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"Health Care Entitlements: The Road Forward"

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Chairman Baucus, Ranking Member Hatch and Senators of this august body, thank you for the opportunity to share some of my thoughts with you today.

Prior to 15 years of public service both in the legislative and executives branches in Washington and in Kentucky, I practiced primary care medicine. I am currently the chief executive officer for Alton Healthcare. Alton provides lean practice management, consultation, electronic health records and information technology development focused on primary care to provide more efficient quality care. To meet our goal for our patient to – *Live Longer, Live Healthier*, we focus on primary and secondary prevention including the detection and treatment of early microvascular disease in order to reduce heart attacks and strokes.

It is great to be back in these halls, I never lose my awe of this place.

Regardless of party affiliation, we all know that our health care system needed reform. We have coverage gaps, entitlement program spending is skyrocketing, and the cost of health care is far too high.

A concise way of stating a broadly shared goal is reflected in the Triple Aim: Better care, Better health, and Lower cost.

Political differences lie primarily in how we reach those noble goals and how we measure success.

It is not only those who serve us here in the nation's capital, but also those who serve closer to people's everyday lives that address the challenges of reaching these goals.

The Medicaid program is a prime example. And there is no question it needs reform to address access and to lower spending for both states and the federal government.

According to the actuary at the Centers for Medicare and Medicaid Services, taxpayers spent $404.9 billion on the Medicaid program last year and the size of the program will more than double to $840.4 billion by 2019. And by 2019, the state share of that spending will be almost $330 billion. Clearly, the costs of Medicaid put tremendous pressure on state budgets.

As with many other governors, in Kentucky I faced an empty rainy day fund and a projected debt of nearly 10% of the budget. As many states are doing today to solve even more challenging shortfalls, I had to examine the areas of the largest expenditures: healthcare and education.

It was quite a transition from my days here on Capitol Hill where I served on the House Energy and Commerce Committee. We could not borrow from the future nor could we print money. We examined bonding non-capital spending, but concluded that the resulting downgraded bond ratings with its higher interest rates would increase future debt payments and only compound the problem – a problem that has not only plagued those states that went that route, but also our nation.

Currently governors face a total projected shortfall of $175 billion over the next two years. The $151 billion in flexible emergency funding that the American Recovery and Reinvestment Act of 2009 (ARRA) provided has expired, and now governors across the country are facing deep spending cuts or tax increases to balance their budgets.

The *Washington Post* recently noted that states are facing "the most severe budget crisis since the Great Depression." The article also noted, "New York Gov. Andrew M. Cuomo (D) called his state 'functionally bankrupt' as he proposed closing most of a $10 billion budget gap by reducing funding for education and Medicaid."

Medicaid is the lion's share of that spending burden as it now consumes about 22 percent of state budgets now and will consume $4.6 trillion of Washington's budget over the next ten years.

Our national debt is mounting. In fact, if we do not change our course we will be paying more on the national debt interest than we spend on Medicaid within six years.

Governors also realize that Washington's own budget situation prevents it coming to the states' rescue yet again – our nation is in no position to bail out the states.

I realize that Washington is broke so there will not -- and should not -- be more state bailout money from Washington. But what states – and the federal government – need to do is take a hard look at how to lower Medicaid spending.

To meet the challenges of Medicaid in Kentucky, we began the long waiver process hoping for flexibility to do the right thing for our beneficiaries and taxpayers. While Section 1115 waivers hold the potential to give tremendous flexibility to states, these waivers can take years to obtain and are subject to the politics of a particular Administration. The time spent on obtaining those waivers from Washington could be better spent on solving our healthcare problems.

Then the Deficit Reduction Act passed in 2005. Kentucky and our neighbor West Virginia were the first states to take advantage of that Act. In Kentucky, with this newfound liberty, we were free to focus on healthcare instead of navigating through the regulatory jungle of outdated models of the past.

We were very pleased with the Deficit Reduction Act for Medicaid and SCHIP populations, and we established *KyHealth Choices* to increase service delivery choices for adults with developmental disabilities, acquired brain injuries, physical disabilities and for the frail and elderly. The new approach provided real choices around accessing long-term care services with an emphasis placed upon receiving the *right care, in the right setting, at the right time*. We introduced proven private health insurance principles, including utilization and intense disease management to ensure that appropriate services and drugs were provided based on medical necessity.

We took calculated business risks. Many of the programs included greater initial costs or reimbursement for services that were not traditionally covered in order to improve health outcomes for individuals and avoid more expensive future health expenditures. Consumer-directed care was a critical piece of encouraging more personal responsibility and involvement and offering more choice, freedom, independence and self-determination in Kentucky's assistance programs.

We tailored provider reimbursement increases to improve access and to insure quality physicians would care for our patients.

I am concerned that many of the flexibilities that allowed governors to innovative win-win solutions are being taken away piece by piece. Many of the successes we implemented in Kentucky may not be possible for other states today.

The maintenance of effort (MOE) requirement, which had never been a part of Medicaid, took away state flexibility to manage eligibility in their programs. States are prohibited from changing "standards, methodologies, or procedures," which is so prescriptive it prohibits states from even making program integrity modernizations.

I – along with the majority of current governors – support legislative efforts to repeal the MOE requirements in order to give governors the flexibility to target scarce dollars to the beneficiaries who need help the most.

Second, the Medicaid expansions in the Patient Protection and Affordable Care Act (PPACA) put what is simply an unrealistic burden on the states. For the Commonwealth of Kentucky, the Medicaid expansions are estimated to cost $675 million. And nationwide, they will mean at least a $118 billion new burden on all states through 2023. That means proven

programs like Kentucky's "Read to Achieve" which focuses on early childhood literacy is cut or eliminated. Without that help many of our children will fall into the abyss of hopelessness and failure.

Third, the Administration has proposed a new set of regulations for states looking for savings in spending on Medicaid providers. While the goal of ensuring access to care is noble, states need the flexibility to set their own rates in a manner that balances both their budget realities and adequate access.

When I was governor, we raised rates to certain providers. But sometimes it is the right thing –and the necessary thing – for governors to lower rates. States – not bureaucrats in Baltimore – are closest to Medicaid patients and providers and are in the best position to make those decisions.

On top of all of this, a court case that will be heard by the Supreme Court this fall could dramatically increase litigation and the associated costs for states. All of these issues make it increasingly difficult for governors to focus on tailoring their Medicaid programs in ways that meet the needs of their citizens.

Governors are close to the challenges and the problems. Give them the freedom to address the challenges, and they will find remarkable success and fair solutions. "Welfare to Work" – developed under the leadership of Governor Tommy Thompson, Mike Leavitt, and others – provided a proven model as Congress enacted bipartisan Welfare reform with President Clinton.

The innovation of the states freed to focus on caring for our vulnerable will result in solutions that meet our shared goals. I have found that often the folks working at our state capitols have worked on Medicaid for years and know many of the solutions, but must be given the freedom and tools to implement them.

My experience, as both a Member of the House of Representatives here and as a Governor back in my home state, is that top down, one-size-fits-all management from Washington does not work. However, setting expectations with clear goals, guidelines, and measured results will motivate and inspire leaders who will rise to meet the challenges.

The Obama Administration's healthcare overhaul is very prescriptive and allows little flexibility. It looks to Washington for the solutions rather than empower those on the ground across the nation who have their hand on the till to find solutions that match specific needs. Patients challenges in the hills and hollows of Appalachia are very different than those in inner city New York.

Having viewed Medicaid's problems as a family physician, as a legislator on Capitol Hill, and as the Governor of a state with unique health care challenges, I strongly recommend that you take the approach of a facilitator. You certainly have the power to take a dictatorial role, but that has not solved our problems in Medicaid; in fact, it has made them worse.

Medicaid is not working very well. Not only do waste, fraud, and abuse plague our current system, but the program does not serve patients well. I know this as a family physician who has treated patients from all walks of life, and I know this as someone who studies the latest peer-reviewed medical literature.

For example, a study published recently in the *New England Journal of Medicine* found "found significant disparities in provider acceptance of Medicaid–CHIP versus private insurance across all tested specialties." Specifically, the study found that "Overall, 66% of Medicaid–CHIP callers… were denied an appointment as compared with 11% of privately insured callers … Among 89 clinics that accepted both insurance types, the average wait time for Medicaid–CHIP enrollees was 22 days longer than that for privately insured children."

In some research, even patients without any insurance do the same or better than those on Medicaid.

According to a 2010 study in the journal *Cancer*, Medicaid and uninsured patients with cancer of the throat were 50 percent more likely to die than privately insured patients.

According to a 2011 study in the *American Journal of Cardiology*, Medicaid patients undergoing coronary angioplasty were nearly 60 percent to have major adverse events than privately insured patients.

According to a 2011 study in the Journal of Heart and Lung Transplantation, certain Medicaid patients undergoing lung transplants had a significantly lower 10 year survival rate compared to privately insured and even uninsured patients.

And these studies represent only the treatment failures. They do not begin to address wellness and prevention shortcomings.

There are solutions to these problems that states understand better than any bureaucrat, and need only the freedom to implement these proven innovations.

For example, in Northern Virginia's Care First Plan by Anthem, CEO Chet Burrell with his team is making a real difference.

They stratified their patients and, according to Chet Burrell, found that:

- Those with "Advanced Illness" constitute 3% of the population and accounted for 29% of the cost.
- 7% had Multiple Chronic Conditions and accounted for 23% of the cost.
- 10% were defined as "At Risk" and accounted for 19% of the cost.
- 30% were defined as "Stable" and accounted for 22% of the cost.
- The remaining 50% were defined as "Healthy" and accounted for only 7% of the cost.

They hired Regional Care Coordinators and Local Nurse Coordinators to work with Primary Care Physicians to focus on the most ill.

They have seen not only better care but also lower costs.

They share realized savings with the Primary Care providers, and this incentive is working.

They recognized that only 6 percent of healthcare spending goes to pay primary care and yet primary care physicians make the two most important decisions: when to refer and to whom to refer.

Another example was the subject of a *New Yorker* magazine article back in January entitled "*The Hot Spotters.*" It is about a primary care doctor, Dr. Jeffrey Brenner in Camden, New Jersey, that dared to be different.

His calculations revealed that 1 percent of the hundred thousand people who made use of the Camden's medical facilities accounted for 30% of the cost.
Fighting the bureaucracy hampered and slowed his progress, but he eventually got access to the information on patients he needed.

Dr. Brenner and his Camden Coalition have been able to measure long-term effect on his first 36 super utilizers: "Those patients averaged 62 hospital and ER visits per month before the program and 37 after joining. Their hospital bills averaged $1.2 million per month before and just over half a million after--a 56% reduction."

Another model, the patient-centered medical home is being piloted across the country and is proving to provide better care and in some cases realize savings of up to 20 percent. The new health care law makes cursory mention of the medical home on one hand, but takes away flexibility to effectively implement it on the other.

As these examples illustrate there ***are*** some proven models to save cost and deliver better care, but states currently do not have the flexibility to prioritize their limited dollars.

Without the flexibility states may not be able to direct money from mandated areas to take advantage of these proven models. And states may have to follow Washington's prescriptive regulations that could thwart implementation of an otherwise good idea.

Earlier I mentioned education and healthcare as the two frequently targeted areas when having to make budget cuts, and Governor Cuomo referenced these as targeted areas of budget cuts for New York. The fact is that governors have few choices now of where to save money and with mounting Washington mandates they will have even fewer.

The ability to make targeted cuts and to tailor programs is important – not only because they are the big-ticket spending items in a state budget, but also because they are interrelated. Poorer healthcare reduces school performance, and lower educational levels are associated with poorer healthcare outcomes.

When mandates further limit states by requiring them to spend money in a prescribed way it strangles innovation. Flexibility will give them a choice to implement innovative methods that can truly save money, provide better services to their constituents, and target scarce resources to the most vulnerable in our society. Reform does not have to be the zero sum game that health care reform has created.

PPACA established a Center for Innovation within CMS to talk about transforming our broken fee-for-service system and addressing the worthy goal of promoting innovation. However, the problem is that this Center is premised on the flawed idea that innovative solutions must come from bureaucrats in Washington.

This Obama Administration's signature delivery system reform – Accountable Care Organizations – was modeled after high-quality, integrated care facilities across the country like Geisinger and Mayo. But when CMS tried to proscribe this private-sector innovation through a 400 plus page rule, even the Geisingers and Mayos of the world told Washington it would not work. Washington is in no better position to develop solutions for each state's unique Medicaid program and patient populations. When it comes to Medicaid, solutions best come from States who are closest to the needs and challenges of their citizens.

Medicaid is in dire need of reform. It is bankrupting both states and the federal government, while failing patients. I recommend eliminating restrictive mandates, such as the maintenance of effort requirements, and granting the states the freedom to be creative and implement what works. More broadly, Washington should establish clear goals, guidelines, and defined budgets, but then empower 50 sites of innovation across the nation.

You will be providing the most vulnerable a much better healthcare system.