Medicaid Redesign Team
Medical Malpractice Work Group

October 17, 2011

Working together to build a more affordable, cost-effective Medicaid program
Opening Remarks

Ken Raske, Co-Chair
Joseph Belluck, Co-Chair
Review the cost of malpractice coverage, including identification of significant cost drivers of coverage and review the available data, insurance and otherwise, about the costs of malpractice. Develop recommendations to:

- Reduce the cost of coverage for providers,
- Improve health care quality and patient safety,
- Control the costs of health care for the State’s Medicaid program and other participants in the delivery system.
Scheduled Meetings

- **October 17 - NYC**
  - System Costs of Medical Malpractice coverage and Adverse Outcomes and their effects on providers, the State’s Medicaid Program and Health Care Delivery; The impact of practices being undertaken to reduce the number of Adverse Events.

- **October 27 - Albany**
  - Tort System and Insurance discussions

- **November 9 - NYC**
  - Procedural and Systematic Proposals and Recommendations
Medical Malpractice Work Group Members
Medical Malpractice Work Group Members

- Arthur Fougner, Physician; MSSNY Governing Council Diagnostic Ultrasound and Fetal Evaluation, Long Island Jewish Medical Center; Queens Hospital Center

- Hon. Douglas McKeon, Administrative Judge Supreme Court of the State of NY - Appellate Term, First Department

- Edward Amsler, Vice President, MLMIC

- Joel Glass, FOJP / HIC Saretsky, Katz, Dranoff, & Glass, L.L.P.

- Lee Goldman, Physician; Dean of the Faculties of Health Sciences and Medicine and Executive Vice President for Health and Biomedical Sciences, Columbia University College of Physicians and Surgeons
Medical Malpractice Work Group Members

- Fred Hyde, Consultant, Attorney and Clinical Professor of Health Policy and Management, Mailman School of Public Health, Columbia University Fred Hyde Associates

- Christopher Meyer, Vice President, External Affairs Consumer Union

- Nicholas Papain, Partner Sullivan, Papain, Block, McGrath, & Cannavo, P.C.

- Matthew Gaier, Partner Kramer, Dillof, Livingston, & Moore

- John Bonina, Jr, Partner, Bonina & Bonina, P.C.
Medicaid Redesign Team Overview
Medicaid Redesign Undertaken in a Phased Approach

- **Phase I**
  - Initial MRT recommendations passed in 2011-12 Budget
  - Implementation underway

- **Phase II**
  - 10 Work Groups convened to make further recommendations
Medicaid Redesign Team Members
MRT Members

- **Co-chair:**
  - Michael Dowling
- **Co-chair:**
  - Dennis Rivera
- Kenneth E. Raske
- George Gresham
- Dan Sisto
- Frank Branchini
- Eli Feldman
- Carol Raphael
- Linda Gibbs
- Ed Matthews
- Commissioner Nirav R. Shah
MRT Members

- Mike Hogan
- James Introne
- Arlene Gonzalez-Sanchez
- Lara Kassel
- Stephen J. Acquario
- Ann F. Monroe
- Steve Berger
- William Streck

- Elizabeth Swain
- Senator Kemp Hannon
- Senator Tom Duane
- Assemblyman Richard N. Gottfried
- Assemblyman Joseph Giglio
Members

- Joseph W. Belluck
- Courtney E. Burke
- William Ebenstein
- Tina Gerardi
- Robert J. Hughes
- Wade Norwood
- Chandler Ralph
- Harvey Rosenthal
Phase I
Implementation Update
DOH, in concert with other state agencies, is currently implementing the 78 Phase 1 MRT proposals that were approved in the budget.

Implementing Phase 1 proposals is a huge challenge for New York State.
MRT Phase 1: Bottom Line

- Reduces Medicaid spending by $2.2 billion in FY 2011-12.
- Enacts a series of measures to both control costs in short-term and enact longer-term reforms.
- Caps Medicaid spending growth in state law.
- Begins three-year phase-in to care management for all.
- The MRT is making a real difference.
## Phase 1 MRT Proposals Implementation Status

<table>
<thead>
<tr>
<th>Status</th>
<th># of Proposals</th>
<th>Original Projected Savings ($M)</th>
<th>Current Projected Savings ($M)</th>
<th>Current Achieved Savings ($M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed (all elements of proposal are completed)</td>
<td>16</td>
<td>(175.71)</td>
<td>(195.67)</td>
<td>(195.67)</td>
</tr>
<tr>
<td>Substantively Completed (key elements of proposal including those associated with savings are completed)</td>
<td>10</td>
<td>(337.5)</td>
<td>(288.21)</td>
<td>(288.21)</td>
</tr>
<tr>
<td>In Progress (elements of proposal have been initiated and are in progress)</td>
<td>48</td>
<td>(747.13)</td>
<td>(750.76)</td>
<td>(112.47)</td>
</tr>
<tr>
<td>Merged with other (certain proposals were merged to ensure better project management)</td>
<td>3</td>
<td>(0.0)</td>
<td>(0.0)</td>
<td>(0.0)</td>
</tr>
<tr>
<td>Cancelled (unable to be implemented)</td>
<td>1</td>
<td>(0.0)</td>
<td>(0.0)</td>
<td>(0.0)</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>78</strong></td>
<td><strong>(1,260.34)</strong></td>
<td><strong>(1,234.64)</strong></td>
<td><strong>(596.35)</strong></td>
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</table>
2011-12 Medicaid Global Cap Update
The Budget set a Global State Medicaid (DOH) spending cap of $15.3 billion in 2011-12 and $15.9 billion in 2012-13.

The Global cap is consistent with the Governor’s goal to limit total Medicaid spending growth to no greater than the rate for long-term medical component of CPI (currently at 4%).

DOH and DOB will closely monitor and report on program spending on a monthly basis to determine if spending growth is expected to exceed the Global cap.
## 2011-12 Enacted Budget Savings

As part of the 2011-12 Budget agreement, $2.2 billion in State savings (growing to $3.3 billion in 2012-13) must be achieved so that spending is in line with the projected cap:

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2012-13</th>
<th>Two-Year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRT Savings*</td>
<td>$973</td>
<td>$1,130</td>
<td>$2,103</td>
</tr>
<tr>
<td>Trend Factors</td>
<td>$185</td>
<td>$304</td>
<td>$489</td>
</tr>
<tr>
<td>2% ATB Reduction</td>
<td>$345</td>
<td>$357</td>
<td>$702</td>
</tr>
<tr>
<td>Industry-led Contribution**</td>
<td>$640</td>
<td>$1,525</td>
<td>$2,165</td>
</tr>
<tr>
<td>Acceleration of Payments</td>
<td>$66</td>
<td>$0</td>
<td>$66</td>
</tr>
<tr>
<td>**Total *</td>
<td>$2,209</td>
<td>$3,316</td>
<td>$5,525</td>
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</table>

*There were 78 discrete Medicaid Redesign Team (MRT) savings actions endorsed by the Legislature that will achieve $973 million in savings in 2011-12 and $1.13 billion in savings in 2012-13. Please see [http://www.health.state.ny.us/health_care/medicaid/redesign](http://www.health.state.ny.us/health_care/medicaid/redesign) for more information on these savings items.

** The Industry Led contributions ($640 million in 2011-12; $1.5 billion in 2012-13) represent the total amount of additional savings/system efficiencies that may be required (without additional State/Legislative action) to achieve fiscal neutrality under the cap.
Spending is $172.9M below the target (2.5%) through August:

<table>
<thead>
<tr>
<th>Category of Service</th>
<th>Medicaid Spending (Thousands)</th>
<th>Estimated</th>
<th>Actual</th>
<th>Variance</th>
<th>% of Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td></td>
<td>$910,346</td>
<td>$900,933</td>
<td>($9,413)</td>
<td>(1.0%)</td>
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<tr>
<td>Outpatient/Emergency Room</td>
<td></td>
<td>$167,357</td>
<td>$145,551</td>
<td>($21,806)</td>
<td>(13.0%)</td>
</tr>
<tr>
<td>Clinic</td>
<td></td>
<td>$179,313</td>
<td>$180,701</td>
<td>$1,388</td>
<td>0.8%</td>
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<tr>
<td>Nursing Homes</td>
<td></td>
<td>$1,422,974</td>
<td>$1,402,942</td>
<td>($20,032)</td>
<td>(1.4%)</td>
</tr>
<tr>
<td>Other Long Term Care</td>
<td></td>
<td>$843,360</td>
<td>$823,176</td>
<td>($20,185)</td>
<td>(2.4%)</td>
</tr>
<tr>
<td>Medicaid Managed Care</td>
<td></td>
<td>$1,421,378</td>
<td>$1,437,784</td>
<td>$16,405</td>
<td>1.2%</td>
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<tr>
<td>Family Health Plus</td>
<td></td>
<td>$277,573</td>
<td>$301,991</td>
<td>$24,418</td>
<td>8.8%</td>
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<tr>
<td>Non-Institutional / Other</td>
<td></td>
<td>$1,900,100</td>
<td>$1,736,690</td>
<td>($163,411)</td>
<td>(8.6%)</td>
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<tr>
<td>Cash Audits</td>
<td></td>
<td>($151,920)</td>
<td>($132,185)</td>
<td>$19,736</td>
<td>13.0%</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>$6,970,482</td>
<td>$6,797,581</td>
<td>($172,900)</td>
<td>(2.5%)</td>
</tr>
</tbody>
</table>
Phase II
Update and Discussion
In Phase II, the MRT was directed to create a coordinated plan to ensure that the program can function within a multi-year spending limit and improve program quality.

The MRT has been subdivided into ten work groups, with specific charges.

Work groups are co-chaired by MRT members and membership is made up of non-MRT members, involving more stakeholders in the MRT process.
Phase II: MRT Work Groups

The Work Groups:

- Managed Long Term Care Implementation and Waiver Redesign
- Behavioral Health Reform
- Program Streamlining and State/Local Responsibilities
- Payment Reform/Quality Measurement
- Basic Benefit Review
- Health Disparities
- Affordable Housing
- Medical Malpractice
- Workforce Flexibility/Change of Scope of Practice
- Health Systems Redesign: Brooklyn (reports directly to Commissioner Shah)
Phase II MRT Public Participation: Work Group Meetings

- Web sites have been created for each of the 10 Work Groups formed.
- Members of the public are invited to listen-in to work group meetings through a conference call.
- All meeting materials are posted to work group web sites.
- Meeting audio and minutes are posted within a few days after each meeting.
Phase II: MRT Work Group Process

- Each work group will meet at least three times and submit a final package of recommendations to the MRT for consideration.
- The MRT will review recommendations and vote on whether to include work group recommendations in final report to Governor Cuomo.
- Work groups submit final recommendations in a phased process – beginning in mid-October, and ending by early December.
- Recommendations will be posted to work group website, and circulated to MRT members.
Phase II: MRT Work Group Process

- MRT members will have opportunity to review work group recommendations and provide comments to work group co-chairs/lead staff.
- Revised work group recommendations will be presented and voted on at full MRT meeting.
- Final package of approved recommendations will be included in final MRT report to Governor Cuomo.
Phase II: MRT Work Group Process

November 1: MRT Meeting (NYC):
- Program Streamlining and State/Local Responsibilities
- Managed Long Term Care Implementation and Waiver Redesign
- Behavioral Health Reform
- Health Disparities

December 13: MRT Meeting (Albany):
- Basic Benefit Review
- Payment Reform and Quality Measurement
- Workforce Flexibility and Change of Scope of Practice
- Affordable Housing
- Medical Malpractice Reform
Phase II: MRT Work Group Process

December 31:
- Final MRT Report, consisting of approved work group recommendations, submitted to Governor Cuomo.

Mid-January 2012:
- Governor Cuomo’s Executive Budget Release.

Spring 2012:
- MRT Update Meeting.
MRT Final Product

- A summary of Phase 1 reforms and the approved recommendations of the ten work groups.
- This combined product will establish a comprehensive action plan for true Medicaid reform in New York State.
- The action plan may be turned into a comprehensive 1115 waiver to ensure that the state has sufficient flexibility to enact all of the reforms.
- The plan will be the most significant overhaul of the New York State Medicaid program since its inception.
Medicaid Redesign Team and Medical Malpractice
• Medical Malpractice premiums
  • OB physician premium downstate between $146,000- $200,000 and upstate between $53,000- $132,000,
  • On average, medical malpractice expense is 3-4% of a hospital budget.

• Premium Rates
  • Some reports of growth in premiums at 15-18% annually/Insurance Department approved growth at  5% on average for regulated carriers and 9.9% for MMIC.

• Obstetrical service drive increases in payouts
  • Claims and payout growth over last 5 years have not increased markedly, except average payouts in OB have.

• Limited number of underwriters of medical malpractice
  • No significant new entries into the market but some entries lately
  • Captives and Risk Retention groups created
Hospitals spend an estimated $1.6 B on medical malpractice expense (3% of operating expenses)

An estimated 35-50% of medical malpractice premium is attributed to obstetrical cases
- Of claims filed, OB accounts for 18% of frequency of claims but account for 23% of the severity ($) of claims

Medicaid pays for over 50% of the births in the State; higher in NYC
Medical Malpractice Reform

Enacted State Budget
2011-2012
Components of Enacted Legislation

- Medical Indemnity Fund (MIF) for birth related neurologically impaired infants that have received a settlement or jury award
- Hospital Quality Initiative with an obstetrical safety workgroup
- Hospital Quality contribution for the MIF and the initiative
- County incentives for Medicaid lien recovery
- Mandatory court settlement conferences for malpractice cases
Eligibility

- Children who have been found by a jury or court to have sustained a birth related neurological injury as a result of medical malpractice or have settled a claim or lawsuit based on a birth related neurological injury allegedly caused by medical malpractice.

- Application can be made by child’s parent or defendant.

- Applies to all cases settled or decided after April 1, 2011.
Administered by the Department of Financial Services (DFS); became operative on October 1, 2011. Emergency regulations were developed by DOH and DFS with feedback from a consumer advisory group and have been promulgated.

The Fund pays for future “qualifying health care costs,” including:
- Expenses for medical, hospital, surgical, nursing, dental, rehabilitation, and custodial care,
- Durable medical equipment,
- Home modifications, assistive technology, vehicle modifications,
- Prescription and non-prescription medications and
- Other health care costs for services rendered to and supplies utilized by qualified plaintiffs that are medically necessary as determined by their treating physicians, physician assistants or nurse practitioners.

Qualifying health care costs are those not covered by a collateral source other than Medicare or Medicaid.
Monies of the Fund will be held by the Commissioner of Taxation and Finance and kept separate from all other accounts and cannot be co-mingled.

Reimbursement from the Fund will be released only upon signed certification by the Superintendent of Financial Services.

Funding of $30 m for fiscal year 2011-2012.

Annual actuarial calculation: if liabilities are 80% or more of fund assets, enrollment will be suspended until new contributions are received.

- Notification is required when Fund enrollment is suspended or reinstated.
Hospital Quality Initiative

- Will oversee general dissemination of initiatives, guidance and best practices to hospitals, including:
  - Building cultures of patient safety
  - Initiating evidence based care in targeted areas

- Comprised of stakeholders chosen by the Commissioner
  - Medical, hospital, academic and other experts
  - Will include academic evaluation component to assist with development of metrics and evaluation
Hospital Quality Initiative

- Initiative will include an obstetrical patient safety workgroup

- Charged with improving outcomes and quality. Possible initiatives include:
  - Reviewing current best practices and exploring the use of “virtual grand rounds” to disseminate the results;
  - Reviewing medical malpractice claims to develop a standard set of best practices for New York State deliveries;
  - Using regional perinatal center network to assist in keeping smaller hospitals informed;
  - Making recommendations to Commissioner regarding best practice standards and new programs

- Workgroup’s efforts will include an academic evaluation component focused on outcome metrics
Beginning July 2011, a quality contribution equal to 1.6% of inpatient obstetrical revenue will be collected and deposited in the HCRA resources account.

- If this percentage does not achieve the required amount (see below), adjustments to the percentage can be made.

For the State Fiscal Year beginning April 1, 2011, the Hospital Quality Contribution shall equal $30m.

Annually thereafter, the requisite amount will be increased by the ten year rolling medical CPI.
The Court will hold mandatory settlement conferences for dental, podiatric and medical malpractice actions within:
- 45 days from the filing of a note of issue and certificate of readiness; or
- 45 days from a denial of motion if a party moves to vacate the note of issue

Persons authorized to act on behalf of a party to the case will be permitted to attend a settlement conference; the only attorneys permitted to attend will be those familiar with and authorized to settle the case.

The court may also require other interested parties in the case to attend

Chief Judge to adopt rules for implementation.

Effective 90 days from April 1, 2011
Commissioner authorized to approve a social services demonstration program to improve collections

- Based on evaluated results and certification by Budget, Commissioner may share 10% of savings with social service districts

Notice of the commencement of a personal injury act by a Medicaid recipient shall be sent to the local social services district in which the recipient resides or the DOH within sixty days of completion of service

- Proof of sending notice will be filed with Court.