Testimony of Daniel Baxter, MD
Chief Medical Officer, William F. Ryan Community Health Network
House Committee on Ways and Means
Hearing on "Health Reform in the 21st Century: Proposals to Reform the Health System"
Wednesday, June 24th, 2009

Chairman Rangel, Ranking Member Camp, Distinguished Members of the Committee:

Thank you for the opportunity to testify before the Committee today, and thank you for all of the hard work that each of you has put into the crucial task of reforming the nation's health care system. My name is Daniel Baxter, and I am a board-certified internist and the Chief Medical Officer of the William F. Ryan Community Health Network, one of the oldest health center organizations in the country, and one of the largest in New York. As with many of the 18 million patients served by nearly 1,200 health centers across the country—including the districts of most members of this Committee--the vast majority of Ryan's patients represent those groups most often left behind in our health care system, including the poor and working poor (80%), racial or ethnic minorities (75%), those publicly insured, and—perhaps the most rapidly growing segment of patients—those who have no insurance at all. In fact, in the last year alone, the percentage of patients at the Ryan Center with no health insurance rose from 20% to 35%, and 24% of Ryan Network patients were at 151 percent of the Federal Poverty Level or above, an historic high. At our Center, in our waiting rooms and exam rooms, and in the faces of our patients we are privileged to serve, we witness the urgent need for fundamental health care reform every day.

"Safety Net" Providers and the Role of a Public Plan

From the perspective of the nation's health centers, our current public programs are uniquely qualified to meet the needs of our most vulnerable communities. Patients can access not just primary care, but a full spectrum of services tailored to meet their individual and family needs, including specialty care, case management, and transportation and language assistance, as well as dental care, mental health services, and prescription assistance programs.

For all of these reasons, **we strongly support the inclusion of a public plan option as part of any health care reform proposal this Committee recommends**. Not only are current public programs the only insurers that cover our low-income and medically underserved citizens, they are also the only payers that recognize the unique role of "safety net" providers such as community health centers, and are the only insurers that pay us adequately. By contrast, nationwide, the private insurance market pays health centers less than 50 cents on the dollar for the comprehensive primary care they deliver to the 3 million privately-insured patients they serve. For example, at the Ryan Center, we have been forced to drop certain private insurance plans, due to unsustainable revenue losses from treating patients covered by these plans. Moreover, these plans are often high-deductible, limited-benefit plans made available to the low-income workers we see at our center. It is our strong hope that as more and more patients gain coverage, a new public plan will follow the example set by *current* public payers, by reimbursing health centers and other safety net providers **appropriately** and **predictably** for the care they provide. Finally, as already provided in the Committee's proposal, it is critical that insurers enrolling people in underserved communities be required to include in their networks health care providers located in those communities.

Apart from the very real and serious challenges America's community health centers face in the current health care environment, there is an over-arching, urgent need for comprehensive health care reform, which can wait no longer. As the Committee well knows, the current system is unsustainable, irrational, and obscenely wasteful, and any failure to change it portends a bleak future where *real* rationing of care will become the rule. At the Ryan Center, it is a common daily occurrence to see new patients who, because of prior lack of access to basic primary health care, including preventive care, present with serious long-term complications of treatable diseases such as high blood pressure and diabetes. Moreover, it is also a very common daily occurrence to care for uninsured patients who cannot afford medically necessary,

but costly, out-patient hospital investigations such as MRIs or cardiac stress tests. With transparency, accountability, proper regulation and regular monitoring, a public health care plan will devote precious resources to ensure efficient and cost-effective care for such patients, without being preoccupied with the need to balance appropriate medical care against profits.

The Clinician's View of Health Reform

As a clinician for almost 35 years, I am especially intent on America having health care reform which is both efficient and cost-effective. I can attest to the adage that the most expensive piece of medical equipment is a pen in the hand of a doctor. I strongly support any plan to establish panels of recognized clinical experts to clarify for front-line practitioners important evidence-based "best clinical practices," as a reference point which will help restore rationality, integrity, and common sense to medical care. However, such clinical guidance alone is not sufficient to diffuse the fearsome costs of modern medical practice: the knowledge of "best clinical practices" must be accompanied by a system that recognizes doctors who in good faith follow these practices and improve quality of care, as well as by credible reimbursement for primary and preventive care. This three-pronged approach—guidance for "best clinical practices," integration and recognition of those who strive to improve quality, and fair reimbursement for primary and preventive care--will save untold billions of dollars in wasteful, unnecessary, and often dangerous medical care.

Health Centers as "Medical Homes"

In discussions about reforming the health care system, the imperative across all platforms and all proposals must be a serious and credible investment in **accessible, affordable, high-quality primary care for all,** as a down payment on a more effective *and* efficient health care system. I say "investment," because we know that comprehensive primary and preventive care saves untold billions of dollars on down the line, and that, paradoxically, with medical care, "less can often be more"—that is, thoughtful care supported by evidence-based, best medical practices,

as above, ensures both good health *and* significant cost savings. Currently, 60 million people in America—the "medically disenfranchised"--lack consistent access to primary care. They and millions of others who confront additional barriers to care require a source of regular, primary and preventive care, a "medical home," to maximize the value of our investments in health reform.

For more than four decades—long before the term became fashionable--community health centers have routinely practiced a model of care that has provided a genuine "medical home" for their patients. Even though many patients have complex health problems, including daunting psychosocial issues, community health centers have demonstrated a record of quality care and cost control unmatched in the health care system. **I want to applaud the House proposal for recognizing the need not only to preserve this system of care, but to expand the "medical home" model to communities nationwide, through increased funding for the Health Centers Program as part of the new Public Health Investment Fund, and through the "medical home" demonstrations in the bill.**

Strengthening the Primary Care Workforce

As coverage expands, we must also ensure that patients have access to doctors and other health professionals. The National Health Service Corps is a vital tool for recruiting new clinicians, and Committee's proposal would effect an historic investment to the NHSC, and thereby encourage thousands more practitioners to practice in medically underserved areas.

The Ryan Center is an active participant in several different primary care residency training programs, as well as a training site for City University of New York's Sophie Davis School of Biomedical Education. We recognize the importance of doctors-in-training gaining experience in community-based settings with underserved patients. However, to achieve this goal, health centers across the country must have financial support for such training, since the direct and indirect costs of such training are often prohibitive. The Committee's proposal invests

significantly in primary care workforce training, particularly the National Health Scholars Program and graduate medical education in primary care, and recognizes that community health centers must play an important role in primary care training.

Conclusion

Mr. Chairman, and Honorable Members of the Committee, daily I see patients who personify the importance of what this Committee is trying to do, and who remind me of the urgency of bringing fundamental reform to our health care system. Community health centers across America are proven, established, cost-effective models that can bring their considerable experience and expertise to solving many of the challenges facing our current system.

Every congressional session is *a priori* historic, but I am certain that we all can agree that, with regard to the magnitude of the problems we face with our current health care system, this session will be truly historic. Thank you, Chairman Rangel and other members of the Committee, for your willingness to undertake such an enormous and challenging task. America's community health centers stand ready to provide you support and guidance, as you negotiate final proposals in the coming weeks and months. Thank you for your time and attention, and I'd be happy to answer any questions you may have.