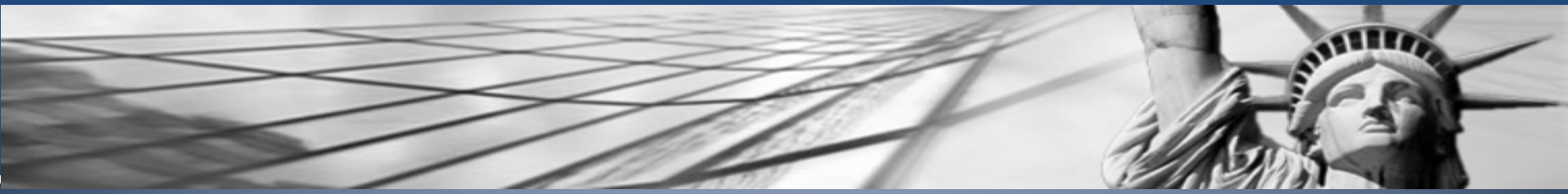
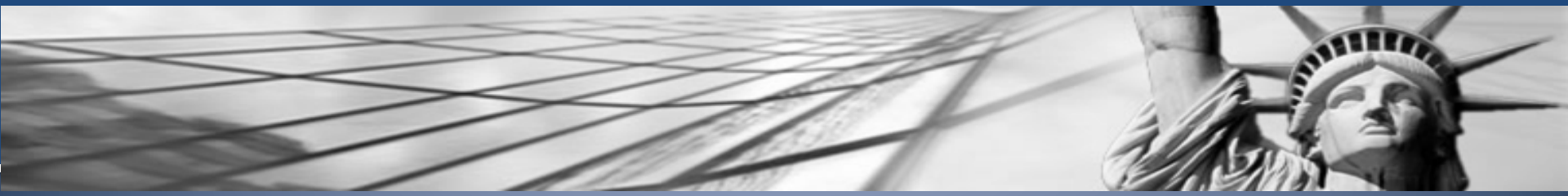


Medicaid Redesign Team
Medical Malpractice Work Group

October 17, 2011

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



Opening Remarks

Ken Raske, Co-Chair

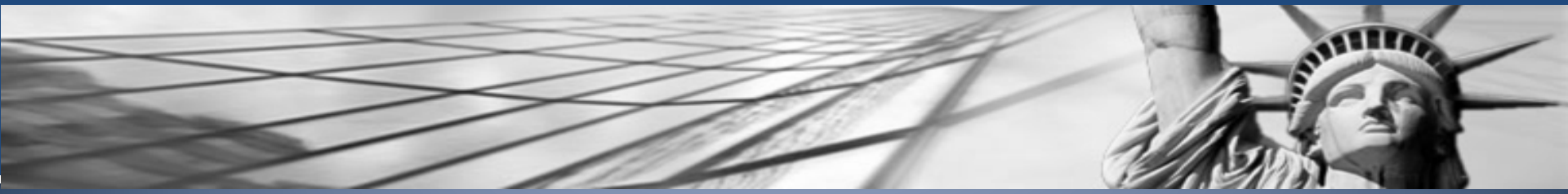
Joseph Belluck, Co-Chair

Work Group Charge

- 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

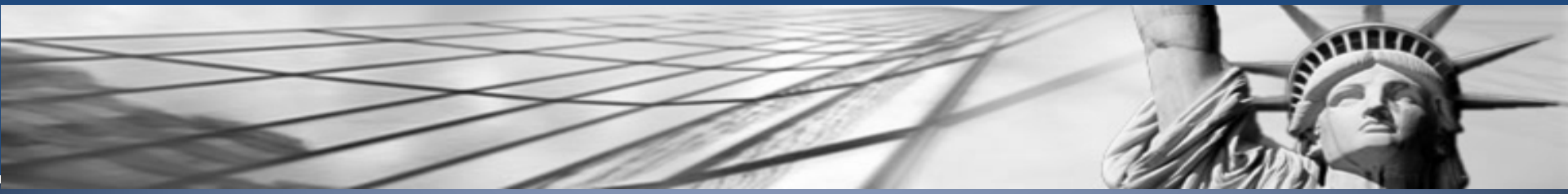
- **Co-chair:**
  Michael Dowling
- **Co-chair:**
  Dennis Rivera
- Kenneth E. Raske
- George Gresham
- Dan Sisto
- Frank Branchini
- Eli Feldman
- Carol Raphael
- Linda Gibbs
- Ed Matthews
- Commissioner Nirav R. Shah

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

MRT Implementation Process

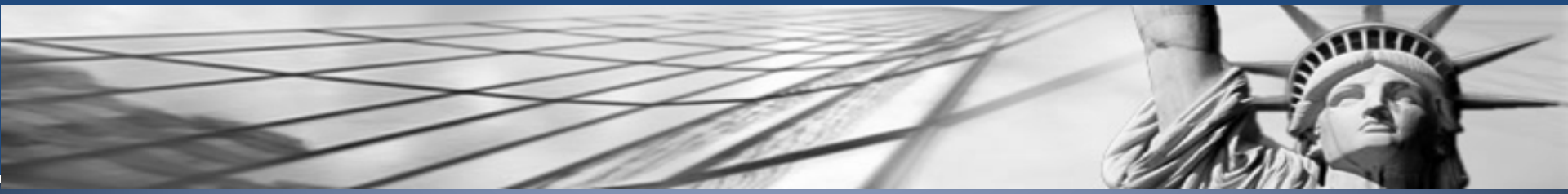
- ☑ DOH, in concert with other state agencies, is currently implementing the 78 Phase 1 MRT proposals that were approved in the budget.
- ☑ Implementing Phase 1 proposals is a huge challenge for New York State.

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

Status	*# of Proposals*	*Original Projected Savings ($M)*	*Current Projected Savings ($M)*	*Current Achieved Savings ($M)*
Completed *(all elements of proposal are completed)*	16	(175.71)	(195.67)	(195.67)
Substantively Completed *(key elements of proposal including those associated with savings are completed)*	10	(337.5)	(288.21)	(288.21)
In Progress *(elements of proposal have been initiated and are in progress)*	48	(747.13)	(750.76)	(112.47)
Merged with other *(certain proposals were merged to ensure better project management)*	3	(0.0)	(0.0)	(0.0)
Cancelled *(unable to be implemented)*	1	(0.0)	(0.0)	(0.0)
TOTAL	78	(1,260.34)	(1,234.64)	(596.35)



2011-12 Medicaid Global Cap Update

Background

- 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:

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

***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 for more information on these savings items.**

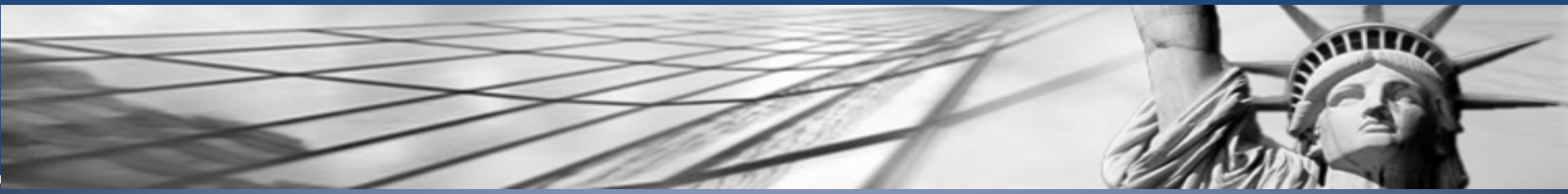
****** The Industry Led contributions ($640 million in 2011-12; $1.5 billion in 2012-13) represent the total amount of additional savings/system efficiencies that may be required (without additional State/Legislative action) to achieve fiscal neutrality under the cap.**

Medicaid Enrollment

Global Cap Spending Results

Spending is $172.9M below the target (2.5%) through August:

AUGUST SFY 2011-12 Statistics				
Category of Service	Medicaid Spending (Thousands)			
	Estimated	Actual	Variance	% of Variance
Inpatient	$910,346	$900,933	($9,413)	(1.0%)
Outpatient/Emergency Room	$167,357	$145,551	($21,806)	(13.0%)
Clinic	$179,313	$180,701	$1,388	0.8%
Nursing Homes	$1,422,974	$1,402,942	($20,032)	(1.4%)
Other Long Term Care	$843,360	$823,176	($20,185)	(2.4%)
Medicaid Managed Care	$1,421,378	$1,437,784	$16,405	1.2%
Family Health Plus	$277,573	$301,991	$24,418	8.8%
Non-Institutional / Other	$1,900,100	$1,736,690	($163,411)	(8.6%)
Cash Audits	($151,920)	($132,185)	$19,736	13.0%
TOTAL	**$6,970,482**	**$6,797,581**	**($172,900)**	**(2.5%)**



Phase II
Update and Discussion

Phase II: MRT Work Groups

- 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:

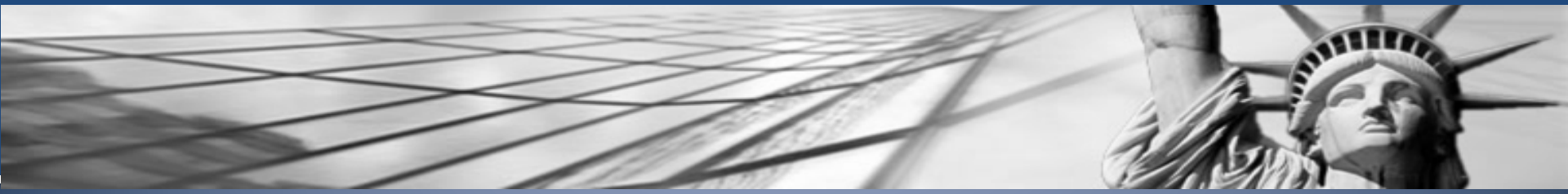
- *Governor Cuomo's Executive Budget Release.*

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

New York Healthcare Liability System Landscape

- **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

Malpractice Liability and Medicaid

- 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

Medical Indemnity Fund

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.

Medical Indemnity Fund

- 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.

Medical Indemnity Fund

- Monies of the Fund will 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

Hospital Quality Contribution

- 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.

Settlement Conferences

- 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

Medicaid lien collection

- 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.