Medical Malpractice Medicaid Redesign Team Work Group Meeting Summary

October 17, 11:30 AM – 4:30 PM
NYC - NYS Department of Health Metropolitan Area Regional Office
90 Church Street, 4th Floor, Conference Room A/B, Manhattan

Co-chairs, Joseph Belluck and Kenneth Raske, welcomed the group and made introductions.

The charge to the work group and an overview of the MRT process was presented by Lora Lefebvre, New York State Department of Health (DOH).

The work group's charge is as follows:

- **to review the cost of malpractice coverage, including the identification of significant cost drivers of coverage;**
- **to review the available data (insurance and other relevant data); and**
- **to develop recommendations to reduce the cost.**

Presentations on 2011 Medical Malpractice Initiatives were given by Lora Lefevbre on the implementation of the New York State Medical Indemnity Fund and the Agency for Healthcare Research and Quality Grant to the Unified Court System by Susan Senecal, Director, NYS Medical Liability Reform and Patient Safety Demonstration Project.

The following speakers gave presentations on the topic, "The Cost of Medical Coverage for Hospitals and Physicians in New York State, and the Impact of These Costs on Providers, the State's Medicaid Program, and the Delivery of Health Care, followed by a question and answer period after each presentation.

- **Geoff Taylor, Senior Vice President for Corporate Communications and Public Policy, Excellus BlueCross Blue Shield:** Mr. Taylor reviewed Excellus's study of malpractice premiums in NYS that showed variations as much as 300% between the lowest cost region and the highest cost region. A comparison of NYS premiums to other states' premiums in three specialty areas in 2010 revealed that NYS was in the top 10 highest in every category and second only to Florida in rates for obstetrics and gynecology.
- **Donald Fager, Vice President and Assistant Secretary, Medical Liability Mutual Insurance Company (MLMIC):** Mr. Fager gave an overview of the history and process for establishing malpractice premium rates in New York State. MLMIC's rates are based on specialty and geographic territory. While claims frequency is down, claims severity is up. MLMIC's financial health is better than it was (greater surplus than at times in recent past), but he is not comfortable with its status.
- **Susan Waltman, Executive Vice President and General Counsel, Greater New York Hospital Association:** Ms. Waltman's presentation focused on hospital medical malpractice coverage costs, the causes of high costs, and the impact of these costs, and hospitals' efforts to improve patient safety and reduce malpractice costs. Her data mirrored MLMIC's data-the frequency of claims has dropped but the severity (in terms of cost) of claims has increased. Because of NYS's high rates, ercial coverage is really not available/affordable for NYS hospitals except at the initial level. Ms. Waltman also referred to studies that the overhead costs of the tort system to be high (over 50%).

- **Michelle Mello, Professor of Law and Public Health, Harvard School of Public Health:** Professor Mello presented pooled data from three Harvard studies that showed of the malpractice claims reviewed (data from Utah and Colorado, injuries due to medical care were approximately 3-4%, with injuries due to negligent medical care at 1%g. Actual claims made were-2-5%. Of these claims, 30 % had no merit, 26% were of uncertain merit and 44% were valid claims. Of the 30% cases with no merit, 24% received financial compensation. Of the 26% of uncertain merit, 53% received financial compensation; and of the 44% of valid claims, 79% received financial compensation.

The following speakers gave presentations on the topic: "The Impact of Adverse Outcomes on Provider Malpractice Costs; Practices Being Undertaken to Reduce the Number of Adverse Events; Success of Those Practices; and Impact on Malpractice Coverage Costs."

- **Arthur Levin, Director, Center for Medical Consumers:** Mr. Levin stated that despite the patient safety efforts that have been undertaken by various hospitals, there has been difficulty in maintaining such improvements and spreading the use of such improvements to more facilities. He cited a number of sources indicating that the number of adverse events reported by hospitals is underreported and a 2010 study by the Inspector General that found that 1 out of 7 Medicaid patients was impacted by an adverse even; in one month alone, such adverse events cost Medicaid 324 million dollars. In NYS, Mr. Levin stated that there is no functional medical error data base and that there should be a commitment by the State to develop and maintain a data base that will be useful for making decisions and for the public to understand.
- **Lorraine Ryan, Senior Vice president, Legal, Regulatory and Professional Affairs, Greater New York Hospital Association:** Ms. Ryan agreed with Mr. Levin regarding the need for funding for the development and maintenance of a more complete NYS data base of reportable adverse events but also stated that it can be difficult to define what constitutes an adverse event. Among the steps that can be taken to improve patient safety are documented, evidence-based practices for each discipline, incentivizing physicians for following good practice procedures, requiring periodic testing of proficiency, providing intensive root cause analysis training, and teaching effective communication skills. CMS has committed $1 billion for achieving specific patient safety goals by 2013; and GNYHA and HANYS have applied to CMS for funding.
- **Andrew Kleinman, MD, President of the New York State Plastic Surgeon Society and Treasurer of the Medical Society of the State of New York:** Dr. Kleinman stated that not all adverse event are preventable and that it is virtually impossible to measure the cost of defensive medicine because it is difficult to parse what is defensive medicine from what is good patient care. He spoke about his own experience of being sued for malpractice once in a case in which he never treated the patient; he was merely the plastic surgeon on call for the emergency room at the time that the patient was treated. Subsequently, he stopped taking emergency room cases.

As a result of the presentations and the question and answer sessions following them, there appeared to be a consensus that the lack of reliable data and/or the accessibility of such data should be an area of focus and that specific recommendations regarding the types of data that members of the work group feel are important to develop and maintain should be made.