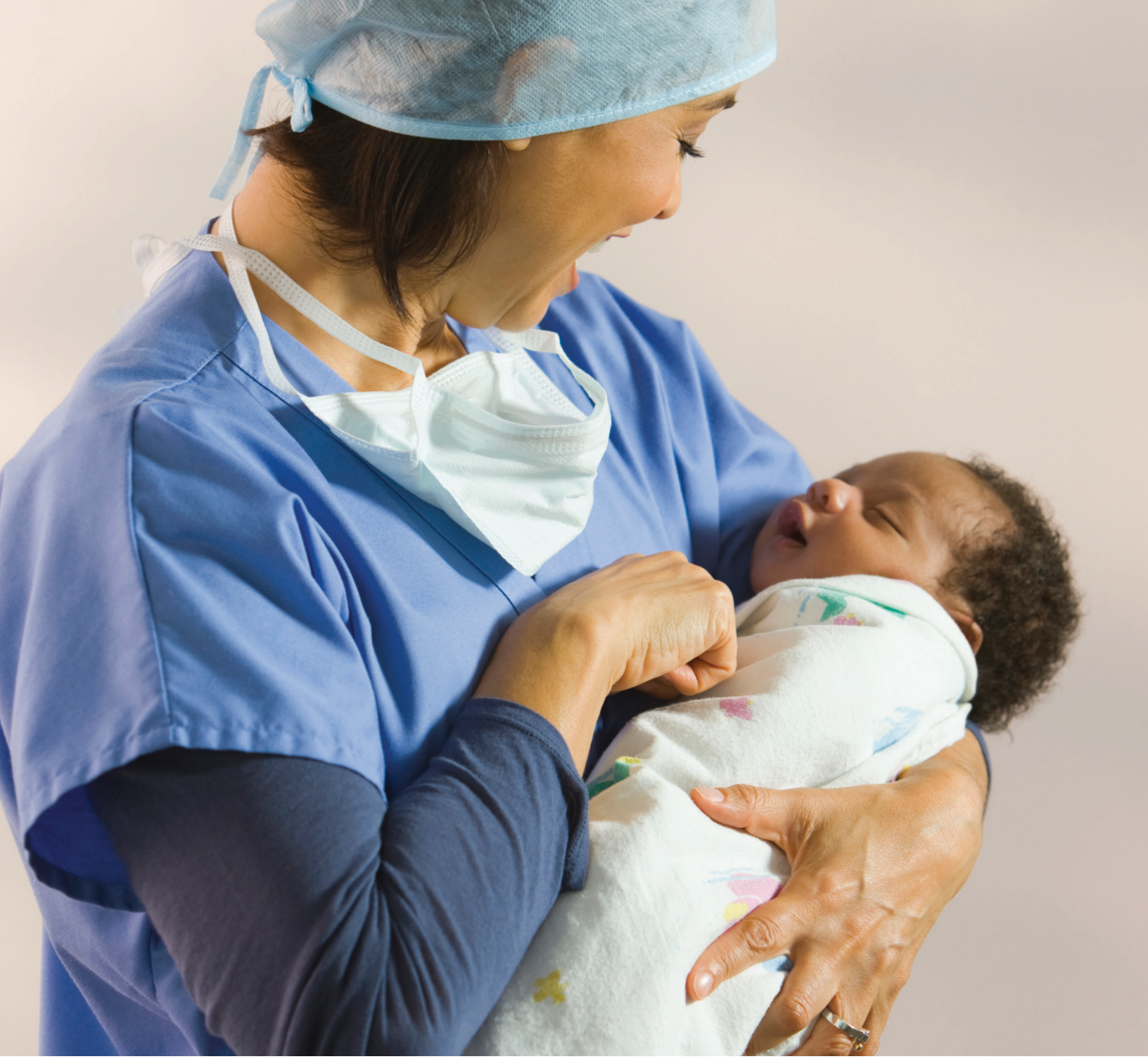

LANDMARK MEDICAL MALPRACTICE REFORM

Frequently asked questions about New York State's Medical Indemnity Fund

Greater New York Hospital Association
FEBRUARY 2012

GNYHA has prepared these FAQs for the purpose of facilitating its members' understanding and implementation of the New York State Medical Indemnity Fund. They are not intended to replace, however, a member's consultation with its own counsel or insurer with respect to the application of the fund to the member's cases or in assessing the impact of the fund on the member's premiums or future payouts.

Effective April 1, 2011, New York State created a medical indemnity fund (fund) to pay the future medical costs associated with birth-related neurological injuries to reduce the cost of malpractice coverage for providers. The creation of the fund is a major milestone not only in reducing the unsustainably high costs of medical malpractice coverage, but in recognizing that many adverse outcomes are not caused by provider negligence. GNYHA and its members had long advocated for such a fund, and since its creation, many hospitals have reported significant savings.

After the fund was created, GNYHA prepared a frequently asked question (FAQ) document to provide an overview of the fund and answer some of the commonly asked questions members have raised. This updated version of that document highlights some of the interpretational issues that have been presented to date.

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1. How was the medical indemnity fund created?

Article VII of the New York State 2011–12 budget created the "New York State Medical Indemnity Fund" by amending the State's Public Health Law to add a new title (Title 4) to Article 29-D. Statutory references throughout this document are to new Title 4 of Article 29-D unless otherwise noted.

2. What is the fund's purpose?

The fund is intended to 1) pay or reimburse the costs necessary to meet the future health care needs of "qualified plaintiffs" as defined by the new law; 2) reduce expenses associated with medical malpractice litigation; and 3) reduce the cost of malpractice coverage for providers in New York State. Sections 2999-g, 2999-j (6), and 2999-j (13).

3. How does the fund reduce provider costs and what is the rationale for its creation?

A significant portion of hospital malpractice coverage costs stems from a hospital's obstetric (OB) service, due in great part to cases of neurologically impaired newborns. While devastating, these cases are often not the result of provider negligence. Yet the full cost of defending and paying for such cases has historically been borne by providers. This is because research shows that the greatest predictor of compensation in malpractice cases is not the presence of provider negligence, but the degree of patient disability.

Creating the fund helps to share some of the costs associated with neurological injuries more broadly and equitably by requiring the fund—rather than the defendants or their insurers—to pay the cost of all future medical expenses related to such injuries as they are incurred. The defendants and their insurers remain responsible for all other components of a settlement or award, as well as for that portion of the plaintiff's attorney fee attributable to the future medical damages component of a settlement or award. Section 2999-j (6). (See question 13 regarding payment of attorney fees.)

Given that future medical expenses are often estimated to be at least one half of a settlement or award, the fund alleviates a significant portion of the expenses of such cases, thereby reducing malpractice premiums, reserves, and/or payouts for providers, depending on their coverage arrangement.

4. Does the fund change how claims or lawsuits are filed or pursued?

The fund does not change the way claims are brought or lawsuits are pursued. However, if 1) a jury or court finds that a child sustained a birth-related neurological injury as a result of malpractice or 2) a child has sustained a qualifying neurological injury as a result of alleged malpractice and his or her claim or lawsuit is settled, then the fund will pay for the future medical expenses of the qualifying plaintiff as those expenses are incurred over time, rather than the defendants or their insurers paying those costs as part of the settlement or award. Section 2999-j (6).

5. Who qualifies for coverage by the fund?

An individual who qualifies for the fund is referred to as a "qualified plaintiff," which is defined as "every plaintiff or claimant who (i) has been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice, or (ii) has sustained a birth-related neurological injury as the result of alleged medical malpractice, and has settled his or her lawsuit or claim therefor." Section 2999-h (4).

6. What is a "birth-related neurological injury?"

The statutory definition of a "birth-related neurological in-

jury" is "an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation or by other medical services provided or not provided during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as that term is defined by section 1.03 of the mental hygiene law, or both. This definition shall apply to live births only." Section 2999-h (1).

7. Is the definition of "birth-related neurological injury" limited only to the birth process?

No. The definition includes qualifying injuries during labor, delivery, or resuscitation or by "other medical services provided or not provided during delivery admission." The definition is broader than just the birth process, and the last category of "other services provided or not provided during delivery admission" was added because there are frequently allegations that injuries arise, for example, while a newborn is in a neonatal intensive care unit as part of the delivery admission. Section 2999-h (1).

8. Does the term "delivery admission" extend to transfers of newborns to other facilities?

GNYHA assumes that the term "delivery admission" should extend, in general, to transfers to other facilities that are necessitated by the problems presented by a newborn during the initial delivery admission and that are more appropriately addressed by the facility to which the newborn is transferred. GNYHA has brought this issue to the attention of the State Department of Health (DOH) and the State Department of Financial Services (DFS), the key New York State agencies charged with overseeing the fund.

9. How does the settlement or award process take into account the operation of the fund? Does the fund's presence change the amount of the settlement or award?

The presence of the fund is not intended to change the process leading up to a settlement or award. In general, settlements and awards are to be entered and made as they have in the past, and the total amount of the settlement or award should not increase in any way from what the settlement or award amounts have been in the past.

However, once the settlement or award amount is identified for a qualified plaintiff, and the plaintiff is accepted by the fund, any payments for future medical expenses are to be made by the fund as those expenses are incurred and in lieu of a payment by the defendants or their insurers. In other words, the fund is not intended to be additive to a settlement or award, but rather to replace a portion of the settlement or award amount, specifically the future medical expenses portion. Section 2999-j (6).

10. Settlement agreements do not typically allocate the settlement amount among the components of the settlement. How do the parties identify what portion of the settlement is to be paid by the defendants or their insurers and what portion is to be paid by the fund?

The parties will have to agree to the allocation of the settlement amount between future medical expenses and all other non-fund damages, which will be paid by the defendants or their insurers. Although each case is different, some insurers have estimated that, based on past awards and settlements, typically at least one-half of an award or settlement for individuals intended to be covered by the fund is attributable to future medical expenses. In many cases, the proportion is much higher. It may be of value to defendants, their insurers, and their counsel to review past cases having similar disabilities and future needs to support the allocation of a settlement between fund and non-fund damages. In addition, the judge handling the settlement of the case or the approval of the minor compromise is presumably available to be of assistance in the allocation of the damages. See page 6 for a sample allocation and calculation of damages.

11. What language should appear in the settlement agreement to ensure that future medical expenses are covered by the fund?

The law requires that every settlement agreement for claims arising out of birth-related neurological injuries subject to the fund and that includes payment of future medical expenses must "provide that in the event the administrator of the fund determines that the plaintiff or claimant is a qualified plaintiff, all payments for future medical expenses shall be paid [from the fund]…in lieu of that portion of the settlement agreement that provides for payment of such expenses." When a settlement agreement does not include such a provision, the law states that the court shall direct the modification of the agreement to include such a term as a condition of court approval. Section 2999-j (6)(a).

DOH recommends that applicable settlement agreements and judgments specifically provide that all payments for future medical expenses will be paid in accordance with Title 4 of Article 29-D of the Public Health Law, in lieu of that por-

tion of the settlement agreement (or judgment) that provides for payment of such expenses.

It should be noted that all settlements involving minors require court approval. Therefore, the court will be involved in any event. The New York State Office of Court Administration (OCA) has issued a memorandum to administrative judges throughout the State and to the presiding judge of the Court of Claims that provides the following example of language that could be used for this purpose.

> The [judgment/settlement] is based, inter alia, on a [finding/stipulation] that the [plaintiff/claimant] has suffered a birth-related neurological injury subject to the provisions of Title 4 of Article 29-D of the Public Health Law (PHL §§2999-g et seq.), and the [judgment/settlement] includes provision for payment of future medical expenses addressed by that Title. In the event that the Administrator of the Medical Indemnity Fund determines that [plaintiff/claimant] is a qualified plaintiff, all payments for future medical expenses shall be paid in accordance with Title 4, in lieu of that portion of this [judgment/settlement] that provides for the payment of such expenses.

12. What language must appear in the jury or court award to reflect the operation of the fund?

With respect to a jury or court award for future medical expenses arising from birth-related neurological injuries, any party may make an application to the court that the judgment reflect that, in lieu of that portion of the award that provides for payment of such expenses, and upon acceptance of the plaintiff by the fund, the future medical expenses shall be paid from the fund. Upon a finding "that the applicant has made a prima facie showing that the plaintiff is a qualified plaintiff, the court shall ensure that the judgment so provides." Section 2999-j (6)(b). See sample language issued by OCA that appears in response to question 11.

13. How are plaintiff's attorney fees to be paid given that a plaintiff typically pays the fees from the amount received in settlement or pursuant to an award?

The law specifically provides that a plaintiff's attorney fee shall be based upon the entire sum awarded by the jury or the court or the full sum of the settlement, as the case may be. (With respect to jury or court awards, GNYHA assumes that the fee will be calculated on the amount of the award ultimately agreed upon or upheld on appeal, as applicable.) Section 2999-j (14).

The plaintiff's attorney fee is to be calculated pursuant to Section 474-a of the State Judiciary Law, which contains the contingent fee provisions applicable to medical malpractice cases. The medical indemnity fund law states that the defendants and/or their insurers are required to pay the attorney fee amount in a lump sum. The law then directs the defendants and/or their insurers to deduct that portion of the attorney fee attributable to the non-fund damages from their payment of the non-fund damages to the plaintiff. Section 2999-j (14).

The effect of this provision is that the plaintiff's attorney will receive his or her full fee even though a part of the damages will be paid by the fund. The defendants and/or their insurers will be responsible for the fee attributable to the fund portion of the damages. The plaintiff will effectively be responsible for the fee attributable to the non-fund damages, given the defendant's deduction of this portion of the fee when it pays the non-fund damages, a step that is consistent with the fact that the plaintiff typically pays his or her attorney fee from the amount received from the defendants in any event. An illustration of how the attorney fee is to be calculated and paid appears on page 6.

14. How does someone become enrolled in the fund once there is a settlement or award involving a qualified plaintiff?

The law provides that either 1) the plaintiff or someone authorized to act on behalf of the plaintiff or 2) any of the defendants may make an application for enrolling a plaintiff in the fund by providing the fund administrator with a certified copy of the judgment or the court-approved settlement agreement. In either case, the applying party must give the other parties notice of the application. The fund administrator must then determine, based on the judgment or the settlement agreement and any additional information the administrator may request, that the plaintiff is a qualified plaintiff. Section 2999-j (7). DOH, in consultation with DFS, has promulgated regulations outlining the application and enrollment process, which DOH states has been designed to be as streamlined as possible. 10 NYCRR Subpart 69-10. The application is available on the DFS Web site at *http://www.dfs.ny.gov/insurance/mif/mif_indx.htm.*

15. What is the effective date of the fund provisions?

Pursuant to Section 111 of Article VII of the 2011–12 State budget, the fund provisions became effective April 1, 2011. Section 111 (q) provides that the fund provisions apply to

birth-related neurological injury lawsuits "as to which no judgment has been entered and no settlement agreement has been entered into by the parties before the date of enactment[.]" Given that Governor Cuomo signed Article VII of the budget on March 31, 2011, the fund provisions are therefore applicable to all qualifying lawsuits "as to which no judgment has been entered and no settlement agreement has been entered into by the parties" before March 31, 2011. For simplicity, the State is treating April 1, 2011 as the effective date of the fund provisions.

16. When did the fund actually become operational?

As required by Section 111 (q) of Article VII of the 2011–12 State budget, the fund began operations on October 1, 2011.

17. What happens to cases that were resolved between March 31, 2011, and October 1, 2011, the date the fund became operational?

Section 111 (q) of Article VII of the 2011–12 State budget provided mechanisms for the coverage of qualifying health care services that may have been required by qualified plaintiffs before the fund began operating. If the costs of those services are qualifying costs under the fund, the fund will reimburse the costs incurred between the date the court approves a settlement or judgment for the plaintiff and the date the qualified plaintiff is enrolled in the fund.

18. What types of costs are covered by the fund?

The costs covered by the fund are "future medical, hospital, surgical, nursing, dental, rehabilitation, custodial, durable medical equipment, home modifications, assistive technology, vehicle modifications, prescription and non-prescription medications, and other health care costs actually incurred for services rendered to and supplies utilized by qualified plaintiffs, which are necessary to meet their health care needs as determined by their treating physicians, physician assistants, or nurse practitioners and as otherwise defined by the commissioner in regulation." Section 2999-h (3).

The feature of requiring that the qualified plaintiff's treating physician, physician assistant, or nurse practitioner determine the services or supplies necessary to meet the qualified plaintiff's health care needs is designed to facilitate coverage of needed care.

19. Who is responsible for administering the fund?

The DFS Superintendent or his or her designee has responsibility for administering the fund, and is given all powers necessary and proper to carry out the fund's purposes. To ensure that the fund could begin operating on October 1, the law gave the Superintendent the authority to enter into a contract or contracts to administer the fund for the first year of operation without a competitive bid or request for proposals. The current fund administrator is Sedgewick Claims Management Services, Inc. Sections 2999-i (2) and 2999-h (5).

20. What efforts will be made to ensure that qualified plaintiffs will have appropriate access to needed care?

The law provides a number of safeguards intended to ensure that qualified plaintiffs have access to needed care, many of which are addressed in more detail in regulations promulgated by DOH. See question 30 regarding regulatory guidance.

Minimal prior authorization: First, the law provides that the provision of qualifying health care shall not be subject to prior authorization, except as may be described in regulations promulgated by the DOH Commissioner. The law states that the regulations may not prevent a qualified plaintiff from receiving care or assistance that would, at a minimum, be authorized under the Medicaid program. In addition, the law states that, to the extent that any prior authorization may be required by regulation, the regulation must require that requests for prior authorization be processed within a reasonably prompt period of time, as well as identify a process for prompt review of any denial of a prior authorization request. Section 2999-j (2).

Access to private physician practices: Second, as a general proposition, the law states that the fund shall pay providers on the basis of Medicaid payment rates. However, to ensure access to care in "private physician practices," the law states that private physician practices will be paid on the basis of 100% of "usual and customary rates, as defined by the (DOH) commissioner in regulation." Section 2999-j (4).

Acceptance of assignment: Third, all health care providers shall accept assignment of the right to receive payments from the fund for qualifying health care costs. Section 2999-j (11).

Determination of need for health care services: Finally, as noted in the answer to question 18, the law provides that the services and supplies necessary to meet a qualified plaintiff's health care needs are to be determined by the qualified plaintiff's treating physician, physician assistant, or nurse practitioner, thus facilitating coverage of needed services specific to each qualified plaintiff.

21. What happens if a qualified plaintiff has insurance coverage?

Under the law, health insurers other than Medicaid and Medi-

care are to be the primary payers of qualifying health care costs of qualified plaintiffs. Payments will be made from the fund only to the extent that the insurers are not obligated to make payments for such services. In addition, the law provides that the insurers will have no right of subrogation or recovery against the fund. Section 2999-j (12).

22. What is the fund's size and source of funding?

The State's budget for fiscal year 2011–12 required the State to deposit $30 million in the fund. The Governor's proposed budget for fiscal year 2012–13 would require the State to deposit an additional $37 million in the fund. The source of the funds in each case is the Health Care Reform Act (HCRA).

Neither the law nor the State's 2011–12 budget states a specific funding amount for future years. However, based on conversations GNYHA has had with the State Executive during the development of the fund provisions and subsequently, GNYHA understands that the State is committed to providing adequate funding to cover the estimated future needs of the fund each year. Estimations of future funding needs are based on estimates of the anticipated number of qualified plaintiffs who will enroll in the fund over time, and their anticipated medical needs during the relevant timeframes. The State Executive has expressed a strong commitment to making sure the fund serves the purposes for which it has been established. In addition, GNYHA has requested that stakeholders be kept informed of the fund's progress to help ensure that it is adequately funded.

23. Is it possible that the fund will be suspended?

The law requires that, following the required annual deposit, the DFS Superintendent will conduct an actuarial calculation "of the estimated liabilities of the fund for the coming year resulting from the qualified plaintiffs enrolled in the fund." The law also provides that the administrator will "adjust" such calculation "from time to time." If the "total of all estimates of current liabilities [for the coming year] equals or exceeds eighty percent of the fund's assets," then the fund may not accept new enrollments until a new deposit has been made into the fund and/or the fund's liabilities no longer exceed 80% of the fund's assets. Section 2999-i (6)(a).

When a new deposit has been made and/or the fund's current liabilities no longer exceed 80% of the fund's assets, the fund administrator will enroll new qualified plaintiffs in the order that applications were filed. Section 2999-i (6)(a).

24. How will people be informed of the suspension of the fund?

Whenever suspension of new enrollment occurs, DOH and DFS will post this information on their Web sites. In addition, the fund administrator will inform pending applicants and all parties in the action. Section 2999-i (6)(b).

25. What happens to cases settled or in connection with which there are verdicts while the fund is suspended?

Under the law, judgments or settlements for individuals for whom applications are denied due to the suspension of the fund are to be satisfied as if the fund were not in existence. Section 2999-i (6)(b).

26. What happens to qualified plaintiffs already accepted into the fund if the fund is suspended to new enrollment?

The law specifically provides that the suspension of enrollment will not affect payment under the fund for qualified plaintiffs already enrolled in the fund. Section 2999-i (6)(d).

27. I have heard about a number of large settlements that are expected to be covered by the fund. Does that mean the fund may be suspended soon after it becomes operational?

Based on assumptions regarding the projected number of qualified plaintiffs who might enroll in the fund and their anticipated medical needs each year, it is not currently anticipated that the fund will be suspended. It should be kept in mind that the fund is intended to pay only the qualifying health care costs that are actually incurred by each qualifying plaintiff each year. In contrast, a settlement includes the total amount of agreed upon non-fund as well as fund damages over the plaintiff's lifetime. Thus, a settlement in the total amount of $4 million, for example, might anticipate expenditures for health care costs in the range of $100,000 per year for the qualified plaintiff involved. Given that the deposit for the fund's first year was $30 million, it would take a large number of settlements or awards to trigger suspension of the fund, which is currently not expected to occur. As noted in the answer to question 22, the State proposes to deposit $37 million in the fund in State fiscal year 2012–13 and is committed to ensuring that the fund meets its intended purposes.

EXAMPLE OF MEDICAL INDEMNITY FUND CALCULATIONS FOR $2M SETTLEMENT

STEP 1

Allocate settlement based on facts of case

- Future medical expenses (fund damages): $1.1M or 55%
- All other damages (non-fund damages): $900,000 or 45%

STEP 2

Calculate plaintiff attorney fee on settlement amount ($2M) using fee schedule: $350,000

STEP 3

Allocate $350,000 attorney fee based on settlement allocation

- Percent attributable to future medical expenses: 55% or $192,500
- Percent attributable to all other damages: 45% or $157,500

STEP 4

Deduct attorney fee attributable to all other damages (non-fund damages) from all other damages amount:

$900,000 - $157,500 = $742,500

STEP 5

Make payments

Step 5 (a): Fund pays all future medical expenses, as incurred

Step 5 (b): Defendants pay attorney fee: $350,000

Step 5 (c): Defendants pay plaintiff "all other damages" less attributable attorney fee: $900,000 - $157,500 = $742,500

TOTAL PAYMENTS BY DEFENDANTS:

$350,000 + $742,500 = $1,092,500

TOTAL SAVINGS FOR DEFENDANTS:

$2M - $1,092,500 = $907,500

28. I understand that the Medicaid program will save money from the fund. How does this occur?

The Medicaid program has historically provided Medicaid coverage to many children who, moving forward, will be qualified plaintiffs under the new law. The high rate of Medicaid coverage begins at birth, with the Medicaid program covering approximately 50% of all births in the State, 60% of all births in New York City, and 70% of all births in the Bronx and Brooklyn. Studies undertaken by the State indicate that the Medicaid program covers an even higher proportion of children who would presumably be qualified plaintiffs pre-settlement or award—nearly 80% of these children. This is not surprising given the large medical expenses associated with their disabilities.

The State Medicaid program also has historically covered many of these children even post settlement and award, because many families of these children take the proceeds of the settlements and awards and deposit them in supplemental needs trusts. The children then continue to receive Medicaid for health coverage purposes. The State has estimated that as many as 50% of all children who would be qualified plaintiffs have continued on Medicaid in the past.

Moving forward, the fund will assume responsibility for future medical expenses of qualified plaintiffs as those costs are incurred. This will eliminate the need for the Medicaid program to provide coverage, and thus will save the Medicaid program money.

29. I understand that the fund helps to eliminate what have been referred to as over-recoveries, as well as double recoveries. How does that occur?

Under the current judicial system, future medical expenses are often estimated or projected based on a wide array of potentially needed health care services. It is believed that this approach often over-estimates what might be needed by a plaintiff. Because the fund will pay for such services only as they are needed, the operation of the fund will eliminate some of the over-projections and over-payments that are thought to occur under the current system.

With respect to double recoveries, the prior question discussed how the Medicaid program often continues coverage of plaintiffs even though the defendant and/or an insurer pay the settlement or award that includes payments for future medical expenses. The fund will eliminate this double recovery because the fund alone will pay for future medical expenses.

30. Has the State provided regulatory guidance regarding the fund's operation?

DOH, in consultation with DFS, has issued emergency regulations that add a new Subpart 69-10 to Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York. The regulations include definitions of key terms and describe the application and enrollment process, which services require prior approval, how to submit claims for payment, the process for reviewing denied claims, and how and when actuarial calculations will be undertaken. 10 NYCRR Subpart 69-10.

In addition, DOH and DFS have developed FAQs, which are available on their respective Web sites, to assist providers, plaintiffs, and other stakeholders with implementing the law. They will also post information on their respective Web sites about the law, future regulations, and guidance as they become available.

31. Will there be education of the judges who will hear medical malpractice cases?

OCA has distributed a memorandum summarizing the law to administrative judges and the presiding judge of the Court of Claims. It is also anticipated that OCA will offer education to judges. In addition, there has been at least one court decision that discusses the application of the fund. See decision/order dated November 14, 2011, of the Honorable Douglas E. McKeon in *Mendez v. NewYork-Presbyterian Hospital*, Index No. 350722/09, NYS Supreme Court, Bronx County.

32. The law calls for providers to pay a "quality contribution" to the State. How is that calculated and what is its purpose?

Section 52-c of Article VII of the 2011–12 State budget imposes a "quality contribution" on hospitals equal to 1.6% of their inpatient OB revenue, with the intent of generating $30 million each State fiscal year. In implementing the contribution, DOH has imposed the fee on maternity and normal newborn revenues from all payers. For State fiscal year 2011–12, because the fee assessment began July 1 instead of April 1, the State adjusted the assessment to 2.4% to achieve the $30 million target.

The contribution is intended to help reduce the State's budget deficit, and was not initially proposed for the purpose of funding the fund, notwithstanding that the amount deposited into the fund for year one is the same amount as

the quality contribution amount. The quality contribution in future years is intended to remain at $30 million and does not increase, other than by an inflation factor, even though the deposits into the medical indemnity fund are expected to increase in future years.

33. Although the creation of the fund recognizes that many adverse events are not caused by provider negligence, what efforts are being made to reduce avoidable adverse events?

Section 52-a of Article VII of the 2011–12 State budget creates the New York State Hospital Quality Initiative, which is intended to bring together experts and others to oversee the dissemination of initiatives, guidance, and best practices for general hospitals, focusing heavily on ways to improve obstetrical care outcomes and quality of care. The law states that the initiative will identify and implement "evidence based practices, and clinical protocols that can be standardized and adopted by hospitals."

34. What steps is GNYHA taking to support hospitals in reducing avoidable adverse outcomes?

Many of the best-practice examples set forth in the law's New York State Hospital Quality Initiative reflect those that have been implemented as part of GNYHA's Perinatal Safety Collaborative, which was formed in 2007. This Collaborative brought together more than 40 hospitals to improve perinatal care using evidence-based clinical protocols and safety practices. Collaborative hospitals came together with a commitment to identify and implement the best practices for care delivery that can be standardized and implemented across a region, with the goal of reducing adverse events, enhancing patient safety, and improving the quality of obstetrical and perinatal care for patients. The Collaborative was led by a Perinatal Safety Collaborative Advisory Panel that included representatives of the American Congress of Obstetricians and Gynecologists (District II/New York), DOH, the Healthcare Association of New York State (HANYS), OB and neonatal clinical leaders from GNYHA member institutions, risk management professionals from medical malpractice carriers, and consumer organizations. Many of the Collaborative's activities are being assumed by the NYS Partnership for Patients, which is a partnership between GNYHA and HANYS and is funded in part by a contract with the Centers for Medicare & Medicaid Services. Additional information regarding GNYHA's Perinatal Safety Collaborative and the NYS Partnership for Patients is available at *http://www.gnyha.org/perinatal* and *http://www.nyspfp.org/.*

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