REMARKS AS PREPARED
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Division of the Budget Public Hearing
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Opening

Although this is a budget hearing, I believe it is important to place this preliminary discussion of the Department of Health's approach to the 2008-2009 budget in the context of our single overarching goal. That goal is to improve the quality, efficiency and accessibility of health care, in a word, the value of the health care and public health services that New Yorkers get for the large investment in health that this budget represents. Although we may use a variety of terms such as improving quality, enhancing safety, optimizing health status, eliminating disparities or reducing waste and inefficiency, I invite you to challenge the Department and our budget to demonstrate that each of our proposals is directed at achieving the ultimate goal of delivering better health value in terms of improved health status and better efficiencies, to all New Yorkers.

This budget builds on the work we began in last year's budget, informed by the knowledge gained over the last ten months. Before looking ahead, I want to describe what I believe are the critical financial issues facing the Department.

- As I will detail later, Medicaid represents both the State's principal direct investment in the health of the most vulnerable New Yorkers and by a large margin the single largest discrete state and local financial obligation. Nevertheless, the Medicaid program was not previously structured and managed as a health insurer with strict attention to continuity of care, quality of care, achievement of optimal health outcomes, economy and proper incentives. In many respects, it was treated as an essential funding stream for institutional providers, in effect an "institutional entitlement," and as a mechanism to bring more federal dollars into the State.
- For these reasons, as well as for more laudable goals, our Medicaid spending, indeed our health care spending overall, leads the nation, weighs far too heavily on our taxpayers and competes with other priorities. At the same time, the status quo and the costs it drives have proven remarkably resistant to real reform in budget cycle after cycle.
- The work of the Office of the Medicaid Inspector General (OMIG) is a key check on Medicaid fraud, abuse and waste. We are fully behind this effort and applaud the energy and purpose Jim Sheehan has brought to the task. At the same time, we are mindful of the need to rebuild our Medicaid systems, often from the ground up, so that they do not offer such an inviting target for those who would defraud the system or who waste resources meant for the care of patients.

- I firmly believe in doing more with less. However, the Department needs to rebuild the infrastructure and personnel to do the job appropriately. The Governor's Executive Budget last year began that rebuilding effort by adding 75 new staff, which the Legislature included in the final budget. That effort must continue.

- New Yorkers are rightly demanding a high performing health care system, where insurance is affordable; care is provided in the right setting, at the right price and at the highest standards; and, patient need, not institutional desires, drives our choices. The money is in the system; the challenge is to spend it wisely and strategically.

Much work has already begun. Implementation of the Berger requirements is a critical first step and we are well under way. Earlier this year, the State adopted a budget that heralded a new approach to health care spending – one that puts patients first and imposes on Medicaid the quality standards and financial discipline expected of the single largest insurer in the State.

This year we have devoted substantial time and resources to analyzing where we are spending our Medicaid dollars and the quality of the services the State is buying and Medicaid enrollees are receiving. This information will inform our budget proposals. We are working closely with our colleagues in the behavioral health agencies. We know that our sickest and most expensive patients have needs that cross agencies; 80 percent of our highest utilizers have either a substance abuse or mental health problem. Our programs cannot focus on one medical need but on the whole person.

Financial Underpinnings

Medicaid now costs $47 billion each year, 50 percent more than it did in 2000. Medicaid constitutes nearly 35 percent of the state budget and underwrites almost one-third of all health care costs in New York. This past year has seen some slowing in enrollment. However, we are expecting the enrollment numbers to go up as our outreach efforts take hold and if the economy slows. The sheer magnitude of the Medicaid program drives home the importance of our spending decisions. We have an obligation both to the 4.5 million children and adults who depend on Medicaid for their health insurance and to the taxpayers who pay for the program to ensure that we receive maximum value for every dollar spent.

At the inception of the Medicaid program in New York state in 1966, state law required counties to underwrite one-half of the non-federal share. The State, in turn, funded the balance of the non-federal share. Over time the local share was reduced. However, with each passing year local governments found it increasingly difficult to meet their obligation until it became an unmanageable burden. The State responded and enacted legislation, which took effect on January 1, 2006, to cap the local share at 2005 levels subject to a modest trend.

Costs above the cap, including counties' costs for administering the Medicaid program and all costs related to Family Health Plus, are now the State's responsibility. In State Fiscal Year 2006-07, the cap saved 33 counties and New York City over $198 million. Four counties received refunds totaling just over $600,000.

The Medicaid cap places responsibility for Medicaid expenditures squarely on the State. We take that responsibility seriously and we are reviewing where and how the shift in the fiscal responsibility should trigger changes in program administration at both the state and local level. As part of this process, we are evaluating related recommendations made by both the Citizens Budget Commission and the United Hospital Fund.

Transparency & Accountability

We must make certain that we understand what we are buying and what we are getting. Without that information, we cannot make informed spending decisions and we cannot hold providers to the standards of care New Yorkers deserve. Over the past few months, the Department, in conjunction with external stakeholders, has been carefully analyzing two areas that cried out for more transparency: the $1.7 billion in annual Graduate Medical Education (GME) funding and the $847 million in annual Hospital Indigent Care funding.

Currently, New York State spends $1.4 billion in Medicaid funds and $300 million from the Health Care Reform Act (HCRA) Professional Education Pool on GME, significantly more than any other state in the nation. That equates to about $100,000 per resident in total or about $72,000 per resident in Medicaid funds. Last June, I asked the Council on Graduate Medical Education (COGME) to work with the Department in analyzing this spending with the goals of understanding what costs it underwrites and whether we are doing all we can to address critical shortages in some specialties and some areas of the State. Those efforts are ongoing.

Our examination of the Hospital Indigent Care funding was mandated in last year's budget. As required, the Department convened a Technical Advisory Committee (TAC) to assist us with our efforts. The third and final meeting of the TAC will be in November. In December, I will issue my findings and recommendations. One thing is already clear: the current allocation formula and the data on which it is based is overly complicated and ambiguous at best. Indeed, it would not be unreasonable to describe it as opaque. While there may not be complete agreement on the fix, no one involved in the review process can defend the current methodologies.

The third area where examination and reform is desperately needed is our ambulatory care system.

Investing in Ambulatory Care – A Critical and Multi-Pronged Initiative

Primary and preventive care is the lynch pin of a reformed health care system. We cannot afford universal coverage unless we provide more effective care and case

management; and, universal coverage will not succeed without a strong network of primary care physicians and other providers to meet the increased demand for medical services. We want a "health care" not a "disease care" system. This means an investment in an ambulatory care system that delivers the outcomes patients want and deserve. We have much to do.

While year after year, New York has invested additional dollars in inpatient services, rates for physicians are the third lowest in the country and rates for diagnostic and treatment centers (D&TCs) and hospital clinics have been frozen for more than a decade. Our hospitals see hundreds of thousands of patients in their clinics and emergency departments annually. They will be important partners in the effort to improve ambulatory care and keep patients out of emergency rooms and prevent unnecessary admissions.

We must rethink our priorities and reallocate our dollars. That means investing more money in ambulatory settings, but only after we implement a more refined method of reimbursement for ambulatory care, one that is sensitive to the services provided and responsive to the quality of those services. We cannot move forward until we reform our 'per visit reimbursement' methodology, which is blind to the scope and intensity of the services provided in any visit.

Our investment in ambulatory care will focus special attention on the needs of patients with chronic illnesses and multiple co-morbidities. Special attention must also be given to the standards we expect our primary care providers to meet. We must also determine how to most effectively integrate residency training into ambulatory care settings and how to ensure sufficient numbers of physicians in primary care areas and in every part of the State.

Improving Clinical Outcomes – Demanding Patient Safety and Quality

Through our regulatory role and our purchasing role, we will seek to hold providers to the highest standards. One of the Department's primary missions is the surveillance of health care institutions to ensure hospitals, nursing homes, clinics, adult care facilities and home care agencies are providing a consistently high level of care to all patients and residents. We must continually improve our efforts in this area and take other necessary steps to ensure New Yorkers receive safe, high quality care. For example, this year the Governor and the Legislature enacted the Department's initiative to oversee the rapidly growing business of office based surgery.

The Department is also working to ensure that the Medicaid program only contracts with high quality providers, rather than simply requiring them to meet minimum standards. When multiple providers offer the same specialized services, we should only contract with those that have the best outcomes. Additionally, like Medicare, we should not pay for "never events." We will collect the data that will permit Medicaid to deny payment for "potentially preventable conditions." We have some of the finest hospitals in the nation. We will turn to them in our efforts to improve safety and quality.

Outside of Medicaid and the surveillance system the Department has many ongoing initiatives to promote patient safety including, development of the near miss project in conjunction with New York College of Physicians, review of hospital data to identify potentially preventable complications and development of a report card for hospitals on health care required infections, to name just three.

Managing Patients, Care and Costs

The Department has spent much of the past six months analyzing the characteristics of the most medically complicated and high cost patients and the areas where spending is increasing most rapidly. We need to understand these characteristics if we are going to improve the quality of care and manage health care costs. And, we need to identify successful intervention strategies. For example, several hospitals and community health centers have developed innovative programs to address diabetes, one of the most prevalent and expensive chronic diseases in New York's Medicaid population. We must replicate these models throughout the system.

Recent quality reports show that Medicaid Managed Care continues to improve access to and quality of care. We need to take the successes of the managed care program and apply them to the Medicaid fee-for-service program where little has been done to measure or improve the quality of care.

Obsolete utilization review programs that simply count visits as though all patients are the same must be replaced with state-of-the-art programs built on clinical evidence. Current utilization management programs burden providers and miss the opportunity to improve care.

Data used in the past to count the dollars spent is being looked at in new ways in order to better understand the care that patients are, and are not, getting. Here are just a few examples:

- Despite the billions of dollars spent on prescription drugs, little has been done to ensure that patients receive the right medication. One recent analysis shows that only 57 percent of adult asthmatics received the recommended inhaled corticosteroids. Of those patients who were hospitalized for their asthma, only 32 percent received the recommended medications. We need to ensure that the Medicaid program is buying the right drug for the patient at the best possible price.

- A recent study of Medicaid fee-for-service patients most likely to be hospitalized shows that nearly 1/3 had no primary care visit in the 12 months prior to the hospital admission. Twenty-nine percent had no primary or specialty care visit and less than 10 percent had a case manager. Many of these admissions could have been avoided if the system was properly invested in primary and specialty care.

- Eighty percent of the highest cost patients have chronic medical conditions and a mental health or substance abuse diagnosis. Yet, the care coordination system in place is organized in silos around single diseases. If we want to improve the health of the patient, we need care coordination models for the whole patient.

Long Term Care Restructuring

The Governor created the Office of Long Term Care to provide a focal point for addressing the growing demand for long term care services by creating a high quality rebalanced system of care for vulnerable populations.

New York supports a $10 billion program for Medicaid long term care services. Everyday approximately 300,000 individuals receive Medicaid long term care services. Our nursing homes and home care agencies are vital to the well being of our elderly and disabled citizens and these institutions will be even more important in the future. It is projected that the over 65 population will increase by 50 percent by 2030. While New York's program is expansive, it is not sustainable in its current configuration given this growing demand. We must develop creative and efficient strategies to ensure we are providing programs to address the quality issues presented by such an expansive system and initiatives that drive services to be provided in the most integrated setting. We must also examine who is currently receiving Medicaid-funded long term care services and devise strategies to encourage more private funding of these services.

Over the last five years our spending on personal care and home care has increased by over 40 percent reaching almost $4 billion, and we spend significantly more on personal care than any other state in the nation. Right now we are spending over $2 billion on personal care annually for approximately 82,000 people. Over the same five years, nursing home spending has increased by more than 20 percent. We are troubled by the data. Our home care spending has increased rapidly, but the number of people served has not. And, at the same time that our home care spending is rising, so is our spending on institutional long term care.

Again, we must discuss transparency, accountability and integrity. Is the money we are spending on home care and personal care being spent wisely? Are we providing the right number of hours of care to those who need it? Why are nursing home costs rising at the rate they are, when we are spending so much on home care? We must ensure that our dollars are going to the right care in the right setting and achieving the right results.

The Department will continue to focus on the development and implementation of strategies designed to improve quality assurance, improve access to outcome-based long term care, and redesign community–based programs.

F-SHRP/HEAL

The Federal-State Health Reform Partnership (F-SHRP) Waiver required the State to meet several performance milestones in the first year of the waiver. These included

submission of a plan for achieving the fraud and abuse recovery targets, implementation of Medicaid cost containment initiatives, development of an evaluation design for the 1115 demonstration, establishment of an initiative to increase employer sponsored health insurance coverage for the working uninsured, updating the State's plan for reviewing managed care compliance with the federal American with Disabilities Act and submission of a report on implementation of the Berger Commission recommendations.

To date the Department has met each of these required milestones and the Center for Medicaid and Medicare Services (CMS) has acknowledged the successful and timely completion. Whatever stringencies this budget cycle presents, it is critical that we continue to meet these milestones to ensure the availability of this critical funding. Combined with the Health Efficiency and Affordability Law (HEAL NY) funding, these programs provide essential resources necessary to enable reform of our health care system.

Berger Commission

Implementation of the Berger Commission recommendations will leave New York with stronger hospitals and nursing homes by taking unneeded capacity out of the health care system and concentrating services in fewer, financially healthier providers.

Though progress among facilities varies, most facilities are on or ahead of schedule with their implementation activities. Two facilities slated for closure, one hospital (St. Vincent's Midtown Hospital) and one nursing home (Brunswick Hospital Center, Inc.), closed well ahead of schedule. In addition, two hospitals and two nursing homes have submitted closure plans and are moving forward on an expedited schedule.

In September, 23 hospitals and seven nursing homes around the State were notified that they will receive $362.3 million to assist them in complying with the mandates of the Berger Commission.

The state and federal investment in implementing the Berger Commission has allowed for an orderly transition as providers close, merge and re-configure care. The next step is further state and federal investment in community-based services through HEAL NY/F-SHRP.

Health Information Technology (IT)

Over the past year, the Department has started to set a foundation for widespread adoption of health information technology with investment from HEAL NY. This program will support our progress in improving the quality, safety and efficiency of health care, and much work remains.

The important aspect of health IT is not software and computers – it is physicians making better treatment decisions, nurses and pharmacists delivering safer care, and New Yorkers making better choices among treatment options. It is the way people connect

together across a fragmented delivery system – from physician offices to hospitals to nursing homes and even to the consumer's home.

We therefore need to implement the organizational, clinical, financial and technical building blocks to produce the socially optimal level of health IT adoption in New York.

Public Health

Achieving the Governor's "patients first" agenda requires a renewed investment in a public health agenda that focuses on promoting and improving health and preventing disease. Prevention is the hallmark of public health.

New York's current public health efforts are threatened by a heavy reliance on federal funding. For example, 87 percent of the staff positions in the Department's Center for Community Health are federally-funded. Concurrently, federal funding has been shrinking in almost every program. Federal support for the Department's preparedness program has been reduced by 40 percent since 2002. This funding comprises the bulk of the Department's critical infrastructure support for preparedness efforts, which include computer systems that collect disease data and communicate with critical partners as well as laboratory testing.

In addition to reduced federal support, the State's public health system has been strained by declining local support in some areas. County health departments are a key partner in providing public health services in their communities. However, the local public health infrastructure has suffered in recent years from declining local funding and an inability to recruit and maintain skilled staff. These challenges make it critical that the State provide stable resources to support its basic public health infrastructure.

While resources for current public health priorities are shrinking, new public health threats and opportunities continue to emerge. These opportunities include new developments that hold great potential to improve health. Advances in information technology permit the population to be monitored in real time and new preventative measures, such as vaccines, are becoming available. At the same time, New York must constantly confront new public health threats, such as the emergence of new diseases including hepatitis C and avian influenza. New York's public health infrastructure needs to be better positioned in order to respond to these new public health challenges and opportunities.

Both to ensure the continued health and well-being of New Yorkers and, ultimately, to reduce health care spending, making much needed investments in public health, as initiated by the Governor last year, must continue.

Last year the Governor and the Legislature recognized the need to shift the focus from expensive curative care to preventative measures and took several important initial steps to rebuild the public health infrastructure. The budget included $22 million to address a number of critical areas, including the prevention of childhood lead poisoning, access to

cervical cancer vaccines, expanding prenatal and postpartum home visits, reducing childhood obesity and supporting a broad health promotion campaign.

It is vital to continue last year's down payment and to find ways to shift limited resources to expanding existing initiatives and address gaps in other public health program areas. New York must find ways to use our health care dollars more wisely to continue to make incremental investments to maintain the current public health infrastructure, to improve the State's ability to respond to new public health threats and to position the Department to address emerging challenges.

Coverage

National studies report that New York has done more to increase access to insurance coverage than many other states, but there is still a long way to go. We must continue on the path started in last year's budget to streamline eligibility rules to make it easier for those who are eligible for these programs to get coverage and keep that coverage. We must also strengthen our marketing, outreach and enrollment efforts to reach the 1.3 million uninsured children and adults who are eligible for these insurance programs but not currently enrolled. Then, we must ensure that resources are in place to accept and process applications for insurance coverage.

There are approximately 1.3 million uninsured New Yorkers whose incomes make them ineligible for public coverage. We must find ways to permit them to access affordable coverage. We began this process over the summer, and in total, will hold six hearings around the State to solicit input from New Yorkers. We have also issued a Request for Proposals (RFP) for a consultant to assist with modeling different options.

Unfortunately, our efforts to make insurance accessible to every child in the State hit a road block in Washington DC. In August, CMS rejected our State Plan Amendment expanding the income eligibility level for our Child Health Plus program from 250 percent of the federal poverty level to 400 percent of the federal poverty level. The basis of the rejection was new CMS rules announced in an August 17th letter. These rules prevent states from covering children in families with incomes above 250 percent of the federal poverty level unless they meet a series of new requirements, which in fact no state can meet. We believe that the August 17th rules are inconsistent with Congressional intent and represent bad health policy. We have challenged the new rules in court. Nine states have joined us. At the same time, Congress passed legislation extending the SCHIP legislation and effectively overturning the new rules. The President vetoed the bill and we are now awaiting Congress' efforts to pass a new SCHIP bill that the President will sign. In short, we still do not know when or if CMS will approve our CHPlus expansion.

It is disheartening to see the federal government pulling back its support for health insurance and health care. Whether its children or rehabilitation services or sexually transmitted diseases provided under our family planning waiver or chemotherapy for certain immigrants, we are increasingly hearing from CMS that New York is on its own--

no federal matching funds will be available. The State does not have unlimited resources to fill in this growing gap. Without a real federal partner, New York's work to reform our health care system and move toward universal coverage becomes significantly more difficult.

Conclusion

This is a budget hearing, but much of this has been about broader policy issues. Let me bring this all back to the budget. We believe we need to invest money to improve coverage, access, safety and quality. We know that these investments must be funded out of current resources. Accordingly, cost containment and strategic reallocation of resources is a must.

We cannot deliver the coverage and care New Yorkers deserve without making smart choices. We know this will not be easy – we are facing a tough budget. But we cannot use that as an excuse to delay what needs to be done to ensure the health of the people of this state.