

Source:

[http://www.state.ny.us/governor/keydocs/0126071\\_speech.html](http://www.state.ny.us/governor/keydocs/0126071_speech.html)

Highlighted = added by NYSAAAA

**AS PREPARED FOR DELIVERY  
GOVERNOR ELIOT SPITZER  
THE NELSON A ROCKEFELLER INSTITUTE OF GOVERNMENT  
JANUARY 26, 2007**

## **“Patients First”**

### **An Agenda to Fundamentally Reform New York’s Health Care System**

In my State of the State Message, I pledged to reform our health care system to make health care affordable for each person, family, business, and for government.

Today, I will outline an agenda that begins to do just that. My Executive Budget will propose fundamental changes to reform and restructure our health care system – decreasing costs while increasing coverage. Our reforms will not only save taxpayers billions of dollars, but, most importantly, will lower the cost of health care while improving patient outcomes.

Our agenda is based on a single premise: patients, not institutions, must be at the center of our health care system. That means that every decision, every initiative and every investment we make must be designed to suit the needs of patients first. The result will be a high-quality health care system at a price we can all afford.

This guiding principle stands in stark contrast to the principle that has guided health care policy for the last decade. Instead of a “patient-centered” approach to health care policy driven by the needs and demands of New Yorkers, we have had an “institution-centered” system.

I am not saying that these other actors in the system are unimportant or irrelevant. Quite the contrary. They all have vital roles to play. But it is government’s job to make sure that the first need we consider is that of our patients.

For too long, government has ignored the inevitable changes in health care delivery, technology, financing and planning. For too long, we have stared at the opportunities posed by progress, and made poor choices or simply no choices at all. For too long, we have financed the health care system we have, not the health care system we need. So we’re left pumping billions of dollars into a broken system with no deliverables and no accountability.

This upcoming budget is designed to change all that. It is time, indeed the time is long overdue, to examine what went wrong and fix it.

## The Status Quo: An Institution-First System

What went wrong is that health care decision-making became co-opted by every interest other than the patient's interest. Government abdicated its responsibility to set standards, demand results and hold institutions receiving billions in state tax dollars accountable to the State and to the people those institutions serve.

Let me give you a few examples:

Take the Berger Commission. This was a process that should never have been necessary in the first place. In most industries, when the demand for a specific service falls permanently, as has the demand for long stays in hospitals, supply inevitably follows. Yet because of wasteful State subsidies and the State's failure to make strategic choices, tax dollars have been spent on empty hospital and nursing home beds instead of insuring our 400,000 uninsured children. Now we face dramatic instead of gradual change to rationalize a system in desperate need of reform.

These changes are painful – and we will use every effort to implement them in a way that is sensitive to patients, communities and workers. But because of the State's inability to confront the status quo, these are the kinds of hard choices we must now make to increase health care quality and decrease health care costs.

Another example of institutions driving the system is the way the State pays for graduate medical education. New York's Medicaid program has spent more than \$8 billion over the last five years on graduate medical education – \$77,000 per graduate resident in 2005 compared to similar states like California that spent just \$21,000 per resident.

This education is critically important, but we're currently funding it in an excessive and irrational way that isn't directly correlated to the actual students being taught – thus costing the State exorbitant amounts of money in what amounts to general subsidies to teaching hospitals. In fact, when we looked closer at this broken formula, we discovered that many of those dollars are going to pay for phantom residents and doctors who don't even exist.

The same lack of accountability has also been evident in the special subsidies the State gives hospitals to underwrite labor costs. In January 2002, with hundreds of millions in new revenue on the table for health care, the time was ripe for a debate on how best to invest this money. But instead of a public debate, the State committed billions of dollars in new spending to underwrite a portion of the increased costs of the hospitals' pending labor agreement.

As a result of this deal, well over \$3 billion alone was pumped into the health care delivery system with little to no accountability. Don't get me wrong: labor costs are real, and the need for training is real. What made this a poor choice instead of a wise investment is that the money was not based on the number of patients served and it didn't create a robust system of accountability for institutions that were growing out of control.

And take prescription drugs: Despite years of scare tactics used by drug companies to block progress, New York finally implemented a Preferred Drug List for our Medicaid program, a commonsense reform other states and the private sector have used for years to save money. Every year we delayed implementing this program, it cost us \$200 million. And once we finally did implement the program, it did not go far enough.

We must summon the will to do even more to lower drug costs. With the actions we will take in our upcoming budget to enhance the Preferred Drug List and ratchet down prescription drug costs, we will save an additional \$200 million each year.

All of these examples have one thing in common: Whether it was spending on unused hospital and nursing home beds, excessive levels of Graduate Medical Education support, subsidized labor agreements, or soaring pharmaceutical drug costs, no one asked the essential questions: is this the best use of this money for the *patients* in the health care system? And do these expenditures help transform the health care system from the one we have into the one we need?

Given that our health care policy decisions have been driven by institutions instead of patients, it cannot be surprising that New York spends more money on Medicaid per capita than any state in the nation – \$2,215, over double the national average. Our Medicaid budget costs taxpayers over \$45 billion each year, with more money going to hospitals and nursing homes than any state in the country.

And for all this money, what are we getting? The answer is far too little.

Despite leading the nation in health care spending, we are not leading the nation in results:

2.6 million New Yorkers, including 400,000 children, are uninsured.

New York has a higher percent of deaths due to chronic disease than any other state in the nation.

New York's nursing homes rank among the nation's worst in citations for placing their residents at immediate risk for serious injury or death.

Statewide, one in every twelve of our children is afflicted with asthma. And almost one in four is obese.

All of this money and this is what we're getting in return.

Let me be very clear: the problem with our health care system is not our dedicated doctors, nurses, aides and other health care professionals. It is certainly not people on Medicaid, all of whom are low-income and many of whom are the most medically vulnerable residents of our State – these are our children, our disabled, our frail elderly

and our chronically ill. The problem is a system – co-opted by entrenched interests – that resists making hard choices to change the status quo.

I was elected to change that. Here's how we will do it.

## **A Patient-First System**

My first Executive Budget will begin to implement a new Patient-First Agenda to lower the cost of health care while improving patient outcomes. To do this, we will shift money away from the institution-centered health care system of our past, towards a more effective patient-centered system for our future. In the process, this paradigm shift will save taxpayers billions of dollars in efficiencies. But it is our desire to lower the cost of health care and increase quality that drives our agenda, not some arbitrary savings figure to close a budget gap. From now on, health *policy*, not health *politics*, will guide us.

Let me outline the main features of our plan:

### **Health Insurance Coverage**

First, we will provide access to health insurance to all 400,000 of our uninsured children, making our first investment in the health care system to people, not to institutions. To do this, we will expand Child Health Plus to cover kids in families up to 400 percent of the federal poverty level, so that every family in New York will be able to provide their children with the health insurance they need.

And we will remove the bureaucratic hurdles that prevent vulnerable New Yorkers from getting on and staying on Medicaid. While implementing measures to guard against fraud, we will no longer require that families produce documents for continued eligibility of coverage, when the State can simply confirm that information from its own data.

These two steps will not only save the State hundreds of millions from reduced charity care in emergency rooms, but it will enable us to cut New York's uninsured population in half over the next four years.

But we won't stop there. As we achieve this goal, we will develop a plan for affordable, universal health insurance for all New Yorkers. To be clear, we cannot achieve this goal unless we first restructure our health care delivery system to lower health care costs. Otherwise, we will force an undue burden on families, businesses and government to cover the cost of universal coverage.

As more New Yorkers become insured and more health insurers play by the rules, hospitals and other health care providers will see increased revenue as well.

As we do all of this, we will demand that private HMOs and other health insurance companies also contribute to this effort. Our State Department of Insurance will demand a heightened level of transparency and accountability by reviewing regulations

concerning provider contracting requirements, the pre-certification process and technical denials. We will not tolerate gamesmanship that results in denial of care or delay in payment for care.

### Medicaid Reform

Second, as we expand coverage, we must reform Medicaid and the delivery system it supports. If we truly want to move toward universal health care coverage, **we cannot continue to fully subsidize the old system while we build the new one.** That's why we must **intelligently redirect and reinvest our Medicaid dollars to further reform.**

While we cannot complete the overhaul of our delivery system or fully rationalize our reimbursement system in the first year, we will start the process. **We will impose a freeze on the Medicaid rates paid to nursing homes and hospitals and a partial freeze on managed care plans.** New York spends more on hospitals and nursing home care than any State in the nation. This spending is unsustainable and unwise. We need to stop, evaluate and reallocate funds to more effective community-based settings instead of continuing to pour more money into a broken system. These freezes will be strategic. **Because we want to move the system toward a patient-centered model of care, we will not freeze rates to home care providers.**

But our reform effort must extend well beyond our reimbursement system. My upcoming budget will take the following steps to accomplish this patient-first Medicaid reform:

**First,** we will no longer pay for graduate medical residents who don't exist, freeing up money for uninsured New Yorkers who actually do exist. And while we will continue to invest in graduate-medical education at our academic medical centers and teaching hospitals, we will ensure that the GME system provides us with the value we want for the funds we invest.

**Second,** we will no longer use Medicaid dollars to bail out institutions for poor management decisions or pay for unrealistic labor deals or to underwrite inadequate reimbursement paid by Medicare and private health insurance companies. Medicaid will no longer cross-subsidize commercial insurers. We will not let health insurance companies get away with deep discounts that don't support the hospital services their members use.

Instead, the State will pay a fair reimbursement that reflects the true costs of providing high-quality care through a workforce whose needs are met fairly. And we will begin to redirect Medicaid money to those facilities that serve the bulk of Medicaid patients, which is where Medicaid dollars belong.

**Third,** we will no longer pay for out-of-control pharmaceutical costs. To do that, we must ensure that Medicare Part D plans cover the drugs needed by people on Medicare: seniors and people with disabilities. Once again, the State can't be the path of least resistance – allowing Medicare to shirk its responsibility. For example, EPIC, a vital

program whose resources must be protected, should be the insurer of last resort when identical coverage exists elsewhere that is not funded by New York's taxpayers.

We will also strengthen the State's Preferred Drug List. It has already saved the state millions of dollars without harming patients' access to medications. Increasing the use of clinical equivalents and other strategies already widely used by other states and commercial health plans will allow us to promote best practices among doctors and save money. Let me be clear on this last point: under our proposed system, physicians will always be able to ensure patients get the drugs they need. Beyond these changes in the budget, we will look at other ways to save costs, like bulk purchasing and the federal 340B drug discount program.

**Fourth**, we will buy health care in the right settings, at the highest standards and at the best price. We will start by addressing the way care is delivered for vulnerable patients with multiple medical needs, who require care across different systems. These are the people whose mental illnesses, substance abuse problems and diabetes or pulmonary diseases require coordinated care.

While there is much we can and will do administratively, we will also seek legislative authority to fund additional initiatives that zero in on this vulnerable population. It is the right thing to do clinically, and it is certainly the right thing to do financially. Medically complicated Medicaid patients make up 20% of beneficiaries but account for 75% of all Medicaid spending. With coordinated care, medically complicated patients get better care, their diseases are better managed – and, we estimate, taxpayers will save tens of millions of dollars from greater efficiencies over the next four years.

**Fifth**, we will expand the managed long term care program which has proven so successful in managing and coordinating long term care needs. As we know, the vast majority – our grandparents, parents, children or neighbors – want to live in their community and in their home. Yet this is another example where the demand for health care services has changed, yet the supply has remained the same. This successful program reaches less than 20 percent of the 100,000 people who could potentially benefit. Our actions will realize the potential – both in savings and in quality of care – of coordinated long term care.

**Sixth**, we will drive the implementation of health information technology, vital to improving quality, reducing bureaucratic barriers and saving money. We will invest in electronic health records, electronic prescribing, telemedicine and other innovative approaches. And, we will make certain that commercial insurers fully participate in reform of the delivery system.

**Seventh**, we will increase our efforts to ferret out Medicaid fraud, an insidious parasite that saps precious resources and hurts quality of care. We will increase our efforts in this area by not only devoting more resources to the Medicaid Inspector General, but will augment these resources by proposing to the Legislature a Martin Act for Medicaid and a

State False Claims Act – legislation that has saved the federal government billions of dollars since inception.

Finally, no patient-first health care strategy can be complete without a comprehensive effort to address public health. I will arm Dr. Daines and the Department of Health with the resources and the mandate to implement a strategy that targets primary and preventive care – resources that will go to support programs that decrease obesity rates and increase healthy eating and physical exercise, prevent childhood lead poisoning, expand access to cervical cancer vaccines, prenatal and postpartum home visits, and public health education on the quality of mammograms and other important issues.

To meet these challenges, we need a Department of Health that is organized to implement a patient-first agenda. We have already established an Office of Health Insurance Programs to bring together all of all our public insurance programs in order to coordinate, streamline and simplify these programs so they reach the maximum number of eligible people. And we will establish an Office of Long Term Care to zero in on efforts to expand options for long term care in the least restrictive, most integrated settings possible. We will continue to take these kinds of steps to remake our Department of Health into the preeminent health agency in the nation.

This is an ambitious agenda and I know that change, especially such fundamental change, will not be easy. But its time has come.

I want us to work together for a real solution, the main components of which I have outlined here today in this Patient-First Agenda. We will need partners to get this big job done – from individual New Yorkers whose paychecks are consumed by soaring health care costs, to businesses that want to lower New York’s cost structure, to health care workers who are a vital component to high-quality care, to taxpayers who are paying too much for a broken system of care.

Because for us to transform our broken health care system, we will have to come together as One New York. I know that those who have benefited from the status quo will fight hard to resist these necessary reforms. I hope we can convince them to become part of the solution. But, if we can’t, then I will do what the people elected me to do and fight for what I believe is right and for the good of all New Yorkers.