009, Sept). Let's Pay Doctor: Couldn't we fix the health care system by paying doctors less? Slate. https://slate.com/news-and-politics/2009/09/do-american-doctors-get-paid-too-much.html

NHMS Welcomes New Members

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Li Liang, MD
Sage Gale, DO
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Steven P. Beaudette, MD
Vikas Veeranna, MD
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Holly Alyssa Tuttle Schroeder, MD
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Arshi Parvez, MD
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Linda Elise Haller, MD
Christopher J. Knox, DO
Hassan Yameen, MD
Michelle S. Mancherje, MD
Andrew Yee, MD
Bonnie De Vries, MD
Dingxin Qin, MD
James E. Stahl, MD
Meghan Zimmerman, MD
Daniel Wesley Lampignano, MD
James C. Spencer, MD
Alireza Vaziri, MD
Sabrina Paganoni, MD

Have You Asked About Alcohol?

Jennifer Mazzei
NHMS Director of Marketing and Project Management

with help from Seddon Savage, MD

Alcohol use is the leading preventable cause of death in the United States, contributing to more than 140,000 deaths annually.

Alcohol consumption in the United States has steadily increased over the last decade, and the COVID-19 pandemic has only exacerbated the problem. The Centers for Disease Control and Prevention (CDC) have reported that alcohol-induced deaths have increased 30% between 2009 and 2019, with a sharp 26% increase from 2019 to 2020, the first year of the pandemic. With the increasing harm caused by alcohol, the NH Medical Society is taking action.

The NH Medical Society, with the support of a grant from the New Hampshire Department of Health and Human Services, is launching a new online alcohol resource and awareness campaign. The goal of this campaign is to increase recognition of alcohol's potential contribution to diverse health problems and to improve care for people whose alcohol use may negatively impact their health.

Alcohol use is the leading preventable cause of death in the United States, contributing to more than 140,000 deaths annually. Alcohol use can contribute to numerous health conditions, including common ones such as hypertension, sleep disturbance, cardiac arrhythmias, anxiety, and gastroesophageal reflux disorder, often in the absence of an identified alcohol use disorder. Healthcare providers can improve their patients' health by identifying and addressing unhealthy alcohol use.

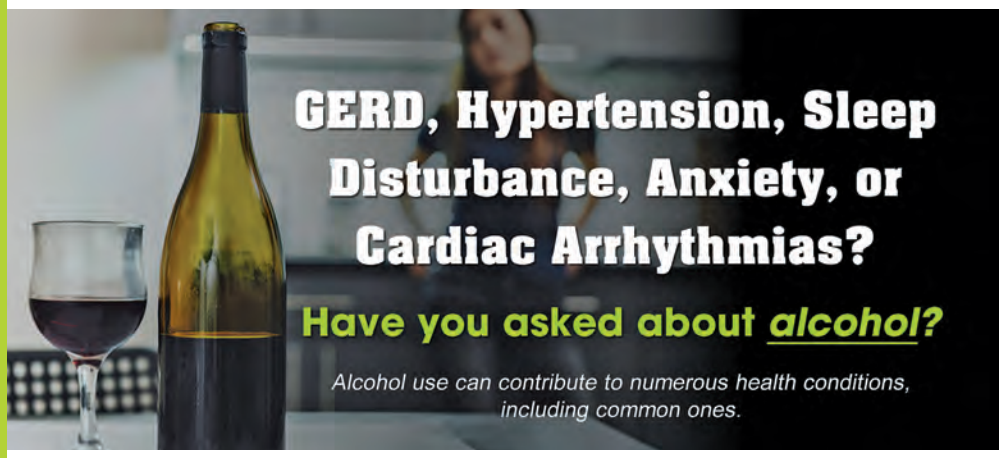
Molly Rossignol, DO, FAAFP, FASAM, Medical Director of the New Hampshire Professionals Health Program, said, "Alcohol use is associated with so many of the common medical problems we see among our patients, but we often either don't make the connection or we don't feel comfortable asking or advising our patients about alcohol use. Our hope is to change that with this campaign."

The NH Medical Society's new resource is designed for busy clinicians. It provides critical information about alcohol and its effects, resources to conduct alcohol screening and brief intervention, and information about options for evidence-based treatment when indicated. It also contains vital information for clinicians to share with patients and their families.

With this campaign, the NH Medical Society hopes to make a significant impact on bringing awareness to physicians in reducing alcohol-related harm. To learn more about the NH Medical Society's online alcohol resource and awareness campaign, visit nhms.org/alcohol-misuse.

1 Spencer MR, Curtin SC, Garnett MF. Alcohol induced death rates in the United States, 2019–2020. NCHS Data Brief, no 448. Hyattsville, MD: National Center for Health Statistics. 2022. DOI: https://dx.doi.org/10.15620/ cdc:121795. https://www.cdc.gov/nchs/data/databriefs/db448.pdf

2 Centers for Disease Control and Prevention. (2022, July 6). Deaths from excessive alcohol use in the United States. Centers for Disease Control and Prevention. Retrieved March 17, 2023, from https://www.cdc.gov/alcohol/features/excessive-alcohol-deaths.html



This campaign is financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

Biopsy Specimen

Mismanagement of biopsy specimens in the office practice setting can lead to claims of delay in diagnosis. Factors contributing to these claims are:

- **Mislabeling of the specimen(s).**
- **Failure to:**
  - Track receipt of the results.
  - Notify the patient in a timely manner of the biopsy results.
  - Provide treatment planning options, including specialty referral.
  - Document biopsy results and treatment plan.

Recommendations for improving biopsy specimen management in the office practice setting:

- **Establish a written, standardized specimen collection process.**
- **Utilize two patient-specific identifiers when performing biopsies.**
  - Request the patient state their full name and date of birth at check-in.
  - Use the same two patient identifiers to confirm the correct medical record is obtained for the patient.
  - Prepare labels with the patient-specific information and use them to identify all specimens and patient forms specific to the biopsy. Printed labels are preferred.
- **Prepare for biopsy.**
  - Prepare equipment/supplies needed for the procedure.
  - Take only the necessary biopsy tray(s) into the treatment room.
  - Label specimen containers and forms in front of the patient in the treatment room.
  - Do not pre-label specimen containers and forms.
- **Implement a double-check system that includes a "time out" for biopsies.**

In the treatment room:

  - Have patient review the labels for accuracy.
  - Have provider review the labeled requisitions and specimen containers.
  - Have provider confirm the specimen information, including the specific origin of the specimen and laterality.
  - Place the specimen containers and the requisition slips in the transport packaging provided by the pathology lab, document appropriate information on the specimen pick-up log, and place the specimen in the pick-up area for transport.
- **Track the specimen.**
  - Establish a manual or electronic system to track specimens. Establish a timeframe for receipt of result report. Reconcile results not received within this timeframe.
  - Require providers to review, initial, and date reports upon receipt.
  - Establish a process to assure the provider documents review of biopsy reports.
  - Establish a process to address STAT biopsy results.
  - Assure covering providers review biopsy results.
- **Follow-up with the patient.**
  - Notify the patient of the normal and abnormal biopsy results.
  - Document patient notification and any discussion/recommendations.
  - Schedule follow-up appointments for treatment or further testing if needed, and document.
  - Assure the patient completes any necessary follow-up or document an explanation regarding why recommended follow-up/treatment was not completed. For more information, please see Appointment Management: Missed and canceled appointments, referrals not completed.
- **Monitor for patient safety improvement opportunities.**
  - Track all specimen labeling errors.
    - Identify opportunities for improvement.
    - Implement system changes as necessary.

Medical Mutual Insurance Company of Maine's "Practice Tip" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific

Resources

WHO Collaborating Center for Patient Safety, May 2007.

The Joint Commission. (2016, April 11). Retrieved from https://www.jointcommission.org/standards/standard-faqs/home-care/national-patient-safety-goals-npsg/000001545/

Who are my patients and what am I doing to them?, https://www.qualityhealth.org/wpsc/

https://www.medicalmutual.com/risk/practice-tips/tip/appointment-management/36

Steve Ahnen
President New Hampshire Hospital Association

We've seen waves and surges of COVID-19 over the past three years that have challenged our frontline caregivers like never before.

Recognizing the 3rd Anniversary of COVID-19

March 2 marked the third anniversary of the arrival of the COVID-19 pandemic in New Hampshire. It was on that day that the first case of COVID-19 in New Hampshire was diagnosed.

And while strains of COVID have shifted and become more manageable, the challenges facing New Hampshire hospitals today remain as significant as they've ever been.

Three years ago, health care leaders had to pivot to address the COVID crisis, and they did so immediately. There was so much we didn't know about this new, novel coronavirus, COVID-19. Reports from China, Europe, and elsewhere showed that COVID-19 was exploding and could potentially overrun our health care system and its capacity to care for these very sick patients. To help ensure that hospitals would have the capacity to treat every patient who needed care, national leaders were calling for the suspension of elective procedures. Hospitals in New Hampshire and across the country paused those elective procedures in mid-March of 2020 while they simultaneously worked to expand their overall bed capacity to meet what was anticipated to be overwhelming demand.

Pausing elective procedures had significant and immediate consequences for patients and for hospitals and the health care system. For patients, it meant delays to the kinds of ongoing, routine preventive health care that allows them to remain healthy, catch diseases early in their progression and manage their chronic health conditions. For hospitals and the health care system, shutting down those elective procedures meant the loss of hundreds of millions of dollars in revenue on a monthly basis. Thankfully, Congress and state officials stepped forward to provide some financial relief and to make certain federal and state rules more efficient and effective to allow the health care system to meet the needs of the patients and communities who needed them more than ever.

We've seen waves and surges of COVID-19 over the past three years that have challenged our frontline caregivers like never before. Hospitals organized themselves through the New Hampshire Hospital Association to work with one another to support their colleagues and ensure that no one hospital would be unable to serve their patients and communities. When a hospital was in need of assistance, be that a small, rural hospital or a large, urban hospital, their colleagues were there to offer assistance to help them get through whatever challenge they faced. We were able to get through those dark and challenging days not because of what one individual or institution was able to do on their own, but because of what we were able to do working together and with our partners at the local, state and federal levels.

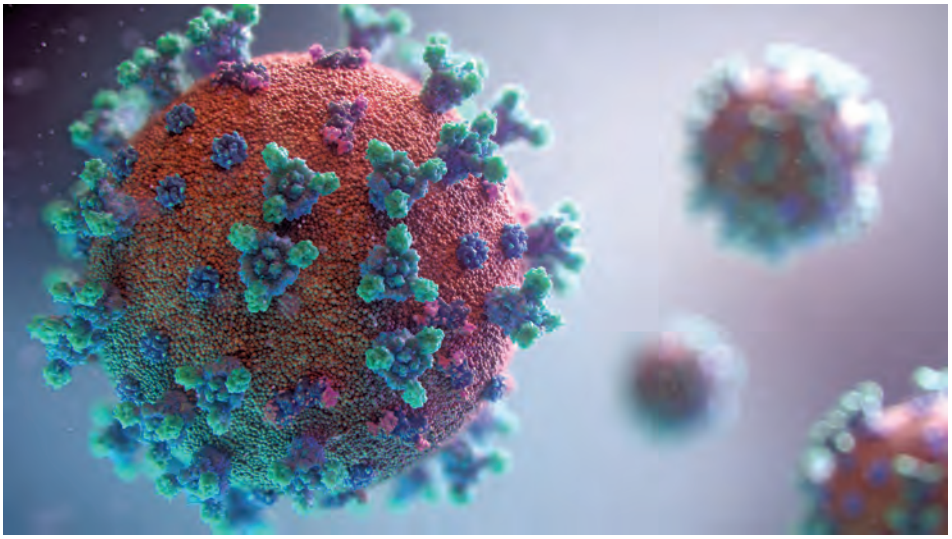
Safe and effective vaccines and therapeutics were brought to market helping to save lives, reduce suffering, and ultimately allowing us to achieve some level of normalcy in our lives. As we stand here in March of 2023, those moments from the darkest days of the pandemic seem so long ago. And while we are in a dramatically different phase of the COVID-19 pandemic today, the virus continues to claim over 400 lives each day in the United States and far too many here in New Hampshire. So, yes, we are not where we were 12, 24 or 36 months ago, but there are still many challenges that continue to confront hospitals and will for the foreseeable future as they struggle to meet the growing demand for health care amidst one of the greatest workforce challenges we have ever seen.

While difficulties in recruiting and sustaining staff are everywhere, they have been severely exacerbated in health care. Prior to the COVID-19 pandemic, hospitals across the state were seeing a roughly 9% vacancy rate for registered nurses, but that has doubled to 18%. These shortages are not just in nursing, but across the board, from licensed nursing assistants,

respiratory therapists and so many more. Working in health care is a particularly stressful environment these days, with providers and staff routinely going above and beyond to meet demand. Given the workforce shortages and heightened need for health care services, hospitals have had to turn to temporary staffing agencies to fill positions to ensure patients are able to get the care they need. As a result of the skyrocketing fees charged by staffing agencies, hospitals saw an unsustainable increase of 133% in their contract labor costs from 2021 to 2022.

Over the past several months, hospitals statewide are running at well over 90-95% capacity on any given day, and many even higher. We see this play out in many ways, but most visible to patients is in wait times across the system, most acutely in the emergency department.

Further challenging hospitals in serving their patients is the inability to discharge patients who no longer need the level of care they provide. When a patient is ready to be discharged to the next appropriate level of care, but the nursing home, skilled nursing facility or rehabilitation center is unable to admit them because they don't have enough staff to serve them, those patients remain in the hospital, taking a bed that another



acutely ill patient needs.

In health care, we are surrounded by caregivers who are committed to the patients and communities they serve. They come to work every day with one goal in mind: helping their patients get the care they need so that they can live healthy and productive lives. But there is no question that they are facing some of the most difficult challenges they have ever faced in their careers, and that is saying a lot when put into context of what we've all experienced over the past three years.

When you come to the hospital or your physician's office, please bring with you a heavy dose of patience and grace and know that your health care provider is doing everything they can to provide you with the highest quality of care because they care about you.

The blue and white H behind your community hospital is, has been, and always seeks to be there for our patients and families when they need us most. To ensure hospitals are able to do that, we will continue to need assistance, resources and new, innovative solutions. We will continue to collaborate and lean on our partnerships that have helped us get through the darkest days of the pandemic. Working together, I am convinced we can do just that.

This article was originally published in the New Hampshire Bulletin on March 1, 2023.

Advocacy for New Hampshire on the Hill

By Eric Loo, MD, NHMS President and Alan Hartford, MD, NHMS AMA Alternate Delegate

From Feb 13-15, your NH Medical Society sent a delegation of two physician representatives and two NHMS staff members to the AMA National Advocacy Conference to get updates on current hot issues and to provide advocacy on the Hill for New Hampshire physicians. We met with the offices of Representatives Kuster and Pappas, as well as with Senators Hassan and Shaheen. A summary of advocacy efforts are highlighted below.

Drs. Hartford and Loo with Emily Kane, Sen. Maggie Hassan's Legislative Correspondent

Medicare Physician Payment Reforms:

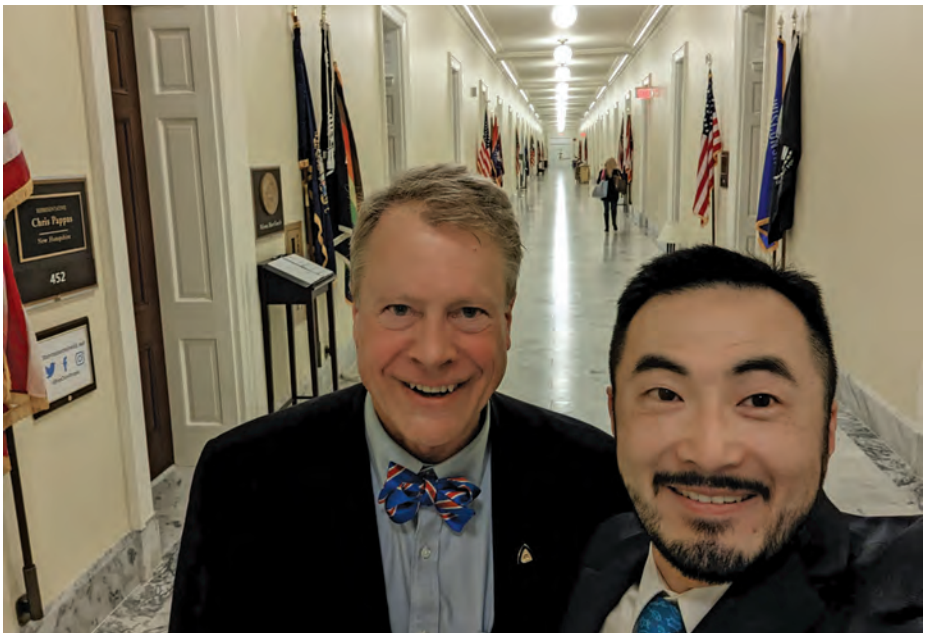
This issue touches all of us. Despite ongoing protestation by provider groups, physicians have been forced to endure a series of Medicare payment cuts the last several years, triggered by the flawed Medicare budget neutrality and congressional PAYGO rules. This is on top of lowered valuation for our services. Between 2001 and 2021, the AMA estimates that the value of Medicare physician pay fell 22% when adjusted for inflation in practice costs. Unlike all other Medicare providers, physicians do not get an automatic yearly inflation-based payment update. Rather, we have been saddled with the flawed SGR and subsequently the flawed MACRA/MIPS programs; and most have found that the actual cost of participating in the latter program outweighs any realized reimbursement benefit. We advocated for our representatives to support efforts to urgently hold hearings focused on developing long-term sustainable solutions for the Medicare physician payment system, to support legislation to provide an annual physician payment update equal to the full Medicare economic index (the index CMS uses to measure practice-cost inflation), and for prior authorization reform in the Medicare Advantage program.

Workforce Shortage Issues:

The United States is facing a shortage of between 54,100 and 139,000 physicians by 2033—numbers that will be exacerbated by rising rates of physician burnout and early retirement. Our state has an older population, and we additionally must contend with access to care issues and difficulty hiring talent in the more rural regions. We provided affirmative advocacy for three specific pieces of legislation that would help alleviate these burdens. The Resident Physician Shortage Reduction Act[1] is bipartisan legislation that would take steps to better alleviate the physician shortage by gradually providing 14,000 new Medicare-supported GME positions over seven years. These positions would be targeted to hospitals with diverse needs, including rural teaching hospitals, hospitals serving patients in health professional shortage areas, and hospitals already training over their Medicare caps. Our own Senator Hassan introduced the Opioid Workforce Act/Substance Use Disorder Workforce Act[2], which would create an additional 1,000 Medicare-supported GME positions over five years. These positions would be specifically earmarked for training in addiction medicine, addiction psychiatry, and pain management. Finally, the Conrad 30 and Physician Access Reauthorization Act[3] would reauthorize this important program for international medical graduates, creates a process for increasing the number of waivers per state, and makes targeted improvements so that rural and underserved communities continue to have access to a physician.

Telemedicine Oversight:

We reiterated the need for better Federal regulatory oversight of telemedicine as a means to improve access to care and reduce physician burdens. We have significant numbers of 'snowbirds'



in state, and difficulties in provision of continuing care to these persons during winter months remains a challenge. There was interest for looking into this; possibly with easement of licensure reciprocity across states for physician telehealth services when there is an established patient-physician relationship.■

1 https://www.congress.gov/bill/117th-congress/senate-bill/834

2 https://www.congress.gov/bill/117th-congress/house-bill/3441?s=1&r=54

3 https://www.congress.gov/bill/117th-congress/senate-bill/1810

L. to R., Dr. Alan Hartford, Vic Goetz, Legislative Asst. on Health Policy, Alison Macdonald, Chief of Staff for Sen. Shaheen, and Dr. Eric Loo

WANTED

NH Licensed Physicians to perform consultative examinations in your office for the Social Security Disability program. Perform as many, or as few exams per week, or month as you like. Disability exam training is provided, as are free dictation services and secure web portal access to transact your reports. All exam scheduling is provided by the NH DDS. No billing is required and payment is processed upon receipt of the report. You are not rendering a disability determination but providing current medical evidence for disability claim adjudication. Please contact Anne.Prehemo@ssa.gov or call (603) 271-4138 for additional information.

OR

NH Licensed physicians specializing in Internal Medicine, Neurology, Orthopedic, General or Family practice interested in providing part-time or full-time staff medical consultant services for the NH Social Security Disability program in Concord. This position requires the successful completion of a federal background check and a minimum of 24 hours of on-site SSA disability program training per week, before a successful candidate can work remotely. There is no patient contact, so insurance is not a requirement. Please contact Anne.Prehemo@ssa.gov or call (603) 271-4138 for additional information.

Meredith Milligan, MD

Comprehensive health insurance coverage is one of the most important ways to avoid these haunting questions...

What if Medicaid Expansion isn't Reauthorized?

Ask your doctor – they'll tell you.

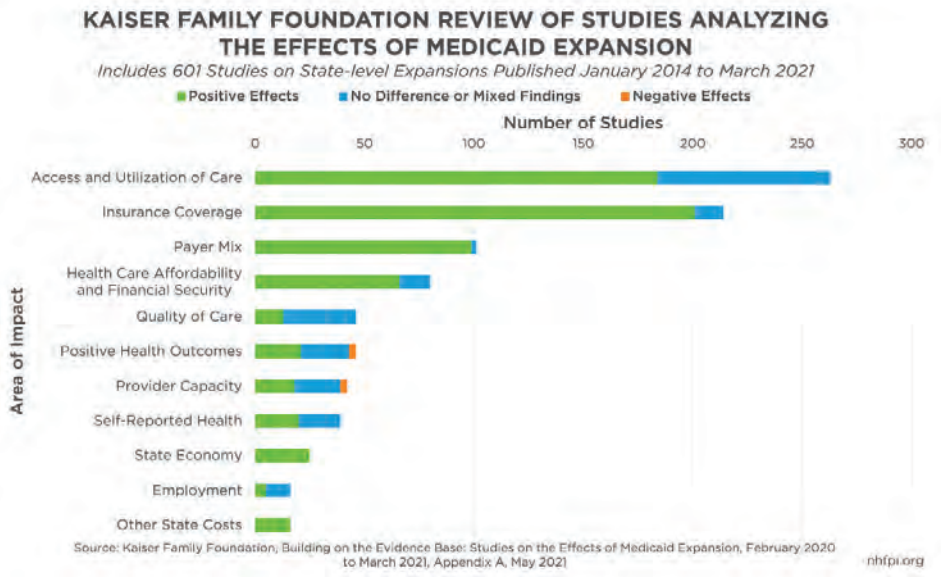
As a family physician, I often find myself wondering "What if?" What if we had made a diagnosis sooner? What if insurance had covered that medication? What if the patient had been seen for regular wellness visits instead of only when feeling sick? Comprehensive health insurance coverage is one of the most important ways to avoid these haunting questions, but right now the access of thousands of Granite Staters to Medicaid coverage is at risk.

When I first met "Mary," she was more than ten years overdue for breast cancer screening. She hadn't gone to see a doctor in many years because she didn't have insurance and couldn't afford to pay the bill. When she was finally able to enroll in an insurance plan and complete recommended screening tests, her mammogram showed a mass. She was diagnosed with breast cancer and was scheduled for surgery, with radiation and chemotherapy to follow.

When I first met "Jody," she had recently lost her job and, with it, her health insurance. She had started rationing her antidepressant medications, taking one pill every couple of days so that she wouldn't run out. Unfortunately, her medication was not effective when taken this way and, with her depression uncontrolled, it was a struggle to get out of bed, let alone find new work.

Unlike "Mary" and "Jody," when I first met "Dennis," he did have insurance, though his coverage did not include the medications he needed to manage his diabetes effectively. Without these essential drugs, his blood sugar remained high and several months later he was facing amputation due to complications of a diabetic foot wound.

Each of these patients struggled to access the medical care they needed due to lack of comprehensive health insurance. Had "Mary" been able to enroll in health insurance ten years ago, it is likely that her cancer would have been diagnosed much sooner, allowing for earlier and more effective treatment.

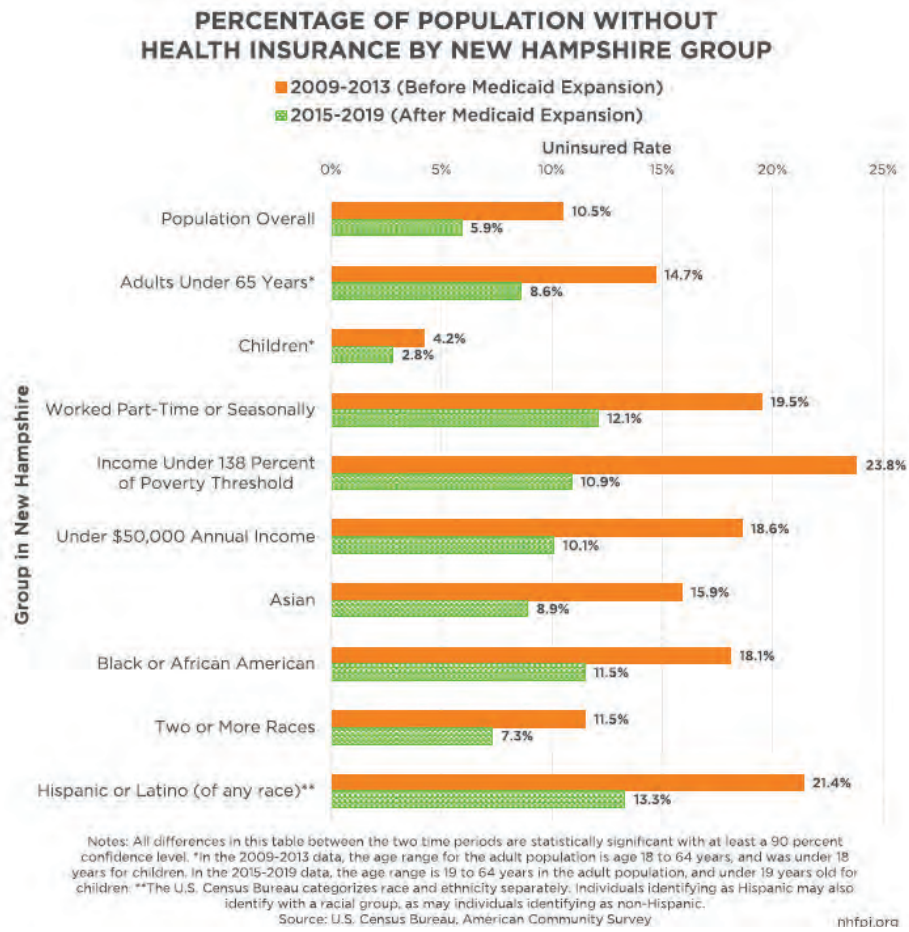


Had "Jody" remained insured without a lapse in coverage, it is far more likely that she would have continued treatment to manage her depression, increasing her chances of finding a new job when she needed one. Had "Dennis" been enrolled in an insurance plan that covered his diabetes medications, his blood sugar would have almost certainly been better controlled and it is possible that his foot infection and the resulting amputation could have been avoided.

Almost all Americans rely on health insurance coverage to access high-quality healthcare. Lack of insurance is associated with delayed diagnoses, decreased preventative health care, inadequate treatment of chronic conditions, and increased mortality, not to mention significant medical debt. In contrast, enrollment in a health insurance plan has been associated with improved health outcomes. In states that adopted Medicaid expansion following passage of the Affordable Care Act (including New Hampshire), residents are more likely to have a primary care doctor, have access to mental health and substance use disorder treatments, and report improvements in health and wellness when compared to peers in states that did not expand access to insurance. Medicaid expansion has even been linked to decreased rates of violent crime. Ultimately, our communities are healthier when our neighbors are too.

Without reauthorization by the state legislature this legislative session, Medicaid expansion in New Hampshire could expire on December 31, 2023. What would this mean for our state? It would mean that there would be an estimated 90,000 more Granite Staters (equivalent to roughly the entire population of Nashua) just like "Mary," "Jody," and "Dennis." It would mean that more people with cancer would face delayed diagnoses. It would mean that more people with mental health concerns would go untreated. It would mean that more people with diabetes would suffer from the long-term complications of high blood sugars. It would also mean that our healthcare system, which is already overwhelmed and understaffed, would face even more pressure trying to care for patients who are sicker, waiting in the packed waiting rooms of hospitals that already don't have any available beds. How can our lawmakers help? Step one is to reauthorize Medicaid expansion to ensure that all Granite Staters have access to the healthcare that they need when they need it. Take it from a primary care doctor - our healthcare system can't handle one more "what if." ■

Meredith Milligan MD is a practicing family physician, preventive medicine resident, and MPH candidate who resides in Concord, NH. The views expressed above are her own and do not represent those of her employer or any academic affiliates.



NEW HAMPSHIRE MEDICAID EXPANSION ENROLLEES BY COUNTY

Number and Percentage of County Population Age 19 to 64 Years
Enrollment as of June 30, 2022

County	Enrollees	Percent of Population
Belknap	5,157	14.5%
Carroll	3,734	13.8%
Cheshire	5,684	12.3%
Coos	3,080	16.5%
Grafton	5,973	10.9%
Hillsborough	28,375	10.9%
Merrimack	10,108	10.9%
Rockingham	14,264	7.5%
Strafford	8,540	10.3%
Sullivan	3,446	13.6%
Grand Total	88,361	10.6%

Source: New Hampshire Joint Legislative Fiscal Committee, Fiscal Item FIS 22-375, from the Department of Health and Human Services, Analysis from EBI with Data as of September 7, 2022

nhfpi.org

By Oge Young, MD

Members' Corner includes selections focusing on personal and professional issues impacting doctors in New Hampshire - a forum for sharing the "voices" of NHMS members. We also encourage "Letters to the Editor," responding to articles published in prior editions. Please submit articles for our Members' Corner to mary.west@nhms.org

Members' Corner

Opinion: Why are we criminalizing obstetricians?

In late February, the NH House Judiciary Committee listened to testimony regarding HB 224 which would repeal the criminal and civil penalties of the fetal life protection act.

This "24-week ban on abortion" passed as an amendment to HB 2, the state budget. Presently, a physician can be incarcerated for up to seven years and fined up to $100,000 if he or she is found to have terminated (delivered) a pregnancy at 24 weeks or more.

It should be made clear that without this law, there never have been elective abortions of healthy pregnancies at 24 weeks or more in our state. There are three uncommon, but not rare tragic circumstances, where pregnancies are terminated (delivered) at 24 weeks or later.

The first is when a baby dies late in pregnancy. In these cases, women are offered induction of labor rather than carrying the dead baby for weeks while awaiting spontaneous labor. Prolonging a pregnancy with an intrauterine fetal demise can be associated with a maternal coagulation disorder that threatens a mother's life.

A second circumstance where we offer pregnancy termination after 24 weeks or later is when there is a fetal diagnosis of an abnormality incompatible with life. By ultrasound, we can identify a baby without a brain (anencephaly) or without kidneys (Potters syndrome) or a fatal bone malformation (skeletal dyslasia). Most women make the decision to induce labor and deliver their baby before he or she dies so that they can hold their live newborn for the few hours or days it lives.

The third situation is when we deliver a baby prematurely because of a complication threatening the baby and/or mother's life. Severe hypertension (pre-eclampsia), hemorrhage (placenta previa and abruption), or overwhelming infection (chorioamnionitis) are examples of these complications warranting an early delivery.

I cared for a woman and her husband (a physician) whose three pregnancies were all complicated by severe hypertension at 25-26 weeks, a very unusual case of recurrent early pre-eclampsia. She survived, but her first two babies died of complications of prematurity. Her third baby survived, but has developed cerebral palsy, a common complication of prematurity.

The decision to deliver a pregnancy early is often extremely difficult for an obstetrician and deeply personal for a woman. Given the complexities of some late 2nd trimester and early 3rd trimester pregnancies, criminalizing a physician for the delivery of a premature baby is unjust. This decision should never have to weigh the threat of incarceration.

These penalties jeopardize the recruitment of obstetricians to New Hampshire, where there is a scarcity of maternity care in the North Country. In particular, the criminal and civil penalties of the fetal protection act will deter maternal-fetal medicine specialists (those doctors who care for high-risk pregnancies) from practicing here. Two of our five maternal-fetal specialists in this state are retiring this year.

I strongly urge our legislators to pass and our governor to sign HB 224, repealing the criminal and civil penalties of New Hampshire's fetal life protection act. Please make your feelings known to your legislators and our governor. ■

2023 NHMS GOLF TOURNAMENT

Concord Country Club
June 19,2023

Registration: 8:00 am
Shotgun Start: 9:00 am

REGISTER

Tickets are available for cash purchase at check-in for mulligans and the 50/50 raffle.

Enjoy a scramble style golf tournament with your fellow Granite State physicians at one of NH's best golf courses. Join us for breakfast, lunch, and 18 holes of fun! All abilities welcomed! Register as an individual or a team.

Register today at NHMS.org!

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The New Hampshire Medical Society envisions a State in which personal and public health are high priorities, all people have access to quality healthcare, and physicians experience deep satisfaction in the practice of medicine.

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