

**Confirmation Hearing  
Department of Public Health and Human Services  
Robert E. Wynia, MD  
February 7, 2005**

SENATE STAFF ADMIN.  
EXHIBIT NO. 1  
DATE 2-7-05  
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Madam Chair Squires, and  
Senator Balyeat,  
Senator Cocchiarella,  
Senator Cooney,  
Senator Ellingston,  
Senator Essman,  
Senator Gallus,  
Senator Laible,  
Senator Lewis,  
Senator Shockley,  
Senator Tropila.

I am glad the hour has finally arrived when you will make your decision regarding my tenure as Director of the Department of Public Health and Human Safety.

You have asked me to respond to the following questions: Why do I seek this position? What do I know about it? And what would I like to accomplish?

For a number of reasons, I have been reducing my private practice in Internal Medicine over the past several months. I decided to discontinue active private medical practice completely at the end of 2004. However, I was not ready for retirement. I was looking for a challenge wherein I could utilize my years of experience and expertise to positively affect patient choice, access, and quality of health care in Montana.

I have heard that some people consider me **too old** and fear that I do not have the energy to manage DPHHS. I believe that is a discriminatory and judgmental statement. I can't do anything about my age, and neither could Ronald Reagan when he was elected President at the age of 69. There are many examples of older people in charge of significant governmental organizations—such as Greenspan, Rumsfeld, the head of SEC, and within our own state, former Representative Francis Bardanouve of Harlem. I don't pretend to be the type of statesmen these people are and were, but they were my age and older, and they served their constituents well.

I have been on the job now for 25 workdays or 5 weeks. My days have been long, as have yours. Most weekends have been filled with work and study to learn the many facets of this large department. However, I have found this study in terms of reading, observing, listening and participating, to be extremely fulfilling and interesting. Deputy Director John Chappuis, who is a veritable expert in Medicaid and its nuances, has very generously shared his time and expertise with me. Division managers likewise have been available and eager to assist and teach me. Some have expressed the opinion that it is

good to have a physician director. When I have asked why, they say they believe it will give them direction and feedback on programs they develop. The Division Managers and Deputy Director are great and knowledgeable people, who are working hard to present our department overview and budget priorities to the Joint Subcommittee.

What I have learned is that the department comprises 2700+ employees, (950 in Helena, in 9 different buildings, all of which I have seen), 11 Divisions, 350+ programs, I would swear 5000 acronyms, and the responsibility for a 2.4 billion dollar biennial budget, a good portion of which comes from federal sources. As such, care has to be exercised in handling these funds to avoid losing the 3-1 and 4-1 match that they provide. When you look at the pot, it seems as though there should be money enough for everything. When you look inside the pot, you discover multiple smaller pots, all designated for specific programs. It's easy to think that we can transfer money from one program to another, but we can't without losing 75% or more of its value.

Can healthcare delivery and social programs be improved in Montana? You bet. Is our healthcare delivery system in need of reform? Absolutely! Is healthcare financing in need of improvement? Yes! Can legislators and politicians alone get the job done? Not even close! However, they can be the catalyst for a better tomorrow. Constructive and meaningful change begins in the boardrooms of hospitals, local organizations, profitable companies, and responsive and responsible government.

We all have a responsibility to help those who cannot help themselves and to provide training and education to those who can to get them back to work. That is the mission of DPHHS: to improve and protect the health, safety and well-being of all Montanans. People who are down and out must be given the opportunity to become productive members in their communities. Everyone knows we cannot mandate a solid human services program that works for everyone. It will take hard work, significant collaboration, and great vision. I believe I have the experience, tenacity, work ethic, and vision that can mold a formidable program all Montanans can be proud to be a part of. We need to reach out and touch Montanans.

I have **heard concerns that I will change the direction of the Department.** My position description reads that I am "responsible for overall management and coordination of programs." Those goals are accomplished through the efforts of the director's office and 11 divisions. I have learned that this is a very good department with people who care for one another and who work together to accomplish the task of providing a safety net for Montanans. We should be proud of them and thank them. One of my visions and goals will be to take this good department and make it one that all state departments of public health and human services would like to model themselves after. I believe it is an achievable vision and goal.

I have heard some concerns as to a physician's ability to manage the health department. A review of the directors of the 56 US State and Territory Health Departments, reveals that 62% of them are MD physicians. There must be a reason! In addition, there is one RN and one DDS director.

My visual concept of this Department is one that shows two strong arms (one Public Health, the other Human Services, supported by a strong trunk (Medicaid), as well as an open heart and mind. The arms are holding a safety net).

What can I bring to this equation?

Governor Schweitzer and I share a vision for developing and teaching preventive health care priorities. Given the obesity crisis, which affects children as well as adults, efforts need to be directed toward changing that health problem, which in turn is directly associated with Type II Diabetes, High Blood Pressure, High Cholesterol, and the increase in Heart Attacks and Strokes. Not to mention certain types of Cancer and Kidney failure. These are costly problems, which are easier and less expensive to prevent than to treat. In addition they adversely affect quality of life.

Evidence is conclusive that Obesity is paramount in causing disabilities in people by its effects on accelerating Cardiovascular disease and disorders, High blood pressure with consequent strokes, Type II Diabetes, Lipid disorders (Cholesterol) all of which promote early disability and death. We need to start changing this obesity trend in our youth if we expect to see clear and effective results. People seem to think that with the advances in diagnostics, technology advances, surgical interventions and pills, that they are at low risk for these events or that they can be cured. This is absolutely not true as evidenced by the soaring costs for procedures and technology to extend a low quality life for limited time. Congestive Heart Failure is a prime example of this. New technology costs of \$20-100,000 dollars to provide one month of poor quality life is not as effective as is preventing the cause of CHF and providing an active and quality life.

A graph that I saw several years ago while researching the value of preventive health, pointed out the truism of Public Health. Human lifespans in the late 1800s averaged in the 40s; there was a gradual increase in longevity over the years, even though the practice of medicine was very crude. In the late 1930s there was a definite and significant increase in our lifespan. This coincided with the advent of antibiotics. Infectious disease was then the main killer. Since that time, longevity has increased very slowly and the effects of technology and interventions in recent years have not done much to extend the life span. In essence, Public Health has done far and wide more to lengthen our quality of life and our lifespan than anything else. Now with our current lifestyles, lifespans are again beginning to shorten. So preventive health will be a sharp focus of mine.

I would like to quell any concerns that I will come in and change the focus or programs of the Department. The federal health agencies, such as the National Institutes of Health and the Centers for Disease Control, initiate the majority of state health programs. They do allow for local innovations in order to fit the programs to the demographics of the state. They do not generally pretend to know how any of their programs will work in a given locality. But we are required to adhere to the program basics. Otherwise we will be forced to relinquish federal funding.

Likewise the Medicaid program gets its direction from the Centers for Medicaid and Medicare Services. Some innovations are allowed, but primarily through Waivers, Grants and negotiations. If federal rules and regulations are not followed, the federal match can and will be lost. So there is little discretion in which programs we offer. Instead, I will work to improve their effectiveness and efficiency.

Over the years, a gap has developed between providers, physicians and the department—both in terms of the public health arena, but more significantly with the provision of services to our Medicaid population. I intend to try to narrow that gap. There are at least two ways I think we can improve our relationship. One is to develop systems to streamline the identification and certification of eligible Medicaid recipients, and by utilizing electronic billing to speed the correction and collection of billing charges (beneficial to both the department and the providers).

This will reduce some of the labor-intensive work for providers' staffs resulting in a cost saving. If we expect to keep the necessary providers (inclusive) we need to make every effort to lower their overhead and hassle, and improve and speed their reimbursement. With the combination of these two issues, increases in amounts of reimbursement may be controlled. All providers are seeing major cost increases in their ledgers and they need to cover these costs as a bare minimum in order to continue providing Medicaid services.

This concern about providers translates directly into a concern for all vulnerable Montanans. If we facilitate the Medicaid reimbursement process for providers, we help to ensure that there will be affordable health care available for all. If providers are unwilling to provide Medicaid services because of the hassle, then we have failed in providing access to our health care system for the needy and uninsured.

I intend to promote innovative changes to address this issue. One idea is to utilize an electronic card, which will at minimum prove the patient is eligible, and upon completion of the visit, will electronically evaluate the charge and provide payment.

Hopefully we will be able to extend this further by implementing a SMART CARD where the Medicaid patient can carry their DATA (PMH, FH, Social History, Allergies, Surgeries, Injuries, Current Dx and Medication use) with them at all times.

There is a need to develop a system to provide choice, access, quality and some semblance of controlled costs to those Montanan's who are uninsured or under insured. How do we do this? There is a program between the Department and Insurance Commissioner, John Morrison to utilize the HIFA Waiver to provide this to a group numbering between 15-20,000 uninsured now. This a small number in terms of the estimated 165,000 who need this assistance. However, it is a start and we need to pursue this effort.

There is another program, utilizing MSA's and or HSA's to provide pre-tax dollars for individuals who are determined to provide coverage for themselves and their families. Buying catastrophic health coverage \$3000-6000 deductible programs, should save on

premium dollars, especially for those in the younger age bracket. Couple this with cash for service to pay for outpatient and hospital visits, could save these individuals at least 40% of charges over those that are charged to insurance covered patients.

There are seven nations within the boundaries of Montana, and they are the Indian nations. Poverty, social, public health and individual health problems abound there. I grew up in Poplar on the Fort Peck Nation and personally witnessed these problems. I learned a lot about their cultural differences while growing up in Poplar, but also during my years of practice in Great Falls. We need to pay especial attention to these peoples needs. They do not want our sympathy, they need our assistance to overcome their problems, which are impacting their self reliance and self esteem. My past experience with them will help me visit their nations to establish effective ways to give them the assistance they need to improve their health and to pull themselves away from their poverty problems.

Another new and innovative program I would like to explore would be to provide a program wherein our medical wisdom is not lost because of the current and progressive improprieties of the Tort system. We have a significant number of physicians who are now retired or are nearing retirement. The cost of Medical Liability Insurance is without a doubt an impediment to their providing competent and intellectual services to a system in need. A proposal being developed by a Great Falls group is exciting and I'm willing to join them in their effort. Sen. Shockley is interested in developing an idea for an interim study of several access-to-care issues in Montana.

There are a lot of innovations that can save taxpayer time and money. As a physician with years of front-lines experience, I think I am uniquely qualified to serve as Director of DPHHS.

I certainly am excited about this chance to work with the department, the governor and you to make Montana a better place to live for all Montanans.

